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## Introduction

Following the impetus of the grand and middle-range theories' development eras, a considerable drop in theoretical analysis was noted in the discipline (Chinn, 2019; Im, 2015; Oermann & Jenerette, 2012; Yarcheski, Mahon, & Yarcheski, 2012). As Im (2015) pointed out, the nursing theory evaluation movement that started during the years 1960 and 1970 seems to be slowed down. This is evidenced by a very small number of theoretical evaluations (Bohner, 2017; Valentine, 2014) identified in the nursing literature of the last decade. The declining use of nursing theories in research probably contributes to this phenomenon (Barrett, 2017; Jensen, 2019).

As asserted by Smith and Parker (2015), "the major reason for structuring and advancing nursing knowledge is for the sake of nursing practice" (p. 8). A nursing theory is reputed as useful to nurses if it provides clarification to the purposes, processes, and outcomes of their practice (Smith & Parker, 2015). In content presented in educational programs, nursing theories may develop students' professional identity and understanding of their contribution to patients' health (Pepin, Ducharme, & Kérouac, 2017). Evaluating nursing theories appears relevant to the pursuit of these practical and educational matters.

The purpose of this article is to describe and critique a French-Canadian conceptual model of nursing, the Humanistic Model of Nursing Care–Université de

Montréal (HMNC-UdeM) elaborated by Cara et al. (2016), based on Chinn and Kramer's (2018) description and critical reflection of empirical theory. This method was chosen over others (Alligood, 2018; Fawcett, 2005; Meleis, 2012; Parse, 2005; Risjord, 2019), because it focuses "… on asking questions to consider in relation to (the researchers') purposes, rather than a standard that a theory is expected to meet" (Chinn & Kramer, 2018, p. 202). As some authors of this paper also contributed heavily to the development of the HMNC-UdeM, Chinn and Kramer's (2018) method was judged more suitable, as it can be an opportunity for further expansion and refinement of this conceptual model of nursing.

**Background of the HMNC-UdeM**

In 1995 before the HMNC-UdeM was developed, the Faculty of Nursing of the Université de Montréal (FN-UdeM) in Quebec, Canada espoused the concepts related to the caring school of thought as a disciplinary perspective for its undergraduate program (Cohen, Pepin, Lamontagne, & Duquette, 2002). Dr. Chantal Cara, who completed her doctoral thesis under Dr. Jean Watson's supervision (Cara, 1997), devoted her career to caring science and supported its integration at the FN-UdeM. In late 2009, Dr. Cara was solicited by the former dean of the FN-UdeM, Dr. Francine Girard, to develop a more pragmatic conceptual model of nursing grounded in caring (Girard & Cara, 2011).

One purpose was to help nursing students and graduate nurses better understand caring's humanistic underpinnings. Eight focus groups were held with professors, clinical nurse specialists, nursing directors, graduate students, and patient partners throughout a 2-year process of creation of the HMNC-UdeM that followed (Cara et al., 2016). When the HMNC-UdeM was created, it influenced the revision of the nursing care plan utilized

by undergraduate students (Faculté des sciences infirmières de l'Université de Montréal, 2012) and the actualization of the baccalaureate's competencies framework (Faculté des sciences infirmières de l'Université de Montréal, 2015), both important to the FN-UdeM's undergraduate program. These efforts sought to inspire nursing students' becoming humanistic and caring practitioners.

**Method of Conceptual Model Development**

Chinn and Kramer (2018) proposed 11 questions (Table 1) for describing and critically reflecting on a nursing theory. Rather than insisting on a specific method (i.e., literature review, focus groups, or interviews), these meta-theorists suggested a sound analysis based on multiple and iterative readings to clarify the concepts included in a conceptual model. In this perspective, Chinn and Kramer stated that "describing a (conceptual model) is a process of posing questions about the components of the (conceptual model)," as suggested by the HMNC-UdeM, then responding to the questions with your own reading" (Chinn & Kramer, 2018, p. 190).

The authors of this paper read five articles (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011) iteratively and thoroughly, and analysed the content that would inform the conceptual model's purpose, concepts, definitions, relationships, structure, and assumptions (Chinn & Kramer, 2018). Following a similar process by Bohner (2017), a word-processing software was used to extract and summarize data (sentences and paragraphs) as a means to "make the content of the (documents) accessible and comparable" (Bohner, 2017, p. E4). Bohner's approach formed the basis for answering the questions (Chinn & Kramer, 2018) pertaining to the

critical reflection, and the reviewed documents were also used to enhance this reflexive process. These documents will be briefly presented in the next section.

## Article Review

Despite formal development in 2011, the HMNC-UdeM is still in its early stage of development. In the past 8 years, this conceptual model has been created (Girard & Cara, 2011), refined (Cara & Girard, 2013; Cara et al., 2015), and presented at several conferences. One of the conferences (Cara, 2017) was recorded and available online; hence, it was included with four other documents for the purpose of this conceptual model development: 1) first official publication (Girard & Cara, 2011), 2) a poster (Cara & Girard, 2013), 3) a synopsis (Cara et al., 2015), and 4) an article (Cara et al., 2016). The next section is organized according to Chinn and Kramer's (2018) 11 questions and because of space limitation, elements of the discussion will be added to this section rather than being in a separate one.

## Conceptual Model Description

### *Purpose*

One of the reasons the HMNC-UdeM was developed was to create a pragmatic, conceptual model of nursing easily understood by nursing students and graduate nurses (Cara et al., 2016). The model (Cara & Girard, 2013; Girard & Cara, 2011) was expanded to integrate humanistic nursing practice into different areas, education and administration, as a strategy to contribute to the discipline and the profession of nursing.

Earlier publications used to analyse the model referred explicitly to a vision (Cara & Girard, 2013; Girard & Cara, 2011), whereas others described goals, objectives (Cara,

2017; Cara et al., 2016; Girard & Cara, 2011), or the nurse's role (Cara et al., 2015). The HMNC-UdeM's most repeated purpose is the excellence of nursing care grounded in humanism and caring, based on a collaborative nurse-patient relationship, and demonstrated by competency, commitment, and accountability (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011).

Some differences were noted when reviewing objectives in the first document describing the model (Girard & Cara, 2011). These objectives may not be included in the structure of HMNC-UdeM; some are general rather than specific. For instance, the first objective, to conceive a nursing practice congruent with the definitions of the HMNC-UdeM's concepts, is a broad statement (Girard & Cara, 2011). Some objectives were eliminated and others were replaced by examples of attitudes and behaviors compatible with the values and the assumptions of the HMNC-UdeM.

In two definitions of the conceptual model's concepts, aligned with the metaparadigm (health and nursing), nursing contributes to the patient's health, more specifically well-being, more-being, and harmony (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011). This clinical purpose remained, for the most part, stable over time. Only slight variations in the vocabulary used were observed.

### *Concepts in the conceptual model*

Chinn and Kramer (2018) argued that concepts need to be sorted by nature (empirical or conceptual) and organization (major or minor). See Table 2 to review the concepts of the HMNC-UdeM that are supported by the five reviewed documents. Six

Major concepts within the HMNC-UdeM are person, environment, health, nursing, and core concepts, caring and competency. They are also found in Figure 1.

A number of minor sub-concepts are included in the HMNC-UdeM, identified in the documents reviewed in this analysis (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011). All concepts, major and minor, are regrouped and located in Table 2. When a concept was referred or alluded to in documents, "presented" was indicated; "defined" was used when a definition was also provided or when it was possible to infer one implicitly from the text; "examples" was stated when they were offered by the model's authors. "Absent" means that the concept could not be found in the document. In this perspective, the present authors identified 23 minor concepts, outnumbering the six major concepts.

As shown in Table 2, some inconsistencies were identified among the HMNC-UdeM's minor concepts. For instance, "transition" was a concept originally found in Girard and Cara (2011) as a type of lived experience by the person. It was not found in subsequent documents. Some concepts, such as "resources" and "strength," only appeared in late documents (Cara et al., 2016; Cara et al., 2015). Several concepts were more abstract (less empirically grounded), such as "humanism," "harmony," or "values;" others, for example "reflective practice," "well-being," "attitudes," or "behaviors," are concepts with the potential for empirical assessment with further development. Other concepts such as "potential," "power to act," "resources," and "strengths" suggested a similar idea, but because none of them were explicitly defined, it may be difficult for readers to grasp the different images they represent (Chinn & Kramer, 2018). A comparable pattern was observed with "needs," "priorities," "concerns." Overall, the

HMNC-UdeM focuses on broad concepts (i.e., caring), meaning it can "be applicable to a very wide range of situations" (Chinn & Kramer, 2018, p. 193) as expected for a conceptual model of nursing.

***Definitions of the conceptual model***

According to Chinn and Kramer, "a definition is an explicit meaning that is conveyed for a concept" (2018, p. 194). As for the six major concepts of the HMNC-UdeM, all documents analysed provided an explicit definition, that overall was consistent. The concept of "person" is defined as an individual, a family, or a community in an interaction with his/her "environment." "Health" is repeatedly conceptualized as unique to the perspective of the "person," whereas "nursing" corresponds to humane assistance.

Coherence is also present in the concepts of "caring" and "competency," which are respectively defined as: 1) a commitment to develop a reciprocal relationship with the "person," and 2) as the integration of a set of competencies that develop with the nurse's knowledge and experience. Several minor concepts are not defined, either explicitly or implicitly. Of 23 minor concepts, 10 are defined and those definitions are located in the synopsis (Cara et al., 2015) and in the article (Cara et al., 2016). These 10 defined concepts are as follows: "humanism," "well-being," "more-being," "harmony," "dimensions," "reflective practice," "meaning," "values," "attitudes," and "behaviors." Two minor concepts are implicitly defined in the text ("dimensions" and "meaning") and other definitions are explicit. Because of space limitation, Table 3 summarizes definitions of major concepts.

Because minor concepts are chiefly defined in two documents (Cara et al., 2016; Cara et al., 2015), it reduces the odds of finding variations. However, a second definition

of “humanism” was found in the synopsis (Cara et al., 2015). In this document, “humanism” was said to privilege values of respect, human dignity, recognition of the integrity, and freedom of choice of the person and belief in his/her potential (Cara et al., 2015). Although this definition highlights humanistic values, another provided by Cara (2017) focuses on “an approach centred on the Person, his/her experience, his/her meaning, and his/her relationships” (p. 11). The two definitions do not convey the same idea; they might complement each other. A clarification of this issue could benefit the HMNC-UdeM in future publications.

Chinn and Kramer (2018) described general or specific concept definitions. A “specific” definition can: 1) be associated to an empiric experience, 2) define what a phenomenon is, or 3) provide possibilities for empiric indicators that represent the phenomenon (Chinn & Kramer, 2018). The authors believe that definitions in Table 3 represent general meanings. For example, “everything that surrounds the Person” (see “environment” in Table 3) is too broad to describe an empiric experience or to develop indicators. Concepts that convey general meanings are not necessarily inferior because they might be “preferred in (conceptual models) that are not likely to be empirically tested” (Chinn & Kramer, 2018, p. 195) such as the HMNC-UdeM.

Two publications (Cara et al., 2016; Cara et al., 2015) provided examples of “humanistic attitudes” and “humanistic behaviours,” for instance “wanting to be attentive to the Person with sincere listening, openness, and presence” (see “humanistic attitudes” in Table 4). It is possible, with further work, to develop empirical indicators. These indicators might be useful in building an assessment tool similar to the one created by Cossette, Cara, Ricard, and Pepin (2004) to assess caring interactions.

### *Relationships in the conceptual model*

According to Chinn and Kramer, "relationships are the linkages among and between concepts [and] the nature of the relationships in (conceptual model) may take several forms" (2018, p. 195). These meta-theorists added that the nature of these relationships may be descriptive ("projects what something is or the features of its character"), explanatory ("suggests how or why it is") or predictive ("projects circumstances that create or alter a phenomenon") (p. 196). The definitions of major (Table 3) and minor concepts were used to identify those relationships as well as the 5 reviewed documents (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011) for other sentences that could convey said relationships.

These relationships were then classified as "descriptive," "explanatory," or "predictive" based on the aforementioned explanations (Chinn & Kramer, 2018). First, 11 descriptive relationships were identified, for instance "The Person is composed of inseparable dimensions." Second, the present authors recognized 10 explanatory relationships, such as "caring consists in developing links of reciprocity with the Person in order to promote his/her health." Third, there were 8 predictive relationships that were noticed, for example "humanistic values influence attitudes, which guide the nurse's behaviors," On these 29 relationships, 13 necessary to understand the next sections in this article are presented in Table 5 and italics are added to highlight concepts in the statements.

### *Structure of the conceptual model*

The structure represents the form of the conceptual relationships from which they emerge within the conceptual model (Chinn & Kramer, 2018). Because the HMNC-

UdeM has multiple concepts, hence several relationships, representing this conceptual model as a sole, coherent pictorial structure is difficult without creating a maze of links. It also is challenging to understand the relationships between the major concepts of the HMNC-UdeM as shown in Figure 1 (Cara & Girard, 2013). In this respect, it is possible to suppose that "caring" and "humanism" serve as foundations to the HMNC-UdeM, because of their position at the bottom of the illustration, and that the "person" is considered to be at the center, which in turns can convey a "person-centered approach." Likewise, the duplication of "environment" (left and right) might have been done for aesthetic purposes or to reflect how it is surrounding the "person" (see Figure 1). Most of the relationships presented in the previous section are not demonstrated in this illustration. This interpretation of the HMNC-UdeM's structure remains hypothetical, because it is difficult to retrieve an explanation in the reviewed documents of the meaning of this compass rose shape or the reasons it was chosen to represent the four concepts of the metaparadigm and the two core concepts.

The last found illustration (Figure 2) originated in the synopsis of the HMNC-UdeM (Cara et al., 2015) where many described relationships between concepts are shown. In this figure, 6 out of 29 relationships are properly represented (surrounded by blue dotted lines), and 7 relationships are partially portrayed (green dotted lines). Some relationships cannot be illustrated because some minor concepts, such as "potential," "well-being," "more-being," are missing.

There are four elements that may be critiqued regarding this network of relationships in Figure 2. First, the compass rose containing the four concepts of the metaparadigm has been retained to remain consistent with other documents, even if this

leads to a duplication of these concepts in the Figure's left side. Second, some double-sided arrows indicate a reciprocal relationship between two concepts that may not be adequate. For instance, "nursing contributes to health" seems correct, but "health contributes to nursing" might not be the best statement to represent how the patient's health might influence nursing care. Third, "knowledge," a concept not salient enough to be considered as a "minor concept" in this paper, is not only colored differently, but is repeated twice. The repetition can be explained because there are slight differences in the meaning of this term in the French language that are harder to communicate in the English language. Fourth, the patterns of knowing on the upper right corner of the Figure are not visually represented in a way coherent with the meta-theorists (Chinn & Kramer, 2018). Indeed, the emancipatory pattern of knowing could be more prominent, given its vital relationship with the other patterns, and arrows between them could perhaps be added to reflect their connectedness and interinfluence (Chinn & Kramer, 2018).

Because there are a number of concepts in the HMNC-UdeM, reconciling all existing relationships into a coherent structure is challenging. Yet, an implicit and coherent hierarchy is revealed by shapes, sizes, and colors regarding the HMNC-UdeM's major concepts. The Figure connects the majority of the concepts (minors included) into one network. However, a more parsimonious diagram could convey the HMNC-UdeM's most important relationships and ideas.

### *Assumptions of the conceptual model*

Assumptions are "those basic givens or accepted truths that are fundamental to theoretic reasoning" (Chinn & Kramer, 2018, p. 199). According to Chinn and Kramer, some assumptions may be confused with relationship statements, but they are believed to be

separable. The authors of this paper are convinced that some assumptions of the HMNC-UdeM remain embedded in several concept definitions and relationship statements. For instance, “the Person is composed of inseparable dimensions” is a descriptive statement linking the concepts of “Person” and “dimensions,” but it could be argued that it also represents an accepted truth within the HMNC-UdeM. Considering that Chinn and Kramer (2018) insist on differentiating assumptions from other aspects of a conceptual model, and because of space limitation, explicit assumptions embedded in concept definitions and relationship statements were not included in this paper.

Chinn and Kramer (2018) asserted that assumptions can be factual (potentially knowable through perceptual experience) or inherent to values (imply what is right, good or ought to be). Owing to the fact that the authors of the five reviewed documents (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011) did not declare explicitly the HMNC-UdeM’s assumptions, all components of this conceptual model (i.e., purposes, concepts, definitions, relationships and structure) had to be examined again in order to identify implicit assumptions. They are summarized in Table 6.

In the HMNC-UdeM, it is implied that a nurse cannot reach professional competency without being caring. In other words, an uncaring nurse could not possibly achieve professional competency because this statement would become incoherent with the HMNC-UdeM’s central purpose, the excellence of nursing care grounded in humanism and caring (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011). Perhaps it would be valuable to state this assumption clearly in the future. Otherwise, the HMNC-UdeM emphasizes the meaning given by patients to

their health experience to the extent that it might be a desire from the perspective of patients as well as from a professional standpoint. This explanation also applies to the importance given to establishing links of reciprocity within the HMNC-UdeM. It is assumed that nurses may seek those links with patients and that this is also sought-after in nursing practice.

In the next section, the HMNC-UdeM will now be examined through the critical reflection processes of Chinn and Kramer (2018).

## Critical reflection

### *Clarity of the conceptual model*

The clarity of a conceptual model refers to how well its ideas are understood by readers and the extent to which those ideas are consistent (Chinn & Kramer, 2018). Additionally, they divide clarity into four elements: semantic clarity, semantic consistency, structural clarity, and structural consistency.

#### Semantic clarity

Semantic clarity depends on the definitions of concepts, borrowed terms, coined or varying words for the same intended meaning and self-explanatory illustrations (Chinn & Kramer, 2018). As previously stated, only 10 out of 23 of the HMNC-UdeM's minor concepts are defined, which in turn obscures semantic clarity. It could be profitable to define and use a different term other than "resources" in the context of "person" or "competencies" because it seems that this concept shares a double meaning. First, it is implied that "resources" are aspects held by the "person," which is the reason why it was identified as a minor concept. Second, "resources" are alluded to as components of

"competencies;" this might lead to confusion, hence interfere with semantic clarity. Moreover, semantic clarity could be improved if concepts such as "potential," "power to act," and "strengths" were defined because their subtle differences are left to the readers' interpretation. The same comment applies to the concepts of "needs," "priorities," and "concerns," A definition of the concept of "experience" would be valuable because it appears to be used in different ways: "lived experience", "health experience", "illness experience", "personal and professional experience", and "acquired experience". On that account, Chinn and Kramer (2018) caution that excessive verbiage reduces semantic clarity. When "caring" is said to be both an art and a science (Cara et al., 2016), it appears that the meaning given to those two aspects remain unclear for the readers. It could be asked whether caring is displayed when a nurse crafts his or her practice in an artful way, or if it has a meaning close to what is intended by Chinn and Kramer (2018), with the aesthetic pattern of knowing. Besides, "caring" viewed as a science could refer to a body of knowledge (i.e. caring science) or it could indicate that knowledge pertaining to caring would be required in order to be caring with patients. Semantic clarity would most likely be strengthened if "art" and "science" were to be explicitly clarified in the context of "caring", even if the authors (Cara et al., 2016) specified that they were drawn from the thoughts of Watson (1988/2007, 2012). The illustration shown previously (see Figure 2) could be seen as obstructive to semantic clarity because the number of concepts and relationships is moderately high, hence it could discourage comprehension, as put forth by Chinn and Kramer (2018).

Semantic clarity is heightened because most major concepts' definitions provided in an article (Cara et al., 2016) are consistent with authors on nursing and education. For

instance, the definition of "competencies" is based on and is coherent with an author on education (Tardif, 2006) that has been consistently used in several Canadian nursing studies (Blanchet Garneau & Pepin, 2015; Boyer, Tardif, & Lefebvre, 2015; Goudreau, Boyer, & Létourneau, 2014; Goudreau et al., 2009).

### Semantic consistency

Semantic consistency refers to the consistent use of the concepts with their given definition (Chinn & Kramer, 2018). As previously mentioned, the six major concepts of the HMNC-UdeM remained consistent, both in terms and in meaning, throughout the five reviewed documents, but some minor concepts appeared or disappeared over time. Those inconsistencies have already been outlined in the section "Concepts in the Conceptual Model." The present authors also illustrated two complementary definitions of the concept of "humanism" in the section "Definitions of the conceptual model." No inconsistencies were identified at the basic roots of the HMNC-UdeM, in other words, between purposes and assumptions as stipulated by Chinn and Kramer (2018).

### Structural clarity

Structural clarity refers to the ease to which relationships and structure are identifiable and apparent (Chinn & Kramer, 2018). As demonstrated in previous sections, only 13 out of 29 relationships were either fully (6) or partially (7) portrayed in Figure 2, thus creating an incongruence between what is implied in the text and as visually illustrated. Because this illustration is already dense in terms of links and concepts, it might be, however, difficult for the authors to add those missing relationships without impeding semantic clarity.

### Structural consistency

The consistent use of the same structural form within a conceptual model supports structural consistency (Chinn & Kramer, 2018). Over time, the HMNC-UdeM remained consistent with the same core structure, the six major concepts and their respective relationships (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011). Because there were divergent terms of minor concepts (appearing, disappearing, varying terms), structural consistency seems hindered. Even if Figure 1 and Figure 2 share the same compass rose shape, the second illustration is more elaborate than the first one. This significant difference makes the comparison of the two figures challenging.

There are some possible avenues to enhance clarity for the HMNC-UdeM. For example, a definition could be given to the 13 undefined minor concepts and maybe some of them could be removed if the intended meaning among those is the same. A new illustration could refine and rearrange the most important relationships implied in the text in a parsimonious manner.

### *Simplicity of the conceptual model*

Although Chinn and Kramer (2018) do not state a specific threshold of concepts and relationships in order to consider a conceptual model "simple," the present authors could argue that the HMNC-UdeM is rather "complex" because of its given high number of concepts (6 major, 23 minor) and relationships (29).

### *Generality of the conceptual model*

When a conceptual model can be applied to a broad array of situations, it is said to be "general" rather than "specific" (Chinn & Kramer, 2018). Because the HMNC-UdeM was created as a conceptual model of nursing, it is thus intended to have a wide breadth of scope. In this respect, the HMNC-UdeM does not seem limited to a specialty of nursing nor does it restrict its use to a precise population. As Chinn and Kramer (2018) pointed out, "nursing theories that address broad concepts (e.g., individuals, society, health, environment) have a high degree of generality" (p. 209). Following this, the present authors believe that the HMNC-UdeM can be considered "general".

### *Accessibility of the conceptual model*

Accessibility is strengthened when empirical indicators can be identified from concepts and when the purposes of the conceptual model can be reached (Chinn & Kramer, 2018). As mentioned earlier, very few concepts are defined in a way that could permit an empirical assessment, but that also is not the main purpose of a conceptual model of nursing (Chinn & Kramer, 2018). It was asserted in this paper that an assessment tool could be created from the humanistic attitudes and behaviors identified in the synopsis (Cara et al., 2015) and the article (Cara et al., 2016).

As for the HMNC-UdeM's purposes (Cara, 2017; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011), it is uncertain if the conceptual model of nursing is considered pragmatic for students and nurses. It appears difficult to evaluate if graduates anchor their nursing practice in humanism and caring; nor is it more possible to assess if they demonstrate competency, commitment, and accountability. These uncertainties take place because no studies have been conducted to assess its

applicability in clinical settings. However, the HMNC-UdeM warrants further development.

### *Importance of the conceptual model*

The practical value or the clinical significance of a conceptual model is dependent "on the professional and personal values of the person who is addressing the question" (Chinn & Kramer, 2018, p. 211). A person who does not have a high opinion about the importance of humanizing nursing care might think that the HMNC-UdeM is unimportant to nursing. A theory might appear more important to a person if its given definitions and relationships match his or her beliefs (Chinn & Kramer, 2018). Because some of the authors of this paper contributed to the HMNC-UdeM's development, it could seem unusual to judge it unimportant. Not to mention that evidence shows with very little doubt that patients and their families wish for caring and humanistic nursing care (Delmas, O'Reilly, Iglesias, Cara, & Burnier, 2016; Dewar & Nolan, 2013; Finfgeld-Connett, 2013; Griffiths, Speed, Horne, & Keeley, 2012; Haugan, Innstrand, & Moksnes, 2013; Merrill, Hayes, CIukey, & Curtis, 2012; Wiechula et al., 2016).

## Strength and limitations

Chinn and Kramer emphasized that no published descriptions and analyses are more accurate or authoritative than the others, and that "conclusions should be trusted to be an accurate understanding of the (conceptual model)" (p. 202). Some of the present authors (CC and DL) are conscious that they have a dual role as both the HMNC-UdeM's developers and reviewers. However rigorous this work has been, this fact might indicate bias for some scholars. It is hoped that readers will notice how close this description/reflection is to Chinn and Kramer's (2018) method and that the authors strove

to bring up all issues they noticed through this evaluation. The present authors also acknowledge that, despite best efforts, it is possible that some issues could not be discovered because of their inner understanding of this conceptual model of nursing. Perhaps a description and critical reflection conducted from outsiders who did not author the HMNC-UdeM could offer a complementary perspective to this work.

## Conclusion

Using Chinn and Kramer's (2018) method, the HMNC-UdeM was described and critically reflected on. The description revealed that some purposes had been replaced or deleted over time, that a considerable number of minor concepts (13 out of 23) were not defined and that nearly half of the relationships (13 on 29) were partially or fully shown in a coherent structured network. The critical reflection showed that the HMNC-UdeM could be clearer by adding missing definitions to minor concepts and by reorganising the most recent illustration according to the relationships that will eventually be retained. Moreover, the high quantity of concepts and relationships brings this conceptual model on the "complex" side rather than the simple one, and on the "general" pole rather than "specific" given its broad conceptual spectrum. In addition, the HMNC-UdeM was found to lack accessibility, mainly because there are few opportunities for empirical assessment and that current evidence could not yet support the achievement of its purposes. Based on the values of the authors of this current paper, the HMNC-UdeM was considered important to the discipline and the profession of nursing, more specifically for its potential in humanizing nursing care. This conceptual model of nursing is still in its early stages of development and this paper raised some opportunities for its refinement and improvement.

**Table 1.**

*Chinn and Kramer's Questions on Theory*

| **Questions for theory description** |
|---|
| **1.** What is the purpose of this theory?<br>**2.** What are the concepts of this theory?<br>**3.** How are the concepts defined within this theory?<br>**4.** What is the nature of the relationships within this theory?<br>**5.** What is the structure of the theory?<br>**6.** On what assumptions does the theory build? |
| **Questions for critical reflection** |
| **7.** How clear is this theory?<br>**8.** How simple is this theory?<br>**9.** How general is this theory?<br>**10.** How accessible is this theory?<br>**11.** How important is this theory? |

*Note*. Chinn & Kramer's (2018, pp. 201, 203)

**Table 2.**

*Concepts in the Humanistic Model of Nursing Care–UdeM*

| **Concepts** | | **Girard and Cara (2011)** | **Cara and Girard (2013)** | **Cara et al. (2015)** | **Cara et al. (2016)** | **Cara (2017)** |
|---|---|---|---|---|---|---|
| **Major concepts** | | | | | | |
| 1 | Person | Defined | Defined | Defined | Defined | Defined |
| 2 | Environment | Defined | Defined | Defined | Defined | Defined |
| 3 | Health | Defined | Defined | Defined | Defined | Defined |
| 4 | Nursing | Defined | Defined | Defined | Defined | Defined |
| 5 | Caring | Defined | Defined | Defined | Defined | Defined |
| 6 | Competency | Defined | Defined | Defined | Defined | Defined |
| **Minor concepts** | | | | | | |
| 1 | Humanism | Presented | Presented | Defined | Defined | Defined |
| 2 | Commitment | Presented | Presented | Presented | Presented | Presented |
| 3 | Accountability | Presented | Absent | Presented | Presented | Presented |
| 4 | Well-being | Presented | Presented | Presented | Defined | Presented |
| 5 | More-being | Presented | Absent | Presented | Defined | Presented |
| 6 | Harmony | Presented | Presented | Presented | Defined | Presented |
| 7 | Dimensions | Defined and examples | Examples | Defined and examples | Defined and examples | Defined and examples |
| 8 | Reciprocity | Presented | Presented | Presented | Presented | Presented |

| | | | | | | |
|---|---|---|---|---|---|---|
| 9 | Reflective practice | Defined | Presented | Defined | Defined | Presented |
| 10 | Transition | Presented | Absent | Absent | Absent | Absent |
| 11 | Experience | Presented | Presented | Presented | Presented | Presented |
| 12 | Meaning | Presented | Presented | Defined | Defined | Presented |
| 13 | Potential | Presented | Presented | Presented | Presented | Presented |
| 14 | Power to act | Presented | Presented | Presented | Presented | Presented |
| 15 | Resources | Absent | Absent | Absent | Presented | Absent |
| 16 | Strengths | Absent | Absent | Absent | Presented | Absent |
| 17 | Values | Examples | Examples | Examples | Defined and examples | Examples |
| 18 | Attitudes | Examples | Examples | Examples | Defined and examples | Presented |
| 19 | Behaviours | Presented | Presented | Examples | Defined and examples | Presented |
| 20 | Relationship | Presented | Presented | Presented | Presented | Presented |
| 21 | Needs | Absent | Presented | Absent | Presented | Presented |
| 22 | Concerns | Absent | Absent | Presented | Presented | Absent |
| 23 | Priorities | Absent | Absent | Presented | Presented | Absent |

**Table 3.**

*Major Concept Definitions in the Humanistic Model of Nursing Care–UdeM*

| **Concepts** | **Definitions** |
|---|---|
| Person | "The Person with a capital *P* can represent individuals, family members and relatives, the community or the population, continuously and dynamically interacting with its environment. It is composed of inseparable dimensions (i.e. biophysical, psychological, sociocultural, developmental, spiritual), from which concerns and priorities can emerge. The Person possesses credible and valid knowledge, potential, power to decide and act, leading him/her to give unique meaning to his/her health experiences." (Cara et al., 2016, p. 23) |
| Environment | "The environment is everything that surrounds the Person, including the material, cultural, ecological, and socio-political aspects. The interaction between the Person and his/her environment is continuous, reciprocal, dynamic, and decisive to his/her health." (Cara et al., 2016, p. 24) |
| Health | "Health, as a unique experience, is the ongoing optimization of well-being, more-being, and harmony as defined by the Person." (Cara et al., 2016, p. 24) |
| Nursing | "Nursing is the assistance to the Person in a humane, relational and transformative way in order to contribute to his/her health by focusing on his/her potential, by strengthening his/her power to act and by co-creating an environment favorable to his/her health. Nursing starts with the recognition of the unique experience of the Person and the meaning he/she gives to his/her health experience, which evolves over time according to his/her rhythm. |

| | |
|---|---|
| | Nursing therefore invites the Person as a partner by valuing, incorporating, and recognizing the importance of the aforementioned meaning in the choice of relevant interventions. This assistance encourages the nurse to rely on the Person's resources to assure his/her harmonious development. Therefore, the ultimate goal of nursing is to contribute to the Person's well-being, more-being, and harmony while preserving his/her human dignity." (Cara et al., 2016, p. 24) |
| Caring | "Caring is both an art and a science. Indeed, it corresponds to a conscious and renewed commitment to help and accompany the Person to be and to become what he/she is. It consists in developing links of reciprocity with the Person in order to promote his/her health. Caring is based on humanistic values that influence attitudes, which guide the nurse's behaviours." (Cara et al., 2016, p. 25) |
| Competency | "Professional Competency is developed based on both the knowledge and the experience (personal and professional) of the nurse. Competency, with a capital *C*, represents the integration of a set of competencies (i.e. clinical reasoning in nursing) that are expressed in the nurse's action. These competencies correspond to complex knowing to act that mobilize and combine a variety of resources, including knowledge." (Cara et al., 2016, p. 25) |

**Table 4.**

*Examples of Humanistic Attitudes and Behaviors*

| **Attitudes** | **Behaviours** |
|---|---|
| Wanting to be attentive to the Person with sincere listening, openness, and presence. | Accompany the Person to explore the meaning he/she gives to his/her health experience. |
| Wanting to be concerned about the Person's health experience by displaying availability and compassion. | Point out and emphasize the Person's efforts. |
| Wanting to assist the Person by commitment, proactivity, and creativity. | Encourage the Person to maintain his/her hope. |
| Be interested in getting to know and understand the Person by reciprocity and collaboration. | Avoid having an interest only in his/her health problems (or pathology). |

(Cara et al., 2016; Cara et al., 2015)

**Table 5.**

*Nature of Relationships in the Humanistic Model of Nursing Care–UdeM*

| **Descriptive** | **Explanatory** | **Predictive** |
|---|---|---|
| The *Person* is composed of inseparable *dimensions*. | The interaction between the *Person* and his/her *environment* is continuous, reciprocal and dynamic. | The interaction between the *Person* and his/her *environment* is decisive to his/her *health*. |
| *Caring* corresponds to a conscious and renewed | *Health*, as a unique *experience*, is the ongoing | *Nursing* contributes to the *Person*'s *health* by |

| | | |
|---|---|---|
| *commitment* to help and accompany the *Person* to be and to become what he/she is. | optimization of *well-being*, *more-being* and *harmony* as defined by the *Person*. | focusing on his/her *potential*, by strengthening his/her *power to act*. |
| *Humanism* puts forward *values* of respect, human dignity, recognition of the integrity and freedom of choice of the *Person* and belief in his/her *potential*. | *Nursing* is the assistance to the *Person* in a humane, relational, and transformative way. | Humanistic *values* influence *attitudes*, which guide the nurse's *behaviours*. |
| | *Caring* consists in developing links of *reciprocity* with the *Person* in order to promote his/her *health*. | Professional *Competency* develops based on both the knowledge and the *experience* of the nurse. |
| | *Dimensions* are interrelated and inseparable: they constitute the *Person* as a whole. | |
| | *Reflective practice* is a process of individual and collective development that leads nurses to analyse, synthesize, integrate, and enrich *experience* and nursing knowledge. | |

**Table 6.**

*Implicit Assumptions in the Humanistic Model of Nursing Care–UdeM*

| **Factual assumptions** | **Value assumptions** |
|---|---|
| Caring is required to reach professional competency. | A nursing practice grounded in caring and humanism is good and desired. |
| Patients may want to be accompanied by the nurse to explore the meaning that they give to their health experience. | Exploring the meaning given by patients to their health experience is good and desired in nursing practice. |
| Patients may desire to establish links of reciprocity with the nurse. | Establishing links of reciprocity between patients and the nurse is good and desired in nursing practice. |

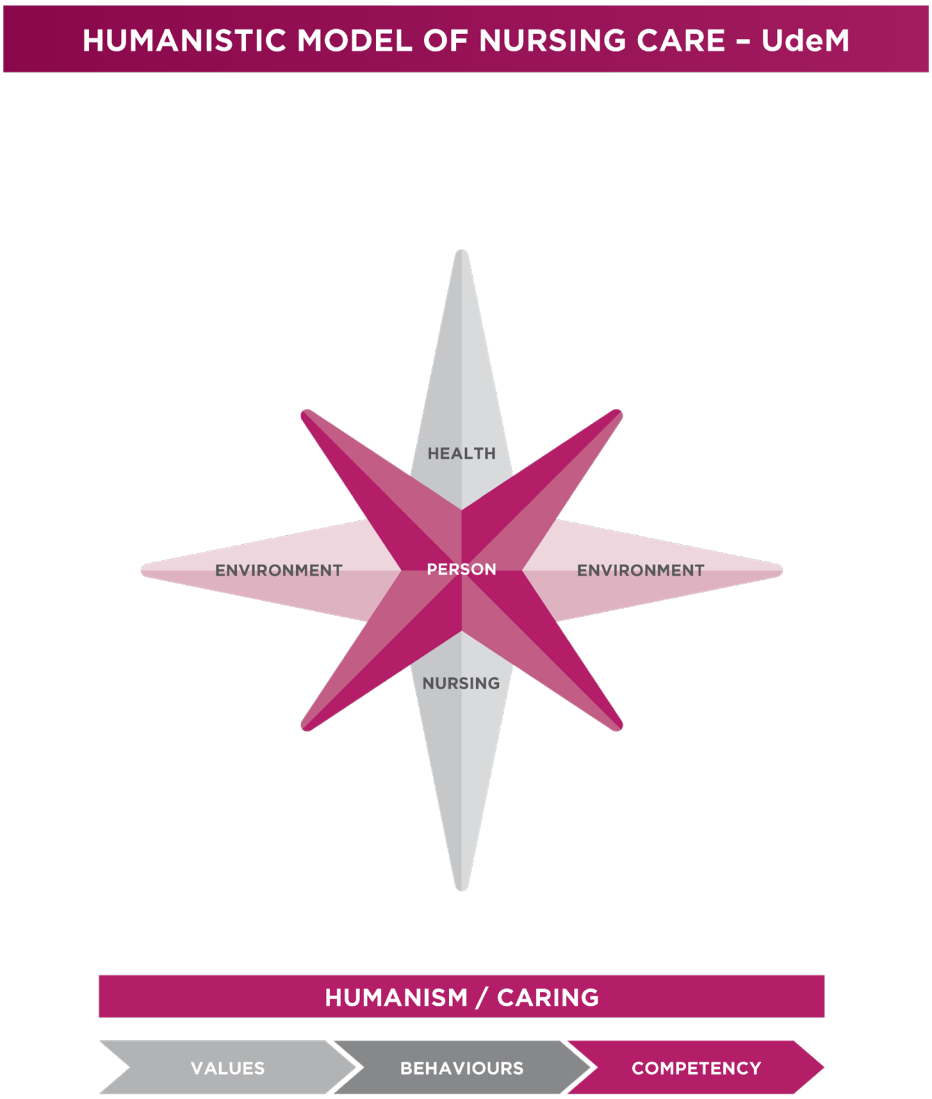


**Figure 1**. Humanistic Model of Nursing Care – UdeM (Cara & Girard, 2013)

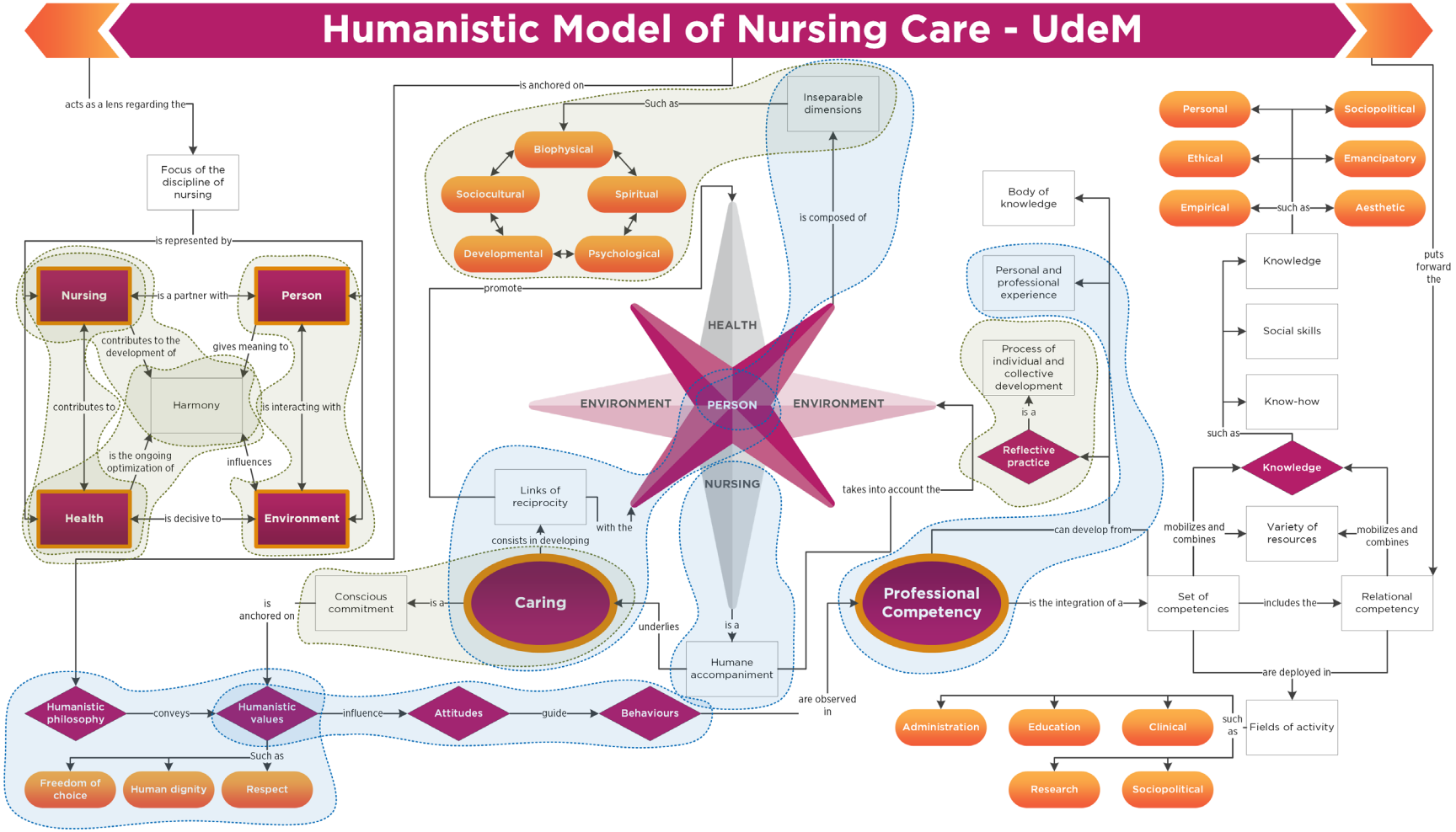


**Figure 2**. Network of Relationships in the HMNC-UdeM, translated and adapted from the synopsis (Cara et al., 2015)

**References**

Alligood, M. R. (2018). *Nursing theorists and their work* (9th ed.). Saint-Louis, MO: Elsevier.

Barrett, E. A. M. (2017). Again, what is nursing science? *Nursing Science Quarterly, 30*, 129-133. doi: 10.1177/0894318417693313

Blanchet Garneau, A., & Pepin, J. (2015). Cultural competence: A constructivist definition. *Journal of Transcultural Nursing, 26*, 9-15. doi: https://doi.org/10.1177/1043659614541294

Bohner, K. (2017). Theory description, critical reflection, and theory evaluation of the Transitions Theory of Meleis et al according to Chinn and Kramer (2011). *Advances in Nursing Science, 40*, E1-E19. doi: 10.1097/ANS.0000000000000152

Boyer, L., Tardif, J., & Lefebvre, H. (2015). From a medical problem to a health experience: How nursing students think in clinical situations. *Journal of Nursing Education, 54*, 625-632. doi: https://doi.org/10.3928/01484834-20151016-03

Cara, C. (1997). *Managers' subjugation and empowerment of caring practices: A relational caring inquiry with staff nurses* (Doctoral dissertation). Available from ProQuest Dissertations & Theses Global. (UMI No. 9728055)

Cara, C. (2017, February). *Le modèle humaniste UdeM : quelques travaux entourant son évolution [The Humanistic Model UdeM: Some work surrounding its evolution]*. Conference held as part of the Grand conferences of the Vice deanship of research and international development, Montreal, Quebec.

Cara, C., Gauvin-Lepage, J., Lefebvre, H., Létourneau, D., Alderson, M., Larue, C., . . . Mathieu, C. (2016). Le Modèle humaniste des soins infirmiers – UdeM : perspective novatrice et pragmatique [The Humanistic Model of Nursing Care - UdeM: An innovative and pragmatic perspective]. *Recherche en soins infirmiers, 125*, 20-31. doi: https://doi.org/10.3917/rsi.125.0020

Cara, C., & Girard, F. (2013, May). *The humanist model of nursing care: A driving force for nursing education*. Poster session presented at the 34th International Association for Human Caring Conference, Lake Buena Vista, FL.

Cara, C., Roy, M., Thibault, L., Alderson, M., Beauchamp, J., Casimir, M., . . . Robinette, L. (2015). *Modèle humaniste des soins infirmiers - UdeM. Synopsis du Modèle pour son opérationnalisation [Humanistic Model of Nursing Care - UdeM. Synopsis of the Model for its operationalization]*. Montreal, Quebec: Faculty of Nursing of the Université de Montréal.

Chinn, P. L. (2019). *The discipline of nursing: Moving forward boldly*. Retrieved from https://nursologycom.files.wordpress.com/2019/03/2019-03-21-case-keynote-7.pdf

Chinn, P. L., & Kramer, M. K. (2018). *Knowledge development in nursing: Theory and process* (10th ed.). Saint-Louis, MO: Mosby Elsevier.

Cohen, Y., Pepin, J., Lamontagne, E., & Duquette, A. (2002). *Les sciences infirmières: genèse d'une discipline [Nursing: Genesis of a discipline]*. Montreal, Quebec: Les Presses de l'Université de Montréal.

Cossette, S., Cara, C., Ricard, N., & Pepin, J. (2004). Assessing nurse-patient interactions from a caring perspective: Report of the development and preliminary psychometric testing of the Caring Nurse-Patient Interactions Scale. *International Journal of Nursing Studies, 42*, 673-686. doi: 10.1016/j.ijnurstu.2004.10.004

Delmas, P., O'Reilly, L., Iglesias, K., Cara, C., & Burnier, M. (2016). Feasibility, acceptability, and preliminary effects of educational intervention to strengthen humanistic practice among hemodialysis nurses in the Canton of Vaud, Switzerland: A pilot study. *International Journal for Human Caring, 20*, 31-43. doi: 10.20467/1091-5710-20.1.31

Dewar, B., & Nolan, M. (2013). Caring about caring: Developing a model to implement compassionate relationship centred care in an older people case setting. *International Journal of Nursing Studies, 50*, 1247-1258. doi: https://doi.org/10.1016/j.ijnurstu.2013.01.008

Faculté des sciences infirmières de l'Université de Montréal. (2012). *La démarche de soins infirmiers humaniste-caring [The humanistic-caring nursing care plan]*. Montreal, Quebec: Author.

Faculté des sciences infirmières de l'Université de Montréal. (2015). *Référentiel de compétences. Baccalauréat en sciences infirmières [Competencies framework. Baccalaureate in nursing.]* (2nd ed.). Montreal, Quebec.

Fawcett, J. (2005). Criteria for evaluation of theory. *Nursing Science Quarterly, 18*, 131-135. doi: 10.1177/0894318405274823

Finfgeld-Connett, D. (2013). Meta-synthesis of caring in nursing. In M. C. Smith, M. C. Turkel & Z. R. Wolf (Eds.), *Caring in nursing classics. An essential resource* (pp. 103-114). New York, NY: Springer Publishing Company.

Girard, F., & Cara, C. (2011). *Modèle humaniste des soins infirmiers - UdeM [Humanistic Model of Nursing Care - UdeM]*. Montreal, Quebec: Faculté des sciences infirmières de l'Université de Montréal.

Goudreau, J., Boyer, L., & Létourneau, D. (2014). Clinical reasoning in nursing practice: A cognitive learning model based on a think aloud methodology. *Advancement in*

*Nursing Education - Avancées en formation infirmière, 1*(1). doi: https://doi.org/10.17483/2368-6669.1009

Goudreau, J., Pepin, J., Dubois, S., Boyer, L., Larue, C., & Legault, A. (2009). A second generation of the competency-based approach to nursing education. *International Journal of Nursing Education Scholarship, 6*, 1-15. doi: https://doi.org/10.2202/1548-923X.1685

Griffiths, J., Speed, S., Horne, M., & Keeley, P. (2012). 'A caring professional attitude': What service users and carers seek in graduate nurses and the challenge for educators. *Nurse Education Today, 32*, 121-127. doi: https://doi.org/10.1016/j.nedt.2011.06.005

Haugan, G., Innstrand, S. T., & Moksnes, U. K. (2013). The effect of nurse-patient interaction on anxiety and depression in cognitively intact nursing home patients. *Journal of Clinical Nursing, 22*, 2192-2205. doi: https://doi.org/10.1111/jocn.12072

Im, E.-O. (2015). The current status of theory evaluation in nursing. *Journal of Advanced Nursing, 71*, 2268-2278. doi: 10.1111/jan.12698

Jensen, K. T. (2019). Nursing research: A marriage of theoretical influences. *Nursing Open, 6*, 1205-1217. doi: 10.1002/nop2.320

Meleis, A. I. (2012). *Theoretical nursing: Development and progress* (5th ed.). Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Merrill, A. S., Hayes, J. S., CIukey, L., & Curtis, D. (2012). Do they really care? How trauma patients perceive nurses' caring behaviors. *Journal of Trauma Nursing, 19*, 33-37. doi: https://doi.org/10.1097/JTN.0b013e318249fcac

Oermann, M. H., & Jenerette, C. M. (2012). Scientific nursing journals over 25 years: Most studies continue to focus on adults and psychological variables, with a decline in theory-testing studies and an increase in qualitative studies. *Evidence-Based Nursing, 16*, 117-118. doi: 10.1136/eb-2012-101115

Parse, R. R. (2005). Parse's criteria for evaluation of theory with a comparison of Fawcett's and Parse's approaches. *Nursing Science Quarterly, 18*, 135-137. doi: 10.1177/0894318405275860

Pepin, J., Ducharme, F., & Kérouac, S. (2017). *La pensée infirmière [The thinking in nursing]* (4th ed.). Montreal, Quebec: Chenelière Éducation.

Risjord, M. (2019). Middle-range theories as models: New criteria for analysis and evaluation. *Nursing Philosophy, 20*, 1-10. doi: 10.1111/nup.12225

Smith, M. C., & Parker, M. E. (2015). Nursing theory and the discipline of nursing. In M. C. Smith & M. E. Parker (Eds.), *Nursing theories and nursing practice* (pp. 3-18).

Tardif, J. (2006). *L'évaluation des compétences. Documenter le parcours de développement [The assessment of competencies. Documenting the developmental path]*. Montreal, Quebec: Chenelière Éducation.

Valentine, J. L. (2014). Why we do what we do: A theoretical evaluation of the Integrated Practice Model for forensic nursing science. *Journal of Forensic Nursing, 10*, 113-119. doi: 10.1097/JFN.0000000000000041

Watson, J. (2007). *Nursing: Human science and human care. A theory of nursing*. Sudbury, MA: Jones and Bartlett Publishers. (Original work published 1988)

Watson, J. (2012). *Human caring science: A theory of nursing*. Sudbury, MA: Jones & Bartlett Learning.

Wiechula, R., Conroy, T., Kitson, A. L., Marshall, R. J., Whitaker, N., & Rasmussen, P. (2016). Umbrella review of the evidence: What factors influence the caring relationship between a nurse and patient? *Journal of Advanced Nursing, 72*, 723-734. doi: https://doi.org/10.1111/jan.12862

Yarcheski, A., Mahon, N. E., & Yarcheski, T. J. (2012). A descriptive study of research published in scientific nursing journals from 1985 to 2010. *International Journal of Nursing Studies, 49*, 1112-1121. doi: 10.1016/j.ijnurstu.2012.03.004