A Transtheoretical Evolution of Caring Science within Complex Systems

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Abstract

This article illustrates the transtheoretical evolution of caring science within complex systems from the discovery of the theory of bureaucratic caring, in 1981, to the emergence of the metatheory relational caring complexity in 2011. The theory of bureaucratic caring, derived from research, is the sentinel grounded theory in the area of caring and economics, and complex healthcare systems in general. Its tenets remain applicable to contemporary nursing practice. Other grounded theories advanced from the original theory, including struggling to find a balance, the paradox between caring and economics, relational complexity, and relational self-organization in workforce redevelopment, as well as professional and patient relational caring questionnaires are presented and discussed.

Key Words: Theory of bureaucratic caring, caring, economics, losing trust, relational caring complexity, struggling to find a balance, professional and patient relational caring questionnaires

Introduction

Caring science focuses on the study of the dynamic relationship of caring (loving kindness) and healing within complex physical, ecological, sociocultural, and organizational environments (Davidson, Ray, & Turkel, 2011; Ray, 2010a, b, c). Emerging within this complex integral human-environment relationship is ethical, spiritual, and societal understanding. Modern science began with Einstein’s discovery of the theory of relativity, followed by quantum mechanics, which sought the unity of mind and matter revealing a physical reality that is holistic. Transformed in the 1970s by the “science of change” or the realization of deterministic chaos (the discovery of order in a chaotic world) and self-organizing behavior, complexity theory emerged and was firmly established in the 1980s and 1990s. Complexity theory, or now complexity sciences, revealed that the earth is like a “living organism.” Everything in the universe is interconnected and relational. These networks of relationship, or patterns, of energy and relational self-organizing phenomena show that the slightest change in the properties of the components or in their rules of interaction can produce quite unpredicted behavior, known as the emergent properties of complex systems (Goodwin, 2003; Peat, 2002; Ray & Turkel, 2011; Tudge, 2003). Given the advancement of the state of nursing as a relational caring science and art within the integral human-environment relationship, the union of nursing and complexity science is a natural combination (Davidson, Ray, & Turkel, 2011; Newman, Smith, Dexheimer-Pharris, & Jones, 1978; Rogers, 1970). Together they are the science of quality—a symphony of mutual continuous change and transformation first established within Rogers’ (1970) (Madrid & Barrett, 1994) conceptual system of the science of unitary human beings. Watson’s (1979, 1985, 2008) transpersonal caring theory, Leininger’s (1991) (Leininger & McFarland, 2006) theory of culture care diversity and universality, and Ray’s (1981, 1984, 1989, 2010b) (Davidson, Ray, & Turkel, 2011) theory of bureaucratic caring. These theories and others that emerged continually inform the practice of caring in professional nursing to promote healing and harmony of body, mind, and spirit and strengthen the work life of nurses.

The purpose of this paper is to illuminate the evolution of caring science within complex healthcare systems, principally hospitals. The paper will highlight the transtheoretical evolution of a specific caring theory followed by subsequent theories within organizational caring science. Transtheorizing in this presentation reflects the relevance of theory to practice and practice to theory through caring research in practice. The transtheoretical evolution begins first with Ray’s theory of bureaucratic caring (the integration of humanistic spiritual-ethical caring and organizational foci—the political, legal, technological, and economic systems), second with Turkel’s, struggling to find a balance: The paradox between caring and economics (the study of caring within an economic context), third with relational complexity: Cocreating the future (the evolution and cocreative process of the self-organizing patterns of the nurse, patient, and administrator), and finally with the emergence of relational self-organization in workplace redevelopment (ethical choice-making within the challenges of organizational complexity and nursing practice issues) (Coffman, 2010; Davidson, Ray, & Turkel, 2011; Ray, 1981, 1984, 1989, 1998, 2001, 2010a, b, c; Ray & Turkel, 2004, 2011; Ray, Turkel, & Marino, 2002; Turkel, 1997, 2001, 2007; Turkel & Ray, 2000, 2001, 2004, 2009).
Transtheoretical Evolution: Definition and Perspective

The concept of transtheorizing is coming of age in nursing (Alligood & Marriner Tomey, 2010; Parker & Smith, 2010). Theory is viewed primarily as conceptualization of some aspect of reality that pertains to nursing for a systematic, rigorous, and purposeful end (Parker & Smith, 2010). Transtheorizing can be defined broadly as the systematic emergence of new theories or an integrated theory by means of research or analysis from the study of the underlying structure of one or more theories in nursing science or other scientific theories. Theories in nursing are either grand theories resulting from the nature and goals of nursing and healthcare, such as, theories of Nightingale, Leininger, and Watson (Alligood & Marriner Tomey, 2010; Watson, 1979, 1985, 2008), middle range theories resulting from research in nursing situations, such as, Smith and Liehr (2009); grounded theories resulting from research in nursing practice, such as, theories of Ray (1981) and Turkel (1997) and Turkel and Ray (2000, 2001); and micro theories devised from research and reflection on practice experience in nursing situations (Parker & Smith, 2010). Ray (2006) (Ray & Turkel, 2010) also presented the notion of holographic theory (the whole in the part and the part in the whole), wherein a grand or universal humanistic and ethical concept, such as caring is synthesized with sociocultural/organizational concepts generated in complex organizational systems.

Transtheoretical development in nursing and caring science was identified in the discourse of Watson and Smith (2002), wherein Watson’s transpersonal caring theory and Rogers’ science of unitary human beings were compared and contrasted. The authors concluded that a creative synthesis of the uniting of two grand theories invites further inquiry into ethical-ontological and epistemological scholarship to influence knowledge and practice in an ever-changing world. As a result of this transtheorizing analysis and systematic study of the underlying structures of the two nursing theories, a metatheory of unitary caring science was advanced. Transtheorizing, thus, facilitates change and demonstrates value in the advancement of nursing science.

Evolution of Caring Science within Complex Systems

Ray (1981, 1984, 1989, 2006, 2010a, b, c; Coffman, 2010; Ray & Turkel, 2008, 2009, 2010; Ray, Turkel, & Cohn, 2011; Turkel, 1997, 2007) proposed the theory of bureaucratic caring in 1981. The original grounded theory demonstrated how the organizational context (the bureaucracy) played a major role in the meaning structure of caring, facilitating the emergence of both substantive and formal theories: Differential caring and a synthesis, bureaucratic caring, respectively. As such, caring is a whole, yet is a part of the complexity of the organization of the hospital. The substantive theory, differential caring (Ray, 1984) identified that within each unit in the hospital, there were dominant caring characteristics or patterns based upon the system itself and the illumination of the meaning within. For example, in the intensive care unit, technological caring was the dominant caring characteristic and economic caring was an administrative or system phenomenon. The theory of bureaucratic caring, symbolizing the dynamic structure of caring, emerged from a Hegelian philosophical perspective—a synthesis of the dialectic between the thesis of caring as sociocultural, ethical, educational, and spiritual/religious (elements of humanism and spirituality) in relation to the antithesis of caring—the bureaucracy, as political, legal, technological, and economic. Through the analytic process of the negation of both as separate entities, the theory of bureaucratic caring was synthesized as the formal theory (Figure 1). Caring interactions and symbolic

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**Figure 1.** Original theory of bureaucratic caring (1981).

Note: a, b Note that the political and economic structures each occupy a larger dimension to illustrate their increasing influence on the nature of institutional caring.
systems of meaning were constructed from the dominant values in the human and the complex organizational system. The theory reveals that nursing in organizational practice is experiential, contextual, and structural—caring is influenced by the social structure of the organization, especially the technological, legal, political, and economic. Note that in Ray’s (1981) original Theoretical Model (Figure 1) the political and economic dimensions are shown as larger than the other dimensions that continue to be part of the reality of nursing and administrative caring practice today.

Moving toward understanding the complexity of the system in this theory prompted additional research and a recreation of the model. The bureaucratic caring theory, as a holographic theory, is based upon the new science of complexity—the interconnectedness of all things. It reveals that the implicit order (the whole) and the explicit order (the part) represent the interconnectedness of caring as spiritual and ethical patterning in relation to the patterning of the social structure of the organization. As a “holon,” everything is a whole in one context and a part in another—each part being in the whole and the whole being in the part (Figure 2). The spiritual and ethical dimensions now represented as spiritual/ethical caring were based on new research. As such, they became the center of this interconnectedness and the center of

*Figure 2. Transtheoretical evolution of caring science within complex systems.*
the model (Ray, 2006; Turkel & Ray, 2000; 2001, 2004; Ray, Turkel, & Marino, 2002). The whole of caring is the spiritual/ethical, the sociocultural, educational, physical, and the dimensions of the bureaucracy are the political, legal, technological, and economic. Each is a whole and a part. The outermost open circles represent the between the macro-culture of the society and healthcare system and the micro-culture of the hospital.

A fuller understanding of how caring and business science within the culture of the hospital, particularly economics and politics, impact nursing, administration, and patient caring evolved. A theoretical position by Ray (1987a, b) and research by Turkel (1997), and further research by Turkel and Ray (2000, 2001, 2002) on caring within an economic context and organizational political context was conducted. This research facilitated the transtheoretical emergence of the theory of struggling to find a balance: The paradox between caring and economics (Turkel, 1997); relational complexity theory: Cocreating the future (Turkel & Ray, 2000, 2001); and relational self-organization in workforce redevelopment theory (Ray & Turkel in Ray, Turkel, & Marino, 2002).

**Transtheorizing of Bureaucratic Caring Theory to a Metatheory of Nursing, Caring, and Complexity in Healthcare Organizations**

*Struggling to Find A Balance: The Paradox Between Caring and Economics*

Turkel (1997, 2001) conducted grounded theory research to study the nurse-patient relationship within the context of economics. The research was informed by Ray’s theory of bureaucratic caring and Watson’s theory of human caring. Two theories were discovered, a substantive theory identified as diminishing healthcare resources and the formal theory of struggling to find a balance: The paradox between caring and economics (Figure 3).

The study focused on the nurse-patient relationship within a framework of benefit-cost parameters from the perspective of nurses, patients, and administrators. Registered nurse (RN) and patient themes emerged.

Three distinct RN themes (categories) emerged. The theme of RNs entering into the relationship included the sub-themes of establishing trust, creating the nurse-patient relationship, and maintaining the nurse patient-relationship. The theme of RNs practicing caring included the sub-themes of being, knowing and doing all at once, caring in the moment, caring beyond, and investing in patient education. The theme of RNs entering a new reality included sub-themes of managing in the presence of chaos, contending with costs, valuing the humanistic interaction, and fearing for patient’s well-being.

Patient themes included being in the relationship, interpreting caring, and feeling threatened by the new reality (reality controlled by costs). Sub-themes for being in the relationship included developing trust in the nurses, recognizing the nurse-patient relationship, and having the nurse there for me. Interpreting caring included sub-themes of distinguishing between caring and non-caring, caring making a difference, and valuing the educational process. Feeling threatened by the new reality included sub-themes of surviving in the presence of chaos, deserving to be cared for despite the costs, and fearing for themselves.

![Figure 3. Struggling to find a balance: The paradox between caring and economics.](image-url)
Administrator themes included viewing the nurse-patient relationship, judging caring and non-caring, recognizing the chaos, and profiting in the new reality. Subthemes for viewing the nurse-patient relationship included entering into the relationships and having a vested interest in the nurse patient relationship. Judging caring and non-caring included the subthemes of defining caring and defining non-caring. Sub themes for recognizing the chaos included wondering how they do it, knowing the nurses are on call to everyone, and giving the nurses credit. Profiting in the new reality was characterized by the sub-themes of accounting for the costs, accounting for the caring, valuing registered nurses, and positioning for future survival.

The concepts of caring and economics are not mutually exclusive within the healthcare system. Each influences and informs the other. As illustrated in the model, RNs valued caring over economics when making decisions, but also understood the need to understand economics. According to one nurse, “Having a caring presence and knowing my patient as a person, is important…costs are what the “suits” [administrators or managers] worry about.” Patients only value the caring when it comes to decisions about healthcare. One patient was very vocal when the word cost was mentioned, “Costs should not matter…healthcare and caring are rights and money should not matter.” Administrators valued economics over caring when making decisions, but still valued caring interactions. As one administrator stated, “Caring increases customer satisfaction, which is good for return business and we don’t want our patients to be treated like a widget but more as a person…but the reality for me is reimbursement, less dollars from Medicare and Medicaid.” Caring reflects quality and healing and occurs in the interrelationship between nurse and patient. Although caring and economics may seem paradoxical, contemporary healthcare concerns emphasize the importance of understanding caring and quality in terms of traditional and non-traditional economic outcomes.

**Theory of Relational Complexity: Cocreating the Future**

The theory of relational complexity: Cocreating the future illuminates the self-organizing relationship between the nurse, patient, and administrator within complex healthcare organizations (Turkel & Ray, 2000).

In Figure 4, the model of the theory of relational complexity is a result of a grounded theory study of nurses, patients, and administrators in for-profit, not-for-profit, and military hospitals. The Theoretical Model illuminates complex categories of meaning and is an illustration of relational self-organizing relationships among the nurses, patients, and administrators. It shows that together a
The theory of relational complexity: Cocreating the future highlighted that the nurse, patient, and administrator value caring, “…values are resources that propel all technical and economic systems” (Turkel & Ray, 2000, p. 312), a first step in organizational caring. When caring resources, as well as traditional economic resources of goods, money, and services, are interwoven within the context of caring practice, nurses, patients, and administrators move toward a deeper understanding of the meaning of relational self-organization. As an explanation, patterns of relational self-organization within the economics of caring in healthcare highlight the fact that an economic theory must be not only the exchange of goods, money, and services (traditional economics), but must also be the acknowledgement of the value of interpersonal resources, such as love/caring ethics. Interesting, this was an original view from the father of capitalism, Adam Smith, in his first book, *The Theory of Moral Sentiments*, published in 1759/1976). Moral sentiment, or love and ethical caring, first characterized by Smith hundreds of years ago, was probably considered too difficult to measure in national or organizational economies. Moral sentiments became a hidden variable in terms of valuation. It was not until 1971 when the theorist, Foa, incorporated the idea of interpersonal resources, such as love, information, and status, in relation to traditional economic exchange phenomena of goods, money, and service (Ray, 1987b).

The theory of bureaucratic caring illuminated the notion of economic caring. The theories of bureaucratic caring, struggling to find a balance between caring and economics, and relational complexity illustrate what Foa articulated, as well as the contemporary economist, Eisler (2007). She named, “the real wealth of nations” as caring economics. Eisler (2007) noted in her book, “it pays to care—in dollars and cents” (pp. 47-68). Nurses have always known that successful outcomes are not just merely traditional economic exchange phenomena, but also relational caring exchange phenomena (Turkel & Ray, 2000, 2001).

Relational Self-Organization in Workforce Redevelopment: The Dynamic and Transformative Process for Nursing Caring Science

The theory of relational self-organization in workforce redevelopment emerged from continued research, including instrument development and theory testing in for profit, not-for-profit, public, and military hospitals (Figure 5).

The model represents the universality of categories of meaning from the qualitative and quantitative research conducted in these hospitals. The reality of the hospital cultures showed that overall, the management focus was economic survival. Work life for nurses in hospitals was associated and continues to be associated with issues of the “bottom line” or economics and finance. The Theoretical Model illustrates that losing trust was the substantive theory and the formal theory was relational self-organization. Losing trust in relation to economic survival cocreated disillusionment in practice and subsequently decreased loyalty to hospitals in terms of nursing practice. When trust was broken, caring and healing could not occur and, consequently, nursing practice issues emerged. The call for attention to the nursing practice issues was clear in this research. The turning point for transformation of organizational relationships and organizations themselves that emerged was an ethical caring choice point. This interpretation facilitated a process—a movement within the context of dialogue from disorder to order or transformation. The research revealed that categories of meaning first dealt with the “ill-health of nurses and the organizations” followed by discourse that illuminated a desire for healing or “relational self-organization.” The transformation only could emerge by attention to ethical choice from mutual dialogue. Nurses stated that rebuilding trust would come forth by respecting the nursing staff, communicating with the nursing staff, maintaining visibility of administrators, and promoting engagement in participative decision making.
During the process of evolution of the grounded theory from a synthesis of all qualitative data of the categories of meaning of relational caring within a complex economic context, tool (questionnaires) development with psychometric analysis was realized (Turkel & Ray, 2001). Two final reliable and valid questionnaires, a Professional Relational Caring Questionnaire (Appendix A) with 26 items based upon three subscales of caring: Administrative culture, professional ethics, and trust, and a Patient Relational Caring Questionnaire (Appendix B) with 15 items based upon subscales of professional ethics, trust, and caring emerged (Ray & Turkel, 2009, Watson Caring Science Institute, 2011). Between 2002 and 2004, the two final professional and patient questionnaires were distributed to RNs, patients, and administrators in five hospitals. The overall mean scores on the questionnaires were then compared to economic and patient outcome data collected by hospitals. These findings validated what RNs verbalized in the qualitative research, “Living the caring values in everyday practice makes a difference in nursing practice and patient outcomes” (Ray & Turkel, 2009, p. 218).

Mapping the future of work redesign and workforce redevelopment is a relational caring complexity science. Complexity science emphasizes the interconnectedness of all things. Organizational patterns in healthcare delivery are complex and, ultimately, evolve toward self-organization from chaos (disorder and order) through ethical choice within networks of relationship. Ethics is rooted in relationships not just principles. The ethical choice point toward relational self-organization in this theory revolves around ethical caring relationships. Beginning with trust or the surrender of our lives to each other is a commitment to one another. This surrender is the key to understanding all serious moral problems and positions. Healthcare systems are living organizations just like nature is a living organism. In the redevelopment of the work life for nurses, a shared work life can only come through genuine ethical caring. In summary, the theory of relational self-organization in workforce redevelopment emerged from a transtheorizing process from the original theory of bureaucratic caring. By integrating a caring consciousness into organizational life, “transforming nursing through ethical choice and the relational [caring] strategies established in this research will build constructive human relationships and cocreate and facilitate [relational] self-organization in a continuously changing healthcare work environment” (Ray, Turkel, & Marino, 2002, p. 13).

Relevance of Research to Contemporary Nursing: The Advancement of Caring Science within Complex Organizations

With the emergence of the American Nurses Credentialing Center (ANCC) Magnet Recognition Program (Magnet), nursing theory has moved from its central place in academia and research to practice. Theory-guided practice advances the discipline of nursing and transforms practice. Contemporary nursing practice positioned within the tenets of caring science focuses on creating caring-healing environments for nurses, patients, and families. Ray and Turkel (2009) view caring in healthcare organizations as a complex relational caring process within the economic context of quality, cost, and outcomes.

The original theory of bureaucratic caring remains applicable to professional nursing practice. Research revealed that the economic and political dimensions of caring were dominant in 1981 and remain so today (Figure 1). In 2011, nurses continue...
to be faced with choices relevant to the economics of practice in terms of human and physical resources. The political healthcare debate in the United States is centered within the financial context. Issues regarding “is healthcare a right for all?” and, if yes, “who will pay?” are at the forefront of discussion. Although technology was identified in 1981, it was not as dominant as it is today, but it is increasing in importance. The advent of information technology, electronic health records, and computers at the bedside (Campling, Ray, & Lopez-Devine, 2011; Swinderman, 2011), and even robotics or the human-humanoid revolution (Locsin, Purnell, Tanioka, & Osaka, 2011), are fueling the fire. Leadership in nursing administration is a key element in nursing practice and central to the theory of bureaucratic caring. The five components of the ANCC Magnet Model include factors that are crucial to the health of healthcare organizations, such as transformational leadership, structural empowerment, exemplary professional nursing practice, new knowledge and innovations, and empirical outcomes (ANCC, 2008). The theory of bureaucratic caring can be integrated into each of these components (Ray & Turkel, 2010).

In addition, Turkel (1992, 2003) conducted a phenomenological study looking at the meaning of caring as experienced by nurse managers during interactions with staff nurses. Almost 20 years later, the interpretive themes of nurses’ way of being, reciprocal caring, and caring moment as transcendence define leadership practices grounded in caring science. Two direct quotes, “It is frustrating being trapped in a bureaucracy that values money instead of caring,” and “sometimes I find it so frustrating—I do battle in the name of caring every day” describe practice environments where tenets of caring science do not inform the practice and philosophy of leaders in the organization. A growing body of literature advances the value of nurse-manager caring behaviors in terms of RN satisfaction, becoming a caring stateperson with the intent to create caring-healing practice environments (Longo, 2009; Ray, 1997; Uhrenfeldt & Hall, 2007; Watson, 2006, 2008).

The theory of struggling to find a balance: The paradox between caring and economics refers to sustaining the caring ideal in a healthcare reality controlled by costs (Turkel, 1997, 2001). In 1997, the cost was related to a managed care environment where reimbursement was constrained. Today, administrators are faced with reduced reimbursement from Medicare, Medicaid, and private insurance. Currently, as in 1997, nurses value caring, yet continue to practice in environments where economics and costs influence decisions. It remains a paradox that nurses have less time and resources to provide patient education and as patients have less information to guide future healthcare decisions the readmission rate is higher. Although current pay for performance initiatives have resulted in the non-reimbursement to hospitals for the cost of care associated with the readmissions (National Quality Forum, 2010), the reality is that often RNs need to advocate for the required time, and human and physical resources to do effective patient education.

Qualitative research conducted by Turkel (1997) revealed that both patients and RNs valued patient education or patient teaching as a caring behavior or caring practice. An outcome of this caring behavior was enhancement of learning when the teaching was done by a caring nurse. Patient participants talked about being able to ask questions and wanting to learn when they had a caring nurse. They believed they “could remember better” with a caring nurse. In terms of economic outcomes, caring makes a difference. If patients are re-admitted within 30 days after discharge with the same diagnosis because they do not understand how to care for themselves, the hospital will not be reimbursed. Thus, recidivism is costly to patients and hospitals—costly to patients in terms of increased time required for healing and recovery and costly to hospitals administrators who will not be reimbursed for treatment.

Relational complexity: Cocreating the future informs us that nurses must be able to articulate the economics of healthcare and nursing practice in terms of patient quality and outcomes. Furthermore, nurses must collaborate with leaders to influence economic decision-making within complex organizations. Professional models of care that focus on increasing the quality and intentionality of interactions among the healthcare team will promote positive outcomes for patients and employees. Practicing from a caring science framework in complex organizations provides a unifying structure that guides choice-making and allows for creative solutions to emerge. As D’Alfonso reminded us:

Leaders at all levels of the healthcare organization must awaken to new ways of leading lasting change, remaining continually aware of and seeking to balance the fiscal and often dehumanizing aspects of the healthcare business debate with the ethical-moral demands to care for the whole person (bodymindspirit) who remains central to our “raison d’être.” (2011, p. 186)

The substantive theory of relational complexity: Cocreating the future was losing trust. This idea of losing trust guided a recent leadership practice approach articulated by Kingston (2011) when the trust between nursing administration and nursing staff was broken. The situation causing the loss of trust was an extremely complex issue. But clearly the negative energy impacted everyone, including the patients. A healing process grounded in a caring science professional practice model was initiated. Practice changes included the following: Open forums for dialogue to occur between leadership and staff, increased visibility and presence of leaders on all shifts and weekends, restructuring of shared governance processes to foster open communication, an intentional focus on nursing leadership creating a caring-healing environment, and practicing
authentic presence and listening when interacting with staff.

Conclusion
The Past is the Future: The Metatheory of Relational Caring Complexity as a Foundation to Support New Ideas for Nursing

Factors from the past history of nursing cocreate opportunities to further the maturation of the notion of transtheorizing for nursing. Grounded theories, such as, struggling to find a balance: The paradox between caring and economics, relational complexity: Cocreating the future; relational self-organization in workforce redevelopment, and the Professional and Patient Relational Caring Questionnaires that emerged from the original grounded theory of bureaucratic caring show the value of transtheoretical analysis. A metatheory (Ritzer, 1991) has emerged from the integration of all these theories. The metatheory is Relational Caring Complexity and it evokes the complexity of the nursing practice situation today and provides a foundation for new ideas for nursing (Davidson, Ray, & Turkel, 2011; Kingston & Turkel, 2011; Ray, Turkel, & Cohn, 2011). Transtheorizing and metatheorizing address the past history of caring as the essence of nursing and the critical nature of the context, environment, or organization toward a human-environment unity in nurse caring practice. Far-reaching ideas, or concepts of the past, illuminate the future related to patterns of wholeness. In this analysis, the authors discover that what may be considered new is new again as a result of the past, which, to a large extent, has not been fully brought to light.

For example, let us look at the idea of the past is the future, new overarching theoretical perspectives, such as what occurred with caring science from 1978 to the present with the development of the International Association for Human Caring, the advance in the 1990s of caring in the human health experience as the foundation of the discipline of nursing (Newman, Sime & Corcoran-Perry, 1990), and the concept of relationship with caring and unitary science illuminated as the state of the science in the late 2000s (Newman et al., 2008). Within these views are important phenomena, such as the essential nature of relationship and caring science, the art of nursing as caring, unitary science and the sciences of complexity, the importance of economics and politics in the practice of nursing, and how caring knowledge changes healthcare practice and outcomes organizations. As the delivery of healthcare moves from the medical model focusing on tasks, procedures, objectivity, and prescriptive routines to focusing on caritas, which is centered on ethical values, caring science, and human and organizational relationships, a new way of practice emerges (Watson, 2008). As an example, theory that was once invisible has become visible as evidenced through the caritas movement” of the Watson Caring Science Institute (Davidson, Ray, & Turkel, 2011). In practice, Ray, Turkel, Watson, and Eisler have advanced the idea of caring economics by challenging us to change the conversation toward the valuation of caring resources and, thus, caring needs to be incorporated into all organizational discourse. What creates opportunities for financial success, now and in the future, is the way in which people actually care. In the past, bureaucracies used to be hierarchically dominated. Now they must be hierarchies of actualization with effective leadership, caring, and the reinvention of work (Davidson, Ray, & Turkel, 2011; Eisler, 2007; Fox, 1994; Turkel & Ray, 2004). Economic policy development must become a part of the nursing curriculum and organizational culture. Caring needs to be valued, role modeled, and integrated within the realm of administrative practice.

The focus on healthcare economics is not a transient response to decreasing reimbursement. Instead it remains the catalyst for change at the national level within healthcare organizations and healthcare financing and decision making. M. Brooks Turkel, then a hospital administrator, made the connection between healthcare economics and caring in 1993. Drawing on the work of the caring science of Sister M. Simone Roach (1987/2002), healthcare economics can be understood with another group of Cs other than Roach’s six Cs of commitment, conscience, compassion, confidence, competence, and comportment. Turkel’s (1993) six Cs are: Complicated, counterintuitive, convoluted, confusing, chaotic, and complex. An example of the counterintuitive is occurring in today’s healthcare environment. Reimbursement to healthcare organizations is no longer driven by volume and procedures (quantity), rather it is driven by new regulations that focus on value in terms of patient satisfaction and patient safety, including some central concepts of caring. This means hospitals can actually do or produce less and realize higher profit margins.

By continually giving voice to the value of caring in nursing within complex organizations, ethical caring transformation will occur. The Professional and Patient Relational Caring Questionnaires (Ray & Turkel, 2009) generated from this research trajectory on caring within an economic context provide continued opportunities for learning about caring in complex organizations. Other ideas emerging from complexity and nursing caring science, such as patterns of energy (Madrid & Barrett, 1994; Smith, 2011); patterns of relationship between macro and micro cultures, socio-organizational theory, and transcultural caring (Davidson, Ray, & Turkel, 2011; Ray, 1981; Ray, 2010a); transdisciplinary, translational analysis, and global theories (Leininger & McFarland, 2006); and high imagining and/or low imagining in cultures (replacing notions like developed or developing in world cultures) (Friedman & Mandelbaum, 2011) will influence the way healthcare will evolve. Furthermore, transdisciplinary emergence to formulate new theories or relational interprofessional education and communication (Eggenberger,
personal communication) and continuous meta-methods and meta-analysis of nursing, caring science, and other disciplines (Beck, in press) will be important phenomena for contemplation and further study. The movement toward a transtheoretical position in nursing emphasizes the need for continual inquiry—how researchers and theorists seek understanding of theoretical integration and creative synthesis by advancing new theories (and questionnaires) from the discovery of one theory, such as what is featured in this article. Seeking understanding of the transtheorizing process and metatheorizing is the beginning of a transformative process for the enlightenment of nursing education and practice as we grow and develop in the 21st century.

References
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APPENDIX A

Relational Caring Questionnaire©
(Professional Form)

Introduction:

Nursing is important to health care in the United States. This questionnaire is designed to assist nursing and health care organizations/hospitals to understand the important components of organizational caring. Your completion of this questionnaire implies consent to participate in this study. Assisting in this research will not in any way affect your status as a professional in this hospital or any health care facility.

This is strictly voluntary. Do not write your name on this questionnaire.

Demographic Information:

Directions:

Mark an “X” in the box or add the information requested which applies to you.

1. Gender: Female □ Male □
2. Highest Completed Education
   □ Associate Degree
   □ BS (Non-Nursing)
   □ BSN
   □ MS/MA/MBA (Non-Nursing)
   □ MS (Nursing)
   □ Doctoral Degree

3. Age:
   □ 21 – 25
   □ 26 – 35
   □ 36 – 45
   □ 46 – 55
   □ 56 – 65
   □ 66 – 70
   □ Over 70

4. Cultural Background: Black or African American □
   Hispanic or Latino American □
   White or Caucasian American □
   Asian American □
   North American Indian □
   Other (Specify) □ (________________)

5. Job Status: Administrator (Non-Nurse) □
   Administrator (Nurse) □
   Registered Nurse □

6. Years of Nursing and/or Administrative Experience:

   Under 2 □ 2 – 5 □ 6 – 10 □ 11 – 15 □
   16 – 20 □ 21 – 25 □ 26 – 30 □ Over 30 □
Questionnaire Directions and Example

Background:

Caring is important within health care organizations. Your responses to the statements on the following questionnaire will help identify and give researchers the opportunity to analyze your answers regarding factors important to the concept of organizational caring.

Directions:

Please answer the 26 numbered statements. Using a pen or pencil, mark an X in the area that represents your response. Mark only one area for each question. If your answer is that you Agree with the statement, then you would mark an X in the (4) for the statement as shown below.

Example:

Nurses are treated with respect by other professionals in the organization. This frequently happens within the organization where I work.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree Nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</table>

1. Nurses are valued as individuals. This frequently happens within the organization where I work.

2. Nurses are treated with respect by other professionals. This frequently happens within the organization where I work.

3. Nurses are able to live their caring values in practice. This frequently happens within the organization where I work.
4. Nurses are involved in policy decisions that affect patient care. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |

5. We see administrators making rounds and helping out when needed. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |

6. The focus of administrators is working on the budget and attending meetings. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |

7. Nurses receive effective communication from administrators, which means we know exactly what is going on and why decisions are made. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |

8. Nurses are counted only as numbers. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |

9. Nurses are trusted by administrators. This frequently happens within the organization where I work.

| Strongly Agree | Agree | Neither Agree | Disagree | Strongly Disagree | Disagree | (1) | (2) | (3) | (4) | (5) |
10. Nurses treat each patient as an individual. This frequently happens within the organization where I work.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree</th>
<th>Agree</th>
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11. Being there with the patient is part of nursing practice. This frequently happens within the organization where I work.

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<th>Strongly Disagree</th>
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<th>Agree</th>
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12. Nurses recognize the needs of the family. This frequently happens within the organization where I work.

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<th>Strongly Disagree</th>
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13. Nurses integrate awareness of the patient’s body, mind, and spirit in their practice. This frequently happens within the organization where I work.

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14. Listening is a way nurses build relationships with patients. This frequently happens within the organization where I work.

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15. Administrators providing support for what nurses do increases the loyalty of nurses. This frequently happens within the organization where I work.

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16. Administrators empower nurses to make changes in the organization. This frequently happens within the organization where I work.

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17. Nurses demonstrate compassion for what the patient is experiencing. This frequently happens within the organization where I work.

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18. Nurses are committed to the nursing profession. This frequently happens within the organization where I work.

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19. Nurses are viewed as organizational overhead rather than organizational assets. This frequently happens within the organization where I work.

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20. Support from administrators results in increased nurse retention. This frequently happens within the organization where I work.

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21. Administrators recognize the value of nursing. This frequently happens within the organization where I work.

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22. Awareness of the value of nursing facilitates the choices that administrators make when allocating the budget. This frequently happens within the organization where I work.

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23. The integration of interpersonal resources (caring, patient education, professional nursing practice) with traditional economic resources (money, goods, services), is included in the budget. This frequently happens within the organization where I work.

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24. The relational partnership between practicing nurses and administrators guides economic choice making in the organization. This frequently happens within the organization where I work.

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25. Nurses have financial knowledge to participate in organizational decision making. This frequently happens within the organization where I work.

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26. A supportive relationship between the nurses and the administrators results in improved economic and patient outcomes. This frequently happens within the organization where I work.

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<th>Strongly Disagree</th>
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APPENDIX B

Relational Caring Questionnaire©
(Patient Form)

Introduction

Nursing is important to health care in the United States. This questionnaire is designed to assist nursing and health care organizations/hospitals to understand the important components of organizational caring.

Your completion of this questionnaire implies consent to participate in this study. Assisting in this research will not in any way affect your status as a patient in the hospital or any health care facility.

This is strictly voluntary. Do not write your name on this questionnaire.

Demographic Information:

Directions:

Mark an X in the box or add the information requested which applies to you

1. Gender: Female □ Male □

2. Highest Completed Education:

□ Less than High School □ High School/GED □
□ Associate Degree □ Bachelors Degree □
□ Masters Degree □ Doctoral Degree □

3. Age: 18 – 25 □

26 – 35 □
36 – 45 □
46 – 55 □
56 – 65 □
66 – 70 □
Over 70 □

4. Cultural Background: Black or African American □ Hispanic or Latino American □ White or Caucasian American □ Asian American □
North American Indian □ Other (Specify) □

5. Number of Times Hospitalized as a Patient:

□ 1 – 5 □ 6 – 10 □ More than 10 □

6. Length of Stay This Admission:

□ 1 – 3 Days □ 4 – 6 Days □ 7 – 10 Days □ Over 10 Days □
QUESTIONNAIRE DIRECTIONS AND EXAMPLE

Directions:

Caring is important within health care organizations. Your responses to each statement on the following survey will help identify behaviors that are important for caring between the registered nurse and patient in a health care organization.

Example:

Using a pen or pencil, mark an X in the area that best describes your understanding of caring in terms of your interactions with registered nurses in this hospital. Mark only one area for each question. If your answer is that you Agree with the statement, then you would mark an X in the (4) for the statement as shown below. A sample of the completed question is provided below as an example:

1. I am treated with respect. This frequently happens when I am a patient in this hospital.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree Nor Disagree</th>
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Do not write your name on this questionnaire.

1. I am treated with respect. This happens when I am a patient in this hospital.

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2. I am given care based on what is important to me. This happens when I am a patient in this hospital.

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<th>Strongly Disagree</th>
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<th>Agree</th>
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3. I take an active part in my own health care decisions. This happens when I am a patient in this hospital.

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<tr>
<th>Strongly Disagree</th>
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4. Knowing the nurse knows what to do for me builds my trust in the nurse. This happens when I am a patient in this hospital.

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5. The nurses treat me as a person instead of an illness. This happens when I am a patient in this hospital.

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<th>Strongly Disagree</th>
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<th>Neither Agree</th>
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6. Interacting with the nursing staff fosters trust between the nurse and me. This happens when I am a patient in this hospital.

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7. Personal interactions (for example, eye contact or touch) help me trust my nurse. This happens when I am a patient in this hospital.

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<tr>
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8. Nurses being there with me is a part of showing that they care. This happens when I am a patient in this hospital.

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9. Nurses’ teaching helps to prevent me getting sick again and having to come back to the hospital. This happens when I am a patient in this hospital.

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<th>Strongly Disagree</th>
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10. When the nurse is concerned about me, I learn more from his/her teaching. This happens when I am a patient in this hospital.

    | Strongly Disagree | Disagree | Neither Agree | Nor Disagree | Agree | Strongly Agree |
    |-------------------|---------|---------------|-------------|-------|---------------|
    | (1)               | (2)     | (3)           | (4)         | (5)   |
11. Nurses being good at doing treatments or procedures, such as: starting IVs or changing a dressing requires compassion and skill. This happens when I am a patient in this hospital.

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<th>Strongly Disagree</th>
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12. Nurses’ teaching prepares me to take care of myself at home. This happens when I am a patient in this hospital.

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13. Nurses recognize the needs of my family when giving me care. This happens when I am a patient in this hospital.

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14. Nurses listening to me is a part of showing that they care. This happens when I am a patient in this hospital.

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15. The nurse shows compassion for what I am experiencing as a patient. This happens when I am a patient in this hospital.

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