Expert Nurses' Conceptualization of Healing

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EXPERT NURSES’ CONCEPTUALIZATION OF HEALING

a dissertation

by

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Abstract

Expert Nurses’ Conceptualization of Healing

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Despite the concept of healing being central to nursing, there has been a lack of conceptual clarity. This study sought to understand how expert nurses in practice conceptualize healing and how this conceptualization affects their practice. The sample consisted of 50 practicing nurses from multiple practice settings in an academic health system in Western Massachusetts. The study used a mixed method design using an electronic adaptation of the Delphi method.

Findings from the study suggested a high level of consensus about the concept of healing in nursing. Qualitative data from the open-ended questions of Round 1 were coded into items about healing on subsequent quantitative surveys in Rounds 2 and 3. Participants ranked their level of agreement or disagreement with these statements. Ultimately, 49 statements met the \textit{a priori} criteria for consensus as to what healing means from a nursing perspective. The overarching themes of statements were comprised of Nursing Actions to Promote Healing, Theoretical Understanding of Healing, Nurse Attributes to Promote Healing, Other Factors that Promote Healing, Types of Healing and Assessment of Healing.

This study adds to the literature an exclusively nursing perspective on healing. The nursing-specific concept of healing synthesized from the data could be described as progression towards wholeness, with subjective and objective outcomes, promoted by the actions of nurses.
The clarification of the concept of healing can inform research to create measurements for healing. It also can improve practice by articulating an existent conceptual framework, allowing nurses and administrators to better promote healing both directly and indirectly. Lastly, the results of this study offer students a simple yet accurate way of prioritizing nursing interventions.
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Chapter 1

Background

Nurses comprise the largest segment of the health care workforce in the United States, with over 3 million registered nurses licensed, including Advanced Practice Nurses (Health Resources and Services Administration, 2010). According to the Institute of Medicine, the U.S. health care system is evolving after the passage of the Patient Protection and Affordable Care Act (2010). Increased access to care is offset by increased pressure to reduce costs while delivering higher quality care and achieving better health outcomes. Nurses are well positioned to actualize the goal of better care for lower cost. The sheer number of nurses and the adaptability of nurses create the potential for a large positive impact on the health and wellbeing of people across the country. The Institute of Medicine recognized that “nursing practice covers a broad continuum from health promotion, to disease prevention, to coordination of care, to cure—when possible—and to palliative care when cure is not possible” (2011a, p. 4). The Institute of Medicine’s statement alluded to a concept integrally related to nursing—healing.

Healing has been described as central to the discipline of nursing, and it has been recognized since Nightingale’s time that nurses are intimately involved in the healing process (McElligott, 2010; Nightingale, 1946; Watson, 2009). Yet there is considerable ambiguity about the meaning of concept of healing (Kritek, 1997; Taylor, 1995; Wendler, 1996; Willis, Grace, & Roy, 2008). The concept of healing has gained renewed interest in modern nursing, perhaps due in part to interest in complementary and alternative medicine (Robb, 2006) and complementary therapies (Engebretson, 1999). Similarly, scholarship has burgeoned in an attempt to clarify the
concept of healing (Egnew, 2005, 2009; Glaister, 2001; Hsu, Phillips, Sherman, Hawkes, &
Cherkin, 2008; McElligott, 2010; Wendler, 1996; Zahourek, 2012). Healing as one of the central
foci of nursing has been validated by promulgation of the Willis, Grace and Roy (2008) article,
resulting in its inclusion in such important foundational texts as Theoretical Nursing (Meleis,
2011) and Perspectives on Nursing Theory (Reed & Shearer, 2012). These widely read texts
highlights healing as a concept central to nursing.

Despite efforts to clarify the concept, there exists a range of ways healing is
conceptualized in the literature, and these conceptualizations sometimes contradict one another.
For example, a 2008 article in the British Journal of Nursing described wound healing as “a
well-orchestrated, systematic, interdependent but overlapping, complex process that leads to
repair” (Benbow, 2008, p. S5) without any mention of intentionality. This is not surprising as
typically wound healing is considered an automatic process at a cellular and tissue level. Yet
Zahourek argued “healing does not occur without intentionality” (2012, p. 13). These two ways
of conceptualizing healing seem at odds with one another. A natural question arises as to
whether such divergent interpretations refer to the same concept.

Literature review is one way to clarify a concept, although it is important to follow such
work with the addition of empirical research to increase the utility of the clarified concept
(Lakanmaa, Suominen, Perttilä, Puukka, & Leino-Kilpi, 2012). Another manner of inquiry is to
seek information from those who directly develop and/or utilize the concept. Despite the
disagreement in the literature, nurses in practice are experts in operationalizing healing in the
clinical setting, although it is unknown what these lay theories of healing are and what is their
import on patient outcomes. In the case of nurses operationalizing the concept in practice, nurses
are both the creators and the users of the concept of healing. Drawing on the knowledge of
practicing nurses offers the possibility of a more integrated approach to clarifying the concept of healing than can be derived from a solely theoretical or academic approach. Furthermore, identifying the concept and its characteristics could ultimately lead to enhanced measurement, improved interventions, and the development of middle-range theory, all having implications for research, education and practice.

The idea of seeking theoretical knowledge from practice is not new in nursing. Decades ago Ellis (1969) asserted that the practitioner was indeed a theorist. She claimed that nurses in practice are theorists in the sense of developing “a coherent … concept, [and] forming a general framework … for a purpose. For nursing, that purpose is practice,” (Ellis, 1969, p. 1434). This line of thinking continues today with the notion that nurses are “an untapped resource for generating nursing theories to enhance human well-being and health care” (Reed, 2008, p. 315). The current study drew upon the knowledge of nurses to create a more integrated approach to clarifying a central focus of the discipline—healing.

Though no studies to date have been found that specifically explore nurses’ understanding of healing as a concept, research has explored the concept of healing in various other contexts. Studies have explored healing from a nursing perspective in contexts such as healing at the end of life (Gauthier, 2002), healing with chronic pain (Smith, 2001), healing from childhood sexual abuse (Draucker et al., 2011), spiritual healing (McGlone, 1990) and self-healing (Robb, 2006). Still other studies have explored healing in a medical framework (Egnew, 2005, 2009). One study sought to develop an instrument to measure healing as defined by social and psychological constructs (Meza & Fahoome, 2008). Verhoef and Mulkins (2012) described the healing experience of patients with chronic illness and mental health challenges. A 2008 study explored the meaning of healing in primary care with informants including a combination
of physicians, nurses, medical assistants and patients (Hsu et al., 2008). The role of the environment in healing has been examined through the perceptions of nurses (Lincoln & Johnson, 2009) and through analysis seeking to operationalize the concept of the optimal healing environment (Findlay & Verhoef, 2004). The research identified here contributes meaningful knowledge to the concept of healing in health care, but no study has explored the unique nursing perspective on the concept by expert nurses in practice.

**Significance**

As noted, healing remains a vague and at times contradictory concept in nursing. Despite the increasing interest in the concept of healing from nursing and other health disciplines (Egnew, 2005, 2009; Meza & Fahoome, 2008) there remains a need for a more cohesive integration of the concept of healing within the discipline and profession of nursing (Malinski, 2002; McElligott, 2010). For example, in a 1996 concept analysis Wendler (1996) concluded that the term healing refers to a caring relationship, with self or other, yet also describes the wound healing process with its well-documented stages. In contrast to the author’s assertion, many would argue that a relationship is not required for physiological wound healing, however much a relationship may support that process. Reflecting a potential middle ground, Dossey (2003) defined healing as

> Those physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably), order and coherence. Healing is an emergent process of the whole system and may or may not involve curing. (p. A11)

It is unclear from this definition how curing of a physiological wound, or removal of signs or symptoms of disease would not be a healing process as claimed by Dossey (2003;). These
examples reflect the lack of clarity and occasional contradictions around the concept of healing, thereby decreasing the utility of the concept in research and practice.

The lack of conceptual clarity regarding healing is problematic for the following reasons. First, the lack of clarity regarding this central construct diminishes the cohesion of the discipline. Healing as one of the central foci of the discipline requires that “nursing must be unified within an inclusive focus that transcends divisions” (Willis et al., 2008). Lacking unity in a disciplinary focus leaves nursing at risk for concentrating less on the social mandate of nursing and more on priorities defined outside the discipline (Newman, 2005; Willis et al., 2008). In 1969 Ellis warned that “there is some danger of neglecting, or even rejecting, some of the traditional, familiar components in nursing as we grow in our emphasis on science anl [sic] research” (p. 1438). It is through the integration of theories and models consistent with the philosophical focus and clinical practice of nursing that nurses are able to meet the social mandate “to contribute to the good of society through knowledge-based practice” (McCurry, Revell, & Roy, 2010, p. 43). Increased clarity regarding the central construct of healing could increase disciplinary cohesion and allow for a clear, focused fulfillment of the social mandate.

Second, the lack of clarity of the concept of healing prevents widespread operationalization and measurement of healing. This lack of widespread operationalization and measurement undermines the ability of nurses to evaluate their effectiveness in addressing a central focus of the discipline. Nurses believe they are promoting patient healing through their interventions (Kritek, 1997) and use logical theories to direct their work, whether explicit or implicit (Ellis, 1969). Currently, the concept of healing remains vague in the scholarly literature and in practice. Concepts used in science require a much greater degree of precision for usefulness in research (Hupcey & Penrod, 2005). Because there is no unified understanding of
healing, it is difficult to rigorously assess whether nursing interventions have the intended effect on healing in patients. The Institute of Medicine’s report “The future of nursing: Leading change, advancing health” (2011a) begins with a quotation from Goethe that states that one cannot simply know, one must also do. An assumption of the current study is that nurses in practice are currently doing much towards promoting healing that the scholarly community has not been able to fully articulate. Understanding, then, becomes a key to improving action and thereby improving patient health.

A clear conceptualization of healing would improve the ability of nurses to assess the effectiveness of their interventions; clarification of a concept must precede measurement of that concept (Grove & Burns, 2009). While there are currently ways to measure some outcomes associated with particular interpretations of healing (e.g. improvement in peak flow monitoring, reduction in anxiety), these measures remain difficult to interpret in light of the lack of an overarching concept of healing within the discipline.

Some existent literature has attempted to measure healing, however not as a concept of healing from an exclusively nursing perspective. Past research corroborates the difficulty in measuring healing through a scaled instrument as an outcome in complementary and alternative medicine (CAM) interventions (Verhoef & Mulkins, 2012). In Verhoef and Mulkins (2012), the researchers developed a model of healing and an Integrative Medicine Index to evaluate the effect of a healing environment on patients. During their study, the authors determined the Index was not accurately capturing the concept of healing. Therefore, they changed methods to a qualitative study to better understand the concept of healing. Other scholarship has offered narrative as a way of understanding healing outcomes, even in terminal illness (Repede, 2008). Rosa (2006) pointed out that while frameworks and measurement methods exist for
physiological healing of aspects of chronic skin wounds, few studies have addressed the phenomenon from a nursing perspective (Chase, Melloni, & Savage, 1997; Ebbeskog & Ekman, 2001; Krasner, 1998; Walburn, Vedhara, Hankins, Rixon, & Weinman, 2009; Wilson et al., 2011). This inadequate conceptualization and measurement of healing reduces the ability of nurses to demonstrate the effectiveness of their interventions and improve them through rigorous inquiry and scientific research.

Finally, the lack of conceptual clarity regarding healing is problematic because it negatively impacts research, policy and financial structures. The clarification, operationalization and measurement of healing from a nursing perspective could articulate the value nursing adds to the health care team and could support healing interventions through policy and financial structures. If nursing is healing work, as many have suggested (Kritek, 1997; Taylor, 1995; Willis et al., 2008), and yet nurses have no clear way to articulate and measure that healing, the impact of nursing on patients’ well-being could be grossly underestimated. The Institute of Medicine (2011a) recommended that nurses partner in leadership roles with other leaders to reform health care; describing healing and how nurses promote it would send a powerful message about the unique contribution of nursing in health care.

Lastly, as the number of people living with chronic illnesses rises, healing becomes a more important concept in defining the care nurses deliver to these populations. Due to the nature of chronic disease as largely incurable the focus of nursing must include promotion of healing that extends beyond the limited scope of cure and symptom management. Currently, about half of all Americans have at least one chronic disease and about 25% of those with a chronic disease are limited in their daily activities (US Centers for Disease Control and Prevention, 2009). The health needs of these people would be better served with a clear
understanding of healing because even though people with chronic illness may not be cured, healing remains a viable option for improvement of quality of life and wellbeing.

To date, most research has focused on healing as both a process and an outcome. Examples are found in research on the care of wounds and fractures, in conceptual explorations of healing from specific theoretical frameworks, in studies of healing from specific health concerns, and in research on the role of the environment on healing. Other research has examined interventions to promote healing such as Reiki and therapeutic touch. The current study examined the foundational conceptualization that undergirds such interventions as well as mainstream nursing interventions.

To summarize, the lack of conceptual clarity on healing is problematic for several reasons. First, the lack of clarity is problematic because of the discordance it brings to the discipline. Next, it is problematic because of the difficulty it confers in operationalizing the concept in practice and/or research and the subsequent effect on policy and financial decisions. Lastly it is problematic because of the growing numbers of people living with incurable chronic illness in need of healing. Therefore, the aim of this study was to understand how nurses conceptualize healing and the effect of this conceptualization on their practice, given the dearth of literature addressing the nursing viewpoint.

**Purpose**

The purpose of this study was to understand the existent nursing knowledge regarding the concept of healing in practice. The conceptualization of healing guides the actions nurses take to promote it and justifies which actions are not required. Rogers (2005) asserted that despite the importance of what nurses do, it is the knowledge behind their actions that distinguishes the discipline. She went on to suggest, "the most important question for nurses to address really
concerns not what they do, but what they know” (Rodgers, 2005, p. 2). A similar idea has been asserted in medicine: “Today’s physician can diagnose hypertension or early lung cancer because of something at their disposal that was unavailable to their predecessors: a theory of the processes in the body. This theory is medicine” (Unschuld, 2009, p. 5). It is because of the foundational importance of theory in the relatively new profession of nursing that the current study sought to enhance understanding of a concept that remains vague despite being ubiquitous in both academic and public spheres.

The goal of adding to nursing knowledge by clarifying the concept of healing will be accomplished by (a) developing consensus on the conceptualizations of healing of expert nurses and (b) exploring practice implications based on input of expert nurses. One method for developing consensus is the Delphi method. This method was originally developed to predict the effect of novel technology used in war by the Douglas Aircraft Company under a project named RAND in the mid-1900’s. Early writings describe the use of expert consensus as a way to make scientific predictions due to the fact that “the expert has at his ready disposal a large store of (mostly unarticulated) background knowledge and a refined sensitivity to its relevance, through the intuitive application of which he is often able to produce trustworthy personal probabilities regarding hypotheses in his area of expertness” (Helmer & Rescher, 1959, p. 38). The technique was used to predict future events, but was quickly adapted by nurse researchers (Dalkey & Helmer, 1963). The goal of the Delphi method became to achieve consensus of experts through serial questionnaires with feedback from the group with limited time expenditure (Keeney, McKenna, & Hasson, 2011). It has most frequently been used in nursing research to determine priorities and to gain consensus on a variety of issues (Bramwell & Hykawy, 1974; Lindeman, 1975; MacNeela, Morris, Scott, Treacy, & Hyde, 2010; Scheffer & Rubenfeld, 2000). The
Delphi Method is therefore an ideal way to draw upon expert nursing knowledge in the practice setting to provide consensus on the concept of healing since the goal of the method is to arrive at agreement where there previously was none on a matter of import to a group of experts (Keeney et al., 2011).

Specific aims of the current study were to:

1. Identify common elements of the concept of healing recognized by expert nurses in practice.

2. Synthesize a concept of healing based on the perspectives of nurse experts from diverse practices settings.

3. Describe the implications of this synthesized concept for nursing practice, research and education.

**Research Questions**

How do nurses in practice conceptualize healing?

How does this conceptualization affect their practice?

**Definitions**


Concept: According to Hupcey and Penrod (2005) “Concepts are mental abstractions or units of meaning derived to represent some aspect or element of the human experience (Chinn & Kramer, 1995; King, 1988)” (p. 198).
Nurse: A licensed professional who engages in nursing, “a health care discipline and healing profession, both an art and science, which facilitates and empowers human beings in envisioning and fulfilling health and healing in living and dying through the development, refinement, and application of nursing knowledge for practice” (Willis et al., 2008).

**Assumptions**

- Healing is a natural phenomenon.
- Healing is a natural process that influences a patient in ways that can be observed, systematically interpreted and acted upon by nurses.
- Healing is a central focus of the discipline and practice of nursing.
- A major goal of nursing practice is to promote healing.
- Nurses in practice represent a largely untapped source of knowledge regarding the concept of healing.
- Nursing knowledge is derived from multiple sources, including those outlined by Carper (1978): empirics, esthetics, personal knowing and ethics.
- Nursing practice is guided by nursing knowledge and theory, both explicit and implicit.
- Group opinion is more valid than individual opinion; this is the foundational assumption of the Delphi Method (Keeney et al., 2011).
Chapter 2

This literature review describes the current state of science regarding the conceptualization of healing in nursing and provides a background for the results and discussion of the current study. This review also addresses non-nursing scientific literature as well as the related concepts of holism and caring. Finally, this review discusses several important nursing documents that guide nursing practice both nationally and internationally.

The American Nurses Association (ANA) stated that one of the 6 essential features of professional nursing is the “provision of a caring relationship that facilitates health and healing” (American Nurses Association, 2014). Despite the importance given to healing by a leading nursing organization like the ANA, the concept of healing remains elusive. Indeed, one author summarized concerns about the concept of healing pointing out that it is at once an intervention, an outcome and a process, some times in a single piece of writing; such vagueness, he agreed renders the concept nearly worthless for research (Levin, 2008).

Others have recognized multiple meanings of healing and have attempted to contribute to a more useful conceptualization and a description of how these meanings affect nursing practice. In this review I explicate what is currently known about nurses’ conceptualizations of healing and related literature on the concept of healing in health care. The purpose is to provide a thorough overview of relevant literature on how healing is conceptualized in health care. The method of this literature search was consistent with the process outlined by Polit and Beck (2004). The steps included: selecting appropriate search terms for healing and related concepts, gathering a large set of potential sources through electronic and manual searches, screening each potential source and retaining only relevant ones, full text review, organization of sources and finally, analyses and integration. It is noted that this process is not completely linear; it is
iterative in that reading sources helps identify new sources, which then are screened and added to the review as appropriate.

**Distinguishing Healing from Curing**

Many authors highlight the differences between healing and curing. Decades ago the two related concepts were differentiated, with curing described as the removal of symptoms or disease and healing described as becoming whole (McGlone, 1990). Similarly Quinn (1997) stated that curing and healing could occur independently of one another; that curing was only sometimes possible but that healing was always possible. Likewise, another definition stated that “healing is how we recover, repair, restore and retain health and wholeness in mind, body, spirit, community and environment. Healing may or may not result in cure” (Samueli Institute, n.d., p. 3). In a similar vein, Newman (2008) described medicine as a curing profession and nursing as a caring profession. These definitions stand in contrast to standard definitions that equate healing and curing. One such example is the Oxford English Dictionary’s definition of the verb *to heal* as “to make whole or sound in bodily condition; to free from disease or ailment, restore to health or soundness; to cure (of a disease or wound)” (“Heal,” 2015). This dictionary definition shows the terms are often conflated. Interestingly, the definition includes not only the action of *to heal* but also the “Mending, reparation; restoration of wholeness, well-being, safety, or prosperity; spiritual restoration, salvation” (“healing”, 2015). While the latter definition does not mention curing, these dictionary definitions do not differentiate whether healing and curing are the same or whether curing could be a subset of healing.

The findings of a study examining mucosal healing in inflammatory bowel disease could be considered in line with a conflation of healing and curing. In this study the authors pointed out that "there is no validated definition of what constitutes mucosal healing in IBD...mucosal
healing should imply the absence of ulcerations and erosions” (Dave & Loftus, 2012, p. 30). The authors went on to say that it is yet unknown what degree of lesion resolution is required before there is clinically significant resolution of symptoms. Like other authors writing about healing, Dave and Loftus (2012) also echoed the need for a validated, standard definition of mucosal healing for the term to be clinically useful.

As alluded to previously, Quinn (1997) differentiated healing and curing, discussing the difficulty in assessing healing as both a process and an outcome. The author described the “creative and unpredictable” (Quinn, 1997, p. 4) nature of healing as the reason why it is difficult to assess healing outcomes using the empirical way of knowing (Carper, 1978). According to Quinn the nurse is well-positioned to assess healing based on the richness of relationship and abundance of non-empirical knowledge about a patient.

Just as art and science can be part of one practice, body and mind can also be connected in healing. A quantitative study (N=72) of adults with burn injuries found a correlation between higher distress about injuries and slower healing times (Wilson et al., 2011). This study illustrated a commonly held belief that the body and mind are interconnected in both wellness and illness. The authors went on to discuss the potential addition of physiological measures of psychological distress, such as cortisol levels, to better understand the phenomenon. While adding physiological measure of psychological distress may be useful, doing so would remain within what Carper (1978) described as the empiric way of knowing.

Glaister’s (2001) concept analysis of healing presented discussion of scholarly work from a nursing perspective. According to this analysis, “healing is a natural, active and multidimensional process that is individually expressed with common patterns. Healing is influenced by body-condition, personal attitudes and relationships” (Glaister, 2001, p. 67). The
author acknowledged that healing is an important part of nursing, though attention to healing is overshadowed by more technical nursing tasks. Glaister asserted the importance of understanding healing from multiple viewpoints, including that of nursing. While the author described healing as multidimensional she was clear to delineate healing from biomedical curing, stating that curing is not required for healing. If healing is holistic as many suggest, it is unclear why improvement on the mental or spiritual level without physiological improvement counts as healing whereas physiological improvement without mental or spiritual improvement is not equivalent to healing.

There exists a double standard; if we accept healing as possible without complete body, mind and soul wholeness, we should also accept as healing a return to wholeness in any combination of these domains of human experience; some, however, preclude purely physiological improvement from being considered healing. (Paskausky, In Preparation, p. 9)

The assertion that physical improvement alone is not healing whereas mental or spiritual improvement alone would be results in a double standard for the body and the mind—thus the holism double standard.

Levin (2008) made a compelling argument that Western medicine values the objective signs or data over the subjective experience of illness by those living the experience. This argument is in keeping with the prioritization of the experience, or at worst, the convenience of the clinician rather than the patient’s experience and autonomy. Levin made an insightful observation that some of the resistance of the discipline of medicine to adopt certain healing modalities, such as therapeutic touch, may persist because these interventions have been adopted by nursing. Nurses tend to be female and nurses in general have less education than physicians.
Levin suggested that the power, class, educational and gender dynamics between medicine and nursing may prevent these non-mainstream types of healing interventions from being accepted and studied more widely in medicine. Levin went on to call for collaboration between scientists and healers, but with several recommendations to improve collaboration and dialogue. Recommendations include scientists partnering with healers rather than being authoritarian leaders and healers letting go of the stereotype of the soul-less scientist. Ideally, each would recognize that both bring value to the collaboration between healers and scientists.

There may be no clearer differentiation between curing and healing than in clinical care at the end of life. Death could be viewed as a clear failure to cure whatever physiological process ultimately causes the person (as an organism) to die. Death is also a natural part of life, and one that many believe can be synonymous with healing (Quinn, 1997b). Viewed in this way the statement “healing is always possible even when curing is not” (Trevithick, 2008, p. 382) takes on its most potent meaning. Trevithick’s literature review explored how integrative medicine, or the blending of allopathic medicine with complementary and alternative medicine, can address challenges associated with end of life care. One author defined healing as “the attainment of a holistically conceived, health-related goal” (Feudtner, 2005, p. S 27) and goes on to state that what this means at the end of life varies by person, but that there are interventions which can increase the chances of the attainment of healing. Other authors showed areas where nurses could have more positive effects on families and loved ones dealing with the end of life in intensive care units (Lind, Lorem, Nortvedt, Hevrøy, & Gastmans, 2012). Nurses are well positioned to help those nearing the end of life and their loved ones heal, even as death is inevitable and cure, in the conventional sense, is impossible.
A concept analysis using the Walker and Avant method published by McElligott (2010) offered an excellent analysis of the concept of healing from a nursing perspective. The author asserted that the purpose of nursing is healing, as opposed to the purpose of medicine, which is curing (McElligott, 2010). McElligott grounded her analysis in historical roots ranging from Nightingale to non-Western medical understanding of healing. The author described healing used in the literature as a process, a relationship and an outcome that is preceded by willingness, consciousness and suffering. She defined the concept theoretically in conscious adults as “a positive, subjective, unpredictable process involving transformation to a new sense of wholeness, through a spiritual transcendence and a reinterpretation of life,” and operationalized the concept as “the personal experience of transcending suffering and transforming to wholeness” (McElligott, 2010, p. 255).

McElligott’s work underscored the importance of healing as a central focus of nursing. Limitations to the work include the exclusion of unconscious and pediatric individuals and the lack of validation through qualitative or quantitative studies. While the operational definition of healing may resonate with nurses and patients alike, it falls short of providing concrete operationalization of the concept for use in clinical and research settings. It is clear from her work that McElligott hoped the concept analysis would inspire further work to better define the concept of healing and the role of nurses.

Using a Singular Theoretical Perspective

Many scholarly inquiries into healing stemmed from a singular theoretical perspective as is common with research programs in many disciplines. While studies that utilize a single theoretical perspective can be very powerful in describing the phenomenon of healing from that particular perspective, there remains a great deal of discordance in what healing means looking
across those multiple perspectives. While one could argue that studies from a singular theoretical perspective have a biased perspective, I argue that this is no different from most of modern science. However, a challenge to interpretation of studies from a singular perspective is sample bias. For example, say a researcher has a hypothesis that the Boston Red Sox is the greatest team in baseball. While this may be a reasonable hypothesis, recruiting for a study that aims to determine “what is the greatest team in baseball?” at a Red Sox game may introduce a substantial amount of bias into the results.

Much of the literature with a singular theoretical perspective on healing comes from biomedicine. A majority of the scientific literature on healing referred to discrete physiological processes, such as wound, bone, or specific tissue healing. A search of CINHAL in August 2013 revealed approximately 4 times the number of results when searching for the headings “wound healing” or “fracture healing” (6,282) as the headings “spiritual healing” or “mental healing” (1,431). That same search re-run in April 2015 shows a lesser growth rate of research on mental or spiritual healing (9%) when compared to physiological research on healing (164%). In that 2015 search CINHAL headings returned 1/10th as many results for spiritual and mental health (1,615) when compared to results on wound and fracture healing (16,596). One such example of a biomedical perspective on healing is found in a recent article that offered a thorough biomedical summary of the healing process in bone fractures and proposed a hypothesis about the utility of flexible fixation to improve bone fracture healing (Epari, Wehner, Ignatius, Schuetz, & Claes, 2013). Though this work does not represent a scientific study, it nonetheless proposed a clear, testable hypothesis with strong logic that could be used in further study.

A similar work presented not only a detailed analysis of the biology of epithelial cells, but also offered a hypothesis for a novel way of promoting healing in this type of tissue
“airway epithelial healing is defined as restoration of health or soundness; to cure” (Reynolds et al., 2012, p. 27) in the first sentence of the abstract. They did not further address what restoration to health means, but later stated “the process that restores the epithelium to health…requires a balance between regeneration and repair” (Reynolds et al., 2012, p. 34). This statement both includes a requirement for new growth and addresses imbalances. Such a statement may resonate equally well with those examining healing from biomedical and spiritual perspectives.

One of the most concrete usages of the concept of healing is in literature on bone healing, yet defining the concept even in this context is harder than one might expect. The outcome measures indicative of bone fracture healing were discussed by Kooistra, Sprague, Bhandari, and Schemitsch (2010). Using a biomedical approach the authors acknowledged that there was indeed a real need for better-validated and standardized measurements of bone fracture. Despite the detail with which the process of bone healing was described there was still a lack of a clear outcome measurement. Considering the lack of clarity on healing within biomedicine, a discipline that is ostensibly more amenable to rigorous inquiry, one can appreciate the difficulty of measuring an amorphous concept such as healing from a broader perspective.

Attempting to understand the concept of healing at a unit of analysis larger than tissue or organ systems presents a great deal of complexity. Considering healing at the level of the individual can often lead to obtuse literature on the subject. Smith, Zahourek, Hines, Engebretson, & Wardell (2013) sought to describe the experience of those involved in healing, rather than “a growing body of conceptual and theoretical descriptions of and explanations about healing” (p. 173). Their qualitative descriptive study utilized narrative and story inquiry of
participants who volunteered during an American Holistic Nurses Association conference. According to the authors, the major themes identified by the participants included call to the healing encounter, the experience of healing, and insights. Unlike other authors mentioned, these authors believed that healing and curing were independent and that there were scenarios where neither cure nor healing was possible. While this study did indeed offer a research-based contribution to those involved in healing work, the population sample presents obvious bias. Nurses attending an American Holistic Nurses Association conference may verbalize healing experiences differently than would other nurses or laypersons.

Measurement of healing remains difficult. A scaled instrument was developed in an attempt to measure healing at the level of the individual; however, pilot work showed the target construct was not being captured by the measure (Verhoef & Mulkins, 2012). Therefore the authors altered the research plan and instead conducted a qualitative study to explore the experience of healing and factors promoting the healing process (Verhoef & Mulkins, 2012). The study arose within a complementary and alternative medicine (CAM) context, recognizing the need for a more robust way to evaluate non-standard healing interventions.

Many authors writing about healing in nursing subscribe to a unitary perspective as articulated by Martha Rogers, Margaret Newman and Jean Watson. These perspectives tend to emphasize the individual’s summative experience with illness and health, rather than focusing on healing within specific components of the individual, such as particular organs or the psyche. One author (Cowling, 2000) asserted that mainstream healing seeks to understand parts and relationships, then restore balance among those parts and relationships. This is in contrast to a unitary perspective that requires for healing appreciation of the inherent wholeness and bringing that wholeness to light. The author did not describe the sample and approach to data collection,
but rather stated he came to his conclusions about healing and appreciation for wholeness through years of involvement in a praxis experience. Cowling spent a great deal of time discussing the philosophical foundations of the unitary perspective. The author stated that his participants were persons who came to him in the community because of his research and work. As I have discussed before, this introduces an obvious bias based on the self-selection of individuals who already hold certain beliefs. Extrapolating the meaning of a general and universal concept like healing from such a population risks making generalizations that, while highly supported by the data, are derived from a biased sample. A potentially important sample bias is especially problematic without thorough explication of a study’s method and rigor. In such a case the results may be reliable but not valid when generalized to a different sample or the larger population.

Another author grounded in a Newmannian/Rogerian perspective conducted a conceptual analysis according to Walker and Avant’s method (Wendler, 1996). In her findings Wendler (1996) concluded that healing is "an experiential, energy-requiring process in which space is created through a caring relationship in a process of expanding consciousness and results in a sense of wholeness, integration, balance and transformation and which can never be fully known” (p. 841). She highlighted the theme of relationship in healing, which may be more relevant to the level of the individual than to the level of the tissue or organ system.

If one is willing to expand the typical meaning of relating, one might see relationships present in strictly physiological healing, e.g. in wound healing in which cells communicate through chemical signals. This could be considered a form of relationship even at a cellular level. One could further expand the meaning of relating to relationship between physiological and mental variables. A small qualitative study found that persons with non-healing ulcers were
acutely aware of the impact of negative and positive nursing relationships (Morgan & Moffatt, 2008). This study did not seek to correlate the effect of the experience of the nurse-patient relationship on outcome, be it wound size, depression, or quality of life. However, it was clear from the results that the relationship with the nurse could either be an added challenge to an already frustrating situation or make that situation easier.

Despite their focus on the holistic experience of the individuals, many scholars with a unitary perspective see the importance of discrete health challenges, such as chronic wounds. A qualitative study with 18 adults with chronic skin wounds used a research-as-praxis approach based on the work of Newman (Rosa, 2006). As seen in other studies, participants were self-selected from patients of an advanced practice wound care specialist nurse whose practice was built on Newman’s 1999 theory of Health as Expanding Consciousness (HEC). Again, the sampling method introduced bias into the study by only selecting participants who have an appreciation for or prior knowledge of an HEC practitioner. Furthermore, a requirement for participation was having worked with this practitioner for at least 6 weeks, enough time to create a strong bond. While that strong bond may have been therapeutic, it also increased the risk for social desirability bias, especially in participants who depended on the nurse for care. The resultant model of transformation and personal healing describes a journey of healing “when guided by the nurse through phases of self-awareness, deepening awareness, appreciating meaning, and transformation” (Rosa, 2006, p. 357). While this model of healing highlights the important power of nurses and their relationship with the patient in co-creating opportunities for healing, it does little to disentangle the issues surrounding holism in healing. The resultant model claimed to developed a “holistic model for practice” (Rosa, 2006, p. 292). One might assume that this model included the body, though little attention was given to the physiological
domain of participant healing. Interestingly, the author validated the research’s value by stating that helping to change behaviors could mitigate chronic skin wounds.

Scholars have used theoretical perspectives to extrapolate the role of nurses in relationship to healing. Based on Watson’s conceptual model, Hemsely, Glass and Watson (2006a) argued that since nursing is healing work, nurses must be healers. Their study used a phenomenological approach consistent with the work of van Manen. Similar to other studies discussed, the sample was purposive and selected from persons “well-known in holistic nursing circles as practitioners, authors, and/or teachers of healing and healing modalities” (Hemsley et al., 2006, pp. 86-87). Again, this presents problems of sample bias and a potential threat to the validity of the study’s findings. The sample from self-identified holistic nurses also raises an important concern about the role of holism in nursing in general.

Holism and nursing are often considered synonymous. Some would argue that nursing is by definition holistic, so the existence of holistic nursing associations and holistic nurses is redundant. I suggest that while this is to some extent true, these groups and identities capture some particular aspect of nursing, though holistic may not in fact be the most appropriate term. A better term might be integrative or complementary and alternative medicine nursing. In a study conceptualizing nurses as separate from healers, the authors focused on questions about experiences as a nurse healer (Hemsley et al., 2006). The authors also stated that while not all nurses consider themselves healers, many have learned therapeutic touch, which implies this discrete intervention is correlated with healing. There was some evidence from participants’ quotes that there was a dichotomy between the world of professional nursing and the identity and work of being a healer in a more spiritual way. For example, one participant stated “I started to walk two worlds as a nurse, and do healing. You know, there was this temporal, socially
constructed, organized thing called ‘nursing,’ in the social context” (Hemsley et al., 2006, p. 87). This quote shows a sense of division between mainstream nursing and healing work.

Like many other scholars who engage the concept of healing, Zahourek (2012) recognized the lack of clarity on the concept while also acknowledging the centrality of the concept to nursing and other health care professions. Her study used a qualitative grounded theory design based on previous data she had collected for a qualitative study examining intentionality in healing, which I discuss below (Zahourek, 2005). The author defined healing as “the awareness of a shift, a change, or a transition to a new or restored sense of balanced wholeness and wellness. Healing was multifaceted and multidimensional and evolved unpredictably in jumps forward to new states of awareness and sensations” (Zahourek, 2012, p. 13). She went on to say “healing does not occur without intentionality but intentionality exists without healing” (Zahourek, 2012, p. 13). Zahourek stated that physical and spiritual healing were part of the same phenomenon, while maintaining that intentionality was an integral part of the process. The author addressed an obvious concern about physiological healing not requiring intentionality by stating the body has its own awareness of and thus intentionality over wounds and other problems. The work presented strong analyses yet was limited by the scope of the data from the original study that explicitly explored intentionality in healing; the original study is addressed in the next paragraph. Therefore, the conclusions reached by the study, however rich, may represent a degree of circular logic.

Zahourek’s 2005 article used a grounded theory design and sampled 10 pairs of nurse-healers and healees. The analysis confirmed her assertion that intentionality is essential to healing. A major limiting factor was the homogenous sample of white, female, educated and middle-class participants. Another limiting factor was self-selection bias for participation;
participants had to be involved in a nurse-healer-healee relationship. Although not explicitly stated, the work of the nurse-healers tended towards CAM interventions such as therapeutic touch, Reiki, guided imagery, hypnosis, and Amma therapy. This heavy reliance on CAM interventions may limit the relevancy of the findings to nursing in general, as some of the nurse-healers in the study described leaving mainstream health care after being frustrated by the impediments to holistic practice.

**Aiming at Reaching Consensus**

Some scholarship on healing has focused on consensus, whether from a deterministic biomedical perspective or a holistic nursing perspective. The following are several examples from the literature that aimed to synthesize a clearer understanding of healing.

On the topic of wound healing, which is one of the most prevalent usages of the term healing, a recent literature review sought to delineate a practical definition of wound healing. Benbow (2008) described in detail the wound healing process, as well as different types of healing (primary and secondary intention). In addition to robust descriptions of the wound healing process, she offered a concise operational definition in light of her focus on moist wound healing: "The moist wounds healed faster, as measured by the migration of new skin cover of the wound bed" (Benbow, 2008, p. S4). Not all physiologically based conceptualizations of healing are as straightforward.

Despite the strong association between the terms healing and fracture a systematic review of 123 articles regarding fracture healing found there was no consensus in the literature regarding the definition of fracture healing (Corrales, Morshed, Bhandari, & Miclau, 2008). Among the definitions the authors found were clinical measurements, such as the ability to bear weight without pain, and radiological evidence, such as callus formation bridging the fracture.
Like others writing about healing, the authors emphasized the importance of accurate measurement for clinical and research applications. Furthermore, they acknowledged that fracture healing is a process rather than a single event. They suggested that patient priorities be taken into account in measuring the outcomes of bone healing. It could be argued that standardizing healing definitions unnaturally dichotomize the phenomenon, yet without standardized definitions, bias already exists.

The Samueli Definitions and Standards of Healing Committee (Dossey, 2003) offered definitions and standards relating to healing as derived from two conference calls resulting in a publication. The Samueli Institute is an organization dedicated to applying rigorous scientific research methods to understanding healing within the modern health care environment. As previously discussed, this group defined healing as improvement in physical, mental, social or spiritual ways that encourages movement towards wholeness, and may or may not result in a curing (Dossey, 2003). This definition is quite broad and could be applied to a range of processes. However, like many definitions of healing, it is not immediately clear how to operationalize this definition. Again, in the previous definition, the selection of the sample that developed the definition presents a degree of bias and the definition must be interpreted with this knowledge in mind. The reader is not clear on who makes up the Samueli Definitions and Standards of Healing Committee, nor their qualifications for participation.

Since health and healing are closely related, how health is defined affects how healing is defined. Many authors describe health as multifaceted. Willis, Roy and Grace (2008) stated that “health is the embodiment of wholeness and integrity in living and dying,”(p. E35) taking care to point out that health is an experience grounded in the body. Thus, according to this highly cited publication, the discipline and practice of nursing focuses on multiple domains of human
EXPERT NURSES’ CONCEPTUALIZATION OF HEALING

experience. Willis, Roy and Grace (2008) went on to define healing as “the multidimensional unitary human-natural world process of restoring bodily experiences (perceptual-physical) of wholeness, meaning, and integrity in living and dying when it is disrupted” (p. E35). Like other authors previously discussed, they acknowledged that physiological curing is not synonymous with healing. Still, the authors suggested that the nurse might be instrumental in promoting healing through a nursing assessment of the meaning of events, physiological, mental or spiritual, to patients experiencing them.

In the related discipline of medicine, a qualitative study using semi-structured interviews explored the meaning of healing within that field (Egnew, 2005). The purposive sample was small (N=7), but each physician was selected for participation based on publications relating to healing or because of a reputation as an educator. Like McElligot’s (2010) work, Egnew (2005) pointed out the incongruence between the idea that healing is a central part of the discipline (in this case, medicine) and the lack of a robust definition that fully captures the concept. The three themes that emerged from his analysis were wholeness, narrative and spirituality. He arrived at an operational definition—“healing is the personal experience of the transcendence of suffering” (Egnew, 2005, p. 258). Again, similar to McElligott (2010), Egnew (2005) acknowledged that cognitively or mentally impaired persons, or those who are unwilling to heal, may not be able to heal in the sense he has defined it. This study was limited by sampling only a small number of experts in the field of healing or education.

There are many disciplines and people involved in healing work, not just nurses and physicians; a qualitative study attempted to clarify the concept of healing through identifying its meaning to various stakeholders in the primary care setting, namely physicians, nurses (RN and LPNs), medical assistants and patients (Hsu et al., 2008). Interviews were conducted to guide
focus groups, the transcripts of which became the data for analysis. Each focus group was required to come to consensus on the meaning of healing. The resultant definition was that "healing is a dynamic process of recovering from a trauma or illness by working toward realistic goals, restoring function, and regaining a personal sense of balance and peace. Healing is a multidimensional process that includes physical, emotional, and spiritual dimensions" (Hsu et al., 2008, p. 310). In addition, the authors asserted that the essential role of relationships is a theme that appeared in their data.

The study by Hsu et al. attempted to build consensus on the meaning of healing using focus groups with different combinations of stakeholders, a method which results in evidence with both merits and liabilities. Social factors play into focus groups, especially where there are interactions between people with different levels of power, such as patient-physician or nurse-medical assistant dyads. While attempting to address healing from multiple perspectives, the definition resulting from this study lacks specificity for each discipline involved. It is unknown from the study whether there are differences in the way patients, medical staff and nurses see healing. One might argue that healing should have a singular definition, regardless of the discipline involved. Because of the differences in the goals of each health care discipline, however, it is reasonable to expect different definitions of healing based on discipline.

**Concepts Related to Healing**

There are many concepts related to healing that influence both the academic and practice-based conceptualizations of healing. Below I will address two concepts related to healing that are most relevant in light of the above review of the literature. These concepts are caring and holism. Both caring and holism have obvious connections to the practice of nursing when taken at face value, yet both are complex and sometimes self-contradictory phenomena in the
literature. Caring and holism are closely related to healing and therefore will be addressed as such below.

Caring

Caring is a concept closely related to healing. The word caring is sometimes used synonymously with healing (Sitzman & Watson, 2014). Caring has been described as “the central concept and essence of nursing” (Leininger, 1979, p. xii) and this position is echoed by other leading nurse scholars (Watson, 2002). Caring is a requirement for curing (Leininger, 2002). Care is common to all cultures (Leininger & McFarland, 2006) and to humanity throughout history.

Viewing caring as an essential focus of nursing extends back into the historical roots of the discipline:

Caring has been at the heart of nursing’s identity before its recognition as a profession or discipline. The root of the word “nursing” means nurturance or care. Nursing, as a set of nurturing activities focused on caring for the sick, was assigned or ascribed as a role in all societies to healers, members of religious orders, or women in their homes before the role became formalized (Smith, Turkel, & Wolf, 2013).

Even the fact that we call the product of the discipline “nursing care” attests to the important role of caring within nursing. Indeed, this is also true of the terms medical care and care providers.

As noted in a significant comparative review, there are several ways that the term caring has been used in the nursing literature; among these are use of the term to refer to a trait, a virtue, an affect, an intervention, or an interpersonal exchange (Morse, Bottorff, Neander, & Solberg, 1991). Caring in nursing has been described as “an interpersonal process that is characterized by
expert nursing, interpersonal sensitivity and intimate relationships” (Finfgeld-Connett, 2008, p. 198). According to the author, caring may extend to families and loved ones of patients and requires a need in either a physiological, mental or spiritual domain. While caring is a similar concept to healing, it is distinct in that caring is a process that occurs within the bounds of an interpersonal relationship. Some authors have conceptualized relationship as necessary for healing. As previously discussed, healing on the tissue or organ level could be considered to be relational if one considers the multitude of chemical, hormonal and physical communication within an organism. The idea of caring as interpersonal that Finfgeld-Connett (2008) described remains at the level of the individual human. There is a strong association between caring and holism, and Finfgeld-Connett (2008) included as consequences of caring improvements in mental well-being for nurses and patients as well as physical improvements for patients.

Jean Watson is closely associated with the formalization of caring theory in nursing. She described a caring occasion as a transpersonal interaction between patient and nurse (Watson Caring Science Institute, 2013). This work stated that “the transpersonal [caring] nurse has the ability to center consciousness and intentionality on caring, healing, and wholeness, rather than on disease, illness and pathology” (Watson Caring Science Institute, 2013). Within this statement there are themes similar to those previously discussed, such as the differentiation between healing and curing, and the role of intentionality in healing and holism. A major difference between curing and healing is the locus of action. In caring, the locus of action resides in the nurse, whereas in healing it lies in the patient.

Caring is different from healing in other ways, including its requirement of intentionality. As I have discussed previously, some authors believe healing requires intentionality, despite evidence I have discussed to the contrary. It would be difficult to argue that unconscious people
The idea of caring and consciousness is often focused on the consciousness and intentionality of the caregiver-patient dyad. However, literature on caring for the unconscious patient does exist (Geraghty, 2005). I suggest the notion of an unconscious patient caring is a foreign notion to most, whereas the notion of an unconscious patient healing would be much less so. Conversely, an unconscious patient may certainly be cared for, but that same patient may not be healed, even if the care is intended to promote healing. This difference highlights an important distinction between these two related concepts.

The argument for scholarly work on caring is similar to my own argument for studying healing. Essentially, both caring and healing are complex concepts and latent variables that in theory play a large role in health and the work of nursing. Despite this, both concepts retain a degree of ambiguity that inhibits the promotion of these conceptual values of the discipline. Leininger (2002) pointed out that caring is culturally located despite there being some universals surrounding the concept within the human species. In the end, the utility of a concept, whether caring or healing, lies in the ability of individuals to interpret and use the concept in a meaningful manner. When it comes to multiple ways of understanding nursing knowledge and implementing this range of knowing “the ultimate synthesizer of knowledge and its uses in practice must be the nurse” (Roy & Jones, 2007, p. 188). Thus I acknowledge that the import of clarification of any concept is bound within a cultural and historical setting. Yet this is not to dissuade work that may refine existing concepts and interventions to better promote health.

Holism
Holism is a term that is frequently associated with both nursing and healing, yet also remains conceptually vague. The word healing comes from the Old English root hale, meaning whole; this linguistic heritage echoes the assertion that healing is essentially holistic in nature (Engebretson, 2009). There are strong cultural and social associations with the word that can make discussing it dispassionately difficult. The main idea of holism seems to hinge on attending to the multiple factors relevant to human health (whether on the individual, family or population level). This conceptualization is often used in contrast to other approaches that tend to focus on a single, usually physiological, problem.

The American Holistic Nurses Association (AHNA) in 1998 defined holistic nursing as “all nursing practice that has healing the whole person as its goal.” Their website states that “the holistic nurse is an instrument of healing and a facilitator in the healing process;” (American Holistic Nurses Association, 2014) the website stated that using (CAM) interventions was one way these goals were achieved.

The above assertions are problematic for several reasons. First, it is unclear what healing of the whole person means. This lack of conceptual explication of healing is not surprising in light of the other evidence I have presented.

Second, the mention of CAM interventions illustrates a larger issue with the term holistic; namely, that by simply adding some interventions to existing care, the whole spectrum of the person is addressed. Surely no one would argue that adding acupuncture to the care of a person would necessarily address his or her physical, mental, spiritual, cultural and sociological status. While it is possible that whole-person care may occur by virtue of the skill of the nurse, this is not unique to CAM interventions.
The AHNA website stated that holistic nurses were trained and licensed in both mainstream nursing and CAM methodology. This raises the question as to whether one could be a holistic nurse without practicing CAM intervention. The conflation of holism with CAM is problematic in that this definition excludes many providers who try to address physiological, mental and spiritual needs in a sociocultural context regardless of association with CAM or holistic nursing groups. The conflation of CAM and holism is further problematic in that it assumes that practice of CAM automatically takes these variables into consideration.

Third, the very existence of a specialty for holistic nurses seems to imply that those nurses not in said specialty are not holistic in their practice. This is quite a strong claim, especially when the organization has stated that “holistic nursing is not necessarily something that you do: it is an attitude, a philosophy, and a way of being” (American Holistic Nurses Association, 2014). This statement reflects an almost immeasurably nuanced state of being, so one has to consider whether the idea of codifying this state into ANA specialty certification is contradictory. The assumption implicit in the existence of the AHNA is that other nurses are not holistic. With other specialties, the relevancy of the specialty certification is much easier to appreciate. Critical care nurses and school nurses are defined by the setting in which they work and the specific skills and knowledge they use, not the essence of their nursing practice or their way of being. Some have suggested that holistic nursing might be more aptly called “Complementary Nurse[ing]” (Johnson and Johnson, 2014). Some authors previously mentioned were acting as healers from a CAM paradigm more than from a traditional nursing one. Acting as non-traditional healers who also happen to be nurses would be inconsistent with the idea of holistic nursing as integrating CAM into mainstream nursing. Engebretson (2009) discussed the risk of overly valuing the alternative healing systems and disregarding science-based approaches.
The author suggested that “a consistent holistic framework incorporates science but does not hold that paradigm as sufficient for explaining the human experience or for bringing about health or healing” (Engebretson, 2009, p. 230). She recommended a multiparadigmatic approach that acknowledges four major paradigms of health and healing: mechanical, purification-based, balancing and supernormal. She asserted that nurses could better appreciate patients through such a framework by moving between different paradigms and addressing the patient in a way that resonates with the patient’s approach to health and healing.

This dilemma of defining holism and the issues surrounding the term in literature have been appreciated previously by other scholars. Reed (2009) stated that “holism is a default term employed too often in place of clearer and more precise language to describe the perspective and unique contribution of nursing” (p. 103). She pointed out that either “holism is not useful in conveying an integrative perspective for nursing” (Reed, 2009, p. 104) or holistic nursing is redundant. Regardless, she points out that the focus of the discipline should be on what defines nursing rather than what defines holism.

Literature on holism has increased such that some authors are separating complex from simple holism, or holism that is not reductionist from holism that is (Stiles, 2011). Others have explored holism as a philosophical concept. Wolfe (2012) explored the conflict between holism and reductionism by adding chance to his analysis. Two Swedish researchers performed a literature review comparing holism and health promotion in nursing within a Nordic context; they concluded that the terms were similar but distinct. They stated that holistic care often refers to personalized care that takes into account the many variables that affect a person’s wellbeing (physiological, mental, spiritual, sociocultural, and financial) (Povlsen & Borup, 2011).
The concept of holism, like that of healing, is challenging to integrate into or extract from mainstream practice because of its esoteric nature. A good example of this is the statement that “the holistic mode of consciousness is nonlinear, simultaneous, intuitive, and concerned with relationships rather than the elements that are related” (Newman, 2008, p. 39). The author goes on to state that this mode of appreciating reality cannot be understood by “the verbal-intellectual mind.” She asserted that the whole is revealed in the parts. Discussion of holism in this manner borders on mystical.

Still, an almost mystical approach echoes from various other great thinkers and in works of literature on the topic of healing, such as the Tao Te Ching. A passage from this ancient Chinese text reads “once the whole is divided, the parts need names. There are already enough names. One must know when to stop” (Lao Tsu, 1972, p. 32). An empirical, positivist position tends to name parts, whereas other positions allow for particulars to remain embedded in their whole. Arguably, the breadth and depth of scientific knowledge emanating from the scientific literature on healthcare are evidence that there are identifiable particulars. On the other hand, human experience is debatably not merely summative of the various elements that make up each unique life. The idea that holism in nursing practice can somehow address all the various particulars may be overreaching. As Lao Tsu pointed out, “the Tao that can be told is not the eternal Tao. The name that can be named is not the eternal name” (Lao Tsu, 1972, p. 1). As with all language, the concept of holism is a proxy for many things that come together in a gestalt experience of being human.

The root of the complexity of holism is the ontology of being in a world that holds such apparent paradox of both wholeness and particulars. Exploring that essential problem regarding the role of mystical knowledge within a scientific-based paradigm is far beyond the scope of this
review. However, I acknowledge that in as far as wholeness and holism relate to healing, it
remains culturally and intellectually relevant to attempt to understand the meaning of
particularity in a universe conceptualized as whole.

**Nursing Standards**

In this section, I discuss the how important nursing standards address or remain silent on
healing. The selected documents examined have been widely circulated and reflect social,
ethical and historical perspectives.

**American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive
Statements**

The ANA code of ethics helps nurses determine which actions are allowable, which are
forbidden and which are required. The role of healing within the duties of nursing is not stated
explicitly, but related concepts reveal the importance of healing as identified in the following
statement: “Nursing encompasses the prevention of illness, the alleviation of suffering, and the
protection, promotion, and restoration of health in the care of individuals, families, groups, and
communities” (American Nurses Association, 2001, p. 2). The previous quotation aligns with
the multiple ways healing has been articulated within the nursing literature. The document went
on to say in Provision 8 that the duty of nurses includes addressing broader threats to health of
individuals and communities, such as hunger, violence, iniquity and pollution. This statement
supports the holistic nature of nursing.

**The International Council of Nurses (ICN) Code of Ethics for Nurses**
In the preamble to the International Council of Nurses Code of Ethics (International Council of Nurses, 2012, p. 1), two of the four foundational duties of the nurse involve healing: “Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering.” This statement mirrors closely the ANA Code of Ethics in that the restoration to health and the easing of suffering are easily construed as healing.

**America Nurses Association Social Policy Statement**

The American Nurses Association Social Policy Statement is more explicit in referencing the concept of healing. The document states that one of the major defining characteristics of nursing is the “provision of a caring relationship that facilitates health and healing” (American Nurses Association, 2010, p. 10). This depiction echoes the nursing literature in highlighting the importance of relationship and healing.

However, despite healing taking a prominent role in the ANA’s social policy statement, the meaning of healing here is not clearly defined, a fact that has implications for both practice and research. Arguably, it is not necessarily the role of an organization such as the ANA to define such a broad concept that has such import to the discipline. This raises the question as to who should be defining the concept. I argue that tapping into the lived wisdom of expert nurses regarding healing is appropriate, practical and democratic.

**Nightingale’s *Notes on Nursing; What it is, and what it is not...***

Over 150 years ago Florence Nightingale professed that observation and experience were the key elements to promoting healing, a central goal of the nurse. She described this goal in
contrast to the aim of medicine and the conflation of medical intervention with curing or healing that persists today:

We know nothing of the principle of health the positive of which pathology is the negative, except from observation and experience. And nothing but observation and experience will teach us the ways to maintain or to bring back the state of health. And nothing but observation and experience will teach us the ways to maintain or to bring back the state of health. It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions…neither can do anything but remove obstructions; neither can cure; nature alone cures…and what nursing has to do…is put the patient in the best condition for nature to act upon him (Nightingale, 1946, p. 133)

This passage, a widely cited encapsulation of nursing, and balances the need for both a rigorous, scientific approach and one that acknowledges intuition and pragmatism. Nightingale’s sentiment could be considered a foundational statement upon which modern nursing has developed. In the context of the current study, it is important to note that Nightingale uses the word curing where I have used healing. Based on the scientific literature and dictionary record previously reviewed, the conflation of healing with curing is not surprising. The usage of these terms remained stable in the literature from 1800 until around 1970 when the usage of the term healing increased dramatically in published books (Michel et al., 2011), as showed in Figure 1. I argue that the concept of healing has been present in nursing for at least as long as it has existed in modern form.
Incidence of the terms “curing” and “healing” in published books.

Figure 1. Based on a sample of millions of published books. Graph adapted with permission from Google Books Ngram Viewer. http://books.google.com/ngrams

Conclusion

Much is known about healing, yet much about the concept of healing remains obtuse and disconnected from mainstream nurses in practice. Healing is used to mean a process, an outcome and occasionally to describe an intervention. These usages can reflect a physiological, mental or spiritual perspective, or some combination thereof. Therefore, the aim of this work is not to discover something unknown, but rather to explicate what is already known and has been known by generations of nurses as caregivers/healers. This explication of knowledge was accomplished by utilizing an e-Delphi study capitalizing on the strengths of both qualitative and quantitative methods and their respective philosophical perspectives. Special attention was given to avoid the problem of sampling bias noted in the literature. The end result was a set of consensus statements from expert nurses from a variety of settings about the meaning of healing and how it affects nurses’ practice.
Chapter 3

Study Methods

The current study employed an e-Delphi method, which is an electronically delivered series of surveys used to extract data from expert opinion. The Delphi method utilizes both qualitative and quantitative data to systematically develop knowledge from the input of a group of experts. The Delphi method was developed in the 1950s to exploit expert knowledge in predicting outcomes (Helmer & Rescher, 1959). The method reduces pressures from social desirability inherent in any group, yet allows for consensus to emerge. The Delphi method does not produce correct or incorrect answers, but rather “produces valid expert opinion” (Keeney et al., 2011, p. 9). The research questions of the current study, on how nurses conceptualize healing and how this conceptualization affects their practice, are ideally answered by expert opinion. The Delphi method was selected because it is ideal for generating consensus and for determining underlying assumptions that affect nursing judgments and actions (Turoff, 1970).

A key challenge for any researcher using the Delphi method is how to quantify the qualitative data received in the first round. This challenge has long been noted in the literature on the Delphi method and persists as an essential issue for the researcher (Turoff, 1970).

Aside from the utilization of the Internet to deliver the actual survey, this study employed a classic Delphi design over 3 rounds of surveys. The classic approach to Delphi involved the generation of input from experts in Round 1 through qualitative, open-ended questions. When the first round is conducted in this manner it is essentially “an anonymous brainstorming session” (Murry & Hammons, 1995, p. 424). This feature of the method is one of its greatest assets, removing the demand of social desirability from the group consensus-building process. Some have argued, however, that Delphi studies are more accurately described as quasi-
anonymous, as the researcher could connect answers with participant identifying information (Keeney et al., 2011). Collecting some identifying information is not unusual in many study designs and is often a requirement in order to reduce attrition in subsequent rounds. Participants who are late in responding are contacted to encourage full participation, preventing avoidable dropouts from the study with multiple rounds.

The second round consisted of returning the consolidated responses from Round 1 in the form of statements to participants. Participants were asked to rank each statement according to their level of agreement with the statement. The feedback of results from previous round to participants represents another characteristic feature of the Delphi method. This study presented the results in the form of statements about healing as it relates to the work of nurses. Participants were asked to rate how much they agreed or disagreed with each statement using a 4-point Likert scale. The scale was intentionally missing a neutral midpoint. A space was given for comments regarding rationale for selections or other thoughts.

The third round consisted of feedback given to participants as the mean values of responses from Round 2 for each item and combined comments. Comments were reworded and combined into new sentences to reduce the likelihood of being identified by coworkers. Although it is typical for participants to be reminded of their own previous responses, this was not possible due to limitation of the electronic delivery format (Tufts University REDCap [Research Electronic Data Capture]). In the current study when participants were asked to respond to each question again they could answer freely and without the bias of knowing for each item their previous answer. They also were given the option to provide a rationale for why they answered as they did or to give any other comments.

Following the 3rd round, final analysis included mean scores and standard deviations
along with the percent of consensus based on *a priori* criteria set to 70%. Researchers have used a variety of standards for consensus, ranging from 51% to 100% (Keeney et al., 2011; Lakanmaa et al., 2012; Sumsion, 1998). Consensus percentage for an item was calculated by coding responses 1 and 2 (*strongly disagree* and *disagree*) as 0 percentage points and responses 3 and 4 (*agree* to *strongly agree*) as 1 percentage point. The *a priori* consensus level was set to 70%. This consensus number was chosen as slightly less than the midpoint of the recommended range (75.5% is the midpoint of the recommended consensus range of 51 to 100%). This decision anticipated divergent opinions on healing in the nurses from diverse specialties sampled but also sought a strong majority in order to reasonably say that consensus was obtained.

The e-Delphi is essentially a mixed-method approach to consensus; it begins with a qualitative round, followed by two quantitative rounds. Because of this qualitative genesis, the sampling was non-probabilistic. Instead I sampled purposively at the level of the units I selected for recruitment of individual participants. Although preferable, I did not have the option of inviting the entire population of nurses in the health system. In order to obtain a diverse sample of nurses, a variety of specialty areas were targeted for recruitment. I aimed to recruit from specialties such as medical-surgical and intensive care that reflected the national nursing population. I also chose specialties that could potentially have specialty-specific concepts of healing, such as oncology, hospice, wound care and orthopedics. I also selected primary care due to the large percentage of advanced practice nurses practicing in that specialty, although not all advanced practice nurses in this study were in primary care. Therefore, the following units from a large teaching health care organization in New England, a health system of which I am an employee, were included for recruitment: Emergency, Intensive Care, Neonatal Intensive Care, Pediatric Intensive Care, Wound/Ostomy, Orthopedics, Medical-Surgical,
Oncology/Hematology, Pediatrics, Hospice, Palliative care, Psychiatry, Primary Care and Home care. I intentionally sampled from a diverse range of specialties to prevent any group from being over-represented, as the study aimed to study expert nurses in general.

There is no set recommended sample size for a Delphi study (Keeney et al., 2011). The sampling method is not random, but rather recruits participants who can provide valuable information to address the research question. The sampling approach I used reflected the qualitative nature of the first round. It has been suggested, however, that as the diversity of the sample grows, so should the size of the sample to capture the breadth of opinion (Keeney et al., 2011). As with any study, more data presents the opportunity for more richness and/or statistical power, yet also demands more resources. Given the homogeneity of the sample (all nurses from the same health care system) despite the diversity of practice settings, I aimed to recruit 7 to 10 individuals from each setting, with a goal of 77 to 110 participants total.

The validity of the study was threatened by the commitment required for three rounds of participation. This commitment may have introduced selection bias towards persons with strong opinions or persons with enough time for the study. It also presented the risk of attrition, with some authors estimating that a 70% response rate in each round is required to maintain rigor (Keeney et al., 2011; Sumsion, 1998). I assumed the study would enroll 77 participants, therefore, a 70% response rate in Round 2 would result in 53 participants. Typically in Delphi studies, dropout occurs most between Round 1 and 2, so I estimated a final sample size around 50.

Considerable debate exists regarding how experts are defined in Delphi studies. The lack of universal standards around defining experts has been described as a weakness of the method (Hasson, Keeney, & McKenna, 2000). Expert nurses have been defined in many ways, such as
the well-known categories from Novice to Expert (Benner, 2001). Using years of experience is common, but does not address the quality of the experience, nor the knowledge and critical thinking skills developed therein (Baker, 2006). The benchmark of at least 5 years as criteria for expert practice has been suggested (Benner, 2001; Reischman & Yarandi, 2002). This number can be supported by the assertion that "experience is... a requisite for expertise" (Benner, 2001, p. 3). However, both education and experience have been found to be related to self-reported measures of expertise (McHugh & Lake, 2010). I thus aimed to balance the variance caused by experience and education. Therefore, years of experience in a specialty in combination with highest degree earned were used as inclusion criteria.

**Inclusion Criteria**

1. Licensed Practical Nurse (L.P.N.), Registered Nurse (R.N.), or Advanced Practice Registered Nurse (A.P.R.N.)
2. Full-time or part-time clinical nursing work with direct patient care
3. Experience as a nurse in current setting (e.g. Emergency, psychiatric, primary care): 3 years with a Bachelor’s degree (BSN); 2 years with a Master’s (MSN) or doctoral degree (DNP or PhD); or 5 years with Associate’s degree (ADN) or diploma.
4. Identified by manager/supervisor as nurse expert in their practice setting: skilled “know-how,” emotional involvement with patient care and pattern-recognition/intuition (Morrison & Symes, 2011).
5. Willingness to complete 3 rounds of surveys (although completing one survey was the minimum requirement).
Setting and Sampling methods

A challenge of the e-Delphi method is balancing each component of the mixed methods nature of the study. Sampling priorities for qualitative studies often are very different from quantitative studies. Therefore, I used the following method for sampling. First, to ensure that robust qualitative data was generated, I used purposive sampling of units/work settings within the health care system. I selected these specialty settings based on predictions that each would contribute meaningfully to the data. Furthermore, I assumed that the specialties sampled are typical of nurses nationally as previously described. Nurse managers were asked to identify potential participants in their unit based on the above inclusion criteria. They generated and provided me with a list of names so as to prevent a coercive element by having nurses approached by their supervisors for recruitment. Nurse managers were also eligible to participate in the study, assuming they met the inclusion criteria. Nurse managers had an additional screening question asking them to critically consider whether they were nurse experts. (See Appendix B).

After communicating with nurse managers, I invited via email all potential participants in each selected specialty setting to join the study. Before deciding whether to participate, the potential participant was required to determine whether he or she were indeed an expert; “an expert has confidence in his or her knowledge, an expert provides high-quality care” (Enskär, 2012, p. 151). This step required the potential participant to be self-critical, a characteristic which other research has shown expert nurses indeed possess (McHugh & Lake, 2010). In addition to the self-identification of expertness, this study used recommendations from managers as a way to provide both a more objective assessment of nurse expertise and to provide the incentive of the positive feedback of being identified by their supervisor as an expert nurse. It
was hypothesized this identification as a nurse expert and selection for invitation to participate by a manager would improve retention. It is important to note that study materials explicitly stated that there was no obligation to participate and that there were no negative consequences for failure to enroll or failure to complete the study. Potential study participants were informed that managers would not know whether they enrolled or not in the study, nor would managers have any access to information gathered in the study.

Potential participants responded via a secure link within the recruitment email. Informed consent information and agreement were built into the prescreening survey prior to beginning Survey 1. Study data were then collected and primarily managed using REDCap (Harris et al., 2009). This electronic data collection and management tool is hosted at Tufts University, the academic affiliation of the health care system hosting the current study. REDCap is a secure, web-based application designed for capturing data in research applications.

**Instruments**

In Round 1 information was collected through a demographic survey and through open-ended questions. The demographic survey collected data about practice specialty, setting, years as a nurse, entry to practice degree, highest degree obtained, discipline and years in current specialty. Open-ended questions were as follows:

- What does healing mean to you in your nursing practice?
- Are there different kinds of healing and if so, what are they?
- What does healing mean from a nursing perspective in general?
- How do you know when healing is occurring?
- How do you promote healing in your nursing practice?
- What gets in the way of patient healing?
Round 2 featured a survey derived from qualitative content analysis of Round 1. Statements about healing based on the content of Round 1 were accompanied by a 4-point Likert scale score that ranged from 1 (strongly disagree) to 4 (strongly agree) for each statement. Groups of approximately 5 statements were prefaced by a lead-in phrases such as “healing means….” Participants then indicated their agreement or disagreement with the statement.

Round 3 consisted of the same survey used in Round 2 with statistics and aggregated comments for each statement from Round 2. Statistics consisted of mean, standard deviation and consensus level. Factor analysis was planned in the event the sample was large enough, although ultimately the sample size did not meet the assumptions for factor analysis.

**Reliability**

Reliability is the ability to repeat a test on the same sample and obtain the same results each time (Grove & Burns, 2009). Reliability in the Delphi method presents unique challenges. Located in a neomodernist position balancing both positivist and naturalist values and methods makes establishing reliability challenging. Delphi studies have advantages in terms of reliability in that they avoid “group bias and group think scenarios,” (Keeney et al., 2011, p. 97) and as numbers of participants increase, so too does reliability. In a sense, reliability is ensured by the feedback built into the study by means of repeated rounds, especially with the opportunity for comment on responses. The strength of content analysis is that the findings are grounded in data coming directly from participants, thus avoiding forcing preconceived ideas onto participants (Hsieh & Shannon, 2005). This is similar to member-checking, or the process of having participants of a study check the analysis to make sure it accurately reflects the phenomenon. The feedback built into the current study therefore is in line with Whittenmore, Chase and
Mandle’s (2001) meta-synthesis on validation strategies in qualitative research. They summarized validation into the following categories: credibility, or accurately representing participant perspective, authenticity, or the ability to hear a variety of voices in the data, criticality, or a well-thought out overall research plan and integrity, or reflective and self-critical researchers. In considering these four criteria, the first two are clearly related to reliability, or the ability to arrive at the same findings should another researcher undertake the program.

Quantitatively, reliability can be judged by the stability of participant responses between repeated surveys. Greater stability indicates that quantitative results are accurately reflecting participant opinions. Although recommended, few researchers who undertake a Delphi study replicate the study to confirm findings; this is an excellent way to establish reliability (Keeney et al., 2011). Furthermore, this technique could also be adapted for the assessment of reliability in more resource-limited projects by replicating only the quantitative survey.

Validity

Validity describes whether or not an instrument measures the concept it is intended to measure (Grove & Burns, 2009). As with reliability, validity in a Delphi study is complex, given its nature as a mixed method. The definition of validity in qualitative research is not settled. The opinions on validity range from a belief that it is relatively unimportant, to a belief that validity is allegory to quantitative approaches, to a conception that validity requires a postmodern perspective open to metaphor (Creswell, 2007). As discussed previously, Whittenmore, Chase and Mandle (2001) reduced validity to credibility, authenticity, criticality and integrity. In terms of validity, the latter two ideas are most important. Criticality refers to whether appropriate methods were chosen to explore a given question. Integrity measures whether researchers were
adequately self-critical. Both these criteria affect whether a study is able to answer the question for which it was ostensibly designed.

The validity of the current study is bolstered by the generation of items from a group rather than a single individual and the practice experience of the group in the concept of interest (Keeney et al., 2011). That this group sample provides more valid items than item generated by an individual assumes the panel of participants is representative of the population and thus the resulting items are more representative of the ‘real world’ (Keeney et al., 2011). Major threats to validity include selection bias based on individual interest in the study topic and researcher bias during the qualitative content analysis. Researcher bias was mitigated through memoing and transparent coding analysis checked by an outside reader. Selection bias was mitigated by diverse and representative sampling of professional nurses in a large region health system. Because the study does not attempt to establish causality, there is no internal validity to address. Rather, external validity here relates to how applicable the findings are to the larger population of nurses. The diverse sample of nurses in the current study increases validity, but replication of the study in other populations of nurses would augment and clarify the findings of this study.

Data Analysis

As previously noted this e-Delphi study used a mixed method design. The results are reviewed below. Results are discussed by round; the first round was qualitative and the subsequent two rounds were quantitative.

Round 1

Round 1 was analyzed using content analysis. Patterns in responses of participants were collapsed to create statements about healing. Conventional content analysis as described by
Hsieh and Shannon (2005) was used as it is well suited to projects in which the literature lacks a firm theoretical framework and instead allows categories to arise inductively.

The open-ended questions in the first survey sought to elicit responses that captured the disciplinary perspective on healing, ways nurses promote healing, ways nurses assess healing and barriers to healing. Content analysis (Hsieh & Shannon, 2005) was used to reduce the responses into codes and overarching categories. After reading through all participant responses, each response was broken down into meaning units. Meaning units were sections of participant responses that held discrete meaning compared to the complete response. Each meaning unit was extracted from the raw data with associated Participant ID number. All meaning units were then analyzed by the question to which they were responding. The meaning units were read through for overall meaning, then re-read with notes taken regarding themes, noting where other meaning units were similar. Material was iteratively reviewed and responses were collapsed into statements about healing.

Statements were assertions about healing reflecting participant responses that were created for use as items on the quantitative surveys 2 and 3. These statements intentionally avoided using the actual language of participants. Avoiding using the direct quotes from participant comments was done to protect the quasi-anonymity of participants. Participants were anonymous to each other, but would learn of specialties represented and could theoretically make guesses about other participants’ identities. Therefore, changing the wording of responses was done to promote free responses.

A second reader, the dissertation chair, reviewed a random sample of the meaning units with the raw data from which they were extracted. She evaluated the accuracy of the representations of the statements for the meaning units. Questions and concerns regarding
specific meaning units and statements were discussed and either changed or kept depending on the consensus after discussion.

**Round 2**

The next round of the study consisted of a survey with 53 statements about healing. These statements are reviewed in Chapter 4. These statements and demographic information about the group were presented to the participants in Round 2, during which they rated their agreement with the statements on a Likert scale that ranged from 1 (*strongly disagree*) to 4 (*strongly agree*). There was intentionally no midpoint value; this forced participants to agree or disagree with a statement. Mean scores, standard deviations and consensus levels for each item were calculated.

Although the statements were derivatives from the original data as captured in the meaning units, it is useful to consider their relative proportion compared to meaning units. This is because the statements formed the instrument for measuring consensus in Rounds 2 and 3. Statements were grouped by *theme*, the broadest categories that represented the statements (See Table 1).
There were several instances in which the percentage of meaning units and statements for a given theme varied greatly. I will review each.

The theme Nurse Attributes to Promote Healing had a large proportion of meaning units yet was substantially collapsed to 6% of statements. The extensive collapsing of meaning units into relatively few statements was largely in part through grouping how attributes are enacted and therefore visible to patients as shown by nursing action. In addition, the methodology of this study required collapsing the statements to a reasonable number to reduce respondent burden and Nurse Attributes to Promote Healing was a theme where it was possible to do so while keeping the integrity of the original data.
The greater proportion of statements than meaning units about Types of Healing may reflect that the types of healing statements were simply less amenable to collapsing into final statements in a way opposite to what was observed in Nurse Attributes to Promote Healing.

The relatively high representation of the Types of Healing theme by count of statements should be taken in context; this theme was derived from many brief statements that could not be reduced much without losing the original meaning. For example, in the literature, typically body, mind and soul are discussed as domains of healing. In the current study, however, this theme contains many variations of these domains including Psychic, Nutritional Energy and Family healing, all of which have distinct meanings. Statements such as these were not collapsed, thereby inflating the number of statements relative to meaning units and to other themes. The list of types of healing in statements on surveys 2 and 3 was almost equivalent to the list of items generated by the sample.

In the theme Assessment of Healing there was a discrepancy between the representation of meaning units and statements. This theme comprised 6.6% of all meaning units and 13% of all statements. The higher proportion of statements could be related to the challenge in collapsing meaning units into statements. That is to say, there was enough diversity in the participant responses to warrant the construction of proportionally more statements than meaning units in order to represent the full range of responses.

**Round 3**

The statistics of mean, standard deviation and consensus level were provided to participants with each question in Survey 3. Analysis of Round 3 included mean, standard deviation and consensus level, or scores of statements indicating which met the *a priori*
consensus level. Changes in mean, standard deviation and consensus were compared between Survey 2 and Survey 3.

**IRB Approval at Boston College and Study Site**

Institutional Review Board (IRB) approval was granted by the academic health system agency prior to submission to the Boston College IRB. In accordance with Boston College IRB Policy, I elected to have Boston College defer IRB oversight to the health system IRB. The Boston College IRB granted this oversight to the health system prior to initiation of the study. This was valuable, as I was required to submit modifications to the IRB after developing Statements for use on Survey 2.

**Conclusion**

In conclusion, this study utilized a Delphi design, a mixed method approach. The Delphi method is ideal for gaining consensus from a group without the bias introduced by social interaction. This study used email and an online data collection package (REDcap) to invite nurses from a variety of specialties, education levels and experience levels to participate. The first round of the study involved qualitative measures, using open-ended surveys. The responses of these open-ended questions were used to develop the items on the survey used in the second and third rounds of the study. The second and third rounds used quantitative measures, with a Likert scale to assess the level of agreement or disagreement of participants on a given statement about healing derived from Survey 1. Participants were able to make comments on each block of questions in Survey 2 and Survey 3. Comments from Survey 2 and statistics regarding consensus were provided to participants in Survey 3 so they could see group feedback. Results of each round of the study are discussed in Chapter 4.
Chapter 4

To review, the purpose of this study was to understand existent nursing knowledge regarding the concept of healing from a practicing-nurse perspective. Since the conceptualization of healing affects how nurses care for patients this study sought to develop consensus on conceptualizations of healing by expert nurses and explored implications for practice.

Specific aims were to: (1) identify common elements of the concept of healing recognized by expert nurses in practice; (2) Synthesize a concept of healing based on the perspectives of nurse experts from diverse practice settings; and (3) Describe the implications of this synthesized concept for nursing practice, research and education.

The following research questions were posed: (a) How do nurses in practice conceptualize healing? (b) How does this conceptualization affect their practice?

First, demographic information on participants will be reviewed. This will include both personal and professional factors. Next, results will be discussed. Any spelling errors in participant responses have been corrected for readability and are otherwise verbatim.

Sample Characteristics

Approximately 200 nurses were invited to participate in the study, of which 50 ultimately participated in the study. This final sample size represented an overall 25% response rate for the study. The number of 200 was determined by summing the number of nurses invited to the study by group: nurse managers (71), nurses (77) and the estimated number of nurse practitioners (52). The exact number of nurse practitioners invited was estimated due to recruiting from a group of roughly 52 nurse practitioners on a listserve.
A total of 65 nurses who responded to the invitation were eligible for the study and completed the consent form (see Figure 2).

Figure 2

*Study recruitment, enrollment and completion*

These 65 participants were invited to participate in Survey 2 and Survey 3, even if a participant did not complete Survey 1. This flexibility was an intentional design element to reduce attrition. Forty-six participants completed Survey 1. Four individuals did not complete Survey 1 but later completed Survey 2 and/or Survey 3. Thus the final sample of expert nurses consisted of 50 participants.
To check for systematic selection bias in participants who chose not to participle in the study, demographics were reviewed if available. Overall, 86 individuals responded to the email invitation to the study by clicking on a secure link. Of these, 21 participants were either ineligible or chose not to participate during screening. No demographic information was available for these individuals. Fifteen other individuals consented to participate in the study but never completed a survey. Demographic information was available on 13 out of these 15 individuals. Notable differences between these individuals and the sample are reviewed. The ages were similar except that for the nurses who dropped out the average age was 44 years whereas the sample average was 51 years. Of the 15 individuals who consented but dropped out 2 individuals were male and 2 were Black; there was only 1 male, 1 Black person and 1 Hispanic person in the final sample. Of the nurses who dropped out, 27% were from a medical-surgical specialty whereas in the sample medical-surgical nurses accounted for only 10%. Years of experience as a nurse had a somewhat more compressed range for the group that dropped out (1 to 35 years) than the final sample (1-45); the mean years of experience for the group that dropped out was 17 compared to 25 years in the final sample. The mean years of experience in current specialty was lower in the dropout group, with an average of 10 years compared to 25 years in the final sample. Furthermore, the group that dropped out had a more compressed range with a maximum of 25 years compared to a maximum of 42 years of experience in the final sample. Overall, the group that dropped out (for whom there is demographic data) was disproportionately younger, more likely to be in the medical-surgical specialty, and more likely to be male or Black as compared to the final sample. Given the low numbers (fewer than 5) of persons identifying as Black or male, it is not possible to draw conclusions about such small
numbers in both the drop-out group and the final sample and whether the difference in the dropout group and the sample reflects chance or systematic bias.

**Demographic Characteristics of the Sample**

**Personal Characteristics**

Age of participants ranged from 29 to 67 years (mean: 51; SD: 11) and is shown in Figure 3 (see below).

Figure 3

*Age of Participants*

The sample was predominantly female, with 1 male and 1 participant who did not disclose gender. The sample was also primarily self-identified as white, while 1 participant identified as
Black or African American and one as Hispanic. The majority of participants identified as Christian (62%) (see Table 2 below).

Table 2

Religion of Participants

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>%</th>
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</thead>
<tbody>
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<td>10</td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Christian</td>
<td>31</td>
<td>62</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
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<td>8</td>
</tr>
<tr>
<td></td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

Professional Characteristics

The mean years of experience as a nurse was 25 years (SD: 12), ranging from 5 to 45 years (see Figure 4).

Figure 4

Years of Experience as a Nurse
Years of experience in current specialty ranged from 1 to 42 years, with a mean of 15 years (SD 10) (see Figure 5).

Figure 5

*Years of Experience in Current Specialty*

Three participants reported only 1 year of experience in specialty despite inclusion criteria being set to a minimum of 2 years of experience in clinical setting. However, after the study had advanced to Round 2, it was discovered that the screening questions only asked about nursing experience, rather than years of experience in current specialty. The responses of each of these participants were reviewed to assure that none represented an outlier. The qualitative and quantitative responses were in line with other data and thus with dissertation chair consultation the response were retained in the dataset.

The spread of highest nursing degree was skewed towards those with graduate degrees; 7 participants (15%) had an associate’s degree or a diploma, 14 participants (29%) had a bachelor’s degree, 24 participants (50%) held a master’s, and 3 participants (6%) had doctorates, including PhDs and DNPs (see Figure 6).
Most participants did not report having a degree higher than their nursing degree. Nursing licensure was split between advanced practice and RN/LPNs, with notably only one LPN in the sample (see Table 3). One participant had published a paper on a topic related to healing.

Table 3

<table>
<thead>
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<th>Nursing Licensure</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>RN</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>APRN/DNP</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

The range of specialties represented was diverse (See Figure 7).
The largest single group was Primary Care with nearly a quarter of the participants. The sample composition was fairly consistent with expected distributions. Table 4 compares the sample to the sample from a 2008 National RN study (Health Resources and Services Administration, 2010). It is also notable that 8% of participants were considered to be in the other categories. These participants practiced in urgent care, adult intercare flex team, intermediate care and multispecialty care.
Table 4

Percent of Nurses in Specialty Settings

<table>
<thead>
<tr>
<th>Specialty</th>
<th>HRSA 2008</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Women's Health</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Oncology</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Cardiac</td>
<td>17\textsuperscript{a}</td>
<td>10</td>
</tr>
<tr>
<td>ICU/step down</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Medical/surgical</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>Neurology</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Palliative or hospice</td>
<td>7\textsuperscript{b}</td>
<td>4</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Inpatient only  
\textsuperscript{b} Hospice only

This is a survey the U.S. government undertakes every 4 years as part of an effort to maintain and develop a nursing workforce that meets the needs of the population. When comparing the results of this national survey to the sample of this study, it is notable that the current study Medical/Surgical nurses were underrepresented in the study as were ICU/step down nurses.

**Round 1**

**Summary of Responses**

Approximately 200 nurses were invited to participate in the study. Forty-six participants responded to Survey 1 by the due date (one participant completed Survey 1 after this date and was therefore not included in analysis). This represents a 23% response rate for Survey 1.
Results of Round 1 Survey

Round 1 addressed the first aim of the study—to identify common elements of the concept of healing as recognized by expert nurses in practice and their opinions. This round posed 6 open-ended questions to participants:

- What does healing mean to you in your nursing practice?
- Are there different kinds of healing and if so, what are they?
- What does healing mean from a nursing perspective in general?
- How do you know when healing is occurring?
- How do you promote healing in your nursing practice?
- What gets in the way of patient healing?

These open-ended questions allowed participants wide-ranging freedom in their responses.

During analysis, data was reduced from a large number of individual responses to a smaller number of broader but more useful units. First, responses of participants were broken into meaning units (n=472). These meaning units were direct quotes of participants that represented discrete ideas. Next, the meaning units were reduced to statements (n=53). Statements were assertions about healing that captured the essence of multiple meaning units and therefore the responses of participants. These statements were used as the items on quantitative surveys 2 and 3 to determine consensus about how nurses conceptualize healing. Finally, themes (n=6) were developed in analysis of Survey 3 and represent broad over-arching categories of statements. These themes were useful in organizing the results (See Table 5).
Table 5

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Actions to Promote Healing</td>
<td>158</td>
<td>33.5</td>
</tr>
<tr>
<td>Theoretical Understanding of Healing</td>
<td>135</td>
<td>28.6</td>
</tr>
<tr>
<td>Nurse attributes to Promote Healing</td>
<td>67</td>
<td>14.2</td>
</tr>
<tr>
<td>Other Factors that Promote Healing</td>
<td>47</td>
<td>10</td>
</tr>
<tr>
<td>Types of Healing</td>
<td>34</td>
<td>7.2</td>
</tr>
<tr>
<td>Assessment of Healing</td>
<td>31</td>
<td>6.6</td>
</tr>
<tr>
<td>Total</td>
<td>472</td>
<td>100</td>
</tr>
</tbody>
</table>

Results are discussed here by themes. The themes are organized and discussed in the order of the percentage of the meaning units for which they account. This organization weights more heavily the substantive content participants discussed in their responses to the questions related to healing. For example, this organizational logic assumes that if a participant’s response contained 20 meaning units and 15 of the meaning units were related to one theme then that particular theme had greater importance to the participant.

Themes

**Nursing Actions To Promote Healing.** Participants in Survey 1 made more comments relating to the theme Nursing Actions to Promote Healing than any other theme (see Table 4). Of the 472 coded meaning units, a third (n=158) were associated with this theme. The theme *Nursing Actions to Promote Healing* was comprised of the following statements: Viewing and caring for the patient as a whole; Anticipating patient needs and making sure they are met; Encouraging healing practices: for example, meditation, exercise, prayer, physical therapy,
complementary and alternative medicine; Connecting patients with resources, whether community, hospital, or office-based; Frequent contact (rounding, phone calls, visits, etc.); Good assessment and implementation of realistic care plans, with reassessment; Collaborating with team, including family; Offering encouragement/support; Educating patients using clear communication; Advocating for patients; Developing relationships with patients and families; Minimizing or eliminating emotional or physical discomfort; Listening both verbally and non-verbally.

Participant responses demonstrated many actions nurses take to promote healing. One participant answered the question “How do you promote healing for your patients in your nursing practice?” with “by actively listening to both verbal and physical cues. I am aware of different support groups and places of worship. I provide phone numbers and referrals when needed. Something so simple as holding a hand of a scared patient or family member.” This participant’s response was ultimately collapsed into the following statements: Listening both verbally and non-verbally; Minimizing or eliminating emotional or physical discomfort; Connecting patients with resources, whether community, hospital, or office-based; Presence/Caring. It is important to note that the last statement was not an action to promote healing, but a nurse attribute to promote healing. This participant response is an excellent example of how one comment may have layers of meaning, crossing the researcher-imposed boundaries of themes.

Many participants echoed a response about “providing evidence based and other knowledge based recommendations to help patients,” including education, administration of medications and performing treatments. A unique comment was “looking at your patient when
you talk, not at your computer.” This was ultimately collapsed into the statement Viewing and caring for patient as a whole.

**Theoretical Understanding Of Healing.** This was the second largest theme of responses accounting for 28% of coded meaning units (135 out of 472). The theme *Theoretical Understanding of Healing* included the following statements: Providing appropriate diagnoses, treatments and medications, evidence-based when possible; Nurse interventions to promote physical, mental and/or spiritual wholeness; Health optimization or balance; Feeling whole; Improvement in health-feeling well again, Recovery to baseline of health after injury or illness; Transitioning from disequilibrium to new state of balance; Healing is an ongoing, endless process; Healing is not the same as curing; Physical and non-physical healing can happen together OR separately; Physical and non-physical healing happen together, NOT separately; Absence or minimizing of pain or suffering; Achieving state of health acceptable to patient; and Being disease-free.

Participant responses under this theme were varied and addressed several theoretical perspectives. Most participants described healing as occurring in multiple domains. For example one participant stated that, “healing happens mentally, physically and/or spiritually.” Other participants described healing as a transitive action; one nurse asserted that healing meant “providing care to a patient that contributes to improving their well-being, whether acute or chronic illness.” Still others explored the concept of healing in opposition to curing; e.g. “different from being 'cured' as with healing you may be at a different baseline.”

Other perspectives highlighted healing as process, as a “progression to an improved state of health.” Another participant was more specific in calling healing a “transition from a pain (of any kind) or chaos, to a new equilibrium.” This example distinguishes between improved health
and balance. Improved health describes the process of moving from one state to another, in this case a qualitatively or quantitatively better state of health. Balance, or equilibrium, describes a state, in this case, a stable state of health.

Another perspective that was clear from the responses was that healing has a subjective component: “Healing means to feel whole on a physical, mental, and spiritual level.” This statement is about the feeling, or subjective experience, of healing. This sentiment of subjectivity is also strongly echoed in an answer to the question “how do you know when healing is occurring in your patients?” One nurse went so far as to say “[we know healing is occurring by] their own perspective, validated by subjective and/or objective impressions of the caregiver and significant others.” This assertion relies on the assessment skills of the nurse to validate healing as a subjective process.

There were also a number of responses that referred to the objective nature of healing. One participant stated healing meant “when a patient is progressing. They are tolerating their prescribed plan of care and meeting their post-op goals.” Many participants’ responses positioned healing as both a subjective and objective concept: “Improvement based on objective and subjective measures.” The simple idea that healing means “getting better,” as one participant put it, can be viewed in both subjective and objective ways. Observing healing from subjective and objective viewpoints will be discussed in greater detail later in analysis of the theme Assessment of Healing.

**Nurse Attributes To Promote Healing.** There were 67 out of 472 meaning units that referred to attributes of nurses that promote healing. This was the third largest theme of responses accounting for 14.2% of meaning units. The theme Nurse Attributes to Promote
Healing were comprised of the following statements: Critical thinking and expert skill; Patience/compassion without judgment; Presence/Caring attitude.

Many meaning units relating to attributes of nurses were collapsed into actions. This resulted in considerably fewer statements on the quantitative surveys than the proportion of meaning units participants wrote about in the qualitative survey. For example, the initial statement “using gentle nudging rather than commands” was coded into the statement “offering encouragement/support.” The iterative process of coding participant text, collapsing statements and then returning to the original text was important in preserving the original meaning of the participants’ responses. One participant wrote, “I am present. I give my patients the time that they need and I listen. Only then do I offer helpful suggestions. With nursing it’s gentle nudges not commands that get the healing started.” In the context of the complete statement from the participant, one can see how Critical thinking and expert skill, Listening both verbally and non-verbally, and Offering encouragement/support are all part of this participant’s response.

Multiple participants discussed the importance of being non-judgmental. One participant wrote, “I try to empathize with my patients, without a sense of judgment or condescension.” Others discussed compassion: “I try to remember that my patients are going through a difficult time in their lives.” Another participant implored nurses to “always be kind and considerate.” These are examples of meaning units that were collapsed into the statement Patience/Compassion without Judgment.

Another participant highlighted the importance of critical thinking and skill. The participant wrote that healing means “the ability to make a patient feel better through critical thinking, physical care and emotional care.” Although this harkens back to the category Nursing Actions to Promote Healing, here the participant is describing qualities of the nurse, namely, her
or his ability to think critically and perform appropriate interventions. This was one of the meaning units that contributed to the statement Critical Thinking and Expert Skill.

**Other Factors That Promote Healing.** Of the 472 meaning units 47 (10%) addressed non-nursing factors that promoted healing. This proportion is somewhat lower than expected, given that one of the six open-ended questions asked participants to “What Facilitates Healing?” after other questions specifically asking about nursing. The theme Other Factors that Promote Healing included the following statements: Access to resources to meet basic human needs e.g. fluids/nutrition/O2/rest; Individual resilience/desire to heal; Love; Supportive networks; Time/distance; and Well-resourced care environment.

Other Factors that Promote Healing captures items not directly related to nursing but which nurses identified as contributing to healing. This category spanned such statements such as “keeping a calm quiet environment” and “access to resources to meet basic human needs” to “love” and “individual resilience.” Answering the question “what facilitates healing?” one participant answered “it varies; for some patients it is medication or physical therapy. Others, it is education. Still others, it is creating a medium for self-actualization and emotional healing.” This participant’s insight as to the variability of healing mirrored the diversity of responses by other participants.

**Types Of Healing.** An explicit question was posed to participants: “Are there different kinds of healing? If so, what are they?” Despite this being one of 6 questions on Survey 1, only 7.2% of meaning units fell under this category. The theme Types of Healing was comprised of the following statements: Emotional, Energy, Family, Mental, Nutritional, Physical, Psychic, Self-healing, Social, and Spiritual.
Most participants wrote about some combination of body, mind and spirit. One participant wrote, “healing is healing. Where is the wound or brokenness? Is it a physical, spiritual or emotional? Or any combination? [sic] Healing can happen on any or all of these planes.” Another pointed out that healing in one domain does not necessarily result in healing in another: “One can be physically healed from an infection yet still be suffering the psychological effects related to the infection/illness.” Another participant described how these different types of healing catalyst or antagonize each other:

Each affects the other. Many times it is seen that if a person has the mental and spiritual will to live they often survive longer than expected. If the will mentally is not there healing is slowed or halted all together.

These comments help explain some of the items that did and did not reach consensus in later rounds. For example, one could see that this comment might relate to a statement that did not reach consensus, Physical and non-physical healing happen together, NOT separately. In the example from the participant, there is an assertion of connection between physiological, mental and spiritual healing.

The following description from a participant of the types of healing illustrated an interesting perspective on self-healing: “self-healing (an individual goes through a deliberate process), physiologic healing (like from a cut or a burn, or a cold), healing through love and compassion, healing through empowerment.” Although the latter two phrases refer to ways of healing, the participant separated physical healing from an intentional healing process. The former two became statements and types of healing used in later rounds of the survey.

**Assessment Of Healing.** Interestingly, this theme represented the smallest proportion of meaning units that participants discussed in their responses (6.6%). The theme *Assessment of*
Healing included the following statements: Objective findings: for example. A decrease in request for nursing assistance, vital sign stabilization, symptom control, wound improvement, no longer needing treatment; Improved relationships; Increased coping/better mood; Peace or reduced fear; Progressing according to care plan; Increasing autonomy/function; and Patient reports it.

Participants’ responses to the question “How do you know when healing is occurring in your patients?” were generally either subjective or objective, although some were both perspectives. One participant stated simply “the patient tells you so.” Many echoed this statement regarding the subjective component of healing. Another participant described it as “their own perspective, validated by subjective and/or objective impressions of the caregiver and significant others.” This statement added the dimension of observable objective assessment. Still another participant described how he or she knew healing was occurring: “Physically, when they are no longer requiring treatment and have returned to their 'baseline' state of being. Psychologically when they no longer have the negative effects of the disease/illness.” This last statement touches on both the subjective and objective elements discussed regarding how nurses know healing is occurring. Some of the statements like “improved relationships” and “increased coping/better mood” could be either subjective or objective. Even statements that at face value appear objective—like “Progressing according to care plan” and “increasing autonomy/function,”—could be interpreted in either a subjective or objective context. Another participant wrote about increasing autonomy: “accomplishing something that before felt unmanageable (walking, engaging in a difficult conversation, going home).” This quote shows that the assessment of healing has both subjective elements and objective actions that a nurse can observe.
Round 2

Summary of Responses

Survey 2 was sent to the 65 eligible participants who responded to and consented to participate in the study, regardless of whether they had completed Survey 1. One participant responded to Survey 2 who had not completed Survey 1. There were 29 respondents to Survey 2. Determining the retention rate is complex in this study given that participants were eligible to remain in the study even if they completed only one of the surveys. Given that the final sample size was 50, the retention rate in this round was 58%; the retention rate is the number of participants retained divided by the sample size multiplied by 100% (Grove & Burns, 2009).

Survey 2 Results

The total number of respondents to Survey 2 was 29. It is not unusual for Delphi studies to have low response rates, especially in subsequent rounds; this is a well-known limitation of the method (Keeney et al., 2011).

Of the 53 statements derived from the first survey, 51 reached consensus in the 2nd Round (see Table 6).

Table 6

<table>
<thead>
<tr>
<th>Survey 2 Results</th>
<th>Mean</th>
<th>SD</th>
<th>Level of Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educating patients using clear communication</td>
<td>3.89</td>
<td>0.32</td>
<td>100%</td>
</tr>
<tr>
<td>Being patient/compassionate without judgment</td>
<td>3.85</td>
<td>0.36</td>
<td>100%</td>
</tr>
<tr>
<td>Emotional</td>
<td>3.86</td>
<td>0.36</td>
<td>100%</td>
</tr>
<tr>
<td>Viewing and caring for patient as a whole</td>
<td>3.82</td>
<td>0.39</td>
<td>100%</td>
</tr>
<tr>
<td>Collaborating with team, including family</td>
<td>3.82</td>
<td>0.39</td>
<td>100%</td>
</tr>
<tr>
<td>Category</td>
<td>Mean</td>
<td>SD</td>
<td>Completed %</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>-------------</td>
</tr>
<tr>
<td>Individual resilience/desire to heal</td>
<td>3.82</td>
<td>0.39</td>
<td>100%</td>
</tr>
<tr>
<td>Advocating for patients</td>
<td>3.81</td>
<td>0.4</td>
<td>100%</td>
</tr>
<tr>
<td>Improvement in health; feeling well again</td>
<td>3.79</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Offering encouragement/support</td>
<td>3.78</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Presence/Caring attitude</td>
<td>3.79</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Mental</td>
<td>3.79</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Nurse Interventions to promote physical, mental and/or spiritual wholeness</td>
<td>3.75</td>
<td>0.44</td>
<td>100%</td>
</tr>
<tr>
<td>Feeling peace or reduced fear</td>
<td>3.75</td>
<td>0.44</td>
<td>100%</td>
</tr>
<tr>
<td>Energy</td>
<td>3.75</td>
<td>0.44</td>
<td>100%</td>
</tr>
<tr>
<td>Connecting patients with resources, whether community, hospital, or office-based</td>
<td>3.74</td>
<td>0.45</td>
<td>100%</td>
</tr>
<tr>
<td>Developing relationships with patients and families</td>
<td>3.74</td>
<td>0.45</td>
<td>100%</td>
</tr>
<tr>
<td>Listening to patients both verbally and non-verbally</td>
<td>3.74</td>
<td>0.45</td>
<td>100%</td>
</tr>
<tr>
<td>Healing is not the same as curing</td>
<td>3.71</td>
<td>0.46</td>
<td>100%</td>
</tr>
<tr>
<td>Access to resources to meet basic human needs e.g. fluids/nutrition/O2/rest</td>
<td>3.71</td>
<td>0.46</td>
<td>100%</td>
</tr>
<tr>
<td>Physical</td>
<td>3.71</td>
<td>0.46</td>
<td>100%</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3.71</td>
<td>0.46</td>
<td>100%</td>
</tr>
<tr>
<td>Health optimization or balance</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Assessing and implementing good and realistic care plans, with reassessment and adjustments</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Increased coping/better mood</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Patient reports healing</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Self-healing</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Achieving state of health acceptable to patient</td>
<td>3.64</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Anticipating patient needs and making sure they are met</td>
<td>3.64</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Encouraging healing practices: e.g. meditation, exercise, prayer, physical therapy, complementary and alternative medicine</td>
<td>3.63</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Minimizing or eliminating emotional or physical discomfort</td>
<td>3.63</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Supportive networks</td>
<td>3.65</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Transitioning to new state of equilibrium</td>
<td>3.57</td>
<td>0.5</td>
<td>100%</td>
</tr>
<tr>
<td>Absence or minimizing of pain or suffering</td>
<td>3.43</td>
<td>0.5</td>
<td>100%</td>
</tr>
<tr>
<td>Concept</td>
<td>Score</td>
<td>Standard Deviation</td>
<td>Consensus</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------</td>
<td>--------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Love</td>
<td>3.61</td>
<td>0.5</td>
<td>100%</td>
</tr>
<tr>
<td>Nutritional</td>
<td>3.57</td>
<td>0.5</td>
<td>100%</td>
</tr>
<tr>
<td>Well-resourced care environment</td>
<td>3.56</td>
<td>0.51</td>
<td>100%</td>
</tr>
<tr>
<td>Critical thinking and using expert skill</td>
<td>3.61</td>
<td>0.57</td>
<td>96%</td>
</tr>
<tr>
<td>Family</td>
<td>3.61</td>
<td>0.57</td>
<td>96%</td>
</tr>
<tr>
<td>Social</td>
<td>3.38</td>
<td>0.57</td>
<td>96%</td>
</tr>
<tr>
<td>Increasing autonomy/function</td>
<td>3.5</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Psychic</td>
<td>3.56</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Improved relationships</td>
<td>3.36</td>
<td>0.62</td>
<td>96%</td>
</tr>
<tr>
<td>Feeling whole</td>
<td>3.63</td>
<td>0.63</td>
<td>93%</td>
</tr>
<tr>
<td>Recovery to baseline of health after injury or illness</td>
<td>3.43</td>
<td>0.63</td>
<td>93%</td>
</tr>
<tr>
<td>Physical and non-physical healing can happen together OR separately</td>
<td>3.61</td>
<td>0.63</td>
<td>93%</td>
</tr>
<tr>
<td>Making frequent contact (rounding, phone calls, visits, etc.)</td>
<td>3.46</td>
<td>0.64</td>
<td>93%</td>
</tr>
<tr>
<td>Providing appropriate diagnoses, treatments and medications, evidence-based when possible</td>
<td>3.29</td>
<td>0.66</td>
<td>89%</td>
</tr>
<tr>
<td>Objective findings: E.g. A decrease in request for nursing assistance, vital sign stabilization, symptom control, wound improvement, no longer need treatment</td>
<td>3.26</td>
<td>0.76</td>
<td>89%</td>
</tr>
<tr>
<td>Time/distance</td>
<td>3.04</td>
<td>0.79</td>
<td>86%</td>
</tr>
<tr>
<td>Progressing according to care plan</td>
<td>3.14</td>
<td>0.8</td>
<td>82%</td>
</tr>
<tr>
<td>Healing is an ongoing, endless process</td>
<td>3.15</td>
<td>0.86</td>
<td>70%</td>
</tr>
<tr>
<td>Physical and non-physical healing happen together, NOT separately</td>
<td>2.11</td>
<td>1.07</td>
<td>32%*</td>
</tr>
<tr>
<td>Being disease-free</td>
<td>2.18</td>
<td>0.77</td>
<td>25%*</td>
</tr>
</tbody>
</table>

Note: * Did not meet the *a priori* 70% consensus level

The consensus criteria was *a priori* set to 70%, meaning that at least 70% of participants rated a given statement about healing with *agree* or *strongly agree.*

The two statements in this round that did not meet the consensus criteria were “Physical and non-physical healing happen together, NOT separately” and “Being disease-free.” The
former statement had a higher standard deviation relative to other statements and the mean response was lower (Mean = 2.11, Standard Deviation= 1.07). The higher standard deviation indicates that there was a more variable response to this statement. The latter statement had a mean of 2.18 and standard deviation of 0.77, making the statement similar to the larger sample of statements (Field, 2009). In general the responses had low standard deviations relative to the means of each statement, indicating more stability in responses and therefore appropriateness of the mean as a reasonable measure of central tendency.

Notable comments for Survey 2 are discussed below. Participants rejected the idea that healing means being disease-free. One participant wrote in the comment section, “I believe it is possible that a person could achieve 'healing', for example spiritual healing which could mean, for example, acceptance of a diagnoses, in the absence of physical healing.” Another participant echoed this: “Non-physical healing can take place even if physically the patient is physically failing. The spirit can be resilient even if the body isn't.”

Another participant shared insight about larger challenges and implications for the discipline.

[These statements are] the nursing 'ideal.' To suggest that this always happens is not accurate. Barriers to the achievement of these nursing goals often exist, e.g. time constraints, etc. The only reason why I did not 'strongly agree' is because of the constraints facing nurses every day that may impede their accomplishment of these noble goals

This participant identified challenges facing nurses in executing actions that promote healing and also went on to assert that while nurses promote healing, healing is not unique to nursing.
Round 3

Summary of Responses

Survey 3 was sent to the same 65 eligible participants who consented to participate in the study, regardless of whether they had completed Survey 1 or Survey 2. The total number of participants for Survey 3 was 27. This is a 54% retention rate (Grove & Burns, 2009). Three participants completed Survey 3 who did not complete Survey 2.

Survey 3 Results

Most notable in the results of Survey 3 was a decrease by two in the number of statements that met the a priori consensus level of 70%; in Round 3 there was consensus on 49 statements about healing whereas in Round 2 there were 51. Results are presented in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Survey 3 Results</th>
<th>Mean</th>
<th>SD</th>
<th>Level of Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Interventions to promote physical, mental and/or spiritual wholeness</td>
<td>3.93</td>
<td>0.27</td>
<td>100%</td>
</tr>
<tr>
<td>Educating patients using clear communication</td>
<td>3.92</td>
<td>0.27</td>
<td>100%</td>
</tr>
<tr>
<td>Emotional</td>
<td>3.89</td>
<td>0.32</td>
<td>100%</td>
</tr>
<tr>
<td>Collaborating with team, including family</td>
<td>3.88</td>
<td>0.33</td>
<td>100%</td>
</tr>
<tr>
<td>Advocating for patients</td>
<td>3.88</td>
<td>0.33</td>
<td>100%</td>
</tr>
<tr>
<td>Offering encouragement/support</td>
<td>3.88</td>
<td>0.33</td>
<td>100%</td>
</tr>
<tr>
<td>Mental</td>
<td>3.85</td>
<td>0.37</td>
<td>100%</td>
</tr>
<tr>
<td>Viewing and caring for patient as a whole</td>
<td>3.84</td>
<td>0.37</td>
<td>100%</td>
</tr>
<tr>
<td>Achieving state of health acceptable to patient</td>
<td>3.81</td>
<td>0.40</td>
<td>100%</td>
</tr>
<tr>
<td>Access to resources to meet basic human needs e.g. fluids/nutrition/O2 rest</td>
<td>3.81</td>
<td>0.40</td>
<td>100%</td>
</tr>
<tr>
<td>Health optimization or balance</td>
<td>3.78</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Physical</td>
<td>3.78</td>
<td>0.42</td>
<td>100%</td>
</tr>
<tr>
<td>Category</td>
<td>Score</td>
<td>SD</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----</td>
<td>------------</td>
</tr>
<tr>
<td>Encouraging healing practices: e.g. meditation, exercise, prayer,</td>
<td>3.77</td>
<td>0.43</td>
<td>100%</td>
</tr>
<tr>
<td>physical therapy, complementary and alternative medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual resilience/desire to heal</td>
<td>3.77</td>
<td>0.43</td>
<td>100%</td>
</tr>
<tr>
<td>Developing relationships with patients and families</td>
<td>3.73</td>
<td>0.45</td>
<td>100%</td>
</tr>
<tr>
<td>Supportive networks</td>
<td>3.73</td>
<td>0.45</td>
<td>100%</td>
</tr>
<tr>
<td>Connecting patients with resources, whether community, hospital,</td>
<td>3.69</td>
<td>0.47</td>
<td>100%</td>
</tr>
<tr>
<td>or office-based</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased coping/ better mood</td>
<td>3.69</td>
<td>0.47</td>
<td>100%</td>
</tr>
<tr>
<td>Feeling peace or reduced fear</td>
<td>3.68</td>
<td>0.48</td>
<td>100%</td>
</tr>
<tr>
<td>Minimizing or eliminating emotional or physical discomfort</td>
<td>3.65</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Improvement in health; feeling well again</td>
<td>3.63</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Psychic</td>
<td>3.63</td>
<td>0.49</td>
<td>100%</td>
</tr>
<tr>
<td>Making frequent contact (rounding, phone calls, visits, etc.)</td>
<td>3.48</td>
<td>0.51</td>
<td>100%</td>
</tr>
<tr>
<td>Self-healing</td>
<td>3.78</td>
<td>0.51</td>
<td>96%</td>
</tr>
<tr>
<td>Nutritional</td>
<td>3.63</td>
<td>0.57</td>
<td>96%</td>
</tr>
<tr>
<td>Listening to patients both verbally and non-verbally</td>
<td>3.81</td>
<td>0.49</td>
<td>96%</td>
</tr>
<tr>
<td>Healing is not the same as curing</td>
<td>3.77</td>
<td>0.51</td>
<td>96%</td>
</tr>
<tr>
<td>Assessing and implementing good and realistic care plans, with</td>
<td>3.77</td>
<td>0.51</td>
<td>96%</td>
</tr>
<tr>
<td>reassessment and adjustments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being patient/ compassionate without judgment</td>
<td>3.77</td>
<td>0.51</td>
<td>96%</td>
</tr>
<tr>
<td>Patient reports healing</td>
<td>3.65</td>
<td>0.56</td>
<td>96%</td>
</tr>
<tr>
<td>Transitioning to new state of equilibrium</td>
<td>3.62</td>
<td>0.57</td>
<td>96%</td>
</tr>
<tr>
<td>Anticipating patient needs and making sure they are met</td>
<td>3.58</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Well-resourced care environment</td>
<td>3.58</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Absence or minimizing of pain or suffering</td>
<td>3.46</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Critical thinking and using expert skill</td>
<td>3.46</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Increasing autonomy/function</td>
<td>3.46</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Love</td>
<td>3.54</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Presence/ Caring attitude</td>
<td>3.8</td>
<td>0.50</td>
<td>96%</td>
</tr>
<tr>
<td>Physical and non-physical healing can happen together OR</td>
<td>3.44</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>separately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>3.44</td>
<td>0.58</td>
<td>96%</td>
</tr>
<tr>
<td>Statement</td>
<td>Mean</td>
<td>SD</td>
<td>Consensus</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>-----------</td>
</tr>
<tr>
<td>Energy</td>
<td>3.67</td>
<td>0.62</td>
<td>93%</td>
</tr>
<tr>
<td>Feeling whole</td>
<td>3.52</td>
<td>0.64</td>
<td>93%</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3.59</td>
<td>0.75</td>
<td>93%</td>
</tr>
<tr>
<td>Improved relationships</td>
<td>3.08</td>
<td>0.48</td>
<td>92%</td>
</tr>
<tr>
<td>Providing appropriate diagnoses, treatments and medications, evidence-based when possible</td>
<td>3.33</td>
<td>0.68</td>
<td>89%</td>
</tr>
<tr>
<td>Family</td>
<td>3.41</td>
<td>0.69</td>
<td>89%</td>
</tr>
<tr>
<td>Time/distance</td>
<td>2.96</td>
<td>0.53</td>
<td>85%</td>
</tr>
<tr>
<td>Objective findings: E.g. A decrease in request for nursing assistance, vital sign stabilization, symptom control, wound improvement, no longer need treatment</td>
<td>3.04</td>
<td>0.72</td>
<td>85%</td>
</tr>
<tr>
<td>Recovery to baseline of health after injury or illness</td>
<td>3.27</td>
<td>0.78</td>
<td>81%</td>
</tr>
<tr>
<td>Healing is an ongoing, endless process</td>
<td>2.85</td>
<td>0.68</td>
<td>69%*</td>
</tr>
<tr>
<td>Progressing according to care plan</td>
<td>2.77</td>
<td>0.71</td>
<td>69%*</td>
</tr>
<tr>
<td>Being disease-free</td>
<td>2.12</td>
<td>0.59</td>
<td>23%*</td>
</tr>
<tr>
<td>Physical and non-physical healing happen together, NOT separately</td>
<td>2.12</td>
<td>0.77</td>
<td>19%*</td>
</tr>
</tbody>
</table>

Note: * Did not meet the a priori 70% consensus level

The statements that failed to gain consensus from Round 2 remained stable and two additional statements dropped below the 70% consensus mark. The two additional statements that lost consensus in this round were “Progressing according to care plan,” and “Healing is an ongoing, endless process.” It should be noted however, that the negative change in consensus level pushed each statement to 69% consensus, just below the acceptable level. “Healing is an ongoing, endless process” in Survey 2 had 70% consensus. More surprisingly, “Progressing according to care plan,” had 82% consensus in Survey 2 (SD: 0.80) but was rated at 69% consensus in Survey 3 (SD: 0.71). In Survey 2, these two statements had the lowest consensus of those meeting the a priori standard.
Most responses stayed stable or decreased slightly in consensus level. The average change in consensus level from Survey 2 to Survey 3 was -2%. The average change in mean score was -0.99. Three statements increased slightly in consensus level.

There were few comments in Survey 3. One participant wrote, “explain the difference between emotional and mental.” Unfortunately this comment was not seen by the other participants, which could have theoretically made other participants question this difference. This is one of the ways in which the Delphi method seeks to gain consensus through reevaluation with input from peers in a non-social setting. In another comment regarding the statement “Anticipating patient needs and making sure they are met” one participant wrote that “nurses cannot make 'sure' patient needs are met, they can assist the patient in meeting needs, that is all.” This is a point well taken regarding the subtleties of language and how minor changes can alter meaning. Another participant wrote “as someone with a chronic illness, my definition of healing changes all the time. Adjusting my outlook is often needed to feel 'healed.’” This participant was sharing the comment on a personal level in contrast to the professional level, which was the level of the study. Another participant articulated healing as the idea of not letting trauma stop her from doing what she loved personally; when asked specifically about the nursing perspective on healing she offered other interventions, but did not echo the idea she described for herself. Lastly, in an example of how the Delphi method works in consensus building, a participant echoed the comment from Survey 2 about healing not being unique to nursing. This participant wrote in Survey 3, “not unique to nursing-- Strongly agree!!!” after reading the comment in Survey 2.
Synthesized concept of healing

The second aim of this study was to synthesize a concept of healing based on the perspectives of nurse experts from diverse practices settings. Healing is a complex concept, as the findings have demonstrated. This nursing-specific concept of healing that emerged from the data could be described as progression towards wholeness, with subjective and objective outcomes, promoted by the actions of nurses. Ideally these actions take place within a holistic context, although this context is not necessary for healing.

It has been argued that "to some, healing is an intervention: to others, healing is an outcome: to still others, healing is a process. In some unfortunate pieces of writing, healing is all three of these things at the same time" (Levin, 2008, p. 302). My analysis suggests that healing from a nursing perspective, in its most broad context is in fact all three. While Levin’s argument has merit, it may be that the concept of healing is simply a complex phenomenon, which explains why it has been so challenging to utilize in research. To address the diminished conceptual utility of this concept that seems to be three-in-one, it is useful to describe the concept in greater detail as it relates to nursing. Specifically, within the broad concept of healing in nursing are three latent sub-concepts: Healing interventions, healing processes and healing states. All of these sub-concepts can exist and co-exist in multiple domains. SUMMARIZE

Healing Interventions

Healing interventions are actions that nurses take to promote healing. In the participant responses there was no discussion of transactional healing, other than in types of healing such as faith or energy. Instead, the healing interventions area encompasses actions that catalyze a process of healing occurring within an individual or group of people. That is, nurses did not refer to healing as in “he healed the man’s illness,” but rather “his actions helped the man to
heal.” Actions can be primary, or directly affecting an individual or group with a specific outcome desired. Examples of this include administration of medication, dressing of wounds, counseling, education, therapeutic communication, scoliosis screening in schools, or community vaccination events. Actions can also be secondary, or actions that indirectly affect an individual or group. Examples of this are efforts to promote safe staffing, design and maintenance of a care environment, advocacy for populations and health promotion programs. Lastly, healing interventions can be tertiary, or actions that promote healing in a much more distant way.

Participants in this study identified that access to basic human needs was part of healing, which could be considered a tertiary intervention. Patient advocacy was also identified as a healing intervention and this could mean direct or indirect advocacy, such as policy, though this was not explicated in the study. Examples of tertiary interventions are research, education and policy-making.

It could be argued that many of the healing interventions discussed in this study are not nursing-specific. One participant commented that the statements in the surveys were “all noble goals, which by the way, may not be peculiar to 'nurses' but which are an essential part of any genuine nursing response.” I argue that labeling these interventions done by nurses as nursing healing interventions lays claim not of healing to nursing, but of nursing to healing.

**Healing Process**

The healing process is a natural process, yet participant responses yielded little discussion about what that process was or how it worked. This lack of exploration may reflect the clinical nurse’s priorities of action and outcome rather than the more academic or scientific interests in how or why. There seems to be an inherent assumption that the healing process is a natural process, which we see documented in nursing as far back as Nightingale. Given the responses in
this study I conclude that the healing process can occur with or without an individual’s intentional effort. For example, administering physical treatments to an unconscious patient may result in improved objective outcomes. Equally true would be a patient who desired healing and actively sought it in a variety of ways—physical, mental and spiritual.

Participants did frequently describe healing using transitional language such as evolve, become, move on, return to, progression, transition and recovering. This usage of transitional language validates the idea of healing as a process, even if the mechanism is unclear or simply unarticulated. It may be that given the opportunity for more in-depth interviews participants would have described things like the wound healing process, stages of change (as in the Transtheoretical Model) or adaptation to chronic illness as examples of well-understood healing processes. To be clear, no question specifically asked about how healing works. Therefore, further study would be needed in order to determine how practicing nurses conceptualize the mechanisms of healing actions.

**Healing State**

The healing state corresponds to a discrete moment of an individual’s overall health. Interestingly, health and healing are related words. According to the Oxford Dictionary of English Etymology, *health* is example of the Old English –*th* ending in as a “suffix denoting action or process, formed of verb stems” (Onions, Friedrichsen, & Burchfield, 1967). In this case *heal-*th is a noun used to describe a state of restoration to wholeness, which becomes the modern word *health*.

The healing state is ideally an improved, optimized or more balanced state than that of previous time points. One could call this good health or balanced health. As the process of healing is essentially invisible, the healing state can be considered the proxy to measure the
healing process. Just as in plotting a complex curve mathematically requires multiple data points to accurately describe it, mapping the healing process requires multiple data points to articulate that invisible process. It must be noted that this conceptualization of healing is inherently optimistic. Such an optimistic characterization is consistent with the literature and lay understand of healing.

Consider mapping the process of healing—here will be better and worse times, set-backs as well as progress. Examining any of these points in isolation may be cause for despair in some circumstances. However, a conceptualization of healing that allows for this variability even while moving forward allows nurses and patients to continue efforts supporting a healing process, even as challenges and set-backs arise.

The most extreme example of this is end of life. Hospice and palliative care gaining wider acceptance is testimony to the possibility of healing despite decline in certain domains. Nurses are often the frontline providers when patients die, caring for and comforting patient and family alike. Medicine has a reputation for rejecting death and fighting it at all costs; nursing has been and remains the pioneer of the good death. I argue that in part this historical proximity to death as a natural part of life has shaped this implicit nursing concept of healing.

In conceptualizing healing as either a nursing action, a process, a state or an outcome, it is important to recognize the limitations inherent in such a conceptualization. The state or outcomes of this healing process may take on inflated importance, as they are observable. The process of healing, which is arguably the most essential latent sub-concept, is largely invisible. This is due to the lack of suitable methods of observation and the scale of these observations. It is also possible that the current conceptualization of healing is imprecise or inaccurate. It would be dangerous to give greater value to the observable; doing so runs the risks of artificially
assigning outcomes as proxies for healing that may not be occurring. On the other hand, valuing only the process irrespective of outcome ignores the socially mandated duty of the nurses to positively affect change in health.

**Conclusion**

The findings of this study sought to answer two questions: (a) How do nurses in practice conceptualize healing? (b) How does this conceptualization affect their practice? The resulting findings provide insight into the concept of healing in nursing and also demonstrate great consensus on the concept across the sample. The qualitative and quantitative data obtained through the Delphi Method used in this study represent a rich source for understanding the unique nursing perspective on healing. The implications of these results will be examined in Chapter 5.
Chapter 5

Discussion

Based on the results of this study there appears to be a concept of healing for nurses that enjoys broad consensus across multiple specialties and educational backgrounds. As previously discussed, the nursing-specific concept of healing that emerged from the data could be described as progression towards wholeness, with subjective and objective outcomes, promoted by the actions of nurses.

In this chapter first I will discuss specific results from each round of the study. Next I will discuss the synthesized concept of healing. This will be followed by limitations. Lastly, I will discuss implications for practice, education and research.

Demographics

Before I discuss the final sample’s demographics, there are several points worth acknowledging about the demographics of the group who initially consented to the study but dropped out. This group tended to be younger, more likely to be in the medical-surgical specialty and more likely to be Black or male than the final sample. Nurses from a medical-surgical specialty represented 27% of the drop-out group, but only 10% of the final sample. It is possible that there may have been systematic bias in that either these nurses had less time to participant in the study given their work setting or nurses in this specialty are less interested in the subject matter. It is possible that their expectations of the study were not consistent with the actual demands of the study once they completed the screening process. Finally, nurses who dropped out were younger, with a mean age of 30 as opposed to the mean age of 51 in the final
sample. It is possible that younger age may have been associated with poorer time management skills to enable participation in the study; alternatively, younger nurses may have had less interest in sharing knowledge about the concept of healing.

The demographics of the final sample revealed two noteworthy points for discussion. First, the variable years in current specialty by group was positively skewed whereas the variable years since initial licensure was negatively skewed. This difference in distribution means that on average, participants had more experience as nurses in general than in their currently specialty. The average years of experience as a nurse was 25 years (SD 12) while the average years experience in current specialty was 15 (SD 10). This difference indicates that many nurses in the sample switched specialties during their nursing careers. It would be interesting to see the results of a replication of this study with a group of nurses who had not switched specialties. It could be argued that nurses who move within specialties may represent a subset of nurses who desire a higher level of challenge and/or mental stimulation. On the other hand, nurses who stay in a specialty longer may have more insights into the nursing role in their particular specialty and may be able to provide richer data. It is not clear why this inverse relationship between total years of experience as a nurse and years in specialty arose in this sample.

There was a greater proportion of nurses with graduate degrees than expected in this sample. This finding may reflect the possibility that nurses with higher levels of education were more willing to participate in the study, especially given that the content of the study was arguably more intellectual than common nursing tasks. Nurses with more years of education may also better understand the importance of research. Alternatively, nurses with graduate degrees may have been more willing to participate because of in-group bias. By in-group bias I mean that APRNs may have noted the Principle Investigator was an APRN and therefore have
been more likely to participate in the study because they identified with the APRN or graduate nursing trait.

**Round 1**

The responses in the first survey of this study produced a diverse set of data on how expert nurses conceptualize healing. In the results, I noted many themes also present in the scientific literature on healing. Below, I will discuss several notable similarities and differences between the findings of this study and those of the larger body of literature.

**Healing versus Curing**

There is considerable discussion in the literature comparing and contrasting healing and curing (Dossey, 2003; Glaister, 2001; McGlone, 1990; Quinn, 1997; Samueli Institute, n.d.; Trevithick, 2008). The results of the current study are consistent with the frequently expressed idea that healing is not always synonymous with curing. In fact, one of the statements in the current study that failed to gain consensus in the quantitative survey rounds asserted that healing meant being disease free. One could extrapolate this to mean healing is equivalent to curing. That such a statement failed to gain consensus in the current study means that most nurses did not see healing and curing—or the absence of disease—as one and the same. It should be noted, however, that a few did see healing and curing synonymous. The fact that participants spontaneously addressed both healing and curing in the qualitative round validates the argument in the literature that healing and curing are related. Furthermore, the findings of this study suggest that healing and curing are not equivalent. The findings also suggest that healing can mean things like improvements in wounds, vital sign stabilization and the lack of need for
treatment or medication, all of which could be considered synonymous with curing. According to
the participants of this study, the concepts of healing and curing overlap but are not synonymous.

**Subjectivity and Objectivity of Healing**

The findings of this study suggest that healing can be described in both subjective and
objective terms. For example, in one of the most agreed-upon statements in the current study,
healing means “achieving state of health acceptable to patient” and therefore represents a
subjective perspective on healing. On the other hand, a statement specifically naming “objective
findings: E.g. A decrease in request for nursing assistance, vital sign stabilization, symptom
control, wound improvement, no longer need treatment” also met consensus. Nurses in this
study agreed that healing has both subjective and objective elements.

This study found more a broad set of views on healing than Egnew’s (2005) operational
definition of healing, which limits healing to the subjective “personal experience of the
transcendence of suffering” (p. 258). The findings of the current study also acknowledged that
healing was not limited to observable, physiological states. These findings are significantly
broader than a purely physiological index, which is arguably easier to quantify. Consider a
statement about physiological healed by Dave and Loftus (2012) that “mucosal healing should
imply the absence of ulcerations and erosions” (p. 30). The consensus on the concept of healing
in the current study accommodated both objective and subjective outcomes regarding healing.

Participants in this study acknowledged that healing has subjective and objective
elements, some of which are readily assessable to observation. Objective outcomes are by
definition observable while subjective outcomes, such as improvement in mood, may be
observable only in some cases. In the current study a statement derived from participant
comments was “Increased coping/better mood” and was an example of how nurses assess for
healing. In the case of improving mood, a patient may report a change in mood and a nurse may observe the patient is more relational, is more interested in enjoyable activities and is eating and sleeping normally. Improved mood and better coping are ideal examples of outcomes that patients may experience subjectively but that also may be observed objectively.

Healing is both a subjective and an objective phenomenon, and ideally the subjective and the objective indicators of healing align. However, in the case where they disagree the objective may matter less than the subjective, as ultimately it is the meaning of a given state that is important. Just as some disabled persons consider themselves differently-abled, and in fact, improved by their anomaly, so too can some find wholeness or a sense of healing despite external appearances to the contrary. This re-interpretation of one’s state is reflective of the fact that meaning is the ultimate currency of humanity. Meaning has driven wars, the development of modern society, political processes, family dynamics, religions, and the experience of unpleasant but important experiences like childbirth, death and loss.

Although the subjective experience of healing may triumph over objective observations, the nurse is bound to assess both the subjective and the objective and make recommendations on what he or she believes to be most helpful to the individual. Nurses ideally work with patients to set goals based on the priorities of the patient whenever possible. However, they must also use their knowledge and experience in setting priorities based on objective information, not just subjective information. For example, a nurse is obligated to educate a patient on the risks of not taking seizure medications even if the patient believes he is cured of his epilepsy and feels well. It is the purview of the nurse to consider the multiple domains of healing and encourage patients to also consider these. This broad approach to healing is especially important in the mainstream health care system dominated by medicine, fee-for service care and outcomes that may or may
not be relevant to patient goals across multiple domains. Nurses ideally touch on domains representing the whole person, recognizing strengths and barriers; the healing work of the nurse sometimes involves bringing awareness and sometimes involves connecting patients with more appropriate resources.

**Healing as a Process**

Many expert nurses in this study echoed a theme in the literature that healing is a process. Statements such as “transitioning from disequilibrium to new state of balance” “Improvement in health; feeling well again,” and “recovery to baseline of health after injury or illness” all are good examples of healing as a process. Healing as a process was a theme that appeared multiple times in the literature, as discussed in chapter 3 (Dossey, 2003; Glaister, 2001; Hsu et al., 2008; McElligott, 2010; Rosa, 2006; Wendler, 1996; Willis et al., 2008). Even harkening back to Florence Nightingale, healing as a process has been a part of nursing since its modern roots.

Healing is often associated with stages, for example stages of wound healing or stages of grief; therefore, it is a process of moving between stages. While these two examples come from the physiological and mental/spiritual perspectives, it has been suggested that a synthesized concept of healing integrating the physiological, mental and spiritual domains is possible (Paskausky, In Preparation). The complex interaction of these domains is difficult to describe accurately and may not represent a straightforward process.

That healing may not always be linear is consistent with the ideas of many great thinkers in nursing. Most nurses recognize the ebb and flow of progress in patients, whether it is the afternoon temperature spike, the decreased coping after steady improvement in adapting to a new
disability, or relapsing and remitting neurological disease. Healing, then, may not be the linear process we expect for specific cases like wound or bone healing.

**Wholeness**

Participants frequently mentioned wholeness as an important component of healing. The notion of wholeness mirrors an idea well-represented in the literature that healing is a process towards a state of wholeness (American Holistic Nurses Association, 2014; Cowling & Swartout, 2011; Dossey, 2003; Egnew, 2005; McElligott, 2010; McGlone, 1990; Samueli Institute, n.d.; Watson Caring Science Institute, 2013; Wendler, 1996; Willis et al., 2008; Zahourek, 2012). This finding on the importance of wholeness to healing is consistent with the Oxford English Dictionary’s definition of healing as “restoration to health… restoration of wholeness” ("Healing," 2012). That the results of the current study corroborated both the nursing literature and a simple lay definition of healing is encouraging.

Participants’ discussion of the idea of movement towards wholeness was consistent with the arguments other nursing literature such as Roy’s (2008) assertion that “adaptive responses… promote integrity or wholeness” (p. 48). The idea of healing as movement towards wholeness also relates to the assertion that “it is time for nurses to heed our planetary call for healing by expanding their focus beyond nursing the individual-as-client to include nursing the Whole(s) to which they belong” (Stiles, 2011, p. 49). This statement connects not only healing and wholeness, but sets healing into a cosmic perspective.

In a sense, wholeness is at the very heart of the concept of healing. It can refer to the body or the mind, a bone or an emotion. Healing can be subjective or objective, occurring through a linear or a non-linear process. Wholeness then is a flexible yet essential component of the concept of healing.
Healing from a Nursing Perspective

This study contributes to the literature on healing by adding the perspective of mainstream practicing nurses. The current study builds upon Zahourek’s (2005; 2012) work focusing on alternative and complementary healing concepts, and practitioners thereof. It also augments Egnew’s (2005, 2009) work addressing healing in the medical model from a social work scholar’s perspective. The current study enriches Hsu et al.’s (2008) work to understand healing from an interdisciplinary perspective. Furthermore, it builds on the work of McElligott (2010), who published a concept analysis of healing from a nursing perspective. The insights from practicing nurses help clarify what healing means within the discipline.

Importantly, none of the nurses in the current study expressed a sense of division between healing and nursing work. This contrasts with the findings of Hemsely et al. (2006) who reported some participants feeling division between healing work and nursing work. The participants of that study identified healing work more in line with energetic healing and consistent with indigenous shamanic traditions. It is intriguing, and indeed perhaps encouraging, that participants in the current study reported no philosophical barriers to integrating their concepts of healing into their work as nurses. In fact, comments from participants made it clear that healing work is nursing work, even as substantial barriers, such as time and financial pressures, can impede the enactment of this ideal.

Healing and Holism

A concept related to wholeness is holism; six participants directly used the term holism while nearly as many described healing with language about whole-person care. The domains of body, mind and spirit were commonly mentioned, delineating the essential units of the whole
person. One participant stated that healing meant “achieving an acceptable level of functioning in multiple domains including body, mind and spirit.” Another participant responded to the question of what healing meant from a nursing perspective by saying, “nurses provide holistic care. We provide care for the mind and body, assessing the 'whole picture.'” These insights on the role of holism in healing imply that whole-person care does not necessitate a person healing all at once across multiple domains. Rather, healing happens in one or multiple domains and can occur at different times in each domain(s). Nurses ideally consider the whole person in assessment and planning of care, but this does not mean that healing happens all at once across the domains. One participant described the unfortunate expectation of some patients that symptoms should simply be fixed instead of looking at a whole individual; a corollary idea is that whole-person care may not always result in complete or simultaneous resolution of symptoms.

The healing process may not affect all domains equally at the same time, and for some individuals, not all domains will undergo healing. The healing process is not unlike human development, where growth and change occur along a general trajectory, but proceed in a unique way for each individual, with different aspects of growth occurring each at a differing pace. The idea that healing occurs at different rates across different domains resulting in unique patterns for individuals is consistent with a sentiment about healing that Glaister expressed in 2001: “Healing is a natural, active and multidimensional process that is individually expressed with common patterns” (p. 67). The results of the current study supported the multidimensionality of, or the holistic nature, of healing.

Participants in the current study rejected the idea that physical and non-physical healing must occur at the same time. In fact, the statement “Physical and non-physical healing can
happen together OR separately” increased in consensus level between Survey 2 (93%) and Survey 3 (96%). Its inverse statement, “physical and non-physical healing happen together, NOT separately” lost consensus between rounds, moving from 32% to 19% consensus, attaining the lowest final consensus level for any item. This indicates that most nurses in the current study believed that healing in the physical and non-physical domains could occur asynchronously. Specifically, participants rejected the idea that physical and non-physical healing necessarily occurred together.

To address the holistic double standard I discussed in Chapter 2, I argue that holistic care can result in healing in as little as one domain, whether body, mind or spirit. The holism double standard, described by Paskausky (In Preparation), states that if one assumes healing is holistic and can occur without complete resolution of health challenges, or without complete cure, then to exclude purely physiological improvements as healing while allowing for purely mental improvements as healing is inconsistent. I argue instead that holistic care and healing can occur in any or a combination of body, mind and spirit. Avoiding the holism double standard is possible in two ways: first, due to limitations of input from the person doing the healing actions and second, due to internal processes despite the healing actions. Healing as an intrinsic process can be affected positively or negatively by the input received from the interventionist. If a patient needs surgery the finest psychotherapist does not match the need, just as for a patient in need of mental health care the greatest surgeon cannot help. Thus, it is unrealistic to expect any person, nurse or otherwise, to fulfill all the needs of an individual. Nurses are experts in connecting patients with resources as appropriate based on keen assessments. There was 100% consensus on the statement that healing involves “connecting patients with resources, whether community, hospital, or office-based.” Second, given the three domains of healing—body, mind
and spirit—it is possible that even interventions that address the multiple domains of human experience do not yield improvement across those outcomes or states. For example, patients given care that addresses both physical and mental health care may improve in either domain or neither despite the best efforts of the caregiver.

Furthermore, the idea that holistic or whole-person care results in simultaneous whole-person healing may be similar to the myth of multitasking. Miller and Buschman (2015) review evidence from studies on the limited nature of conscious thought, as opposed to the seemingly unlimited nature of other cognitive functions, such as long-term memory. Individuals cannot hold more than a few thoughts in mind during a given moment, even though they may have access to near-countless memories or facts. Healing may be similar in that there are boundaries on what an individual can attend to, to borrow a term from psychology; there may be a limited number of healing processes that can occur at once. That is not to say healing is limited to conscious intention, as I have argued purely physiological improvement in unconscious patients can be healing. However, there may be limits to how much healing can occur at once. For example, a patient re-establishing himself in primary care after ten years who has uncontrolled diabetes, heart failure, chronic back pain and depression likely does not have the capacity to heal in all of these areas simultaneously; the improvement of his hemoglobin A1c may hinge on healing in the mental domain or vice versa. An individual will either consciously or unconsciously prioritize areas from healing based on his needs.

It is important to note the importance of language regarding healing. In the preceding example I discussed healing in the mental domain rather than healing from depression. At present, discussing healing in a given domain, whether physiological, mental or spiritual, may be more appropriate than discussing healing from a given medical condition, such as depression. It
is not clear whether it will ultimately be appropriate to say healing from, healing with, healing in spite of, or simply depression (or other condition) and healing. Further work is required to better understand the more accurate language and how this language affects how nurses practice.

Round 2 and 3

Several findings from Rounds 2 and 3 warrant more extensive examination. I will review and comment on these findings in the following sections.

Consensus on Statements

In the quantitative rounds of this study, the most notable finding was the high level of consensus on most statements generated from the qualitative round. In Survey 3, 49 of 53 statements gained at least 70% consensus. Forty-four statements had over 90% consensus and 23 had 100% consensus. Given the diversity of the sample in specialty setting, age and experience, these strong consensus findings suggest a stable conceptualization of healing amongst nurses. Although this study did not set out to test a formal hypothesis, it can be deduced that if there is a singular concept of healing in nursing, nurses from very different experiences would describe the concept in similar ways. The results of this study support the assertion that there is, in fact, a cohesive conceptualization of healing in nursing. Further studies comparing the concept of healing in nursing to the concepts of other professional and lay groups would help delineate what differences exist between professional groups.

Statements and Meaning Units

As noted in Chapter 4, there were discrepancies in the proportions of statements and meaning units by theme. These discrepancies may have arisen from selection bias on the part of the researcher in the creation of statements based on meaning unit. In this case researcher bias
would have been the undue influence on the coding process of preconceived ideas about healing. The discrepancies could also have developed because some ideas were more or less amenable to collapsing. Steps to limit this bias have been described elsewhere, but it remains a possible explanation or partial explanation for the discrepancy. The relative difficulty of reducing certain ideas is also a plausible explanation for the discrepancy. Overall, these discrepancies did not substantially impact the aims of the study and in some cases may have helped provide insight.

For example, the large proportion of total meaning units in the largest theme, Nursing Actions to Promote Healing, may reflect the action-orientated nature of nursing. Nurses know what actions are important, indicated and effective given various clinical scenarios. The statements in this theme essentially delineated the scope of nursing practice, described tasks of nursing healing-work and outlined ways to execute these tasks. For example, one could say that the scope of nursing is to “anticipat[e] patient needs and mak[e] sure they are met” while “caring for patient as a whole” through “good assessment and implementation of realistic care plans.” The above sentence built from statements in this theme is a succinct encapsulation of the discipline and reflects action-heavy participant responses.

The high proportion of meaning units relating to action stands in contrast to the theme of Assessment of Healing, which had the lowest number of meaning units. Participants wrote substantially less about how to assess whether healing is occurring than what it is or what is done to promote it. I argue that this difference between participant comments about actions to promote healing and assessment of healing reflects the lack of clear operationalization and delineation of characteristics of healing within nursing and particularly amongst nurses in practice. One could argue that the order of the questions may have affected this finding; there was an explicit question regarding assessment of healing that was listed third out of 6 questions.
One could argue that questions presented sooner were given more attention and a more thorough response. I believe this is less likely a significant factor since participants addressed various themes in all questions.

The theme Nursing Attributes to Promote Healing reflects expert nurses’ recognition of nursing presence as therapeutic intervention. As this was the third largest theme by count of meaning units, nurses clearly recognized that there were ways of being or interacting that promoted healing. Interestingly, the attributes “Patience/compassion without judgment” and “Presence/Caring attitude” are hardly represented in licensing criteria. It is notable that the state of Massachusetts has a limited good moral character requirement for licensure as a nurse, but this does not address anything on the order of caring presence, patience or compassion.

Care Plans

A surprising finding was the loss of consensus regarding the statement about care plans in the 3rd round. The wording of the statement was “[healing means] progressing according to care plan.” For this statement, the mean level of consensus dropped 13%, while the standard deviation remained essentially unchanged. The average change in mean level of consensus on all items from Survey 2 to Survey 3 was negative 2%. This decrease means that many participants disagreed that progression according to care plans was a way of practically understanding healing. The number of participants who agreed that progression according to care plans is an indication of healing decreased in the last survey. This indicated more participants did not think progressing according to care plans was a useful measure of healing than in the first two rounds of the study.

There are several possible explanations for the change in consensus seen regarding care plans. First, the change could represent a regression to the mean, which is to say in the second
quantitative survey individuals gave answers that more accurately reflected the population mean (Yu and Chen, 2014). Alternately, this change could also reflect a diminishing demand of social desirability on the part of the participants, again allowing them to give their true opinions. Lastly, reviewing the comments and/or statistics about each statement in the 3rd round may have emboldened nurses to reject care plans as a way of observing healing given the pedagogical importance of care plans. This result could be considered a rejection of one of the essential nursing tools, the care plan, calling into question its value in current nursing practice.

At face value, improvement according to care plans seem like an ideal way to measure a patient’s progress, and this measure should correlate with healing. The negative change in this statement’s consensus level from 82% to 69% raises questions about why this statement saw such a large change between rounds and also why so many in the study ultimately felt care plans did not capture healing. While consensus levels changed by negative 2% on average, this statement changed by negative 13%, the maximum percent change between rounds. While 69% consensus is only 1 point below the *a priori* level, in the current study I cannot demonstrate consensus about care plans as tools for monitoring healing. It is possible that there is lack of valuation of meaningful care plans by administration, insurers, policymakers or consumers. Another possibility is that care plans may be crafted such that they do not capture meaningful healing states or outcomes.

Care plans appear to be created by nurses in the inpatient setting of the health system using templates for creating electronic medical records. No clear guidelines for care plans were discovered upon reviewing the intranet nursing guidelines at the health system in which the study took place. This lack of clear guidelines for care plans stands in contrast to a host of resources about task-specific guidelines, which extended from inpatient care to outpatient procedures.
Notably absent were guidelines for primary care nursing. While participants in this study did not comment specifically on the quality or ease of use of care plans, participant noted barriers to enacting ideal nursing practice. Care plans may be well-intentioned tools that can bring out the best in nursing practice. However, given barriers such as time, financial and staffing pressures these tools may become cumbersome, losing the essence of their intent. Also, some nurses may not be adequately prepared to use care planning effectively based on their educational background, although the results of this study did not speak directly to this question.

**Limitations:**

There were several limitations to this study. Many of these limitations relate to the characteristics of the sample. First, the response rate was lower than anticipated. A low response rate can indicate that results may not be representative of the general population (Grove & Burns, 2009). Furthermore, not all specialties initially targeted were represented in the final sample; notably absent from the final sample were wound and home care nurses. These missing specialties limit the strength of generalization of findings to nursing more generally.

Another limitation is the lack of LPNs included in the study. Screening questions were not piloted nor checked for face validity with LPNs in the health system where the study was conducted. After the study went live, it became clear that there was considerable confusion about the language of diploma versus certificate program for LPNs. This resulted in many eligible LPNs not participating.

Another limitation could be that this study offered no incentives. It could be argued, therefore, that participants were unusually interested in the subject matter and thus not representative of the population of nurses. Lack of incentives may have reduced the retention rate in subsequent rounds.
It also should be noted that the health system in the current study is anchored by a Magnet hospital that may represent a different population of nurses than the general population given the rigorous standards for Magnet designation. That many of the participants were employed by a Magnet hospital could make the results of this study less applicable to the general population of nurses, as the Magnet designation of the hospital requires exceptional professional practice for nurses with a focus on new knowledge, innovation and improvement (American Nurses Credentialing Center, 2014). Nurses employed by a Magnet hospital may have a different educational and practice background than those not practicing in a Magnet facility.

There were also several limitations to this study regarding analysis of data. First, during the coding process there was a lack of team coding. The principle investigator coded all data and a random sample of these codes was reviewed by and discussed with the dissertation chair. However, a stronger approach to analysis would have been to use a team of coders to avoid potential bias or errors in coding, resulting in greater rigor.

**Implications**

Aims one and two, discussed in the previous chapter, identified conceptual elements of healing according to expert nurses in practice and synthesized a concept of healing based on the sample of expert nurses: progression towards wholeness, with subjective and objective outcomes, promoted by the actions of nurses. The third aim of this study was to describe the implications of the synthesized concept of healing for nursing practice, research and education. I will address area each of these topics in the following sections.
Implications for Nursing Practice

The profession of nursing clearly has healing as a goal. The current study validates that goal by demonstrating that nurses from very different specialties and levels of experience have high levels of consensus on what healing means in nursing. The concept of healing has suffered from a lack of conceptual clarity, making clear intervention and assessment difficult if not impossible. Promoting healing requires agreement first on the concept itself, and then on ways of assessing and promoting healing.

Nurses in practice may question the usefulness of theoretical inquiry, arguing it is not practical to patient care. Such an argument could be made by any professional discipline, yet consider the argument previously discussed that “today’s physician can diagnose hypertension or early lung cancer because of something at their disposal that was unavailable to their predecessors: a theory of the processes in the body. This theory is medicine” (Unschuld, 2009, p. 5). Medicine has strongly established the importance of theoretical understanding of the body in informing practice. Similarly, “the heart of nursing must lie in the theoretical understanding of the relationship of the physiological, the mental and the spiritual domains of human experience as they relate to healing” (Paskausky, In Preparation). Even the busiest nurse should appreciate that without concepts and theories about how those concepts relate, nurses are powerless to affect patient health beyond random chance. Using knowledge and theory is at the root of how care improves and patients’ lives are impacted for the better.

Both the literature and the results of the current study suggest that there is a nursing concept of healing guiding practice and that this concept is not driven by financial concerns, even if the concept is affected by such limits. This study adds knowledge about this nursing-specific conceptualization of healing; this knowledge is essential for developing language to
discuss healing in clinical work. From this language, nurses can start to describe their existent assessments and interventions with the central concept of healing in mind. More specific language around healing could also help nurses develop new assessments and interventions based on clinical experience. These interventions could lead to improvements in patient satisfaction, quality of life and other outcomes that have proven challenging to affect in the current patchwork health care environment. As health care trends towards global payments and accountable care organizations, such less-concrete but equally important outcomes may play a greater role in positively advancing the discrete outcomes measured by insurers and government agencies.

As health care becomes increasingly fragmented fostering healing on a system level to promote patient and population healing or wholeness becomes more important. As health care systems try to improve population outcome measures in light of global payment reform, patients are often frustrated by the fragmentation present in health care (The Commonwealth Fund, n.d.). Not only is fragmented care frustrating, but it can also be dangerous or costly in that services may be unnecessarily duplicated (The Commonwealth Fund, n.d.). Nurses are well-positioned to interpret medical information and plans of care from advanced practitioners and physicians, collaborate with other professions (behavioral, physical therapy, occupational therapy) and provide continuity in this fragmented care environment. While some employers are replacing nurses with less educated, less costly personnel, hiring highly skilled, broadly educated nurses can actually save money through providing a less fragmented experience for patients, reducing duplication and costly mistakes. Furthermore, financially it may be more viable to employ a single expert nurse rather than several non-licensed staff members who then require oversight
and time from other licensed staff. Using nurses in this way could positively impact care in both
the inpatient and the outpatient settings.

Framing care teams around healing could help improve patient outcomes. For example,
nurse practitioners could benefit from working with RNs to improve discrete patient outcomes,
increase patient satisfaction and promote opportunities for healing. As advanced practice nurses
are often tasked with billable visits and procedures, RNs would be able to round out the nursing
approach in collaboration with the NP through more contact points with patients and by acting as
advocate, assessor, interpreter, educator, and coach. Nurses are ideal touch-points in the
fragmented health environment given their skills and knowledge in health assessment,
therapeutic communication, education and connecting patients with resources.

Although nurses in this study rejected care plans as useful in assessing healing, nurses are
ideal for coordinating interdisciplinary teams through integrative care plans. Integrative care
plans would involve interdisciplinary input and translate medical, physical therapy, occupational
therapy, nutrition and chaplaincy recommendations into a comprehensive plan to drive care.
Revisiting the care plan as a dynamic tool could allow for planning and monitoring of both
subjective and objective goals relating to patient healing. Improved technology could make
these dynamic, integrated care plans available to anyone with access to electronic medical
records (EMR). Furthermore, technology is now available to allow much of this work of
coordination to occur remotely. Opportunities like home warfarin monitoring, wireless
pedometers and accelerometers, video chat, wireless blood pressure monitoring and telemedicine
could make access to high quality nursing care possible for a greater number of patients.
Technology can reduce the cost of travel time for visiting nurses and the inconvenience of
patients traveling to a clinic. Imagine the scenario in which a rural patient engages in a
telemedicine consultation where his primary nurse is able to remotely join the visit by therefore helping maximize the utility of the visit on the patient’s behalf. The nurse is both a resource to the specialist seeing the patient and to the patient by interpreting information from the specialist and integrating recommendations into the plan of care. Computerized pillboxes that transmit data wirelessly could alert nurses to diminished medication adherence, especially with high-risk medications like Coumadin, anti-seizure medications or diabetes drugs.

Although it is easy to focus on technology and its promise, it is important to address the specific language used to describe healing because this language sets boundaries, expectations and opportunities. Considering the language surrounding healing in nursing is akin to the efforts of NANDA delineating and describing nursing knowledge through standardized nursing diagnoses (NANDA International, 2015). Research in psychology suggests that language is important in creating novel conceptual representations in order to allow the thinker to engage in more rich and complex representations (Carey, 2009). Much as language is a powerful tool, so too is the ability to conceptualize. An improved conceptualization of healing offers opportunities for not only improvement in the development of interventions to promote healing and ways of monitoring and measuring that process, but also for development of novel care delivery systems that address modern patient needs.

Nurses who appreciate and frame their work around the concept of healing could have a unique opportunity for business growth. As public interest in healing grows, framing oneself as a nurse/healer or a nurse healer could present new business opportunities. Claiming healing as an essential part of nursing care that results in nurses being healers requires more clear language and understanding about healing and the nurse’s role. Having that clear language would allow nurses to market their services directly to patient-clients.
The conceptualization of healing derived from the results of this study presents an opportunity for nursing to move from reacting to medical trends to setting nursing healing agendas. Nurses failing to set the healing agenda leads to the question, what exactly are we healing? Nurses can work to develop a less reactive and more robust approach to healing and healing outcomes. The process of bootstrapping from available conceptual representation allows for “the creation of mental symbols that are not yet connected to anything in the world” (Carey, 2009, p. 474). It is through this process that nursing has the opportunity to describe a concept and a way of interacting with that concept in order to ultimate creating that reality. A clearer conceptual goal guiding interventions would allow nurses an opportunity to increase the probability that patients will experience healing.

A more proactive approach to healing in nursing will require going a step further to explore not only the nurse perspective, but also the patient perspective and what is missing in currently available options for healing intervention and promotion. The social mandate of nursing suggests that nurses must be accountable to the needs and wants of patients while still using the specialized skills and knowledge of the discipline to satisfy these patient desires in a reasonable fashion. Understanding what patients truly want in their healing care and outcomes will require further research.

**Implications for Nursing Research**

Considering the results of this study, it would be fruitful to more fully describe the current proxy measurements of healing and what they *ought to be* according to patients and nurses alike. Exploring current proxy measures for healing and patient opinion about ideal proxy measures will help articulate patient-centered nursing care within an interdisciplinary care model.
A specific next step for this line of research will be to retest the statements used in Surveys 2 and 3 with non-nurse health care professionals. Replication of the study with other groups of nurses would also be powerful in testing the reliability of the results of this study. These proposed further studies could shed light on the unique disciplinary perspective of nurses and help define the specific contributions of the discipline to health. It would be useful to determine how other disciplines, be they medicine, physical therapy or pharmacy, would respond to the nurse-generated statements conceptualizing healing. Furthermore, in a replicated study in a non-nursing sample I expect more comments that may provide qualitative data and insight into reactions to the statements about healing developed by nurses. I hypothesize there would be significant differences in the number of statements gaining consensus between the results of the current study and results from medical, mental health or physical therapy providers taking the same survey. Since nurses generated the items on the survey, I hypothesis that there would be less consensus in these non-nurses samples. Furthermore, replicating the complete study with participants from other disciplines would likely yield a very different set of statements about healing.

Related inquiry could examine context-specific types of healing, whether in areas like wound care, mental disorders, obesity or chronic pain. Understanding healing in specific contexts could help describe what factors may promote or prevent healing in certain health challenges. Examining context-specific types of healing could help expose underlying mechanisms of action while articulating unique processes for each health disturbance. For example, one could examine the way interventions are framed and effectiveness across domains for various nursing diagnoses relating to medical diagnoses diseases. Doing so could yield insight into the way healing processes are promoted across disciplines.
Connecting nursing diagnosis and medical diagnosis presents increased opportunities for funding, administrative support and inter-professional collaboration, all of which are in the patient’s best interest. I would expect healing in a patient with a nursing diagnosis of chronic pain and a medical diagnosis of lumbago to differ from healing in a patient with a nursing diagnosis of impaired physical mobility and a medical diagnosis of multiple sclerosis.

Understanding a concept from the universal to the particular, then back from the particular to the universal, allows for a robust refinement of the concept, ultimately leading to better utilization of the concept as a tool. Some argue that a concept can lead to tools, such as instruments for measurement. However, I argue that the concept is a tool in much the way a mold is a tool, setting the parameters for the use of subsequent instruments.

While lay conceptualizations of healing are ubiquitous and useful to the practitioner, formal conceptualizations are essential for research to further refine the concept and utilize it in formal theory testing. A prominent psychologist points out that nonscientists do not build research programs intended to systematically test theories about the world (Carey, 2009). Therefore, the contributions of this study in formalizing nurse conceptualizations of healing provide a more rigorous and useful concept for further study, opening up lines of inquiry for novel research programs. Although nurses in practice are often sources of insight and innovation, it is the nurse scientist who ultimately systematically tests theories and improves upon those insights and innovations.

Further research clarifying the concept of healing could lead to scale development and validated instruments to measure healing, both subjective and objective aspects. Such tools would allow for more rigorous testing of nursing interventions, whether on individual level, or direct interventions, or on a population level, or indirect intervention. Such tools are
essential for providing the valuable quantitative data that informs financial and policy decisions. For example, rigorous study of nurse interventions on an inpatient unit may show correlation or causation of X with healing outcomes that predict lower readmission rates. Such research would allow nurse managers to argue for the time and staffing levels to perform such interventions. In primary care, the use of integrative care plans by nurses may also be correlated with healing outcomes which I hypothesize would in turn correlate with important global payment criteria such as hemoglobin A1c levels, influenza vaccination rates, emergency room utilization and total cost of care.

Nowhere is the concept of healing more important than in chronic disease, which is by definition, illness that cannot be cured. If as a discipline, nurses hold that healing is possible even with chronic disease, these conditions provide significant opportunities to explore healing further. Chronic pain is an example of a growing problem in need of innovation. Chronic pain may come to be similar to hospice care for two main reasons. Both pain and death are avoided at great cost, however, both are natural and—in the latter, unavoidable—experiences. Just as hospice nursing has reframed death such that there can be a “good death” from the perspective of healing presented by nurses in this study so too could there be “good pain.”

There is a great need for innovation in dealing with chronic pain, and studying healing in the context of chronic pain could not only improve quality of life for patients and reduce provider stress, but also save lives. Treatment of chronic pain with opioids and benzodiazepines has greatly contributed to prescription overdose deaths surpassing motor vehicle accidents as leading cause of injury death (Centers for Disease Control and Prevention, n.d.). It is well known, scientifically and anecdotally, that chronic pain is a complex physiological, mental and spiritual state that causes great strife in patients and health care providers alike and frequently is
not well controlled (Bickley, Szilagyi, & Bates, 2013; Institute of Medicine, 2011b; Jarvis, 2012). Therefore, a qualitative study examining healing and chronic pain could shed light on ways to improve care for those suffering with this terrible health condition. Determining factors that promote healing and prevent healing in this population could lead to much needed innovation in a treatment modality that often offers little relief and carries great risks. Chronic pain is often not amenable to curing; therefore healing is often the only possible outcome available.

The word *healing* has powerful connotations, ranging from Biblical to scientific. An interesting line of inquiry would be exploring whether an individual’s associations with the word may itself confer therapeutic qualities. One could argue the meaning an individual ascribes to the term *healing* is a sort of placebo effect inasmuch as labeling something *healing* then taps into the expectation thereof. One could also argue that using existent personal narrative and conceptualizations of the word *healing* could serve as a catalyst to interventions and therapeutic approaches already available. Scientists could study whether there are different patient outcomes based on simply naming therapies or interventions as *healing* when compared with the same therapies or interventions not labeled as healing. Of course, it would be important to explore whether the people involved in the administration of such interventions or therapies were somehow also affected by the label of *healing*.

Given that one of the common meanings of healing is returning to a state of wholeness, nurse-led interventions to promote less fragmented care could create more cohesive health care experiences and thereby better healing outcomes. Positive health care experiences that acknowledge the body, mind and spirit through integrative care plans and team care would likely improve patient satisfaction along with reimbursable measures. Utilizing integrated behavioral
health would acknowledge and aid patients in attending to the variables that currently affect their care decisions, but are not always formally addressed. Directly addressing some of these variables could include addressing family issues arising out of illness, making available resources for social or employment issues and offering health care cost-benefit counseling. Studying such interventions would be fruitful in determining how organizations can make their processes more conducive to healing.

**Implications for Nursing Education**

Healing is a foundational concept in the discipline and profession of nursing, yet the concept has been plagued by a lack of clarity. This lack of clarity may have contributed to the opinion by some that healing is a fringe concept in nursing, given some of the popular uses of the term. Instead, the results of the current study suggest healing is a central concept already present in mainstream nursing. Education that helps student nurses use the concept of healing as an overarching purpose can help guide students’ practice towards whole-person focus and promote the nursing perspective of multiple ways of healing. Utilizing the concept of healing in this way is akin to the inclusion of ethics in nursing education. Even as scholarly interest in healing increases it is not an academic concept at heart, but rather one close to anyone who has been a nurse or has been nursed. The findings of the current study suggest that this concept, like the related concept of caring, has long been at work directing the actions of nurses. A more direct focus on the concept of healing in nursing education would make explicit some of those features of ‘good nursing’ that educators hope to develop in students.

A framework of nursing that focuses on healing is flexible and can accommodate multiple theoretical (and atheoretical) perspectives. Given that healing outcomes can be difficult to measure, such a framework would focus on healing as a natural process that the nurses can
support but do not monopolize. The current study suggests that a framework with healing central to nursing may already exist as a latent concept undergirding the profession.

Much as the nursing role has existed throughout history in many forms, health and healing are ubiquitous concepts found in all cultures throughout history, even as they are re-conceptualized. They provide a human concept for an evolutionarily advantageous state or process. Having a concept then allows individuals and groups to strive for this goal. Concepts like food are easier to see as motivating human behavior, in fact, we share motivation for this concept with organisms that have no conceptual frameworks. The human concept of healing allows for complex organization of cognitions, intentions, and actions to seek goals that are interpreted as health or healing.

In some ways, the utility of healing as a guiding concept in nursing education is less about explanatory power in a theoretical sense, but rather as a watchword or a thesis (e.g. the aim of nursing is to promote health and healing). If one assumes that the goal of nursing is to promote health and healing, all subsequent actions should have those purposes, much as in an essay all points support the thesis. This is to say that in education, health and healing as watchwords provide a simple way for students to take pause in complex clinical situations and evaluate the situation with this goal in mind. For example, a student nurse may wonder how best to care for a patient sickened by community-acquired pneumonia the treatment of which has been complicated by severe personality disorder and poor treatment adherence. A situation such as this may present risk for serious physical decompensation, risk for increased level of care (outpatient to inpatient or from a medical-surgical floor to a critical care unit) and risk for enabling maladaptive mental health behaviors, all in very emotionally challenging interactions. A student could use the thesis of “the goal of nursing is to help patients heal” to explore his
options. This thesis could provide an opportunity for structured review of nursing knowledge about physiological, mental and spiritual needs of patients and intervention options. The student nurse may decide based on a physical assessment that the risk for physical decompensation is too great, thus outweighing other potential therapeutic approaches. The student nurse may also decide that the physiological status is stable, and thus turn to mental health interventions to help the patient improve his health-state.

Another more simple way of putting this idea is for students to ask “How is [a given action] helping a patient heal?” If the student cannot answer this question, she should clarify the goal of the action with instructors or preceptors or reconsider whether this is an appropriate intervention. Using the concept of healing in this way does not replace broader explanatory nursing or biological or psychological theories. However, healing as a guiding concept would serve as a litmus test as to whether the actions of a nurse are answering the social mandate of promoting health and healing.

Conclusion

The results of the current study suggest that there is an underlying concept of healing in nursing. The nursing-specific concept of healing that emerged was that of progression towards wholeness, with subjective and objective outcomes, promoted by the actions of nurses. There was a high level of consensus on the statements about healing created from participant responses.

Within a nursing-specific concept of healing the body, mind and spirit innately have healing potential that can be activated or disrupted through a variety of mechanisms. This potential for promotion or prevention of healing is similar to pharmacology where drugs act on existing pathways: “Drugs primarily have to act at some existing site in the body to have an action... so they really just ‘modulate’ an existing function.” (E. Tessier, personal
communication). Nurses heal through catalyzing natural, existent mechanisms in an individual or community.

Clarifying the concept of healing from a nursing perspective provides the opportunity to help distinguish the current contributions of nurses to improving health and also improve the ways nurses, and health care systems, promote healing. Much like healing itself, work to better understand and promote healing will not be a cure for all that ails people, populations or health care organizations. Instead, a healing-centered approach offers the chance for wholeness despite brokenness, improvement even when incomplete and hope in situations that otherwise appear hopeless.

Healing is not unique to nursing, but the findings of this study suggest a concept of healing is shared among expert nurses in practice. In their everyday work, these nurses catalyze healing through their actions and assessments, through their knowledge and presence in diverse settings. Just as Florence Nightingale (1946) declared the duty of nurse to put the patient in the best position for the natural healing process to unfold, so too is it the duty of nursing scholars to put the nurse in the best position to promote healing for each patient. Thus, the results of this study may ultimately help patients heal by helping nurses improve the ancient practice of promoting health and healing.
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Patient Protection and Affordable Care Act, 42 § 18001 et seq (2010).


Appendix A.

Eligibility Survey

Confidential

Expert nurses' conceptualization of healing: Survey 1

Please complete the survey below.

Thank you!

Eligibility

Are you a licensed L.P.N., R.N., or APRN?  □ Yes □ No

Do you work full- or part-time performing clinical nursing work with direct patient care?  □ Yes □ No

Does one of the following apply to you?  1. ADN/ diploma and at least 5 years nursing experience  □ Yes □ No
2. BSN and at least 3 years nursing experience  3. MSN/doctorate and at least 2 years nursing experience

Are you an APRN or a nurse manager?  □ Yes □ No

Do you consider yourself an expert nurse based on having each of the following?  1. skilled “know-how,”  □ Yes □ No
2. emotional involvement with patient care  3. pattern-recognition/intuition

You are not eligible to participate. Thank you for your interest in the study.

☐ End Survey Now
Appendix B.

Informed Consent

Confidential

Congratulations! You are eligible to participate as an expert nurse. You may now complete the first of the 3 surveys.

Informed Consent Information: Thank you for taking the time to be part in these surveys for research purposes. The purpose of this research is to clarify and gain consensus on a concept that is used frequently in healthcare and nursing, but remains vague: the concept of healing. We expect to include between 50 and 110 people in this study. The surveys will take between 30 to 45 minutes of your time. Your participation in this study is voluntary and your decision will have no impact on your relationship with your colleagues, your supervisor/s or with Baystate Medical Center. This survey includes some questions that may be sensitive or personal. You are free to skip any question for any reason. There is a minimal risk in participating in this series of surveys but there is always the risk of negative feelings while reflecting on patient or personal suffering that precedes healing. We will record the following information about you: your work email address and we will protect the confidentiality of your research information by limiting the ability to connect your responses with your email address to only the Principle Investigator on a secure, Baystate Medical Center approved electronic research platform that is HIPPA compliant. Neither your supervisors nor your colleagues will know whether or not you participate, nor will they know how you respond. You may not benefit from this study although you may experience positive feelings while reflecting on positive experiences with healing, but the information gathered from this study may help in improving nursing science and the way that nurses care for patients. By agreeing to continue with this survey you are consenting to participate in this research study with the understanding that you are free to withdraw at any time. If at any time you wish to discontinue your participation, you may not complete the survey and/or notify the investigator and it will not result in any penalty or loss of benefits to which you are otherwise entitled. As a Baystate employee, your decision to participate or not participate will have no effect on your performance evaluation, nor your employment status. No supervisors or Baystate officials will know whether you participated or not, nor would any supervisors or Baystate officials have access to see your individual responses. If you have any questions about this study, or have a complication or injury that you believe may be related to this study, please contact Anna Paskausky, PhD(c), MS, FNP-BC at anna.paskausky@baystatehealth.org or 413-923-4453. If you would like to discuss your rights as a research participant, or wish to speak with someone not directly involved in this study, please contact Baystate Medical Center Institutional Review Board at (413) 794-4356. Version # 1 Date 9/29/2014 By checking this box I agree to participate in this study. ??_??_??

☐ Yes  ☐ No
Appendix C.

Demographic Survey

Background Information

Please confirm your Baystate email address

Please select the specialty that best describes your primary practice setting?

☐ Cardiac
☐ Emergency
☐ ICU/Step-Down
☐ Medical/Surgical
☐ Neurology
☐ NICU/PICU
☐ Orthopedic
☐ Other
☐ Palliative/Hospice
☐ Pediatric
☐ Primary Care
☐ Psychiatric
☐ Respiratory
☐ Wound

Write in your specialty

Years in current specialty

Years since initial licensure as a nurse

Nursing licensure

☐ LPN
☐ RN
☐ APRN/DNP

Highest nursing degree?

☐ Diploma  ☐ Associate's  ☐ Bachelor's  ☐ Master's  ☐ Doctorate

Highest degree other than nursing if applicable?

☐ Bachelor's  ☐ Master's  ☐ Doctorate  ☐ Not applicable

Race

☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Multiracial
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ White

Write in your race

Gender

☐ Female
☐ Male
☐ Transgender

Age

Religion

☐ Agnostic
☐ Atheist
☐ Christian
☐ Jewish
☐ Muslim
☐ Other
☐ Pagan

Write in your religion

Have you authored any publications relating to healing or similar topic?

☐ Yes
☐ No

You may describe your publications in this space.
Appendix D.

Survey 1

Confidential

The following questions ask for your expert nursing opinion about what healing means and how it affects your patient care. You can be completely honest; there are no wrong answers. You may write as much or as little as you like to convey your opinion. Although you may skip any question, completing each one will improve the scientific rigor of this study, making the results of your efforts more likely to improve patient care.

What does healing mean to you?

____________________________

Are there different kinds of healing? If so, what are they?

____________________________

What does healing mean from a nursing perspective in general?

____________________________

How do you know when healing is occurring in your patients?

____________________________

How do you promote healing for your patients in your nursing practice?

____________________________

What facilitates patient healing?

____________________________

You will receive the follow up survey in approximately 2-4 weeks.

At that time you will read statements about healing drawn from the responses of all survey participants.
Appendix E.

Survey 2

Confidential

Expert nurses' conceptualization of healing: Survey 2

The following statements represent the collective answers of all 61 participants in the study. They represent a range of ways nurses think about healing. The group of nurses participating in this study is diverse; below are some statistics about the group.

Demographics of Participants

Please indicate how much you agree or disagree with the following statements about healing. Feel free to make comments about your answers.

Healing Means:

Providing appropriate diagnoses, treatments and medications, evidence-based when possible.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Nurse Interventions to promote physical, mental and/or spiritual wholeness.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Health optimization or balance.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Feeling whole.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Improvement in health; feeling well again.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Recovery to baseline of health after injury or illness.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Transitioning to new state of equilibrium.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Comments: ____________________________

Healing Means:

Healing is an ongoing, endless process.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Healing is not the same as curing.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Physical and non-physical healing can happen together OR separately.

☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Physical and non-physical healing happen together, NOT separately.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Absence or minimizing of pain or suffering.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Achieving state of health acceptable to patient.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Being disease-free.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Comments: ____________________________________________

---

**Ways nurses promote healing:**

Viewing and caring for patient as a whole.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Anticipating patient needs and making sure they are met.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Encouraging healing practices: e.g. meditation, exercise, prayer, physical therapy, complementary and alternative medicine.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Connecting patients with resources, whether community, hospital, or office-based.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Making frequent contact (rounding, phone calls, visits, etc.).

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Assessing and implementing good and realistic care plans, with reassessment and adjustments.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Comments: ____________________________________________

---

**Ways nurses promote healing:**

Collaborating with team, including family.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree

Offering encouragement/support.

- [ ] Strongly Disagree  - [ ] Disagree  - [ ] Agree  - [ ] Strongly Agree
Educating patients using clear communication.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Advocating for patients.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Developing relationships with patients and families.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Comments: __________________________________________

Ways nurses promote healing:

Minimizing or eliminating emotional or physical discomfort.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Critical thinking and using expert skill.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Being patient/ compassionate without judgment.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Presence/ Caring attitude.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Listening to patients both verbally and non-verbally.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Comments: __________________________________________

Ways we know healing is occurring:

Objective findings: E.g A decrease in request for nursing assistance, vital sign stabilization, symptom control, wound improvement, no longer need treatment.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Improved relationships.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Increased coping/ better mood.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Feeling peace or reduced fear.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
Progressing according to care plan.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Increasing autonomy/function.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Patient reports healing.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Comments: ________________________________

Other Factors that promote healing:

Access to resources to meet basic human needs e.g. fluids/nutrition/O2 rest.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Individual resilience/desire to heal.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Love.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Supportive networks.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Time/distance.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Well-resourced care environment.
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Comments: ________________________________

The follow is a type of healing:

Emotional
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Energy
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

Family
☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree
EXPERT NURSES’ CONCEPTUALIZATION OF HEALING

Confidential

Mental
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Nutritional
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Physical
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Psychic
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Self-healing
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Social
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree
Spiritual
☐ Strongly Disagree  ☐ Disagree  ☐ Agree  ☐ Strongly Agree

Comments: ___________________________________________________

Thank you for your time and opinions! You will receive the final survey with results from today’s survey in 1-2 weeks.
Appendix F.

Survey 3

Confidential

Final Survey

Here are the results from the previous survey round where you were asked to rate how much you agreed or disagreed with statements about healing: 51 statements reached consensus as defined by 70% of the group agreeing with a statement. Below you will find the same statements from the last survey with the following information:

- The level of consensus (percentage of people that agreed or strongly agreed with it),

- The average score (1-4 with 1 lower meaning disagreement and higher meaning agreement), and

- The standard deviation (how spread apart the answers were). As before, please indicate how much you agree or disagree with the following statements about healing. You may answer irrespective of any previous responses. Feel free to make comments about your answers.

As before, please indicate how much you agree or disagree with the following statements about healing. Feel free to make comments about your answers.

Healing Means:

91) Providing appropriate diagnoses, treatments and medications, evidence-based when possible. -Consensus: 89% Mean: 3.29 SD: 0.66
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

92) Nurse interventions to promote physical, mental and/or spiritual wholeness. -Consensus: 100% Mean: 3.75 SD: 0.44
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

93) Health optimization or balance. -Consensus: 100% Mean: 3.68 SD: 0.48
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

94) Feeling whole. -Consensus: 93% Mean: 3.63 SD: 0.63
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

95) Improvement in health; feeling well again. -Consensus: 100% Mean: 3.79 SD: 0.42
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

96) Recovery to baseline of health after injury or illness. -Consensus: 93% Mean: 3.43 SD: 0.63
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

97) Transitioning to new state of equilibrium. -Consensus: 100% Mean: 3.57 SD: 0.5
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

Previous comments include:

When cannot return to baseline, optimize what is possible

Most of above must occur for patient to feel healed.
EXPERT NURSES’ CONCEPTUALIZATION OF HEALING

Healing Means:

99) Healing is an ongoing, endless process. -Consensus: 70% Mean: 3.15 SD: 0.86
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

100) Healing is not the same as curing. -Consensus: 100% Mean: 3.71 SD: 0.46
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

101) Physical and non-physical healing can happen together OR separately. -Consensus: 93% Mean: 3.61 SD: 0.63
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

102) Physical and non-physical healing happen together, NOT separately. -Consensus: 32% Mean: 2.11 SD: 1.07
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

103) Absence or minimizing of pain or suffering. -Consensus: 100% Mean: 3.43 SD: 0.5
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

104) Achieving state of health acceptable to patient. -Consensus: 100% Mean: 3.64 SD: 0.49
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

105) Being disease-free. -Consensus: 25% Mean: 2.18 SD: 0.77
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

Previous comments include:

These are nursing ideals, which often do no occur because of barriers and everyday constraints to practice

106) Comments:

Ways nurses promote healing:

107) Viewing and caring for patient as a whole. -Consensus: 100% Mean: 3.82 SD: 0.39
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

108) Anticipating patient needs and making sure they are met. -Consensus: 100% Mean: 3.64 SD: 0.49
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

109) Encouraging healing practices. e.g. meditation, exercise, prayer, physical therapy, complementary and alternative medicine. -Consensus: 100% Mean: 3.63 SD: 0.49
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

110) Connecting patients with resources, whether community, hospital, or office-based. -Consensus: 100% Mean: 3.74 SD: 0.45
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
111) Making frequent contact (rounding, phone calls, visits, etc.). -Consensus: 93%  Mean: 3.46  SD: 0.64
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

112) Assessing and implementing good and realistic care plans, with reassessment and adjustments. -Consensus: 100%  Mean: 3.68  SD: 0.48
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

113) Comments:

   Ways nurses promote healing:

114) Collaborating with team, including family. -Consensus: 100%  Mean: 3.82  SD: 0.39
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

115) Offering encouragement/support. -Consensus: 100%  Mean: 3.78  SD: 0.42
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

116) Educating patients using clear communication. -Consensus: 100%  Mean: 3.89  SD: 0.32
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

117) Advocating for patients. -Consensus: 100%  Mean: 3.81  SD: 0.4
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

118) Developing relationships with patients and families. -Consensus: 100%  Mean: 3.74  SD: 0.45
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
   Previous comments include:
   These are good goals, not unique to nursing.

119) Comments:

   Ways nurses promote healing:

120) Minimizing or eliminating emotional or physical discomfort. -Consensus: 100%  Mean: 3.63  SD: 0.49
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

121) Critical thinking and using expert skill. -Consensus: 96%  Mean: 3.61  SD: 0.57
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

122) Being patient/ compassionate without judgment. -Consensus: 100%  Mean: 3.85  SD: 0.36
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

123) Presence/ Caring attitude. -Consensus: 100%  Mean: 3.79  SD: 0.42
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
124) Listening to patients both verbally and non-verbally. -Consensus: 100% Mean: 3.74 SD: 0.45
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

125) Comments: _____________________________________________

**Ways we know healing is occurring:**

126) Objective findings: E.g A decrease in request for nursing assistance, vital sign stabilization, symptom control, wound improvement, no longer need treatment. -Consensus: 89% Mean: 3.26 SD: 0.76
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

127) Improved relationships. -Consensus: 93% Mean: 3.36 SD: 0.62
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

128) Increased coping/better mood. -Consensus: 100% Mean: 3.68 SD: 0.48
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

129) Feeling peace or reduced fear. -Consensus: 100% Mean: 3.75 SD: 0.44
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

130) Progressing according to care plan. -Consensus: 82% Mean: 3.14 SD: 0.8
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

131) Increasing autonomy/function. -Consensus: 96% Mean: 3.5 SD: 0.58
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

132) Patient reports healing. -Consensus: 100% Mean: 3.68 SD: 0.48
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

   Previous comments include:

   Required for healing.

133) Comments: _____________________________________________

**Other Factors that promote healing:**

134) Access to resources to meet basic human needs e.g. fluids/nutrition/O2 rest. -Consensus: 100% Mean: 3.71 SD: 0.46
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

135) Individual resilience/desire to heal. -Consensus: 100% Mean: 3.82 SD: 0.39
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree

136) Love. -Consensus: 100% Mean: 3.61 SD: 0.5
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
137) Supportive networks. -Consensus: 100% Mean: 3.65 SD: 0.49
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
138) Time/distance. -Consensus: 86% Mean: 3.04 SD: 0.79
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
139) Well-resourced care environment. -Consensus: 100% Mean: 3.56 SD: 0.51
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
140) Comments: ________________________________

The follow is a type of healing:

141) Emotional -Consensus: 100% Mean: 3.86 SD: 0.36
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
142) Energy -Consensus: 100% Mean: 3.75 SD: 0.44
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
143) Family -Consensus: 96% Mean: 3.61 SD: 0.57
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
144) Mental -Consensus: 100% Mean: 3.79 SD: 0.42
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
145) Nutritional -Consensus: 100% Mean: 3.57 SD: 0.5
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
146) Physical -Consensus: 100% Mean: 3.71 SD: 0.46
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
147) Psychic -Consensus: 96% Mean: 3.38 SD: 0.57
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
148) Self-healing -Consensus: 100% Mean: 3.68 SD: 0.48
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
149) Social -Consensus: 96% Mean: 3.38 SD: 0.57
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
150) Spiritual -Consensus: 100% Mean: 3.71 SD: 0.46
   □ Strongly Disagree □ Disagree □ Agree □ Strongly Agree
151) Comments: ________________________________

Thank you for your time and opinions! You will receive the final results as soon as analysis is complete.