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A framework for holistic nursing care in paediatric nursing

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CHAPTER ONE

ORIENTATION TO THE STUDY

I.1 INTRODUCTION

In this chapter, I intend to orientate the reader to the background and the rationale of the study, the purpose, and objectives that guided the study. The reader is introduced to the journey that has led to this conceptualisation of the research. I will give a brief explanation of the concept of holism and holistic care and its current usage within the health care system in South Africa. The concept of caring in nursing is briefly explained. This chapter further outlines the methodology, explaining the problem statement, research questions, and the aim of the study, the researcher's assumptions, research design, sampling procedures, and data collection methods and data analysis procedures. Measures used to ensure trustworthiness are briefly described and ethical considerations articulated.

1.2 CONCEPTUALISATION OF THE STUDY

I have been a paediatric nurse for twenty-five years and have had the privilege of working in three different hospitals in Johannesburg. As a paediatric nurse, I am often fascinated by the health seeking behaviours of the majority of parents of African descent. These parents would consult the Western system of medicine for immediate symptomatic relief while traditional healers would be consulted for the cause of the

illness in relation to the holistic view of peace and harmony. Parents would first consult their traditional healers and later present the child to hospital. Once the initial symptoms are treated, the same parents would request discharge from hospital so that the child can be taken to a traditional healer or faith healer. The traditional healer would perform a traditional family ritual to seek the cause of the illness and often the family would perform a bloodletting ceremony by slaughtering either a goat or chicken for the ancestors as a peace offering. Consulting the traditional or faith healer and a medical doctor can happen at the same time.

This consultative process has been acknowledged as based on differing world-views between parents and health professionals with respect to definitions and meaning of health and illness (Herselman, 1997: 38). Explanations for the incidence and causes of sickness differ as evidenced by a range of treatment options to which people turn to in order to lessen the burden of anxiety related to illness. Some of the parents who prefer to consult traditional healers before presenting their children to hospital would continue to administer their prescriptions from traditional healers to their children while under the care of a paediatrician. In talking to some of these parents, often they would state that traditional healing addresses illness in a holistic manner. The treatment modalities used by traditional healers according to these parents involve re-establishment of good relationships with the social and natural environments as well as the supernatural worlds, rather than treatment of specific disease symptoms. Hammond –Tooke (1989: 10) concurs and explains that consulting an indigenous healer or faith healer may be first to impose meaning and significance on the existential experience for those who prefer to use the traditional system of health care. Herselman (1997: 38) confirms this and argues that reasons for the dual consultation

vary and clients in their quest for optimal health may use the two systems as a means of maximising their chances of recovery. Muller (1999) is of the opinion that indigenous health care beliefs view western medicine as inadequate in addressing the cause of the disease while the alternative traditional healers are perceived to be giving instructions to relieve the causative hostility as well as the advice and treatment on how best to restore harmony and holism (Muller, 1999). This dual consultation can be understood from the holistic view of the traditional treatment modalities. In the following discussion, the South African system of health care is described incorporating the formalised view on how to incorporate the traditional health care system within the mainstream of health care delivery.

1.3 SOUTH AFRICAN HEALTH CARE SYSTEM

A health care system originates and develops based on health care perspectives and at the very core of people's health views are culturally determined beliefs and values (Tjale & de Villiers, 2004). The health care system in Southern Africa is described as western medicine co-existing with traditional indigenous medicine. The two health systems have existed side by side and the health care consumers do not necessarily experience it as separate or mutually exclusive. Both health care systems have emerged from two distinct cultural perspectives. Two dominant and different paradigms are in existent: the biomedical and the magico-religious paradigms; based on health care values that are culturally diverse with differing world-views especially with respect to the definition and meaning of health and illness (Tjale & de Villiers, 2004). The biomedical paradigm is scientifically characterised by several forms of symbolic thought. According to this worldview, life is controlled by a series of

physical and biochemical processes that can be studied and manipulated by humans. It is explained by means of empirically based cause and effect (Andrews & Boyle, 1999: 321). The magico-religious approach, on the other hand, can be understood through the holistic explanatory model. The holistic explanatory model is the belief that harmony must exist within the body, the physical and social environment. A state of harmony leads to health while disharmony will result in illness (Andrews & Boyle: 1999: 321).

This worldview largely influences and informs clinical practice, education of nurses and all forms of nursing specialisation in this country. It is in the clinical nursing settings that conflict arises between the biomedical and the magico-religious worldviews. The organisation of daily activities in clinical practice is characterised by high technology, medical advances and specialisation, which leads to fragmentation of care threatening the holistic nature of personhood. This is in direct conflict with the nursing ideal of holism and the challenge facing the nursing profession is that the patient still expects the professional nurse to care for him/her as a *whole person*. The biomedical approach and technicalisation of health care (with good intent) has deeply eroded the holistic idealism of nursing practice as advocated by the South African Nursing Council, resulting in a reductionist, task- oriented approach to nurse-patient relationships (Millard, Hallet and Luker (2006).

Current legislation in South Africa fosters comprehensive health care by encouraging facilitative measures between magico-religious and biomedical paradigms (National Health Care Plan, 1994). While this approach is widely acknowledged, the medical model has remained the dominant model used in all types of care, including paediatric

care in these research settings, evidenced by the dominant bio-psycho-social treatment modalities in care practice.

The African National Congress (ANC) made provision in the National Health Care Plan in 1994 to recognise the traditional indigenous health care practices as legitimate for those people who prefer to utilize this health care system (ANC, 1994: 72). The guidelines of the National Health Care Plan have since been translated into a South African National Health Act of 2005. From as early as 1997, the South African Department of Health (1997) had planned to incorporate the traditional healers and birth attendants as important components of the broader primary health care team but not of the public health care services. Issues pertaining to transformation, regulation and safety delayed the process. Measures to regulate the practice of traditional healers have now culminated in the Traditional Health Practitioners Bill of 2003, which makes provision for the formation of a regulatory framework to ensure the efficacy, safety, and quality of traditional health care services and to provide for control over the registration, training, and practice of Traditional Health Practitioners.

1.4 HOLISM AND HOLISTIC NURSING CARE

The term holism originated in South Africa in 1926 from the philosophy expounded by Jan Smuts and grounded in the philosophy of Holism and evolution (Smuts, 1999). Smuts conceptualised the world, the life and person and everything else in it as always forming a whole (Lessem & Nussbaum, 1996: 42). Holism relates to the study of the whole organism or whole systems. The noun *holism or wholism* is derived from the Anglo - Saxon root “hal” which means whole or to heal (Blattner, 1981: 2-3). It is a

concept that incorporates the interrelationships between all aspects of bodily functions and psychosocial functions. Holism emphasises the importance of understanding a person's whole being, rather than breaking down, studying or treating only the component parts (Lessem & Nussbaum, 1996). It represents the human organism as a self-contained living system whose components are interconnected and interdependent. Narayanasamy (1999) defines a whole person as someone whose body, mind and spirit are integrated.

For Shealy (2003: 333) the first use of the word "holism" in medicine was in 1952; the concept body–mind has always been recognised by the medical profession however, the spirit remained isolated from medicine and psychology since Descartes led the scientific community to discard spirit and separate body and mind (Shealy, 2003: 333).

Van Velden (1998: 42) disagrees with Descartes by saying "… *we are not our temporary material bodies, but the eternal spiritual souls within our bodies"*. According to Van Velden (1998: 42), health professionals must be aware of the consumer movement that is responsible for the renaissance of alternative medicine worldwide. As a paediatric nurse, I concur with the above statement as many of my own patients have brought their alternative treatment and herbs to hospital creating awareness of the growing use of alternative treatments. The difficulty arises when these herbs are used in conjunction with western medicine and the efficacy of these herbs has not been ascertained, with the potential for drug interaction.

The concept holistic nursing care is widely used in nursing literature (Allen, 1991; Owen & Holmes, 1993; Boschma, 1994; Kolcaba, 1997; Wong & Pang, 2000; Locsin, 2001; Limacher, 2001; Thorne, 2001; Hjelm, Rolfe, Brayar, Andersson, Fletcher, 2003; Hassed, 2004; Feudtner, 2005). The focus of holistic nursing care is healing rather than curing. There is recognition in holistic nursing care that the disease occurs in the whole person and therefore nursing modalities of caring should take care of the totality of the whole person and their lived experiences.

The holistic perspective refers to the nurturing of the whole person– body, mind/emotions and spirit. The spirit is the essence of who a person is. In caring for the whole, there is recognition that the bio-psycho-spiritual dimensions of the person are intricately connected and any imbalance in one of these dimensions alters the harmony, contributing to disease. Efforts to restore balance should consider the total whole being. Holistic nursing care stems from an appreciation of the self as a whole being in relationship to others. Holistic nursing care, therefore, should include nursing care behaviours that promote and take care of the entire being. This wholeness embraces the bio-psycho-spiritual self in relation to caring of others (Hjelm et al., 2003).

1.5 CARING IN NURSING

Nursing theorists Leinenger (1984), Watson (1985) and Benner and Wrubel (1989) describe caring as the essence of nursing and occurring at an interpersonal level (Smith-Campbell, 2000). Morse, Bottorff, Neander and Solberg (1991:123) identified five emerging conceptualisations of care and caring in the literature namely: caring as

a human trait/state, a moral, an affect, and an interpersonal interaction and as a therapeutic intervention. These are described below:

1.5.1 Caring as human trait

Caring as a human trait is seen as a universal trait of human beings as they exist in the world Bellah, Madsen, Sullivan, Swindler and Tipton (in Smith-Campbell, 1999). Leininger (1988b: 101) describes human caring as "the subjective feelings, experiences and interactional behaviours between two or more persons (or groups) in which assistive or enabling acts are performed..." Leininger in her theory of caring expands the description of caring beyond the individual to more persons or groups. This idea of caring is consistent with paediatric caring, which involves more than just the child but includes parents and siblings in every nurse/child encounter. When a child is admitted, the immediate family becomes involved in care of child and decision-making.

1.5.2 Caring as a moral imperative

A moral imperative is recognisable in the call made by Watson in 1988 to view caring as a philosophy of moral commitment toward protecting human dignity and preserving human reality (Marriner- Tomey, 1994: 154). Caring as a moral imperative should move beyond the individual into community level bringing emotions and

passion on issues pertaining to patient care beyond hospital wards into issues affecting communities such as poverty and homelessness (Smith-Campbell, 1999: 407).

1.5.3 Caring as affect

Morse et al. (1991: 123) describe emotion or affect as “a feeling of compassion or empathy for the patient which motivates the nurse to provide care for the patient”. Based on caring as a human trait and moral imperative, caring as affect moves the nurse to seek knowledge to help those in need with sympathy and empathy (Smith-Campbell, 1999). In caring for children, often the paediatric nurse is often required to search deeper within her/himself to bring out compassion and empathy, as children are not all able to express and articulate their feelings when in pain or any form of discomfort.

1.5.4 Caring as an interaction

In a caring relationship, a feeling of compassion, knowledge and empathy compels the nurse to act. Caring in nursing is viewed as a mutual endeavour between the nurse and the patient and it is through this interaction process that interventions are initiated. Smith-Campbell (1999: 407) argues that the terms “therapeutic” and “intervention” in a caring relationship are grounded in the medical model and individualistic ontology. Morse et al. (1991: 123) concur as they state that theorists who view caring as a therapeutic intervention are patient–centred or focusing on individualistic ontology assuming that the individual has significant control over their health and behaviours. In this study the care of a paediatric patient goes beyond the patient and includes the whole family: mother, father and siblings, who become important participants in the

caring interactions. Each parent brings his or her own beliefs, values and expectations of care to the environment of care.

Scotto (2003: 290) argues that there has been a tendency in the literature to discuss the affective component within the psychomotor component. Scotto (2003) defines caring as offering of the intellectual, psychological, spiritual and physical aspects that one possesses as a human being in the caring environment in order to achieve the nursing goals.

The intellectual aspect consists of an acquired, specialised body of knowledge and the analytic thought and clinical judgement necessary to meet the needs of the patient. The psychological aspects includes the feelings, emotions and memories that are part of human experience while the spiritual aspects seeks to answer the questions related to "why and what is the meaning of this". The nurse in the spiritual aspects endeavours to facilitate and support the process of questioning. The physical aspect includes skilful interventions designed to accomplish the caring goals.

Caring is a central aspect of nursing, the fuel of the nurse's interaction with her patients (Husted & Husted, 1997). Because caring in literature is defined in terms of feelings, Scotto (2003) suggests a more holistic practical definition, which is advocated as a framework for teaching nurses about caring. Holistic nursing care and the view of South African Nursing Council (SANC) is explained below.

1.6 SOUTH AFRICAN NURSING COUNCIL

The concept to be investigated in this study is 'holistic nursing care". This concept is espoused in the philosophy of the South African Nursing Council (SANC). The SANC philosophy of nurse education do not give a specific definition of holistic nursing care and this has led to different interpretations and meaning in the application of this concept at patient care level. The basic premise underlying the Scope of Practice of the registered nurse (R2598 of November 1998, as amended) is that nurses are concerned with the human being as a holistic being (Searle, 2000). According to the Scope of Practice the expected outcome of the nurse-patient/client encounter in nursing practice is that registered nurses will render comprehensive nursing care to their patients in order to meet the objectives of health stated in the White Paper (Department of National Health, 1997). There is, however, a difference between comprehensive nursing and holistic nursing. Comprehensive is defined in the Collins concise dictionary (1993) as complete, extensive and thorough. The emphasis in holistic nursing care is being whole. Collins (1993) defines the *whole* as complete, total, sound, perfect, sum total and containing all elements.

The provision of health care as stated in the White Paper advocates for the biomedical system of health care and it is in the primary health care approach, where provision is made to accommodate traditional health care system. Efforts to resolve the conflict that is between the two coexisting health care systems have not been finalised and yet nurses at clinical level continue to experience conflict between the two differing worldviews.

1.7 PROBLEM STATEMENT

Holistic nursing care is widely advocated and espoused in the philosophy of primary health care approach, philosophy of the SANC and in traditional caring modalities. The SANC as the regulatory body of nursing does not provide definition of holistic nursing care to guide the meaning and interpretation in clinical nursing environment. As a result, this concept is unclear and variously interpreted and poorly understood in paediatric nursing within the academic hospitals in Johannesburg. Additionally, the very nature of differing worldviews of biomedical system and traditional system and their co-existence in nursing environments further confound the meaning of holistic nursing care. Current usage of holistic nursing care within these paediatric wards illustrates a lack of common meaning which would form the basis for conceptual understanding of this concept applicable to paediatric nursing care practice (Searle, 2000; Maluleke, 2003; Bodkin, 2003).

Based on the problem statement three questions emerged:

- What is the meaning of the concept “holistic nursing care”?
- What are the characteristics of “holistic nursing care”?
- What framework of “holistic nursing care’ is appropriate for the paediatric nurses working in the academic hospitals.

1. 8 RESEARCH PURPOSE

The main purpose of this research is to examine the meaning of holistic nursing care and develop a framework for holistic nursing care, which can be utilised in nurse education settings and in clinical nursing practice in the context of paediatric nursing in the academic hospitals in Johannesburg.

1.9 STUDY OBJECTIVES

In order to meet this purpose, the following research objectives were set in two distinct phases:

Phase 1:

- Conduct an analysis of the concept “holistic nursing care”.
- Obtain an emic viewpoint of holistic nursing care from paediatric nurses working in the academic hospitals.

Phase 2

- Identify the characteristics and dimensions of “holistic nursing care”
- Develop a framework of holistic nursing care for the paediatric nurses working in the academic hospitals.
- Validate and refine the framework for paediatric nursing.

1.10 PARADIGMATIC PERSPECTIVES

According to Creswell (2003), researchers start a project with certain assumptions. The assumptions need to be situated within the context of a paradigm to provide the direction of the study. Terre Blanche & Durrheim (1999) state that researchers can draw on more than one paradigm within the same study. The assumptions that guided this research are given below:

1. 10.1 Meta- theoretical Assumptions

Meta-theoretical assumptions are statements that have their origin in philosophy and are made by the researcher and influence the research decisions throughout the course of the entire study. These assumptions serve as a point of departure. Meta-theoretical assumptions do not lend themselves to testing and do not offer pronouncements about the nature of knowledge and knowing (Botes, 1994). The meta-theoretical assumptions below are health, paediatric nursing, human being inclusive of the child, the parent and the nurse as well as community and environment.

To situate this discussion I need to tell you about myself. I am a married woman with three children. A single mother in the Transkei, Eastern Cape, raised me during the days of apartheid. As a rural South African child I was brought up to appreciate the traditional ways of thinking which later influenced my conduct both in childhood and adult life. Certain values such as respect and communal living influenced by the philosophy of **Ubuntu** *(humanness)* helped to shape my initial interest in nursing.

The person in the philosophy of Ubu*ntu* –humanness is greater than parts and the recognition of the spirit of the person is of greater importance than the individual parts. Being raised to appreciate humanness and understand that *I am because you are and you are because we are* I became fascinated by concepts such as becoming and existentialism. In Xhosa, language (Nguni) humanness is expressed as *umuntu ngumuntu ngabantu. I*n other words to be human is to affirm one's humanity by recognizing the humanity of others in variety of content and forms of life.

My mother was a nurse for all her working life and as young girl; I would to go to the clinic where she worked with three white male doctors. Even though I was young at

the time, these visits impacted my life to such an extent that when time came to choose a career, nursing was the obvious choice.

As a nurse I have worked in three public hospitals, two of which were for African people only and one is mixed serving different groups of people from White, Asian, North African and a diverse South African community. Since my student days in nursing, I often found my values in conflict as the training and education of nurses in this country is modelled on the biomedical approach of the West and throughout the basic nursing courses no reference was made to the dominant traditional philosophy that is espoused by the majority of the patients that we nurse. As a paediatric nurse I was often confronted by parents who simultaneously use the two health care systems expecting me to understand because they knew that as a child of the soil of Africa I know and understand the common values espoused by the majority of the African people and their subsequent health seeking behaviours. Even though I had a fair knowledge of the traditional health care practices, the institutional norms and the influence of the bio-medical education and training provided no scientific quantifiable justification for the inclusion of traditional health care practices within the biomedical treatment modalities. Use of alternative treatment therapies in children admitted in these research settings have often been discouraged in favour of bio-\medical treatment.

This has since changed with the move towards Primary Health Care (PHC) approach and home-based care, which was mandated by the government of National Unity in 1994. For the last twelve years, emphasis on health care has focused on issues such as

health rather than illness, client autonomy and family focused care influencing the theory and practice of childcare.

Recently there has been a widespread interest in complimentary medicine and a move away from a biomedical approach in health care to a more holistic nursing care which is consistent with the traditional African philosophy of human existence and living in harmony with environment. The rising interest in holistic nursing care has brought awareness on spirituality and care of the children. This is evidenced by the health seeking behaviours of our clients in paediatric nursing for instance an indigenous healer or faith healer may be consulted first simply to impose meaning and significance on the existential experience which is sought from the spiritual realm (Tjale & de Villiers, 2004).

The holistic perspective refers to the nurturing of the whole person; body-mind and spirit, which is the essence of who a person is and the nurse as a whole person becomes the instrument of healing. When the nurse embraces the self as a whole, valuing and appreciating others become easy.

Below the meta-theoretical assumptions, relating to the concepts commonly used in the discipline of nursing are explained, namely, person, health, environment, and nursing.

- **Person** refers to both the nurse and the client (child and parent). I believe that a person is a complex, ever changing being viewed as a **whole** being (mind, body and spirit), with physical, social, emotional, cognitive and spiritual needs. The person is a dynamic being in constant interaction with his

environment. The identity of the person is constructed by constant interaction with his environment and the totality of the context, which forms the identity of the person. The person has the virtues of sharing and compassion, which is the cardinal values, espoused in the spirit of Ubuntu expressed as: ‘a person is a person through other persons’.

- **Health** is a dynamic state of well being in which persons experience a balance between mind, body and spirit and interrelatedness with others and the environment. The experience of health is uniquely perceived according to a personal, cultural and historical context.
- The **environment** is the total context in which the person exists. It encompasses the physical, social, ecological and world-view factors that influence person’s perceptions and interactions with regard to health. The relationship between person and his environment is reciprocal: the environment influences the person’s life, health, and death while the person in turn influences the environment. The environment is all embracing. Within the spirit of ubuntu there has to be harmonious reciprocal coexistence between the person and his environment.

- **Nursing**

The South African Nursing Council describes nursing as a human clinical health science that constitutes the body of knowledge for the practice of persons, registered or enrolled under the Nursing Act as nurses of midwives. It encompasses the knowledge of preventive, promotive, curative and rehabilitative

health care for individuals, families, groups and communities and covers man's life span from before birth.

1. 10.2 Methodological Assumptions

Assumptions regarding the methodological commitments pertain to the process considered as scientific and to the methods and instrumentation by means of which a given view of what is scientifically valid may be realised (Mouton & Marais, 1990). In this study, it is assumed that:

- Paediatric professional nurses' emic perspectives about holistic nursing care that have been derived from their subjective experiences are valid sources of knowledge.
- Consensus can be achieved by sharing personal perspectives clarifying and co-constructing an agreed upon understanding of a construct within a defined context.
- That people not only have a unique view of reality, but act on it as if it were real and true.
- People can agree by co-constructing that reality thereby creating domains of consensus through language.

1. 10.3 Theoretical Assumptions

Theoretical assumptions include theoretical models, definitions and concepts that will be used as a point of departure in this study.

1. 10.3.1 Ubuntu

Ubuntu is an indigenous African philosophy of humanism and co-existence. Africans in most parts of the continent practice Ubuntu. It represents a way of life based on self-respect and respect for others as human beings, the latter becoming the source for finding one's own humanity. The 1997 South African Governmental White Paper on Social Welfare officially recognises Ubuntu as:

> "The principle of caring for each other's well-being…and a spirit of mutual support. Each individual's humanity is ideally expressed through his or her relationship with others and theirs in turn through recognition of the individual's humanity. Ubuntu means that people are people through other people" (<http://www.gov.za/whitepaper/index.html>).

1. 10.3.2 Holism

Holism is a theory that describes the living matter or reality as made up of organic or unified wholes that are greater than the sum of their parts. The parts cannot be understood if considered in isolation from the whole and the parts are dynamically interrelated and interdependent (Allen, 1991: 259).

1. 10.3.3 Nurse

A nurse is a person who has successfully completed a four-year programme (Diploma or Bachelor's degree) in an accredited nursing school and registered as a professional nurse with the South African Nursing Council in terms of the Nursing Act (Act No. 50 of 1978).

1. 10.3.4 Paediatric Nurse

A paediatric nurse is a professional nurse who has undertaken an additional post-registration course and registered with the South African Nursing Council in childcare.

For the purpose of this study, the paediatric nurse is a registered nurse who is working in the paediatric wards of the three academic hospitals in Johannesburg for a period of more than two years.

1. 10.3.5 Academic hospital

An academic hospital is a public hospital designated by the Department of National Health as a teaching hospital for health care professionals.

1. 10.3.6 Child

A child is a person from birth to 18 years of age. (Convention on Right of the Child, 1989). The ages of the children admitted in these hospitals vary from 0 -12 years old.

1. 11 RESEARCH DESIGN AND METHOD

1.11.1 Research design

A qualitative, exploratory, interpretive and contextual design guided by the phenomenological approach, was used to understand the meaning of holistic nursing care. Within this design, I conducted a philosophical inquiry using concept analysis to examine meaning. A *philosophical inquiry* involves the use of intellectual analyses to clarify meaning, make values, identify ethics and study the nature of knowledge. The research was guided by philosophical questions and the purpose is to examine meaning and develop theories of meaning through concept analysis. A detailed account of the research design is given in chapter two.

1.11.2 Research methodology

The purpose of this research is to examine the meaning of holistic nursing care and develop a framework for holistic nursing care, which can be utilised in nurse education settings and in clinical nursing practice in the context of paediatric nursing in academic hospitals. To accomplish this aim and justify the process, the *qualitative methodological* perspectives employed in this research are based on the purpose, aim, sampling data collection and analysis, population and trustworthiness. The research method employed refers to the philosophical inquiry using Rodgers framework of concept analysis. Literature was explored for meaning of the concept “holistic nursing care”. To obtain an emic viewpoint of holistic nursing care from paediatric nurses, data were collected through focus groups. The *qualitative* research methods permitted the researcher to study the concept ‘holistic nursing care’ and understand the meaning as an experience requiring a description of intentional stance or situated perspective of the event from the point of view of the experiencing person (Pollio, Henley & Thompson, 1997: 8). According to Denzin & Lincoln (1994: 365), phenomenological

purposes can be served where group interviews are conducted in a very structured or unstructured manner in the field. In this study, focus groups (n=5) were conducted in the field serving phenomenological purpose as advocated by Denzin & Lincoln (1994: 365). The development and the exploration of the meaning of holistic nursing are described in Table 1.1 provided as an overview of the process followed.

1.11.3 Phenomenological Approaches

A Heideggerian phenomenological approach in interviewing was used in this study, the aim being to gain an understanding of the meaning and characteristics of the concept of holistic nursing care as understood by the practising paediatric nurses in an academic hospital. The purpose of phenomenology is to explicate the structure or essence of the lived experience of a phenomenon in the search for unity of meaning, which is the identification of the essence of a phenomenon, and its accurate description through lived experience. Lived experiences are those experiences that reveal the immediate, pre-reflective consciousness that one has regarding events. These events are used as the basis for recalling how the event was lived (Kleinman, 2004: 10). Heidegger (1889-1976) saw phenomenology as ontology, a way of knowing and a way of understanding reality (Maggs-Rapport, 2001; Dowling, 2004; Wilkin, & Slevin 2004: 52). Heidegger maintains that understanding an ontological orientation is by interpreting; the ‘existential’ and through ‘Being in the world’ the researcher interprets by presence and therefore could not eliminate previous experiences of the world that are already present (Dowling, 2004: 33). The founder of the phenomenological movement is Martin Husserl, a German (1859 – 1938, Heidegger (1889 – 1976) and this work was further developed in France by

philosophers such as Satre (1905 – 1980) and Merleeau –Ponty (1908 –1961). Several nursing theorists advanced phenomenological methodologies Paterson and Zderad (1976), Watson (1985), Benner (1994) and Parse (2003), all of these theorists tended to assume an affinity to the interpretive with attention to understanding unique meaning and significance of the phenomenon (Dowling, 2004: 8). This movement is conceived as the foundation for rigorous science of absolute knowledge (Maggs-Rapport, 2001).

In applying Martin Husserl's phenomenology in nursing, the researcher's conceptualisation of the study has to focus the description of the lived experience on the participants' as subjects detached from their real everyday world (Walter, 1995). Even though there are merits for the use of Martin Husserl's phenomenology on this study, Martin Heideggerer's views are more appropriate. The basic tenet applicable for this study is based on:

"An existential perspective, which considers that an understanding of the person cannot occur in isolation from the person's world" (Walters, 1995: 792***). (Italics added)***

Heidegger, a student of Husserl argued that Husserl's attempt to explain everything as products of consciousness overlooked dimensions of existence and he also refuted that it is not possible to bracket one's "being in the world" in the process of philosophical inquiry. Heidegger refers to human existence as 'Dasein' or 'being there', which emphasizes the situatedness of human reality (Walters, 1995; Dowling, 2004), openness to interpreting relationships (Maggs-Rapport, 2110).

Heideggerian phenomenology is an attempt to understand the foundational dimensions of “being in-the-world. The concepts comprising the phenomenon are “in-the-world”, the quality of the existence and the uniqueness of the “being –in”. The fundamental way of being ‘in –the world’ is “Sorge”; translated into English as “care” (Walters, 1995: 793). Care is about Being and it is about caring for things and other people. Both concepts of ‘being in the world’ and ‘Sorge’ are not in conflict with Ubuntu principles about caring for people.

Ubuntu is an African philosophy that promotes the common good and includes humanness as an essential element in human relations (Mbigi & Maree, 1995; Venter, 2004). The noun uBuntu in Nguni language means humanness. It is reflected in the African maxim u*mntu ngumntu ngabantu, the* literal translation means *'a person is a person through other people'*. Ubuntu has its origins in oral traditions of the African people and its central concepts are communalism, caring for each other and collective unity (Christie & Lessem, 1993; Khoza, 1993; Boon, 1996; Dandala, 1996, Venter, 2004). Ubuntu has a central premise of connecting different human beings in the same community (Mbigi & Maree, 1995). Human kindness in Ubuntu way is seen in its relationships with others increasing human value, trust and dignity (Venter, 2004). The philosophy of Ubuntu therefore leads to social harmony and cohesion starting with family into cultural communities.

The notion of Ubuntu on human relations and collective unity and the existentialism, “being in the world” and “Sorge” of Heideggerian phenomenology is the key principles that in influenced this study.

1.11.3.1 Personal Becoming

When I was a child, I was taught the principles of Ubuntu as well as some of the participants involved in this study. Some of the paediatric nurses working in these research settings come from communities that believe and practiced the principles of Ubuntu. As a researcher, therefore I cannot eliminate the impact of the previous experiences of the Ubuntu, which were already present when I joined the nursing profession. In "being- there" the researcher and the paediatric nurses, therefore shares the existence with patients and family and it also means "being there" along the patients and "being with" is being actively involvement in the "life - world" of the patient (Draucker, 1999).

In Ubuntu, an individual person is an integral part of society and individuals can therefore exist corporately. Man is inseparable from the community (Teffo, 1996: 103). U*buntu* has the central premise of connection where different beings are united as beings. It is the link binding individuals and groups together: not only of the unity in multiplicity, but of the concentric and harmonic unity of the visible and invisible worlds (Blankenberg, 1999). Ubuntu flows within people's existence, an epistemology in which the two aspects **Ubu** and **ntu** constitute a wholeness and oneness. Thus, Ubuntu expresses first oneness of being human and the wholeness because Ubuntu cannot be fragmented because it is continuous and always in motion (Teffo, 1996; Venter, 2004 Teffo, 1996).

In relation to Heideggerian hermeneutic phenomenology, the involvement of the researcher does not include the notion of bracketing instead the researcher and their beliefs will be an important part of the research process. The notion of *being- in- the --world* enables the researcher to legitimately bring their experiences and understanding to the phenomenon under study, a *closer involvement* and *a shared experience and interpretation of being* (Walters, 1995). This notion of *interpretation of being* is consistent with the training and education of nurses which the researcher and paediatric nurses are familiar with from the very beginning of their training as nurses where, they were taught and encouraged to use their analytical thought processes in interpreting their observations during each encounter with patients. Their analytical process is categorized under the different stages of the nursing process model of care applicable to all forms of clinical nursing practice.

Packer (in Walters, 1995), is of the opinion that "if nurse researchers are to gain understanding of everyday practical activity, nurses must examine what people actually do in practical circumstances, not what they speculate that they, of fictional others, might do in a hypothetical situation".

Wilkes (1991) concurs: "the uniqueness of the world of nursing stands on its appreciation of caring and holism and if nursing is holistic it should be explored and analysed by research methods that look at lived experiences."

1.12 SIGNIFICANCE OF THE STUDY

The concept ‘holistic nursing care” is espoused in the philosophy of the South African Nursing Council (SANC) and yet there is no explicit definition and interpretation of holistic nursing care in the philosophy of the SANC. Because the meaning of this concept is elusive, common understanding is important to guide the practice. The findings of this study will fill an important gap in the knowledge of holistic nursing care in both nursing education and practice and expand practice knowledge by explicating the apparent lack of a unifying framework on what is meant by the concept holistic nursing care. The conceptual framework to be developed will provide a unique contribution to nursing and will guide the teaching holistic nursing care both in undergraduate teaching of child and family nursing care and in specialists’ paediatric nurse education. The results and recommendations of this study will form the basis for future decisions about holistic nursing care and its usage in nursing practice.

1.13 TRUSTWORTHINESS

Strategies to ensure accuracy of data collection and analysis will follow the model of framework of trustworthiness in qualitative research described by Lincoln and Guba (1985) and expounded by Sandelwoski (1986). The four criteria to assess trustworthiness are:

1.13.1 Credibility

The researcher has been a paediatric nurse involved in clinical nursing and in education in the same field. Going through the empirical data on the paediatric nursing in two of the settings for this study and persistent observation and discussions with colleagues on the same topic, the researcher has a need to analyse the concept holistic nursing care in order to interpret, understand this complex concept. The researcher undertook frequent member checks and peer reviews with regard to relevant literature searches, data collection, and analysis.

1.13.2 Transferability

Transferability judgements were facilitated through purposive sampling of paediatric professional nurses and dense descriptions of context and settings.

1.13.3 Dependability

Using an audit trail, dependability was ensured by maintaining a research journal, field notes, and a personal journal where the researcher's feelings and reactions will be recorded. The reflective journal will assist the researcher in isolating her thoughts and bracketing throughout the data analysis.

1.13.4 Confirmability

The researcher provided an audit trail, by keeping track of all references used; audiocassettes made; transcripts of interviews with accompanying field notes and all

rough copies of data analysis for peer review and member checking in order to validate how the results were obtained.

1.14 Outline of the Thesis

The research was conducted in two phases (please refer to table 1.1)

Chapter 1: Research overview and philosophical positioning

Chapter 2: Research design and methodology

Chapter 3: Context of the study

Chapter 4: Philosophical inquiry: Concept analysis

Chapter 5: Emic perspective of Holistic Nursing Care

Chapter 6: Conceptual Framework for Holistic Nursing Care

Chapter 7: Evaluation of study, limitations, and recommendations

1.15 CONCLUSION

The conceptualisation of this study presents a journey that began long before I became a nurse. The observations and questions that plagued my mind, though without significant relevance to my life experiences' at the time and without obvious answers, have now become a reality in the composite of thoughts that have found meaning in the experiences as a paediatric nurse, a nurse educator and researcher surrounded by diverse cultural people.

This chapter presented an overview to assist the reader to understand how this study was conceived. The rationale and the current legislative landscapes and philosophical paradigms that bring out holistic nursing care locally and internationally are

described. Paradigmatic perspectives and philosophies that shaped the thought processes necessary for undertaking a philosophical inquiry are described. The research design is briefly explained in relation to the problem statement, purpose, and objectives of the study. Ethical considerations that guided the research with respect to the conduct of the researcher are explained.

In the following chapter, the context of the study is described.

Table 1.1 Research phases

Research Phases & Research Objective	**Data Collection**	**Sample and Sampling**	**Trustworthiness**	**Data Analysis**	**Reasoning Strategy**
Phase 1: (a) Conduct and analysis of the concept "holistic nursing care"	Utilisation of literature sources where holistic nursing care appears	**Sample:** 77 Articles on holistic nursing care **Sampling method:** Purposive	Rodgers (1989) steps of concept analysis	Literature Control & Rodgers (1989) steps of concept analysis	Inductive logic and analysis
(b) Obtain an emic viewpoint of holistic nursing care from paediatric nurses working in the academic hospitals (through focus group)	Focus group discussions	Focus groups (n=5) Sample size (n= 33)	Lincoln & Guba (1994) Prolonged engagement Researcher and professional nurses Triangulation Sources & methods	Giorgi's Analysis	Inductive logic, analysis & synthesis
Phase 2	Results from		Lincoln & Guba		Deductive

(c) Identify the characteristics and dimensions of "holistic nursing care"	(a) and (b)		(1994)		and inductive logic, analysis and synthesis
(d) Develop a framework of concept "holistic nursing care" for the paediatric nurses working in the academic hospitals in Johannesburg	Results from (a), (b) and (c) Dickoff, James and Wiedenbach (1968)		Panel of expert in paediatric nursing and expert research reviewers		Deductive and inductive logic, analysis and synthesis

CHAPTER TWO

CONTEXT OF THE STUDY

"For most children in South Africa life is their biggest challenge".

Unknown Author

2.1 INTRODUCTION

As the aim of this study is to examine meaning and characteristics of the concept of holistic, nursing care as understood by the practising paediatric nurses in academic hospitals, it became clear in the planning stage that the study context is worthy of entire chapter. To understand the characteristics of concepts, firstly we need to understand that concepts have a meaning that is understood within a given context. Secondly within the Heiddegerian phenomenology, the notion of *being- in- the--world* necessitates a detailed description of the context, which is the world of the participants, the researcher and the clients involved in this study. The concepts of

"being in the world" and "Sorge" are not in conflict with Ubuntu principles about caring for people.

Ubuntu, an African philosophy, has as central premise, the connecting of different human beings in the same community (Blankenberg, 1999). Human kindness is seen in its relationships with others, increasing human value, trust, and dignity (Mbigi & Maree, 1995: 1-3; Venter, 2004).

The notion of Ubuntu in human relations and collective unity, and "being in the world" and "Sorge" of Heideggerian phenomenology are the key principles that influenced this study. In Heideggerian phenomenology the aim is to progressively uncover the researcher's understanding of the situation of the study. A detailed description of the social context of the participants of this study is described below. The context is described in two levels: the broader, macro context and micro-level context.

2.2 RESEARCH MACRO RESEARCH CONTEXT

In discussing the macro context of this study, the historical background of South Africa forms the backdrop of the context. The macro context is situated in the heart of South African history. As the story of South Africa unfolds in the quest to build one democratic nation, the people of this nation and its leaders keep stumbling over massive obstacles and tremendous diversity. The passion and zeal to pursue the dream of freedom compels the people of this nation to overlook the obstacles in an effort to bring reconciliation and build a new democratic nation.

This diversity can be seen from the different people that make up this country: the indigenous people of the south, the Settlers and those who came to South Africa

during the gold rush and later. Notably, all these people have brought a new ingredient to South Africa's racial and cultural mix accompanied by religious beliefs.

The country's racial inequity ideals under the Nationalist Party caused the country to be in the world’s spotlight. The first democratic election was held on April 27 1994; in his unifying inaugural speech as president, Mr. Mandela referred to South Africa as a “rainbow nation.” The rainbow has distinct colours; some colours are brighter than the others.

Mr. Mandela's presidency was characterised by the successful negotiation of a new Constitution.

The country’s racial inequalities of the past government were also evident in the organisation of the health care system and the challenge for the new government was to create a unified system of health care. The re-organization of the health care system will now be discussed.

2.3 HEALTH CARE SYSTEM

The health policies prior to 1994 created tangible disparity in the planning and provision of health care in the private and public sector. The facilities varied from first world-class hospitals serving the white minority to overcrowded hospitals in Black townships and rural areas. The disparities caused by the past injustices resulted in a relatively advanced private sector. The private hospitals are generally very expensive and are serviced by Medical Aids on a fee for service basis.

The emphasis of public sector has been a shift from curative hospital-based care to integrated community healthcare within a primary health care (PHC) approach. Payment for treatment is in accordance with income and number of dependents of the health service user. The provincial government may partly or relatively finance patients' treatment as in the case of free healthcare for children under the age of five years.

Anthropologists recognise health care as a symbolic system representing society's core values, beliefs and attitudes (Helman, 2002:59; Hammon –Took; Herselman, 2004: 137). The meaning constructions of health, 'disease', 'illness', or 'sickness' differ from society to society. Health care views are cultural constructions and their meanings are determined by the culture of the people concerned (Herselman, 2004: 138). Two dominant health care systems: the bio-medical system and traditional indigenous co-exist in South Africa and are briefly explained.

2.3.1 Bio-medical system

The concept of 'biomedicine' results from the focus on biological issues in health care system. It emphasises human physiology (or biology) in the diagnosis and treatment of sickness, and attempts to link physical symptoms with some underlying physical process that are scientifically assessed (Herselman, 2004: 143). The focus in biomedicine is on 'disease', which is a physiological condition that can be identified and labelled based on specific symptoms. A disease has its own 'disease personality', consisting of particular signs and symptoms according to which it is identified (Helman 2002:80).

Andrews and Boyle (1995: 26) differentiate between disease and illness. Disease in the western medical paradigm is the malfunctioning or mal–adaptation of biological and psycho-physiological processes in the individual while illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Biomedical practitioners therefore, emphasise physical and/or chemical changes such as symptoms of pathology in the body. Because biomedical research results are documented, biomedical knowledge is shared knowledge and forms the basis for generating further knowledge (Herselman, 2004: 143-144). For Hammond-Tooke (1989:145-146) scientific rationality constitutes the basis of biomedicine, which means that information on disease processes can be tested, measured and verified by scientific procedures under objective, empirical circumstances, universally agreed upon by medical practitioners. Once the information has been gathered it becomes 'clinical facts', which constitute the criteria for identification of a cause and diagnosis of the condition (Helman 2002:79). Theory and experimentation are basic to biomedicine and all clinical observations are interpreted in terms of theory. Helman (2002:80) describes biomedicine as 'reductionistic' in that by focussing on a physical system, diseased organ, or group of cells, attention is focussed on smaller and smaller parts of the human body rather than on the patient as a whole. Reductionism can be attributed to the developments in diagnostic technology such as X-rays, scans, blood tests which can indicate biochemical changes in cells, as well as the development of sophisticated therapeutic procedures such as chemotherapy, radiation, and surgery amongst others. It is from this that specialisation in medicine and nursing has developed. Because of this thinking, western medicine in SA has enjoyed a greater official acceptance to the detriment of the indigenous traditional system. Biomedicine is offered in both public

and private health care. The indigenous traditional system has been slow in development because it has been viewed as complex by the medical profession and in some cases, dismissed as superstition based on false assumptions of disease causation (Tjale & de Villiers, 2004). The medical profession has expressed some concerns about the benefits of traditional healing especially that their care practices are unknown and dependent on magical ideas that are not properly defined (Muller, 1999; Peltzer, 2000; Prinsloo, 2001).

2.3.2 Traditional indigenous system

In non-specialised, traditional societies, the health care system is symbolic of various religious beliefs, the significance of kinship, group membership or collectivism and mutual dependence between persons. Restoration of harmony or balance in these societies between the natural (geographical), supernatural (magico-religious), and social (human) worlds is of particular importance (Herselman, 2004: 136). Among traditional South African societies health is regarded as a balanced relationship between people, nature and the supernatural in relation to the belief in the ancestral spirits. Disruption of this relationship is followed by some incident of misfortune such as crop or livestock losses, theft of property or illness. Illness therefore is regarded as a type of misfortune. It is explained and dealt with in the same way as types of misfortune, namely in terms of the meaning that can be ascribed to it. Questions like 'why me?', 'why now?' or 'who caused this to happen to me?' are part of the subjective process of ascribing meaning to various incidents of misfortune that affect people's lives in inexplicable ways (Herselman, 2004: 146). Although there are no obvious answers to such questions in terms of the rational principles of biomedicine,

the principles of traditional indigenous health care include the need to determine the source of the conflict and to provide explanations for them. Both the meaning and what people do about the incidents are determined by the social and cultural contexts in which they occur (Helman 2002:83).

The illness experience is shaped by a patient's perceptions, experiences, and emotions concerning the condition, and various culturally prescribed holistic health-seeking strategies. Healing focuses on both the emotional and somatic aspects of a patient's condition and their relation to the patient's health-belief system is recognised and addressed. Healing is therefore more than merely a physiological process; it implies restoration of the wholeness, balance, or equilibrium, which constitutes health. Addressing illness through holistic treatment involves re-establishment of good relationships with the social and natural environments as well as the supernatural worlds, rather than treatment of specific disease symptoms. By implication traditional health care does not only focus on physiological malfunctioning of the body but also cater for the psychological, spiritual, social, and cultural aspects of a patient's existence in its entirety, pointing to the existence of a complex mind-body-spirit continuum (Herselman, 2004: 143).

The mind-body-spirit dimensions of the whole person are recognised in holistic care and any imbalance in one of these dimensions alters the harmony, contributing to disease. The indigenous knowledge pertaining to health care is often the possession of an individual healer who understands the cultural beliefs of the community. This kind of knowledge may be kept secret since it constitutes the exclusive 'property' of the healer concerned and maybe "handed down" from generations of ancestors; at most it

may be shared within a broader kin-group, the descendants of the particular ancestors (Herselman, 2004: 143). The traditional healers know and understand their patients' cultural orientations and speak their languages. Patients are treated at the healer's home and merge with a therapeutic group consisting of healer, assistants, patients, and kin. Patients receiving treatment are not removed from their social environments and this is in direct contrast to a patient's removal to cold clinical and impersonal environment of a hospital typical of biomedicine (Herselman, 2004: 144).

Disease causation is explained as a thing, person, or set of circumstances, which give rise to a condition of ill health. Identifying a cause in traditional health care systems is the first step in the diagnosis of sickness. By ascribing a cause to a condition it becomes more meaningful to both the sufferer and his/her kin-group. Causation therefore, determines the recognition, diagnosis, management, and control of a condition, and helps people to 'make sense' of what is happening to themselves or to others. Three categories of causation can be discerned in traditional systems of health care: natural, supernatural causation and belief in the ancestor spirits (Herselman, 2004: 145).

2.3.2.1 Natural causation

The natural causation is located in the natural world, which means that the cause of a condition cannot be defined with certainty. Natural causes are identified most readily for common conditions, for those that do not produce an emotional reaction in a patient, or for those for which the prognosis is good.

2.3.2.2 Supernatural causation

Supernatural causation is based on the assumption that sickness is believed to have been caused deliberately, giving rise to questions of 'why me?' or ‘who targeted me?’ This implies that the condition has been ‘sent’ and the sufferer is the target of the malicious intentions of a wrongdoer. The question ‘why me?’ is usually answered with reference to the disfavour of some personal supernatural being such as a god or spirit, or frequently, to the intentional malevolent activities of witches or sorcerers. Underlying such causation is therefore, the idea of blaming others for one’s sickness or misfortune and consequently, it is located in the social and cultural world (Helman 2002:93).

2.3.2.3 Belief in the ancestor spirits

When a natural cause does not explain a condition, a cause associated with the supernatural, most likely would be attributed to the spirits. The ancestors and associated supernatural are believed to be concerned with the interests, prosperity, and well being of people, who in the case of the ancestral spirits are the descendants of the particular ancestral clan. Harmonious relations between the ancestors and their descendants are mutually dependent and reflected in conditions of health and well-being. When these relations are disrupted, the ancestors withdraw their protection, and sickness or some other misfortune befalls those who trespassed. The implication is that such a condition or misfortune was 'sent' in reaction to the misdemeanour perpetrated by the sufferer especially if the person neglects to perform a ritual at a

particular crucial moment. Sickness therefore, is frequently regarded as a consequence of neglected duties owing to the ancestors. Omissions such as these justify the anger of the ancestors and must be rectified to restore the equilibrium (Herselman, 2004: 136- 143).

Sickness associated with the ancestor spirits therefore can be interpreted as a symbolic form of communication; a reminder of an outstanding ritual; an indication that the ancestors have for some reason 'turned their heads' and are not watching over their descendants; as punishment for unacceptable behaviour, or a reminder of deviation from accepted norms (Herselman, 2004: 143).

The South African Department of National Health and Welfare (1997) recognises traditional practitioners as an important component of the broader primary health care team. The practice of traditional healers is now being regulated through the Traditional Health Practitioners Bill of 2003, which makes provision for the formation of a regulatory framework to ensure the efficacy, safety, and quality of traditional health care service and to provide for control over the registration, training, and practice of traditional health practitioners.

There appears to be two divergent views from the review of literature regarding the two health care systems (Hammod-Tooke, 1989; Pretorius, 1989; Muller, 1999; Peltzer, 2000; Prinsloo, 2001). Those in favour of the bio-medical health care system find it difficult to imagine the traditional healers as part of a health care system that is based on quality standards and expect consensus founded on proven scientific facts. Some believe that the traditional healer's knowledge of the beliefs; values and psyche of their patients could inform western medical practitioners (Hammond -Tooke, 1989;

Pick, 1996; Muller, 1999). According to Hammond-Tooke (1989), one of the obstacles for the co-operation between the western and traditional medicine is prejudice. Prejudice is evident when health practitioners carry the notion that traditional beliefs and practices are the reality of primitive thought process, which is different from modern society. Pick (1996) asserts that traditional healing has a significant contribution to make provided that harmful practices are not condoned. Even though the traditional care practices are unknown, families in these research settings continue to use them. As indicated before the impact of these differing values is mostly felt at clinical interface. Generally, the preparation of nurses is based on bio-medical health systems and the potential for conflict is greater since the environment of care has not yet resolved how these two systems could merge or work together for the benefit of those who choose to use either or both. The implications of these differing worldviews to paediatric nursing are discussed.

2.3.2.4 Implications for paediatric Nursing

The influence of the dominant biomedical system within the paediatric nursing has resulted in ignoring the inclusion of the traditional healing modalities both in nursing curricula and paediatric practice. The difficulty within this speciality is that parents in hospitals often assume that nurses understand the context under which they operate and that their beliefs are context- based and linked to their health and illness seeking behaviours. Parents in childcare are the decision-makers about their children's health matters, issues about who and where to consult and what treatment to use is often the parental responsibility.

In paediatric nursing in general there has been a move away from a reductionist approach towards a holistic approach, with the emphasis upon meeting the needs of the child and the parents. Developments in children's nursing have been further improved in countries like United Kingdom and USA by acknowledging the vital role that the family plays in the life of a child and the emergence of a philosophy of 'family-centred care' (Irlam & Bruce, 2002).

Family-centred care is the care that is parent-led with the nurse acting as a consultant or counsellor fostering open, honest dialogue with family. Parent participation requires narrowing of the appropriate knowledge and competence gap between the nurse and parent. In family-centred care the family decides who constitute the family (Irlam & Bruce, 2002). In South Africa application of family-centred care has not yet developed to level of other countries in that paediatric nurses are still the leaders of the care given to the child even though parents are allowed to participate in the basic care of children where necessary.

When children and their families require care in hospital or the community, they will act and react within the context of their particular family, community, and societal culture. While political debates continue about collaboration between biomedicine and traditional health system, parents continue to use the two systems and do not treat them as mutually exclusive. The health care reform efforts put in place by the new government are discussed below

2.4 TRANSFORMING THE SOUTH AFRICAN HEALTH CARE

Prior to 1994, the South African health care system had fourteen separate departments of health within the health sector. Health care services were fragmented racially, geographically, structurally and functionally. The health services had a top-down approach. Racially, white areas had better health care services and facilities than black townships and homelands. Whites could access private health services while blacks had to be content with poorly serviced, overcrowded public health care services in black-zoned areas. Functional fragmentation resulted from a highly centralized structure of services because there was no coordination and integration of health services. Preventive and curative services were offered separately and this resulted in duplication of services (Savage & Benatar, 1990). To dismantle the country's race-based health system, the government used the framework of the reconstruction and development (RDP). In line with the purpose of this study, I will discuss RDP in relation to children's health.

2.4.1 Reconstruction and development

Reconstruction and Development Programme (RDP) contain a series of national goals for children, which form the basis of a cross-sectoral national programme of action. Women and children are amongst the most vulnerable groups in South Africa. The population is young with

23.6% of children in Gauteng province under 15 years of age (http://en.wikipedia.org/wiki/Gauteng_Province). The RDP of South Africa focused on redressing the social imbalances created by the apartheid government to the majority of the population of South Africa. In relation to health care of women and children, the RDP provided goals to direct health care priorities and setting specific

targets to meet the health needs of these categories at district and provincial health level. Children in South Africa have a right to basic health care and this is guaranteed through the South African Constitution. The goals of RDP serve as a means to entrench the rights of the child. The goals below are those that relate to the health needs of children.

- Free health for all children under six years of age.
- To provide programmes to improve maternal and child health through access to quality antenatal clinics, delivery and post-natal services to all woman.
- Encourage breast-feeding.
- Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations. Children in especially difficult circumstances include children displaced by political violence; children who are victims of crimes, including murder, kidnapping, and rape, as well as domestic abuse; children in custody; homeless or “street” children; children living in institutions or foster care; child labourers; disabled children and AIDS orphans.

In June 1995, the South African Government ratified the United Nations Convention on the Rights of the Child (CRC). By ratifying these rights, South Africa pledged itself to improve the general well being of the children of South Africa and to ensure that all children have the right to develop to their full potential physically and mentally, to express their opinions freely, and to be protected against all forms of abuse and exploitation.

The goals to enhance the survival, protection and development of children in South Africa, guided the development of the framework of the National Programme of Action for Children (NPA). This goal was to reinforce the “call for children first” as the strategy to protect the rights of children in this country. This call was ratified through the Child Care Amendment Act of 1996 bringing the 1983 Child Care Act in line with the new Constitution and the Convention, by enhancing measures to protect children and promote their rights (Mtshali, 1996).

Children and youth from disadvantaged backgrounds fall under the category of children with special needs. They grow up in poverty. They have been subjected to physical, emotional, and/or sexual abuse (Mtshali, 1996). Most children would have experienced or witnessed various forms of violence in their families and communities; and some are addicted to alcohol and habit-forming drugs. Such children are at risk of various mental health problems. Examples of such problems are anxiety states; attention deficit hyperactive disorders; post-traumatic stress disorders; behavioural and antisocial disorders: and depression results in suicide (Mtshali, 1996). To improve the health of these children and increase accessibility to health care, a primary health care approach was adopted.

2.4. 2 Primary health care

Primary health care (PHC) is to provide the preventative health care in the community that is accessible, affordable, and acceptable to clients. The goal of PHC is to achieve universal access to health especially for the vulnerable groups particularly for people who live in rural, peri-urban, and urban poor, and women and children (National Health Care Plan, 1994). This has resulted in a substantial shift of patients away from

large hospitals to primary health care centres in the community. Prevention of illness, promotion of health, management of common diseases and referral are part of the government's mandate of PHC. In an effort to improve the health of these children 700 clinics have been built, 2 298 clinics upgraded and 125 new mobile clinics introduced increasing the total number of clinics in the public sector to more than 3 500 (Bradshaw & Steyn, 2001). Free health care for children under six, and for pregnant or breastfeeding mothers, is also available at these clinics. Despite the efforts to improve the primary health care centres, staff shortages in the face of increasing patient load is of major concern. According to Bradshaw & Steyn (2001) the PHC clinics are plagued by limited numbers of trained staff and inadequate facilities, equipment and medication, and chronic disease prevention is inadequate under such conditions.

2.4.2.1 Disease profile of children

The disease and death profile in SA reflects the society with some sections being more-affluent while other sections of the population such as those who are economically disadvantaged continue to suffer related pathologies. According to the profile, infectious diseases and increasingly, HIV and AIDS affect the poor. Chronic diseases affect both rich and poor and are associated with an urbanized diet and lifestyle, and a large burden of disease, particularly among the poor, is the result of trauma and violence (Sanders & Chopra, 2006: 67). The effects of poverty on health of families and children can be measured by life expectancy, infant mortality, and adult illiteracy. The infant mortality rate (IMR) in South African stands at 62.18 per 1000 live births (www.capegateway.gov.za/eng/yourgovernment/gsc). This is

expected to increase with deaths mainly due to the HIV and AIDS epidemic. To reduce the infant mortality the government embraced the integrated management of childhood illness (IMCI) led by WHO and UNICEF as a strategy to reduce childhood mortality and improve the quality of care of children less than five years of age. The main childhood diseases included in the IMCI programme are pneumonia, diarrhoeal diseases, measles, malaria, and malnutrition. Poverty complicates these diseases increasing the infant mortality.

Child poverty and malnutrition is a major issue of concern in these research settings. In July 2003, the Department of Social Development released a first draft baseline document for the development of a national policy for families. The document states that 59% of children aged 0 – 17 in South Africa are poor. Poverty affects children by reducing their chances of living beyond their first five years, by stunting their growth, rendering them vulnerable to infectious diseases and disabling injury. In turn, reduce their confidence and hope in the future limiting their education capacity for developing to their full intellectual potential. The African Vitamin A. Consultative Group (1994) surveyed children between the ages of 6-71 months and found that 33% of children are vitamin deficient. Poverty and inequality is still very evident and widespread in these research settings. Additionally, families headed by women and those families affected by HIV are mostly affected.

HIV and AIDS is the fastest growing epidemic and due to the high rate, HIV has become a priority health care need.

In 2000, the Department of Health outlined a five-year plan to combat AIDS, HIV and sexually transmitted infections (Department of Health, 2000). National AIDS Council

was set up to oversee these developments. By the end of 2001, the HIV prevalence rate among pregnant women was 24.8% (Department of Health, 2000).

By the end of 2003, there were about 5.3 million people living with HIV in South Africa. UNAIDS estimates that more than 1,000 AIDS deaths occur daily as a result of HIV and AIDS (UNAIDS, 2006).

In November 2003, the Government approved a plan to make antiretroviral treatment publicly available. The rollout of antiretroviral drugs in these research settings began in March. The number of people receiving antiretroviral drugs is still well below the envisaged targets (Pembrey, 2006).

The AIDS Law Project, a Non Governmental Organisation based in Johannesburg, estimated that 50,000 children in South Africa were in need of Anti-Retroviral drugs (ARV) at the beginning of 2006, but that only around 10,000 were receiving the drugs (Mail and Guardian Online, 2006). UNAIDS estimated that at the end of 2005, children accounted for 8% of those receiving ARV's. Children who are infected with HIV in South Africa are suffering from the loss of their parents and family members from AIDS. In 2003, UNAIDS estimated that 1.1 million children are living as orphans due to AIDS in comparison to 660,000 in 2001 (UNAIDS, 2006). Once orphaned, these children are likely to face poverty, poor health and lack of access to education.

2.4 MICRO– CONTEXT

The micro–environment of this study is contextually bound within the paediatric wards of the academic hospitals in Johannesburg and is defined by the beliefs and

cultural values that are inherent within a particular time-space dimension. The context of this study is the paediatric wards of three academic hospitals in Johannesburg. Children between the ages 0-12 years are admitted and nursed in these wards. Experienced paediatric nurses run the wards. The hospitals recommend a specialised nurse to manage the ward. With the current nurse shortage, nurses who are not specialised in child health care now manage some wards.

Children are admitted accompanied by their parents or caregivers. Parents or caregivers are allowed to stay with the child for the duration of admission. Each hospital uses a referral system from the surrounding primary health care clinics where the majority of children are seen first and diagnosed and those requiring further treatment and emergencies are sent to hospital for further management. Some children would come to hospital referred from the private general practitioners operating within the surrounding communities.

These children come from a variety of settings and different cultural backgrounds and their status of health is influenced by where they live. Their socio -economic backgrounds range from affluent society to semi-rural informal settlements. Each hospital is serving a formal township together with a large community of people from an informal settlement that stay in shelter homes without running water and sanitation services to affluent homes. The consequences of scarce and sometimes unsafe water supplies are highlighted with reference to health care associated infections. The present government has successfully reduced the number of people not having access to water by 50% in 2002 by delivering water in tanks and according to Duse, da Silva

and Zietsman (2003) this does not necessarily guarantee that its quality is safe for consumption.

Because the three hospitals are situated in different places within a twenty-kilometre distance from each other, the health of these children in the wards tend to reflect the spectrum of the communities that each hospital serves. In the townships, there are private medical doctors, an unknown numbers of traditional indigenous healers and faith healers serving this population. Traditional medicines may be purchased from traditional healers and also from roadside stalls and spaza (unregistered) shops (Bland, Nigel, Rollins, van der Broeck & Coovadia, 2004).

Children in South Africa are known to be recipients of non-prescriptive medicines at home (Bland, et al, 2004). Common medicines that are reported and given at home are associated with life threatening diseases such as gastro enteritis (Bland et al, 2004; de Wet, 1998).

It is a known fact that the majority of children admitted in these hospitals are first treated at home with these home remedies and this may delay seeking much needed assistance for conditions such as diarrhoea and electrolyte imbalance (Bland et al, 2004, Tjale & de Villiers, 2004). Water and herbal enemas are common methods of treatment in young children in these communities. These enemas are given to “clean the baby out” a process believed to cool the baby down and protect him/her by purging harmful evil influence (Bland et al, 2004). These enemas are not without problems and sometimes they have caused preventable deaths.

A typical ward consists of main ward divided into different cubicles. Children are placed according to their age groups with neonates nursed in incubators. Most mothers

especially for the younger infants are with their babies. Bigger babies may or may not have their parents on their bedside. The unit manager is responsible for directing the care of the babies and is a liaison person between the medical and allied health professional and the other nursing team members. Interactions between the nurse and parent are nurse directed and due to shortage of staff in all of these research settings, one of the preferred methods of delivery of nursing care is task-based care. This results in limited interactions between the mothers and the nurses. Various students at different levels are allocated to paediatric wards and their learning needs drives interactions between the nurses and students.

2.5 CONCLUSION

In this chapter, the broader context was described with special emphasis on the historical background and how this has shaped the structural landscapes and decisions taken in transforming the current health care systems. The inherent values espoused by the communities served by the participants in this study were discussed. The micro context is described in relation to disease profile, primary health care and HIV and AIDS and how the implementation of these is affected by socio-political and legislative imperatives in relation to the health of children.

In the following chapter, the research methodology is discussed in detail.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The aim of this chapter is to explain the research design and methodology that has been used in conducting this study. Since the guiding question for the study is aimed at analysing the meaning of the concept “holistic nursing care”, this research is therefore directed at meaning and human experiences. This chapter begins by explaining the qualitative research design and methods chosen and procedures followed to achieve the study objectives. An explanation of the philosophical inquiry, concept analysis and data collection and analysis methods are given. The chapter will conclude with a discussion on trustworthiness and ethical considerations.

3.2 RESEARCH DESIGN

A qualitative, exploratory, interpretive and contextual design guided by the phenomenological approach, was used to understand the meaning of holistic nursing care. A research design is the detailed plan of how a research study will be conducted (Green & Thorogood, 2004). The process of how the plan of the study came about is elaborated. Conceptualisation of the study emerged from a series of iterative, cycling process of thinking, reading and observing clinical nursing interactions, informal discussions with families of children in hospital. The observations were constantly compared to the dialogue and prevailing socio-cultural and political dynamics impacting health care. Initially the process of conceptualisation was rather haphazard. The logical conceptualisation that helped to shape the research design from a broad area of interest to a workable research proposal was guided by a hierarchy of questions similar to those suggested by Mason in (Green &Thorogood 2004: 43). In conceptualising this study design I was guided by the following:

- What is the nature of the phenomenon that I want to investigate?
- What broad topic is my research concerned with?
- What might represent knowledge or evidence of this phenomenon?
- What is the intellectual puzzle?
- What is the purpose of my research?

I will elaborate on each of these questions.

The phenomenon to be investigated in this study is the concept holistic nursing care. This concept is widely used in these research settings. To clarify the meaning of this concept the ensuing thought process led to an in depth analysis of the research context. Because the purpose of this study is to clarify meaning, my thoughts vacillated between the different meanings that can be attached by these different groups depending where they come from: traditional African worldview or biomedical worldview. In thinking about holistic nursing care my thoughts led me to an investigation of the broader issues in health care system and the differences in thought patterns inherent in different health care systems practiced in and around the communities served by the three hospitals. This journey started unfolding and culminated in a book, which I edited and co-authored, entitled: *Cultural issues in health and health care* by Tjale & de Villiers, 2004).

In chapter one of the book I wrote about the history of the two health care systems. A health care system originates and develops based on health care perspectives and at the core of peoples health views are culturally determined beliefs and values. Both health care systems have to be understood from the perspective of the consumer and the cultural context from which they are operating (Tjale & de Villiers, 2004). Ninety nine percent of the families nursed in these research settings come from townships traditionally designed for African people only. Some African people from these communities live and practice their values and their health seeking behaviours are influenced and shaped by the same values **(**Etherington, 1987; Hammod-Tooke, 1989; Pretorius, 1989; Tjale & de Villiers, 2004).

The dominance of the bio-medical model of care is evident in nursing in general and in particular within the paediatric speciality. This, however, has not deterred some of these families from using their traditional therapies. Anthropologists have reported that African people move comfortably between Western and traditional indigenous medicines (de Wet, 1998).

In pursuing the meaning of holistic nursing care, my search led me to the documents of the South African Nursing Council (SANC). The concept holistic nursing care is mentioned in the philosophy of the SANC; no definitions are given by SANC on this concept. The absence of a guiding definition has led to different interpretations and meaning of the concept especially at practice level. Holistic nursing care is used widely and rather illusively in the nursing documentations of the wards where this research was conducted. It appears in the training and nursing documents of the wards as the intended vehicle and style of nursing care that will be provided for each of the children admitted in these wards (e.g. in the vision and mission statements).

Initial literature review on holistic nursing care produced no scientific evidence on the previous studies done on this phenomenon in South Africa. As I pondered on this puzzle referring to the literature from countries such as USA, Canada, United Kingdom and Australia on the use of this concept, it became clear in my mind that, in South Africa, the concept holistic nursing care has been used as a borrowed cliché; this gave me the impetus to investigate it further. With this in mind, I asked myself what would be the purpose of this study?

The intellectual process that ensued helped to shape my thoughts towards a qualitative approach and a philosophical inquiry, framed around the objectives to meet the

purpose of study, which is to develop a framework of the concept "holistic nursing care" appropriate for paediatric wards in local hospitals. This approach highlighted the ontological and epistemological concerns right from the outset and helped to shape my thinking towards a philosophical inquiry within the umbrella of qualitative approach as the choice for this study. The preoccupation with thoughts about the meaning of holistic nursing care and the philosophical nature of this study led to questions such as: what is knowledge, what is science and what is philosophy?

Knowledge and knowing

Different ways of knowing are described by (Du Plooy (2002: 17): non-scientific and scientific methods of knowing. In acquiring knowledge in a non-scientific way three methods are described: tenacity, authority and reasonableness. **Tenacity** is the unsophisticated method of finding answers to problems. This method is based on the assertion that something is true or false simply because we believe it so. In using the method of **authority,** the knowledge is dependent on the acknowledgement of the person as an authority in that particular area of knowledge. The third way of knowing is **reasonableness**. This involves arguments, as they are self-evident. This method is based on the premise that if an argument is accepted as truth, it must have withstood the evaluation of several people. The criticism against this method is that the criteria used to determine truth maybe personally motivated and maybe rejected by some people (Du Plooy (2002: 17). The ways of knowing described above differ from the scientific ways of knowing explained below.

Patterns of knowing and Knowledge

Carper (1978) identified four patterns of knowing held to be valuable in nursing: empirics, aesthetics, personal knowing and moral knowledge. **The empirical knowledge** is factual and descriptive. It is direct or indirect observation and measurement representing objective, verifiable and is research-based. It aims at developing abstract and theoretical explanations. It is expressed in practice as science grounded in scientific theories and knowledge (Van der Zalm & Bergum, 2000: 213).

Moral knowledge involves making moment-to-moment judgments about what ought to be done, what is good, what is right, and what is responsible (McKenna, Cutliffe & McKenna, 1999: 16). Van der Zalm and Bergum (2000: 216) claim that the synthesis of this knowledge in nursing seeks to bring the meaning via discovery, engaging, interpreting and envisioning.

Ethical knowledge guides and directs how we conduct our life and work, what we consider important, where our loyalties are placed, and what priorities demand advocacy. This ethical knowledge in nursing is constructed through understanding the person. This knowledge is found in relationship and has to do with mutual respect, engagement, mutual thinking. It is expressed through moral codes and ethical decision-making (McKenna et al, 1999: 16).

Personal knowledge is concrete, subjective and existential. It is an effort to know the self in relation to another human being. Full awareness of the self and the context of interaction make possible meaningful, shared human experience (Van der Zalm & Bergum, 2000: 213). An example of personal knowledge used in this study is the

knowledge of the child and family as persons who come from specific cultural groups. This knowledge is gained through interactions.

Aesthetic knowledge is subjective, individual and unique. Intuition, interpretation and valuing are central to this knowledge. It involves deep appreciation of the meaning of a situation and calls forth inner creative resources that transform experience into what is not yet real; bringing to reality something that would not otherwise be possible. (McKenna et al., 1999: 16). Nursing knowledge has emerged through traditions, authority, borrowing and trial error, intuition, reasoning and research (Burns & Grove, 2001: 10). The ultimate aim of this body of knowledge is to provide the direction and development and interpretation of science and theory of nursing. It is hoped that this study will contribute to this knowledge and stimulate dialogue that can be further subjected to scientific refinement.

Science

Chinn and Kramer (1995: 74) differentiate between science the process and science the body of knowledge. Science the process is defined as the process that uses methods that are valid and reliable within a defined area of concern. This process of science creates systematic representation of reality that is accessible to human senses and is called empiric. Science as a body of knowledge is the facts, theories and descriptions generated when using the empiric process of science (Chinn & Kramer, 1995: 74). Science therefore is empirical, factual, systematic and objective.

Science and philosophy

Science is the logical body of knowledge composed of research findings and tested theories for a specific discipline, a form of disciplined inquiry that discerns general traits of reality and sets forth rationale on which value principles rest (Chinn and Kramer, 1995: 74; Burns & Grove, 2001: 10). Philosophy on the other hand is the basis of all truth from which different scientific discipline are developed. Philosophy makes statements about science and the statements have a scientific basis in historical, psychological and sociological factors (Lemmer & Badenhorst, 1997: 99). Science and philosophy are therefore inseparable. In pursuing the understanding of science and wisdom and the nature of knowledge I was led to the logical construction of knowledge and the reasoning strategies applied in building knowledge. The reasoning strategies are described below.

Inductive and deductive reasoning

Induction is usually described as moving from the specific to the general, while deduction begins with the general and ends with the specific. Arguments based on experience or observation is best expressed inductively and those arguments based on laws, rules, or other widely accepted principles are best expressed deductively. An inductive argument succeeds whenever its premises provide some legitimate evidence or support for the truth of its conclusion (Chinn & Kramer, 1995: 65-67; De Vos Strydom, Fouche & Delport, 2005: 47). An example of inductive reasoning in this study involves the process of categorising the focus groups transcribed data into themes.

The meaning of holistic nursing care cannot be used as proof but can be used a basis to form ideas and generate further research. Deductive reasoning is the process by which a person makes conclusions based on previously known facts. It is a system of reasoning in which propositions are interrelated in a consistent way. Judgment based on deductive reasoning is perfectly true when each step in the process of deductive reasoning follows logically from the previous step (Chinn & Kramer, 1995: 65). An example of deductive reason in this study is the construction of relational statements and drawing conclusions (refer to chapter five and six and Table 6. 1). In the next discussion, the qualitative research used to build knowledge is discussed.

3.2 1 Qualitative Research

Qualitative research is mostly associated with naturalistic inquiry, which emphasises understanding of human experiences or phenomena through the collection of data that are narrative and subjective (Polit & Beck, 2004: 16).

Several features and assumptions of qualitative research are recurrent in the literature and are also reflected in the present study summarised as follows:

It is assumed that the nature of reality in qualitative research is subjective *(ontological*). This reality can be described in terms of meaning that people attach to communication experiences. In this study, it is based on the beliefs that paediatric nurses' emic perspectives about holistic nursing care have been derived from their subjective experiences and are valid sources of knowledge *(epistemology)*. This is an attempt to capture and capitalize on the subjective as a means to understand and interpret human experience. To explore, interpret, and understand the subjective world

of paediatric nurses, their values and perspectives were validated through literature control of the existing knowledge on the concept holistic nursing care.

The relationship between researcher and participants is interactive, interpretive in nature involving recording and observing the phenomenon, which is researched within its natural context (*methodology).* Observations can be analysed thematically and holistically within the context that consist of relationships. The researcher is essentially the main instrument in the study. Understanding the context and social reality of paediatric nurses was important for the researcher in facilitating the interpretive nature of this study by exploring the depth, richness and complexity inherent in the concept holistic nursing care and making sense in understanding the whole, which is consistent with a holistic philosophy of nursing (Burns & Grove, 2003: 357). The researcher respects the values attributed to this phenomenon by the participants. The philosophical and theoretical constructs relating to the phenomenon holistic nursing care were explored responsibly and scientifically *(axiological).*

A qualitative inquiry is assumed to be inductive in nature according to Burns and Grove (2001) and oriented towards theory construction, which is expected to emerge from the qualitative inquiry. This is an important methodological assumption inherent in qualitative approaches, which is congruent with the aim of developing a framework of the concept holistic nursing care in this study. Below an exploratory study design is explained.

3.2.2 Exploratory

An exploration is undertaken to find out more about the phenomena to be studied. The goal in exploratory studies is the exploration of a relatively unknown research area allowing the researcher to explicate the central concept of a study (Mouton, 2002). Because the aim of this study is to understand the concept holistic nursing care, this approach permitted the researcher to gain insight through in-depth interviews with participants and explore the concept holistic nursing care as contextually understood and applied by paediatric nurses working in academic hospitals in Johannesburg.

3.2.3 Interpretive

Thorne, Kirkham and MacDonald first introduced an interpretive descriptive approach in 1997 as a non-categorical research approach specifically tailored to nursing. Interpretive description is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of an illness experience while allowing for shared realities (Thorne, et all, 1997:172). Prolonged engagement with individual participants is recommended by Thorne, et al, in order to interpret and describe the greater and shared phenomenon of an experience, which can then be applied back to individual participants. In keeping with this, the authors also recommend analytic techniques, such as Giorgi's method of phenomenological data analysis, that encourage immersion in the data prior to beginning coding, classification and creating linkages (Thorne, et al., 1997:175).

The interpretive nature of this study was preceded by the collection of data through focus groups interviews, which were transcribed verbatim. These arose from inductive logical processes, which require interpretation of data through a process of prolonged

engagement with participants' views and opinions on the concept holistic nursing care in the context of paediatric nursing. This method allowed the researcher to draw the concepts that will ultimately form the basis for the formulation of a framework of holistic nursing care for the paediatric nurses in academic hospitals in Johannesburg.

3.2. 4 Contextual

The context is the world in which the person is situated and understood and context is valid within certain time-space dimension and is culturally bound within specific beliefs and values. The context of this study is divided into two: the macro and the micro – context. The macro context refers to the collective community that is made up of different people within a particular culture living in a changing South African environment. The micro-context refers to the setting wherein the data collection and data analysis took place. Straus and Corbin (1990: 101) define the context as a "specific set of properties that pertain to a phenomenon and a particular set of circumstances in which the action takes place. The beliefs and values situated in a specific cultural context have profound influence in shaping the meaning of health and illness hence in this study a whole chapter was devoted in describing the context.

Below the research methodology is described.

3.3 RESEARCH METHOD

The methods employed in this study refer to the data collection methods, sample and sampling methods, measures of trustworthiness and data analysis. Each of these methods is integrated and discussed in accordance with the research objectives and the

purpose of the study. In the following text, the term philosophy is defined and the philosophical inquiry as applied on this study is described.

3.3.1 Philosophical Inquiry

The term philosophy has its origin from the Greek language meaning love of knowledge or wisdom (Dibartolo, 1998: 350). According to Collins concise dictionary and thesaurus (1993), the term philosophy is defined as "pursuit of wisdom, study of realities and general principles. A philosophical inquiry is the research inquiry that uses intellectual analysis to clarify meaning making values to emerge and identifying ethics in developing knowledge (Burns & Grove, 2001). Whall, Sinclair and Parahoo (2006: 30) suggest that the importance of philosophical inquiry for nursing should be to clarify important issues in the development of nursing knowledge.

The primary purpose of the philosophical inquiry is to clarify meaning and to develop theories of meaning (Burns and Grove, 2001: 616). This purpose may be accomplished through concept analysis or linguistic analysis. The linguistic analysis of the phenomenon describes the meaning and practical consequences of the concept as it is used in practice and related theories. In Burns and Grove (2001) three categories of philosophical inquiry are described namely: foundational inquiry, philosophical analysis and ethical analysis.

3.3.1.1 Categories of Philosophical Inquiry

In foundational inquiry the focus is the analysis of the structure of a science and valuing certain phenomena held in common by members of a scientific discipline.

Ethical inquiry involves the intellectual analysis of problems of ethics related to obligation, rights, duty, right and wrong about science and these issues are debated in relation to science. In this study various sources were searched on the popular concept analysis methods currently used in nursing in search of one that would reveal the meaning leading to the achievement of the purpose and research objectives. To examine meaning a more holistic approach was embraced using a philosophical inquiry through concept analysis popularised by Rodger's (1989, 2000). In the following text, I will focus on various concept analysis methods as discussed in literature in general and follow with the concept analysis as applied in this study.

3.3.2 Concept analysis as method

A concept is a term denoting an abstract description of an object or phenomenon providing it with meaning or identity, thus a concept analysis is essentially a strategy, where the connotative meaning of a concept is identified (Burns & Grove, 2001). The procedure in concept analysis requires an exploration of the characteristic that can be used to clarify the scope of ideas to which the concept maybe applied. Walker and Avant (1995: 37) define the concept analysis as "a strategy that allows us to examine the attributes or characteristics of a concept". Chinn and Kramer (1995:50) describe this process as a technique or mental activity that requires critical approaches to uncovering subtle elements of meaning that can be embedded in concepts. Concept analysis therefore, is the strategy used to examine characteristics of a concept. Walker and Avant's (1995) method of conceptual analysis which has its basis on Wilson's' earlier work, has been subjected to some criticisms described by Morse (1995: 32) as a method which "simplifies the complexity of concept development and often

produces trivial and insignificant results". Paley (in Keil, 2004) suggests that Walker and Avant's (1995) method by which defining attributes are arrived at is arbitrary and that a linear approach to concept analysis does not reflect intellectual reality (Keil, 2004).

Morse (1995) also criticises the linear approach and the positivistic nature of Walker and Avant (1995) in comparison to Rodgers' (1989) evolutionary approach (McCance, McKenna & Boore, 1997). Despite these criticisms Walker and Avant's method of concept analysis is used widely (McCance et al., 1997; Almond, 2002; Meghani, 2004).

Rodgers' (1989, 2000) method called the evolutionary approach to concept analysis provides an alternative to Walker and Avant's (1995) method. The goal of the evolutionary approach to concept analysis is not to search for absolute truth but a relative reality that is pragmatic, temporal and context–dependent, which is consistent with the purpose of this study (Rodgers & Knafl, 2000). Rodger's evolutionary approach to concept analysis is appropriate for this study as it allows for the examination of the contextual dynamics through which the concept of holistic nursing care is being applied. The contextual dynamics in South Africa are rapidly changing in pursuit of building a united "rainbow nation." Constructions of meaning come from values and beliefs held in individuals and groups. It is assumed, therefore, that the meaning is deeply embedded within the practical reality of persons in their daily activities. With reference to the main purpose of this research, which is to examine the meaning of holistic nursing care within a diverse cultural population, constructions of holistic nursing care in paediatric clinical practice are considered contextually–specific and deemed dynamic.

3.3.2.1 Rodgers' concept analysis

By exploring the usage, application, and significance of holistic nursing care in this specific context, the goal is to determine how this concept is interpreted, understood, and applied in clinical practice. Rodgers (1989) views a concept to be an abstraction that is expressed in some form, discursive or non–discursive and subjected to continual change. The process of concept development is presented in a cycle that continually progress through time (Figure 2.1). Three distinct elements of concept development namely: significance, use, and application are explained.

3.3.2.2 Process of concept analysis

Rodgers' evolutionary perspective offers inductive approach to concept analysis based on the idea that concepts are constantly evolving and changing. This theory development strategy allows the concepts to be examined for its significance; use and application as it unfold over time. Knowledge and understanding derived from the analysis, although tentative is gained through scholarly examination of the evolution of a concept (Menzies & Taylor, 2004; Brilowoski & Wendler, 2005).

The different aspects of concept analysis are described below:

Significance

Significance refers to the prominence of the concept (Rodgers & Knalf, 2000). Toulmin (in Rodgers, 1989) points out that concepts acquire a meaning through serving the relevant human purpose in actual practical cases. This significance is

influenced by the internal and external factors that provide for its use and refinement stimulating continuing development. In this study the concept holistic nursing care is variously interpreted and is used as intended process of caring for the child. The concept is very visible in paediatric wards displayed in mission and visions of the different wards. In this research it is intended to develop a conceptual framework that will be used in these research settings.

Use

The use of a concept is the common manner in which the concept is currently employed to its application in appropriate situations (Rodgers & Knalf, 2000; Brilowski & Wendler, 2005). The concept holistic nursing care is widely used and can be found in nursing books, research articles and nursing curricula published in this country and its interpretation depends on the individual since no guiding definitions are given through the regulatory body and its application varies.

Application

Application is the identification of the scope and range over which the concept is effective. The scope of application extends to areas of alternative or complementary practices, discussions on holism and where spiritual healing and wholeness are an intended outcome. In this study all these areas were searched in order to identify the attributes and relevant uses.

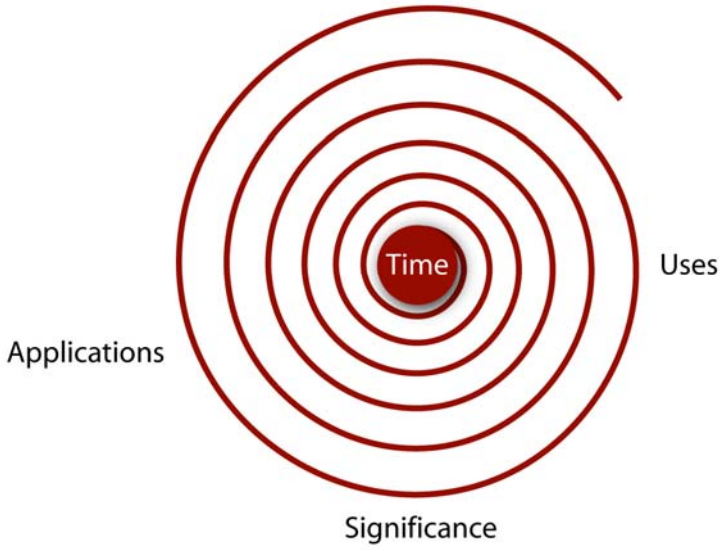


Figure. 3.1 Cycle of concept development

In this study the acquired meaning of the concept holistic nursing care, its significance, use and applicability was explored through a review of the literature and from the emic perspectives of the paediatric nurses working in the academic hospitals in Johannesburg. Rodgers' (1989) elements of concept analysis (Fig. 2.2) were chosen for this study.

3.4 ELEMENTS OF CONCEPT ANALYSIS

3.4.1 Identify and name the concept of interest

According to Rodgers and Knafl (2000: 133) this is the foundational phase of concept analysis aimed at developing an initial definition and ends up with a working definition for the second phase. The initial usage of the concept within the country

was drawn from nursing literature. The starting point was the nursing educational policy documents from the SANC. Even though the registration body responsible for training paediatric nurses does not give the definition, initial literature review of the current usage of the concept in nursing literature and clinical paediatric nursing practice revealed that the literature was inundated with the use of this concept (Searle, 2000; Maluleke, 2003; Bodkin, 2003).

To find out how paediatric nurses construct, interpret, understand and apply this concept in their practice, a sample of paediatric nurses working in academic hospitals was purposively selected. Morse (1995) argues that gaining up to date understanding of how the concept is actually used by people can increase the meaning and clarity of a concept. To investigate the concept holistic nursing care, data were generated and obtained from focus group interviews (Morgan, 1998). The levels of experience among the participants ranged between two and half to twenty-five years.

3.4.2 Identify surrogate terms and relevant uses of the concept

The focus of this stage it to investigate the literature, empirical evidence, and theoretical analysis that support the presence and frequency of this concept within the population selected for the empirical study (Rodgers & Knafl, 2000: 147). Surrogate terms are terms associated with holistic nursing that serves as manifestations of the concept and may portray more than one term (Rodgers, 1989. The frequency of holistic nursing care in this study was sought from nursing evidence and medicine, psychology, and allied health related discipline and complementary and alternative health care. This stage helped towards selecting the sample.

3.4.3 Identify and select an appropriate sample for data collection

Rodgers (1989: 333) advocates the identification of appropriate sampling because of its significance on rigour. The sample is selected from different disciplines examining the variations and similarities in the use of the concept. When selecting the sample, attention is given to the historical development of the concept. This contributes to the relevance of the analysis. When the sample is drawn using the computerised databases the likelihood of representivity is increased and thus enhancing credibility (Guba & Lincoln, 1985).

3.4.4 Identify the attributes of the concept

Attributes are characteristics of the concept that tend to occur recurrently in literature. Attributes are not immutable and can change as the understanding of the concept improves (Walker & Avant, 1995: 41). In examining the attributes Walker and Avant (1995:41) suggest a method of reading through different instances of the concept and making notes of the characteristics that appear over and over. The list of characteristics is called defining attributes. With the volume of literature at our disposal different meanings of the concept are possible. Decisions about which is the most useful meaning is guided by the objectives of the analysis.

3.4 .5 Identify the references, antecedents and consequences of concept.

The identification of references, antecedents and consequences of holistic nursing care adds further clarity. Antecedents are events or phenomena that are generally found to

precede an instance of the concept and consequences follow an occurrence of the concept (Rodgers, 1989: 334). The terms that seem to appear before holistic nursing care were noted and coded, the terms that demonstrated relationship were categorised and guided the process in identifying the antecedents and consequences. Consequences are useful in determining neglected ideas, variables or relationships of the concept (Walker & Avant, 1995: 45).

3.4.6 Identify concepts that are related to the concept of interest

Related concepts are concepts that bear some relationship to the concept of interest but do not seem to share the same set of attributes (Rodgers, 2000: 92). Concepts related to holistic nursing care were searched and discussed and situated within the broader discussion to demonstrate this relatedness. Once the iterative process of analysis between the steps one to six is completed, a model case is constructed.

3.4.7 Identify a model case

A model case is the real life example of the use of the concept. Model case may be constructed or an actual case from real life situation may be used to clarify the meaning of the concept (Refer to 4.2.4.5 and 4.2.4.6).

The discussion that follows describes the methods of collecting data, capturing the emic viewpoints of the paediatric nurses through focus group interviews.

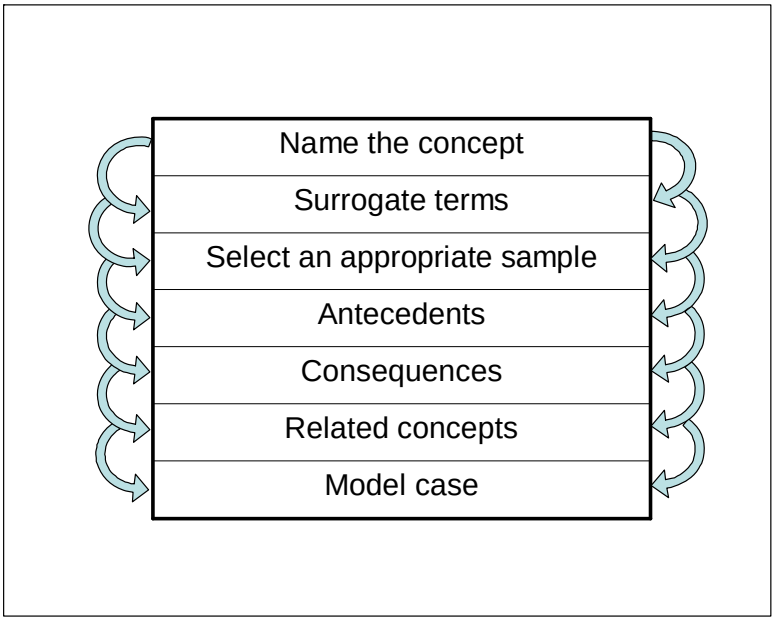


Figure. 3.2 Elements of concept analysis (Rodgers, 1989: 333)

3.5 FOCUS GROUP INTERVIEWS

Focus groups interviews were conducted with paediatric nurses to explore the meaning, interpretation, and application of the concept holistic nursing care in relation to clinical practice. Focus groups in qualitative research draw on three fundamental strengths: exploration and discovery, context and depth and interpretation (Morgan, 1998). As the phenomenon under study resides in the participants' experiences, the intention and the purpose of the study had to be disclosed to the participants, their willingness to participate was respected. Participants were purposely selected on the grounds of their experience in paediatric nursing. The aim of purposive sampling according to Green and Thorogood (2004: 102) is to include "information – rich participants for in depth study".

The choice of non-probability sampling technique is consistent with the exploratory nature of this study, which Burns and Grove (2001: 374) view as "not intended for generalisations to large populations". As the purpose of the study relied on the experiences of the paediatric nurses and the construction of holistic nursing care, the sample size was small but sufficient as smaller samples are preferred when more in depth and richer understanding of a phenomenon is explored (Kvale, 1996; Burns and Grove, 2001)). In qualitative research sample size does not determine the importance of the study but the richness of data collected from participants who will provide rich detail to maximise the range of specific information that can be obtained (De Vos, 2002: 335), guided by the research question (Creswell, 2003: 185).

3.5.1 Planning for the focus groups

The three basic steps outlined in De Vos (2002: 309) and Morgan (1998) were followed in organising for the focus groups namely planning, recruitment and conducting the group. Permission to conduct the focus groups was first sought from the Department of Health, Gauteng province (Appendix A). Individual letters were sent to the Chief Executive Officers (CEO) requesting permission to enter the hospitals and Nursing Service Managers, who subsequently gave permission to contact the participants in paediatric units in each hospital (Appendix B). The researcher and the moderator arrived forty-five minutes before the scheduled time to arrange the room and set up the equipment (de Vos, 2002). This procedure was followed for all five focus groups.

3.5.2 Recruitment of Participants

For the productivity of the conversation participants were purposively recruited. According to De Vos, (2002: 311) when participants perceive each other as fundamentally similar, they spend less time explaining themselves to each other and focus on the topic at hand. All participants, at the time of this study, were working as full time registered paediatric professional nurses. Selection was based on their clinical experiences and common demographics; the paediatric units in the academic hospitals in Johannesburg in order to collect typical and divergent data on the topic (De Vos, 2002: 311) meeting the two qualitative principles of appropriateness and adequacy in sampling (Morse and Field, 1996). None of the paediatric nurses had less than two years experience in the area of work. The total number of participants was 33 (one male and thirty two females). Five focus group interviews were conducted in three different hospitals. The rationale for using focus groups was the ability of this method to explore a complex phenomenon through synergy of ideas to allow for contrasting opinions (Greenbaum, 1998: 77). Four of the five groups comprised six participants and the fifth comprised of nine participants. Morgan (1998) points out that mini focus groups are becoming popular when dealing with complex topics. For maximum variation paediatric nurses were selected from medical, surgical, intensive care units, premature units, and oncology units. All the focus group interviews were conducted in the natural settings with each group.

Personal letters of invitations with a reply slip attached were distributed to the units where potential participants were working at the time of data collection. This shortened the 14 days period advocated by Morgan (1998) and Krueger (1997: 89).

A day prior to the interview date, a telephonic follow up was made to ensure participants' attendance.

3.5.3 Planning the focus group questions

As the study design was exploratory in nature, the questions were in depth, conversational and the style of questioning was comfortable and simple (Morgan, 1998; De Vos, et al. (2002). Questions were formulated in the format advocated by De Vos, et al., (2002: 309) namely: introductory, transition, key and ending questions. The opening question was a round robin question in relation to participants' duration in paediatric nursing. Each participant was asked to share with the group what they enjoy most at home and why and what they like to do when relaxing at home. The main purpose of this question was to allow the participants to shift their thinking from general to specifics (De Vos et. al., 2002) (Table 1.1). Three main questions were planned which allowed the participants to interpret the questions according to their understanding. The initial questions were developed with the intention of providing participants with the open opportunity to describe their interpretation of holistic nursing and the activities they include in practice as part of holistic nursing care.
Subsequent probing questions were planned guided by the discussion. Each interview was concluded by a question that was designed to check if any further issues on the topic were omitted. The session was ended with a summary and an expression of gratitude for participation (Appendix G).

- ***I would like to hear from you as many ideas as you have of what you know*** *and practice when it comes to holistic nursing care?*
- *I appreciate your experience and I consider you as experts in paediatric clinical practice.*

- *What I would like to know from you is what holistic nursing care is and what activities do you do in caring for your patients in a holistic manner?*

Probing questions included:

- *Can you please tell us more about…in holistic nursing care?*
- *I would like to know more about …..…*
- *Please explain.*

3.5.4 Conducting the focus group

All five interviews were conducted at the work location of the participants. While the venues may not have been neutral as advocated by Greenbaum (1998), Krueger (1994), they were convenient, safe and accessible for the participants (Greenbaum, 1998; de Vos, et al., 2002). The services of a moderator were employed to assist the researcher. The role of the moderator, though guided by the interview guide, was to facilitate the participants' discussion ensuring a flow in responses to the questions without restricting the unanticipated data (Mayan, 2001). Morse and Field (1991) argue that semi-structured interviews allow the researcher to obtain the information required while permitting the participants' freedom of responses and description to illustrate concepts. The presence of the moderator was explained verbally to participants before each focus group and permission to tape record the interview was secured prior to commencing the interview. Issues pertaining to confidentiality were reiterated and to facilitate the conversational nature of focus groups, participants were asked to give pseudo-names to ensure anonymity. Each interview commenced with the explanation of the purpose and the approximate duration of the session. Both the

researcher and the moderator collected field notes observing participants' interactions and group dynamics. Relevant information that would not necessarily be on tape were noted and explained such as Kvale's (1996: 130) who, when, what, and how of human activity. As the guiding question for this study is to understand meaning, it was necessary to listen intently to the descriptions and meanings, as well as what was said between the lines (Kvale, 1996: 130). The average time spent in each focus group was one hour fifteen minutes. All the interviews were captured on a micro-cassette recorder. These recordings were directly transcribed verbatim for preservation. As Marshall and Rossman (1995: 112) point out the process of preserving the transcribed data increases data efficiency in preparation for data analysis.

After five focus group interviews data were saturated, as there were no new themes emerging. The saturation limit is a point where no new additional information is emerging; only duplicates of the previous data are achieved (Morse & Field, 2002: 65). Saturation of data was attained after interviewing the fourth focus group. At this point no new information was provided as emerging, only redundancy. One more focus group was conducted to confirm saturation.

3.5.5 Analysis of focus group data

The purpose of data analysis in qualitative research is to impose order on a large body of information so that general conclusions can be reached and communicated in the research report (Polit & Hungler 2000: 329). The interpretive nature of this study necessitated a qualitative research procedure of listening, reading, and explication as I faced the mountain of data needing analysis. The raw data in the transcribed interviews in qualitative research can contain a massive amount of words, which

makes processing more complicated than dealing with numbers of quantitative research. An overwhelming sense of consternation came over me, as pages and pages of raw data stood waiting to be “unpacked” to reveal the underlying patterns concealed in this mountain of words. The initial data processing procedure as Field and Morse (1992: 96) point out is “embedded in the process of recording and analysing field notes and interviews” followed by the narrative texts derived from the transcribed interviews. Other than sequential and narrative accounts of experiences, there was very little inherent structure. Step one of this data analysis was the transcription of the taped interviews. The interviews were transcribed verbatim (Appendix, M). Pauses were denoted with four dots and prolonged silence was indicated by straight line. Laughter was also indicated as *ha..ha* and a long space was left to denote where the tape was inaudible. A generous margin was left on the right hand–side margin for the researcher to include own comments.

Giorgi’s method of analysis of phenomenological data was used in this study (Maggs-Rapport, 2001). Giorgi emphasises the interdependence of the disciplinary perspective of the researcher with the research question, transforming meaning units into disciplinary language revealing the structure of the phenomenon. This method of phenomenological data analysis was chosen, as Giorgi advocates that a sense of whole to be maintained and the relationships should be drawn between the identified themes and to the whole. This is consistent with the overall purpose of this study in understanding a sense of whole of the concept “holistic nursing care”. Giorgi’s five steps of data analysis of phenomenological are given below.

- Read through each interview to obtain a sense of the whole.
- Reread each interview to delineate each time a switch in meaning occurs. This results in a series of meanings or themes.

- Examine the previously determined meanings / themes for redundancies, clarification, or elaboration by relating themes to each other and to a sense of the whole.
- Reflect on the themes (as expressed by the participant) and comprehend the essence of the experience for each participant. Systematic interrogation of each theme is undertaken for what it reveals about the phenomenon under study for each participant.
- Formalize a consistent description of the structure of the phenomenon under study across participants by synthesizing and incorporating the insights achieved in the previous steps.

In this study the researcher repeatedly read through the transcripts to get a sense of the whole. The aim of reading the transcripts repeatedly was to familiarize the researcher with the underlying meaning. Notes were made in the margins of the transcribed interview. Themes were written in the margin with different colour pens. The initial themes were examined to determine meanings. Themes were then related to each other to get a sense of the whole. This process was repeated for all the transcripts. Descriptive codes were used, initially, written in the participants' words. Following descriptive codes, interpretive codes were used. Morse and Field (1985) suggest different innovative strategies for coding qualitative data. Colour pens and highlighters and colourful stickers were used to indicate themes as they became clearer. Systematic interrogation of each theme was undertaken to reveal the dimensions and meaning of the concept holistic nursing care, its uses and application by each participant. The more I engaged with data the clearer the explanation codes began to emerge. Explanation codes involved justifying, giving reasons, supporting or making relational claims (Denzin & Lincoln, 1994: 432). Reflective notes were

written with different colour pens in the margins. With prolonged engagement with transcribed data, themes became clearer and these were written on long sheets of white paper displayed all over the walls in my working space (Refer 5.3).

The development of the knowledge of holistic nursing care through understanding of attributes, antecedents and related concepts discussed in literature formed the background information, which formed bedrock for eliciting and understanding of the current debates in nursing literature on holistic nursing care. The emic view of paediatric nurses, which were collected through focus groups discussed above, allowed the researcher to understand the practical application and contextual–based information on the use of holistic nursing care in clinical practice. In chapters four, five and six, an inductive process will be used to formulate the relational statements identified from the results of the concept analysis process and from the analysis of the result of the analysis of the data collected from the emic perspectives of the paediatric nurses . These concluding statements will be used to draw the framework of holistic nursing care.

Below the strategies for trustworthiness are described.

3.6 TRUSTWORTHINESS

Lincoln and Guba's (1985) well-developed criteria for ensuring trustworthiness in qualitative research were applied in this study (Krefting, 1991; Miles & Huberman, 1994; Flick, 2002). The merit of any empirical research is the ability to meet the

epistemological standards of good scientific practice. These standards define what "good research practice" is in qualitative research (Green & Thorogood, 2004: 191). The criteria for trustworthiness include truth–value, applicability, consistency and neutrality. Each criterion is described below.

3.6.1 Truth-value

Truth refers to the credibility of the study (Miles & Huberman, De Vos, 2002; Flick, 2002: 228). Strategies to ensure truth-value in this study are discussed.

- Firstly, the Postgraduate Committee of the University of Witwatersrand approved the proposal for this study.
- The second truth in this study depended on the ability of the paediatric nurses to provide information that is truthful. The resultant truthfulness was observed and demonstrated by the depth and richness of the data collected during the focus group interviews.
- The researcher knows and understands both the macro and micro context of the study very well having spent twenty-four years in child nursing in these very research contexts. Three years prior to the study, the researcher was totally immersed in culture conducting research in preparation for the material to be included in the book, *Cultural Issues in Health and Health Care*.
- This element of truth-value was further ensured by the presence of the moderator during all focus group sessions conducting, listening, observing and taking field notes during the interviews.
- Both the moderator and I wrote extensive notes during the interviews. At the end of each session, I would summarise to allow the participants and the

moderator to verify the truth (Flick, 2002: 228). A reason for this summary was to make sure that our accounts correspond to those of the participants (Green & Thorogood, 2004: 103).

- Paediatric nurses, colleagues and recent appropriate literature sources were consulted during the identification of themes.
- The transcripts of the focus groups were stored safely for later verification and audit checks.

3.6.2 Applicability

Applicability refers to the ability to transfer the research findings to other settings. Applicability and transferability are used synonymously (Miles & Huberman 1994: 279; Flick, 2002).

- For maximum variety participants were purposively sampled from medical, surgical, intensive care units, oncology units and premature infants units. The levels of experience in paediatric nurses among the participants ranged between two and half to twenty-five years. To ensure further transferability of the results of the study, thick descriptions of the research design and research methods are given to allow the reader to assess the potential for transferability of results by comparison to other population and samples in other contexts (Miles & Huberman, 1994: 279; De Vos, 2002; Flick, 2002: 228-229).

3.6.3 Consistency

Consistency refers to the dependability and auditability of the findings and whether the process was reasonably stable over time (Miles & Huberman, 1994: 278). Strategies used to ensure consistency in this study are described below:

- In order to ensure consistency the role of the researcher and the moderator was explained to the participants and maintained throughout the study.
- After every focus group, the researcher and moderator would meet to discuss the interview and compare field notes. The data was also exposed to external auditing aiming at consensus validation.
- A thick description of the study is provided in this research report to ensure auditability.

3.6.4 Neutrality

Neutrality refers to confirmability of the study. It is the freedom from the inherent bias that the researcher depicts in the study (Miles & Huberman, 1994: 278).

- The thick description of data of this study is given to reduce bias. This provides the reader the opportunity to audit the study.
- A copy of the interview transcripts is included in this report for auditing (Appendix H).
- Literature control was used to develop themes and ensuing discussion. A more experienced researcher was consulted to discuss the themes and sub-themes; the aim was to ensure investigator triangulation.

3.7 ETHICAL CONSIDERATIONS

This study requires an involvement of paediatric nurses and the rights of these participants were ensured in accordance with the University of the Witwatersrand' s code of ethics for research on 'human subjects' as well as the ethical standards for nurse researchers prescribed by the Democratic Nursing Organisation of South Africa (DENOSA). Ethical issues applied are described.

- **Informed consent: Institutional aspects**

From the outset the application to conduct this study was sought from the Committee for Research on Human Subjects (Medical) of the University of the Witwatersrand. On receipt of the ethics approval (Appendix G- **Ethics No. 40427**), a letter with the copy of the ethics approval was sent to the Department of Health requesting permission to conduct the research in three academic hospitals in Johannesburg. On receipt of the confirmation from the Department of Health, Gauteng Province, individual letters requesting permission and entry to hospitals were then sent to the Chief Executive Officers (CEO) and Nursing Service Managers of each participating hospital. Two of the hospitals communicated their permission in writing and one gave verbal permission.

- **Informed consent: participants**

Participants in the study received an information letter (Appendix E) stating the purpose of the study and giving them an option to voluntarily participate or not

participate. Informed written consent was also obtained from the participants for the tape-recording of the interviews.

- **Autonomy**

Participants were informed that they could terminate the study at any point if they so wish. None of the participants refused to participate in this study.

- **Confidentiality and anonymity**

All participants' names have been replaced with pseudonyms to ensure confidentiality and anonymity. All hard copies and recordings of the interviews were kept under lock and key and kept in case needed for audit trail.

- **Access to reported findings**

Feedback of the research findings has been offered to all participants in the study, should they request it. Research results will be disseminated to the following:

- To the authorities at the Department of Health, Gauteng
- To the paediatric nurses working in the academic hospitals in Johannesburg through in-service training.
- Research results will be presented at the Department of Nursing Education, University of the Witwatersrand's research day.
- An article covering the study will be published in an accredited Nursing Journal.

3.8 CONCLUSION

In this chapter, the methodology of the study was described. The theoretical foundations selected by the researcher were explained in relation to the philosophical inquiry and research design used in this study. An attempt to justify the reason for the choices regarding research methods and design were given and explained. Data collection, analysis, trustworthiness and ethical consideration were outlined. Finally, the criteria to guarantee the rigor in conducting the study were discussed as they pertain to qualitative research.

CHAPTER FOUR

PHILOSOPHICAL INQUIRY THROUGH CONCEPT ANALYSIS

4.1 INTRODUCTION

The purpose of this study was to examine the meaning of holistic nursing care using a philosophical inquiry through concept analysis as proposed by Rodgers (1989). Elements of concept analysis include the identification of the concept of interest, surrogate terms and relevant uses of the concept. The evolution of the concept holistic nursing care will be described as advocated by Rodgers' (1998). An appropriate sample on holistic nursing care was purposefully selected from a variety of data sources to identify the attributes; antecedents, surrogate terms and consequences and related terms. Concepts used in relation to holistic nursing care will be discussed. A model case was constructed.

4.2 CONCEPT ANALYSIS

4.2.1 Identification of the concept "holistic nursing care"

Rodgers' (1989) approach to concept analysis emphasizes that concepts are dynamic, evolving and not meant to be static. The literature confirms that the concept holistic nursing care is evolving (Blattner, 1981; Sarkis and Skoner, 1987; Owen and Holmes, 1993; Kolcaba, 1997; Campbell & Campbell, 2005). The concept of holistic nursing care can be defined as a concept that reflects a humanistic view of the individual with a mind, body and spirit, and interacting with the environment. 'Holistic' is an adjective and has its roots from holism.

Holism – a noun, means that the 'whole is greater than the sum of its parts'. (www.thefreedictionary.com/holism). The noun holistic is derived from the Anglo-

Saxon root ‘hall’, which means whole or to heal. The letter ‘w’ maybe added to the base ‘ho’ accounting for ‘wholistic’, which is used interchangeably with ‘holistic’ (Blattner, 1981:3). Holistic nursing care is based on the premise that there is a balance between body, mind and spirit, each of these is interconnected and affect the others. (Narayanasamy, Clissett, Parumal, Thompson, & Annasamy, Edge, 2004: 6). The adjective ‘holistic’ in medicine is assimilated by the practice of comprehensive and humane nursing care. The Canadian Holistic Medical Association defines holistic health as “a system of health care which fosters a cooperative relationship among all those involved, leading towards optimal attainment of physical, psychological, social and spiritual well-being (http://www.applesforhealth.com/holistmed1.html).

Nursing as a discipline emphasizes the whole-person (Kolcaba, 1997). Whole-person occurs when the physical, psychosocial and spiritual needs are met in ways that supports maximum functioning (Ress, 2001: 69).

With reference to the above the concept holistic nursing care is based on care that embraces and emphasises the “whole-person”. The sample selection is discussed below.

4.2.2 Sample Selection

The target population for the concept holistic nursing care was qualitative and quantitative studies from the fields of nursing, medicine, anthropology, sociology and psychology that examine the concept. Eligibility criteria included the concept holistic nursing care and holistic care in the fields identified above. The selection included scholarly articles and books with a definition, use and historical exposition of the concept holistic nursing care as recommended by Rodgers (1989: 332). A purposive

sampling method was used. Several databases: EBSCO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Pubmed, CD Rom databases were searched, identifying literature published from 1926 onwards. These were searched to enhance the credibility of this research (Rodgers, 1989: 333). Google search was also used to search the World Wide Web for information on holistic nursing care. Google search was selected because it uses text material software with unique technology that allows a quick find of the greatest number of relevant links, based on number and quality of those links (Burke, Peper, Burrows & Kline, 2004: 1115 – 1121). Key terms used to search the database on the Internet for holistic nursing care included a combination of 'holistic nursing care', 'holistic care', 'holism', 'mind and body and meaning', 'holistic care and health', 'paediatric and holistic nursing care', 'paediatric and holistic care', 'paediatric and holism", 'pediatric' and 'holistic nursing care', 'pediatric holistic care' and 'pediatric holism'. This search was further broadened to 'holistic care and child', 'child and holistic nursing care', 'child holistic care', 'child and holism', 'child and holistic nursing care', 'nursing care and holism', 'caring and holism'. The initial search using holistic nursing care on Google search produced unmanageable results of 5,650,000 because of the many uses of the concept. Mind-body–spirit search generated 57, 5000, 000. On further analysis, the majority of these references were found to be a mixture of books, research papers, advertising sites and anecdotal viewpoints and editorial papers in relation to holistic nursing care. After trying different combinations the research papers amounted to 2188. Following scrutiny of the available articles and because of the volume of papers retrieved, the following criteria were set to guide sampling:

- Holistic nursing care and definition

- Holistic care and holism
- Holistic nursing care and health
- Holistic nursing care and child
- Holistic nursing care and paediatrics
- Holistic care and complimentary medicine

Based on the criteria, the data sources sample provided a purposive sample of 77 articles that met the eligibility criteria and the rest of the articles provided useful background information. With respect to the different dimensions of holistic nursing care a further differentiation was necessary in order to manage the data.

Of the total sample 21 journal articles represented holistic nursing care within paediatric nursing, 49 articles dealt with holistic nursing care in general. Of the 49 articles 4 represented psychology and 2 represented sociology. Eighteen articles focused on inclusion of spirituality in adult nursing as part of holistic nursing care. Seven articles discussed holistic nursing care and the caring presence. Because of the paucity of research on the holistic nursing care South Africa in this country, anthropological view was searched in books with special reference to nursing and medicine and 3 books were found that met the above criteria.

4.2.3 Data collection and analysis

Each of the 77 articles on holistic nursing care was labelled according to the categories mentioned above. Each study collected was read to gain an overview of the

paper. During the second and sometimes third reading, data were organised into terms indicating antecedents, attributes and consequences of holistic nursing care. For each of these aspects key terms were tallied to determine frequency of use. The key terms and phrases were then clustered into groups, reflecting logical and understandable categories for each aspect of the concept. Each category was labelled using general descriptors obtained from data. Data were inductively analysed.

The remaining general articles and books were read to provide background information as well as to gain understanding on the evolution of the concept of holistic nursing care. In gaining understanding of this concept, the literature search led me to the importance of time and how the concept has evolved over as advocated by Rodgers (1989). It became necessary to situate the evolution of the concept holistic nursing care to its history. The concept holistic nursing care is well established in literature and can be traced from the holism perspectives. The following discussion is very necessary; it brings to light the development of "holism" and "holistic" thought demonstrating its influence in medicine and nursing care.

4.2.3.1 Evolution of "holism" and "holistic" thought

The literature pertaining to holism is vast. According to Owen and Holmes (1993: 1688) the subject of wholes was a common discussion during the pre–Socratic' (469–399 B.C.) times. These philosophers were concerned about how the unity or wholeness of reality is transformed into the plurality of appearance. In the 17th century Descartes generated a different focus by presenting his views on separation of subject and object, which deviated from the current thinking about wholeness of reality. This discussion, as Owen and Holmes (1993: 1688) point out, caused divisions in the scientific fraternity and Hegel (1929) attempted to heal this rift. Hegel (1929)

elaborated on the nature of internal relations between the parts of an organics whole, an approach that gained popularity in the 19th century. Hegel (1929) explained that the 'whole is greater than prior to and determinate, of its parts, whilst the parts can only be studied and appreciated as they participate in internal reality that comprise the wholes Allen in (Owen and Holmes, 1993: 1689).

An attempt to develop coherent views on these ideas was led by Jan Christian Smuts in 1926, a Prime Minister of South Africa, who wrote the foundations of a major world philosophy in his work called Holism and Evolution (Sheally, 2003: 333). Smuts' area of interest was philosophy, mathematics and biology. He postulated a philosophy in which the interdependent and interrelated parts were treated not within the dominant positivistic scientific paradigm, but from a new perspective for which he coined the term 'holism'. Smuts described holism as the principle, which makes for the origin and progress of wholes in the universe (Owen and Holmes, 1993: 1689). In his seminal work Smuts (19269) emphasized the ideal wholes, or holistic ideals, or absolute values, and opened debates on the ultimate reality explaining that the universe is neither matter nor spirit but wholes. He argued that the mind is the third great fundamental structure of holism (Sheally, 2003: 333). His scientific education, the theory of evolution and the Darwinian theory influenced Smuts' ideas, which was contemporary thought during his time.

The holistic philosophy influenced a number of disciplines and as it was applied it was being refined and modified. Engel's ((1977) work cited by Owen and Holmes (1993: 1689) utilized the term 'bio-psycho-social' based on systems theory instead of holism, because of the latter's association with faith and belief systems …handed down from remote or charismatic authority figures". In 1977, psychiatrist George

Engel, MD, published an article in Science proposing the "bio-psychosocial model of medicine'' which is now considered as one of the founding principles of modern field of holistic care. Engel's (1977) "bio-psychosocial model" treats biological and social issues as systems of the body. The model draws distinction between the actual pathological processes that cause disease and the patient's perception of his or her health called illness. The influence of the 'bio-psycho-social' model is recognizable in health being the preferred model used in health care assessments.

The first use of the word holism in medicine was in 1952 by Weil cited in (Sheally, 2003: 333). Sarkis and Skoner (1987) conducted a search on the term holism on four widely read nursing journals. The search produced 18 papers in 1966 -1970 and mainly in psychiatric journals. The papers retrieved during this time offered no definition of holism but tended to identify with the 'bio-psycho-social' model of the person. A steady growth was noticeable during the period 1980 – 1985 with 220 papers retrieved (Owen & Holmes, 1993: 1691). An interest on holistic medicine was rekindled when the American Holistic Medical Association was founded in 1978 (Sheally, 2003: 333). Prior to this time, conventional medicine ignored the spiritual aspects of health and arguably this is still the case in some health sectors as evidenced by the authority and power that perpetuate the biomedical system ideals over the notion of holism. This emphasis on body and mind in health care can be traced from the dualism of body–mind.

4.2.3.2 Mind and body dualism

Dualism is an ancient concept and deeply rooted in Greek thought. The Greeks held a view that a man's soul was of an entirely different essence than his body. Dualism in

this instance implies the dichotomy of soul and body, an absolute split. Rene Descartes (1596-1650) the father of modern psychology, a philosopher, scientist, physiologist and a mathematician, believed in an independent nonmaterial soul inhabiting and finding expression in a mechanically operated body (Blattner, 1981: 7; Sarkis & Skoner, 1987; Owen & Holmes, 1993). This mind-body approach has worked very well in medicine as seen in the study of the anatomy, physiology, biochemistry, molecular biology and microbiology by medical and nursing students. Proponents of Cartesian dualism medicine interpret the body as nothing more than a compilation of mechanical systems composed of cells, tissues, and biochemistry and this body is understood as a machine void of a mind or soul Benner (in Holden, 2002: 457). This is evident in health care system in general as Leder (in Holden, 2002: 447) points out "modern medicine has continued to use the corpse as a methodological tool and a regulative ideal. Medical education begins with the cadaver, just as the clinical case ends with the patho-anatomical dissection". Because of the close relationship between the medicine and nursing, the Cartesian metaphysics of the health care system has continued to influence the nursing profession as evidenced by the concept analysis process of holistic nursing care described below.

4.2.4 HOLISTIC NURSING CARE

The prominent finding of the concept analysis was the similar definitions and descriptors of holistic nursing care observed from varying qualitative and quantitative studies across disciplines and the circular relationship of the descriptors of attributes, antecedents, surrogate and relevant concepts and consequences observable from literature. Data analysis on attributes of holistic nursing care is described.

4.2.4.1 Attributes of holistic nursing care

The purpose of identifying the attributes of the concept of holistic nursing care is to provide a basis for its occurrence as a phenomenon (Keenan, 1999: 556). Walker and Avant (1995) suggest that attributes are those characteristics that repeatedly appear in literature and may help clarify how the concept is used. To identify the attributes and search for clues in the literature, the questions suggested by Rodgers' (2000: 91) were used:

- What are the characteristics of holistic nursing?
- What is this 'thing' called holistic nursing care?
- How is holistic nursing care used in different situations?
- Has the use of the concept changed over time?

Rodgers' (2000) suggest that concepts change over time and can contribute significantly to the understanding of origins, development and functions of a concept. The use of the concept holistic nursing care is very established in nursing literature. Many authors offered no definition of holistic nursing care but generally infer from the concepts holism and holistic approach to care as the justification for general nursing practice (Allen, 1991; Touhy, 2001). There appears to be an agreement in the literature regarding the attributes of holistic nursing cares even though authors give a myriad of terms to describe the concept.

Bukhardt & Nagai-Jacobson (2001: 23) define holistic nursing as care that addresses the whole being: physical, mental, emotional and spiritual. The American Holistic

Nurse's Association defines a holistic nurse as a "nurse who recognizes and integrates body-mind-spirit principles and modalities in daily life and clinical practice; she or he creates a healing space within themselves to become an instrument of healing to another feel safe and balanced; a nurse who shares authenticity of unconditional presence that helps to remove the barriers to healing process" (Dossey, 2001: 3). Holistic nursing care is based on the premise that there is a balance between body, mind and spirit (Narayanasamy, et al., 2004). Tassanee (2000) suggests that holistic nursing approach should be used to enhance the well-being. The person's well-being reflects the integration of body-mind-and spirit. Even though the authors use different terms in their definitions, there seems to be a convergence of ideas in defining the characteristics of holistic nursing care.

Identification and analysis of attributes of holistic nursing care yielded two dimensions of the concept. Firstly, holistic nursing care appears to have a central whole–person dimension and secondly this whole-person is characterised by the integration and harmonious balance between the body-mind-spirit dimensions (Bukhardt & Nagai-Jacobson, 2001; Dossey, 2001; Norris, 2001; Thorne, 2001; Narayanasmy 2002; Ormsby & Harrington; 2003; Fernros et al. 2004; Burke et al., 2004; Hassed, 2004; Narayanasamy et al., 2004; Zengerle–Levy, 2004; Campbell & Campbell, 2005; DiJoseph & Cavendish, 2005; Hasegawa, 2005; Tzeng & Yin, 2006).

Because of the relationship between two attributes, I will attempt to clarify each attribute and link the discussion where this is necessary. Holistic nursing care according to Dossey (2001: 1) embraces all nursing that enhances the healing of the whole person. The concept "whole" represents an organised group of parts. This wholeness embraces the body-mind-spirit self in relationship with others, with nature

or environment and with God or life sense of the Life force (Bukhardt & Nagai-Jacobson, 2001: 24).

Kolcaba (1997: 291) describes three types of wholes: persons, systems and organisms. Persons are experiential beings, human inventions possess knowledge and have an ethical standing (Kolcaba, 1997: 292). A whole person includes the body, mind, emotions and spirit (Burkhardt & Nagai–Jacobson, 2001: 23) … a self or agent, which owns a body. Ownership of the body means ownership of self (Kolcaba, 1997: 291). Mind-body and spirit is embodied in an organic whole, any disturbance in one dimension can cause distress in the other dimensions creating health problems (O'Connor, 2001: 34). For Thornton (2005: 107) a person is an energy field that is open, infinite, and spiritual in essence, and in continual mutual process with the environment. Each person manifests unique physical, mental, emotional, and social attributes relationally. A harmonious relationship between the three entities of the person is necessary for well-being (Narayanasamy, Clissett, Parumal, Thompson, Annasamy & Edge, 2004: 7).

Kolcaba (1997: 291) describes the second whole as a system in relation to biological sciences. The system is described as a group of interrelated parts that jointly perform the function for an example the taxonomy of systems within biology includes circulatory, digestive, etc. The adjective specifies the function: circulation of blood. The concept function indicates the range of parts required for the function to be performed. Because the elements of the system are decided by function, in biology aspects of the environment are necessary to complete the function. Martha Rogers (1989) was influenced by this contemporary thought and defined a human being as a

unified being integral with the environment in continuous mutual process with his environment (Marriner-Tomey, 1989: 216). In attempting to link the description of the person in the foregoing discussion to Kolcaba's (1997) explanation on the system, it becomes clear that a person when taken together as a whole (mind, body and spirit) is more than a system; a person is intelligent and distinguishable from what is identified as environment (Kolcaba, 1997:292).

The third whole is organism. A whole organism is actualised in genetic codes and interacts with environment. Within a suitable environment, the organism causes a formation of an integrated group system of organism (Kolcaba, 1997:292). In viewing, the person from a system of organs would be reducing the person into a biological entity.

In Watson's (1988: 53) view a person is "a being-in-the-world ….who exists as a gestalt... and possesses three spheres of being-mind-body-soul that are influenced by the concept of self" (Malinowski & Stamler, 2002: 599). In this definition Watson (1988) uses the soul while Burkhardt & Nagai–Jacobson (2001), Dossey (2001) and Narayanasmy et al. (2004) use the term spirit. This observation is noticeable in Collins Concise (1991) dictionary where the 'spirit' and 'soul' are distinguished from another and also considered identical. For Holden (1991: 1376) the word "soul" is synonymous with "mind" and both can be considered as non–material. O'Connor (2001: 34) differs as she uses the "soul" and "spirit interchangeably. Authors agree that both soul and spirit are immaterial entities and are seen as essential characteristics of human life (Holden, 1991; Sims, 1999: 97; O'Connor, 2001; Sims, 1999; Burkhardt & Nagai–Jacobson, 2001).

In dealing with such a subjective immaterial aspect of human beings McEvoy (2003) developed a BELIEF assessment tool to guide the paediatric nurses to initiate discussion with a child or family about cultural, religious and spiritual beliefs. The components represented in the mnemonics BELIEF are B-beliefs, E-ethics, or values, L-lifestyle, I-involvement in spiritual community, E-education, and F- future events. Benefits of spiritual interventions have been reported. Nurses in Narayanasamy and Owen' s study on older patients in (Sawatzsky & Pesut, 2005: 29) reported that recipients of spiritual care appeared more peaceful, relaxed and calm and grateful and that patients and families expressed feelings of being comforted. Activities of the nurse's spiritual interventions are difficult to measure. Sawatzsky and Pesut (2005) suggest that the outcomes should be measured by the patient's reality. In that way spiritual care can be seen as an integrative philosophy rather than an outcome-oriented approach to nursing interventions.

Connection with others is frequently expressed in the literature as an outcome and it is difficult to measure and yet practical steps can be taken to assist patients to connect as in the following statements taken from Narayanasamy et al., (2004: 11) study of nurses and older patients:

"Practically the patient was (after discussion with himself and his family) moved to cubical for privacy and dignity (Nurse 16)."

"I offered her the use of a quiet room or garden area for privacy. I also spent time talking to the lady about her beliefs and her thoughts on dying."

From the above discussion of the attributes, it can be inferred that wholeness of a person refers to the interrelationship of the body-mind-spirit and the spirit is the non-

material aspect, which is the essence of the person. A harmonious relationship between the three entities of the person is essential for well-being. Below the antecedents are described.

4.2.4.2 Antecedent

Data analysis revealed that spirituality is the predominant antecedent of holistic nursing care. Spirituality included a belief in God, supernatural Being or Life force (Tanyi, 2002; Narayanasamy et al., Clissett, Parumal, Thompson, Annasamy & Edge, 2004; MacLaren, 2004; Van Loon, 2005). The centrality of spirituality in making a person unique is acknowledged Carson in (Dyson, Cobb & Forman, 1997: 1183), the essence of life (Heyse-Moore, 1996; Narayanasamy et al., 2002), the core of human existence and the most elusive and mysterious constituent of our human nature (Tanyi, 2002: 500). The word "spirit" has its origin in the Latin word 'spiritus' means to 'breathe' (Van Loon, 2005: 266). To trace the words spirituality, the initial definition was sought from English dictionaries using the words spirit, spiritual and spirituality, and yielded numerous definitions (Table. 4.1).

Data analysis of spirituality in nursing literature revealed different definitions even though there appears to be some agreement on other aspects such as attributes, consequences, and related concepts. (Burkhadt, 1989; Dyson et al., 1997; Tanyi, 2002; Newlin, Knafl & Melkus 2002). Van Loom (2005: 266) defines the spirituality as that which breathes life and vitality into a person.

Table 4.1 Dictionary definitions of spirit, spiritual and spirituality

Spirit	Spiritual	Spirituality
Life principle animating body. Breath life, life force, psyche, soul, liveliness, courage, frame of mind, essential character or meaning, emotional state, ghost, strong alcoholic drink, vital spark Collin Concise English dictionary (1991: 705).	Given to, interest in things of the spirit (Collins Concise English dictionary (1991: 705).	The body of a spiritual or ecclesiastical person; that which has a spiritual character; The quality or condition of being spiritual; an immaterial or incorporeal thing or substance; The fact or condition of being spirit or consisting of an incorporeal essence. Oxford English Dictionary (1989)

Burkhardt in 1989 published the first conceptual analysis of spirituality in nursing. She defined spirituality as a process involving the "unfolding of mystery through harmonious interconnectedness that spring forth from inner strength". Newlin et al. (2002: 65) define spirituality for African-Americans as the:

"Faith in an omnipotent transcendent force; experienced internally and or externally as caring interconnectedness with others, God of higher power: manifested as empowering transformation and liberating consolation for life's adversities and thereby inspiring fortified belief and reliance on the benevolent source of unlimited potential". The notion of 'God' having a central role in the individual's life is discussed and argued. According to Dyson et al. (1997) the concept of having some sort of relationship with God has always been understood from a religious framework and a more liberated and less restrictive view of 'God' is emerging within the literature. The centrality of 'God' is acknowledged as an individual's 'God' that provides the focus and purpose of time and life (Dyson, et al., 1997: 1185).

O'Connor (2001: 35) broadens the definition beyond the person as the sense of connection with life and other people. Narajanasamy (1993) in United Kingdom found that nurses understand that spirituality is about being 'religious' while Moberg in (Dyson et al., 1997: 1184) identified that most Americans, when asked to define spiritual well-being, had no automatic answer but the majority of responses were given in terms of religious faith. Dyson et al. (1997) put forward a view that seeing spirituality from religion alone portrays a very narrow conception of holism, as spirituality is not synonymous with religiosity. Religion is a social institution in which a group of people participate rather than an individual search for meaning. Walsh in (Tanyi, 2002:502) and O'Connor (2001) agree that a religion has definable boundaries and is more about systems of practice and beliefs within which a social group engage. Religion according to O'Connor (2001: 35) can be a rich resource expression of spirituality. Being a member of a religious group does not mean one will be spiritual according to Long in (Tanyi, 2002: 502). Many authors acknowledge that spirituality involves an individual's search for meaning in life, wholeness, peace, individuality and harmony (Tonuma & Winbolt, 2000; Tanyi, 2002; Elkin, 2004; Mahlungulu & Uys, 2004; Sawatzky & Pesut, 2005; Tanyi, 2006). Table 4.2 presents the different definitions of spirituality and related terms found in literature.

There is, however, a paucity of research on spirituality in South African nursing literature. Mahlungulu & Uys (2004) conducted a concept analysis of spirituality in nursing and found no studies done in South Africa. She conceptualised spirituality as a unique, dynamic quest for a transcendent relationship. This quest for a transcendent relationship was manifest in an individual's desire to establish and /or maintain a

dynamic relationship with God/supernatural power, self and significant others (Mahlungulu, & Uys, 2004: 22).

Spiritual needs according to O'Connor (2001: 36) are often felt more acutely during illness. To meet the holistic needs of the child, spiritual interventions are mentioned frequently in nursing literature in addition to the bio- psychosocial needs. In taking care of the family not only the whole-person of the child is considered but also each individual that make up the family unit. Spirituality is advocated frequently in literature with respect to care of children with terminal diseases and end of life care (Dyson et al., 1997; Smith & McSherry, 2004). This care includes the extended family, community and pastoral support for parents during an impending death and continues during period of mourning. Alternative therapies such as therapeutic touch, imagery, music and prayer are offered in providing for the psychological and emotional well-being of the patient as well as in pain management in terminal illnesses (Bodkin, 2003: 40). During these times families often resort to measures that would give them purpose and strength to continue with predetermined life goals. End of life period or death of a child imposes some functional constraints to some family goals and this brings some challenges that need redefining of those goals (Feudtner, 2005: 23; Heuy-Ming, 2006). Spirituality is described as the one aspect of the body-mind-spirit domain that enables the family to continue with their goals in the midst of tragedy (Touhy, 2001; MacLaren, 2004). If an individual is unable to find meaning all domains of life may be affected and spiritual distress will be experienced Kobasa in (Dyson et al., 1997: 1185).

Fehring, Miller and Shaw in (Touhy, 2001) investigated correlation of spirituality, well-being, religiosity, hope and depression in 100 adults living with cancer. The presence of spirituality was identified as a hope-fostering strategy giving pleasure and

hope. From the foregoing discussion we can infer that spirituality has two dimensions: the internal and the external. The internal dimension is the faith or belief in the God or supernatural Being or Life force experienced internally, it is personal while the external dimension refers to the interconnectedness with God, supernatural being or Life force that enables one to connect interpersonally with self and others. Attributes of holistic nursing care are discussed below.

Table 4.2 Different definitions of spirituality

Spirituality	Nursing reference
A quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose even in those who do not believe in any God. The spiritual dimension tries to be in harmony with the universe, and strives for answers about infinite and comes into focus when persons face emotional stress, physical illness or death.	Murray and Zentner in (Fawcett & Noble, 2004)
Unfolding of mystery through harmonious interconnectedness that spring from inner strength.	Burkhardt (1989)
The sense of connection with life and other people.	O'Connor (2001: 35)
"faith in an omnipotent transcendent force; experienced internally and or externally as caring interconnectedness with others, God of higher power: manifested as empowering transformation and liberating consolation for life's adversities and thereby inspiring fortified belief and reliance on the benevolent source of unlimited potential".	Newlin, Knafl & Melkus (2002: 65)
As an innate variable, that is a component of an individual's basic structure, facilitating optimal wellness, health and stability.	Neuman's in Tanyi (2002: 502)
A possession of human beings enabling self-awareness, heightened consciousness and providing the strength to transcend the usual self.	Watson in Tanyi (2002: 502)
As a unique, dynamic quest for a transcendent relationship	Mahlungulu (2004)
Has to do with the integration and coherence of ourselves as experiencing and interacting persons.	Kretzschmar in (Mahlungulu (2004)

Below consequences of holistic nursing care are described.

4.2.4.3 Consequences

According to Walker & Avant (1995: 45) consequences are useful in determining neglected ideas, variables, or relationships of the concept. Identification and analysis of the consequence descriptors of holistic nursing care yielded three categories which are important in the care of children and their families; person-centred care, cultural sensitive care and spiritual well-being. The following discussion of consequences will be discussed and related to the context of paediatric nursing practice where necessary. Person-centred care is very much linked to the whole-person and mind-body-spiritual attributes. It includes recognition of the patient as a whole-person emphasising the spiritual dimension while recognising that the family is an integrated whole (Sims, 1999; O'Connor, 2001; Burkhadt & Nagai-Jacobson, 2001; Narayanasamy et al., 2004; Sawatzsky & Pesut, 2005). The essence of a person is rooted in spiritual sphere (Burkhadt & Nagai-Jacobson, 2001). Spiritual care to the whole-person according to Sawatzsky and Pesut (2005) begins with a perspective of being with the person in love and dialogue that emerges in therapeutically oriented interventions that take direction and cues from the person's religious or spiritual orientation.

Cultural sensitive care includes understanding and appreciation of family traditions, values and beliefs and how these impact on the health of the child. Nursing authors emphasise the importance of dialogue in holistic nursing care as nurses encounter an array of cultural and religious practices on frequent basis. (Dossey, 2001; O'Connor, 2001; Burkhadt & Nagai-Jacobson, 2001; Smith & McSherry, 2004; Sawatzky &

Pesut, 2005). Engaging in interpersonal dialogue is facilitated by excellent verbal and non-verbal communication skills, an attitude of warmth, respect, openness and a non-judgemental attitude (Sawatzky & Pesut, 2005).

Cultural beliefs and practices can affect parental health seeking behaviours and consent to health care (Linnard-Palmer & Kools, 2005). The shift in paediatric care from a paternalistic and controlling approach to negotiation and greater involvement of families in decision-making and care delivery necessitates a more sensitive communication (Smith & McSherry, 2004). Understanding of cultural traditions and values of families is becoming a critical factor in holistic nursing care. Spirituality and or religion may overlap as some cultural practices have a spiritual implication and maybe better conceived as an integrated whole within the concept of culture (Smith & McSherry, 2004). Beliefs about health may also be formed by religion or spirituality and maybe inseparable as often observed in Jewish, Christian and non-Christian and Islamic practising families. Common practices of applying ointments to children, giving alternative medicinal remedies and wearing of jewellery may have a spiritual significance (McEvoy, 2003).

Spiritual well-being is described in relation to helping families cope with life-threatening illness, terminal illness, chronic illness, permanent disability and death and dying (DeTrill and Kovalcik in McEvoy, 2000). Many conceptualised models of nursing care from theorists like Neuman's systems model, Rogers' science of unitary beings, Roy's adaptation model and Watson's theory of human caring support and recognise the impact of individual's spirituality on health and well- being (Marriner-Tomey, 1994).

The goal in spiritual well-being has benefits for nurse-patient relationship. Spiritual expressions such as love, hope and compassion constitute basic spiritual care that can be integrated into all aspects of nursing care. Families who consider their religious faith-based traditions essential for spiritual well-being benefit from inclusion of spiritually-based activities to nursing interventions (Sawatzsky & Pesut, 2005). Antecedents of spirituality such as the ability to make meaning, loving and sensitive care, therapeutic use of self and caring presence have relevance to spiritual well-being of individuals (Sims, 1999; O'Connor, 2001; Burkhadt & Nagai-Jacobson, 2001; Narayanasamy et al., 2004; Sawatzsky & Pesut, 2005). The above antecedents of spirituality allow the nurse to extend beyond the mechanistic outcomes-oriented approaches to intuitive approaches based on the nurse's transcendent awareness (& Nagai-Jacobson, 2001; Narayanasamy et al., 2004). Nursing literature confirms that the inclusion of spirituality in nursing care brings a dimension where patients and family are encouraged to continue openly to question issues pertaining to their quest to find meaning in life with self, others and God with respect to issues pertaining to suffering and end of life. The reason and purpose of this quest includes a search for relationships and situations that give a sense of worth and a reason to live. Illness, suffering and death are perceived to challenge the personal meaning and if meaning can be found, an individual can find peace no matter how severe their illness can be (Tonuma & Winbolt, 2000; Tanyi, 2002; Elkin, 2004; Mahlungulu, 2004; Sawatzky & Pesut, 2005; Tanyi, 2006). Below surrogate and relevant terms are discussed.

4.2.4.4 Surrogate and relevant terms

According to Rodgers and Knafl (2000: 147), the aim of this stage is to investigate literature and analyse the presence and frequency of the concept holistic nursing care within the population selected for the empirical study. The term surrogate according to Collins Concise (1991) dictionary means to substitute. According to Rodgers (1989: 333) identification of surrogate terms is an important step in the analysis. In this step individual concepts are not necessarily employed in association with only one specific term rather they may be several terms that serve as manifestations of the concept and similar terms may be used to convey more than one concept. From all this reading, the frequency of the use of surrogate terms related to the concept holistic nursing care was being tallied across the disciplines. Table 4.3 presents the identified surrogate and relevant terms.

Complimentary alternative medicine (CAM) as a surrogate term requires a special discussion because of its relationship to holistic nursing care. Consumer driven public interest in CAM is increasing worldwide (Velden, 1998; Fernross, Hassed, 2004; Furhoff & Wandell, 2005: 521; Shutz, 2005). Dossey (2001: 5) defines CAM as those interventions that are not readily integrated into the dominant health care model. CAM is also called integrated medicine (Hassed, 2004: 405). CAM incorporates the concepts from Eastern philosophy and diverse cultural notions on healing including use of herb, acupuncture, massage and relaxation techniques (Boschma. 1994: 328; Bodkin, 2003; Hassed, 2004). CAM treatment strategies include mind-body medicine (MBM) techniques: meditation, relaxation, yoga, biofeedback, hypnosis and guided imagery. These strategies are being incorporated to nursing as part of holistic nursing care (Dossey, 2001). The connection between holistic care and CAM is the importance of body-mind and spirit domain with its emphasis on preventative health

rather than curing. Providers of CAM claim that their therapy techniques are holistic medicine caring for the whole person (Hassed, 2004; Fernros et al., 2005: 521). The philosophical foundations of CAM come from a multitude of different medical and human science traditions. The person is treated in wholeness; mind-body-spirit. The spirit being the foundational premise informed by holistic medicine, traditional Chinese, Ayurvedic medicine, homeopathy medicine and medicine of the ancient Greeks as well as and transpersonal psychology.

Table 4.3 Surrogate and relevant terms

Surrogate terms	**References**
Whole-being	Burkhardt & Nagai-Jacobson (2001), Dossey (2001)
Holism	Sarkis & Skoner (1987), Holden (1991), Boshma (1994), Kolcaba (1997), Wong & Pang (2000), Dossey (2001), Limacher (2001), Loscin (2001), Norris (2001), Thorne (2001), Ormsby & Harrington (2003), Hassed (2004)
Biological, -psychological, social and spiritual	Blattner (1981), Burkhardt & Nagai-Jacobson (2001), Loscin (2001), Goldberg (2002), Fawcett & Noble (2004), Hassed (2004)
Physical, mental, emotional and spiritual	Allen (1991), Tassanee (2000), Burkhardt & Nagai-Jacobson (2001),Dossey (2001), Touhy (2001), Narayanasmy (2002),) Ormsby & Harrington (2003), Narayanasmy et al. (2004 Zengerle – Levy (2004), Campbell & Campbell (2005), Tzeng & Yin (2006)
cultural competent care incorporating beliefs and values	Allen (1991)
Comprehensive care	Allen (1991), Burkhardt & Nagai-Jacobson (2001), Sawatzky & Pesut (2005)

Total care, Holistic view of person	Allen (1991), Boschma (1994), Blattner (1981), Campbell & Campbell (2005)
Whole person integrating self-responsibility and self-care, Self-healing	Blattner (1981), Burkhardt & Nagai-Jacobson (2001), Campbell & Campbell (2005)
Relevant terms	**References**
Complimentary alternative medicine(CAM)	Dossey (2001), Burke et al.(2004), Fernros et al. (2004) , Hassed (2004), DiJoseph & Cavendish(2005), Shutz, 2005
Integration of Eastern perspectives	Blattner (1981), Boschma, (1994)
Alternative therapies	Blattner (1981), Sourial (1997), Shutz, 2005 Loscin (2001), Fernros et al. (2004)
Complimentary therapies	Blattner (1981), Loscin (2001), Fernros et al. (2004)
Integrated medicine	DiJoseph & Cavendish(2005), Shutz, 2005 Hassed (2004)
Humanistic caring	Blattner (1981)
Holistic medicine	Sourial (1997), Shutz, 2005

The key factor in CAM is the preventative health with special emphasis to nutrition, stress management, physical fitness, and environmental health. The therapies used in CAM include therapeutic milieu, herbal remedies, meditation and visualization, supportive counselling, energetic healing, intuitive healing, colour therapy, psychotherapy, breathing exercise, spiritual activities, homeopathy and Chinese

medicine and psycho-neuro-immunology (Dossey, 2001: 7; Bodkin, 2003: 40; Hassed, 2004: 405). Therapies used in CAM are also advocated in managing pain, stress and emotional well-being of patients as part of holistic nursing care (Dossey, 2001; Bodkin, 2003; Delzer, 2006). In a systematic review over 13 countries on the estimated use of CAM by adult patients results revealed an average prevalence of 31% to 64% Ernst & Cassileth in (Chong, 2006) and similar studies conducted in United States document a usage ranging from 28% to 91% Henderson & Donatelle in (Chong, 2006). Even though the popularity of CAM interventions is well documented in literature across disciplines, the efficacy of CAM interventions has been a subject of controversy as the apparent effectiveness of these treatment modalities is yet to be empirically supported especially in younger populations. Tsao (2006) argues that CAM interventions which have been studied in children are limited and this is attributed to the low probability of solid effects and adverse events required before the clinical researchers would be willing to test a CAM intervention in paediatric samples. In places like Oxford University, there is openness towards development of CAM research capacity to better understand the popularity and apparent effectiveness of these therapies and support integration of safe and effective CAM in health care (ecam.oxfordjournals.org/cgi/content/abstract/3/1/143). Nursing literature is inundated with research studies where CAM interventions are being used and similar concerns are being raised about efficacy of CAM interventions and possible consequences of these interventions on conventional treatment. The need to include CAM in nursing curriculum is encouraged to increase knowledge capacity and improve preparedness at clinical level (Bodkin, 2003; Hassed, 2004; Chong, 2006; Eschiti, 2006). Other concepts that are linked to CAM include folk medicine, traditional medicine, holistic medicine, traditional Chinese, Ayurvedic medicine,

homeopathy medicine all of which are used by different practitioners in caring for diverse problems of people (O, Connor, 2001; Schutz, 2005).

Two model cases have been constructed and described below:

4.2.4.5 Model case one

Ten years old, Themba is admitted to an oncology ward. He was transferred from a rural hospital in Rustenberg suffering from Leukemia. He has one close relative working in Johannesburg, his uncle, who visits him weekends only. Themba is very quiet and Sister (professional nurse) Nomsa offers him age appropriate toys. Sr. Nomsa notices that Themba is clutching a small wooden cross and very reluctant to put it down unless he is sleeping. Themba is also not familiar with the language spoken by the other children in his cubicle. Nomsa goes home and discusses Themba with her 9-year-old son, John. The following day Sr. Nomsa finds a parcel wrapped and written Themba's name from John. Sr. Nomsa inquisitively hands the gift to Themba at work and waits for Themba to open it. John had wrapped a small CD/cassette player that he got last year as a Christmas gift, inside there was cd and a note written "I hope this will cheer you up." Sr. Nomsa smiles with tears in her eyes because she knew how John loves to listen to his music.

Themba asked Sr. Nomsa to help him plug in the CD player, connect earphones and insert the cd to play the music.

Four days later the night nurse hands a note to Sr. Nomsa written:

"Thank you so much for the gift. I was lonely missing my mother and my little sister Itumeleng. I missed being at home but Mom told me I will be better here because there are many doctors who understand my disease. I am not afraid to die because Mom told me about Jesus. Thank you for the worship tape you left on the tape deck, I played it the whole day."

Sr. Nomsa asks if Themba has been transferred back to his hospital, Sr. Agnes hands over the CD player with tape and cd to Sr. Nomsa and tells her Themba died last night very peacefully.

With tears in her eyes, she looked up and said softly "Thank you Jesus."

4.2.4.6 Model Case two

Fourteen months old baby Tama has been admitted in and out of the hospital. This is her third admission in the same ward. Tama's mother is Zandi. She is a single mother, 22 years old, living with her ailing grandparents. Before her pregnancy, she had a job and used her salary to help and support her grandparents. Both her parents recently died, one after the other, within a period of six months because of HIV related complications. Her boyfriend is unemployed and he lives with his parents.

On her first admission, Zandi disclosed her HIV status and voluntarily agreed for her and the baby to be tested. Sister (Professional Nurse) Tsotsi is an experienced nurse. She has been taking care of Zandi and her baby and she noticed that Zandi looks depressed.

Sr. Tsotsi asked Zandi why she is so depressed. Zandi tells her that, she had a fight with her boyfriend because the boyfriend's parents would like Tama to be treated by a

traditional healer. The last time they took Tama to their traditional healer, Tama came back with a black string around her waist and she had fresh skin cuts all over her body.

Sr. Tsotsi, delegates the care of the baby to a junior nurse and takes Zandi to the office. She quietly puts her hand over Zandi's and tells her it is ok; she does not need to be afraid. Zandi weeps uncontrollably for a while and finally she wipes off the tears from her face and gives Sr. Tsotsi a hug.

Zandi tells her she believes in the miraculous power of God's healing and finds it difficult to reconcile the differences in their belief systems.

Upon hearing this, Sr. Tsotsi holds Zandi's hand and asks her if she would like to pray. Both Sr. Tsotsi and Zandi pray and ask God to protect Tama. Once prayers were finished, Zandi smiles and returns to her daughter. Zandi's countenance was noticed and reported to have changed, she was seen reading her bible and singing over Tama.

Two days later, Tama's condition deteriorates. Zandi tells the nursing staff that Tama's father would like to bring their traditional healer to see Tama. The staff in the ward is divided because it is not in the hospital policy to allow traditional healers to perform their healing rituals in the ward. Sr. Faith calls a meeting to discuss how they should handle this request. They resolve to allow the father to come as long as the traditional healer is not going to give any oral medication to Tama. Upon arrival to hospital, Tama's father introduces the two men with him as the traditional healer and Tama's grandfather. Sr. Faith and Sr. Tsotsi request to have a short meeting with Tama's family. Sr. Faith explains the condition of Tama and confirms to the family that the permission was granted on condition that no oral or inhalation medication may be given to Tama. Sr. Faith requests the family to allow Sr. Tsotsi to stay with

Tama. Mr. Zowi, Tama's grandfather thanks the two professional nurses and requests privacy, allowing Sr. Tsotsi to continue monitoring Tama's condition.

Tama is moved to a side cubicle and Sr. Tsotsi plans her interventions to meet Tama's immediate physical and emotional needs. Mother is looking very depressed during the entire ritual. Sr. Tsotsi discerns that she is spiritually distressed as Tama's condition worsens. Once the traditional ritual was done, Tama's father thanks Sr. Tsotsi and remained with his family for most part of the day.

Later that day, Zandi confides in Sr. Tsotsi that she thinks God is punishing her and she is not ready to face another death in the family. Sr. Tsotsi asked Zandi if she would like to receive pastoral counsel. Pastor Sophie came and prayed with this family and brought communion for mother and baby.

In the early morning of the next day Tama died and Zandi was calm and peaceful and thanked the staff for allowing her to reconnect with God and for making it easy for her to practice her cultural and religious beliefs with dignity and displaying a non-judgemental attitude.

Two days later, Sr. Faith calls her staff to a meeting to discuss Tama condition and the events leading up to her death. Each staff member is allowed to share his or her views and comment on how the request was handled.

The concluding statements are drawn from the preceding discussion.

4.3 CONCLUSION STATEMENTS DRAWN FROM CONCEPT ANALYSIS

A **whole person** is a human being with **body-mind-spirit** dimension **embodied** in an **organic whole**. There is **integration** between the three dimensions.

Spirituality is a quest for a **transcendent relationship** with **God, supernatural being or Life force.** It involves an individual's **search for meaning in life, wholeness, peace, individuality and harmony.** The inclusion of **spirituality** in holistic care is identified as a **hope-fostering strategy** giving the child/family **pleasure and hope** and reinforcing **spiritual well being.**

The **person-centred care** is linked to the **whole-person** and **mind-body-spiritual** attributes. It includes recognition of the patient as a whole-person emphasising the **spiritual dimension** while recognising that the family is an integrated part of the **whole.**

Cultural sensitive care includes **understanding** and **appreciation** of **family traditions, values,** and **beliefs** and the impact these have on the child and family. Cultural sensitive care is facilitated by **good verbal** and **non-verbal communication skills**, **warmth, respect**, **openness and a non-judgmental attitude**

Spiritual well-being is linked to **spirituality** and **divine connectedness** that brings a sense of **peace, comfort, consoling** and **protection** in the midst of challenges related with **coping** with **life-threatening illness,** terminal illness, chronic illness, **permanent disability,** and **death and dying**.

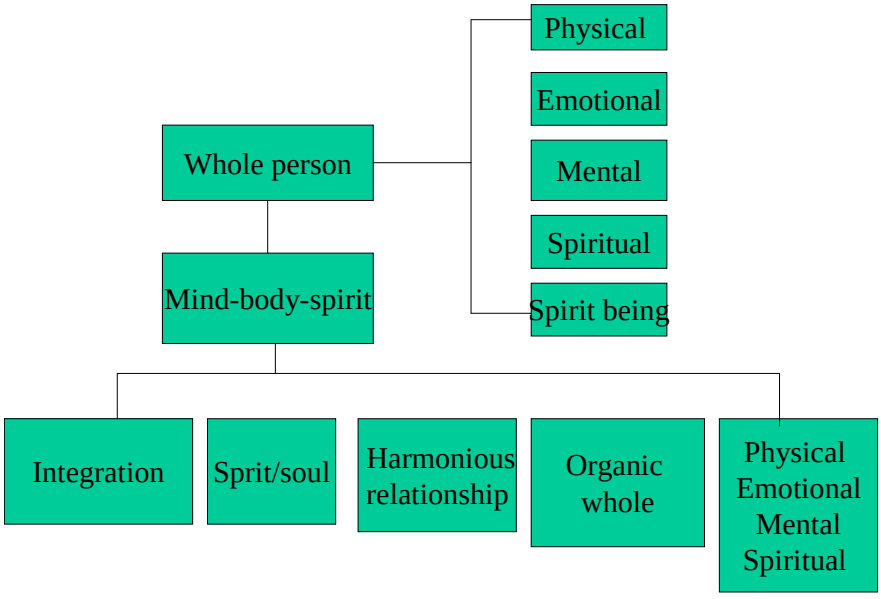


Figure 4.1 Attributes of holistic nursing

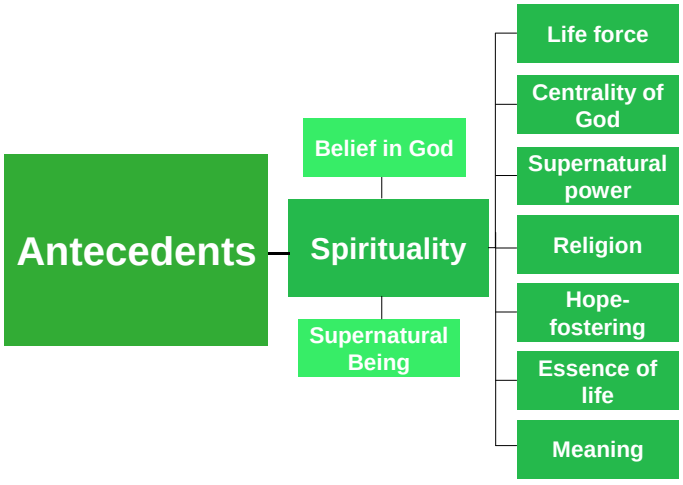


Figure 4.2 Antecedents of spirituality

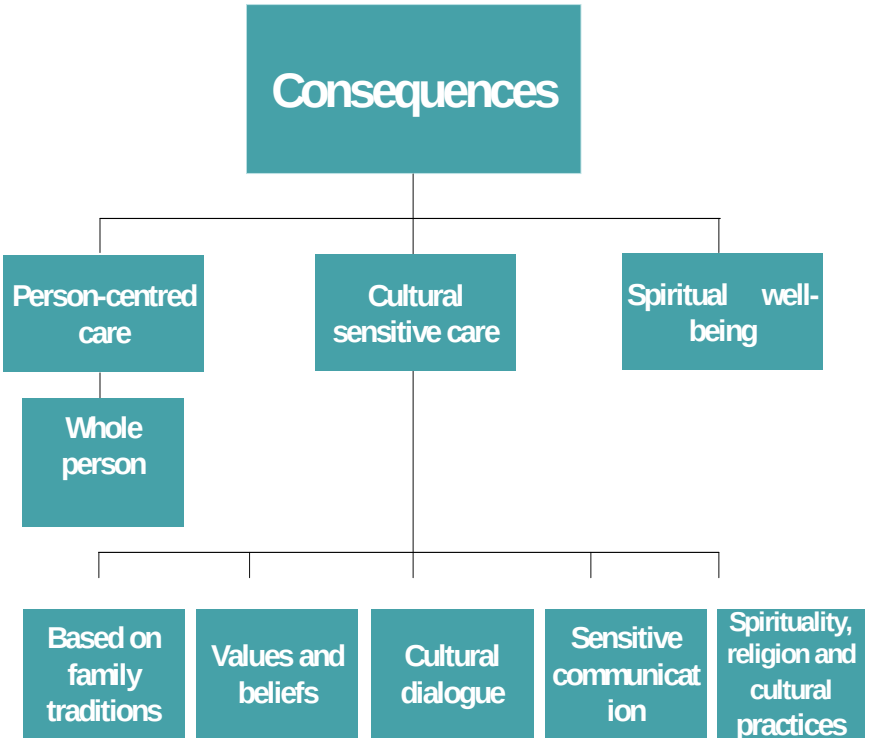


Figure 4.3 Consequences of holistic nursing care

Table: 4.4 Summary of Findings

Summary of Findings
Attributes and their corresponding descriptors of holistic nursing care
Whole-person – spirit being, whole being defined as physical, mental, emotional and spiritual
Body-mind-spirit dimension – physical, mental, emotional and spiritual dimension**,** embodied in an organic whole, spirit/soul, spiritual well-being, immaterial entity, integration and harmonious balance
Antecedents and their corresponding descriptors of holistic nursing care
Spirituality – Belief in God, Supernatural being, Life force, centrality of God, supernatural power, religion, religiosity, essence of life, hope-fostering, meaning,
Consequences and their corresponding descriptors of holistic nursing care
Person-centred care – whole-person rooted in spiritual being
Cultural sensitive care – based on family traditions, values and beliefs, cultural

dialogue, sensitive communication, overlap of spirituality and religion in cultural practices

Spiritual well-being – coping with life-threatening illness, terminal illness, chronic illness, permanent disability and death and dying.

4.5 CONCLUSION

It is evident from the literature across disciplines that holistic nursing care and holistic approach to care is becoming popular. In this chapter the concept analysis of holistic nursing care has been presented. The process of selecting the sample, data collection, and analysis has been explained. The attributes, antecedents and consequences have been discussed with corresponding descriptors from literature. Other concepts and related terms that define the concepts holistic nursing care were presented. Model cases have been given. Consumer demands on holistic approach and use of CAM interventions requires a collaborative approach to building research capacity in order to fully understand the efficacy and safety of CAM interventions in relation to conventional medicines and corresponding holistic nursing care. The focus of paediatric nurses on family-centred approach to care requires a cultural sensitive care that demands an understanding and appreciation of cultural practices. Developments in holistic nursing care in literature suggest changes within the different contexts of health care, with greater emphasis on wholeness and self-responsibility for health. It appears from literature the nursing profession through, holistic nursing care and the prevailing social changes, is beginning to conceptualise the art of nursing and

ultimately carving its professional identity separate from the dominance of the scientific biomedical approach.

In the following chapter data analysis from the focus groups is presented.

CHAPTER FIVE

EMIC PERSPECTIVES OF HOLISTIC NURSING CARE

5.1 INTRODUCTION

This chapter presents the analysis and discussion of emic perspectives of paediatric nurses derived from the phenomenological focus group interviews conducted in three academic hospitals in Johannesburg. A total of five interviews were conducted. The sample size was not predetermined and the focus groups continued to five until saturation of data were achieved. The setting of the five interviews is described. Central themes and sub-themes are presented, discussed and integrated with literature. The discussions of themes and sub-themes will be illuminated and substantiated by verbatim quotations from interview transcripts and field notes. Reference to existing literature will be made throughout the discussion in order to situate the research findings within the context of the general body of scientific knowledge. Giorgi's (1985) stages of data analysis were followed as described in chapter two in order to develop a sense of whole. The phenomenological approach was only applied with reference to the process of collecting emic views of paediatric nurses through focus

groups. Phenomenology is primarily oriented towards experience and its meaning for the participant. Emphasis is based on how the life-world is perceived and described by the participants (Javo, Alapack, Heyerdahl & Ronning, 2003: 151).

5.2 THE INTERVIEW SETTING

The five focus group interviews were conducted with participants in four venues in different settings. In each group (n=5) the interviews were conducted at the participant's workplace. Special care was taken to make sure that all venues were comfortable, safe and allow for freedom of expression (De Vos, et al., 2005: 309). The venues ranged from meeting rooms to private offices. Data were collected in three academic hospitals. The process of setting up the room, explaining the purpose of the moderator and stating the function of the recording data device and ethical considerations were reiterated at every interview.

The first interview was held in a meeting room, which is often used for departmental meetings at this academic hospital. Twelve nurses had originally agreed to be interviewed and only ten arrived. No reasons were given for their absence even though they had originally agreed to participate. This interview lasted for one hour thirty minutes.

The second and the fourth interviews were held in a small classroom within the same hospital. Each session had six participants who agreed to be interviewed and the second interview lasted for one hour, while the fourth, lasted one hour fifteen minutes to complete.

The fourth interview took place in an office with six participants. I had no prior meeting with the participants and fifteen minutes beforehand was taken to explain the purpose of the interview, the presence of the moderator and to address any questions and concerns that they might have. After explaining the purpose of the study and outlining the ethical considerations related to research process, all six participants agreed to be interviewed.

The fifth interview took place at a small seminar room in the paediatric section of this hospital. I had no direct contact with the prospective participants prior to the interview date. Six participants agreed once they understood the purpose of the study, and what their expectations were as participants. The interview lasted for one hour twenty minutes. Saturation in this study was achieved after the forth focus group. Saturation limit is a point where no new additional information emerges and only duplication of previously discussed data (Morse & Field, 2002). Once all the interviews were transcribed (Appendix M), the method of analysis followed was derived from Giorgi's method (1985).

5.3 APPLYING GIORGI'S METHOD TO DATA ANALYSIS

Giorgi's stages of analysis are described in chapter three (3.6.5). This method was chosen it advocates maintenance of a sense of whole and that the researcher should acknowledge the relationship of themes identified to the whole and to each other (Burns & Grove, 2001: 607). The different stages are described below.

5.3.1 Reaching a sense of whole

I approached this stage with some consternation because of the amount of data before me. This concern began when I finished the third interviews. A few days after transcribing the data it suddenly dawned on me how privileged I am to gaze into the hearts and souls of the participants. For that week, I spent time being weepy and journaling about my feelings. The thought of revisiting the data and interrogating each line and precept for meaning was quite daunting. With coaching and self-encouragement I began to recollect myself and approach the task with new zeal.

In order to present this data analysis and create a sense of whole, I would like to present this chapter in a narrative style using "I" instead of the commonly used "third person" scientific writing style. Fulbrook (2003: 229) justifies the use of narrative style as "a deconstructive-reconstructive process that enables knowledge to surface, which might otherwise be buried, … a valuable way of learning about nursing that enables understanding and meaning to be extracted from personal experience". Narrative style enables pragmatic insight to surface and mirrors processes that nurses engage daily in their practice (Fulbrook, 2003: 229; Wilcock, Brown, Bateson, Carver & Machin, 2003).

Firstly, the entire transcripts were read to develop a general idea of the sense of whole. Then I read the text freely to get a good grasp of the whole. At this stage, I was attempting to understand the data from the participant's experience at the same time trying to comprehend the meaning as intended by each participant in relation to the concept holistic nursing care. I wanted to understand the experience as a participant rather than a spectator in order to engage with the data.

5.3.2 Discrimination and clarification of meaning and identifying themes

Having grasped the essence of the whole meaning I started the process all over again with a view to identify specific meaning. As the meaning was becoming clearer, each transcript was re-organised into a more workable summary. This time I had specifically aimed at isolating the meaning units. This was done with each focus group. These were re-grouped and colour coded. Much concentration, comprehension and judging was used to find relevance of the meaning units. This resulted in a series of meanings or themes. Once the meaning units were identified, relationships were sought, ordering the meaning units into themes and sub-themes while at the same time being consciously aware of how the themes relate to another.

5.3.3 Reflection and systematic interrogation of themes

An imaginative process and reflection was used to transform the experience into understandable events while retaining the essence of the experience for each participant (Koivisto, Janhonen & Vaisanen, 2003). This stage was done to systematically interrogate each theme for what it reveals about the concept holistic nursing care. Once themes and sub-themes were identified and examined, investigator triangulation was used to remove the potential for bias (Burns & Grove, 2001: 240). An experienced researcher was consulted to engage with the themes and sub-themes in order to get a sense of whole. In keeping with the sense of whole and in line with the concept of holism in this study, the discussion of themes and sub-themes with reference to family and child will be kept as a unit. Where necessary, reference will be made to the individuals according to interview transcripts. Central themes and sub-themes are described.

5.4 DISCUSSION OF CENTRAL THEMES

Data from the focus group interviews generated five major themes and fourteen sub-themes.

The identified themes are presented in table 5.1.

Table 5.1 Themes and sub-themes from transcribed data

THEMES	**SUB-THEMES**
Wholeness	Wholeness of child Wholeness of family
Whole Care	Physical dimension Emotional and psychological dimension Spiritual dimension Cultural dimension Social dimension
Nurse as whole person	Nurse as person Nurse as professional
Nurse-family relationship	Purposeful communication Nurturing environment
HIV/AIDS impact	Emotional burnout Helplessness

	End of life

5.4.1 THEME ONE: WHOLENESS

Wholeness appeared as a consistent theme in all focus groups (n=5). All focus group participants' described the notion of wholeness in four different ways. Firstly, wholeness referred to the wholeness of the child, the family as a unit and the nurse as a person and a human being, all with body-mind-spirit-cultural and social dimension. This description of wholeness by the participants is consistent with Bukhardt & Nagai-Jacobson (2001: 23) idea of caring for the whole being defined as a physical, mental, emotional, and spiritual being. Secondly, the care rendered to the child and family members was also considered whole when the body-mind-spirit-cultural-social dimensions were all together integrated into the care. This is consistent with wholeness of the person described in nursing literature on holistic nursing care (Allen, 1991; Touhy, 2001; Bukhardt & Nagai-Jacobson, 2001; Thorne, 2001; Narayanasamy 2002; Ormsby & Harrington; 2003). Harmonious relationship between the four entities of the person is necessary for the well-being on individuals (Narayanasamy et al., 2004). Integration of the body-mind-spirit principles in designing daily patient care helps to remove the barriers to the healing process and help to enhance well being (Tassanee, 2000; Dossey, 2001: 3).

5.4.1.1 Sub-theme One: Wholeness of child

Wholeness of child referred to the child as person, described as body-mind-spirit with socio-cultural dimension. Wholeness is opposed to restrictiveness and narrowness (Lamb, 2002), it is the integration of the body, mind, spirit dimensions of personhood (McLaughlin, 1997; Lamb, 2002). Mind- body and spirit is embodied in an organic whole (O'Connor, 2001: 34). The child's well-being reflects the integration of body-mind-and spirit harmoniously integrating with socio-cultural dimensions (Narayanasamy et al., 2004). The notion of wholeness of the child is widely debated in different discipline. Educating the whole child is discussed in education and in psychology (McLaughlin, 1997; Lamb, 2002). Participants' working with neonates through to those working with adolescents all described and agreed that the child is whole.

"*We look at the child ... as a whole and look at the whole child"*.

The personhood of the child was embraced from birth to death, with participants agreeing that the patient is cared for as a whole as explained by one participant:

"*Nursing a patient as a whole…physical, emotional and nursing the condition of thebaby….that is in totality."*

A whole person includes the body, mind, emotions and spirit and manifests unique physical, mental, emotional, spiritual and social attributes relationally (Burkhardt & Nagai–Jacobson, 2001: 23; Narayanasamy et al., 2004). One participant working in the premature baby unit described holistic nursing care as:

"Managing the child as a whole, the needs and then … cultural, social, religious and the psychological."

Reference to the person in nursing literature relates to the integration of the mind-body and spirit dimension embodied in an organic whole (Burkhardt and Nagai–Jacobson, 2001: 23). Embracing the whole person enhances the healing of the whole person (Burkhardt and Nagai–Jacobson, 2001; Dossey, 2001: 1; O'Connor, 2001: 34; Narayanasamy et al., 2004).

In summary, the child is considered a whole person with body-mind-spirit dimension with socio-cultural dimensions possessing unique physical, mental, emotional, social, and cultural attributes. Wholeness of child refers to the inseparability of the child from family, inextricably joined and interwoven with family and finding identity contextually and culturally.

5.4.1.2 Sub-theme Two: Wholeness of Family

Wholeness of the family refers to the unity of oneness in the basic foundational composition of family unit made up of father, mother and child and considered as one. Family represents a set of individuals and sum of its individual members.

"Holistic nursing care is nursing the family as whole and in totality".

"I would think it is nursing a patient as a whole, physical, emotional, nursing family and nursing the condition of the baby…. that is in totality".

The family was considered whole and inclusive of the child and siblings. The basic family is referred to nuclear family, which includes the father, mother and siblings.

" … Involves a family- mom/dad/ siblings/baby and a child."

The extended family referred to the inclusion of the extended family to the nuclear family, for an example grandparents or aunts and uncles. The third category of family that emerged was a caregiver family. The caregiver family takes care of the child in the absence of parents. Reference to caregiver family was given in cases where children came from children's homes or children that are looked after by the grandparents and neighbours.

"We see families from lower socio-economic situation; it could be biological family, grand-parents, care-givers from the different children's homes. So the caregiver is classified as the parent when they bring the child in the hospital and most of the children suffer from different conditions, which I cannot disclose [confidentiality related to HIV and AIDS]. And most children are brought by their grand-parents which are also classified as care-givers".

The child as a person remained whole irrespective of changing family dynamics. The family unity and structure might be broken or dispersed but the child remained whole. Participants interpreted the biological family as a unit. When its foundational structure is broken, there is disruption in the unit's coherence affecting the internal dynamics. Despite the changing dynamics within the environment of the home the child who is affected in that family remains whole. The disruption of family structure was associated with death of parents due to HIV and AIDS. The family unity and structure might be broken or dispersed but the child, as a human being remained whole.

5.4.2 THEME TWO: WHOLE CARE

The participants described wholeness of care as inclusive of the five dimensions namely physical, psychological, emotional, social, cultural, and spiritual. All focus group participants described this care as holistic based on the totality of the human being.

> *"I would think it is nursing a patient as a whole." physical, emotional, nursing family and nursing the condition of the baby…. that is in totality".*

The subject of caring in nursing literature is consistently debated and nurse theories agree that caring is central to nursing and is based on a human science perspective (Leininger's (1984; Watson, 1985; Wilkin, & Slevin, 2004).

However, the current debate on holistic nursing care brings an emphasises on the wholeness of the human being, helping to shape the expressions of nursing care away from patient to a person. Caring for children physically and psychosocially without

the inclusion of the culture and spirituality was not enough for holistic care; all five dimensions had to be integrated.

> *" Holistic nursing of a child is nursing in totality looking at all aspects whereby we nurse emotionally, psychologically and also spiritually."*

Thurgate (2006: 43) concurs and proposes that mental and spiritual needs of children and those of their families must be addressed if children are to have any chance of reaching their full potential. The whole care dimensions are described in detail below.

5.4.2.1 Sub-theme One: Physical Dimension

Participants mentioned the physical dimension as part of holistic nursing care. It is the care that was designed to meet the body dimension of the whole child. The care is exclusively designed to meet the age-appropriate physical needs of the child with respect to the presenting health problem and prevention of potential complications.

> *"…It's nursing a child in totality, with regard to the diagnosis and progress and the problems that you have met so far."*

In the physical dimension care is inclusive of all the individualised nursing care plans designed to meet the physical needs of the patient. Included with the physical care was the multi-disciplinary team.

"Physically we look [assessing] at the condition of the patient and the type of care we have to give for that patient."

"… We bring other disciplines as well, nurse, OT [Occupational Therapist], social worker..."

The physical dimension of health care refers to the care activities designed to meet the diseased part of the body dimension of the whole child. The health and nursing care is exclusively designed to meet the age-appropriate physical needs of the child with respect to the identified health problem to prevent any potential complications that are likely to arise in response to the diseased part of the physical dimension. The care designed to meet the physical care may require a myriad of inputs from a variety of specialities depending on the actual presenting problems. Assessing the physical condition of the whole child involves the application of nursing knowledge and integration of the affective and the appropriate psychomotor skill based on the clinical judgement of the attending nurse (Potter & Perry, 2005).

5.4.2.2 Sub-theme Two: Emotional and psychological dimension

The terms emotional and psychological dimension of care was used interchangeable to mean care that was focused on the mind of the person. The focus of psychological dimension care is to address the symptoms of fear and anxiety associated with processing the effect of the presenting condition to the mind and resultant stress associated with hospitalisation

"I think the emotional is when we look at the mind".

Planning for the emotional and psychological dimension of care included the care of the family as a unit, the member of family present at the bedside of the child and the patient as reflected by the following statement:

"…. *The emotional part of it, I think we involve the parents both and the support people that are related to the patient…"*

For the family members psychological care included care that is planned to address their fears and concerns regarding the condition of the child as one surgical nurse explained:

" The parents maybe very concerned about different conditions, the operation and the different surgical condition and why we operate."

Fears of the family were attributed to their lack of understanding of what is happening with the child in relation to the condition and the care that is planned to meet the needs of the child.

"Maybe if the mother is fearful, the mother does not understand the diagnosis."

Fears of the children were addressed within the emotional and psychological dimension of care and planned according to the developmental stages.

> *"Some of the children do not understand what is happening … and they are afraid."*

> *"… Th**e** bigger children they need to feel that they are welcome and reassured."*

The need for emotional care is informed by fear. Concerns and fears of family were attributed to lack of understanding about the condition and care that is planned to meet the needs of the child. Parental anxiety in literature is established and is related to child fears (MeInyk, Feinstein & Fairbanks, 2006; Saricaoglu, Uzun, Dal, Celebi, 2006). Hospitalisation is also a stressful experience for both child and family. Evidence from multiple studies suggests adverse effects associated with hospitalisation from premature infants to older children. Negative mental and behavioural outcomes include anxiety, depressive disorders and post traumatic stress disorder (MeInyk, Feinstein & Fairbanks, 2006). Factors associated with fear in children include hospitalisation, surgery, procedures, routine nursing and medical care, strangers, unfamiliar hospital environment, body mutilation and pain (Justus, Wilson & Walther, 2006). The presence of parent during painful procedures seems to reduce the child level of anxiety by providing emotional and physical comfort and support through tone of voice, comforting stroking, and holding the child (Justus, Wilson & Walther, 2006). In this study interventions for parental fears and concerns were situated within the emotional and psychological and spiritually dimensions of care. The spiritual dimension is discussed below.

5.4.2.3 Sub-theme Three: Spiritual dimension

The participants used the spiritual/ religious or cultural dimension interchangeably. According to McEnvoy (2003) spirituality, culture and religion are not synonymous even though they appear to be used interchangeably. Spirituality in nursing literature refers to an individual's personal beliefs and transcended experiences. Religion is used to describe an organized system of beliefs while culture is described as a particular set of beliefs of a given group of people (McEnvoy, 2003; Elkin & Cavendish, 2004). Religion may serve as a channel for spirituality. A commitment to spirituality maybe found in expressions such as rituals and symbols connected either to religion and or culture (Elkin & Cavendish, 2004). McEnvoy (2003: 39) does not view spirituality and culture separately, they are seen as an integrated whole within a perceived concept of culture.

Participants in focus groups described spirituality in holistic nursing care as a set of beliefs. To incorporate spirituality in the nursing care plans one participant described as beginning by acknowledging the diversity of beliefs and letting the patient believes in a manner congruent with their family beliefs. McEvoy (2003) concurs in saying paediatric nurses must provide opportunities to acknowledge the cultural, spiritual and religious beliefs of family and draw upon the beliefs and values to reinforce coping strategies for the sick child and family.

"Let [the] patient believe as she believes and not [to] correct the patient."

In order to dig deeper in the richness of the information within the transcribed data and to paint a more holistic picture as intended by the participants, spirituality and religion will be used interchangeably in the ensuing discussion and culture will be described separately. I will attempt to describe the three aspects together to elucidate the meaning as intended by the participants in order to present the themes as truthfully as possible. Smith and Sherry (2004) acknowledges that children in hospital should be given an opportunity to maintain normal home routines to foster family beliefs which includes concepts of faith, sources of hope, coping and ideas about the relationship between beliefs and health (Anderson and Steen (1995).

Spiritual activities practised by the participants were similar whether they were in palliative care or in acute clinical settings. Descriptions of spiritual activities practised by families in the newborn units were similar to those practised in bigger babies and children in all the three hospitals. Spiritual activities commonly mentioned in all focus group sessions and regarded as important for spiritual well being of the child and family included prayer, pastoral care, communion, church attendance and connecting. Participants commonly mentioned connecting to a Higher being through praying. Older children were encouraged to pray alone, with the nurse or with family.

> *"Ok with family I think we usually pray with patient or pray on our own first thing in the morning."*

Parents were also encouraged to pray and seek pastoral care and counsel. Perhaps this was done to help them draw inner resources from their belief system as a form of support during uncertain times.

"Parents who, when realising that the patient is critically ill, they normally organise their priest to come and baptise that child."

Support from the religious community during a time of crisis creates a sense of being loved and serves as a coping mechanism. A prerequisite for meeting the spiritual needs of patient is awareness and intent. The nurse must feel extremely comfortable assessing spiritual needs and ask non-judgmental spiritual questions to assist the patient (Elkins & Cavendish, 2003).

"We also tell the other children that they can go to church as there are pastors to give them communion and pray."

Participants made provision to accommodate the families to perform spiritual rituals that are congruent with their beliefs.

"*Father [priest] will also come and baptise the baby and pray."*

The inclusion of the above activities enabled the family to draw upon their beliefs and values to cope with sickness related event, eliminate guilt-ridden feelings and help the family to find strength and solace from their spiritual beliefs (Tonuma & Winbolt, 2000; Tanyi, 2002; McEnvoy, 2003; Elkin, 2004; Mahlungulu, 2004; Sawatzky & Pesut, 2005; Tanyi, 2006).

Participants showed sensitivity and respect to diverse religious beliefs as explained by one participant working in a surgical ward.

> *"Those who do not believe in Jesus Christ you know, we do not force them."*

Two groups of participants (focus group session three and five) confirmed that Moslem families were allowed to practice their religious rituals that are consistent with family values as in following excerpt:

> " *They [*Moslem families] *normally come and pray in the left ear of the baby and the Imam's gives the baby the name and also if the baby dies, with Moslems, we do not lay the corpse, we just cover the baby with sheet and they come with their own sheet and will pray and wrap the baby and go to the mortuary."*

5.4.2.4 Sub-theme Four: Cultural dimension

The cultural dimension included the recognition of the nurse and family as individuals with beliefs and values that are based on their specific culture. Culture was described in relation to congruence to family values, cultural sensitive care, good and bad practices and cultural conflict arising from the interface of family values and Western values of health care at clinical level. To provide for culturally sensitive care participants' revealed that in dealing with culture, the nurses must first acknowledge their own culture.

"I think we should respect our own cultures first...."

Acknowledging self as a cultural being paves the way for nurses to show respect for other's cultural beliefs and practices as explained by one participant. Prior knowledge of cultural practices of families allowed participants to provide cultural sensitive family care.

> *"In our case we have staff members who belong to different cultures and they have to practice their beliefs as well and sometimes this involves the manner of dress and religious holiday's e.g. a Jewish members of staff."*

> *"…Looking at us Blacks, there are beliefs that we have and so if the parents believe that they think that there is something wrong with their child you can also allow them to practice their beliefs".*

Inclusion of culture in the care of families reinforced culturally sensitive family care in these research settings. Cultural practices were either termed bad or good. Bad cultural practices were those practices or rituals that do not add value to the care of the child or endanger the life of the child especially when cultural values conflict with current treatment of the child. When cultural beliefs leading to decision-making were not in conflict with biomedical treatment of the child, these were encouraged and termed good. All five focus group participants alluded to frequently having to deal with conflicting values between culture and biomedical treatment values exposing

attitudes of disrespect towards families and their cultural health seeking behaviours as described by one participant.

> ***"…*** *Normally when they [families] come from Sangomas [traditional healers] or whatever, our attitude also is quiet bad; we should respect their culture. Sometimes we disrespect them."*

Families' cultural beliefs and practices were conditionally accepted.

> *"As long as they (traditional medicines) are not going to be given orally, as it interferes with the treatment, we[nurses] allow them."*

Cultural symbols identified from transcribed interview data included.

> *"…. Beads around the neck and very common is that thick black strong string around the waist, we try if we can to live it on but sometimes we've had to cut it if the need arise and if there is no parent we keep and we do not discard and give it to parents when they come."*

Cultural sensitive family care reinforces cultural beliefs, values and practice. Culture is the totality of socially transmitted knowledge of values, beliefs, norms and lifeway guiding conduct in relation to health and illness. Certain artefacts often found around children's hospital bed and jewellery or symbols worn by children may have a cultural significance. To show respect to these demonstrated cultural sensitivity.

- **Conflict of interest**

Data analysis revealed a conflict of interest between the participants' and families' cultural practices in relation to delivery of nursing care to the patient. The conflict was based on co–existence of the two differing health care systems: traditional and biomedical health care system as well as how to discern what is potentially harmful for the child without necessarily offending the family who uses both health care systems. Lyon et al. (2001) in their research with parents on family-centred care confirmed that health professionals experience distress when cultural values conflicted with institutional values.

> *" It [cultural practices] can be either negative or positive because of cultural issues patients' ends up not taking the treatment or take them both (the physician's prescription and the traditional healer's medicines) and find out that they [the different medicines] antagonise each other and the prognosis becomes poor."*

Without exception every group of participants' were strongly opposed to any administration of traditional medicine when the child is in hospital under their care.

> *"As long as they are not going to give them orally, as it interferes with the treatment, we allow them."*

"I have heard that people come in with muti (traditional medicine) and they want to give the patient and now this is contra-indicated because now we nursing the patient medically not traditionally."

- **Good and bad practices**

Good and bad practices emerged from the data in relation to cultural rituals that some families practice while the child is in hospital. Such practices were screened and classified as either being good or bad. The following excerpts explain:

"Some cultural practices are good and others are bad…others [other parents] will bring a Sangoma muti (traditional healer's medicine) and will apply on the baby and other patients will inhale the traditional medicine and will start to blame the hospital for the effect of the traditional medicine on other children."

Two nurses working in medical wards of different hospitals narrate their experiences of what was perceived as harmful practice based on cultural beliefs.

"I find that there are some cultural practices that are very harmful to the patient. Like I remember in 2003, I was working in the ward and the traditional healer came to the ward to do the ritual and the patient was on oxygen and so he burned some stuff.... ha-ha-ha and I was not aware and he did not ask for permission and I only heard the mother screaming. "Sister [professional nurse] there is fire there".

So some cultural practices are good and others are bad and so you have to advise the parent and I had to write statement [reporting the incidence] for that."

Participants sometimes had to take drastic measures in order to protect children from parental decisions when perceived to be detrimental to the health of the child as explained by one participant working in a medical ward.

"Like two weeks ago I had a baby who was very, very sick and the parent insisted they want the baby home and so I called the mother and showed her that the baby was very, very sick and so I switched off the oxygen and the oxygen saturation was 80, yes 80 and I quickly switched off the oxygen and I showed her [the mother] that some of the cultural beliefs have a negative impact to the health of the baby."

Results revealed that some parental decisions regarding health-seeking behaviours were viewed with suspicion, as they were perceived as not always for the best interest of the child.

"I still think here now culture affects bad they [families] believe that they are just here [in hospital] temporarily and want to go back and because even in ward [ward number] the [nurses] normally see patients dead on arrival [to hospital] coming from the Sangoma's [traditional healers]."

When the impact of the decision regarding continuation of bio-medical care was perceived to be negative because of the condition of the child, the nurses would advocate for the child and negotiate with families to complete the treatment. Participants' also mentioned some dilemmas where they wanted to protect the child from the family decision while at the same time respecting the families' wishes, even though their decisions were clearly not for the child's best interest.

> *"We cannot dictate to any parents on what they can use but we try and concentrate on moving them from negative impact on their patient depending on their beliefs and sometimes they will insist as they see that the patient is dying, is oxygen depended and will take the child to go and do the rituals … because we are the patient's advocate."*

Once the child is released to the care of the family and the legal institutional procedure is followed, death in such situations was inevitable.

> *"… In one instance one child who was removed from oxygen as the parents signed an RHT form [Refusal of Hospital Treatment] and this child died before getting to casualty."*

> *". In ICU we did have a baby they [family] took him and the following day baby was dead."*

Ethical dilemmas have been reported in nursing literature when working with patients whose religious or spiritual idioms are incongruent with their own beliefs and

traditions (Lyon, Townsend-Akpan, Thompson, 2001). Culture, religion and spirituality influence parental decisions about medical care commonest being refusal of hospital treatment. Refusal of hospital treatment has been defined as "overt rejection by the patient, or his/her representative of medication, surgery, investigative procedures or other components of hospital care recommended by the patient's physician (Appelbaum & Roth, 1983: 1296). In America 170 children deaths were documented in the period 1975-1995 related to withholding of medical care on religious grounds. Treatment refusal presents an ethical dilemma for both the family wishing to adhere to their religious faith or cultural norms and for members of the health care team who must live with the ethical consequences of their actions (Linnard-Palmer & Kools, 2004).

Education of nurses reinforces the role of nurse as patient advocate, they are taught to be cultural sensitive and to participate in mandated treatment prescriptions, when treatment is refused particularly when the child is the patient, tension may result raising questions to issues such as autonomy, harm versus no harm and rights and duties to protection of children to potential abuse and neglect. Inability to decide what is morally and legally right for the child may result in a legal debate. Careful negotiations in such instances require a team effort in order to achieve the best possible result (Linnard-Palmer & Kools, 2004). For Catlin (1997: 289) the two competing harms of withholding critical treatment from a child and overruling parental decision-making create a "*classical ethical dilemma.*"

5.4.2.5 Sub-theme Five: Social dimension

The participants described caring for the social dimension as involving the family in the care of child. This allowed the child to have a member of the family at the bedside.

> *"A mother wants to be near a child when the child is sick, as she does not know whether we are going to help this child."*

> *"Mothers will come and touch, change and feed the baby".*

Studies (Endacot, 1998; Bennet, 2001; Baker, 2004) that examined parental involvement and presence report that children are less anxious and often demonstrate fewer negative effects post hospitalisation if their parents are allowed to stay with them. With the presence of a family member at the bedside of the child, participants recognised the need to identify both the parents and patient needs and respond to each of their needs with appropriate care. Participants adopted a personalised approach to care.

> *" If a child is very ill we ask the mother, if the mother has parents or relatives that live close to the hospital. We call them to come to hospital and relieve the mother. We also encourage the other relatives to come between 16h00 – 19h00, fathers can stay the whole day.*

The above statement resonates with the Ubuntu way of sharing and relational living. Mahlungu & Uys (2004) describe Ubuntu as being concerned with another person and their affairs.

Personal relationships and friendships were encouraged with bigger children by allowing them to meet with their friends during visiting times. School-going age children suffering from long-term conditions were also allowed to attend the government school within the hospital provided for children especially the children suffering from chronic non-communicable diseases. Attending school and meeting other children admitted in different wards increased their social cycle of friendships.

"Bringing friends that he could chat with, we do allow this."

" For the bigger school-going children we allow them to go to school."

Caring within the social dimension as interpreted by participants reverberates with the Ubuntu core values of communal living and sharing. Teffo (1998) describes Ubuntu as a social ethic and a unifying vision that is found and expressed in communal living. Ubuntu is the central premise of connecting and uniting people in the same community (in this case extended family structures) resulting in interdependence (Venter, 2004).

In summary, whole care is family centred, meeting the physical, emotional, and mental, spiritual, social, and cultural dimensions of care. Physical dimension of care is age-appropriate care exclusively designed to meet the individual's child needs based on the presenting health problem and prevention of potential complications and involves the inclusion of multi-disciplinary team. The emotional and psychological dimension of care is care that is focused on healing the mind of the person alleviating fears and addressing concerns. Spiritual dimension of care acknowledges the person in

need of care as a spiritual being and designing care that identify and meet those needs by connecting to a God or higher Being through prayer or other rituals to source out comfort, support and healing. The expression of spirituality included prayer, baptismal, communion, pastoral care, being there and caring presence. Cultural dimension of care includes the recognition of the individual nurse as a cultural being with beliefs and values based on specific culture. Holistic nursing care is culturally sensitive care that is congruent to the person's and or family beliefs and values. Social dimension of care is care that is congruent with Ubuntu ways of communal living. The child belongs to a family and has friends (depending on age). Social bonds are forged and encouraged as part of shared humanity in uBuntu.

5.4.3. THEME THREE: NURSE AS WHOLE PERSON

Participants primarily described nurse as whole person with body-mind-spirit dimension within socio-cultural context, nurse as person and a professional nurse. Nurse as a person was related to being more humane and sensitive to family needs embracing the patient, as a human being and acting as a surrogate mother. As a professional the nurse possesses knowledge and technical skills that enabled the paediatric nurse to make clinically sound judgement.

> *"This nurse is religious, physical, social and also emotional and psychologically made"…we feed our emotional beliefs, spiritual and our physical beings."*

5.4.3.1 Sub-theme One: Nurse as person

Descriptors of the nurse as a person related to being a surrogate parent, humane, empathetic and sensitive to the child and family members needs. Being humane allowed the nurse to act in a loving manner and become a surrogate mother. Acting humanely and embracing the patient, as a human being is consistent with the concept of Ubuntu principles, where the central tenets in personal relationships are respect and human relations. This is evident in the following excerpt:

> *"We try to put ourselves in that person's place if that was my child or daughter how would I feel"*

The majority of families nursed in these research hospitals and or work live and understand Ubuntu ways of living. The key factors symbolizing Ubuntu is the sharing and communal concept that characterizes the African indigenous living. The language used is reflective of these concepts (Mbigi, 1994; Dandala, 1996; Boon, 1996) and reminiscent of the African community spirit (Khoza, 1993). One participant working in a medical ward explains:

> "*They (children) stay in hospital for a long time and so we act as their parents, as their friends and so we need to give them all the love they need."*

A nurse as a person transcends the power relations associated with being a professional nurse with patient to seeing the other as a human being with feelings and as a person (Edvarddsson, Sandman and Ransmussen, 2003). The African idiom u*mntu ngumtu ngabantu* (literally, it means a person is a person through others), greetings in Zulu language – Sawubona means I see you, when greeting the patient in Zulu for the first time, the interpretation maybe taken to mean I see you as a human being just like me (Tjale, 1995). Participants' first described themselves in human terms and relating to other at a personal level. The researcher worked as a paediatric nurse for ten years in one of these research settings and all sick children admitted are encourage to address the female nurses as "mummy" when instead of the usual nurse or sister, which is usually the case in the other two settings, reinforcing the surrogacy role of the nurse. Culturally it is inappropriate to use the adult's first name. Ubuntu has social commitment to share with others and one is judged in terms of his relationship with others in acts of kindness, generosity, respect and living in harmony (Teffo, 1996: 103). Surrogacy perhaps may be interpreted as an extension of actions of empathy and sharing and a continuation of the motherhood responsibilities in hospital thereby personalising the care.

Relating as a person was immediate and reminiscent of Heidegger's (1962) existential work of Being and time. One participant described how the child on admission is immediately introduced to other children in the ward according to the developmental stages. The child is recognized as a human being rather than as an object of "patient". This immediate introduction perhaps is the common understanding of "Being in the world". Walsh (1999) refers to this as a shared humanity, which reminds us of our basic commonality in our everyday living as people. The nurse, child and family

members share what it is to be human when meeting as Beings–in the world. "Being with" allowed the nurses to connect and share more fully in the human experience of the family and child. Compassionate connecting with another person is consistent with the principles of Ubuntu African philosophy of humaneness, compassion, care, understanding and empathy (Boon, 1996).

> "*We try to put ourselves in that person's place if that was my child or daughter how would I feel."*

The above quote reflects the empathy and association that characterises the strong community values of Ubuntu (Dandala, 1996). The sensitivity described by the participants is also consistent with the view of caring described by Wilkin and Slevin (2004: 51) as a process of therapeutic interventions, which is helping and enabling, reflecting a dual component of attitudes/ values and activities consistent with professional role of the nurse.

5.4.3.1 Sub-theme two: Nurse as professional

The nurse as professional was a described as possessing knowledge and technical skills that enabled the paediatric nurse to make sound clinical judgment according to presenting situations during child-family interactions. Being the professional nurse was interpreted as using different kinds of knowing to accomplish holistic nursing care. The nurse possesses technical skills and knowledge that enables to recognise the patient as a person, share her knowledge with the family to enable them to make

informed choices. Participants described this nurse as an advocate able to exercise clinical judgment to the best of the patient's best interest.

> "*We become their (children) advocates, like we speak on their behalf when we feel certain decisions are not to their best interest, to doctors, colleagues or parents."*

Participants frequently interpreted their role as sharing knowledge with child and family. It appeared different types of knowledge were used at different times during nurse-patient/family caring encounters. The first knowing related to knowing the 'other' who is in need of care as a person. This knowing has a strong identification with culture and sharing. This shared humanity (*umntu ngumnutu ngabanye abantu)* prompted the participants to realize the other as a person and relate with other by forming relational bonds. Experiencing others enables the child to know others as people and bonds occur through association and recognition of other as in the following quote.

> "*The most important thing when we have a new child arriving, we introduce her to other children in that age group in the ward so that they can know each other so that they can bond."*

A sense of homeliness (Walter, 1995) is established when we allow ourselves to look at another person as a person because we immediately transcends relational encounters beyond object to subject evoking deep ties and bonds that are shared by persons at homes.

From the above quote, the participant demonstrates a knowing that comes about through interaction and by association. Knowing the other as a human is described in nursing literature as knowledge of the individual as a person (Walter, 1995) personal knowledge (Sweeney, 1994; Fullbrook, 2004).

Acquisition of personal knowledge according to Sweeney (1994: 919) is by recognition of new patterns form environmental and human interactions. The processing may consist of any combination of human and environmental interaction (experience, rational intuiting, appraisal, active comprehension, and personal judgement. This knowledge is accomplished through dialogue (Gitlin, 1990). It is difficult to articulate as it is gained experientially from series of interactions over time and resides within the domain of the individual nurse (Fullbrook (2003).

For the participants this personal knowing has a strong identification with culture and sharing. Knowing the cultural background of patient and understanding the context from which their clients come from enabled the participants to render culturally sensitive care.

> *"…. Like looking at us Blacks there are beliefs that we have and so if the parents believe that they think that there is something wrong with their child you can also allow them to practice their beliefs and not forgetting their cultural background."*

In this study knowing a person as a cultural being with certain values and beliefs allowed the participants to draw from their experiential knowledge and previous encounters with patients from similar backgrounds. Viewing the individual as a holistic being draws on various forms of knowledge. The idealisation of positivistic

ways of generating knowledge evidence within medicine and nursing as “hard science” robs the nursing profession the critical knowledge that can inform clinical nursing practice from a variety of sources (Walsh, 1999; Fullbrook, 2003).

Fullbrook (2003) argues that no single type of knowledge can be sufficient in designing unique care plans, as human beings are behaviourally different. He advocates that care plans must be constructed from an amalgamation of knowledge from different sources.

The second knowing referred to the knowledge of the disease and the acquired specialised skills necessary to meet the patients’ presenting health problem.

- **Knowledge of disease**

The professional nurse possessed knowledge of the disease which Benner, Tanner and Chesla (1996) refer to as ‘know what’ and ‘know how’. This description of the professional nurse coincided with inhumane studious professional attitude consistent with the critical analysis of nursing care plans, where the patient becomes the object of study as described by one participant.

> *“When the patient comes to hospital we observe the total patient appearance and you can tell if there are any abnormalities and we observe the colour of the skin and we plan our nursing care during the time in hospital to prevent complications.”*

From the above quote, it can be inferred that the experience of being a professional nurse in holistic nursing care meant that participants should possess a measure of knowledge in order to make clinically informed decision-making regarding the condition of the patient. The language used by the participant above reflect what Benner et al., (1996: 2) describe as clinical judgment focusing on conscious deliberate analytical process directed toward resolution of problems and clearly defined outcomes. This view, however, the authors refer to it as a clinical judgment based on technical rationality model of practice rather clinical judgment based on a more holistic discriminative and intuitive response typical of a proficient nurse. In the technical rationality model of practice the knowledge that counts is the theoretical knowledge (Benner et al., (1996). Providing knowledge to the family and child was necessary for participants in order to meet the family needs with regard to presenting health problems.

"And the education of both parents especially with regard to the diagnosis."

Fullbrook (2003) described this kind of knowledge in critical nursing care as case knowledge. It is the general knowledge about the diseases process, therapeutic protocols, and pharmacology.

For the participants in this study understanding the scientific medical language was crucial and critical for informed consent and decision-making as described by one surgical nurse.

"We explain the procedure in simple English that the parents can understand."

The three types of knowledge described by participants and associated with holistic nursing can be compared to Paterson and Zderad's (1988) theory of humanistic nursing which holds on the view that nursing is subjective, objective and inter-subjective all at the same time. The objective reality can be observed from a distance, while the subjective can be seen as an awareness of one's experience. The inter-subjective reality is recognisable in the subject-subject relating (Hanson, 2001: 417).

The third type of knowledge was the inner knowing that facilitates the nurse to connect with the family by transcending beyond the physical realm. The three types of knowledge are discussed below.

- **Inner knowledge**

Inner knowledge is personal and was discussed by participants in relation to spirituality. The inner knowing allowed the nurse to connect with the other person as a person. For the participants inner knowing evoked the emotions of being a mother

" *Just the environment that they are nursed in is awkward. Just make them feel there are being cared for, we cuddle them and just being there."*

Spirituality is elusive and the concept spirit is not open to definitive expression in words. The following quotes support what Heelas (1996: 6) noted in that the "spiritual

realm lies beyond the compass of intellectual enquiry" and therefore difficult to express in quantifiable terms and this is evident from the following quote:

"Prayer does something and something from above does happen."

"Prayer really heals you, if you pray something does happen and in that prayer you also assess that they (family) can accept the condition".

Participants' own experiences and testimonies of spiritual encounters were used as evidence to bring hope to family members.

" I also share with them (mothers) my experience sharing, I think that when we talk from experience they (mothers) understand better and they also relate better because they feel that you have been in their shoes."

The three different kinds of knowledge observable from the interview transcripts are consistent with knowledge discourse in nursing literature; personal knowledge (Rogers, 1969; Carper, 1978; Moch, 1990; Chinn & Wheeler, 1985; Bevis & Watson, 1989; Sweeney, 1994; Fullbrook, 2003) knowing how and knowing what (Benner, 1984; 1996), knowledge that transcends the natural realm (Heelas, 1996).

In summary, the nurse as person is an embodiment of personal and professional knowledge with mind-body-spirit-social-cultural dimension. As a person the nurse possesses humanity traits of sensitivity and love and as a professional the nurse has knowledge.

5.4.4 THEME FOUR: NURSE-FAMILY RELATIONSHIP

Nurse-family relationship emerged as one of the main themes. Participants described an enabling nurse-family relationship in terms of sharing information purposefully and nurturing environment. This information was aimed at addressing, concerns, fears and facilitating nurse-family relationships.

5.4.4.1 Sub-theme One: Purposeful communication

The meaning attributed by participants to purposeful communication was goal directed aimed at keeping the family informed and is preceded by respect. This communication was described as goal directed at keeping the family informed and is preceded by respect. One participant explained.

"It usually starts with respecting the patient and not undermining at all."

Information sharing between the nurse and family establishes the foundation for the nurse-family relationship. The way the information is exchanged it helps to shape the basis and tone of the relationship as described by one participant.

"A positive approach also speaks a lot..."

The interactive relationship is crucial for allaying fears and anxieties of the family. Different sources of fear were mentioned during focus group sessions. Fear for the

parents was associated with the actual diagnosis and its related potential complications. For the child fear was attributed to separation from family, loneliness as in isolation because of an infectious disease and unfamiliar hospital environment. Purposeful communication was aimed at addressing concerned and described as helping to eliminate these fears.

> *"When we communicate the prognosis of the child to the family we eliminate the fear for the child and family."*

Fears were attributed to lack of understanding.

> *"Maybe if the mother is fearful, the mother does not understand the diagnosis."*

Consistent conveyance of essential information enhances participation and facilitates dialogue between participants and families (Lyon, Townsend-Akpan, Thompson, 2001; Freyer, 2004).

Ahmann (2004: 418) refers to nurse-family relationship as an active therapeutic relationship, defined as an " an interactive relationship with a patient and family in a caring, clear, positive and professional manner".

For Espezel and Canam (2003: 35) this kind of interaction is thought to be most effective when it is based on reciprocal interchange. Language barriers were mentioned as a challenge to effective family-nurse relationship.

5.4.4.2 Sub-theme Two: Nurturing environment

Participants' described nurturing environment as being loving and homely. Their role in this environment transcends the professional role to a nurturing motherly role.

> *"The children are in our home and we are their mothers."*

From the quote above, the role of being a 'mother-figure' is similar to the intuitive role played by the biological mothers. The 'mother-figure' is founded on the bonds we have and share with own families.

> *"On admission you can see that the child is not happy and you can try to be the mother."*

In assuming the 'mother-figure' role, the ward environment must resemble the familiar home environment.

> *"They (children) must feel they are home from home, we give hugs, give toys, and they should not be made to feel that they are in hospital."*

When the cold, hostile, impersonal environment of the hospital is turned into a home, participants described the environment as creating a place that is familiar. This a place where others can be preserved and nurtured as human beings as demonstrated in the following quote:

"You substitute the environment for the home ….they (children) feel so comforted that you are there and you just go to them rather than just doing routine".

The love relationship is fundamental in the nurturing environment. Interactions with family members were described in relational terms.

"The children are in our home. Basically we care for the children when they are in our homes."

"The attitude that you display shows whether you love the children."

This sense of homeliness is reminiscence of home as a place of love and nurturing.

"Make them (family) feel that they are at home and not feel that they are.… in hospital and … not feel they are in a different environment from home."

Participants mentioned that children are perceptive of a non-loving relationship, which has a potential to ruin the fundamental blocks of the nurturing relationship.

"When you are doing [performing] procedures we swap around because sometimes if you hate the child, the child will not want to come near to you."

Interacting with family enhances working together towards a common goal and it profits the family (Eilertsen, Reinfjell & Vik, 2004). Sensitive approach to communication evokes intense feelings from deep within (Walters, 1995). Sensitive helping attempts to reduce anxiety and restore a sense of well-being allowing both the paediatric nurse and the family member to experience being- in- the-world together through sharing and mutual empathizing (Walters, 1995; Lyon, et al, 2001, Espezel & Canam, 2003; Freyer, 2004).

Participants' in Mackean, Thurston and Scott (2005) in family-centred care described good communication skills to include open discussion and negotiation; communicating in an honest and direct manner; listened; sought; and valuing parental input and just being informative. According to Millard, Hallett and Luker (2006) nurse-patient relationship is fundamental in promoting patient participation in nursing care. The relationship is the vehicle for exchange of information and concomitant transfer of power from nurse to patient and vice versa. Creating a facilitative environment produces a nurturing place where it becomes easier to make care decisions. Sharing of knowledge, skills and communicating with the family was an essential component of the family-nurse relationship.

"We involve the family in the care of the child, what the child are getting and the treatment and what the use of that treatment."

Parent involvement facilitates nursing care as one participant explained.

"… Alleviating anxiety … you get more participation with the patient and it makes nursing easier, you involve the patient and parents."

Parent involvement in the paediatric nursing literature is widely discussed as an essential component of quality of care for children in hospital. Different terms denoting parental involvement are used in literature parents partnership, family centred care (Irlam & Bruce, 2000), parental participation (Coyne, 1995). Parental involvement demands competence, confidence and interpersonal skills (Ygge, Lindholm & Arnetz, 2006). Discussion in child nursing on family-centred care has been widely accepted as a theory in many countries such as United Kingdom, Sweden (Ygge, et al., 2006), Australia (Johnson & Lindschau, 1996) and United States of America (Daneman, Macaluso & Guzzetta, 2003).

The HIV and AIDS impacted the nurse-family relationships in this research negatively increasing acuity levels and changing the landscapes. Emotional burnout, feelings of helplessness and powerlessness addressed below were discussed by participants as being able to draw inner feelings that change the dynamics between nurse, child and family. The impact of HIV and AIDS is conceptualised as a major theme, its summary is placed under the nurse-family relationships because of the impact it has on relationships with subsequent effect on quality of health care.

5.4.5 THEME FIVE: HIV AND AIDS IMPACT

An estimated three to four patients in public hospitals in South Africa are HIV positive and nurses working in public hospitals in South Africa are daily in contact with these patients (Smit, 2005). HIV and AIDS is the fastest growing epidemic in

South Africa. Over 2 million children worldwide are estimated to be living with HIV and AIDS, most of whom, are in the sub-Saharan Africa (Gretchen, 2006). Participants' in this study discussed HIV and AIDS as the single most disease that is changing the caring landscapes of paediatric nursing. Firstly the disease profile is changing because of the higher percentage of patients admitted in the paediatric wards suffering from HIV and AIDS related disease.

> **"***The percentage of patients and big percentage of patients we are nursing with HIV and AIDS."*

Participants interpreted the impact of HIV and AIDS with emotional burnout, feelings of helplessness and powerlessness and end of life issues.

5.4.5.1 Sub-theme one: Emotional burnout

Prolonged engagement with patients living with HIV and AIDS and providing extensive physical care and emotional support left the participants with emotional burnout. Dealing with these children from various age groups was described as taxing emotionally.

"It is draining emotionally."

Descriptors of emotional burnout were described as emotional draining feelings`, weariness and de-motivating feelings. Burnout in nursing literature is associated with feelings of emotional exhaustion, depersonalisation, and reduced accomplishment

(Maslach & Jackson, & Leiter, 1996), accompanied by feelings of insufficiency (Maslach & Jackson, 1996) and disengagement (Demerouti, Bakker, Nachreiner & Schafeli, 2000). The findings of this study are consistent with Smit's (2005) research findings on a study conducted in one of the public hospitals in South Africa. In Smit's (2005) study nurses caring for people living with HIV and AIDS were found to experience physical weariness, emotional exhaustion and stress and all related to the descriptors of occupational burnout (Demerouti, et al., 2000; Smit, 2005).

In this study participants referred to caring for the children living with HIV and AIDS as demanding for the nurse and parents especially for the mothers because they are the ones with children most of the time.

Various sources of emotional stress were mentioned by participants such as increasing workload associated with high percentage of HIV and AIDS related admissions. Additionally, emotional strain was confounded by the inability of the professional nurses to influence the care decisions when it comes to patients living with HIV and AIDS. The current institutional policies and criteria that are used for resource allocation to the exclusion of patients suffering from HIV and AIDS were identified as one of the stressors for the participants. The inability to successfully advocate for the upholding of the rights of these patients in the face of inadequate resources was one of the reasons mentioned as causing the mental and physical exhaustion. One participant working in a renal ward described the burden they face in caring for HIV positive children.

> *" It's very difficult because if a child is HIV positive in our case, it's difficult for them to receive the kidney."*

One other participant working with newborn babies in the premature unit also confirmed this difficulty.

> *"It's difficult especially when some critical children can't go to ICU." …. We do not know what to say."*

This mental fatigue was also aggravated by the fact that participants were not only dealing with children that are positive but they had to deal with the emotional feelings of the parents/mothers who are also positive and have to face up to the realities of inadequate distribution of resources and unfair distribution of health care. Participants acknowledge the difficulty that the mothers have to endure.

> *"It is very difficult for the mothers of HIV positive babies."*

For the emotional well being of the mothers, participants would refer them to other members of the multi-disciplinary team.

> *" And we involve a psychologist and the social worker."*

It was much easier for the participants to share with mothers as much information as possible. Perhaps the sharing of information was a way of taking out the guilt of not being able to help the mothers and their children. This could also be a way of dealing with inner feelings of guilt and inadequacy.

> *"We focus on the mother letting them know what is happening about their HIV/ AIDS status."*

Being able to share what they knew about the diseases was perhaps their way of confirming their position of power in the midst of what appears hopeless. Refer to discussion on knowledge (5. 4.3.1).

One participant explained the reason for teaching the mothers about their HIV status and implications to their unborn children because if they do not empower the mothers with information, some women come back to the ward pregnant again. In trying to break the cycle of admissions and seeing the same family once more and going through the same emotional pain, teaching was one of the ways they could help to empower the families against the surge of this diseases within families.

> *"Because if we don't, (teach) we still see them coming back again into the ward pregnant".*

One nurse from a medical ward described the difficulty she had in caring for mothers of children who are HIV positive especially that in her case she had (*at the time of interview*) a family member going through the same pain and suffering. This nurse found herself in a situation where she could understand the pain the mothers were going through.

> *"Because to see a weeping mother and you know that you have a family too who is also affected by the problem of the "condition."*

The tendency of professional nurses to identify with their patients for whom they feel compassion and empathy have been reported in nursing literature as contributing to emotional stress (Gueritault-Chalvin,

Kalichiman, Demi and Petersen (2000). Her emotional state affected her physical ability to provide quality of nursing care and had a reciprocal effect on the nursing environment.

It really affects us and the conditions at work."

Occupational burnout has been shown to be a serious problem in AIDS care (Gueritault-Chalvin et al., 2000; Smit, 2005). Quantitative studies that have been conducted to investigate stress-producing activities among cancer care and HIV and AIDS care have found that nurses working with people living with HIV and AIDS have greater intensity of occupational burnout symptoms (Gueritault-Chalvin et al., 2000). The emotional state of nurses was reported to affect ward environment and the child could perceive this atmosphere.

"Sometimes the emotional spirit of the nurse can affect the atmosphere e.g. in HIV and AIDS child because if you are affected the child can tell and if you are ok the child can still find out."

Two of the participants working in the oncology wards from two different hospitals confirmed the emotional trauma that is consistently experienced by the nurses working with dying children.

"And most of our patients in the oncology because they are bigger, they start to realise that one of the children is very sick they start to

become emotionally affected and …for the nurses … the environment can be very traumatic."

Participants working in the oncology wards from two different hospitals described a programme of care that has been established to meet the needs of children.

"We began to use the services of the psychologist and on daily basis when they have problems. Children are able to go down to her (psychologist) and for those who are unable to go to her (psychologist) she comes to the ward every Thursday in the afternoon. She does not only treat the child she treats the parent of the child. And then for the nurses because the environment can be very traumatic sometimes, we have a weekly session with the psychologist who comes for an hour or two every Wednesday afternoon."

The burnout syndrome has been associated with psychological effects such as depression and irritability, which indirectly can affect the climate of nursing (Quattrin, Zanini, Nascig, Annuzita, Calligaris & Brusaferro, 2006). Constant confrontation with people's needs, problems and suffering when they overwhelm nurses' personal limits and abilities create stress (Demerouti et al., 2000).

One nurse working in a medical ward was so affected by the conditions of the children and their parents in her ward that she began to question management for not instituting similar palliative programmes provided to families and staff in the oncology unit within the same hospital.

"I wish also we could be given this opportunity of having this psychologist that the oncology department has."

To help this nurse I probed her emotions further with a view to refer her for counselling and she confirmed that she had come to terms with her situation even though it was difficult and it turned out she was seeing someone for help.

" It's adjustment, and… actually. I try counselling, it's the acceptance of the situation, that's the only way that helps you to cope with the situation."

Individuals' coping strategies have been found in nursing literature to be a buffer of perceived occupational burnout. Bennet, Ross and Sunderland (1996) conducted a longitudinal study in Australia with nurse, doctors and social workers in three Australian states on burnout in Aids care. Coping styles were found to be a major determinant of burnout. External coping strategies such as fatalistic attitudes, negative expectations and religiosity were all predictors of burnout as opposed to internal copies strategies such as the expression of feelings and emotions, patience and time out (Bennet et al., 1996).

At the time of the interview in this study hospital management had just introduced a programme in all three hospitals to assist the staff to receive free counselling should they with to see some one. The services were free of charge and the nurse mentioned above was seeing someone and found the services very helpful.

"I had a problem and I heard from the people who had used the service and it really works and it helped me. I have used the service."

This staff programme could be sought for any member of the family.

"The Employee Assisted Programme … accommodates your child and your family and when you want to see a psychologist you are allowed too and it's free of charge."

5.4.5.2 Sub-theme Two: Helplessness

Participants' described the feeling of helplessness as emanating from the inability to cure HIV and AIDS and the non-compliance of some mothers diagnosed with HIV and AIDS. The participants reported distressing emotional feelings of helplessness and frustrations in caring for the patients suffering from HIV and AIDS because there is no known "cure" for their condition.

"*I think it is draining because before [HIV /AIDS] we were aiming at cure but most of the time we are fighting a loosing battle."*

"No Cure"

The feelings of helplessness related to "no cure" for HIV and AIDS positive patients were linked to the sense of futility in knowing that the patient will ultimately die from this disease. One participant in the following quotation described how disheartening

and de-motivating it was to care for these babies when you know that they are going to die.

> *"It is de-motivating, you don't know whether at the end of the day you have reached your goal that you are used to. It is de-motivating."*

Feelings of helplessness in relation to no "cure" have been reported in earlier studies conducted in this country with nurses working in public hospitals (Smit, 2005).

Non-compliance

Non-compliance by the clients to educational programmes from the media and the HIV education provided to parents diagnosed with HIV on admission left the participants hopeless. One participant from a medical ward, in a different hospital from the one above explained her frustrations, as she perceived that some clients do not comply and fully comprehend the extent of the fatality associated with HIV and AIDS. The information given to the general public through community awareness programmes and across the media according to one participant was not followed.

> *"…The disease [HIV/ AIDS] is there, that its killing our people and the programmes are there [HIV/ AIDS programmes available to communities] and you find that they (programmes) are not being followed and some people still do not believe that AIDS is there and is killing our people."*

Feelings of hopelessness and frustrations related to non-compliance with treatment recommendations were reported in a qualitative study conducted with among 16 nurses in Connecticut, United States of America.

In probing these feelings of hopelessness, participants were asked to explain what they use to cope. Prayer was the single most popular strategy used by the nurses to cope as explained in the next quote.

> *"And whatever problem that I am having at work prayer helps me and give me strength to cope in this situation. And that's how I think most of time I cope with things."*

A Moslem nurse working concurs.

> *"I just say prayer inside of me."*

Families were also encouraged to focus in God for their strength.

> *"You speak to them (families) about praying about God having faith and not giving up and things like that."*

> *"If it's a Moslem child I will say the Moslem prayer in Arabic and I will also speak to the mother to pray, there are specific Moslem prayers that we say. If that child has HIV we also pray."*

Prayer is based on person's faith and a belief in a super being, God or life force. Prayer maybe ritualised, as was the case with most participants in this study, praying as a group before commencing work. Acts of prayer may be spontaneous and informal. Prayer maybe linked with mediation and both are used as coping strategies associated with relaxation (Potter &Perry, 2005:62). Spiritual rituals such as prayer, meditation and connecting with Higher power is reported in literature as providing unity, peace, meaning, hope, peace and spiritual well-being (Smith & McSherry, 2004; Potter & Perry, 2005; Tanyi, 2006)

5.4.5.3 Sub-theme three: End of life care

The focus group participants' discussed end of life care in relation to diseases such as HIV and AIDS, chronic diseases and cancer. All participants frequently discussed end of life care in holistic nursing care in relation to spirituality and culture. Discussion around end of life care revolved around caring for the family based on their belief. In end of life care the nurse transcend the physical realm to draw help for the patient, herself, and family. The family was permitted to perform the death rituals to promote well being. Spirituality/religion and or culture were discussed as one of the aspects used to manage family emotions when faced with decision-making based on uncertainty and or being confronted with the inevitability of end of life. Family decisions regarding life and death have been reported in nursing literature as based on family value systems or religious beliefs (Mckinley & Blackford, 2001; Lyon, Townsend-Akapan & Thompson2001).

The increasing death rates in the acute care setting in these hospitals were attributed with HIV and AIDS.

"And the only thing that has increased the death rate in South Africa today is HIV/AIDS."

To care for the emotional feelings of the families with impending death both the nurses working in the oncology units and in the acute care wards used prayer as means to help families to connect with God.

"We talk to the parents and give them time to talk and we take that moment to be spiritual just talk to God."

To enable the families to connect, the ward environment should foster wholeness because psychological wholeness can be hindered by the state of the environment as explained below.

" The environment can be whole and the environment can hinder the psychological whole."

End of life care in the oncology ward was different from that provided for patients facing death in the acute care settings in these hospitals. In the palliative care units the care is designed to meet the needs of the mother and the dying patient. Parents were given an option to allow the child to die in hospital or at home as explained in the following quote:

"For the children in hospital, we allow the children to go home as most of the parents when the child is dying, they (parents) actually prefer the child to die at home and spend quality time at home."

When the child dies at home the parents notify the hospital.

> "*Once the child dies they will phone the hospital to let us know that the child has died this morning at home."*

The parents who choose to take their children to die at home continue to receive emotional support from the ward. A sense of oneness is created in the ward respecting the dead.

> "*… When a child dies at home we light candles even if a child is not in hospital but at home. We light candles as the sign of respect and the condition of the ward changes in respect of the one who died."*

The participants working in the oncology wards found it easy to take care of the spiritual needs of families and this was attributed to inevitability of death.

> *"We usually pray with patient or pray on our own first thing in the morning but we encourage patient to even pray on their own I don't know whether its because we deal with terminal patients."*

The commonest death rituals observed by the participants from their clients include collection of the spirit of the dead and religious death rituals such as prayer, communion and baptismal of the sick

"Like Zulus will come with that branch to come and collect the spirit and we really don't have a problem."

One participant working in a premature unit described an experience she had with the collection of the spirit.

"We once had triplets in the ward and one died and the family came to the ward with the casket to put in the living ones. They (family) had to let the two babies know that the one twin is gone. This was done before collecting the body of the dead baby from the mortuary."

Pastoral support was sought for those families facing impending death.

"There is a pastor who usually comes and they come and pray for the children."

In summary, the nurse-patient relationship in holistic nursing care is enabling and facilitative with purposeful communication and nurturing environment. Purposeful communication is a precursor for effective nurse-family relationship. It is communication that is preceded by trust and respect and is goal directed aimed at keeping the family informed. The holistic nursing environment of care is homely, loving and nurturing and the paediatric nurse acts as a surrogate mother.

The impact of HIV and AIDS within the caring environment brings a dynamic that influences the achievement of holistic nursing care. HIV and AIDS impact relates to increasing patient acuity, non-compliance for some clients and end of life issues. Absence of cure and the continuous suffering of children living with HIV and AIDS

brought out feelings of helplessness and powerlessness in the paediatric nurses associated with emotional burnout. The inability to cure HIV and AIDS coupled with non-compliance to treatment and preventive measures against HIV and AIDS by some mothers left the nurses with feelings of helplessness and frustration especially that at the moment there is no known “cure” for HIV and AIDS. End of life care incorporates family values. Spirituality/religion and/or culture are one of the aspects used to manage family emotions when faced with decision-making based on uncertainty and or being confronted with the inevitability of end of life. Death rituals relate to all dimensions of whole care.

5.5 CONCLUSIONS DRAWN FROM THE EMIC VIEWS OF THE PAEDIATRIC NURSES

Constructions of **wholeness** referred to the wholeness of the **child, nurse** and family as persons with **body-mind-spirit** dimension existing within **socio-cultural** dimension.

The family is a **unity of oneness** composed of father, mother and child and considered as **foundational**.

The childcare environment is where the **physical, psychological** and **spiritual** problems of the person child are assessed and treated by a paediatric nurse and a team of specialised health professionals. The environment is **homely and loving** with the paediatric nurse acting as a **mother figure** to create a **healing** empowering environment where the **whole person** child can be nurtured.

Holistic care is **person centred** and **family centred**, meeting the **physical, emotional, mental, spiritual, social, and cultural dimensions** of care.

The **nurse as person** is an embodiment of **personal** and **professional knowledge** with **mind-body-spirit** dimension and existing and interacting with **socio-cultural** dimension. As a person the nurse possesses **humanity** traits of **sensitivity** and **love acting** as a **surrogate mother** for the **person child** and as a professional the nurse has **knowledge.**

The **nurse-family relationship** in holistic nursing care is **enabling** and **facilitative** with goal directed **purposeful communication** keeping the family informed, preceded by **trust** and **respect,** and is and **nurturing environment** which is **homely**, **loving** and **nurturing**.

The impact of HIV/AIDS within the caring environment brings a dynamic that influences the achievement of holistic nursing care. With **increasing patient acuity, non-compliance** for some clients and **end of life** issues and **continuous suffering** of children living with HIV and AIDS bringing out **feelings of helplessness** and **powerlessness** associated with **emotional burnout** in the paediatric nurses.

5.6 CONCLUSION

This chapter described the process of data analysis of the focus group data generated from the emic views of the paediatric nurses working in three hospitals in Johannesburg. Theme and sub-themes that emerged from the data were described and illuminated by the qualitative narratives from the focus groups data. Relevant

literature were searched and included as literature control in order to situate the data within the current body of knowledge. Concluding statements were drawn from each theme and sub-theme and the concepts identified will form basis for the conceptual framework to be discussed in the next chapter.

CHAPTER SIX

FRAMEWORK FOR HOLISTIC NURSING CARE

6. 1 INTRODUCTION

Chapter four presented the concept analysis of holistic nursing care and chapter five described the emic view of paediatric nurses working in Johannesburg in selected hospital. The purpose of this chapter is to draw a framework of holistic nursing care based on the conclusion statements drawn from chapters four and five. Inductive processes were used to conclude and guided the process to formulating relational statements. The main concepts were identified from concluding statements based on results of chapter four and five and each statement was discussed, analysed and situated within the current body of literature. A summary of the conclusions is presented in Table 6.1. Column 1 presents the concluding statements from the concept analysis. The concluding statements from the emic views of the peadiatric nurses are presented in column 2. In column 3 the identified concept is presented and the number following (Table 6.1) indicate the supportive conclusion statements , which shows the deductive logic that is used to identify the concepts, for an example, whole person (1, 3, 6). The classification process used followed the Dickoff, James and Wiedenbach (1968) survey list with six components. These are described below:

- Agent Refers to the person performing the holistic nursing care.
- The context The context refers to the environment where holistic nursing care is performed.
- Recipient Referring to the person who receives the holistic nursing care.

- The procedure — The procedure refers to the technique used to accomplish holistic nursing care.
- The goal — The overall purpose towards which the activity holistic nursing care is directed.
- The dynamic — The dynamic refers to the driving energy source of the activity holistic nursing care.

The concepts are described in detail.

6.2 AGENT: PAEDIATRIC NURSE

The agent for the provision of holistic nursing care is a **paediatric nurse**. The agent is the person who performs the activity (Dickoff et al., 1968). The performance of the activity includes the necessary skills, attributes and attitudes that are foundational for the agent's function. In this study the paeditric nurse has distinct attributes; a whole person, act as a person, knowledgeable and assumes the function as a surrogate mother. The predominant function of the paediatric nurse is to provide holsitic nursing care to the whole family. The skills and attributes will differ in applicatition depending on the context of care and the severity of illness of the child. In this study the paeditric nurse is conceptualised as a whole person. The nurse as whole person has a body-mind-spirit dimension interacting and living harmoniously within the socio-cultural context. The nurse recognises self, as a person with professional expertise looking after the health needs of the whole family. Nurse as a person is related to the

attributes of being more humane, respectful, empathetic and sensitive to family needs embracing the person child as a human being and acting as a surrogate mother.

Recognition of the other as a person reverberates with the Ubuntu idiom " *I am because you are and you are because we are*." The principles of African philosophy of Ubuntu are described as humaneness, compassion, care, understanding, and empathy (Khoza, 1993; Mbigi & Maree, 1995; Boon, 1996; Dandala, 1996; Teffo, 1996). Ubuntu has social commitment to share one's individual humanity with others and judgment of ones actions with respect to living out the Ubuntu ways demonstrating acts of kindness, generosity, and respect (Teffo, 1996: 103). The conceptualisation of surrogacy in this study is perhaps an extension of actions of kindness, empathy and sharing creating an environment of homeliness, which brings to the child an aspect of familiarity thereby bringing principles of personhood to the caring arena. Surrogacy refers to the motherly role assumed by the paediatric nurse in caring for the hospitalised child. The surrogate mother creates a nurturing loving homely environment where the child can be cared for as a whole person. For Mahlungu and Uys (2004) nurses guided by Ubuntu principles will demonstrate respect for human dignity and acceptance of personhood

Richardson (2002) conceptualised the nurse as a person as emanating from the humanistic approach, related to reliability, honesty, and genuine-ness, and caring.

As a professional, the nurse possesses knowledge and technical skills that enabled the paediatric nurse to make clinically sound judgement. The predominant function of the paediatric nurse as professional nurse is to provide whole care to family. The skills

and attributes will differ in applicatition depending on the context of care and the severity of illness of the child.

The nurse as professional was described as possessing different kinds of knowledge; personal knowledge, knowing how and knowing what of the disease and inner knowledge. All three types of knowledge are important in making sound clinical judgment according to presenting situations during child-family interactions.

Personal knowing is knowledge that comes about through interaction and by association and recognizing the other individual as a person. This knowing has strong association with culture forming bonds and relating. It is accomplished through dialogue. The knowledge of "know what" and "know how" refers to the knowledge of the disease and the acquired specialised skills necessary to meet the patients' presenting health problem. It is the general knowledge about the diseases process, therapeutic protocols, and pharmacology, referred to as case knowledge in critical nursing care (Fullbrook, 2003). The International Council of Nurses (2007) refers to the attributes of specialist nurse practitioner as inclusive of expert knowledge base, advanced health assessment, diagnostic skill, complex decision-making skills and advanced clinical skills.

Inner knowledge is personal and relates to spirituality. The inner knowing surfaces at the point of connecting with the other person, transcends human rationality and it's immediate and based on recognition of the other person as a body-mind-spirit being, the whole person.

Similar attributes and skills of paediatric nurse as a person gleaned from the different authors in nursing literature are presented in Table. 6.2.

Table 6.2 Attributes and skills of the paediatric nurse.

(Adapted from Benner (1997), Dunn, et al (2000), Swanson & Wojnar (2004) and Kotzer (2004).

- Utilises sound knowledge base and apply and integrate to practice
- Demonstrate a high level of assessment skills and clinical judgement
- Demonstrate effective goal directed communication skills
- Collaborates with health care team in achieving desired outcomes.
- Acts as a facilitator and coordinator of holistic care
- Maintains a physical environment which promotes safety and optimal health of patients
- Promote patient well-being by mantianing a physical, psychosocial, cultural and spiritual safe environment.
- Demonstrate knowing, being with, enabling and dialogue.

In this thesis, it is assumed that a peadiatric nurse is a whole person with mind-body-spirit dimension functioning within socio-cultural specifics, embodied with personal and professional knowledge. As a person the nurse possesses humanity traits of sensitivity, nurturing, loving and is reflective and responsive to holistic needs of patient. As a professional, the nurse possesses knowledge of the person as the other being and the knowledge of "know how and know what of his or her work. This knowledge is comprehensive and has been acquired through specialist education characterised by scientific knowledge, clinical skills and humanistic values demonstrated creatively and innovatively in clinical practice.

6.2.1 Conclusion statement on the agent

In conceptualising the agent paediatric nurse, the following statements are deduced:

- ❖ A paediatric nurse within holitsic practice is a person embodied by mind-body-spirit dimensions possessing knowledge about the person child and family and incoporates this knowledge to the exclusive scientific kowledge, skill and attitude obtained through specialist education.
- ❖ Attributes of paediatric nurses include effective goal-directed communication skills, person-centered skills, sensitivity, nurturing, loving, responsive, reflective, enabling skills applied to practice with sound clinical judgement.

6.3 CONTEXT: CHILDCARE ENVIRONMENT

Context refers to the setting or environment in which the activity holistic nursing care occurs (Dickoff et al., 1968). The context is any childcare environment within public hospitals in Gauteng province. The childcare environment refers to the homely and nurturing environment. It is the immediate setting where the actual holistic nursing activities are performed. The childcare environment may include a ward or any other setting where children are taken care of and is managed by a paediatric nurse and a paediatrician. The nurse is specialised and liase between the adminstrative, medical and non-medical personnel for the sole functioning of managing child care. In academic instutions the nurse has an additional teaching role that must be safeguarded for the purpose of providing accountable responsive safe care. These childcare areas are situated within a broader context of care and are structurally and funtionally dependent on individual hospital administrators governed by the provincial health authorities. Provincial health administrators receive their mandate for provision of

health care delivery from the Department of National Health (DOH). In South Africa, health is a fundamental right entrenched in the South African Constitution. The core responsibility of the DOH is to provide quality health care to all citizens of South African through formulation of health policies and legislation, setting up norms and standards for health care and monitoring the provision of the National health goals. The actual delivery of health care is delegated to various health administrators in different provinces. The provincial health departments have a responsibility to provide and render health care services, controlling quality and standards based on the current legislative parameters. In addition

to these functions the Provincial administrators play a significant role in the training of physicians, nurses and supplementary health personnel. Specific functions within these hospital are devolved into specialities such as peadiatric nursing with all the resources necessary for the care of children inclusive of human resources.

Children admitted to these hospitals are referred from primary health care centres and from private practitioners working in and around Johannesburg. At primary health care centres, the services are free for children under the age of six years. At these centres the Primary health care trained nurses treat children and refer to doctors certain children with complications for specialised treatment or for consultation. The specific services provided for children at the primary health care centres are primary preventive and curative rehabilitative services and include:

- Immunisation; communicable and endemic disease, prevention; maternity care; screening of children; Integrated Management of Childhood, Illnesses (IMCI) and child health care; health, promotion; youth health services; counselling, accident and emergency services

(http://www.gcis.gov.za/docs/publications/yearbook02/chap13.pdf, accessed 7/12/06).

Children with complications that need complex level of care are sent to local hospitals. The three hospitals used for this study are academic institutions and the medical health teams rotate among the three hospitals. The paediatric nurses work in the same institution and rotation is restricted to the children's wards within the same hospital unless an individual nurse requests lateral transfer.

The state of the children admitted in these settings is described in chapter two and the process of admitting children from the primary health care centres is explained. Provision of health care delivery in these hospitals follows the guidelines set out in the Children's Act.

The Children's Act 38 of 2005 was promulgated in 2005 replacing Child Care Act, No. 74 of 1983). The child is defined as a person under the age of 18 years. Inherent within this Act is safety and protection of rights of children in various settings, for an example, caring family environment, protecting the child from any physical or psychological harm that may subject them to any form of maltreatment, abuse, neglect, exploitation or degradation. The Act emphasises the need to provide care and protect the children who are in need of care recognising also the special needs of children with disabilities.

The child care facility refers to homely, loving and nurturing environment. At the centre of holistic nursing activities is a paediatric nurse who acts as a mother figure. In case of a physical ward, the environment resembles the familiar home environment. The cold, hostile, impersonal environment of the hospital is transformed into a caring home where others can be preserved and nurtured as body-mind-spirit beings. The

love relationship is fundamental in the nurturing environment. Any non-loving relationship is regarded as potential blockers of the nurturing relationship. Nurse family interactions are goal directed and sensitive evoking deep feelings of love and help to reduce anxiety restoring a sense of well-being.

Quality of care is the responsibility of the nurse and the parent. Parents are actively involved in the care of their children. They are empowered with skills and knowledge to enhance their confidence.

In conclusion, a child care environment is the main context for the application of holistic nursing care. It where the presenting physical or psychological health problem and actual nursing needs of children are assessed and treated led by a paediatric nurse and a team of specialised health professionals. The caring environment exist within a broader context of care situated in a hospital and responsible for providing safe physical, psychosocial, spiritual and cultural health care that is consistent with children's rights and legislative and ethical parameters. The environment is homely, loving and enabling.

6.3.1 Concluding statement from Context

In conceptualising the context paediatric ward the following statement is drawn:

The child care environment within a hospital is the main context where whole care is provided. Provision of whole care within the child care environments is inextricably dependent on the hospital adminitrators and the provincial authorities. The environment which may include a paediatric ward refers to a homely, loving, and

nurturing environment with the paediatric nurse acting as a mother figure to create an empowering environment where the whole person child can be nursed and loved.

6.4 RECIPIENT: WHOLE PERSON-CHILD

Recipient refers to the person who receives the activity (Dickoff et al., 1968). The recipient in the provision of holistic nursing care is a child and his or her family. In general terms, whole is an adjective meaning to complete, containing all elements (Collins Dictionary, 1993: 826). Wholeness, a noun, is described in the dictionary as containing all components or an entity or system made up of interrelated parts (http://www.thefreedictionary.com/wholeness, accessed 31/1/07). Whole person in this study refers to the wholeness of the person child as a human being, the family as a unit and the nurse as a person and a human being, all with interconnected body-mind-spirit existing within a specific socio-cultural. Wholeness therefore is opposed to restrictiveness and narrowness and it can be deduced that human beings are whole and complete in constant interaction with environment. The child is a person with body-mind-spirit residing within specific socio-cultural environments. The personhood of the child is not linked to growth and development; the neonate at birth is whole. The child as a person remains whole irrespective of changing family dynamics. The family unit and structure might be broken or dispersed but the child, as a human being remains whole. When the child and family: father, mother and child are intact the family unit is considered whole existing within community of relationships. When the foundational structure is broken, by the disruption in the unit's coherence, the child remains whole.

It can be inferred from the above discussion that the whole person child cannot be divided into simplistic manageable parts but must be viewed in light of the integrated physical, psychological, emotional and spiritual dimensions.

In summary, the child is considered a whole person with body-mind-spirit dimensions integrated with social and cultural dimensions, possessing unique physical, mental, emotional, social, and cultural attributes.

Wholeness is the recognition of the person child, nurse and family member with body-mind-spirit-and socio-cultural dimensions. The person child with respect to the interrelatedness and interconnection of the dimensions is complete even if the family structure is broken. The wholeness of the child is depended on the harmonious relationships between the different dimensions. Any interference with any of the dimensions will have an effect on the other dimensions. Harmonious relationship between the four entities of the person is necessary for the well-being of individuals. The care rendered to the child and family members therefore has to consider these dimensions and when the body-mind-spirit and socio-cultural dimensions are knitted into the different aspects of caring interventions then whole care would be realised.

6.4.1 Concluding statements on the Recipient

In conceptualising the recipient person child, the following statements are deduced:

- Wholeness is integration of body-mind-spirit dimensions of a person.
- Child is a person complete and whole
- Wholeness of child refers to the inseparability of the child from family.

- ❖ Child and family are inextricably joined and connected and child derives his/her identity contextually and culturally.
- ❖ The care designed for the child and family is person-centred and family-centred care.

Conceptualisation of the recipient is represented in Figure 6.1.

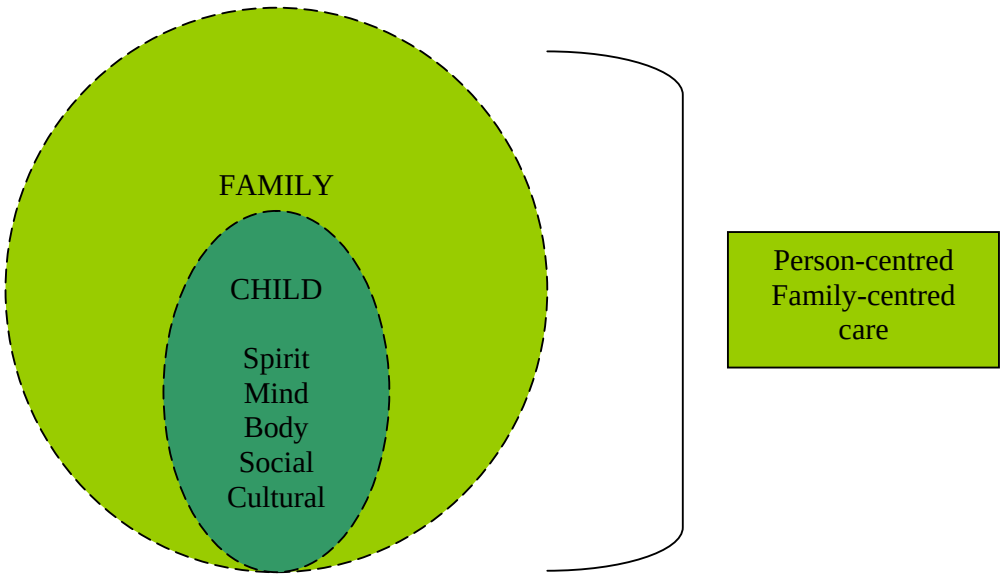


Figure 6.1: Conceptualisation of the recipient

6.5 GOAL: WHOLE CARE

The goal of holistic nursing care is whole care designed to meet the needs of the whole person (Table 6.1, statement 4). Whole care is inclusive of the five dimensions namely physical, psychological, emotional, social, cultural, and spiritual. The emphasis is on the care designed to meet all the dimensions of whole person, helping

to shape the expressions of nursing care away from patient to a person. To achieve wholeness in care, the designed caring interventions must include all five dimensions. Whole care is the caring activities that are child and family focused, culturally sensitive, and congruent with family beliefs and values, planned to meet the physical, emotional, mental, spiritual, social, and cultural dimensions of care.

Concepts care and caring are complex to define. Literature reveals that caring as a concept has been widely reviewed and extensively described and explored. Many authors consider the concept relevant to nursing (Morse et al., (1990); Watson (2002); Leininger (1988a); Swanson (1991); Spichiger, Wallhagen & Benner, (2005).

Dictionary definitions of the word caring (adjective) include feeling or showing concern; relating to professional, social or medical (Collins Concise, 1991). As a verb "care" is described as to attend, foster, like, love, nurse, protect, tend, and watch over. Potter and Perry (2005: 108) give a very simplified general definition of caring:

> *"Caring is a universal phenomenon that influences the ways in which people think, feel and behave in relation to one another."*

In this definition the authors imply that caring is a phenomenon that is common in human interactions. The association of nursing and caring in light of the above definition is understable when considering the nature of nursing which is human to human interactions. Whole care refers to care that incoporates all the dimensions of care.

Centrality of caring to nursing is generated and well accepted and evident in different definitions. Table 6.2 presents different theorectical definitions of caring from nursing literature.

Table 6.3 Theorectical definitions of caring

Leininger (1991: 46)	Care refers actions and activities directed towards assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or way-of-life, or to face death.
Watson (1985:32)	A value, an attitude that has to become a will, an intention, or a commitment, that manifests itself in concrete acts.
Roach (1984: 2)	Caring is not simply an emotional or attitudinal response. Caring is a total way of being, of relating, of acting; a quality of investment and engagement in the other-person, idea, project,thing or self…

Even though nursing literature does not give a single agreed upon definition of caring, critical analysis of literature reveals various qualities of caring. Morse et al., (1990) reviewed the caring literature and classified caring into categories: a human trait, an affect, moral imperative, interpersonal relationship and therapeutic interventions (vide1.5). Concepts such as competence and compassion, presence, being there, trust, concern, advocacy, connectedness, empathy, relationship are linked to caring

(Watson, 1998; Kottow, 2001; Sumner, 2001; Williams, 2001; Yonge, 2002; Espzel & Canam, 2003; Tarlier, 2004).

In the following discusion I will attempt to interpret the different views of caring evident in nursing literature and link the usefulness of such views to whole care.

The discussion will use the format suggested by Stokedale & Warelow (2000); ethics and caring, caring relationships, caring behaviours and attitudes and themes gleaned from literature on caring and non-caring behaviours will be presented.

6.5.1 Ethics and care

Ethics is the branch of philosophy that is based on morality and raises issues such as ought, just, right and wrong providing a framework for people to choose, justify and judge their actions Brody in (Stokedale & Warelow, 2000). The call to recognise caring as a moral imperative by Morse et al. (1990) and Watson (1988) immediately associates caring with issues of morality. When considering caring as a moral principle, the act of caring becomes an obligation and the nurse is persuaded to accept the responsibility to care for sick persons regardless of abilities. Brody in (Stokedale & Warelow, 2000) views caring as a virtue for nursing. A virtue is a quality that one posesses that leads one to behave in accordance with moral or ethical principles. Comparing caring with virtues and ethical principles brings an element by which the way one cares for a person can be subjected to scrutiny based on morals and ethics. For an example patients with similar needs, as Morse et al. (1990), explain need equal similar care and nurses cannot bestow more care on one patient than the other as in doing so the nurse would be violating the moral imperative jeopardising the caring

relationships. Therapeutic caring actions and personal and public moral knowledge is necessary as the basis for nurse-family relatinships

(Tarlier, 2004). When a nurse fully comprehends the ethical foundation of nursing and connect steadfastly their personal moral values to act with beneficence, veracity and fidelity, the iterative process of nurse-family relationships will reflect a deeper meaning of caring, which is more than caring activities, focusing on engaging relationships that reflect ethical knowledge and respect the individuality of the person.

6.5.2 Caring relationship

Expressions of care do not occur in isolation, it involves interpersonal relationships. The relationships are based on exchange of energy and information between the carer and the cared for (Stokedale & Warelow, 2000). Within this relationship, there is a therapeutic connection. Watson (1988: 58) refers to the interpersonal relationship as transpersonal, an intersubjective human-to-human relationship, which the person of the nurse affects. This relationship results in spiritual union and transcends the self, time, space and life history for each other (page 66). In light of the above discussion, caring relationships in whole care integrates all the dimensions of care and implemented in the mundane activities of child and family care. Children are young, growing and developing into unique individuals, in order to achieve their full potential in areas of physical, emotional, cognitive and spiritual development; require protection, support and nurturing caring environment. Whole care attends to all dimensions of an individual with equal importance (Smith & McSherry, 2004). The basis for caring for children is an understanding of development of children and application of whole care must take cognisance of development that parallels

cognitive development. Younger children are unable to interpret the meaning of illness and death. Without guidance, young children can attribute the illness experience with punishment and misconduct. The nurse together with family can facilitate understanding that illness is not related to misconduct and such misconceptions can be corrected and turned into positive experience through love, affection, and nurturing environment. Nurses have a moral responsibility to protect the child emotionally, physically, spiritually and ethically. With the use of whole care approach, nurses perhaps may broaden their ability to care for the individual needs of the child beyond physical care and in the social dimension incorporates issues affecting family such as poverty, child abuse and inadequate resources to necessary for the accomplishment of quality care.

6.5.3 Caring behaviours and attitudes

Caring is an attitude towards another person who needs assistance because of disease, crisis or inability to engage in self care (Brilowski & Wendler, 2005). Nurses have to display a positive attitude to be considered caring. Caring is understood in context. It is not a set of identifiable attitudes, it combines attitudes with action and commitment in preserving a person's integrity and respect. Caring attitudes depend on unique patient situation. To enact caring behaviours personal values, ideas and beliefs of the nurse have to be combined with cognitive, technical, personal and professional competencies. The primary focus of care is nursing, with nurse assuming responsibility for actions directed toward the well being of the person cared for. Table 6.4 presents the different themes gleaned from qualitative studies on caring and non-caring behaviours from adult patients.

Table 6.4 Caring and non-caring

Themes relating to good caring behaviours	**Themes relating to bad caring behaviours**
Facial expression e. g smile Not being in a hurry Open and willing to share Touch Translating, informing, explaining, intructing Getting to know somone Establishing trust, Reassuring presence, demonstrating professional knowledge and skill Promote autonomy Providing comfort measures Respect, closeness Being attentively present and listening, concern for others	Being in a hurry and effcient Doing a job Being rough and belittling patient Not responding

6.5.4 Conclusion statements

- Whole care refers to the nursing activities that meet the child and family's physical, emotional, spiritual, social and cultural dimensions, interrelated and in continous relationship with changing environment. The care is congruent with family beliefs and values. The paediatric nurse recognises the uniqueness of the person in need of care and accept the moral and ethical responsibility to nurture and preserve the uniqueness of the person. The outcome of whole care is person-centred and family-cemtred care.

6.6 PROCEDURE: DIMENSIONS OF CARE

The procedure refers to the technique used to accomplish the activity (Dickoff et al., 1968). In holistic nursing the dimensions of care include the whole care designed to meet the different entities of the person child namely physical, emotional and psychological, spiritual and socio–cultural. In the following discussion I will attempt to clarify each of these dimensions in relation to holistic nursing care. The physical dimension is explained and defined in relation to the literature in child nursing. An attempt to individually describe the different dimensions of care will be made. However, the aim of the discussion is to show the harmonious relatedness of the different dimensions of care as designed and applied in response to the health problem affecting the whole person and family.

6.6.1 Physical Dimension

The term physical in general terms relates to the body (http://www.thefreedictionary.com/wholeness, accessed 1/2/07). The physical dimension of health care refers to the care activities designed to meet the diseased aspects of the body dimension of the whole child. The health and nursing care is exclusively designed to meet the age-appropriate physical needs of the child with respect to the presenting health problem and prevention of potential complications. This care in these research settings is multi-disciplinary involving a variety of specialists input depending on the actual presenting problems. The paediatric nurse is the resident nurse practitioner that is at the centre of the care of the child. The nurse often does the initial holistic assessment of the patient and isolates the actual problem of the child based on the presenting problem. The nurse gathers the necessary data about the presenting problem from family as well as using the techniques of

inspection, palpation, percussion, auscultation and olfaction to observe for abnormalities that may yield information. Once the initial nursing diagnosis is made, the paediatric doctor is called upon to undertake a complete physical examination and refer for appropriate investigative procedures such as collecting X-ray films of the diseased part of the body or collecting blood samples in order to isolate the cause and the extent of the health problem in support of the initial findings. The nurse liase and consults with all related professionals from different disciplines for the sole purpose of meeting the health care outcomes designed to meet the physical needs of child. The paediatric nurse reflexively apply the knowledge of nursing process acting holistically to respond to physical, emotional, spiritual and social needs of the child evoked by the health problem identified in the diseased physical dimension of the whole person. To nurse the physical dimension of the whole child without due consideration of all the dimensions that make up a person would be fragmenting the person into different entities.

The Convention on the Rights of the Child (CRC) in South Africa confers on all children the right to the enjoyment of the highest attainable standard of health and in line with this, is the inherent view that every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health (Institute of children, 2004). In response to the statement of the CRC and in line with the expectations of the SANC on outcomes of nursing care (refer 1.6), the paediatric nurse will design a nursing care plan for the physical health problem incorporating the psychosocial and spiritual needs addressed within a culturally specific context to meet the needs of the whole child and family. Participants in this study referred to this care as holistic or total care. The aim of the designed care is healing the whole person by attending to the

needs of the disordered physical or psychological parts of the person focusing on diseases process and restoration of the integrity of the specific component (usually physiologic). The holistic nurse draws on nursing knowledge, bio-scientific-psycho-behavioural theories, and intuitive processes to create a healing environment. Intuition refers to understanding of a situation without consciously employing cognitive thought processes. According to Potter and Perry (2005:264) intuition occurs when a nurse walks in a room and senses that something usually physical is about to happen without the benefit of the assessment and it triggers a conscious analytical process of data collection that confirms the sense of change. Holistic nurse recognises self as an instrument of healing (Dossey, 2001). The healing process acknowledges whole person by addressing the physical, mental, emotional and spiritual needs of the whole person child (Burkhardt & Nagai-Jacobson, 2001). The nurse develops the healing environment by displaying genuine caring and concern, respecting families' circumstances in a non-judgmental manner. The central idea within holistic nursing is that physical care is more that series of tasks designed to respond to the needs of person's diseased part without recognition of the effects of the disease have to the harmonious relationships of the different dimensions of the human being. In order to fully meet the needs of the holistic needs of the child and family, the nurse must recognise the patient as a person (Tonuma & Winbolt, 2000).

Task-focused approach to nursing care is at the centre of debate in nursing literature and promotes distancing of nurses from the person needing holistic care. In physical care the nurse does perform certain tasks, for an example cleaning of a septic wound on a left leg, the central premise in holistic nursing is that the nurse puts the person before the tasks. Their behaviours should reflect the respect for the patient as a person rather than the task that they feel compelled to complete. Tonuma and Winbolt (2000:

215) quote Kitwood who claims that ‘nursing involves the need to perform tasks’, the same task can be therapeutic or non-therapeutic through the nurses’ approach to the whole person. Implementation of effective holistic nursing care to a person takes into consideration the psychosocial, spiritual dimensions of the person and cultural factors relevant for the child and family.

6.6.2 Psychological Dimension of care

*The term p*sychological *refers to the mind or emotions (http://www.thefreedictionary.com/wholeness, accessed 1/2/07).* Participants in this study used the terms emotional and psychological dimension of care interchangeably to mean care that is designed to address the mind of the sick child and family. The focus of psychological dimension care is to address the symptoms of fear and anxiety associated with processing the effect of the physical condition to the mind and stress associated with hospitalisation. Concerns and fears of family were attributed to their lack of understanding with respect to what is happening with the child in relation to the condition and care that is planned to meet the needs of the child. Hospitalisation is a very stressful experience for both child and family. Evidence from multiple studies suggests adverse effects associated with hospitalisation from premature infants to older children. Negative mental and behavioural outcomes include anxiety, depressive disorders and post traumatic stress disorder (MeInyk, Feinstein & Fairbanks, 2006). Other factors associated with fear in children include hospitalisation, surgery, procedures, routine nursing and medical care, strangers, unfamiliar hospital environment, body mutilation and pain (Justus, Wilson & Walther, 2006). Participants acknowledged the fears of parents and dealt with these fears by giving the parents the

necessary information about the condition of the child, care and treatment planned. Involving the parents in the care of their children and allowed them to make decisions about the treatment and care. Intervening strategies were varied including referral to other health professionals such as psychologists, social workers depending on the need to holding prayers and referral for pastoral care.

Other known sources of fear related to surgical intervention that can evoke anxiety in children include:

- Physical harm or bodily injury in the form of pain, mutilation, or even death
- Separation from parents and absence if trusted adults, especially for preschool children
- Fear of the unknown and unfamiliar
- Uncertainty about “acceptable” and normative behaviour in a hospital setting
- Loss of control, autonomy and competence (Justus et al., 2006)

The responses described above are influenced by the factors such as the child’s developmental level, prior experiences with illness and medical care, the amount and quality of medical and nursing preparation procedures and surgical interventions and the available support from family. The presence of parent during painful procedures seems to reduce the child level of anxiety by providing emotional and physical comfort and support through tone of voice, comforting stroking, and holding the child (Justus, Wilson & Walther, 2006). Spiritual, social and cultural dimensions of care, all contributed to the care of the whole person. The spiritual dimension is discussed below.

6.6.3 Spiritual dimension of care

Spirituality is a quest for a divine connection with God, Life force or Supreme Being. It is based on set of beliefs. Constructions of spirituality began by acknowledging the diversity of beliefs and letting the patient believes in a manner congruent with their family beliefs. Spirituality was interpreted as connecting to a Higher being through praying. The divine connection with God, life force or Supreme Being provided the participants with hope and a sense of wholeness. Participants were to draw the families towards the same hope in times of crisis and in situations that seemed hopeless such as an inevitable death in relation to HIV and AIDS. Acknowledging own spirituality enabled participants to assist families to connect with own beliefs to draw strength and find meaning. Spirituality was used interchangeably with religious or cultural. Descriptors of spirituality included coping, a hope-fostering strategy, comforting, peace, and search for meaning.

To incorporate spirituality, diversity of beliefs had to be acknowledged recognised and accepted. Being comfortable with own spirituality and acknowledge self as a spiritual being enabled participants to ask non-judgmental spiritual questions. Sensitivity and respect to diverse religious beliefs and allowed families to practice their beliefs in non-judgmental manner. Provision of care had to be congruent with family beliefs. Descriptions of spiritual activities practised by families in the newborn units were similar to those practised in bigger babies and children in all the three hospitals. Spiritual activities commonly referred to included prayer, pastoral care, communion, church attendance, being there and presencing. Pastoral care and counselling was encouraged to help families draw inner resources from their belief system.

Prayer was used as the single most popular strategy to help families to cope. Because HIV and AIDS were frequently referred as one of the factors influencing the environment of care negatively, nurses referred to connecting with God/ High Being as drawing strength and taking care of their own wholeness. The reason for the transcending connection was interpreted as hope-fostering. Obstructions within the child environment of care such as burnout brought feelings of hopelessness. To replenish their strength resources prayer was used. Participants referred to this connection as getting to a "*place"* where extra help was drawn. There was divine enabling that was associated with connecting with this *"place"*. Once connected, the participants believed that they were empowered or enabled with divine power to help families emotionally, physically, spiritually and socio-culturally. In relation to HIV and AIDS participants believed that there is divine healing in this "place".

When death was imminent performance of family rituals was encouraged. Families were permitted to perform death rituals to promote spiritual well-being. Family decisions regarding life and death were based on family value systems or religious beliefs. Common strategies used in end of life care included caring presence and being there.

Nursing literature is inundated with spirituality in nursing care and attending to the spiritual needs of the sick person has always been the mandate of nursing, guidelines as to how these needs should be met is the subject of debate in nursing literature. Three main themes gleaned from literature about spirituality include:

- ❖ Debate on how to define spirituality
- ❖ How to develop spiritual models applicable to clinical practice.
- ❖ Spirituality and religion.

Despite the growing body of knowledge, spirituality is acknowledged as an elusive concept. Different definitions of spirituality are presented in Table 6.5.

Table 6.5 Definitions of spirituality adapted from Narayanasamy et al. (2004).

❖ Essence or life principles of person ❖ A sacred personal journey ❖ A belief that relates a person to the world and his/her environment ❖ Gives meaning, purpose, hope and value to people's lives ❖ Faith in God/ super being/life force

For the purpose of this discussion, a useful definition on spirituality that closely relates to the interpretation of spirituality given by the participants is found in the work of Narayanasmy (1999: 123):

> "*Spirituality is rooted in awareness, which is part of the biological make up of the human species. Spirituality is potentially present in all individuals, it may manifest as inner peace, and strength derived from perceived relationship with transcendent God/ an ultimate reality."*

In line with the discussion on spiritual dimension of care in holistic nursing, this definition will serve as a framework to situate the different aspects of spiritual care.

Nursing theories such as Neuman's systems model, Rogers' science of unitary beings, Roy's adaptation model and Watson's theory of human caring (Marriner-Tomer, 1994) recognise the impact spirituality has on individual's health. Providing spiritual care to children and their families is an important aspect of paediatric nursing because nurses' work is aimed at nursing human beings who are spirit beings.

The participants in this research used the spiritual/religious or cultural dimension interchangeably. According to McEnvoy (2003) spirituality, culture and religion are not synonymous even though they appear to be used interchangeably. Spirituality refers to an individual's personal beliefs and transcended experiences. Religion is used to describe an organized system of beliefs while culture is described as a particular set of beliefs of a given group of people (McEnvoy, 2003; MacLaren, 2004). Religion may serve as a channel for spirituality. A commitment to spirituality maybe found in expressions such as rituals and symbols connected either to religion and or culture (Elkin & Cavendish, 2004). Spirituality, culture and religion in this study are seen as an integrated whole within a perceived concept of culture. Theoretical perspectives for this discussion are derived from contemporary sources such as Narayanasmy (1999, 2004) on older clients and spirituality, Thornton's (2005) and Donadio (2005) on whole-person caring and McEnvoy (2000, 2003) and Tanyi, (2006) on family spirituality.

6.6.3.1 Assessment of families spiritual needs

Assessment of spiritual needs in child and family begins with noting of the family religious affiliations supported by objective data collected from the family. Collection of spiritual data from family is deliberate and systematic. The purpose of the

assessment is to determine how spirituality is constructed and how it can be used and incorporated to the overall care of the child and his/her family. Two stages of spiritual assessment are discussed in literature; firstly the assessment is conducted to identify the religious beliefs, affiliation and practices. This information is relevant for adaptation of family's religious practices such as diet preferences and rituals into care. The second stage involves a deeper involvement with a family who is obviously experiencing spiritual distress (Potter & Perry, 2005). Spiritual distress is defined as lack of hope, meaning or purpose in life, and refusal to interact with family, friends or inability to pray (Narayanasamy et al., 2004; Potter & Perry, 2005; Tanyi, 2006). The nurse draws on bio-scientific-psycho-behavioural theories and intuitive knowledge to develop an individualised plan of care that is holistic incorporating all dimensions of care. This is called whole-person caring by Thornton's (2005) and Donadio (2005). The influence of spirituality and or religion in health care is important as it may give direction to specific areas of life such as diet, certain treatments as in no blood transfusion due to religious beliefs. All these bear some significance and a potential for conflict in practice. Various tools have been developed to assist nurses to explore patients' beliefs. McEnvoy (2000) developed a mnemonic BELIEF to help focus paediatric nurses in discussing spirituality with families regarding the health care of their infant or child.

B. Belief systems: Belief and values derived from beliefs system are a significant aspect of family life and have an impact in health care.

E- Ethics: According to McEnvoy (2000), some families do not necessarily follow all the beliefs of a particular religion. They may develop certain code within the same religion that determines on how they want to conduct their lives and raise their children. These codes constitute standards of behaviour. For an example, families may

suggest a non-violence approach to raising their children and opt for time out. This becomes important when planning individualised care plans.

L-Lifestyle: Most religion gives direction that may guide family's lifestyle and health care practices e.g. Jewish, Islamic and Catholic faith. Some of these practices may have impact on issues for bigger children. These practices may have consequences for the infant or child, for an example, a child who is not fed on animal products may be at risk of developing vitamin B 12, calcium, iron, vitamin D, and Zinc deficiency (McEnvoy, 2000). Cultural sensitivity and non-judgmental attitude is recommended in dealing with conflicting culture and bio-medical values.

I-Involvement in community religious activities: Community groups serve as resource for family and may offer parental educational classes that reinforce family values.

E –Education: morals and values are often taught at home and some families may want to reinforce these by enrolling their children in community educational groups. Values such as sharing love and concern for others are reinforced in most religion (Potter & Perry, 2005).

F: Future: Some religion prohibit their families from certain medical interventions that have potential to cause conflict in families, for an example, the refusal of blood by Jehovah's witnesses (Potter & Perry, 2005). In such situations, alternatives are discussed to minimise conflict and grief. Death is an inevitable event and therefore information regarding incorporation of death rituals should be discussed with sensitivity.

Family responses on how to incorporate spirituality in their care during assessment add understanding to their unique spiritual needs. For Tanyi (2006) the process of spiritual assessment is an effective tool that allows family is to openly discuss their

spirituality. Table 6. 5 present topics and questions that may be asked to elicit spiritual history. Following the assessment nurses formulate appropriate intervention activities.

6.6.3.2 Spiritual interventions

The desired outcome for spiritual assessment is spiritual well-being. Because spirituality is very personal, each family must be treated with respect and appropriate intervention may vary from family to family even with families from same religious faith. Nurses must strive to be culturally sensitive in attending to families' spirituality. Table 6. 7 present guidelines to spiritual interventions.

Table 6. 6 Collection of spiritual data adapted from McEnvoy (2000, 2003) and Tanyi, (2006).

Topic	**Questions**
Belief system	What are the family's beliefs? What do these beliefs mean to their health Does the family belong to any religious or spiritual group? Is your child an active member of this group?
Ethic or values	Are there certain values that are important in your family? Which ones are important in raising your child?
Lifestyle	Does your family observe any dietary restrictions? Do you practice any rituals at meal times? Bedtime? Are your family prayers private?
Involvement in spiritual community	Is the family involved in community-based spiritual activities? If yes, which ones? Does the family consider anyone their spiritual leader? If necessary, can the spiritual leader be contacted to assist in spiritual care?
Education	Does your child/children attend a religious school? What do you want your child to know about your beliefs?

	How should we incorporate these beliefs into your child's health care?
Future events	Dietary restrictions Immunization Blood transfusion Death

Table 6. 7: Guidelines to spiritual interventions. Adapted from Narayanasmy (2004) and Tanyi (2006).

Item	**Nursing activity**	**Literature Control**
Spiritual support	Be available for family in a non-hurried manner Respect family's spiritual support and support their practices Provide privacy, comfort and reassurance	Presencing Connectedness Being there
Spiritual well-being	Support and encourage the family's use of spiritual resources Encourage spiritual growth by supporting, acknowledging and applaud peace and harmony.	Helping to connect Encourage spiritual growth
Spiritual distress	Determine the reasons Obtain consent to consult with a spiritual leader of their preference Display empathy, acceptance, kindness in a non-judgmental manner	Create an environment for whole care and healing Creating opportunities to seek meaning and purpose

6.6.4 Socio-cultural dimension of care

The socio-cultural dimension of care is very much interlinked to spirituality and separation of these dimensions in practice maybe difficult and unnecessary when providing holistic sensitive cultural care. Individual's child traditions and beliefs may be derived from their family's spirituality. Spirituality and culture provide directions for children and families with regard to daily practices. Certain ointments, artefacts and symbols may have a cultural significance.

Culture is the totality of socially transmitted knowledge of values, beliefs, norms and lifeway of a particular group guiding their conduct and thoughts. Health, illness and caring are embedded in a culture. Incoporating the culture to the planned caring activities allows the family to continue with family rituals that are significant for the family's well-being and spiritual support. For McEvoy(2003: 41) culture can provide a healthy construct for copiong wih illness. In paediatric nursing cultural assessment is often directed at the family member as the younger children are unable to comprehend and articualte the constructions of the beliefs and how they relate to health and illness.

6.6.4.1 Cultural assessmnet

Cultural assessment is designed to explore the cultural values, beliefs and practices of individuals and families. Culture, religion influence the worldview of the family about health, illness, pain, and suffering, life and death. Newborn babies in many cultures are considered vulnerable and many societies use a variety of ways to prevent the evil eye by using emulents, religious medals, herbs, spices, prayers and ointments (Bruce, 2002; Tjale & de Villiers, 2004; Potter & Perry, 2005). Restrictions as to how long the babies stay in the house after birth is culturally determined. It is important for the

nurses to acquire some operational knowledge of different cultures within the area of work. For some Muslim and Hindus, the colostrum is dirty and therefore breastfeeding maybe postponed until the normal milk appears (Potter & Perry, 2005:126). The dominat ethical values of automomy and self-determination with recognition of human rights places families in position to assume responsibility and make decisions that protect their loved ones when sick. Meaning of health, illness, death and grieving process are all cultural defined and some groups follow culturally defined ways of dealing with each of these aspects and value cultural interdependence during the times of suffering (Potter & Perry, 2005). Culture is very specific and differ from group to group. There are general guidelines that nurses can follow when assessing the patient in order to design individualised cultural specific interventions. Obtaining a rich socio-cultural family history reveals sensitivity and assist in developing individualised effective care plans. Table 6. 8 present guidelines to cultural assessment.

In summary, socio-cultural dimension of care is interlinked with spirituality and religion. Spirituality and or religion can be conceived as part of culture. Constructions of health and illness are linked to culture and religion. In cultural care, the individual nurse is recognised as a cultural being with beliefs and values based on specific culture. Holistic nursing care is culturally sensitive care that is congruent to the person's and or family beliefs and values. Cultural beliefs and values inform treatment to certain health problems and influence individual's openness to non-cultural scientific health interventions. Inclusion of culturally expected patterns of care to scientific models of care may result in conflict. The potential for conflict maybe reduced through acknowledgement of cultural differences, recognition of cultural

ethnocentricity and through individualised non-judgmental sensitive cultural specific care.

6.6.5 Conclusions statement on Dimensions of care

- Dimensions of care are specific to whole care. Aspects of nursing care interventions are designed to include physical, psychological, spiritual, social and cultural dimensions. Physical dimension of health care refers to the care activities designed to meet the diseased parts of the body. The focus of psychological interventions is to address the symptoms of fear and anxiety associated with resulting from the effect of the physical condition. Cultural beliefs and values include the care interventions that are incorporates cultural values and beliefs. Spiritual domain includes spiritual activities designed to improve spiritual well-being.

Table 6. 8 Cultural assessment guidelines adapted from Potter and Perry (2005: 130)

Cultural assessment guide	**Questions to parents**

Cultural identity	Where were you born? What is your ethnic backgraound? How long did your parents? Who lives with you?
Social organisation	Who do you consider your members of your family? Who makes decisions in your family?
Socio-economic status	What do you do for a living? If working who looks after your child when you are at work?
Bio-cultural issues and health	What caused your problem? Are there any members of the family with same problem? How do you treat this problem at home? Who do you go to for this problem? Are you treating the problem at the moment?
Language and communication	What langauge do you speak at home? What langauge are comfortable with? How should we address you? Can you read or write?
Religion and spirituality	What is your religion? Who is your spiritual leader? Do you want to be in touch with your spiritual leader? How do we contact with your spiritual leader? Are there sepcific dietary practices you follow? What are some of the things we need to do within your religion?
Previous experience with professional care	Did you have any problem in your past experience? What were some of the problems encountered? How were they resolved? What were the positive experiences you had?

6.7 DYNAMIC: NURSE-FAMILY RELATIONSHIP

The dynamic refers to the driving energy source of the activity holistic nursing care (Dickoff et al., 1968). Nurse-family relationships were interpreted as enabling, sharing information purposefully and nurturing environment The dynamic for holistic nursing care within paediatric nursing is referred to as the nurse-family relationship. To develop meaningful purposeful, goal directed professional relationships, the paediatric nurse must engage person child and family to promote interaction. This relationship is fundamentally reciprocal and considered important in promoting patient participation to care and it becomes a vehicle for exchange of information. The relationships are preceded by trust and an empowering rapport (Espezel & Canam, 2003; Shattell, 2004). Nurse-family relationships are viewed as being critical to health care and nursing contributing to whole person's health well-being, recovery and quality of decision-making. These relationships are interpreted as an interpersonal activity in which the nurse is able to see the person patient and the patient can see the person in the nurse (Dahlberg, 1996).

In literature nurse-family relationships are referred to as nurse-patitient relationships, nurse-parent relationships or interactions (Walsh, 1999; Williams, 2001; Espezel & Canam, 2003; Shattell, 2004; Millard, Hallet and Luker (2006). Attributes of nurse-patient/parent relationships include: professional closeness, intimacy, partnership, reciprocity, communication, and interactions (Walsh, 1999; Williams, 2001; Shattell, 2004). Quality of parent-nurse interactions is closely related to the quality of child's health care (Espezel & Canam, 2003). The historical view of nurse-family relationaships is that of detachment. Millard, Hallet and Luker (2006) trace the evolution of the nurse-patient relationship, in adult nursing, from the scientific view of the biomedical model with its emphasis on biological body that needs to be managed.

To a lager extent this view created an analogy that the body is a machine, with exchangeable parts that needs to be repaired through biological means (Kottow, 2001). This Cartesian influence of body perpetuated an awareness of the human body as an instrument, which is subject to the laws, flaws and repairs. This view of the body influenced nurses to detach themselves emotionally from the emotional aspects of their patients disregarding the mind, emotions and spirit needs of the patient (Millard, Hallet & Luker, 2006).

It was the introduction of nursing process and individualized patient care approach that focused nurses to personal relationships and a commitment to their patients necessitating a redefining of nurse-patient relationships characterized by closeness, commitment and involvement (Williams, 2001: 662).

Peplau (1988) conceptualised the theory of developing nurse-patient relationships within a social and psychological dimensions. She advocated a professional closeness between the patient and nurse. Critiques of Peplau's theory suggest that in advocating for professional closeness Peplau was promoting the use of empathy to facilitate appropriate nursing responses while at the same time recommending emotional detachment and distancing (Muetzel, 1988; Williams, 2001). Building on Peplau's theory of professional closeness Muetzel (1988) proposed a model of relationships characterised by reciprocity, intimacy and empowerment. Intimacy between the nurse and the patient as suggested by Muetzel (1988: 98) refers to closeness interpreted as 'being there' and present at physical, psychological and spiritual levels. Williams (2001: 662) interprets this model as emphasising a potential for connectedness and unity between the patient and the nurse. Mattiasson and Hemberg cited in Williams (2001: 662) suggest that intimacy forms the basis for potential contact and closeness

with another and may be perceived through the varied needs of the individual including the physical, psychological, social and spiritual needs of the patient.

6.7.1 Intimacy in nurse-family relationships at psychological level

In psychiatric, psychology and psychosocial nursing this concept of intimacy is referred to as therapeutic intimacy, it is preceded by 'self- disclosure of patient information with the expectation of understanding and acceptance" Kader in Williams (2001: 662). Providing intimate personal details between the nurse and the family requires an establishment of mutual trust and an enabling professional attitude as a precursor in creating supportive environment, with resultant willingness to disclose personal information. Tarlier (2004: 237) refers to this as responsive relationships based on use of self and exemplified by respect, trust and mutuality underpinned by personal morals, which are inherently relational and dependent on the individual's acknowledgement of human interdependence and interconnectedness. Respect is an essential quality in nurse-family relationships reflecting ethical concern. The ethical basis for respect in Browne's (1995) research included five characteristics of respect namely: trusting others as inherently worthy and equal, acceptance of other, willingness to listen to others, genuine attempts to understand another and the other's situation with sincerity. Tarlier (2004: 237) argues that these characteristics reflect personal moral knowledge and since respect is a moral value in nursing, as evidenced by inclusion of moral codes at all levels of nursing care, it then implies that there are inherent rights associated with respect within nurse-family relationships and the family has a right to expect respect. When a person child or family is denied their right, they have recourse to justice as enshrined in the Constitutional rights. Attached

to the concept of patient rights are the concepts of autonomy and fidelity. Autonomy refers to the internal will an individual exerts to decide to act in a moral manner and follow through decisions while fidelity refers to keeping promises and allowing others to have an expectation of one to meet those expectations (Paley, 2002: 135).

Appropriate engagement within nurse-family relationships has a facet of intersubjective negotiating, wherein these relationships the nurse engages with family from a perspective of own standpoint as a person and as a professional nurse, while at the same time acknowledging and engaging from a stand point of child as an advocate of care (Tarlier (2004: 239). Acknowledging and engaging reflect sympathising and empathising with another (Warnock, 1998) and compassion (Gyatso, 1999). In constructing responsive purposeful family elationships, the nurse creates a common space in which to engage with child/family despite differing worldviews.

6.7.2 Intimacy in nurse-family relationships within the physical dimension

Physical dimension of intimacy relates to bodily contact and touch. Physical contact and touch are central to caring, as nurses frequently touch their patients consciously and unconsciously in their interactions (Edvardsson, Sandman & Rasmussen, 2003) Touch is an integral part of nursing practice particularly in paediatric nursing and is associated with feelings of comfort, peace, calm and security (Hayes & Cox, 1999) and closeness (Edvardsson et al., 2003).

Sims in Routasalo (1999) describes touch according to purpose: instrumental, expressive, therapeutic and systematic**. Instrumental touch** relates to performance of treatment or procedure. **Expressive touch** refers to spontaneous touch aimed at

conveying feelings and thoughts to another demonstrating empathy, compassion and caring. Giving touch provides comfort and well-being and facilitates closeness and communication (Edvardsson et al., 2003). **Therapeutic touch** is associatd with laying of hands. It is associated with alternative healing methods and often used to assess and treat human energy systems, affecting physical, emotional, mental and spiritual well-being. The purpose of therapeutic touch is to heal a sick person by influencing that person's energy fields (Samarel, 1992; Ott & Mulloney, 1998; Routasalo, 1999: 844). Therapeutic touch is described as a natural potential that can easily be learned and was developed as a nursing intervention by Krieger and Kunz in 1973 (Otto & Mulloney, 1998) and advanced by Rodgers' theory of unitary human beings in which fields are considered the essential units of human beings (Marriner-Tomey, 1994; Hagamaster, 2000). It has its origin from the ancient practice of laying hands and is not necessarily linked to religious context or associated with faith or belief of the patient or practitioner. The distinction between physical and therapeutic touch are not necessarily visible in nursing literature. Physical touch can be therapeutic (Routasalo, 1999). The goal in physical touch is not to heal. **Systematic touch** is associated with massage. The various forms of touch are evident in nursing litarature and are used as interventions and not all forms of touch can be necessarily present in nurse-family interactions. The effects of touch on bio-physical mecahnisms are limited (Routasalo, 1999) but touch has comforting and calming effects (Samarel, 1992; Ott & Mulloney, 1998; Routasalo, 1999). Physical touch plays an important role in paediatric nursing. It is used to communicate affection, comforting, to perform tasks and nurturing. It promotes physical closeness. Negative effects of touch such as anger, rejection and control are discussed (Routasalo, 1999).

6.7.3 Intimacy within the social dimension

As mentioned before professional closeness at social level was conceptualised by Peplau (1969). This closeness enables the professional nurse to appreciate the patient from a person perspective. To initiate interactions the nurse starts the interaction at a professional level, the dialogue is empathic and yet distant (Williams, 2001). Interactions start from a general non-specific to a professional and personal level focusing on patient's condition and related nursing care. Debate on parent-inteaction in paediatric nursing stems from family-centred care. Earlier literature from Western countries like United Kingdom, America, Australia and Europe discusses family-centred care as parent-led. The nurse act as a consultant fostering open dialogue (Bruce & Irlarm, 2002).

Family- centred care is discussed and compared to what is happening in the context of this research.

6.7.4 Family-centred care

The term family-centred care encompasses the concept client as the child and their family. Family refers to two or more individuals who are interconnected and bonded emotionally, biologically, relationally and share a physical space. Family–centred care is the whole care that is designed to place the needs of the child, in the context of their family and community and at the centre of this care is an individualised care plan designed in collaboration between nurse and family to meet the child's needs

(MacKean, Thurston & Scott, 2005, Corlett & Twycross, 2006). Family-centred care emerged in the late 1960s from North American countries; in its early stages parent of children with chronic diseases and disabilities advocated the parent-led movement. These parents were advocating against the dominant expert model of care and wanted more involvement in their children's health and related care (MacKean, Thurston & Scott, 2005). Families of sick children at the time had to contend with restricted visiting hours and limited contact with children and their health care practitioners. The consequences for decision-making with restrictive parent-child contacts have a potential to lead towards professionally dominated care with serious psychological implication for the child. Majority of North American countries have now an open visiting policy and parents can stay with their children for 24 hour a day (MacKean, Thurston & Scott, 2005). Family-centred care is viewed in the literature as the best practice in child-health care settings. The following elements of family-centred care are gleaned and synthesised from the literature:

- Recognising the family as central to the child's life.
- Family as primary source of strength and support for the child
- Acknowledging the uniqueness and diversity of children and families
- Acknowledging that parent's bring personal knowledge and expertise care level and at institutional level.
- Family-centred care is competency enhancing.
- Encourages development of true collaborative relationships and partnerships with health care practitioners.
- Facilitate family to family support.

For effective family-centred care, guidelines are designed and reflected within instutional policies and philosophy of the children's unit. In these research settings,

family-centred care as understood from the literature is not practised. Parents of children are allowed to “room-in” especially for neonates and generally parents are allowed to stay with their sick children daily up to 19h00. Parents of bigger children, on special request, are allowed to stay overnight with their children. Parental relationships are mostly based on parent involvement since there is no formal contractual agreement between parent and institution on family-centred care. Parents are encouraged to get involved in the care of their children and many basic task such as bathing, feeding and comforting are delegated to parents with supervision. In many instances nurses maintain control and hold initiative in decision-making. Parental competence and the inability to understand the social context of health care environments limits their partcipation. Cahill (1996) suggests that parental involvement is a precursor of participation which in turn is a precursor of patrnership.

Literature is inundated with discussion on family-centred care and the inter-related concepts: partnerships, participation, collobaration, involvement, negotiation, parental presence and issues of power-relations are discussed. Parent-partnership is a reciprocal sharing and closeness between a parent and the nurse. Involvement is considered a one-way communication process as the parent’s voice is mostly ignored (Cahill, 1996). Parent-nurse interaction is discussed.

6.7.5 Parent-nurse interaction

Parent-nurse interactions bring elements of collaboration, partnership, involvement, negotiations and participation within the context of interactions in family-centered care. Unlike adult nursing where the patient is responsible for decision-making, in

parent-nurse relationships the parent is the one who makes the decisions on behalf of his/her child necessitating a collaborative relationship between the nurse and the parent.

6.7.5.1 Collaboration

Collaboration is working together as in project and is based on shared power and authority (Bruce,2003: 160). In paediatric nursing collaboration is the process of working together between the parent and the nurse on mutually agreed goals towards the outcome of health care. Collaboration is based on trust and respect leading to partnership and involvement, and is recognisable when the parent is considred a partner in the nurse-family relationship. It begins with the nurse recognises that the parent especially the mother, has instinctive maternal and private knowledge of his/her child while the nurse possesses professional knowledge and competencies necessary for meeting the needs of the child. Both professional and private knowledge are needed to care approprately for the child (Corlett & Twycross, 2006). It is this facilitative nurse-family relationship that opens the door for the parent to negotiate involvement within care. Role definition based on mutually agreed expectations leads to collaboration and participation. The factors that promote collaboration include establishing rapport, facilitative environment and meeting parental expectations of the nurse (Espezel & Canam, 2003).

6.7.5.2 Establishing rapport.

A degree of rapport between the nurse and the parent depends on meeting both the nurses' and parental expectations. The parent expects the nurse to demontrate a degree of professional knowledge about the child's condition and treating the child as a person whilst the nurse expects the parent to be willing to cooperate. An optimistic atmosphere in the health care environment with consistency of staff fosters a climate conducive to establishing rapport (Corlett & Twycross, 2006). Prolonged engagemnet between the parent and nurse allows the parents to know nurse at a personal level. Impersonal, cold environment is a barrier to collaboration and establishment of rapport (Espezel & Canam, 2003). Table 6.9 presents attributes of nurse-family relationship gleaned from literature.

Table. 6. 9 Attributes of nurse-family relationship

- Establishing rapport
- Meaningful purposeful goal directed communication
- Trust
- Interpersonal interaction
- Responsive relations
- Mutual respect

6.7.6 Intimacy in nurse-family relationships within the spiritual dimension

Spirituality is a dimension within every person Stoll in (Tanyi (2006) and is discovered in person to person relations. It begins with recognition that all persons are spiritual beings and the spirit is the thread that connects body and mind. Spirituality manifest within mundane basic care such as touching, listening, comforting, connecting and presencing. Acts of spiritual care begin with intentional awareness of others as spiritual beings. Spiritual care in Bush and Barr (1997) research required mutual knowing, nurses knowing of patient and family as persons and the patient and family's knowledge of nurse as a person. When the nurse and patient meet at a personal level, there is a connection that touches the core of who they trully are spiritually.

Edvardsson et al. (2003) conducted a phenomenological study to investigate meaning of touch with elderly patients. The results indicated that participants described this intimate touch as transcending the power relations connected with the role of being a professional and a patient, to a more valued relationship of persons. According to Walsh (1999) when a nurse encounters another, there is an immediate understanding that is not necessarily thought-through cognitive process, it is something that is grasped in the moment and based on recognition of the patient as living human being rather than an object. This basic understanding is linked to what it is to be human, if its allowed to surface beyond the distant empathetic professional realm, it brings out deeper understanding, with possibilities and genuine concern for the other. Walsh (1999) refers to this as shared humanity.

6.7.6.1 Connecting with person patient

Spiritual connecton begins with vertical connection with God, Super Being and horizontally via significant relationships with others. The spiritual connection maybe expressed through activities such as prayer, presence or physical touch. It is this connectedness that leads to deeper meaning of life. When a person intentionally connects with the other horizontally, spiritual outcomes are realised and power differentials are equalised. It is the moment where both the parent and the nurse become vulnerable resourcing spiritual help, which is beyond their comprehension and reinforcing their personhood and levelling plane field. Knowledge and professional power in the midst of no solutions becomes of no consequence and the power differentials are equalised as the nurse recognises his/her vulnerability and inadequacy and hands her professional power over for supernatural assistance from God/ Supreme Being/Life force. The influence of power to nurse-family relationship is discussed.

6.7.6.2 Power Relations

Professional power is well documented in literature (Williams, 2001; Kottow, 2001; Shattell, 2004; Millard, Hallet & Luker, 2006) and is a threat to effective nurse-family relationships. In assuming a sick role adult person voluntarily give up their power of independency to health professional nurses who are presumed to be knowledgeable. The social context of care is governed by unequal power that leads to diminshed autonomy. The negotiating power for the sick person is limited by the inability to negotiate the social context of care and the infamiliarity with hospital environments

and care routines. This leads to a dependency state with a potential for loss of autonomy and self-esteem.

In paediatric nursing the power relations differs from those of sick persons because of the presence of parent who is not necessarily sick and yet unable to articulate the sick role as experienced by the child but perhaps is vulnerable to the power relations because of the emotional problems associated with the sickness of their loved ones. The parent negotiates and participates in decision-making bringing about a dimension of parent-nurse relationship over and above the child (patient)–nurse relationship. Literature in this area has found that professional power can be flattenned through effective purposeful interaction (Espezel & Canam, 2003; Shattell, 2004). Recognition of the person as an individual accords the child/family the freedom to make independent choices based on their values and promote well-being.

The context of care has a potential to enhace or limit facilitation of purposeful family-nurse relationships. In this study the critical factor mentioned often that interferses with the dynamic of holistic nursing care is the impact of HIV and AIDS in these paediatric settings.

6.7.6.3 Impact of HIV and AIDS

HIV and AIDS is the single most disease that is changing the caring landscapes of nursing within research settings. Shisana, Hall and Maluleke (2003) confirm this assertion in their report on impact of HIV and AIDS on health system in South Africa. According to this report 46% of patients admitted to public hospital are HIV positive and stay longer (mean length of stay 13.7 days) than non-HIV patient (mean length of stay 8.2 days) The HIV and AIDS related burden of disease increases with

Tuberculosis (TB) Pneumonia, Malnutrition and other opportunistic infections being on the rise. The changing disease profile and increasing acuity levels place an additional burden and exert an impact on morale and job satisfaction. The emotional burden of caring for the presumably sick mother and child complicates the nurse-family relationships bringing a different perspective to psychosocial interactions between the nurse and the parent and child. Prolonged engagement with persons living with HIV and AIDS and providing extensive physical care affects the nurse physically, emotionally and spiritually. Marchal, De Brouwere and Kegels (2005) concur and report that high inpatient death rates in public hospitals combined with limited possibilities of effective care contribute to professional frustration, higher absenteeism, burnout and low staff morale. The constant threat of inevitable death and keeping 'night vigil' watching the children dying left the participants emotionally drained and physically exhausted. A major source of conflict was expressed as nurses helplessly watched the children die in some instances triggering an emotional turmoil as they try to reconcile the fundamental nursing value of preserving life espoused by a caring profession.

HIV and AIDS impacted negatively the dynamic of nurse-family relationship because the nurses were constantly tired, emotionally drained and stressed. Impact of HIV and AIDS on health professional's attitudes and their practice has been reported (Marchal, De Brouwere & Kegels, 2005). Participants in this study reported that occupational burnout is one of the factors affecting the quality of childcare and job satisfaction. Being constantly tired physically and emotionally and working in unfavourable conditions with inadequate supplies results in stress and frustration with resultant increasing absenteeism. Such emotionally charged environments has direct and

indirect consequences to parent/child-nurse relationships. The outcomes of continuous physical and emotional feelings of hopelessness and helplessness influence effectiveness and productivity manifesting as an attitude of insensitivity to others (Altun, 2002).

Burnout is an occupational stress reaction among service human professionals, resulting from the demanding and emotionally charged relationships between the nurse and the patients (Demerouti, Bakker, Nachreiner & Schafeli, 2000). It is a syndrome that is characterised by feelings of emotionally exhaustion, depersonalisation and reduced personal accomplishment.

Emotional exhaustion refers to energy depletion of emotional resources. Depersonalisation is the negative, cyclic attitude towards the recipients of one's service resulting in reduced personal accomplishment and is strongly related to disengagement and distancing attitude towards nursing tasks influencing both the environment and the person receiving care (Demerouti, et al., 2000). Attributes of emotional burnout gleaned from literature include: weariness, emotional exhaustion, depersonalisation, reduced accomplishment, feelings of insufficiency, stress, and disengagement (Maslach & Jackson, 1996; Demerouti, et al., 2000; Smit, 2005). Literature on burnout is consistent in associating workload as one of the stressors. In this study, high percentage of HIV and AIDS related admissions and the inability of the paediatric nurses' to influence care decisions when it comes to patients living with HIV and AIDS and the lack of facilitative processes to influence institutional policies related to resource allocation added more strain to the nurses. The inability to successfully advocate for the upholding of the rights of these patients in the face of perceived limited possibilities of effective care and inadequate resources were some of

the reasons mentioned as causing the mental and physical exhaustion. The results of this study are similar to finding described by Smit (2005) on a study conducted on perceptions of nurses on caring for people living with HIV and AIDS. In Smit's (2005) study participants mentioned helplessness, emotional stress, fatigue and fear. Fear was due to constant threat of accidental exposure and the infrequent availability of protective resources; this was not mentioned in this study. Participants in this study were more concerned with the deteriorating hospital infrastructure and the inability of management to meet their staffing needs, which impacts negatively to the therapeutic milieu. Quantitative studies conducted to investigate stress-producing activities among cancer care and HIV and AIDS care have found that nurses working with people living with HIV and AIDS have greater intensity of occupational burnout symptoms

(Gueritault-Chalvin et al., 2000).

Feelings of helplessness and hopelessness were described and interpreted in relation to "no cure" for HIV and AIDS positive and linked to the sense of futility in knowing that the patient will ultimately die from "this disease". This finding is consistent with what is reported in Smit's (2005) study. Inner feelings of guilt and inadequacy in the face of pain and suffering for both the HIV positive mother and child demanded the nurses to draw deeper from their inner resources in order to maintain their professional power and integrity. Sharing what they knew about the diseases was perhaps their way of confirming their position of power in the midst of what appears hopeless.

Nurses used prayer as the single most popular coping strategy. Nurse needed to connect and draw strength from God/ High Being in order to give of themselves emotionally to their patients.

In dealing with end of life care, spirituality and culture dimensions of care were found effective. Spirituality/religion and or culture were discussed as one of the aspects used to manage family emotions when faced with decision-making based on uncertainty and or being confronted with the inevitability of end of life. The care focuses on family belief and rituals. Performance of family rituals was encouraged. In end of life care the nurse transcend the physical realm to draw help for the child, herself, and family. The family was permitted to perform death rituals to promote well-being. Family decisions regarding life and death have been reported in nursing literature as based on family value systems or religious beliefs (Mckinley & Blackford, 2001; Lyon, Townsend-Akapan & Thompson2001).

In conclusion, HIV and AIDS impacts nurse-family relationship very negatively by drawing out of the nurses the inner resources that are necessary for the mantainance of effective purposelful, goal-directed therapeutic relationships. HIV and AIDS in these research settings is reponsible for the increasing workload with resultant high mortality rates leading to emotional burnout. Feelings of frustrations, helplessnes and hopelessness related to “no cure”, inadequate human and material resources, depreciating facilities and the inability to influence decision-making with respect to distribution of resouces contributed negatively to personal well-being of the nurses. Prolonged egengement with pain and suffering and contant threat of death coupled with the inability to assist the parent and child led the nurses to distance themselves emotionally from care. This process of disengaging impacts negatively to nurse-

family relationships and has negative consequnces to quality of care particularly at the end of life. When the nurse perceived the inadeqaucy of medical treatment as in “no cure”, the nurse would bring the spiritual and cultural dimensions of care to effect. Spirituality was used to resource hope for the parent and child. For the nurse, connecting with God/Supreme Being/Life force was their source of strength and hope. Vertical connection with the God/Supreme Being/Life force for strength and hope enabled the nurses to give, encouragement and connect with family horizontally.

The general benefits of spirituality gleaned from a variety of literature and adapted from McEnvoy (2002 & 2003), Narayanasamy et al.(2004) and Tanyi (2006) include: a decrease in stress, assist in mantianing normalcy and cohesion in the midst of crisis, expidite positive adjustment to a loss of a family member and help foster a deeper meaning and purpose. Spiritual rituals such as prayer provide comfort, unity and can help provide hope and meaning (McEnvoy, 2002 & 2003; Narayanasamy et al., 2004, Tanyi, 2006).

The impact of HIV and AIDS and the connection with the spiritual dimension is conceptualislised in Figure 6.2.

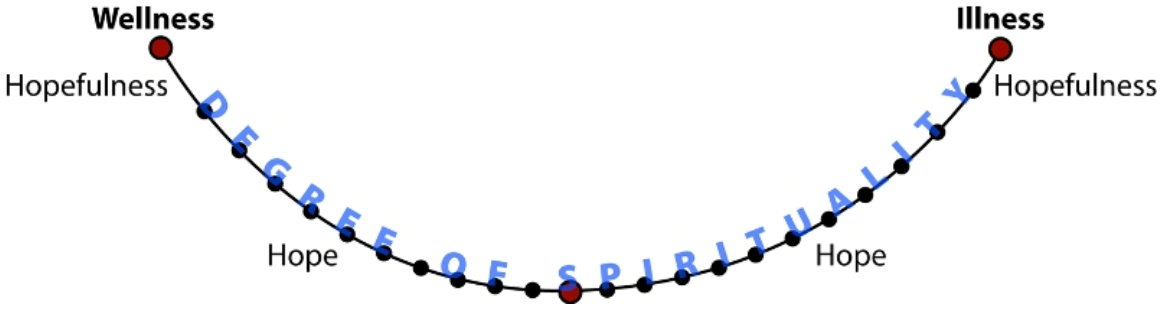


Figure 6.2 Degree of spirituality and hope

In summary, nurse-family relationship is a process of developing meaningful purposeful and goal-directed professional relationships. It is preceded by mutual trust and respect and is fundamentally reciprocal. In constructing responsive purposeful relationships with family, the nurse creates a loving common space in which to engage with child and family despite differing worldviews. The nurse and child/family engages in intimate professional relationship exhibiting genuine concern for each other as persons.

The environment for effective therapeutic nurse-family relationships is enabling and facilitative aimed at the expectations of both nurse and the family in relation to meeting the health outcomes of the child. The nurse recognises parent as central to the child's life and a primary source of strength and support for the child. Power differential are equalised by recognising that parents bring personal knowledge and expertise to the environment and their input to care decisions are equally important for the well-being of the child. Stressful, emotionally charged environment with limited resources negatively affects the creation of therapeutic nurse-family relationships.

6.7.7 Conclusion statements on the Dynamic

In conceptualising the dynamic nurse-family relationship in holistic nursing care, the following statements are deduced:

- Nurse-family relationship is goal-directed aimed at the provision of whole care, using all the dimensions of care and lovingly planned to provide family-centred, person-centred care.
- Nurse-family relationship is the professional intimate closeness that is characterised by mutual respect of each other's personhood.
- Purposeful communication and nurturing environment enhances the quality of nurse-parent/child relationships based on trust, building of good rapport, sincere engaging and connecting as persons.
- Partnership and collaboration between the parent and nurse normalises the power differentials within child care environments.
- Effective, enabling, nurturing family relationships become the bedrock for good quality interactions necessary for promotion of effective quality care.

Conceptualisation of the dynamic is presented in Figure 6.3.

Table 6. 10 Summary of nurse-family relationships

Intimacy in nurse-patient relationships within physical dimension	Intimate touch, bodily contact, performance of treatment, closeness
Intimacy in nurse-patient relationships within the psychological dimension	Self-diclosure, mutual trust, enabling attitude, willingness to sha information, responsive relations, respect, mutuality, engaging
Intimacy in nurse-patient relationships within social dimension	Partnerships, participation, collobbaration, negotiation, parental presence a issues of power-relations based on equality. The foundation for effecti relationship between the nurse and the parent is trust, mutual respect a empowering relationships
Intimacy in nurse-patient relationships within spiritual dimension	Recognition of patient as person, shared humanity, touching, listenir coforting, presencing, genuine concern, connecting

In the following duscussion the development of the conceptual framework is briefly outlined.

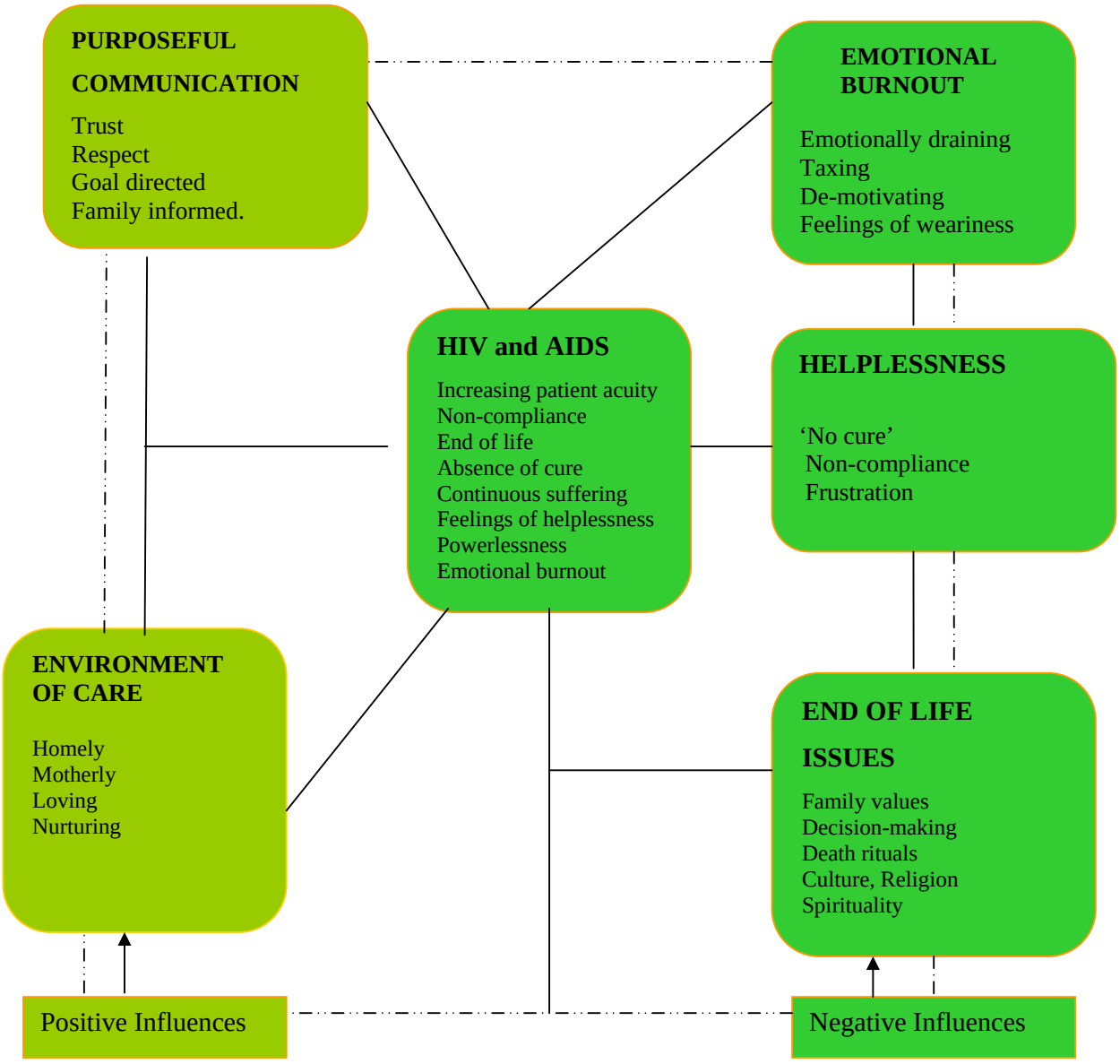


Figure 6.3 Conceptualisation of the dynamic

6.8 HOLISTIC NURSING CARE: CONCEPTUAL FRAMEWORK

The conceptual framework is inferred and synthesised from the deductive processes described at the beginning of this chapter and outlined in Table 6.1. The process of refining and validating the conceptual framework is described below.

The fundamental assumption for developing a conceptual framework for holistic nursing care was based on the absence of guiding definitions and frameworks from the regulating professional body of nursing in South Africa. I entered this process with openness, as there was no other theoretical framework that was used as a point of departure. The background reading for the development of the framework that helped to shape my thoughts followed and adapted the process advocated by Chinn and Kramer (1991), Burns & Grove (2001) and Meleis (2005). The structure of the framework is explained below.

6.8.1 Structure of the framework

The conceptual framework is presented and graphically depicted from within a child care environment. The environment is not limited to a hospital ward. The child could be in theatre, out patient department or any health place where children are cared for. The structural format presents two circles joined together with broken lines. The first circle depicts the paediatric nurse, who plans and directs the care towards the second circle representing the child nestled within the family. The lines are not solid depicting the harmonious relationship between the various components of the framework. The nurse is responsible for developing facilitative therapeutic nurse-

family relationships to provide the goal of holistic nursing care; whole care, integrating all dimensions of care to provide family-centred, person-centred care.

The shaded yellow background depicts the energy field of spirituality. In this study spirituality appears to be the key connecting force and a key component that is visible in all the different aspect of the framework. Spiritual awareness and transformative nature of the individual transcendental connectedness with self, God, life force or Higher being creates a potential for healing. The horizontal and vertical nature of spiritual relationships is depicted at the top and the bottom of the framework. This is consistent with the findings of the study where some families have been observed communicating downwardly to the spirit of the dead and others upwardly with God or Higher being.

6.8.2 Evaluation of the conceptual framework

The purpose of evaluating the conceptual framework relates to the objective: to validate and refine the conceptual framework of holistic nursing care. The conceptual framework was subjected for expert evaluation according to the criteria presented by Chinn and Kramer (1991: 128-139). A purposive sample of nine evaluators was chosen based on the diversity of expertise in research, model development, maternal and child health and spirituality. Four of the evaluators had completed their doctoral studies, three were nurses experienced in child and maternal health and their expertise and contribution to the nursing profession are well recognised within the body of nursing, government structures as well as the professional regulating bodies and one evaluator was included because of her expertise in nursing and spirituality and one is involved in spiritual counselling. Evaluators were requested to critique the conceptual

framework using the guide provided as appendix N. The questions that guided the evaluators included:

- Clarity of conceptual framework, which refers to the understandability, consistency of presentation with respect to semantic clarity, consistency and structural clarity.

- Degree of complexity; referring to the differentiation of concepts and relationships and function of the framework and analysis of whether the framework serves to describe, explain and predict.

- The generality of the framework, which refers to the scope of concepts and purpose within the paediatric nursing discipline.

- Importance of the framework; the extent to which the framework has potential to add value to nursing goals in paediatric practice, research and education.

6.8.3 Feedback from evaluators

Evaluators were purposively selected and required to critique and comment on various structural and graphic representation of the framework using the guidelines described above.

6.8.3.1 Clarity

Clarity of the conceptual framework refers to the evaluator's ability to understand the graphic presentation consistently in conjunction with supportive text. Five of the evaluators commented on semantic clarity and agreed that the framework was clear and understandable. With reference to the structural clarity, three of the evaluators commented on the relationships of the lines representing whole care, dimensions of care and nurses-family relationship. Two of the evaluators suggested that the solid arrow representing whole care should be removed and the broken lines needed explanation. The textual explanation that was submitted with evaluation tools apparently did not provide sufficient explanation for these evaluators. One evaluator suggested that whole care should be reflected as holistic nursing care; this suggestion however, was not implemented since whole care is the main theme in this research. Two evaluators commented on the representation of spirituality and suggested that spirituality should be limited to two sides of the framework. Based on the comments, minor adjustments have been effected on the framework. Two copies of the conceptual framework are presented: the initial copy circulated to evaluators and the copy with changes (pages 234a & 234 b).

6.8.3.2 Potential for practice

All evaluators supported the importance of the framework for paediatric nursing. One evaluator commented that the framework could be readily used in teaching both basic and post-basic paediatric nursing students. The essential components of holistic nursing care are applicable in child care environments with a potential to influence paediatric nursing education and research. The framework reinforces the practical application of family-centred care and person-centred care and articulates well with the ideals of holistic nursing care in clinical practice.

6.8.4 Personal comment on the framework

The conceptual framework was developed through data collected from emic perspectives of paediatric nurses within academic hospitals in Johannesburg. The context of holistic nursing care is discipline and contextually based. However, the framework may be used as a guide in paediatric nursing. The framework may be introduced at undergraduate teaching of child and family nursing care and in specialists' paediatric nurse education. Recognition of the human being as a whole person with mind-body-spirit dimension is not restricted to a child or family. Therefore the framework is presented as a fundamental structure that can be used generally to all intervention activities in relation to human–human interactions. Its use maybe broadened to any therapeutic environments. The framework may be tested in adult nursing in variety of settings in health care. Its application can be tested as a basis for human resource managerial decision-making with respect to how the person is constructed contextually and culturally. There is a potential to expand and transfer certain elements of the framework to other discipline beyond nursing: in doctor-

patient relationships, manager-employee relationships, and person-to-person interactions.

6.8.5 CONCLUSION

The purpose of this chapter was to describe and develop the conceptual framework for the study in order to meet phase two objectives. Concepts from chapters four and five were identified and systematically classified into categories; agent, recipient, context, goal, procedure and dynamic. Each of these categories were discussed and situated to the current body of literature. Conclusive statements were drawn and deduced to serve as the building block for the conceptual framework. The description of the conceptual framework is provided and each concept defined and explained. Implications for operationalisation in nursing practice are outlined.

In the following chapter the summary of the study, evaluation and limitations of the study are presented. Recommendations are offered in relation to paediatric nursing practice, education and nursing research.

CHAPTER SEVEN

EVALUATION OF STUDY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

7.1 INTRODUCTION

In the previous chapter, the conceptual framework for holistic nursing care was presented. This chapter evaluates the study and outlines the limitations of the study. Recommendations are offered for the paediatric nursing, education and for research.

7.2 EVALUATION OF THE STUDY

As I contemplate the end of this study I am overwhelmed by a sense of gratitude and inner joy at the very thought of the word summary. Conceptualisation of the study began as an idea that triggered intellectual processes that culminated into a journey that has changed my life. As I began to reflect on the study and evaluate the main aspects, I intend to journey together with the reader from the beginning of this study highlighting the main process that enabled the achievement of the study objectives.

The purpose of this research was to examine the meaning of holistic nursing care and develop a framework for holistic nursing care, which can be utilised in nurse education settings and in clinical nursing practice in the context of paediatric nursing in academic hospitals. To achieve this aim, qualitative methodological perspectives were employed based on careful selection of the population, sampling, collection and analysis of data and trustworthiness. A philosophical inquiry was employed using Rodgers' evolutionary method of concept analysis. To enable the accomplishment of

the purpose, the study objectives were formulated into two phases. Objective one enabled the identification of the characteristics of the concept holistic nursing care through concept analysis and by obtaining the emic viewpoints of the paediatric nurses working in academic hospitals. As the study is contextual and interpretive examining meaning, chapter two presented the macro and micro context with respect to the current discourse in the transformation of health care and the co-existence of traditional health system with biomedical health care system. The methodological processes and research design employed were described in chapter three.

In chapter four, the process of concept analysis reinforced the wholeness of the person with mind-body-spirit dimension. Attributes of holistic nursing yielded two dimensions; whole person and mind-body-spirit dimension. The decriptors of whole person include physical, mental, emotional, spirit and spitual being. Characteristics of mind-body-spirit included physical, psychological, spiritual and socio-cultural dimensions integrated and in a harmonious relationships. Spirituality is the predominant antecedent. Holistic nursing care is initiated by the recognition of the individual, in need of health care, as a spiritual being with mind-body-spirit dimension. Spirituaity is an ever-present force pervading all huamn experience. It is a search for a transcedent relationship with God, supernatural being or life force. Descriptors of spirituality included search for meaning, hope and healing, peace and harmony. Consequnces of holistic nursing care in relation to child care revealed an outcome of person-centred care, cultural sentive care that ultimatley contribute to the spiritual well-being of the individual. Complimentary alternative medicine was identified as a surrogate term. The connection of CAM with holistic nursing care is the focus of therapetic interventions that are directed to the mind-body-spirit domain.

The emphasis is on health rather than curing and preventative therapeutic interventions are desingned to meet the needs of the whole-person. Caution is advocated in the use of CAM therapies in child nursing, as CAM efficacy has not been sufficiently investigated in child health care. Two model cases were constructed.

In chapter five, the phenomenological approach to interviewing the paediatric nurses was used to collect lived experiences on how the concept of holistic nursing care is constructed and applied in practice. Interviews were conducted, recorded, and transcribed. Recruitment of participants followed the ethical considerations explained in chapter three. The interview transcripts were analysed using Giorgio's data analysis method. Themes and sub-themes that emerged were described in detailed supported with excerpts from transcribed interviews and situated in nursing literature. Five major themes and fourteen sub-themes emerged from the data. Through a process of deductive reasoning, conclusive statements were drawn, which were later used to systematically develop the conceptual framework for holistic nursing care.

Phase two objectives facilitated the development of a conceptual framework in chapter six. The process of developing the conceptual framework followed the concept classification advocated by Dickoff et al. (1968). The concluding statements from chapters four and five were deductively analysed and the relational statements were classified and numerically formatted before incorporation to the conceptual framework.

In chapter one, I alluded to the absence of conceptual framework in these research settings that guide the teaching and application of holistic nursing ideals in paediatric

nursing. This conceptual framework is constructed and presented as one of the final outcomes of this study to guide paediatric nursing education and clinical practice. A panel of nine experts evaluated the framework. Based on the evaluators' critique and comments, the framework was refined. Recommendations for paediatric nursing practice were offered and suggestions for operationalising the different components of the framework were proposed.

7.3 LIMITATIONS

This research was conducted in three academic hospitals and does not include the views and practices of the paediatric nurses working in private hospitals within the same province. Results will have meaning for similar context and can be generalized. This study is contextual; interviews were conducted in Johannesburg, in the Gauteng province of South Africa. The information is contextual and applied to paediatric nurses within public academic hospitals within a specific culture. The methodological and theoretical perspectives and research designs including the macro and micro context of the study are provided for audit trail to enable transferability to similar context.

In reviewing South African-based literature, no studies were found that explored the meaning of holistic nursing or its application in child nursing or nursing in general. Holistic nursing care as a construct appears frequently in different nursing literature and its application to nursing is advocated.

The paucity of research literature directed the concept analysis to nursing studies conducted in other countries. This reinforced the rationale for the method of data collection, which enriched the process of developing the conceptual framework with

respect to how the concept is contextually constructed and applied in child and family nursing.

The conceptual framework has been developed primarily from data collected from paediatric nurses. The paediatric nurse in partnership with family directs the provision of whole care. The role of the paediatric nurse in constructing the healing environment is crucial through enabling nurse-family relationships. Application of the components of the conceptual framework to other contexts may need to be tested.

7.4. RECOMMENDATIONS

In light of the research findings, limitations and the following recommendations are formulated for paediatric nursing practice, education, and research.

7.4.1 Implications for paediatric nursing practice

This study provides certain implications for paediatric nursing practice. Most importantly, the current knowledge about holistic nursing care, its attributes, antecedents, consequences and related concepts and recommendations are provided for incorporation in child nursing practice. Up until now, the paediatric nurses in these research settings have had to rely on current body of literature on studies conducted from other countries to understand the concept holistic nursing care. Culture is very specific and contextually driven. Incorporation of constructs developed from other cultural perspectives may be difficult to implement without subjecting such constructs to research for contextual relevance. The significance of holistic nursing care for the provision of cultural sensitive nursing care is explained.

Hospitalisation of a child brings about fear, concerns and disruption of family lives. The child is removed from familiar environments and in hospital the child is subjected to painful procedures, mutilation, and exposure to strangers. The effect of hospitalisation is associated with fear. When a child is admitted, the unity of family becomes disrupted. Wholeness of family includes the unity of the family and the wholeness of the individual person within the family; mind-body-spirit. The child exists within a family or within an environment that acts as a family unit and is influenced by the contextually based socio-cultural dimension that will ultimately shape the child thought patterns and behaviours. The child is incomplete without the protective covering of the family. In hospital the family becomes central to the care of the child and own the right to control decision-making. Families bring along their cultural values and beliefs about health and illness and how these influence their responses to the caring behaviours and decisions regarding medical interventions. The family is recognised as bringing certain expertise to the caring environment. Their personal values and beliefs are respected even when they differ with medical and nursing values.

Accepting differing family values requires a mind shift that will challenge individual prejudices about culture, health and healing. Traditional healing boundaries based on Western value system are being questioned in light of the existence of other patterns of healing that are acceptable and practiced by different cultures. The resurgence of spirituality and related complementary medicine and the association with healing is well documented in nursing literature and is consumer-driven.

Spiritual discourse about healing and hope presents other sources of healing that are not necessarily included in the current paediatric-nursing curriculum. The subjective experience of sickness for family members brings about spiritual questions about life and meaning that require appreciation with a non-judgmental attitude.

Paediatric nurses do not necessarily have to share family values, however, they do need to be sensitive to family values by providing cultural competent health care.

Perhaps paediatric nurses may look to clarify and judge their personal values as to what extent are they obstructive or facilitative in reinforcing the personhood of child and family members.

The rhetoric about holistic nursing care symbolises a change in the reconstructions of the boundaries of nursing and the realities of the impact of holism and bio-psychosocial models to the detriment of wholeness and well-being. Health care is technical and highly commercialised. Medicine is fragmented into super-specialisation focusing on particular body parts and organs. The nursing profession in general has embraced super-specialisation. The difference between medicine and nursing is that nurses spend 24 hours in the company of sick or afflicted children and their families advocating for whole-person caring, embracing the creation of a healing environment where the needs of the person can be met. Establishment of a trusting, enabling and nurturing environment that honours personhood facilitates healing where questions about meaning can be contemplated. Facilitation of optimal healing includes attention to health care needs, facilitation, adaptation, restoring functioning and attending to the wholeness of the person child.

The biomedical approach of care with its focus on curing has influenced paediatric nurses to think of health in terms of disease that need to be cured without fully acknowledging the realities of what it is to be a human being. Emphasis is healing in holistic nursing care. Healing will emerge when paediatric nurses commit to honouring the wholeness of self and others appreciating and valuing what it means to be a person.

Inclusion of the whole care and person-centred care to paediatric nursing would create a healing work environment by adopting a relationship-centred whole care that is nurturing and enabling. The nurse-family relationships are transcending and rewarding healing both nurse and the family.

The paediatric nurse accepts the surrogate relationship and lead the team by incorporating wholeness in all aspects of child and family care relationships.

The inclusion of spirituality to paediatric practice nursing brings an element of inner healing for both the nurse and the family. The healing comes from interconnectedness. Harmonious connectedness refers to the loving relationship to self, others and God (Newlin et al., 2002). Participants in this study expressed spirituality and belief in the healing power of God through prayer. Prayer was therefore used as means to connect the child, family, and nurse with self, others and God or higher being especially when it was perceived that the bio-medical approach to care is unable to cure. Expressions of spirituality are recognisable in religion and in culture.

Prayers were used by participants in relation to end of life issues especially when they perceived that medical science is unable to provide for the cure. Prayers were said

upwardly to God, Super being or life force or downwardly in relation to speaking with the dead or ancestors as reflected in the collection of the spirit of the dead person.

In the absence of cure participants sought God for assistance, peace, and meaning in the midst of suffering. Spirituality is connected to faith and hope. Hope in God's ability to bring healing was demonstrated in instances when death was inevitable, family members were encouraged to pray and not to loose hope.

Perhaps the greatest impediment to the autonomy of the paediatric nurses to apply holistic nursing care is the pragmatism of the healthcare system. The emphasis on physical task-oriented care over holistic nursing care remains one of the challenges to achieving the professional ideals of holistic nursing care for families. Using the proposed conceptual framework, I argue for the inclusion of the various elements of the framework at every level of health care delivery from planning to evaluate the intended outcomes. I fully recognize and appreciate the current discourse with respect to multi-skilling, cost containment, efficiency, and accountability in health care delivery. I argue that the will to change begins with recognition that the influence of the Cartesian shift and the Western values has robbed children and family members of this land the dignity to be recognized and acknowledged as a person when admitted to hospital.

The inability to transform the health care system by integrating the Ubuntu principles to the established Western values of health delivery within health care environments have robbed and de-valued the person into multiple organs that need fixing. The ideal is to be "culturally correct". I want to propose that it is possible to shift our thought

patterns from the emphasis of patient care to person-centred/ family-centred care by including the principle of wholeness to produce discourses that reaffirms the uniqueness of the individual. I do not foresee a conflict in reconciling managerial objectives and the inclusion of bio-psycho-social-spiritual and culturally dimensions to health care outcomes since all activities are designed to meet the health care need of the person who embodies these dimensions. If truly patient satisfaction is one of the outcomes of health care delivery then care that is family-centred and person-centred should be construed as the way to go.

7.4.2 Nursing education

Nursing education should provide direction and incorporate evidence-based findings and use conceptual frameworks and models to transform curriculum to include teaching whole-person care; it should influence the linguistic ontology from “patient” and “curing” to include constructions of personhood and healing the totality of the human being. This might require an introduction of diverse teaching strategies with emphasis on values clarification, reflection, and personal journaling and communication skills such as listening and understanding culturally acceptable ways of communication.

Inclusion and integration of indigenous philosophies and principles of Ubuntu in the nursing curriculum will facilitate sensitive, non-judgmental communication at clinical practice. Case studies may be introduced at level one (first year) to compare cultural constructions of health and illness, which will form the basis of the individualised care plans at the clinical interface.

The interdisciplinary nature of the contributors to whole care teaching brings in a diversity of specialties that will influence and expose students to a variety of ideas about healing and how to create a healing environment in child and family nursing environments. Emphasis to the multi-dimensional nature of personhood will allow the integration of dimension of whole care to the individualized care plans.

Teaching interpersonal skills and integrating strategies on how to advocate for the child when family values conflict with medical values may prepare the nurse with skills necessary for clinical nursing practice. In transforming the teaching environment from primarily focusing on the individual as a bio-psychosocial being will re-orientate the student to conceptualise the patient as a person. Emphasis on a spiritual being will elevate the students' understanding of the individual as mind-body-spirit being and reinforce the uniqueness of each person, ultimately translating this knowledge to accepting each individual as human being.

It is recommended that the components of this framework may be tested for applicability in nursing in general. Perhaps the SANC as the sole provider for the educational framework of nursing education in this country may adopt this framework in line with their philosophy of nursing to articulate with their intended goal of providing holistic nursing care for the people of this nation. Adoption of the framework may require a shift from the current "patient-centred care" to "person-centred care". It is recommended that the SANC should design guidelines for holistic nursing care in this country and the framework is presented as the fundamental structure that can be utilised as a reference point once subjected to further testing.

7.4.3 Nursing research

Paediatric nursing research on families needs to have a theoretical foundation that is recognizable to the majority beliefs and the values of the families reflecting the uniqueness of setting and this could be later tied to nursing's body of knowledge. The proposed conceptual framework will need further evaluation once implemented for clarity, impact, and applicability. Collaborative multi-disciplinary research can be undertaken to provide ethnographic studies that incorporates spirituality into care.

Explorative studies can be conducted to find out the determinants of parents' satisfaction with respect to cultural sensitive congruent care and quality of communication skills in nurse-family relationships.

7.5 CONCLUSIONS

In this chapter a brief overview of the study is outlined. The study is evaluated, limitations of the study are outlined and recommendations are presented for paediatric nursing, education, and paediatric nursing research. In the summary, I argue for the inclusion of holistic nursing to all levels of child and family nursing.

This study is contextual in nature. The results confirm the current discourse in nursing literature with respect to person-centred, family-centred care as opposed to patient-centred care. The emphasis is on recognition of the need to transform current linguistic ontology from patient care towards the provision of whole-person care. Participants' interpreted holistic nursing care as whole care directed towards a unique and complex human being. The dynamic, which is the driving force for the

achievement of whole care, is established through enabling goal-directed nurse-family relationships. The conceptual framework is presented depicting different components explained above. One of the key finding is the prominence of spirituality and the inclusion of spirituality in different aspects of child nursing. The dependency of individual nurses to spiritual sources for personal strength and support was recognised and acknowledged. Family–centred, person-centred care is the outcome of whole care. Knowledge of disease, person and "know how" are necessary for the acomplishment of ethically, safe person-centred whole care.

As I reach the destination, the journey has been long and sometimes lonely perhaps if this work and the conceptual framework achieve to stimulate discussion no matter how small, it will be all, worthwhile.

Reflecting on my personal journal, the words of Henry Ford describes the subjective emotions at this very moment.

"One of the greatest discoveries a man [*woman]* makes,
one of his [*her*] great surprises,
is to find he [*she*] can do
what he [*she]* was afraid
he [*she]* couldn't do."
Henry Ford
[Italics mine]

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