

This paper explores the topic of bearing witness as it relates to presence, ethics, the nurse-patient relationship, and healing in nursing practice. Reviewing nursing literature and the constituents of moral-ethical nursing practice, this paper highlights the importance of bearing witness for healing as well as the potential negative effect that not bearing witness has on the nurse-patient relationship. Bearing witness is described as a nursing intervention necessary to a caring nursing practice that promotes healing.

*Keywords:* bearing witness, nursing, presence, ethics, nursing presence, caring

### An Exploration of the Concepts of Bearing Witness as a Constituent of Caring Practice

Bearing witness is an important nursing concept—in fact a nursing intervention—that is currently gaining more recognition. This concept is a moral-ethical obligations for a caring practice of nursing. By shifting from a strictly clinical, physical focused practice to the offering of emotional, psychological, and spiritual support, bearing witness creates an environment more conducive to healing. In order to truly uphold ethics in nursing, bearing witness is a necessary intervention for nurses to practice daily with each patient encountered.

#### **Presence**

The concept of offering presence is an integral part of bearing witness. After defining suffering as a discomfort or distress that may or may not be related to physical pain, and healing as transcending that suffering, Cody (2007) defines bearing witness as “a fundamental and central process in being human” (p. 17). Furthermore, he explains that it means “attesting to the authenticity of something through one’s personal presence” (p. 18). Obviously, the nurse being present in the patient’s time of need is essential to the process of bearing witness. Presence as it relates to this body of literature, however, is much more than a physical existence beside the patient. A physical, mental, emotional, and spiritual presence are all encompassed in the term presence relating to nursing practice. Describing the act of presence as a complex nurse-patient encounter, Stanley (2002) writes, “Being fully in the present moment necessitates emptying oneself of personal desires, setting aside thoughts of the past or future, resisting the urge to plan what we will say or do, focusing solely on the person before us, and believing that this moment is the only one possible” (p. 939). She explains that this type of presence requires the nurse to be intuitive, aware of self, and connected to the other person. When the patient senses an authentic

attendance of the nurse in the room, it is easier to express emotions and vulnerabilities and may result in the patient feeling valued and respected as a human in legitimate need. Even if eloquent words are not exchanged, the fact that the nurse cares enough to stay physically and emotionally available to the patient through suffering “can help restore self esteem and dignity” (Stanley, p. 937).

In an example of a case devoid of any true meaningful presence of the nurse attending to the patient’s concerns, Aranda (2001) describes the story of a patient, dying of cancer, whose degrading body smelled very strongly of decay. Because the doctors and nurses completely avoided the subject of the smell, although all were aware of its growing presence, the patient felt disconnected, embarrassed, and ignored. Of course, healthcare staff did not further humiliate one who cannot control the disconcerting smell of his or her dying body, but to pretend as if it does not exist is to reject the wholeness of the person and minimize his or her personal emotions, qualms, and discomforts. True presence involves an awareness and openness to the entirety of the patient’s needs without avoiding subjects simply because they are awkward or uncomfortable. Most often, these subjects are those that the patient has questions or fears about and needs most to feel comfortable discussing in a safe atmosphere. However, it is impossible to feel safe and open to share these concerns when the nurse rushes in and out, treating a body in a bed rather than experiencing each moment *with* the patient through a metaphysical attendance and presence. Nursing theorists, when speaking of bearing witness, use the term *metaphysical* to describe emotional, psychological, mental, and spiritual aspects of client wellbeing. Bearing witness takes into account the metaphysical healing of patient—a holistic nursing approach—that recognizes that the body and spirit of the patient are interwoven and inseparable.

Bunkers (2009) also includes the act of living true presence as a critical listening strategy to build the nurse-patient relationship. “True presence involves listening to what is important to the other and listening to what the meaning of a situation is in the moment for that person,”(p. 22). Instead of seeing the situation from a strictly logical, medical standpoint, the one bearing witness seeks to understand it from the point of view of the sufferer. Although the nurse’s goal may be to change or alleviate the feelings and the pain of the suffering patient, as Aranda (2001) indicated, it is important to recognize and attest to the reality of such things for the patient instead of ignoring or belittling them. By taking the time to stop and orient oneself to the vantage point of the sufferer, it may be even easier to pinpoint what would be most helpful to the patient both physically, emotionally, and spiritually. Through effective listening, by being truly present with a patient, the nurse is “bearing witness to another’s lived experience with love and compassion” (Bunkers, p. 23).

### **Ethics**

The bearing witness-not bearing witness nursing intervention is demonstrated as having a strong ethical implication regarding a nurse’s treatment of a patient. As an ethical construct, bearing witness-not bearing witness delineates attending to each patient’s humanity, uniqueness, and promoting healing versus not bearing witness, which would be neglecting the patient’s humanity, uniqueness, and impeding healing. The concepts of nonmaleficence, respect for human dignity, veracity, and fidelity, which are all core ethical values for nursing, are upheld by the practice of bearing witness. Likewise, by choosing not to bear witness to the suffering of a patient, the nurse is choosing not to fulfill an ethical obligation to truly respect the person and cultivate a relationship that is most conducive to the healing process. Neglecting to bear witness or offer a

real presence is an abandonment that can lead to further distress and a relationship tainted by distrust. In considering Cody's (2001b) reference to the American Nursing Association *Code for Nurses*, it is clear that bearing witness-not bearing witness is rooted in the ethics of healthcare. Cody (2001b) cites the ANA code when arguing that refusing to practice bearing witness is an abandonment of the patient's individuality and dignity and thus a breach of ethics. While the term bearing witness is not explicitly used in the Code of Ethics, in an explanation of the application of the code, Taylor ( in Fowler (ed.), 2008) provides a deeper understanding of the essence of the code. She states, "it is critical for nurses to relate to patients as a healing presence" ( p. 6) Supporting the idea of that not bearing witness constitutes abandonment, Stanley (2002), adds that such abandonment causes excess feelings of loneliness, vulnerability, and alienation. This goes against the ethical principle of respecting the dignity of that human and seeking to provide the greatest good through the care given. Watson (2003), on the subject of love and caring relating to nursing ethics, reminds healthcare professionals that without love, caring is nothing. Incorporating love into practice means that the nurse becomes involved emotionally in the nurse-patient relationship in order that the patient's needs be met through the genuine concern of loving care. This love is the most important aspect of transpersonal caring because without it a shared experience cannot exist, thus the patient is essentially ignored on many levels, and the result is cruelty and possible violence with the neglect of the caregiver (2003).

Eriksson (1995) introduced a theory of caritative caring and its relation to ethics. Exploring this theme, Raholm and Lindholm (1999) conducted a phenomenological study of eight men and women and their experiences of suffering and a return to health after coronary surgery. The study involved interviewing the participants about their feelings surrounding their disease and surgery.

Participants reported increased suffering when others belittled or negated their experiences. Loneliness that resulted was not only the effect of a physical aloneness, but more significantly a lack of being truly heard and understood by healthcare professionals and supporters. Raholm and Lindholm suggest that caring necessitates seeing the “patient as a suffering human being, not as a person who is ill” (p. 529). Suffering is not defined as a physical condition, but as “dying in the deepest sense,” in which the person loses themselves when their will and purpose for living departs (Raholm and Lindholm, p. 536). The ethical obligation of the nurse practicing caritative caring, therefore, is to bear witness to the patient’s own perception of the situation and, through an offering of presence and love, as described by Watson (2003), facilitate the patient in finding meaning in the midst of suffering.

A study by Gilmartin and Wright (2008) offers more insight regarding the patient’s feelings of abandonment when the nurse is absent either physically or emotionally. Interviews with patients about a day-surgery experiences revealed that when left alone in the preoperative room to face their fears and questions alone, they felt abandoned. Much of the fear and uncertainty was attributed to an inadequate offering of information about what to expect before, during, and after the operation. In the interview many patients admitted feeling that their emotions were ignored because healthcare workers were disengaged and inattentive to their anxiety and stress. This abandonment is further described by Milton (2002) as a breach of faithfulness and fidelity—which are foundational to nursing ethics. Based on Parse’s Human Becoming theory, Milton (2002) laments that patients in today’s institutions are too often treated as numbers instead of dignified humans. By neglecting to ask the patient what he or she needs or desires, the nurse-patient relationship is broken down as the nurse fails to uphold faithfulness in the patient’s eyes.

There may be various reasons why a nurse ignores the specific emotional and spiritual needs right in front of them, but one common excuse revolves around a lack of time and knowledge (Young, 2002). The result is an infringement upon the ethics of good care, an act of virtue. For the nurse to bear witness is to act virtuously. While virtue is a human characteristic, its application to nursing requires guidance and therefore can and should be taught (Crigger & Godfrey, 2011). Because of the complexity of the nurse-patient relationship and the need for guidance in directing the desire to do good, the construct of bearing witness should be addressed in formal nursing education and reinforced in nursing practice. However, time is an issue in nursing education. Educators may, in an effort to cover more content, neglect to emphasize not only the need, but the instruction in bearing witness, hence the sense of a lack of knowledge on the part of the nurse in practice. Furthermore, Watson (2006b) identifies the dominant healthcare delivery model as one that uses the business language of the market as opposed to the relational language of caring. “This language conjures up an image of impersonal, functional exchange of fees for services or goods that require no humanity or human relationship, no authentic caring connection, no mutuality, and no compassionate human service ethic, philosophy, or value that guides the system” (Watson, 2006a, p. 88). For nursing, the virtue ethic of bearing witness can be in conflict with the business model in which time is measured in a functional sense rather than an interpersonal sense.

Taking this concept further than simply ethical in perspective, Naef (2006) and Gastmans, De Casterle, and Schotsmans (1998) characterize bearing witness as a moral practice. Basing his claims on Levinas’s ethics of the face (1979, 1998), Cody’s bearing witness-not bearing witness conceptualization (2001a), and Parse’s human becoming theory (1998), Naef calls bearing

witness “a human mode of coexistence” that “involves listening to, being present, and staying with” (p. 147). With regards to the ethics of the face, Levinas, (1979, 1998) surmises that to see in the patient’s face a presence of suffering and to turn away is an act of violence. Without this ethic of face, the treatment given by some nurses and healthcare workers may add to the pain and emotional instability of their suffering instead of facilitating healing that is expected and deserved. Gastmans et. al. (1998) considers nursing a moral practice because it requires viewing this occupation as comprised of technical healthcare expertise combined with an attitude of true caring. Furthermore, instead of basing care on efficiency, it should be based on quality and intention—the intention to do the most good for the patient. A moral and ethical relationship of “good care” combines expert medical practice with a caring attitude that treats the whole of a person and not only the physical body.

### **Healing**

Because bearing witness and the importance of a close, intuitive nurse-patient relationship is an ethical imperative (Cody, 2001b), it is crucial that this subject be addressed expediently. Not only is bearing witness crucial to nursing ethics, it is also a key to facilitating the healing process. Naef (2006) supports this idea and stresses the importance of building a nurse-person relationship that aids in the process of healing. Although Naef holds to Parse’s (1998) belief that each person is the authority regarding the experiences of his or her own life and that the healing can only come from the one being healed, he stresses that, by upholding a moral obligation to be “with” the patient, the nurse may assist the patient in moving beyond a state of suffering in the true, psychological, sense of the word. Bearing witness can to promote healing in the physical, emotional, and spiritual realms. The interconnected should not be ignored, as when a nurse isolates and attends to the physical body alone. Because the person is a whole, attendance to



spiritual needs plays a role in enhancing physical health as well. From the perspective of transpersonal caring, Watson concludes that energy transfer facilitated by love when bearing witness aids in healing (2003). Therapeutic touch, attending to the “Ethics of Face” (Levinas, 1979), and using Longstrup’s (1997) “Hand” philosophy promote healing through the true loving care provided along with a merging of positive energy from nurse to patient as a result of this love (Watson, 2003). Too often nursing is viewed as strictly clinical and scientific in nature and does not address what Cowling called the “wholeness of the experience” (2000, p. 16), and Bohm (1996, p. xv) identifies as the “unbroken whole”. This wholeness means recognizing the patient as much more than a physical body and the suffering experience as more than a disease process. Instead of relating the patient as a complex being with physical, emotional, mental, and spiritual needs, healthcare professionals tend to focus almost exclusively upon the measurable, diagnostic manifestations of suffering. Unfortunately, this ignores the very definitions of the words *suffering* and *healing*. Healing is not dependent upon the absence of disease, but instead on an attitude of peace and wellbeing, even in the face of suffering.

Constructive interactions and conversation between the nurse and patient are a key ingredient in the way bearing witness facilitates healing. Open dialogue is founded on suspending assumptions and finding common ground (Bohm, 1996), common humanity. This openness which can occur when time is invested in getting to know a patient and building a sense of love and trust, is, according to Seikkula and Trimble (2005), a healing element for therapeutic conversations. The open discussion brings to light that the fullness of wholeness which would otherwise be hidden or passed over and allows the nurse to bear witness with the patient. In this open dialogue approach (Seikkula & Trimble, 2005; Bohm, 1996), communication brings the professional and

patient together, allows ideas to emerge, each side to hear and understand the other's point of view, and aids the other in making sense of the experience. This process holds much promise as a means for the nurse to join with the patient as well as suffering family members to recognize and implement thoughts and actions leading to emotional and psychological stability and peace.

Having had firsthand experience with suffering, Frank (1991) reflects on his physical, emotional, and spiritual journey through heart attack and cancer. "The caregiver's art is finding a way to allow the ill person to express his needs," Frank explains (p. 47). The healing process can be either expedited or threatened depending on the attitude, dialogue, and availability of healthcare workers. Furthermore, it is possible to lead a patient to a state of healing without having reached a cure for a physical ailment. The act of bearing witness facilitates healing by attending to the metaphysical needs of the patient.

### **Nurse-Patient Relationship**

Quinn (1992) supports a view of the nurse *as* the environment of a patient, not merely *in* the environment. Based on Newman's (1990) conceptual framework, which suggests that humans are connected to their surroundings by a coexistence of energy fields and the interplay and exchange of forces therein, Quinn advocates that the very presence of the nurse may create or negate an environment conducive to healing. This is in congruence with Cody's assertion that the nurse's presence is fundamental to the act of bearing witness and promoting healing. Bearing witness as an act of affirming the humanity of another is supported by Watson's description of a transpersonal relationship. Watson (2006a) describes this positive relationship as a connection to both the other person and to "the higher energy of the universe" (p. 60). Transpersonal caring, Watson (2006a) explains, is a conscious effort that affirms the patient spiritually and emotionally

and cares for physical, emotional, and spiritual needs. The focus is on *caring* not on the *disease*. A nurse-patient relationship that forms the basis for bearing witness relies on being connected in wholeness and not only addressing a physical ailment.

Buber (1937/1958) presents a philosophical proposition that humans relate on one of two levels. The first is an I-It relation between the subject and an object. The second, ideal level of relating, is on an I-Thou level in which the two subjects are no longer distinct, separate entities, but a unification of being. Buber goes to great lengths to characterize what he calls the primary word I-Thou. He distinguishes further between I-It and I-Thou as an act of experience versus relation, respectively. The term “living mutual relation” is used to describe an I-Thou state that is not based on feelings alone, but on a true connectedness on every level, supporting Quinn’s (1992) description of nurse as environment for healing. On this topic of relating as applied to healthcare personnel, Frank (1991) comments, throughout his reflective autobiography, about the role of healthcare workers and his perception, as the patient, of their interaction with him versus his disease. He explains that when meeting with physicians he “had trouble getting them to make eye contact; most came only to see my disease” (p. 54). Frank further describes how his *illness* was treated in the hospital while a detached nurse-patient relationship left his true *self* virtually untreated and ignored. If an effective nurse-patient relationship can facilitate bearing witness and healing, an absence of any meaningful I-Thou relationship offers no opportunity for bearing witness and can, indeed impede healing.

### **Experience of the Caregiver**

An investigation of the experience of nursing students, who were faced with suffering while participating in clinical learning, further promotes the notion that education to prepare nurses to effectively address patients who are in severe distress or emotional turmoil may be inadequate.

In an interpretive phenomenological study, thirteen nursing students were interviewed about their experiences of suffering in their own lives and also suffering they witnessed in the lives of others. Eifried (2003) relates that students most commonly admitted feelings of vulnerability when in the presence of suffering. Attributing the difficulty to the fact that they had not be adequately trained to handle highly emotional and touchy nurse-patient encounters, the students told stories of their personal encounters in caring for a patient that they were unable to “fix” or comfort with standard procedures. They expressed feeling vulnerable and helpless. Indeed, Buber (1937/1958) forewarns that when one chooses to actually relate to the person as a subject instead of an object there is a risk involved. This opens the door for emotions to flow both ways and this may be overwhelming at times. In elaboration Buber (1937/1958, p. 10) writes, “This is the risk: the primary word can only be spoken with the whole being”. The act of bearing witness does, indeed, require that the whole being of a person be devoted to the other person, eliciting vulnerability and possibly sacrifice.

The experience of the thirteen nursing students (Eifried, 2003) was further complicated, however, by the fact that the students were unable to debrief or verbalize their feelings in class or with clinical instructors. Eifried concluded that nursing students need to be able to talk about their experiences, share stories, and receive support and comfort from fellow students and professors. This must first become a priority for the professors of nursing and also be incorporated into education and curriculum. Eifried also suggested a special time or place for

students to safely decompress after especially stressful clinical experiences in an atmosphere of support from clinical instructors who can give helpful feedback and advice, but withhold judgment. This suspension of judgment allows for open dialogue as described by Bohm (1996), and attending to the undivided whole of the student, thereby allowing faculty to bear witness to students. Many of the students interviewed in Eifried's study admitted that they did not feel comfortable approaching their instructors about their experiences and were afraid they would be chastised for becoming emotional in response to things witnessed.

A similar case study by Moura, Stilos, and Flint (2007), which addresses the subject of ambiguity as related to nursing practice, further emphasizes the lack of knowledge, on the nurse's part, of how to effectively bear witness and offer presence. The case followed the story of a nurse who entered a room in which the patient had just been informed that she would not survive her lung cancer and her husband, in shock and dismay, asked the entering nurse, "How will I go on without her?" Unprepared to answer such a difficult, emotional question, the nurse felt extremely anxious and uncomfortable, but made a conscious decision to remain in the room and, though silenced by the awkward occasion, offer her presence by sitting with the suffering man and wife. Education and training that prepares the nurse to face these ambiguous situations, which are sure to arise, would help ease anxiety and provide the means for bearing witness.

### **Research Question**

After reviewing the literature currently available about bearing witness and its place in nursing education, I explored what further research would be valuable.

**RQ:** How familiar are nursing students at West Texas A&M University with the concept of bearing witness and its importance to their professional practice?

### **Method**

In order to answer my research question, I worked with a professor of nursing at West Texas A&M University (WTAMU), Dr. Lisa Davis, to create a brief survey with open-ended questions to be administered to nursing students at WTAMU, probing them for their level of knowledge about bearing witness. Before administering the survey, IRB approval was obtained and permission to continue research was granted. The survey consisted of four questions, including one yes/no, one fill-in-the-blank, and two open-ended short response questions (see Appendix for survey). The survey was given to two different classes of students; the first was a senior level Medical Surgical class and the second was a junior level Pediatrics and Obstetrics class. Thirty-one responses were procured from the first class and 45 from the second.

**Discussion:** After analyzing the responses from WTAMU nursing students who completed the written survey, the need for more teaching about bearing witness is implicated. A majority of the responses indicated a lack of understanding regarding the meaning of bearing witness in nursing practice as a part of offering presence and supporting caring. While many students simply answered that they did not know what bearing witness in nursing means, many others wrote that they thought it was a legal implication referring to the witnessing of consent forms being signed. Very few were able to offer examples of their own personal experiences in practicing bearing witness with their patients in clinical or other practical settings. These results are not necessarily surprising, but are concerning and further support the need to include training and education about the ethical and practical implications for integrating bearing witness as a fundamental component of quality nursing care.

### **Conclusion**

Bearing witness is an offering of presence fundamental to nursing ethics and crucial to the nurse-patient relationship and its contribution to the healing process. Nurses feeling pressured for time because of the task-oriented business model of healthcare are much less likely to offer true presence or engage in any meaningful nurse-patient relationship and may, therefore, unknowingly ignore crucial details about the patient's mental, physical, or emotional state of suffering and deny appropriate care. Furthermore, bearing witness is not necessarily an inborn quality—it can be a learned skill. Because bearing witness is a complex expression of virtue ethic, it is unreasonable to expect that nurses practice this intervention without having been guided in the art. Nursing curriculum and education thoroughly covers and tests the technical, clinical skills of nursing, but often fails to emphasize the ethic of bearing witness. While bearing witness is an ethic of care, no research has been identified specifically related to bearing witness. And, therefore, it is recommended that research be initiated to further explore both the teaching and practice of bearing witness. To embrace the entirety of good, ethical nursing is to recognize the need for offering genuine, loving presence, engage in a nurse-patient relationship that fosters trust, and promote healing by way of bearing witness.

**Appendix A:**

Nursing Student Survey

ID Code\_\_\_\_\_

Dear Nursing Student,

Please thoughtfully answer the following questions. If you need more room, please attach a continuation sheet. You are not required to complete the survey and your grade will not be affected if you elect not to. You are not required to complete every question, but we would like as much feedback as possible from you. Please do not put your name on this survey form.

By completing and submitting this survey, I consent to participate in the research project of Michelle Campbell and Dr. Lisa Davis.

1. Has the term “bearing witness” been introduced to you in nursing school?

Circle one: YES/ NO

2. In your own words, define what you think “bearing witness” means with regards to patient care.

3. Given your definition, tell a story about a time you incorporated bearing witness into your care of a patient.

4. Complete the following sentence: Bearing witness is like \_\_\_\_\_



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