ISSNe: 2182.2883 | ISSNp: 0874.0283
Available: https://doi.org/10.12707/RIV17108

THEORETICAL PAPER/ESSAY
ARTÍCULO TEÓRICO/ENSAYO

Responsibility in nursing care: placing the patient at the center

Responsabilidad en los cuidados enfermeros: poniendo en el centro a la persona

Responsabilidade em cuidados de enfermagem: colocando a pessoa no centro

María Idoia Ugarte Gurrutxaga*

Abstract

Background: The essence of nursing is care. Although we can find different definitions of Nursing, all of them share this idea. Even though, they all don't agree in the meaning of care.
Objective: Reflect on responsibility in nursing care by placing the person in the center.
Main topics under analysis: A narrative review was carried out in relation to the evolution of Nursing paradigms, the reality of the assistance in the current hegemonic model of health care, the nurse-patient relationship in the care encounter and the proposals for improvement for quality meetings.
Conclusion: Nursing care is not an isolated act. It takes place in certain social and institutional contexts as well as in networks of relationships that confer meaning on it. We should not, we can not *neglect the care*. We have to preserve the responsibility in nursing care, placing at the center the person.

Keywords: nursing care; patient-centered care; professional competence

Resumen

Marco contextual: La esencia de la enfermería es el cuidado. Aun habiendo diferentes definiciones de enfermería, todas ellas comparten esta idea. En lo que quizá no haya un acuerdo sea en el significado de cuidado.
Objetivo: Reflexionar acerca de la responsabilidad en los cuidados enfermeros, poniendo en el centro a la persona.
Principales temas de análisis: Se efectuó una revisión narrativa en relación a la evolución de los paradigmas de la enfermería, la realidad de la asistencia en el actual modelo hegemónico de la atención sanitaria, la relación enfermera-paciente en el encuentro asistencial y las propuestas de mejora para que este encuentro sea de calidad.
Conclusión: El cuidado enfermero no es un acto aislado. Tiene lugar en unos determinados contextos sociales, institucionales y en redes de relaciones que le confieren significado. No debemos, no podemos *descuidar los cuidados*. Tenemos que preservar la responsabilidad en los cuidados enfermeros, poniendo en el centro a la persona.

Palabras clave: atención de enfermería; atención dirigida al paciente; competencia profesional

Resumo

Enquadramento: O cuidado é a essência da enfermagem. Embora existam diferentes definições de enfermagem, todos eles compartilham essa ideia. Naquilo em que pode não haver acordo é no significado atribuído ao cuidado.
Objetivo: Refletir sobre a responsabilidade no cuidado de enfermagem, colocando a pessoa no centro.
Principais tópicos em análise: Uma revisão da literatura foi realizada em relação à evolução dos paradigmas de enfermagem, a realidade da assistência no atual modelo hegemónico de cuidados de saúde, a relação enfermeiro-paciente no encontro de atendimento e as propostas de melhoria para que o mesmo seja de qualidade.
Conclusão: O cuidado de enfermagem não é um ato isolado. Isso ocorre em certos contextos sociais, institucionais e redes de relacionamentos que lhe dão significado. Não devemos, não podemos *negligenciar o cuidado.* Temos de preservar a responsabilidade no cuidado de enfermagem, colocando a pessoa no centro.

Palavras-chave: cuidados de enfermagem; assistência centrada no paciente; competência profissional

*Ph.D., Lecturer, University of Castilla-La Mancha, School of Nursing and Physiotherapy of Toledo, 45071, Toledo, Spain (maria.ugarte@uclm.es). Address for correspondence: E. U. Enfermería y Fisioterapia de Toledo, Avenida de Carlos III s/n, 45071, Toledo, España.

Received for publication: 14.12.17
Accepted for publication: 28.03.18

Introduction

The essence of nursing is care, caring for people. Despite the different definitions of nursing, all of them share this dynamic idea. The meaning of care and how it is operationalized has been changing alongside the evolution of the concept of health care (Queirós, 2015). One of the most consensual definitions was put forward by Collière (1993),

> caring is an act of life, representing an infinite variety of activities to maintain life, allowing it to continue and reproduce . . . human beings have always felt this need as an individual act of an autonomous person and of reciprocity because the person needs help to ensure the maintenance of these vital functions. (p. 7)

A quick look at the history of the development of the nursing discipline shows that care has always been a nursing function at all of these moments; what has changed is the way in which it is approached.

The development of nursing knowledge is part of scientific knowledge, which means that there is a connection between the way in which our discipline has been evolving and the other scientific disciplines. The paradigms influencing this development are a proof of this connection. Undoubtedly, the historical context of each moment is the framework for this development. On the one hand, national policies are structural determinants conditioning the development of all disciplines, both in the way they advance and in the speed of their implementation, and, on the other hand, they also condition and determine the health care systems' design and characteristics (Ruckert & Labonté, 2017).

In turn, health policies are increasingly focused on a comprehensive socio-sanitary care as a result of population aging, the prevalence of chronic diseases, and the cultural diversity of the target population (Palomo & Rabanaque, 2012).

In view of the above, the purpose of this study is to reflect on the responsibility in nursing care, placing the patient at the center.

Discussion

The evolution of the *nursing care* concept

In line with the dominant scientific paradigm, the dominant paradigm in nursing has long been the biomedical model focused on diseases, their management, and treatment. This way of viewing the nursing profession has decreased its independence and hindered its development as a discipline, excluding basic domains of care such as health promotion and psychological and psychosocial aspects. Given the crisis in the biomedical model, nursing has begun to recover and define these dimensions through the effort of many professionals and to develop nursing models.

A model is a schematic representation of reality. Thus, the nursing model is a synthesis of the principles, concepts, and ideas underlying nursing practice, that is, the nursing model supports nursing practice. Ever since Florence Nightingale, many nurses have developed conceptual nursing models or structures to guide and establish a framework for nursing practice based on the following concepts of the nursing metaparadigm: the individual, the family, and the community as clients; the surroundings or environment where they live; the health/disease continuum; and the nursing profession itself.

Based on the assumption that these paradigms exist, Kérouac, Pepin, Ducharme, Duquette, and Major (1996) analyzed nursing models and theories and identified the presence of common beliefs, values, principles, laws, theories, and methodologies, dividing them into three paradigms.

The categorization paradigm is clearly influenced by positivism. In this paradigm, "there are two distinct orientations: one focused on Public Health and the other focused on disease and linked to medical practice" (Martínez, 2008, p. 2). Nursing care is a problem-focused science which requires formal training. The nurse is an expert with an asymmetric relationship (of power) with the patient. Another paradigm is the integration paradigm, which differs from the previous one in that it defends that the context in which the phenomenon occurs should be taken into account to understand and explain it. Nursing models and theories within this paradigm are focused on the individual, placing them at the center of nursing practice. It distinguishes between nursing and the medical disciplines. Peplau (1990), in her theo-

ry of interpersonal relations, argues that the nurse-patient relationship, although "it is a process involving the performance of techniques and procedures and the use of devices, cannot be considered only technical, but rather interpersonal" (Arredondo-González & Siles-González, 2009, p. 1). The third paradigm - transformation paradigm - is the basis for opening nursing science to the world. It was developed in the mid-1970s and its mark can be found in the models and theories by Newman, Rogers, Watson, and Leininger. One of the key features of this paradigm is community participation. The nurse-patient relationship is one of equality but with rather different values and priorities. Within this paradigm, Kérouac identifies and embraces several models and theories of the school of caring. The key characteristic of this school's models and theories is the focus on the individual's culture, values, and beliefs. Leininger and Watson are two authors of this school. According to Guillén (2010),

> with regard to systemizing and conceptually clarifying the notion of care, Leininger described three types of care: generic care, professional care, and professional nursing care. This distinction shows that nursing care is composed of clearly different activities from family care or the type of care provided by other health professionals. Professional nursing care consists of intentional actions based on a body of knowledge that is taught and learned through an academic-professional training. (p. 10)

Leininger is the precursor of the Theory of Cultural Care Diversity and Universality (1960), transcultural nursing. On the other hand, Watson (1992) has identified the philosophical foundations of care which, according to the author, takes place in a given space and is a meeting where two people share an experience that will be part of their future history.

> Understanding the ontological foundations of care and the theoretical components developed by these theorists provides a coherent and consistent meaning to nursing as a human science. For this reason, Jean Watson's theory is useful because it allows implementing a care philosophy, a unique theoretical language, and a relationship between theory and practice that revitalizes aspects of nursing that were lost or invisible. (Urra, Jana, & García, 2011, p. 2)

These aspects have always been a part of nursing but invisible and/or undervalued by the positivist and technological approach. According to Watson, care is essential to nursing. The patient should be accompanied throughout the decision-making process, rather than being an information recipient.

The reality of care within the current healthcare model

After explaining the theoretical development of the nursing discipline, the focus will move to the reality of health care, the daily work of nurses. Whatever we do, nursing is one more piece of the health care system. Among the basic structural features of the hegemonic healthcare model, the following should be highlighted: biologism, the mastery of a purely assistance-based approach where patients are expected to be passive, and an asymmetric relationship where health professionals hold the power. In the current hegemonic health care model, authors such as Velasco (2009) have identifies a series of biases in health care, including the biomedical-technological bias which makes the biopsychosocial dimension invisible. This bias is based on the standardization of action protocols which focus only on diseases, leaving out each individual's psychosocial dimension. In medicine, evidence-based practice is defined as the conscious use of research evidence in the clinical decisions related to patient care. When a *practice* proves to be effective, professionals are recommended to replicate it in patients with similar characteristics. With regard to the type of relationship, the interpersonal relationship established in the therapeutic consultation, although, in theory, it no longer has a paternalistic focus but it is rather a horizontal relationship (where the decision-making process is shared), many health professionals find it difficult to stop *directing* it. Their intention to do what is best for the patient (based on their knowledge and experience) often leads them to give little importance to the patients

in the decision-making process. This is their day-to-day reality; nursing is a part of the health care system and, obviously, our work is developed in this context. According to Arredondo-González and Siles-González (2009),

> In terms of efficiency and power relations taking place within the health system, this competitive effort hinders the relationship between the nurse and the patient, inhibits an effective communication between them, and only has place for the performance of techniques. (p. 5)

This is called the functional relationship. There is no time for care delivery and care is impersonal. In view of this reality, some authors advocate for the revitalization of people-centered humanized care and the promotion of the care relationship. In short, the humanization of health is strongly reconsidered. Thus, Watson's theory of caring, which is integrated into the transformation paradigm, is very useful to *rebuild nursing care* and reflect on and rethink our ways of approaching nursing practice.

The need for a change in health care is also an issue of concern in other disciplines and different areas of society.

Therefore, there is a focus on patient-centered care (PCC), which had its origins in the work of Carl Rogers, a psychotherapist of humanistic psychology who developed the client-centered therapy (Rogers, 1961). Morgan and Yoder (2012) define PCC as a holistic (biopsychosocial-spiritual) approach which promotes respectful and individualized care. Patients are empowered to play a key role in choosing their treatment and deciding on their care process.

For several years now, there has been a focus on health care rights. From this perspective, everyone has rights and countries must respect, protect, and ensure equal rights for everyone. From a rights-based approach, the right to health protection implies recognizing the role of the rights holders, that is, patients and users of health services, which means putting aside the concept of a *person who benefits from/receives* a service and replacing it by the idea that patients are central to the care process. This also means *placing people at the center*, but not as beneficiaries of health care (people in need of our help), rather as people who have the right to health care. The diversity of people has to be managed in an inclusive way, based on their own experiences, with the purpose of ensuring their participation in the process and strengthening their abilities. This will translate into a patient-centered care model, which involves recognizing patients' active role in their health decision-making process and assuming that these decisions must include the patients' perspective. From this rights-based approach, those who play a key role in healthcare can be divided into three profiles: holders of rights – patients and users of the health care system; holders of responsibilities – health professionals, where nurses are included; and holders of obligations – people with political and decision-making power and executive capacity in public organizations (director-general of departments, management departments of health facilities, professional colleges, etc.). Therefore, nursing – as a holder of responsibilities – plays two roles: on the one hand, with holders of rights, with whom we have a functional relationship, where we develop our scientific-technical competence and a caring relationship, that is

> That relationship providing personalized and high-quality care to patients and their families aimed at improving their well-being, autonomy, and quality of life, thus reaching a comprehensive care that includes both emotional and physical aspects. This relationship is based on patient comfort, trust, safety, and serenity, which can be achieved through therapeutic communication, active listening, a helping relationship, affectivity, critical thinking, intuition, among other skills. (Orkaizagirre, 2013, p. 1)

This refers to the relational competence, which is focused mostly on our attitudes and behaviors towards others in terms of acceptance, empathy, listening and reflection ability, and, on the other hand, towards holders of obligations, where we must display our responsibility towards society and others. Political competence is the term being used to define this nursing responsibility. This nursing competence draws on the care relation-

ship with holders of rights when we analyze it in a given social context. The knowledge and experience obtained through our direct work with those requesting our help (holders of rights) allow us to identify their needs and reasons for concern, based on which we build the political competence with the purpose of changing the policies that negatively affect health and health care delivery. I believe that the professional competence in nursing should encompass these three competencies: functional, relational, and political.

Focusing on the relationship that we have with the holders of rights - the patients - and within the scope of the transformation paradigm, the development of our discipline requires establishing a good care relationship, our raison d'être: a relationship that leads to individualized and integral care, starting from the premises that each person is a unique being with unique characteristics and that the care approach should take into account patients' bio-psycho-social-cultural aspects.

Some ideas for reflection

How to manage the nurse-patient relationship?

The nurse-patient relationship is the core of health care. It is the moment when care begins, when there is an opportunity for caring. The person – *patient* – has expectations which were created and influenced by the above-mentioned hegemonic model. The asymmetric and subordination relationships, which are predominant in the Spanish health system, make patients feel that they are in *foreign territory.* Thus, the relationship between nurses and patients is built based on inequality and is characterized by the patients' passivity and obedience and a lack of consideration for their opinions, initiatives, and decisions.

Nurses are responsible for starting a new process and leading this process of jointly creating a relationship, promoting the sharing of different perceptions, beliefs, values, knowledge, and expectations. According to Kleinman and Benson (2006), the therapeutic relationship between patients and healthcare professionals is based on communication and the sharing of values and beliefs; the professional must be able to establish an effective interpersonal communication while taking into account the patient's perspective.

How can we improve this common space, this relationship?

First, we need to be aware of our subjective biases. According to Velasco (2009), healthcare professional's perception is mediated by the intersubjective involvement and relationship established in each case, thus they are far from being neutral, objective. They have to be aware of their subjectivity, not to ignore it or mask it, but rather to identify those biases and address them directly. Within this type of bias, and consistent with the social representations, beliefs, and stereotypes about gender and culture, the gender and cultural biases should be highlighted.

Thus, the gender bias in health care can be defined as "the error from not considering the biological gender differences and the different causes of illness due to gender, or acting based on a gender stereotype" (Velasco, 2009, p. 30). Women and men have different diseases, disease experiences, and ways of seeking help, expressing symptoms and pain, and interacting with health professionals. These differences result from both biological differences and gender behavior models. If health care professionals do not take into account the gender differences, care delivery will be biased (Velasco, 2009). It is essential to recognize the gender stereotypes in society and those of both health professionals and patients to correct these gender biases in health care. These assumptions lead to a tendency to ignore, minimize, and take away credibility from the importance of their symptoms and suffering (Velasco, 2009). Another difficulty is the cultural difference (health professionals and health system *versus* patients). Health professionals' response to these differences can contribute to inequalities in health care delivery, the so-called cultural biases.

The differences in beliefs, behaviors, and expectations can lead to misunderstandings. On the other hand, this *cultural shock* in a therapeutic relationship is not limited to culturally diverse contexts. Conflict is inherent to human relationships and more so in situations where points of view are not shared. In healthcare, it is almost impossible for health

professionals and patients to have the same perspective. It is difficult to provide culturally competent care, largely due to a lack of conceptual clarity about the notion of cultural competence, the lack of distinction between organizational and individual cultural competence, and the tendency for most people to associate culture exclusively with the ethnic origin. The cultural competence model has been widely criticized. One of the most debated aspects is the possibility of creating stereotypes about minority groups and promoting the idea that the *others* are the cultural ones, when everyone has their own cultural identity. With regard to health professionals, in addition to their own culture, the *culture of biomedicine,* which is deep-rooted both in their training and in the development of their work, must be considered (Taylor, as cited in Kleinman & Benson, 2006); ignoring health professionals' prejudice and subjectivities (subjective biases) and other factors which are inextricably linked to culture such as the patients' gender, social status, sexual orientation, economic conditions, and psychobiological characteristics, it drives us to an inadequate attention.

Most cultural competence models were developed in the United States and none of them provides, in a conclusive way, a key to the development of a type of health care system that actually responds to people's needs (and not only in contexts where there is a significant cultural distance between health professionals and patients). One of the models with a comprehensive approach is Kleinman and Benson's (2006) mini-ethnography. It is organized into six steps through which health professionals can help patients build their narrative whenever they come from a different culture. One of the most widely discussed concepts today is cultural humility. It goes beyond cultural competence because it considers the political and social dimensions of society. It is more of an attitude towards people from another culture than knowing the cultural characteristics of a particular group, thus avoiding the stereotypes and homogenization that cultural competence can cause. Addressing health care through cultural humility exempts us from having to have expert knowledge about the characteristics of different cultures. In cultural humility, health professionals have to be willing to change the way in which they learn about other people through the dimensions of Self-reflection, Openness, and Flexibility.

Very close to the cultural humility approach and Kleinman's mini-ethnography model is the model that argues for a complementarity between narrative-based evidence and the current hegemonic evidence-based medicine. The so-called narrative-based medicine is based on the interpretative theories about illness, phenomenology, and hermeneutics. In this model, the significant world of biography prevails: health professionals' active listening, *versus* observation of signs and symptoms focused on physical aspects; the subjective symptom, *versus* importance assigned to biology (biomedical focus). The comprehensive approach to health care, based on the complementarity between the scientific evidence and the narrative evidence, is consistent with the principles, the focus on rights, and the criteria of health care quality which are repeatedly stated in the health legislation of the Spanish Health Care System (*Sistema Sanitario del Estado Español*). In addition to *knowing* about the disease or the life-cycle process, health professionals must *understand* its meaning for the patient. We know that, in the presence of same scientific evidence (in people with similar characteristics at first sight), the care process (perception of diagnosis, adherence, participation, evolution) does not follow the same pattern for everyone. In addition to the signs and symptoms, there is the experience of those same signs and symptoms, which is as varied as the people who suffer from them and the moments in their lives. This is the first step towards incorporating the narrative evidence into the scientific evidence in healthcare (Ugarte, 2012).

Care research: conspicuously absent

Another aspect in which we must advance is care research. The only way to know the impact of nursing care is through research. According to Watson (as cited in Guillaumet, Fargues, Subirana, & Bros, 2005, p. 32), "The Theory of Human Caring continuously reiterates the need to seek new knowledge and a new care practice", which can only be achieved through research.

Without research, both science and the nursing discipline will not advance.
The origin of research in the techniques and procedures is indisputable, but the purely quantitative methodology provides a biased and insufficient view when it comes to further enhancing those invisible, daily care which, paradoxically, are our essence.

How to research the invisible?
According to Huércanos (2013), Invisible Care is defined as "a set of interventions resulting from careful observation, empathy, knowledge, and experience, which help nurses to elaborate deliberate professional and ethical judgments, highly focused on each patient's needs" (p. 1). More and more voices are standing up against the growing influence of biomedical research in its technological component, which occupies a hegemonic position in the health knowledge panorama, to the point of excluding other humanistic research practices such as applied research in health care. Amezcua (2010), one of the renowned authors on this topic, defines it as "a process of producing knowledge based on scientific methodology aimed at improving or preserving people's health, from respecting their way of feeling and living to their possibility for an effective participation" (p. 237). In turn, the conceptual triad supporting this research applied to health care suggests three directions or major areas where to build knowledge: research on the subject's daily life, research on health outcomes, and research on evidence-based practices. These three directions activate a wide range of possible designs, from quantitative studies with an evaluative approach to qualitative ethnographic and phenomenological studies, promoting the subjects' participation. Therefore, we have access to the individual's narratives, perceptions, beliefs, values, experiences, expectations, among others, and focus on the individual, rather than on the disease.

Conclusion

Although care is the core of the nursing profession, an analysis of the current social and health contexts has shown that we must carry out a conscious effort to preserve it within our practice, both in terms of healthcare management and nursing research and training.
To guide us in this work, it would be appropriate to have a conceptual model that would allow for the development of nursing care based on the transformation paradigm principles and the rights-based approach to health care. This approach implies new roles, both for nurses and healthcare users. Moreover, the development of reference models is an essential tool to promote the theoretical-practical integration.
The values are important in the nursing profession because the behaviors and attitudes are key in this profession; they are the essence of nursing, what gives it a distinct character.
In addition, nursing care is not an isolated act. It takes place in certain social and institutional contexts and relationship networks that assign it meaning. Our responsibility goes beyond the technical excellence in care delivery. We must not, we cannot neglect care.
Therefore, the advances in the nursing discipline require the development of qualitative, ethnographic studies to better understand the sociocultural context and the patients' health-illness experiences.
In addition, it is important to promote cultural competence training in all its dimensions: awareness, sensitivity, knowledge, and cultural skills; the integration of subjects aimed to promote specific competencies to equally address social inequalities in health and cultural diversity into health professional's undergraduate, postgraduate, and lifelong training programs. In this way, it will be possible to preserve responsibility in nursing care, placing the person at the center.

References

Amezcua, M. (2010). Investigación aplicada en cuidados de salud. *Index de Enfermería*, *19*(4), 237-239. doi: 10.4321/S1132-12962010000300001

Arredondo-González, C. P., & Siles-González, J. (2009). Tecnología y humanización de los cuidados: Una mirada desde la Teoría de las Relaciones Interpersonales. *Index de Enfermería, 18(*1), 32-36. doi: 10.4321/S1132-12962009000100007

Collière, M. F. (1993). *Promover la vida: De la práctica*

de las mujeres cuidadoras a los cuidados de enfermería. Madrid, España: McGraw-Hill Interamericana.

Guillaumet, M., Fargues, I., Subirana, M., & Bros, M. (2005). Teoría del cuidado humano: Un café con Watson. *Metas de Enfermería*, *8*(2), 28-32. Retrieved from https://www.researchgate.net/profile/Montse_Guillaumet/publication/216704707_Teoria_del_cuidado_humano_Un_cafe_con_Watson/links/550be4de0cf2855640977

Guillén, R. M. (2010). La connotación humana y cultural del cuidado. *Biblioteca Lascasas*, *6*(3). Retrieved from http://www.index-f.com/lascasas/documentos/lc0557.pdf

Huércanos, I. (2013). Cuidado Invisible: Donde los medicamentos no llegan. *Index de Enfermería*, *22*(1-2), 5-6. doi: 10.4321/S1132-12962013000100001

Kérouac, S., Pepin, J., Ducharme, F., Duquette, A., & Major, F. (1996). *El pensamiento enfermero*. Barcelona, España: Masson.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine*, *3*(10), e294. doi: 10.1371/journal.pmed.0030294

Martínez, M. (2008). Hacia la consolidación de los paradigmas de enfermería a través de la universalización de la enseñanza. *Revista Médica Electrónica*, *30*(2). Retrieved from http://www.revmatanzas.sld.cu/revista%20medica/ano%202008/vol2%202008/tema11.htm

Morgan, S., & Yoder, L. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing*, *30*(1), 6-15. doi: 10.1177/0898010111412189

Orkaizagirre, A. (2013). Visibilizando los cuidados enfermeros a través de la Relación de Cuidado. *Index de Enfermería*, *22*(3). doi: 10.4321/S1132-12962013000200002

Palomo, L., & Rabanaque, M. J. (2012). Crisis económica, política sanitaria y salud. *Revista Gestión Clínica y Sanitaria*, *4*(1), 16-19.

Peplau, H. (1990). *Relaciones interpersonales en enfermería: Un marco de referencia conceptual en enfermería psicodinámica*. Barcelona, España: Salvat.

Queirós, P. J. (2015) Cuidar: Da condição de existência humana ao cuidar integral profissionalizado. *Revista de Enfermagem Referência*, *4*(5), 139-146. doi: 10.12707/RIV14079

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. London, England: Constable.

Ruckert, A., & Labonté, R. (2017). Health inequities in the age of austerity: The need for social protection policies. *Social Science & Medicine*, *187*(2017), 306-311. doi: 10.1016/j.socscimed.2017.03.029 0277-9536

Ugarte, I. (2012). La evidencia narrativa y la calidad asistencial en el Sistema Nacional de Salud. In L. Mariano & C. Cipriano (Eds.), *Medicina y narrativas: De la teoría a la práctica* (pp. 95-118). doi: 10.13140/RG.2.1.2769.6485

Urra, E., Jana A., & García, M. (2011). Algunos aspectos esenciales del pensamiento de Jean Watson y su teoría de cuidados transpersonales. *Ciencia y enfermería*, *17*(3), 11-22. doi: 10.4067/S0717-95532011000300002

Velasco, S. (2009). Sexos, género y salud: *Teoría y métodos para la práctica clínica y programas de salud.* Madrid, España: Ediciones Minerva.

Watson, J. (1992) Filosofía y teoría de los cuidados humanos en enfermería de Watson. In J. Riehl-Sisca. *Modelos conceptuales de enfermería* (pp. 179-192). Barcelona, España: Doyma.