Caring and Uncaring Encounters in Nursing and Health Care - Developing a Theory

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Caring must not be a matter of words or talk; it must be genuine, and show itself in action.

(Adapted from I. John 3.18)

Iuvante Deo
Dedicated to All those who Really Care for Another and Especially to my Truly Caring Family Gunnlaugur Gardarsson, Sunna Krístún and María Gudrún and my beloved mother, Krístún Brandís, the wind beneath my wings
This thesis is based on the following papers, which will be referred to in the text by Roman numerals.


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ABSTRACT

The general aim of the present thesis was to develop a theory on caring and uncaring encounters within nursing and health care from the patient’s perspective.

Results of an analysis of two phenomenological studies (paper I), as well as research findings from five other phenomenological studies (papers II-VI), were used to develop the theory.

Caring and uncaring can be conceptualized on a continuum symbolizing five basic modes of being with another, which e.g. involves a neutral mode of being with another, where the individual is perceived as neither caring nor uncaring.

There are two major metaphors in the theory, that of the bridge, symbolizing the openness in communication and the connectedness experienced by the recipient of care in an encounter perceived as caring. The other metaphor is the wall, which symbolizes negative or no communication, detachment and lack of a caring connection, experienced by the recipient in an encounter perceived as uncaring.

In the theory the importance of professional caring within nursing and health care is proposed, essentially involving competence, caring, and connection. The above-mentioned ‘bridge’ is developed through mutual trust and the development of a connection between the professional and the recipient, which is a combination of professional intimacy and a comfortable distance of respect and compassion -- professional distance. On the other hand, uncaring involves perceived incompetence and indifference, creating distrust, disconnection and the above-mentioned ‘wall’ of negative or no communication.

Receiving professional caring influences the recipient very positively and the perceived consequences, which are increased sense of well-being and health, can be summarized as empowerment. Uncaring, however, has the negative consequences of decreased sense of well-being and health, which can be summarized as discouragement. Empowerment and discouragement in this context are defined as a subjective experience of the recipient of care.

In the theory the importance of seeing the recipient in his or her context, inner as well as outer, is emphasized. The inner context involves perceived needs, expectations, previous experiences and sense of self, which in the context of the recipient of nursing and health care can be summarized as a sense of vulnerability and the need for professional caring. The recipient's outer context comprises the perceived environment that is also influential in the provider's context.

It is concluded that nurses and other health professionals can in themselves be very powerful sources of empowerment or discouragement in the lives of whom their mission in society is to serve.

Key words: Nursing Theory; Nursing Care - psychological aspects; Patient Satisfaction; Nurse-Patient Relations; Nursing Methodology Research - Phenomenology.
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INTRODUCTION

Caring in Nursing and Health Care

The concept of caring has a very special place in the discourse of nursing. There is an abundance of literature in nursing addressing the importance of, and the need for, caring in nursing and health care. Nursing has traditionally been concerned with not only people's needs for care, but also with caring as a value or principle for nursing action (Eriksson, 1993; Gaut, 1983; Martinsen, 1993). It has been suggested that caring is central to human expertise, to curing, and to healing (Benner and Wrubel, 1989). Caring has been seen as a nursing term, representing all the facets used to deliver nursing care to clients (Watson, 1988; Eriksson, 1987a, 1987b). It has even been suggested that caring means the same as nursing, which is derived from 'to nourish' (Griffin, 1983). Given our space-age technology, the need for caring in nursing today is paramount (Henderson, 1985; Leininger, 1984). It has, however, been a concern for nurses that it seems to be becoming increasingly difficult for nursing to sustain its caring ideology (Dunlop, 1994; Fry, 1988; Locsin, 1995; Miller, 1987; Moccia, 1988; Ray, 1981).

Caring has been approached from various perspectives, e.g. psychoneuroimmunology, socio-behavioral science perspective, anthropology, fine arts, humanities, philosophy, ethics, theology and, finally, from a nursing perspective (Smerke, 1989). Caring has been studied from the patient's perspective (Riemen, 1986a, 1986b; Larson, 1989; Larson & Ferketich, 1993) and from the nurse's perspective (Amacher 1973; Benner & Wrubel 1989; Goldesborough 1969; Hyde 1977). These and other studies (von Essen 1994; Larson, 1981, 1984, 1986; Mayer, 1986, 1987; Åström, 1995), indicate that there is a discrepancy between nurses' and patients' perceptions of caring. Discrepancies between expectations held by health professionals and clients can result in dissatisfaction with care. The differences in perception have caused "serious difficulties not only in communication with patients but in establishing therapeutic relationships with them" (Leininger, 1978, p.76).

Gaut (1983) makes an interesting distinction between 'caring for' and 'caring about'. She points out that 'caring for' in the sense of providing for or being responsible for, can be discussed apart from any sense of 'caring about'. 'Caring about' the other, Gaut states, eliminates the apathy, indifference, obligation, withdrawal, isolation, manipulation, and possession in one-way relationships of 'caring for' in the limited sense of 'providing for' (1983, p. 316). Gaut further specifies five conditions that must be true to say that someone is caring for X: awareness, knowledge, intention, means for positive change, and the 'welfare-of-X criterion', which is an interesting
concept introduced by Gaut where someone's action on behalf of X is solely based on the welfare of X, meaning a positive change in X.

There is abundance of papers in the literature where the concept of caring is used. In the Cumulative Index to Nursing and Allied Health Literature (CINAHL) alone, there are slightly more than 5000 entries on caring, in the beginning of 1996, where less than ten years ago 'caring' was not even found among the key concepts in nursing indexes. There is multiplicity of meanings in the present use of the concept caring in the literature. Often it seems to be used as a synonym for nursing or giving nursing care, e.g. physically (e.g. Meissner, 1994), or mentally (e.g. Nehls & Diamond, 1993). It is being used in an administrative context (e.g. Hill, 1994), and in an educational context (e.g. Darbyshire, 1994), as well as in an effort to define the essence of nursing (e.g. Leininger, 1988).

The goal of health care is increased health and well-being of its recipients (Tountas, Garanis & Dalla-Vorgia, 1994). Although people always carry with them their own particular value systems and moral standards, health professionals' training socializes students to behave in a certain way and this also influences how they think and feel about what they are doing (Young, 1994). There seems to be a consensus in the literature that the emphasis to benefit patients or clients should be a common commitment of all health professionals. Whether the emphasis on the patient's best interests is called beneficence/non-maleficence or caring differs, however, in that caring is more widely used in the nursing literature whereas beneficence seems to be more prevalent in the medical literature, particularly within medical ethics. However, as Gillon (1994) notes of health care ethics literature: "Regardless of whose perspective is being addressed benefit to the patient/client is at its centre". Wilson-Barnett (1994) asserts that in essence the effects of nursing depend on the quality and meaningfulness of the relationship established between nurses and those they care for. She claims that "the expression of caring and empathy denotes what is valued and identified by patients as the special contribution of nurses" (p 367). Although it seems possible to claim that nursing is a form of caring, it seems much less reasonable to claim it as the form of caring. Such a claim does scant justice to other 'people-workers', such as teachers, physicians and physiotherapists, to name only a few, who are endeavoring to overcome the problems caused by the movement of 'people-work' into the public domain (Halldórsdóttir, 1996b). Downie (1994), for example, asserts that the doctor-patient relationship is commonly seen as the central feature of medical practice. He states: "it is by means of this relationship that a doctor exercises professional skills and pursues the aims of medicine" (p. 343). Neuberger (1994) notes, however, that the list of roles which any health care professional might adopt is wide-ranging, including healer, technician, counsellor, educator, scientist and friend and that these roles may sometimes be in conflict. This concern is e.g. shared by Baron (1985) who, furthermore, asserts that modern medicine has,
through the emphasis on natural sciences, become too ‘anatomicopathologically’
centered and, therefore, sometimes lacks the necessary understanding of what the
sick person is going through. He strongly advocates the use of phenomenology to
“rediscover and realize the human goals of medicine” (p. 606) and thus to
“reconcile scientific understanding with human understanding, using the one to
guide the other” (p. 610).

Examining the caring literature, Morse et al. (1991) found the concept of caring
diffuse. Acknowledging that diversity might be necessary in this early stage of
concept development in order for the concept to be explored and developed as fully
and as richly as possible, they did a comparative analysis of conceptualizations and
theories of caring and identified five major conceptualizations of caring within
nursing. They have also categorized nursing researchers, thinkers and theorists
according to these major categories: caring as a human trait, as a moral imperative,
as an affect, as interpersonal interaction and caring as a therapeutic intervention. A
review of the literature affirms Morse et al.’s (1991) conclusion that caring is
relatively undeveloped as a concept in nursing, not having been clearly explicated
and often lacking relevance for nursing practice.

Theories and Conceptualizations on Caring and Uncaring

In the present thesis the merger of researcher and theorist is attempted. This merger
has been suggested by Morse et al. (1991), who advocate further enrichment of the
conceptualizations of caring. They point out that with the emergence of qualitative
methods and the extraordinarily large number of ‘caring theorists’ skilled in
qualitative research methods one would expect that caring theories would be
developed inductively from qualitative data. However, with the exception of a few
theorists "this is not occurring (p. 126)", they claim. This is attempted, however, in
the present thesis.

Riemen (1986a, 1986b) is a pioneer in caring/uncaring research. The purpose of
Riemen’s phenomenological study was to research the phenomenon of caring and
‘noncaring’, as she chooses to call it, by obtaining from clients verbal descriptions
of their perceptions of caring and noncaring interactions with nurses. In a
description of a caring nurse-client interaction, Riemen identified three clusters of
themes regarding a caring nurse-client interaction: the nurse’s existential presence
which is available for the client; the client’s uniqueness which is recognized by the
nurse in really listening and responding to him or her as a valued individual and a
human being of value; and finally, consequences, where the nurse’s individualized
concern for the client results in the client feeling comfortable, secure, at peace and
relaxed. She also identified three clusters of common themes of a ‘noncaring’
nurse-client interaction: The nurse’s presence, which is only to get the ‘job’ done
and physical presence is therefore available briefly or not at all, even when solicited; the client's uniqueness, which is not recognized by the nurse because he or she does not 'really listen' and appears 'too busy' to pay attention to the client as an individual; and finally, consequences, where the nurse's perceived lack of concern for the client results in him or her feeling frustrated, scared, depressed, angry, afraid, and upset. The study by Riemen (1986a, 1986b) became the inspiration and prototype for this author's research on caring and uncaring encounters with nurses and other health professionals from the patient's perspective.

**Theory Construction in Nursing**

Domain is the perspective and territory of a discipline (Meleis, 1991). It contains the main agreed-upon values, beliefs, and phenomena of interest, with the central concepts and problems as well as the methods used to provide some answers in the discipline. Meleis (1992) claims that the development of the discipline of nursing has gone through four stages: theorizing, developing a syntax, concept development, and philosophical debate. She asserts that these stages have helped in shaping the characteristics of the discipline as a human science, a practice science, and a science with social goals to empower nurses, to empower the discipline, and to empower the recipients of nursing and health care.

Nursing theory and theory development has been analyzed and categorized in various ways. In the journal 'Nursing Research' as early as 1968, Dickoff and James published a position paper on "A Theory of Theories" (1968a), which has had a great impact on nursing theorists and still does. In their paper on "Theory in a Practice Discipline (part I and II)" with Wiedenbach (1968a, 1968b) they furthered their ideas and grouped the various kinds of theories into four levels: factor-isolating theories, factor-relating theories, situation-relating theories and, finally, situation-producing theories. Walker and Avant (1988), however, have proposed four levels of nursing theory development: meta-theory, grand theory, middle-range theory, and practice theory. Finally, Meleis (1991) differentiates between descriptive and prescriptive theories. She claims that if we want to differentiate between different types of theory, then such differentiation is meaningful only in terms of the goals and not the source of the theory.

Nursing thinkers and theorists have since the landmark publication of Dickoff and James (1968) kept on stressing the value of theory development in nursing e.g. Moccia, 1986 and Meleis, 1991 and 1992. Meleis (1991) asserts that theory is "no longer a luxury in nursing" but a "part and parcel of the nursing lexicon in education, administration, and practice" (p. 4). She claims that we need to understand the role of theory in our discipline, the strategies used to develop it, the criteria used to critique it and how to use it to enhance the discipline of nursing.
Meleis states: “Theory is the goal of all scientific work; theorizing is a central process in all scientific endeavors; and theoretical thinking is essential to all professional undertakings” (1991, p. 9). According to Meleis (1991) theory helps to identify the focus, the means, and the goals of practice. She asserts that the discipline of nursing is beginning to establish itself as a theoretical field, the process of its evolution following a unique path that is not clearly understood by those who measure nursing progress and development against the scientific revolutions of the physical and natural sciences.

At its most basic level, nursing is a relational profession that exists by virtue of its commitment to provide care to others. Tinkle and Beaton (1983) point out that if the concerns and perceptions of the recipients of nursing services are considered unimportant factors in nursing research, "then nurses may indeed be providing nursing care that is more meaningful to themselves than to patients" (p. 31). Similarly, if research studies regarding patient behavior fail to ascertain the patients’ perceptions of the rationale for their own actions, "interpretation of research results will reflect only a one-sided bias in favor of what the nurse thinks the patient thinks" (Tinkle & Beaton, 1983, p. 31). The phenomenological research approach reduces this risk by truly introducing the patient's perspective, and the researcher is encouraged to strive to understand the meaning that the experience has had for the patient (Omery, 1983). This is one of the reasons for choosing phenomenology as a research approach in the studies used to develop the theory.

An important contribution to theorizing about caring has already been done e.g. by Watson (1988) in her theory of 'the art of transpersonal caring in nursing as a moral ideal', which she sees as “a means of communication and release of human feelings through the coparticipation of one’s entire self in nursing” (p. 70). She identifies nursing as a human science and human care. Her theory has sensitized nurses at all levels, not the least nurse educators, regarding one fundamental aspect of nursing i.e. the importance of the protection and enhancement of human dignity. Her theory has, however, been criticized (e.g. Morse et al. 1991) for lacking empirical basis. Recently, Swanson (1991, 1993) has developed a factor-naming theory derived from phenomenological studies in three perinatal nursing contexts. Her theory provides a definition of caring and five essential categories or processes that she proposes to characterize caring: knowing, being with, doing for, enabling and maintaining belief. However, more theorizing of caring and not the least its counterpart, uncaring, is needed in order to gain a better understanding of these aspects of nursing and, therefore, health care.
AIMS OF THE THESIS

The general aim of the thesis was to develop a theory on “Caring and Uncaring Encounters in Nursing and Health Care --from the Patient’s Perspective”, using an analysis of two former phenomenological studies (Paper I), as well as from five other phenomenological studies (Papers II-VI). The specific aims include:

1. To analyze the basic modes of being with another (Paper I).

2. To study the essential structure of caring and uncaring encounters with nurses and other health professionals from the perspective of two patient groups i.e. people who have been diagnosed and treated for cancer (Paper II), and women who have given birth (Paper IV).

3. To study the lived experience of the context of a recipient of nursing and health care by studying the perspective of two very different contexts of recipients: the lived experience of having cancer (Paper III) and the lived experience of giving birth (Paper V).

4. To study the lived experience of health in order to understand the subjective side of well-being and health, being the goal of nursing and health care (Paper VI).

METHODOLOGY

Phenomenology - The Philosophy and the Method

Phenomenology was the research strategy in the two studies used in the analysis in paper I, as well as in papers II-VI. Phenomenology is a philosophy, an approach, and a method (Oiler, 1982). The phenomenological method is an inductive research method (Omery, 1983), the task of which is to investigate and describe all phenomena, including the human experience, in the way these phenomena appear "in their fullest breadth and depth" (Spiegelberg, 1965, p. 2). The specific aims of the papers were to study the basic modes of being with another, the lived experience of caring and uncaring encounters with nurses and other health professionals from the perspective of some recipients of health care, as well as to study the lived experience of health, of giving birth to a child, and finally, to study the lived experience of having cancer. Phenomenology was chosen as a research approach for all these studies since phenomenology offers a methodology that can lead to systematic explication of human experiences (Oiler, 1982; Omery 1983; Anderson, 1991).
The researchers using the phenomenological research approach do not believe that their data will be contaminated or biased by the full participation of their participants (Claspell, 1984). Instead participants are invited to become co-researchers (Freire, 1970). Together, they collaborate and try to make sense out of the varying profiles of the phenomenon referred to. Such research, therefore, takes place among persons on equal levels without divisiveness of social or professional stratifications (Colaizzi, 1978). It is impossible to be totally free of bias in reflection on experience. However, it is possible to control it. This is called "bracketing", which means that to see lived experience, individuals must suspend or lay aside what they think they already know about it. Bracketing does not eliminate perspective, it brings it into view. It is a matter of peeling away the layers of interpretation (Merleau-Ponty, 1956). Other ways to practice bracketing are to wonder, to allow oneself to feel confused, in conflict, or uncertain, and to ask for opinions and really wanting to hear them (Oiler, 1982), which was practised by the researcher(s) in all the studies (I-VI) as well as in the theory development itself. An account of the bracketing was brought into perspective by a 'reflexive journal', as suggested by Lincoln and Guba (1985), which was kept in all the different studies as well as in the theory development itself. It is a technique to increase trustworthiness of qualitative research. Such 'reflexive journal', is a kind of a diary in which the investigator(s) on a daily basis, or as needed, record(s) a variety of information about own reflection (hence the term 'reflexive') and method.

The purpose of phenomenology is to describe the lived experience of people and the documentation of that experience should be done in such a way that it is true to the lives of the people described (Anderson, 1991). Phenomenological researchers study the ordinary 'life-world': they are interested in the way people experience their world, what it is like for them, how to best understand them. In order to gain access to others' experience phenomenologists explore their own, but also collect intensive and exhaustive descriptions from their respondents. These descriptions are submitted to a questioning process in which the researcher is open to themes that emerge. A theme is something akin to the content, topic, statement, or fact in a piece of data (Tesch, 1987). Finding commonalities and uniquenesses in these individual themes allows the researcher to crystallize the 'constituents' of the phenomenon resulting in a description of the 'general structure' of the phenomenon studied" (Giorgi, 1975).

Sampling
Before initiating the studies, the researcher(s) obtained approval from the screening committees of the respective funding bodies. The rights of the participants were safeguarded by informed consent and confidentiality. In the studies used for the analysis in paper I, as well as papers II-V, theoretical, or purposeful, sampling was used (Morse, 1991). The underlying assumption when selecting participants in the studies was that people who have experienced the phenomenon being investigated
are the source of knowledge for the understanding of the phenomena. The participants in the studies represented a variety of professions, their socio-economic situations were heterogeneous, and the style of living varied within the different samples. Below is an overview of the different samples:

<table>
<thead>
<tr>
<th>N=</th>
<th>Age</th>
<th>Study - Sample - Dialogues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper Ia</td>
<td>9 33-59</td>
<td><strong>Caring and Uncaring Encounters with Nurses</strong>&lt;br&gt;Former hospital patients. The participants had encountered nurses in a variety of hospital settings e.g. medical-, surgical-, psychiatric-, maternity-, and emergency-settings. Two dialogues with each participant.</td>
</tr>
<tr>
<td>Paper Ib</td>
<td>9 28-47</td>
<td><strong>Caring and Uncaring Encounters with Teachers</strong>&lt;br&gt;Former nursing students. Four had a BSN degree, four had a MSN degree, and one was working toward a PhD. One to two dialogues with each participant.</td>
</tr>
<tr>
<td>Paper II</td>
<td>9 41-72</td>
<td><strong>Caring and Uncaring Encounters with Nurses</strong>&lt;br&gt;Former cancer patients. The participants had suffered e.g. from carcinoid, breast cancer, colon cancer, uterine cancer, kidney cancer and prostate cancer. One to three dialogues with each participant.</td>
</tr>
<tr>
<td>Paper III</td>
<td>9 38-69</td>
<td><strong>The Lived Experience of Having Cancer</strong>&lt;br&gt;Former/present cancer patients. The participants had been treated for e.g. breast cancer, cancer of ovary, cancer of cervix, prostate cancer, skin cancer and cancer of intestines. One to three dialogues with each participant.</td>
</tr>
<tr>
<td>Paper IV</td>
<td>8 33-42</td>
<td><strong>Caring and Uncaring Encounters with Nurses/Midwives</strong>&lt;br&gt;Women who had given birth to a healthy child/children. The women had 1-4 children each. Altogether these women had 21 children between 2 months and 20 years of age. Average length from the latest birth was about 3 years. One dialogue with each participant. Dialogues with two additional women were used for methodological purposes.</td>
</tr>
<tr>
<td>Paper V</td>
<td>12 23-42</td>
<td><strong>The Lived Experience of Giving Birth</strong>&lt;br&gt;Women who had given birth to a healthy child/children. Altogether these women had 28 children. Average length from the latest birth was about 2 years. One dialogue with each participant. Dialogues with two additional women were used for methodological purposes.</td>
</tr>
</tbody>
</table>
N=  Age:  Study - Sample - Dialogues:

Paper VI  1  38  The Lived Experience of Health
A woman who considered her healthy and was ready to
describe her lived experience of health.
A married woman with two school-aged children, with
professional education, in full-time work and with slightly
above-average household wages. Four dialogues.

Data Collection
Since data collection in a phenomenological study necessitates bracketing, the
researcher(s) made conscious attempts to lay aside preconceptions about the
phenomenon under study e.g. by keeping the above-mentioned 'reflexive journal'.
The researcher(s) saw each participant as an expert and saw the whole data
collection process as an inter-subjective interaction where meaning is mutually
constructed. Procedure for data collection was the same in all the different studies.
Data were collected through dialogues, adhering to Strasser's (1969) ideas of true
dialogues: in speaking and listening I must adjust myself to the "you" with whom I
hold a dialogue; in knowing, evaluating, and striving I must adjust myself to the
matter that happens to be the object of our dialogue, and I must approach the matter
under discussion in a way that is formally the same as that of the "you" with whom
I am in dialogue (p. 103). Each participant, each dialogue and each phenomenon
was approached in this way. Participants were asked to describe their experiences
as fully as possible as well as to reflect upon their experiences. It is assumed that
people who are not in the midst of an experience are able to reflect more fully and
are able to provide a more comprehensive picture of the phenomenon. This is the
main rationale for only including in the studies people who were not in the middle
of experiencing the human phenomena being studied. It is, furthermore, assumed
that the reconstitution of the experience reflects how the phenomenon is lived
(Schuts, 1970).

The data were collected in a series of dialogue sessions that took place over a
period of weeks or months. The dialogues were entered into in the homes or offices
of the researcher(s) or participant(s). The dialogues were tape-recorded and
transcribed verbatim for each participant. The taped dialogues were usually from
60-120 minutes in length, with the average length being around one-and a-half
hour. Contact time with the participants was, however, often substantially longer.
Most participants talked freely in the presence of the tape recorder and seemed to
forget the presence of it after a short while.
Qualitative research emphasizes the meaningfulness of findings achieved by reducing the distance between researcher and participant and by eliminating artificial lines between researcher and participant reality (Sandelowski 1986). The construction of transcribed dialogues, the written accounts, reflected an evolving dialogue between the researcher(s) and the participants. The participants were approached with very broad questions that concentrated on the descriptions of the phenomenon under study and the feelings attached to it now, and at the time they experienced the phenomenon. During the dialogue or interaction with the participants they were asked questions that were in direct response to the participants' descriptions in order to arrive at a deeper level of understanding, to reflect and to validate. It was through this inter-subjective interaction or dialogue that the participants and the researcher(s) constructed the essential description of the lived experience being studied.

**Data Analysis**

In phenomenological research data collection and data analysis run concurrently. Thus there is temporal overlapping of these research processes similar to the way Lofland and Lofland (1984) describe. This means that the processes of data collection and data analysis occur simultaneously, and although these processes are presented separately they do not constitute distinct phases in the research process. The final stage of analysis (occurring after formal dialogues have ceased) becomes, then, a period for bringing final order into previously developed ideas (see Figure 1, below).

![Figure 1. Temporal overlapping of literature search, data collection and data analysis in phenomenology.](image-url)
The steps in the process of analyzing data in papers II-VI, as well as in the two studies analysed in paper I, can be summarized in the following way:

- **Reading and rereading the transcript** (the transcribed dialogue) to get a sense of the lived experience as a whole. Each transcript is read as an exciting novel at first with no pen or pencil in hand.
- **Underlining key statements** of the participants that has a special bearing on the phenomenon under study, as one would do in reading an important text to be analysed.
- **Identifying the themes in the underlined statements and giving those themes names** and writing those down in the margins of the transcript of each dialogue (hence wide margins).
- **Identifying the essential structure of the phenomenon in the transcribed dialogue.** Taking all the different themes from the margins and trying to identify the essential structure of the phenomenon in each dialogue.
- **Identifying the essential structure of the phenomenon.** Comparing the different dialogues in order to find the "common threads", as well as the differences, in the dialogues, in order to construct the overriding theme as well as the essential structure of the phenomenon.
- **Comparing the essential structure with the data.** Having identified the essential structure of the phenomenon, it is compared with the transcripts in order to see whether it fits the actual data. Are there some themes in the transcripts not accounted for? Should they be included or excluded?
- **Verifying the essential structure of the phenomenon or phenomena with the participants.** The analytic framework is preferably introduced to some or all of the participants in the study in order to see whether they recognize in it the analytic description of their own experience.

This way of doing phenomenology has been called "The Vancouver School of doing phenomenology" and has been taught personally by Professor Joan Anderson at the University of British Columbia, Vancouver, Canada. No written description exists as yet of this way of doing phenomenology. However, it bears some resemblance to Colaizzi's (1978) variation of the phenomenological method.

**Validity or Trustworthiness**

Within a phenomenological philosophy based on the intentionality of consciousness, validity involves coherence - a harmonious relation between an empty intention and a fulfilled meaning (Giorgi, 1988). Polkinghorne (1989) argues that the validity of the findings of a phenomenological research project depends on the ability of its presentation to convince the reader that its findings are accurate. He distinguishes between three strengths of the arguments. A 'sound'
argument resists attack, a 'convincing' argument can also silence the opposition, and
a 'conclusive' argument puts an end to all possibility of debate. Kvale (1989)
argues for a communal test of validity through the argumentation of the participants
in a discourse. He claims that this focus on the dialogue surpasses the polarity of
objectivism and relativism. He contends, as does Salner, (1989) that the quest for
absolute certain knowledge is replaced by a conception of 'defensible knowledge
claims'. Similarly, Polkinghome (1983) argues that validation becomes the issue of
choosing among competing and falsifiable interpretations, of examining and
providing arguments for the relative credibility of alternative knowledge claims.
The present author agrees with this view. Therefore, the essential structures
described in the different papers (I-VI) and the theory itself are seen as 'knowledge
claims'. The future will tell how 'sound', 'convincing' or 'conclusive' they are.

Validity and the Researcher(s)

In the studies presented in this thesis the researcher(s) were seen as the 'research
instrument(s)', therefore, validity was seen as hinging to a great extent on the skill,
competence, and rigor of the person doing fieldwork (Guba & Lincoln, 1981). This
view is supported by other scholars e.g. Patton (1990) who claims that the validity
and reliability of qualitative data depend to a great extent on the methodological
skill, sensitivity, and integrity of the researcher. Furthermore, Tesch (1990) claims
that one of the most persistent themes in qualitative methodology literature is the
emphasis on the person of the researcher, and the recognition of each scholar's
individuality as a 'research instrument'. She points out that in qualitative research
no two scholars produce the same result, even if they are faced with exactly the
same task. Their differences in philosophical stances and individual styles will lead
them to perceive and present the phenomenon each in their own way. Therefore,
investigator triangulation, the way it was done in papers IV and V (Halldórsdóttir
and Karlsdóttir, 1996a, 1996b), provides a way of combining expertise and diverse
research training backgrounds of two or more researchers (Mitchell, 1986; Kimchi,
Polivka and Stevenson, 1991), which may diminish the potential for bias that can
occur in a single investigator study (Denzin, 1989).

The Research Dialogues

Validation of the dialogues in papers I-VI consisted of continually questioning
interpretations. The essential description of the particular lived experience was
mutually constructed through inter-subjective interaction between the participants
and the researcher(s). An ideal dialogue was considered as one interpreted with the
interpretations verified and communicated in the dialogue situation. In the course
of dialogues, participants told stories and developed arguments, often with cross-
reference to earlier statements. The interaction between researcher and
participant(s) was an essentially communicative process. Both parties introduced,
re-introduced and developed particular themes while closing off other aspects of
'the discursive universe', similar to the way Jensen (1989) describes it in that the
participants ideally negotiate a form of common understanding, and the process of negotiation becomes accessible to analysis through tapes and transcripts.

**Ascertainment Validity or Trustworthiness**

A conscious effort was made to ascertain trustworthiness in all the studies (I-VI), as well as in the theory development itself, by examining the sources of non-validity, and the stronger attempts at falsification a proposition ‘survived’, the more valid and trustworthy the knowledge was considered. From this point of view, validation became investigation, continually checking, questioning, and theoretically interpreting the findings, which is in accordance with Kvale’s (1989) guidelines for ascertaining trustworthiness. Investigator triangulation is particularly useful in this endeavor. Furthermore, Lincoln and Guba’s (1985) guidelines for ascertaining truth value, applicability, consistency, and neutrality proved helpful in the studies used to develop the theory. Lincoln and Guba (1985) claim that the basic issue in relation to trustworthiness of qualitative research is how the inquirers can persuade their audiences (including themselves) that the findings of an inquiry are worth paying attention to, worth taking account of. There are at least four major threats to trustworthiness in qualitative research: ‘holistic fallacy’, ‘elite bias’, ‘going native’ and ‘premature closure’ (Lincoln & Guba, 1985; Sandelowski, 1986). Conscious effort was made to avoid these threats.

Finally, in the different studies, as well as in the theory development presented in this thesis, an attempt was made to build into the research process and the theory development process a continual effort of questioning and critically assessing the quality of collecting, analyzing and presenting the data. This occurred on the basis of the researcher as an individual, as well as through the above mentioned investigator triangulation (Papers IV and V). Last but not least it occurred through feedback from tutor(s) and colleagues, especially in doctoral seminars at the Department of Caring Sciences at Linköping University, in line with Tschudi (1989) who claims that if a research community does not embody validity-enhancing factors, all teachings of methodology may be but empty rituals. The feedback from tutor(s) as well as from colleagues in the doctoral seminars was perceived as an essential aspect of the theory development.

**FROM PAPERS TO THEORY DEVELOPMENT**

The dissertation is a summary of six original papers, two of which are published (I, III), two have been accepted for publication (IV, V), and two are submitted (II and VI). The general aim of the thesis was to develop a theory on ‘The Essential Structure of Caring and Uncaring Encounters within Nursing and Health Care - From the Patient’s Perspective’. Analysis of two phenomenological studies (Paper I) as well as research findings from five other phenomenological studies (Papers II-
VI) were used to develop the theory, involving different contexts of caring and uncaring encounters (Papers II and IV), as well as the lived experience of having cancer (Paper III), of giving birth to a normal child (Paper V) and of health (Paper VI).

Values Underlying the Theory

Values are the beliefs or the value system underlying a theory and must be congruent with the value system of the larger society which nurses serve.

1. Society views nursing as a valuable and necessary service.

2. Society expects nursing to define itself in a manner which is congruent to the values of that society.

3. Society wants and expects nurses to act for the individual who is the recipient of nursing and to take into consideration the recipient’s vulnerability and need for professional caring -- involving nurse competence, caring and nurse/patient connection. Society expects nursing action to increase the recipient’s well-being and health.

4. Society views well-being and health as desirable.

Assumptions Underlying the Theory

Assumptions are the premises or suppositions upon which a theory is based. They form its theoretical foundation. The assumptions underlying the present theory are partly based upon Eriksson’s (1993) and Martinsen’s (1993) ideas.

1. Each human being is equal to others concerning respect and personal rights. Human beings have a conscience and should treat each other with respect and compassion.

2. Each human being is of ultimate value but will not sense his or her true purpose and meaning in life unless having the lived experience, through a relationship with another, of being of ultimate value.

3. As human beings we are interdependent. We always hold the life of another human being in our hand.

4. Suffering occurs when basic human needs, e.g. for caring and connection, are not met.
Historical Evolution of the Theory

The first draft of the theory was presented in a doctoral seminar at the Center for Caring Sciences at Linköping University in 1992 “Essential Structure of Caring and Uncaring Encounters in Nursing”. This first draft of the theory was developed from four phenomenological studies that were conducted in 1988 (Halldörsdóttir, 1988, 1990a), 1989 (Halldörsdóttir 1990b) and 1990 (Emilsdóttir, et al., 1990; Gudmundsdóttir, et al.; 1990). Through the process of conducting studies II-VI in the years from 1991-1995 the theory was constantly in the process of development and refinement. During this time the theory was presented and discussed in seminars and at international scientific conferences in Sweden, Finland, Greece and Canada. The version of the theory presented in this thesis is the latest version of the theory. In the different studies the emphasis was on the patient’s perception of caring and uncaring encounters with nurses. In some cases a former patient described another health professional e.g. a physician, which means that when the word nurse is used in the thesis it can refer to a nurse or another health care professional whom the patient has encountered as a recipient of nursing and/or health care.

Summary of the Six Papers Used to Develop the Theory

Paper I

Paper I is an analysis of two formerly published studies (Halldörsdóttir, 1988/1990a and 1990b) on caring and uncaring encounters. In the former study the research question was: What is the essential structure of a caring and an uncaring encounter with a nurse, from the perspective of the recipient of nursing care? The research question in the latter study was: What is the essential structure of a caring and an uncaring encounter with a teacher, from the perspective of the recipient of nursing education? The research question of the analysis itself was: What are the basic modes of being with another within nursing and health care? The main findings in paper I is that there are five basic modes of being with another:

1. The life-giving mode, where the provider of professional human service affirms the personhood of the recipient by connecting with him or her in a caring way, thus relieving the recipient’s vulnerability and making the recipient stronger and potentiating perceived well-being, healing and learning.

2. The life-sustaining mode, where the provider acknowledges the personhood of the recipient by supporting, encouraging, and reassuring the recipient. It gives the recipient security and comfort, and positively affects the recipient’s well-being but does not increase his or her perceived sense of healing.
Lack of Professional Caring

The Nurse Perceived as Uncaring
Incompetent and Indifferent

The Cancer Patient
Uncertainty
Vulnerability
Isolation
Discomfort
Redefinition

Perceived Effects of Lack of Professional Caring:
Discouragement
i.e. decreased sense of well being and health

Connection with comfortable distance of respect and compassion

Perceived Effects of Professional Caring:
Empowerment
i.e. increased sense of well being and health

The Nurse Perceived as Caring
Competent and Genuinely concerned

Figure 2. Schematic Representation of Study II and III
3. The life-neutral mode of being, where the provider is not perceived to affect well-being in the recipient, neither positively nor negatively.

4. The life-restraining mode, where the provider is perceived as insensitive or indifferent towards the recipient, causing discouragement and uneasiness in the recipient. It negatively affects well-being in the recipient;

5. The life-destroying (or life-hurting) mode of being with another, where the provider depersonalizes the recipient, and increases the recipient’s vulnerability. It causes distress and despair, and hurts the recipient. This destructive mode is manifested e.g. in threats, manipulation, coercion, ridicule, hatred, aggression, dominance and other humiliating approaches.

Papers II and III (see Figure 2 p. 24)
In paper II the aim of the study was to explore caring and uncaring encounters with nurses and other health professionals, from the former cancer patient’s perspective. The research question was: What is the essential structure of caring and uncaring encounters with nurses and other health professionals, as perceived by people who have been diagnosed and treated for cancer? Through thematic analysis of in-depth dialogues, with five women and four men in the remission or recovery phase of cancer, three major categories regarding both caring and uncaring encounters were identified. The essential structure of a caring encounter: 1. the nurse perceived as caring: an indispensable companion on the cancer trajectory; 2. the resulting mutual trust and caring connection; 3. the perceived effect of the caring encounter can be summarized as empowerment, including a sense of solidarity, well-being and healing. The essential structure of an uncaring encounter: 1. the nurse perceived as uncaring: an unfortunate hindrance to the perception of well-being and healing; 2. the resulting sense of mistrust and disconnection; 3. the perceived effect of the uncaring encounter can be summarized as discouragement, including a sense of uneasiness, decreased sense of well-being and healing and even a sense of being broken down. The findings emphasize the primacy of competence in professional caring, as well as that of genuine concern, openness and a willingness to connect with others. The often devastating effects of uncaring encounters on the recipient of nursing and health care raises the question whether uncaring as an ethical and a professional problem should perhaps be dealt with as malpractice in nursing and health care.

In paper III the ‘Lived Experience of Having Cancer’ was described by people who had been diagnosed and treated for cancer. The research question was: What is the essential structure of the lived experience of having cancer, as perceived by people who have been diagnosed and treated for cancer? The dialogues were transcribed and thematically analysed. The findings indicate that the lived experience of
Lack of Professional Caring

The Nurse/Midwife Perceived as Uncaring
Incompetent and Indifferent

connection

The Woman Giving Birth
Circumstances Expectations Vulnerability Perceived Needs Sense of self

Connection with comfortable distance of respect and compassion

The Nurse/Midwife Perceived as Caring
Competent and Genuinely concerned

Perceived Effects of Lack of Professional Caring:
Discouragement
i.e. decreased sense of well being and health

Perceived Effects of Professional Caring:
Empowerment
i.e. increased sense of well being and health

Figure 3. Schematic Representation of Study IV and V
having cancer is many-sided and involves experiencing existential changes. Among the different aspects of this experience is the feeling of: Uncertainty, which all the participants experienced in all the stages of cancer: In the diagnostic phase (is it cancer?), in the treatment phase (will the treatment work?), during the post-treatment phase (will I get cancer again?), and in the terminal phase (when will I die?); Vulnerability, which all the participants felt because of the cancer experience. They all felt that because of this vulnerability encounters with nurses and other health professionals have much greater effect on them when they are well; Isolation, most of the participants felt isolated and alone at some point in time, either because of withdrawal or because of perceived or actual rejection in the environment; Discomfort, which was the common experience of all the participants. It can be mental or emotional, and it can be physical, caused e.g. by appetite and eating problems, nausea and vomiting, constipation or diarrhoea, fatigue, pain, or disturbances in their sleeping patterns; Redefinition. All the participants felt that the cancer experience had changed them. They had redefined their goals and roles or their environment had redefined them for them (see Figure 2, p. 24).

Papers IV and V (see Figure 3 p. 26)
In paper IV women’s experiences of caring and uncaring encounters during childbirth were described in dialogues with eight women who had experienced caring and uncaring encounters during labour and delivery. Dialogues with two additional women were used for methodological purposes. The research question was: What is the essential structure of caring and uncaring encounters with nurses/midwives, and other health care professionals, during labour and delivery, as perceived by women who have given birth to a normal child? The findings indicate that the nurse/midwife perceived as caring is perceived as an indispensable companion on the journey through labour and delivery, having competence, genuine concern and respect for the childbearing woman (and her partner), as well as a positive mental attitude. Positive effects of the caring encounter can be summarized as the sense of being empowered, including a sense of trust and connection, feeling safe and at ease and a sense of a successful birth. The nurse/midwife perceived as uncaring, however, is perceived as incompetent, indifferent or lacking respect for the woman as a person and as a childbearing woman. Perceived negative effects of the uncaring encounter can be summarized as discouragement, including feeling unconnected and alone, insecure and afraid, distressed and out-of-control, hurt, bitter and angry, and sometimes a sense of failure as a woman giving birth. Sometimes the woman is determined not to go through birth again because of the uncaring experience.

In paper V the journey through labour and delivery was described in dialogues with twelve women who had experienced giving birth to a normal child. Dialogues with two additional women were used for methodological purposes. The research question was: What is the essential structure of the lived experience of
childbearing, as seen from the perspective of women who have given birth to a child? The lived experience of journeying through labour and delivery is a many-sided reality. It is composed of the woman's perceived circumstances and expectations before the birth; a sense of vulnerability and a sense of being in a private world during the birth experience; perceived needs during labour and delivery, which can essentially be described as the need for nurse/midwife competence, caring and connection; as well as a sense of self while going through labour and delivery, including the perceived rough journey through labour and the triumphant joy of delivering a healthy baby; the first sensitive hours of motherhood; and finally, the perceived uniqueness of birth as a life experience.

In paper VI the lived experience of health was described in a phenomenological case-study. The research question was: What is the essential structure of health from the perspective of an individual? The purpose of this phenomenological case-study was twofold: firstly, to develop the essential structure of health from the perspective of an individual and thus to develop a more contextual conception of health in order to increase the knowledge and understanding of this important concept within nursing and health care; and secondly, to construct a theoretical definition of health. Three major themes were identified in the study, indicating that health is a contextual, multifaceted and multidimensional lived reality, the subjective perception of which can be increased or decreased by actions of the individual or others. A theoretical definition of health was constructed from the study which can be used in theory development, education, research and practice.
Method Used to Develop the Theory

The method used to develop the theory of 'Caring and Uncaring Encounters within Nursing and Health Care - From the Patient's Perspective' is theory synthesis, as described by Walker and Avant (1988). Theory synthesis is a strategy aimed at constructing theory from empirical evidence and enables a theorist to organize and integrate a wide variety of research information on a topic of interest. Concepts and statements are organized into a network or whole, a synthesized theory. Synthesized theories may be expressed in several ways. The theory in this thesis is presented in graphic form. Walker & Avant (1988) point out that when the relationships within and among statements are depicted in graphic form, this constitutes a model of the phenomenon. Theory synthesis includes three basic steps which were followed in the development of the theory, presented in this thesis, in the following way:

1. Key concepts and key statements for the synthesized theory were specified. Each of the six papers were analyzed for key concepts and key statements. (see Appendices I:1-6). These were then used as building blocks for the theory.

2. The literature was reviewed to identify factors related to the key concepts or key statements and the relationships between these. By using either a single focal concept or a framework of concepts as an entry point into the literature a careful review of the literature was done. During the review, note was taken of variables related to the key concepts or framework of concepts. Relationships identified were systematically recorded.

3. Concepts and statements about the phenomenon of the ‘Essential Structure of a Caring and an Uncaring Encounter within Nursing and Health Care from the Patient's Perspective’ were organized into an integrated representation of it. Having collected a fairly representative listing of relational statements pertinent to one or more key concepts, these were organized in terms of the overall pattern of relationships among variables. A diagram was chosen as a way to express relationships among the main concepts of the theory (see Figure 4, p. 30).
Lack of Professional Caring

The Nurse Perceived as Uncaring
Incompetent and Indifferent

Professional Caring

The Nurse Perceived as Caring
Competent and Concerned

Perceived Effects of Lack of Professional Caring:
Discouragement
i.e. decreased sense of well being and health

Perceived Effects of Professional Caring:
Empowerment
i.e. increased sense of well being and health

The Recipient in Context
-A sense of vulnerability
-The need for professional caring

The Recipient in Context
-WALL

The Recipient in Context
-B R I D G E professional connection with professional distance

Figure 4.
Schematic Representation of a Theory on the Essential Structure of a Caring and an Uncaring Encounter with a Nurse: From the Perspective of the Recipient of Nursing and Health Care.
DESCRIPTION OF THE THEORY

The theory is synthesized from the six papers (I-VI) already described. The result is an empirically derived theory pertaining to the characteristics of ‘Caring and Uncaring Encounters in Nursing and Health Care -- From the Patient’s Perspective’. The major components of the theory are the patient’s perception of a caring and an uncaring encounter with a nurse (Papers I, II & IV), and the patient’s perception of self and own context (Papers III, V & VI) (see Figure 4, p. 30).

There are two major metaphors in the theory, that of the bridge, symbolizing the openness in communication and the connectedness experienced by the recipient of care in an encounter perceived as caring. The other metaphor is the wall, which symbolizes the negative or no communication, detachment and lack of a caring connection, experienced by the recipient of care in an encounter perceived as uncaring.

Definition of the Major Concepts of the Theory

Professional caring involves competence and caring as well as a connection between the care-giver and the care-receiver.

Competence within nursing involves certain skills. Those skills are essentially: competence in empowering patients, competence in building relationships, competence in educating patients, competence in making clinical judgements, and competence in doing tasks and taking action on behalf of people.

Caring within nursing encompasses being open to and perceptive of others; being genuinely concerned for and interested in the patient, as a person and as a patient; being morally responsible; being truly present for the patient; and finally, being dedicated and having the courage to be appropriately involved as a professional nurse.

Connection within nursing involves two interrelated processes -- development of professional intimacy while maintaining professional distance.

The Bridge is a metaphor for the above connection.

Professional intimacy involves intimacy about the patient's present condition and how the patient feels about it. It includes information that the nurse needs to have in order to give nursing care according to the individual needs of each patient.
Professional distance involves a comfortable distance of respect and compassion. It is an element of professional caring that has to be there in order to keep caring within the professional domain.

Empowerment: Increased sense of well-being and health. A subjective sense of being strengthened, e.g. by gaining or regaining a sense of control.

Health: a contextual multifaceted lived reality involving a physical, mental, emotional, spiritual, social and societal dimensions, the personal perception of which can be increased or decreased by actions of the individual or others. The lived experience of health can be summarized as the feeling of empowerment where the individual has the ability to achieve his or her vital goals that are connected with his or her long-term happiness.

Lack of professional caring: perceived uncaring and incompetence on behalf of the nurse.

Uncaring: The patient feels that the nurse does not care about him or her as a person and/or as a patient. The nurse is perceived as inconsiderate, insensitive, disrespectful and disinterested in the patient. Sometimes there are perceived negative personal characteristics e.g. being gloomy, brusque, or unkind.

Incompetence: The patient feels that the nurse is incompetent in some way, e.g. being rough when giving care, ineffectively communicating, not taking initiative when needed, not respecting the patient's need for information, instruction and positive feedback; lacking understanding in what the patient is going through; only comes to the patient when called and does not give him- or herself time to attend to the patient when called.

The Wall: The perceived disconnection between the nurse and the patient. As a result of the perceived uncaring the patient does not trust the nurse and there seems to develop a mutual avoidance: the nurse is perceived as either unwilling or unable to connect with the patient resulting in the perception of a wall.

Discouragement: Decreased sense of well-being and health. A subjective sense of being broken down in some way, e.g. by losing a sense of control.

Vulnerability: the lived experience of being easily hurt and easily set off balance, as well as easily encouraged and supported i.e. easily empowered or discouraged.
Propositions

The client: The recipient of nursing is a vulnerable person in need for professional caring, involving nurse competence, caring and connection.

The context: as perceived by the recipient of nursing and health care is twofold: the inner context, the perceived needs, expectations, previous experiences and sense of self, and the outer context, the hospital reality as perceived by the patient.

Nursing therapeutics - is through professional caring, involving competence, caring and connection. When provided it increases the patient's sense of well-being and health which can be summarized as a sense of being empowered. When it is not provided it discourages the patient.

An Encounter Perceived as Caring

The essential structure of an encounter with a nurse perceived as caring-- from the patient's perspective is composed of three basic components: The nurse perceived as caring; the resulting mutual trust and a connection that develops between the nurse and the recipient, which is one of a perceived bridge, symbolizing the perceived openness in communication and the connectedness with the comfortable distance of respect and compassion; and finally perceived effects of the caring encounter, which are perceived by the recipients as increased well-being and health, which essentially can be summarized as empowerment. The nurse's competence and caring approach is a prerequisite for the nurse-patient connection and together they form the essential structure of professional caring.

Professional Caring
The essential elements of competence, caring and connection is perceived by the participants as evidence of professional caring. The competence aspect includes:

- Competence in empowering people
- Competence in connecting with people
- Competence in facilitating knowledge development (educating people)
- Competence in making clinical judgements
- Competence in doing tasks and taking action on behalf of people
  - including e.g. active advocacy and collaboration.
The caring aspect includes:

- **Being open to and perceptive of others** - e.g. being sensitive to patient needs
- **Being genuinely concerned for the patient** - as a person and as a patient
- **Being morally responsible** - e.g. being respectful of self and others.
- **Being truly present for the patient** - attentiveness to the present moment
  - present in a dialogue, in listening and responding
  - present in a situation, physically and emotionally.
- **Being dedicated and having the courage to be appropriately involved** as a professional nurse

Participants have reported that the combination of competence and caring as described above, promoted in them a feeling of trust, which facilitated the development of a professional connection between them and the caring nurses, which represents the *connection aspect* of professional caring. For many of the participants, this connection, or personal relationship, was the fundamental difference between caring and uncaring.

The *connection aspect* of professional caring:
The actual bridgebuilding can be conceptualized as a process involving five phases:

1. **Initiating professional connection** usually requires some reaching out and responding by both nurse and patient.

2. **Mutual acknowledgement of personhood** occurs through some reciprocal self-disclosure, limited, but sufficient to remove the masks of anonymity, remove the stereotypes of patient and nurse.

3. **Acknowledgement of the bridge**. The patient realizes that a connection has been established, and feels free to follow-up on it e.g. by asking for help when needed.

4. **Professional intimacy**, or intimacy about the patient's present condition occurs when the patient has acquired a trust towards the nurse, has become willing to open up, and feels free to reveal to the nurse some details about his or her present condition, and how he or she feels about it.

5. **Negotiation of care**. As a result of the connection or professional intimacy, the nurse is better able to understand the patient in his or her context. This understanding enables the nurse to appreciate the patient's perspective, which is a prerequisite for truly negotiating care. The nurse works with the patient as an equal toward their common goal, the patient's increased health and well-being.
Although the nurse perceived as competent and caring and who connects with the patient is both with and for the patient, the nurse maintains separateness throughout the development of the connection. This separateness is what constitutes professional distance. The bridge-building therefore, involves two interrelated processes: developing professional connection; and keeping a comfortable distance of respect and compassion. The participants have clearly articulated that from their point of view, the nurse-patient connection belongs to a particular setting, or culture, and should be confined to that setting. Furthermore, they have emphasized that keeping a professional distance was one important way of keeping the nurse-patient connection within the professional domain.

**Perceived Effects of Professional Caring**

The outcome of professional caring is positive change -- empowerment - an increased sense of well-being and health. The former cancer patients in study II described the empowering effects of professional caring including a better self-image, an increased sense of security and well-being, a sense of acceptance and an increased internal sense of healing. They felt that the nurse was on their side, which gave them a sense of solidarity and increased sense of control. The women in study IV described a sense of relief, a feeling of being safe and at ease and of being able to be themselves in their context as childbearing women.

**An Encounter Perceived as Uncaring**

The essential structure of an encounter with a health professional perceived as uncaring from the client's perspective is also comprised of three basic components: The health professional perceived as uncaring, who is perceived by the recipient as incompetent and indifferent to the patient as a person; the resulting wall, consisting of a lack of trust in the health professional, perceived mutual avoidance and disconnection between the nurse and the patient; and finally the perceived effects of the uncaring encounter, which is perceived decrease in well-being and health, essentially described as discouragement.

**Lack of Professional Caring**

The nurse, perceived as uncaring is perceived as lacking in genuine concern for the patient as a person and as a patient. The nurse is perceived as incompetent in some way, e.g. being rough when giving care, ineffectively communicating, not taking initiative when needed, not respecting the patient's need for information, instruction and positive feedback (when relevant); lacking understanding in what the patient is going through; only comes to the patient when called and does not give him- or herself time to attend to the patient even when called; is perceived as inconsiderate, insensitive, disrespectful and disinterested in the patient as a patient and as a person. What characterized the persons the patients described as uncaring was that
they seemed to be people with some negative personal characteristics e.g. being gloomy, brusque or unkind. When there is incompetence it is as if the nurse does not mind the incompetence. Finally, the nurse is perceived as either unwilling or unable to connect with other people resulting in the perception of a wall.

Perception of a wall symbolizes negative or no communication, detachment and lack of a caring connection, experienced by the recipient of health care in an encounter perceived as uncaring. The “wall” can be in various sizes and shapes i.e. there is a difference as to how the recipient of nursing and health care experiences the wall depending upon how negative the approach by the nurse is. In order of increased indifference the following stages are proposed: Disinterest, insensitivity, coldness, and inhumanity.

**Disinterest**, refers to the approach in which the nurse is inattentive to the patient and the patient’s specific needs. It refers to the lack of a positive or caring approach rather than the presence of something destructive. The nurse is perceived by the patient as inattentive and lacking in genuine concern and interest in the patient.

**Insensitivity**, is when the nurse’s indifference to the patient as a person becomes disruptive for the patient. The patient strongly feels that the nurse doesn’t care about him or her and that the nurse’s presence is disruptive in some way. Insensitivity by the nurse is also perceived by the patient as a certain blindness to his or her feelings, and the patient starts to feel bothering the nurse when asking for help.

**Coldness** is when the patient perceives the nurse almost like a computer, a robot, or a machine, as someone cold and unkind. This coldness affects the patient profoundly in a most negative way. Even worse is the message that the patient receives, which is that the patient is a nuisance to the nurse, if it was not for the patient the nurse’s life would be a lot easier. The encounter with a nurse perceived as cold is most often short and abrupt and not the least bit friendly and can be extremely business-like.

**Inhumanity.** The most severe form of uncaring to the patient as a person is inhumanity. It is characterized by various forms of inhumane attitudes, such as being totally ignored as a person, being mistreated, ridiculed, and treated as a pest. This gruesome approach constitutes a very strong negative feedback for the patient. The patient feels that the nurse is against him or her, suffers and feels victimized.

**Perceived Effects of the Lack of Professional Caring**
An encounter perceived as uncaring results in negative change - in discouragement, decreased sense of well-being and health. The former cancer patients in study II described the discouraging effect uncaring had on them as patients. They reported a
feeling of rejection and even of being broken down. All of them felt that they became filled with insecurity, uneasiness and stress, decreased self-confidence and decreased sense of control. They all felt that it had negatively affected their well-being and sense of healing. The women in study IV also described the discouraging effect of uncaring. Their first reaction seemed to be one of puzzlement and disbelief and an effort in trying to make sense of the uncaring. Perceived uncaring increased their anxiety, left them feeling insecure and afraid, distressed and out-of-control, which in some situations made them feel hurt, bitter and angry. Feeling uncared for during labour and delivery sometimes seemed to result in the feeling of being a failure as a woman giving birth and often the perceived uncaring resulted in long-term negative feelings toward the nurse/midwife and an internal decision not to go through birth again.

The Recipient of Nursing and Health Care - in Context

The third and final component of the theory is the recipient of nursing and health care in context, which is mainly derived from papers III, V and VI. However, some aspects of this component are also represented in papers II and IV. It is important to look at a person’s experience of caring and uncaring encounters with nurses/health professionals from the context of what that person is going through. The lived experience of having cancer (Paper III) should be kept in mind, for example, when cancer patients’ perceptions of caring and uncaring encounters with nurses are being looked at (Paper II). The person on the cancer trajectory is experiencing existential changes involving the lived experience of uncertainties, vulnerability, isolation, and discomfort, as well having to redefine roles and goals regarding life and health (Paper III), which is bound to affect that person’s perception of encounters with others. Similarly, a woman’s experience of going through labor and delivery (Paper V) should be kept in mind when looking at women’s experience of caring and uncaring encounters during this vulnerable time in a woman’s life (Paper IV). Finally, a person’s lived experience of health and well-being should also be looked at in the context of that person’s life. The results from paper VI suggest that health is a contextual, multifaceted and multidimensional lived reality. Therefore, in the theory the importance of seeing the recipient in his or her context, inner as well as outer, is emphasized. The inner context involves perceived needs, expectations, previous experiences and sense of self, which in the context of the recipient can be summarized as a sense of vulnerability and the need for professional caring, involving competence, caring and connection. The recipient’s outer context is, for example, the perceived hospital environment.
The Inner Context: The Patient's Sense of Self
It was the participants' unanimous perception that they felt vulnerable and in need of professional caring, involving caring, competence, and connection, when they were in the hospital or the health care context. All participants felt that this made them more sensitive to caring and uncaring. The accounts illustrate the participants' own perceptions of their sensitivity and vulnerability as patients. This idea of vulnerability of the patient was noted by most of the participants.

The Outer Context - The Perceived Hospital Environment
The participants accounts illustrate that they appreciate the restraints put on caring by the hospital reality. Some participants, for example, pointed out how ever-changing shifts made any professional connection difficult. Some participants also pointed out that the hospital environment is often alien to the patient, which makes caring, and even familiarity of a face important. Other participants mentioned lack of time and how nurses today seemed to them to be rushed off their feet. They emphasized, however, that although they had wished for a little longer time with the professional nurse, caring could often be conveyed without being too time-consuming. The participants have also pointed out that lack of every-day stimulation makes the patient even more dependant upon the interactions with the health professionals. The accounts illustrate participants' perception of being dependant within the hospital setting, and how the hospital routine often is contrary to the patient's needs. Some participants expressed their perceptions that although they, as patients, were consumers, they didn't perceive themselves as having the same explicit rights as consumers generally have outside the hospital setting -- that often when there are choices to be made between the comfort of the patient and the needs of the bureaucracy, the needs of the bureaucracy wins.
DISCUSSION

Professional Caring

The importance of professional caring is proposed in the theory, involving competence, caring and connection. The concept “professional” in this connection is used mostly to convey the competence aspect of caring within nursing and health care involving certain skills. The basis of the theory is that there is a difference between caring and professional caring. The latter including the former, thus genuine caring is only one important aspect of professional caring. From the data it can be concluded that competence administered with compassion is an essential component of professional caring. It implies that a professional nurse, is perceived by the patient as caring only if competent and administering care with compassion. Thus caring and compassion are seen as the kind of attitude that makes up true professional competence. This attitude or feeling tone is seen as genuine concern for the patient as a person and as a patient. So, in professional caring competence and caring are not dichotomous. They should go hand-in-hand and if you remove one you diminish nursing.

Riemen's (1986a, 1986b) findings are supported by the present theory in that it represents a part of the phenomena of caring and uncaring as compared to the theory. However, interestingly, Riemen (1986a, 1986b) does not mention competence as an important aspect of caring from the patient’s perspective, as most studies involving the patient perspective of caring have noted. Von Essen (1994), e.g., having done an extensive literature review of patients' and staff perceptions of important caring behaviors, concludes that the presented results indicate that patients and staff do not share the same perspective on the importance of caring behaviors. According to von Essen (1994), staff tends to stress the importance of emotional caring whereas patients seem to stress the importance of the task oriented caring aspect. The question is whether Riemen, being a nurse, overstates the emotional aspect of patient's perceptions of caring and understates their emphasis on the competence of the nurse, which might be an indication of 'premature closure' (Lincoln & Guba, 1985) in the data analysis.

Recipients of nursing and health care come to nurses and other health professionals because of their professional expertise. Undermining that expertise by ignoring competence as an essential element of professional caring is a threat to nurses as professionals. If professional caring is what patients need and want, instead of 'mass-production-line processing' and 'emotional sterility' (Larsson, 1989; Lowenberg, 1994), and judging from the positive outcomes of professional caring, nursing could take the lead in demonstrating that mode within the provision of health care which would probably "increase nursing’s visibility and leadership within the health care delivery arena“ in the way Lowenberg (1994) describes. The
The Competence Aspect of Professional Caring

In the theory there are five aspects of competence that are seen as essential aspects of professional caring within nursing: competence in empowering people; competence in building relationships; competence in facilitating knowledge development (educating people); competence in making clinical judgements; and competence in doing tasks and taking action on behalf of people.

It was clear from the former recipients of nursing and health care that professional caring includes competence in empowering people. They felt empowered by the nurse who was perceived as caring. The encounter perceived as caring made them feel stronger and their sense of well-being and health increased. Gibson (1991) did a concept analysis of empowerment to examine the attributes, characteristics and uses of the concept. According to her the concept is complex and multidimensional. In a broad sense, Gibson claims, empowerment can be seen as “a process of helping people to assert control over the factors which affect their lives” (1991, p. 354). She asserts that empowerment is a difficult concept to define and is easier understood by its absence: such as loss of a sense of control over one’s life, helplessness, powerlessness, hopelessness, and dependency, oppression, paternalism, subordination, victimization and alienation. In study VI the participant emphasized a sense of control over her life as one of the key aspect of feeling healthy. This is supported by Gibson (1991) who claims that the World Health Organization’s definition of health promotion in the mid-1980s as a process of enabling people to increase control over and to improve their own health has already made the link between empowerment, control and health.

Seeing professional caring as an interpersonal interaction and as competence in connecting with people is an important aspect of the theory. This component is emphasized in the former patients’ accounts as well as in the literature. The participants emphasized that this important connection was formed between them.
and the nurses perceived as caring whereas there had been no caring connection established between them and the nurses perceived as uncaring, either because they were unable or unwilling to establish this connection. The participants emphasized that they were not interested in "relationships". However, they wanted to feel "connected" so that they would be able to follow-up on that if they needed anything e.g. help or information. Being able to connect with people is an aspect that has been emphasized in the nursing literature. However, many have tended to call it nurse-patient relationship which would be contrary to the way the participants in the different papers have described the needed “nurse-patient connection”. Meleis (1991) points out that several nurse theorists have addressed nursing as a process of interaction e.g. Imogene King, Ida Orlando (Pelletier), Josephine G. Paterson and Loretta T. Zderad, Joyce Travelbee, and Ernestine Wiedenback. To this list Katie Eriksson, Jean Watson and Kari Martinsen should be added. Eriksson (1990) claims that caring always occurs in a meeting between two individuals and that a caring relation between these individuals necessitates the carers' faith, hope and love. Martinsen (1993) also claims that caring has to do with our relations with another because we, as human beings, are interconnected, woven together like a tapestry. She claims that our story is always a weaving of human relationships and that nursing is essentially a relational profession. She has the vision, inspired by Lögstrup, of a society changed for the better through true caring in human relations. Her vision is shared e.g. by Watson (1988), Eriksson (1990), Dunlop (1994) and the present author.

In the theory presented in this thesis competence in educating people is seen as an essential aspect of professional caring. Even if the caring imperative in education has been noted (Leininger & Watson, 1990), with the exception of Vaughan (1991), the author of this thesis has not seen caring connected with patient education in the literature. However, many nursing theorists have seen patient education as an essential part of nursing (e.g. Benner, 1984; Leddy, & Pepper, 1993; Redman, 1993; and Whitman, et al., 1986). Furthermore, Wallerstein, and Bernstein (1988) have pointed out the need for empowerment education for personal and social change, where Freire's ideas are adapted to health education. Patients' emphasis on being well informed is a clear message to nurses and other health professionals to see patient education as an essential part of their work if they truly care for the person who is their patient. The former cancer patients (Paper II) as well as the women who had given birth to a child (Paper IV) saw the caring nurse as a competent coach on their journey through the cancer or birth experience respectively -- a reliable guide who told them what to expect and explained what was going on during the often tumultuous journey.

*Competence in making clinical judgements* is another important part of professional caring in the theory. It is clear from the data that patients want to feel safe and at ease in the trust that nursing and health care practice is geared towards their
increased health and well-being. They want to be able to trust that nurses and other health professionals know what to do in each situation. To see this aspect as an essential aspect of professional caring is supported by Bishop and Scudder (1996) who point out that the ways of practice have the good of the patient built into them. Thus a practice consists of "historically developed ways of fostering good in which the good sought, the ways of fostering that good, and the personal concern for the other are integrally related to each other" (Bishop and Scudder, 1996, p. 20). Therefore, standards of practice, such as the one described by Lundgren (1995), can be seen as one way of fostering professional caring.

Professional caring as competence in doing tasks and taking action on behalf of people is another important finding emphasized in the theory – professional caring is indeed a therapeutic intervention. Meleis (1991) groups the nursing activities and actions that are deliberately designed for caring for patients, potential patients, or people at risk under "nursing therapeutics". She points out that theorists have described and discussed nursing therapeutics with various degrees of emphasis. In the present theory it is assumed that when professional caring is patient centered and the patient's individual needs for competence, caring, and connection is met, it deeply affects the patient in a most positive way. In fact it results in such positive outcomes that former patients sometimes refer to professional caring as medication of sorts. Receiving professional caring influences the recipient very positively and the consequences can be summarized as empowerment - increased well-being and health, whereas uncaring has a very negative consequences which can be summarized as discouragement - decreased well-being and decreased sense of health. Health in this context is defined as a subjective experience of the recipient. Former patients' descriptions of the positive consequences of professional caring supports Gaut's (1983) analysis of caring as a concept, where someone's actions on behalf of the person is based on the welfare of that person, which in the health care context means a positive change in the patient. The data indicate that the caring nurses get to know the patients as persons and communicate with them in a way that makes them feel accepted as normal human beings, and legitimized as persons and patients. The participants claimed that this helped them to feel all right about themselves and their hospital stay. Professional caring gave them, they claimed, a sense of security and confidence. The participants also reported positive effects on their sense of well-being and healing. Similar reports can be found in the literature (Dass & Gorman, 1987; Drew, 1986; Pauley, 1983; Riemens, 1986a, 1986b; Sarason, 1985).

The Caring Aspect of Professional Caring
In the theory there are five aspects of caring that are seen as essential aspects of professional caring: being open to and perceptive of others - e.g. being sensitive to patient needs; being genuinely concerned for the patient, as a person and as a patient; being morally responsible - e.g. being respectful of self and others; being
truly present for the patient which means attentiveness to the present moment—
being present in a dialogue, in listening and responding, and being present in a
situation, physically and emotionally; and finally, being dedicated and having the
courage to be appropriately involved as a professional nurse.

*Being open and perceptive of others* is an important aspect of professional caring
according to the theory. The former patients emphasized that the caring nurse was
open towards them and towards life in general and was perceptive of their needs.
This existential stance, this essential aspect of professional caring is supported by
Montgomery (1993), as well as Eriksson (1992) who claims that true caring is not a
form of behaviour, not a feeling or a state, but an ontology, a way of living.
Eriksson states: “it is not enough to be there, to share - it is the way - the spirit in
which it is done” (1992, p. 209). Eriksson (1992) further claims that at the heart of
caring communion are different prerequisites which appear to be most important for
its experience. Heading the list, she claims, is a genuine, mature, and professional
attitude. She states: “This is something more than “regular” neighbourliness and
friendship. The professional attitude implies responsibility, genuineness, courage,
and wisdom” (p. 208). In a similar way, Martinsen (1993) claims that caring
necessitates “radical openness to another”. She emphasizes the importance of open
communication, consideration, and hope. Watson (1988) asserts that the ideals of
human caring that are rooted in receptivity, intersubjective relatedness, and human
responsiveness help to counteract the medical ethic of rational principle, fairness,
and equity that objectifies, detaches, and distances the professional from the
subjective world of the human experience. She maintains that in nursing and caring
we are not concerned primarily with justification through ethical principles and
laws in general. In contrast, she states, an ethic of caring ties us to the people we
serve and not to the rules through which we serve them, like Noddings (1984) has
also pointed out.

Caring as *being genuinely concerned for the patient* is another important aspect of
professional caring according to the theory. Seeing caring as an affect, is
strengthened by the former patients’ descriptions of a caring encounter where they
described a feeling of compassion which they felt motivated the caring person to
provide care for them. This aspect is supported by most caring theorists. Martinsen
(1993) claims that caring is manifested in genuine good-will towards another. She
asserts that it is the quality of true serving, caring, giving and forgiving that they
have to be given from the heart spontaneously. She claims that if they are
calculated they lose their power. The primacy of caring as genuine concern in
nursing has also been claimed e.g. by Benner and Wrubel (1989), Leininger (1984)
and Watson (1988). However, many nurses have voiced concern about providing
holistic and compassionate care in the computerized and mechanized environment
of modern health care (e.g. Clifford, 1995; Fry, 1988; Henderson, 1985; and Miller,
1987). Nursing has in some ways reflected the ambivalence of western society
concerning womanhood and caring as Pepin (1992) has pointed out. She claims that although rooted in women's work, nursing in institutions became "routinized" as it was partly deprived of the affective aspect of caring. Furthermore, she asserts that in striving for recognition, nurses faced the necessity of emphasizing the work aspect of caring, running the risk of rejecting altruism and caring itself. Pepin claims that it was only through 'helping relationships' and 'nurse-client interactions' that nurses kept sight of the affective aspect of caring. She states that the recent interest of nursing in caring "marks a return to the feminine perspectives and to a more balanced view of caring" (1992, p. 129).

Caring as being morally responsible is proposed as being another essential aspect of professional caring in the theory. Thus it is claimed that professional caring is a moral imperative which strengthens the view that caring is a moral virtue and that one of the main concerns of nurses and other health professionals should be about patients' good and to maintain dignity and respect of patients as people. This is in accordance with nursing scholars who have advocated this view such as Eriksson (1993), Martinsen (1993), Brody (1988), Gadow (1988), Lützen (1993), Åström (1995), and Watson (1988), who have all offered valuable insights into this perspective. Brody (1988), for example, identifies caring as the central virtue for nursing. She has contended that recognizing and accepting the interpersonal aspect of their practice, nurses seek to show respect for the personhood of the client, within parameters that do not permit their care to bring harm. Similarly, Gadow (1984) and Watson (1988) have held caring as a moral ideal that entails a commitment to a particular end. That end is the protection and enhancement of human dignity and preservation of humanity in a chaotic rapidly changing health care system (Watson, 1988). Gadow (1988) proposes that care is the ethical principle or standard by which interventions should be measured. In her view, care is the moral end, and cure is only a means to that end. For Gadow (1988) 'covenant of care' refers to the commitment to alleviating another's vulnerability as described e.g. in Papers III and V. She inverts the relationship between cure and care, designating care as the highest form of commitment to the patient, encompassing as many different expressions of concern for patient well-being as we are imaginative enough to devise. Watson (1988) has pointed out that until recently, medical ethicists have ignored the field of nursing ethics, now commonly referred to as the 'Ethics of Caring'. Martinsen (1993) claims that life in human relations is what makes our life moral. She regards moral life as a movement from self to the other in order to create the best for the other. Eriksson (1993) has the same view concerning care of the one who is suffering. She claims that alleviation of suffering can only come through genuine caring with a strong focus on caring as a moral virtue. Finally, in a study of subjective aspects of the process of moral decision making in psychiatric nursing, Lützen (1993) introduced the concept of ‘moral sensitivity’, defined as “a type of sensitivity to the moral meaning of actions taken in a situation where one person is dependent on another” (p. 27). She claims that a
focus on the content and process of moral decision making, could increase contextual understanding of the patient's vulnerable situation.

Professional caring as being truly present for the patient is another important aspect of the theory. Being truly present means attentiveness to the present moment, it means being present in a dialogue, in listening and responding, and being present in a situation, physically and emotionally. This is supported by Payne (1994) who claims that the power to be has to do with the power of being 'at home within the present moment', of being centered, of living serenely and contemplatively from our true center. In such a stance, she claims, “one experiences life more directly - that is, one lives in the present moment” (p. 165). As early as 1984 Benner pointed out the importance of being truly present for the patient, what she calls “presencing”. This is supported by Martinsen (1993) in her ideas behind the concept “irreducible presence”, and by Bishop and Scudder (1996) in the way they see nursing ethics as “therapeutic caring presence”. In an analysis of the concept of presence, Gilje (1992) points out that presence is a universal element of an interpersonal phenomenon. She points out that for nurses, the importance of presence has been known intuitively for some time. Now, however, she claims, “this elusive interpersonal, intrapersonal, and transpersonal phenomenon is beginning to be recognized and articulated as a valuable dimension of human experience” (p. 53). The importance of presencing is a major theme in Riemen’s (1986) findings regarding patients’ perceptions of caring interaction with nurses in her notion of the nurse’s ‘existential presence’, which is available for the client. Lack of caring is mostly seen as ‘lack of real presence’ where the nurse does not really listen and does not pay attention to the patient as an individual. Similarly, Eriksson (1992) claims that caring communion provides a culture that is characterized e.g. by warmth and presence. She asserts that it is characterized by “fighting together, succeeding, being together, and going through something together” (p. 208). In Montgomery’s (1993) book “Healing through Communication: The Practice of Caring” she claims that one important aspect of caring in action is being present with the patient. Similar claim is made in Gaut and Leininger’s (1991) book, “Caring: The Compassionate Healer” and McMahon and Pearson’s (1991) book, “Nursing as therapy”. The interrelationship of caring and curing has often been indicated in the literature, both by former patients (e.g. Pauley, 1985), and theorists (e.g. Dossey 1982; Bishop and Scudder, 1985; Benner & Wrubel, 1989). It can be concluded from the data presented in this thesis that nurses can be life-giving by caring for others, that caring - the human contact, dialogue, really listening, spending time, and meeting - are all part of healing. Dossey (1982) asserts that nursing is nurse healing. He claims that a new paradigm has risen about nurse-patient interactions as powerful events. He asserts that they set in motion a host of physiological responses in patients which can be measured, because consciousness matters and the nurse’s presence or words or touch have
impact on the patient's consciousness, and thus on the patient's physiology. This is supported by findings within psychoneuroimmunology (Halldórsdóttir, 1996c).

Caring as being dedicated and having the courage to be appropriately involved as a professional nurse is another caring aspect of professional caring in the theory. This aspect is supported by Eriksson (1992), Larsson (1989) and Martinsen (1993). The importance of involvement as such was emphasized in the nursing literature as early as 1969 by Goldesborough. Courage as a nursing value was emphasized in the literature as early as 1981 by Lanara. Martinsen (1993) proclaims the importance of being wholeheartedly involved and not reserved and uninvolved. She asserts that if a nurse is open and caring she or he becomes vulnerable as the patient is. Not because of the critical situation the patient is in but because of the vulnerability of love - if you are open and receptive you are taking a chance so it takes courage. It has for long been this authors view that it takes courage to care (Halldórsdóttir, 1991c). It has been strengthened by listening to former patients. This view has also been put forward by others such as Eriksson (1992). This view is also strengthened through Tillich's (1977) analysis of the courage to be. Tillich (1977) claims that courage is an ethical reality, but rooted in the whole breadth of human existence and ultimately in the structure of being itself. Tillich claims that the courage to be as a part is the courage to affirm one's own being by participation. He asserts that a human being as a completely centred being or as a person can participate in everything, but participates through that section of the world which makes him or her a person. Only in the continuous encounter with other persons, Tillich (1977) claims, does the person become and remain a person. He points out that Eric Fromm has fully expressed the idea that the right self-love and the right love of others are interdependent, and that selfishness and the abuse of others are equally interdependent. Therefore, the courage to be as oneself and the courage to care for oneself is never completely separated from the other pole, the courage to be as a part and the courage to care for another. The divine self-affirmation is the power that makes the self-affirmation of the finite being, and the courage to care, possible, according to Tillich (1977). A person is not necessarily aware of this source but in the act of the courage to care the power of being is effective in us, whether we recognize it or not. By affirming our being, by daring to be caring, we participate in the self-affirmation of being-itself.

The results of this analysis is that the courage to care can be seen as the ethical act in which persons affirm their own being in spite of those elements of existence which conflict with their essential self-affirmation. Being bio-genic or life-giving involves a life process which shows balance and with it power of being, a vitality or life power. The right courage to care can therefore be understood as the expression of perfect vitality. My conclusion is that one cannot command the courage to care and one cannot gain it by obeying a command. Religiously speaking, it is a matter of grace. The courage to care always includes a risk, it is always threatened by
uncaring. If you open up to another person and connect with that person you become vulnerable. You are more easily hurt. The courage to care therefore needs the power of being, a power transcending the uncaring which is so prevalent in modern society. This courage must be rooted in a power of being that is greater than the power of oneself and the power of one's world. We have to transcend ourselves and the world in which we participate in order to find the power of being-itself and a courage to care which is beyond the threat of ultimate uncaring.

The connection aspect of professional caring

The theory advocates that one of the most important aspects of professional caring is the development of a nurse-patient connection-the building of the bridge-which is seen for the most part as a mutual endeavor between the nurse and the patient where both parties are communicative, trusting, respectful and committed. If the patient is unconscious or in other ways unable to communicate with the nurse the nurse has to do the bridge-building through his or her own caring for the patient. Thus caring is seen as a material for bridge-building as well as the competence in connecting with people. The theory proposes the importance of trust in developing a professional connection. From the data it seems to be a major determinant in developing a relationship, and lack of trust seems to be one of the major reasons for nurse-patient detachment. These findings seem to be consistent with the literature (Campbell, 1984; Kelsey, 1981; Larsson, 1989; Rogers, 1962), where trust is seen as an important aspect of relationship formation. Roach (1987), Watson (1988) and others have rightly claimed that care is a way of being that must be understood, preserved and enhanced in health care in general and by nursing as a caring practice. However, it must be 'well-informed caring' as Bottorff (1991) points out, which is undeniably preferable to 'uninformed caring' or the kind of caring that is simple sentiment. Nurses are fulfilling a social role designed to meet the identified needs of society and there is a need to acknowledge that there are many influences that will shape the caring role of the nurse, as Clifford (1995) has pointed out. Noble (1995) rightly contends that the real challenge for nursing in contemporary health care systems is to maintain a therapeutic relationship with patients. It is proposed in the theory that we have to shift toward a more egalitarian, less hierarchical stance with our recipients of nursing and health care and give the recipient more authority and control within the interaction similar to what Lowenberg (1994) describes as "a model of partnership". Rather than relating like parent and child, as described e.g. by Sidenvall (1995), the interaction needs to proceed reciprocally as between two adults of more comparable status. As nurses we have often deplored the "paternalistic" tendencies of our physician colleagues, while ignoring our own "maternalistic" tendencies of "controlling" our patients through a power differential. Our discourse in the nursing literature reveals this, as Lowenberg (1994) has pointed out, in the use of phases such as "allow the patient" and in the use of concepts such as "compliance" to name only two examples.
In the theory *comfortable distance of respect and compassion*, is seen as an essential aspect of professional caring. Connection without this kind of distance is seen as uncomfortable and even unprofessional by participants. This essential side of the *connection aspect* of professional caring, has not been discussed much in the literature even if the idea behind the concept is not new. Meyeroff (1971) asserts e.g. that to care for other persons, we must be able to understand those persons and their world as if we were inside it. He emphasizes, however, that in being with another, we must not lose ourselves. We must retain our own identity and be aware of our own reactions to the person and his or her world. Seeing this person’s world as it appears to him- or herself does not mean having that person’s reactions to it, and thus we are able to help persons in their world: something they might be unable to do for themselves. Similarly, Dunlop (1986) refers to her own nursing education and states that in a very atheoretical way, nursing sought to teach her to maintain both separation and linkage in her practice -- to remember that the other is a stranger, while acting as if he or she is not. Dunlop concludes: “thus one achieves something like ‘caring’ in it’s emergent sense as it is applied in the public world - a combination of closeness and distance, which always runs the risk of tipping either way” (1986, p. 664). Gadow (1980) argues that the issue of softening the distinction between personal and professional involvement requires a sound and new conceptual framework with the means for unifying and transcending the once contradictory relation between professional and personal. The conceptualization of professional caring involving connection with ‘comfortable distance of respect and compassion’ can be seen as such a framework, were the nurse is personal without being unprofessional -- develops professional intimacy while keeping a professional distance. Benner and Wrubel (1989) and Montgomery (1992) have also pointed out the narrow path that nurses must walk between enmeshment on the one hand and inappropriate distance on the other. They have observed, however, as Montgomery (1992) points out, that there is much common wisdom among nurses as to the right kind of involvement. Finally, Martinsen (1993) emphasizes the importance of being open and present and yet respecting of the private and personal zone of the other. Thus, she emphasizes the importance of being open and involved, yet reserved, which is in a nutshell what “professional intimacy with professional distance” stands for.

**The Empowering Effects of Professional Caring**

The positive patient outcomes of perceived professional caring is encouraging. Professional caring indeed makes a difference. The proposition that professional caring be nursing’s unique service to society is supported by these positive patient responses, that are in line with Riemen’s (1986b) findings that the nurse’s individualized concern for the patients made them feel comfortable, secure, at peace and relaxed. Professions are created by society to meet certain societal needs that
require specialized knowledge and skills. The participants clearly articulated their need for professional caring when in hospital and the positive outcomes of such a caring further support its significance. However, the negative patient outcomes of lack of professional caring should be thought-provoking for nurses and other health professionals. The negative feelings reported by the participants and the perceived negative effects on their well-being and healing are alarming findings, which suggest that professional caring needs to be dealt with more effectively in quality assurance.

Lack of Professional Caring

In order to better understand caring it does help not only to ponder on what professional caring is but also what it is not. Regarding uncaring, this dark side of human encounters within health care, basically, all the positive aspects are turned into their opposites. It is noteworthy that this shadowside of human encounters has scarcely been dealt with in nursing literature even if nurses have identified a professional commitment to be caregivers and have thus seen caring as a professional responsibility in nursing. After conducting studies, participating in international conferences on caring and after extensive feedback from many audiences, it is concluded by the present author that uncaring is a problem that has not been dealt with well enough in nursing and health care. If nurses, or other health care workers, do mistakes, such as medication errors and the like, matters are most often dealt with in an effective and formal way. Uncaring, however, is often not dealt with at all.

Lack of Professional Caring as Indifference to the Patient

In the theory it is proposed that a fundamental characteristics of an uncaring approach by a nurse is indifference to the patient as a person. The fundamental difference in the caring and the uncaring nurse approach seems to be, according to the participants, whether the nurse acknowledges the patient as a person or not. The importance of acknowledging the patient as a person is evident from the literature. Nursing's heritage and many nursing theorists have emphasized this fundamental principle (Benner & Wrubel 1989; Gadow, 1985; Griffin, 1983; Watson 1988). Nurse indifference to the patient as a person is, therefore, contrary to nursing's images and ideals. It is, however, surprising how scarcely it is dealt with in nursing literature. The literature is considerably richer about caring.

Lack of Professional Caring as Lack of Competence

Lack of competence is seen as one of the main reasons behind uncaring in the theory. This is supported e.g. by Bishop and Scudder (1996) who point out that the first moral obligation of a nurse is to become a competent practitioner. They state: "Incompetent nurses do harm... Nursing students and novice practitioners have as
their primary obligation to reach the level of competency...Competent practising nurses have as their moral obligation to become excellent practitioners” (p. 25). Jameton (1984) and others (e.g. Chitty, 1993, and Bishop and Scudder, 1996), have pointed out that the criterion of competence is crucially important to all the health professions. They have explained that the authority, trustworthiness, and responsibility of nurses and physicians to make recommendations and decisions with regard to patient care depend on their claims to be maximally competent in specific practice areas. Thus the significant social value of each profession is linked to the importance of the professionals’ competence. In regard to people’s well-being and health it calls attention to the dangers posed by unskilled practitioners in this socially valuable realm. Professions maintain their autonomy partly through their claims to maximal competence. So long as people believe that the professionals are the only ones who fully understand their work, it is very hard to supervise or criticize them (Jameton, 1984). Therefore, self-criticism is of ultimate importance in each profession. The theory development introduced in this thesis can be seen as one attempt in such self-criticism, which is mostly directed towards nursing.

Lack of Professional Caring as Disconnection

The data indicate that the former patients had not formed any connection or relationship with the nurse perceived as uncaring. The perceived indifference and lack of concern by the nurse made them distrustful and there was a disconnection between the nurse and the patient. Conversely, the participants reported that encountering a caring nurse created in them a sense of trust which facilitated the development of a nurse-patient connection, or relationship. For some of the participants, this connection, or personal relationship, constituted the fundamental difference between caring and uncaring. These findings seem to be consistent with the literature (Gadow, 1985; Pellegrino, 1985; Riemen, 1986a, 1986b; Siegel, 1986; Watson, 1988), where the development of a relationship is seen as the fundamental aspect of a genuine encounter between two persons.

The Discouraging Effects of the Lack of Professional Caring

The discouraging effects of the lack of professional caring should be thought-provoking for nurses and other health professionals. The reported effects are similar to the ones Riemen (1986b) found in her study where the participants reported feeling frustrated, scared, depressed, angry, afraid and upset because of the perceived lack of caring. It is proposed in the theory that the average hospital patient has a need for professional caring, that they have a need for caring and connection -- to be cared for, to be able to talk to someone and be really heard, thus sharing perceptions of self. When a person is ill or ill disposed, the basic human need for caring and connection often seems to be more prominent than before.
Being in a hospital, away from loved ones, in a dependant situation, seems to make these needs even more prominent. This makes the average hospital patient vulnerable and sensitive, and caring and connection, or lack of it, greatly affects the patient for better or for worse. Needing and expecting caring, being in a dependent situation, and sometimes feeling weak in spirit and body seems to make the patient vulnerable and insecure. To receive uncaring in such a vulnerable situation makes the patient feel helpless because in most hospital situations the patient can't leave, he or she is stuck there. Furthermore, they are not in control of themselves or their situation, perceiving themselves rather defenceless and dependant on others. Only very few participants, however, had complained about uncaring to someone in authority. It is apparent that while still in the midst of the hospital experience the patient is sometimes fearful about retaliation for complaining. It might even make the situation worse. This is probably particularly pertinent to long-term hospitalizations, where the patient realizes that he or she will more than likely meet the same nurse or health professional again later. In the case of short hospitalizations, the patient often tries to endure the uncaring. By the time something is done about their complaint they will probably have been discharged anyway, seems to be their reasoning sometimes. Home again, the ex-patient seems to try to forget the uncaring encounter instead of trying to find the time and energy to complain and risk to be deemed as just "another crabby patient".

What is the Reason for Uncaring?

Whether caring is a human trait common to and inherent in all people still remains a question. Were the nurses and other health professionals experienced as uncaring by the patients in the different studies, once caring? Are they just suffering from burn-out? Is there a way then of making them care again? It can be discussed how convincing the view is that caring is the natural expression of what is authentically human when there is so much evidence of lack of caring, both within our personal experiences as well as in the society around us. Roach (1984) has pointed out the obvious fact that we live in an age where violence is commonplace and where atrocities are committed against individuals and communities everywhere. To compound the effect of such violence on the broader social body, many incidents enter our living rooms through the press, radio, and television often as quickly as they occur, as has been pointed out elsewhere (Halldórsdóttir, 1991c). If, however, caring is indeed a human trait common to and inherent in all people, then uncaring is a question of some sort of burn-out. However, there are many possible reasons behind perceived uncaring. Burnout is only one possible reason. In an analysis of the studies involving uncaring it is proposed by the present author that burnout occurs over time and in stages. It is based on the assumption that burnout proceeds through some orderly development. It implies that individuals undergo basic transformations during the development of burnout and thus become somehow
It is proposed by this author that there are four basic steps that signify the four sequential stages the burnout nurse progresses through—the above mentioned stages of *disinterest, insensitivity, coldness, and inhumanity*. From this point of view disinterest in patients can then be seen as a warning sign.

**Vulnerability of Recipients of Nursing and Health Care**

Patient vulnerability and sensitivity is stressed within the theory. Vulnerability of patients within today’s hospital reality has been described by many theorists, e.g. Watson (1979), Gadow (1985), Zaner (1985) Dossey (1982) and Benner (1988). Benner (1988) has pointed out how alienating hospitals can be: how patients can lose their sense of connection to others, their sense of hope, the sense that they matter to someone and that their recovery is important. She states, “patients are not persuaded to return by a world that is cold, impersonal, and technical... they are persuaded by care” (p. 319). The former patients’ perception of being alienated within the hospital reality has been described in the literature. Twaddle (1979), for example, suggests that the main reason people feel alienated is that they are objectively alienated. He asserts that people will sense powerlessness when they have no power, normlessness when they are being manipulated, meaninglessness when events are unreasonable, they will feel isolated when they stand alone, and self-estrangement when what they do is disjointed from who they think they really are. Zaner (1985) points out that patients are stripped of familiar things (clothes and possessions) and made to put on nondescript gowns that permit ready access to their bodies: to disclose their intimate details of personal life to whoever takes their history; to expose their bodies in the most intimate and humiliating postures, for strangers to poke and prod, swab and stick, palpate and feel - in a continuous daily round. Zaner (1985) concludes that to be a patient requires remarkable patience, and that it is hardly surprising that many patients, even to themselves, seem out of place - beyond what their illnesses may have brought about. Seeing the recipient of nursing and health care in context has been emphasized in the nursing literature (Eriksson, 1991, 1993; Martinsen, 1993). Caring for someone means caring for a person in his or her context. The context of a recipient of nursing care can be such that it is difficult to actualize caring for that person, as Saveman (1994) found in her study of abused elderly. She studied formal carers in health care and the social services witnessing abuse of the elderly in their homes. She found that those caring for the abused elderly found it difficult to walk the fine line between patient advocacy and genuine caring. “Rocking the boat” by talking about the abuse could mean that services would be refused and the elderly would become even more helpless. The patient is most often trying to make sense of his or her sickness experience (Tishelman, 1993) and that has to be seen as important part of the inner context of patients. Other researchers have found how certain diseases such as fibromyalgia (Henriksson, 1995) and dysphagia (Gustafsson, 1992) influences daily
life and the total context of that individual. Such information has to be taken into account when caring for a patient and in evaluating that patient’s perception of caring and uncaring encounters with nurses and other health care professionals. Furthermore, seeing the context of the patient means seeing the human suffering which is often the hidden dimension of illness (Stark & McGovern, 1992). Finally, societal factors have to be taken into account in this context as has been pointed out elsewhere (Halldorsdottir, 1991a; Moccia, 1988).

The Future of Caring in Nursing

In a study by Eriksen (1987) the relationship between quality of nursing care and patient satisfaction was examined. Eriksen concludes in her study that staff nurses should be aware that patient reports of satisfaction or dissatisfaction may not be equated with the quality of nursing care they provide. She states, "staff nurses need to be aware that they may receive reports of patient dissatisfaction when they provide high quality physical care" (1987, p. 35). The participants' reports on uncaring, particularly in papers II and IV, indeed emphasize that physical care administered without caring can be perceived by the patient as uncaring. Adhering to procedure and policy without individualizing care to the needs of each patient may thus result in dissatisfaction with care. So, who is to decide what is caring and quality care, solely the provider of care? Andersson (1995) claims that quality of care is of concern to many groups in society, but perhaps most of all for patients, hospital staff and politicians. Similarly, Koch (1994) advocates fourth-generation evaluation where all ‘stakeholders’ have a right to place their claims, concerns and issues on the negotiating table. Fourth-generation evaluation is inspired by Guba and Lincoln (1989) who consider it the culmination of generations characterized by measurement-, objective- and judgement- oriented approaches. The aim of fourth-generation evaluation is to move toward a process of negotiation between all participants. However, participation of patients/clients is central in the negotiation process.

It might seem that in our modern technological world we are faced with an unavoidable trade-off between caring and competence, with all its accompanying technology. However, if we want to be truly progressive it is not a question of either technology and competence or caring. What we need in order to promote the art and science of nursing and professionalized human service is humanized technology and compassionate competence, which are the essential ingredients of professional caring. Assuming that among the foremost ethical principles in nursing and health care are non-maleficence (do no harm), and beneficence (do good) (Beauchamp, 1994; Beauchamp & Childress, 1989; Preston, 1994), uncaring modes of being with another represent an ethical as well as a professional problem in nursing practice and in health care. Furthermore, if caring modes are to be seen
as the essence of nursing and concluding from the seriousness of negative patient responses to uncaring encounters, uncaring modes of being with another in nursing can be seen as malpractice.

It is this author’s belief that professional caring could be the construct that can maintain the humanistic value orientation in nursing, while at the same time preserving and emphasizing the science part of modern nursing. Turning points occur in the history of a profession when radical questioning and clarification of major tenets become essential for further growth (Gadow, 1980). Perhaps such a turning point can be recognized now in nursing. The direction in which nursing develops will determine whether the profession draws closer to the medical model, with its commitment to science, technology, and cure; reverts to historical nursing models, with their essentially intuitive approaches as some of the authors within the caring literature in nursing seem to be heading (e.g. Hawthorne & Yurkovich, 1995), or creates a new philosophy that sets contemporary nursing distinctively apart from both traditional nursing and modern medicine. It is argued, in light of the theory presented in this thesis, that professional caring is such a philosophy, and that nurses indeed have to take a stand to enhance and defend nursing’s images and ideals as a caring profession which includes nurse competence, caring and connection as a central goal.
IMPLICATIONS OF THE THEORY

The theory has implications for nursing practice, nursing education, nursing administration, as well as for nursing research and theory development.

Implications for Nursing Practice

The present theory provides nurses and other health care professionals with a vision based on real life experiences of former recipients of nursing and health care, a vision that can give health professionals metaphorically speaking a goal, a map and a possibility to direct themselves to a desired end, i.e. increased well-being and health of the recipients of nursing and health care. It gives a vision of nursing practice and health care, not of being a mere technology but rather a mode of being, involving methodology but also an attitude that reaches to the core of the person who is the recipient of nursing and health care. Furthermore, the theory presented in this thesis can provide a basis for improving nursing and health care by alerting nurses and other health professionals to experiences and concerns of recipients of nursing and health care that may not be captured by previous modes of evaluation.

The theory proposes that professional competence and caring are a prerequisite for a nurse-patient connection and that competence, caring and connection is the key to a perception of a caring encounter with a nurse from the patients’ perspective. Furthermore, the theory offers some guidance regarding the ‘building of a bridge’ between the patient and the nurse, involving two interrelated processes - developing professional intimacy and yet keeping a comfortable distance of respect and compassion. The value of reflective practice is that it is only through reflection on experience that the practitioner can meaningfully assimilate research findings into practice where "the 'personal', the 'ethical', and the 'aesthetic' ways of knowing can be known and developed" (Johns, 1995, p. 25). It is hoped that the theory can be of aid in such reflection.

Implications for Nursing Administration

The theory has implications for nursing administration. The nursing administrator’s role in creating or enhancing a caring climate in hospitals has been repeatedly reported in nursing literature (Haspedis, 1969; McClure et al., 1983; Mallison, 1988; Jones & Alexander, 1993). At the nursing administration level professional caring necessitates the creation of an environment that demonstrates care for and about nurses within the organizational structure, so that nurses can, in turn, care for and about their patients, as Jones and Alexander (1993) describe. They claim: "the environment within which nurses work must value and foster caring through nurturance, facilitation, co-ordination, integration, flexibility, and support" (p. 18).
It is claimed that allowing ideas involved in *professional caring* to shape the design of nursing organizations means that threads of the idea of professional caring should be reflected in all aspects of the nursing organization, from philosophy to work design to individual job descriptions. For instance, professional caring might be reflected through adoption of departmental philosophies and structure that empower nurses, involving them in decision making, encouraging nurse participation, promoting professional autonomy, and supporting delivery of excellent care, to name but few of the thoughtful ideas presented by Jones and Alexander (1993). Finally, if we see *professional caring* as the essence of nursing, involving competence, caring, and connection, malpractice will be seen from a broader standpoint than heretofore.

**Implications for Nursing Education**

The theory gives directions as to what is important in the education of nurses, what attitudes and skills should be cultivated in nursing students so that the recipient of nursing and health care is more likely to perceive a caring encounter with them as students and later as nurses. The before-mentioned discrepancies between nurses and patients' perceptions of caring and uncaring encounters implies that teaching a caring ideology necessitates introducing the patient's perspective in nursing education. The studies introduced in this thesis as well as the theory itself provide some insight into that perspective and can, therefore, be of value in teaching students what it is like to be a patient and what is perceived by the patient as caring and uncaring in that context.

**Implications for Nursing Research and Theory Development**

The interest of nurse researchers in caring phenomena has been growing over the last ten years. However, even if there appears to be an increased use of the term caring in the nursing literature, the concept of caring seems still diffuse. The theory offers a much needed definition of caring as well as a definition of professional caring and thus a distinction between the two.

The way we see our world is modified by our philosophy as a pair of glasses modifies our vision. All analytic frameworks can, therefore, be seen as tentative analytic frameworks because each one can be reconstructed in light of new data in that area and in changes in the researcher's or theorist's own philosophy. The theory presented in this thesis is, therefore, seen as always being in the process of emerging as is our world view.
CONCLUSIONS
It is proposed in this thesis that caring/uncaring is not a dichotomy, that it is a simplification of the lived experience of human encounters. It is proposed that there are five basic modes of being with another: the life-giving mode, the life-sustaining mode, life-neutral mode, life-restraining mode and life-hurting mode. Furthermore, in the theory presented in this thesis the importance of professional caring within nursing is proposed, essentially involving competence, caring, and connection, i.e. the bridge. On the other hand, lack of professional caring involves perceived incompetence, indifference, and disconnection i.e. the wall. Receiving professional caring influences the patient very positively and the perceived consequences, which are increased sense of well-being and health, can be summarized as empowerment, whereas lack of professional caring has the negative consequences of decreased sense of well-being and health, which can be summarized as discouragement. Empowerment and discouragement in this context is defined as a subjective experience of the patient.

Increased health and well-being is the goal of nursing and health care. In this thesis health is seen as a dynamic state of well-being, which can be increased or decreased with actions of the individual, actions of other people or things happening in the environment. Thus the personal level of health and well-being can be increased or decreased e.g. through caring or uncaring encounters. It is proposed in the theory presented in this thesis that nurses and other health professionals, can in themselves, be powerful means to increase or decrease patients’ sense of well-being and health.

It is concluded that patient’s vulnerability and the threat of patient alienation within today’s technocratic hospitals seems to make the patient more sensitive to caring and uncaring. Needing and expecting professional caring in their context seems to amplify patients’ responses both to caring and uncaring. Assuming that among the foremost ethical principles in nursing and health care are non-maleficence (do no harm), and beneficence (do good), uncaring modes of being with another represent an ethical as well as a professional problem in nursing practice and in health care. Furthermore, if caring modes are to be seen as the essence of nursing and concluding from the seriousness of negative patient responses to uncaring encounters, uncaring modes of being with another in nursing can be seen as malpractice.

As a final conclusion nurses and other health care workers are urged to have the courage and self-criticism to look at uncaring, to acknowledge its existence within nursing and all the helping professions, and to start finding ways of dealing with this serious problem.
EPILOGUE

In the end I would like to share a summary of my own journey of trying to understand my co-researchers in life, i.e. the ones who have been studying life with me when I have been giving nursing care and when I have been teaching or conducting my studies. I see them all as my co-researchers (Freire, 1970). They have shared some of their lives with me so that I might understand. In this final summary I urge us all to listen with all our heart, mind and soul.

In Order to Understand

Build
a bridge
of trust and caring
of openness and sharing

Listen to the words
listen to the silence
listen to the story
of the other

Join
in the dance
of a dialogue

Sigridur Halldórsdóttir
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Appendices 1:1-6

KEY CONCEPTS AND KEY STATEMENTS FROM PAPERS I-VI

Appendix 1:1 - Paper I

Key Concepts in Paper I

There are five key concepts in paper I regarding the five basic modes of being with another:

The life-giving (biogenic) mode of being with another, where one affirms the personhood of the other by connecting with the true center of the other in a life-giving way, thus relieving the vulnerability of the other and making the other stronger and enhancing growth, restoring, reforming, and potentiating learning and healing.

The life-sustaining (bioactive) mode of being with another, where one acknowledges the personhood of the other, supporting, encouraging, and reassuring the other. It gives the other security and comfort, and positively affects well-being in the other.

The life-neutral (biopassive) mode of being with another, where one does not affect well-being, health or life in the other; life-restraining (biostatic) mode of being with another, where one is insensitive or indifferent to the other, causing discouragement and developing uneasiness in the other. It negatively affects well-being in the other.

The life-restraining mode, where one is perceived as insensitive or indifferent towards the other, causing discouragement and uneasiness in the other. It negatively affects well-being in the other.

The life-destroying (or life-hurting) (biocidic) mode of being with another, where one depersonalizes the other, destroying joy of life, and increasing the other’s vulnerability. It causes distress and despair, and hurts the other. This destructive mode is manifested in numerous ways: e.g. in threats, manipulation, coercion, hatred, aggression, dominance and other humiliating approaches.
Key Statements and Key Concepts in Paper II [See Figure 2, p. 24].

Key Statements on Caring

The Essential Structure of a Caring Encounter:
Perception of a caring encounter is comprised of three major themes: the approach by ‘the nurse perceived as caring’, the resulting ‘caring connection’ between nurse and patient and, finally, the ‘perceived consequences of the caring encounter’.

‘The nurse perceived as caring’ seems to be a special person with a special approach to the recipient illustrated by ‘competence and commitment’, ‘genuine concern and respect for the recipient as a person’ and ‘lightness of being and openness to life’, summarized as competence, caring and connection.

The ‘caring connection’ involves a personal encounter encompassing mutual respect and personal relations with combination of closeness and distance, which enables both parties to be themselves, to be who they really are. The nurse communicates with the patient in a reaffirming way and connects with the patient while at the same time keeping a comfortable distance of respect and compassion.

The ‘perceived consequences of the caring encounter’. The participants felt that the caring encounter had a very positive effect on them, including a ‘sense of solidarity’ and an increased ‘sense of well-being and health’.

Key Concepts on Caring

Competence and commitment. From the participants’ accounts it seems that caring almost always includes some action, doing for the patient or being with the patient and that commitment as a professional is included in this aspect.

Genuine concern and respect for the recipient as a person involves the recipients’ perception of being cared for by a nurse who respects them and genuinely wants to increase their well-being and health.

Lightness of being and openness to life involves a positive approach to people and towards life in general which is characterized by openness and promotes in the recipient a feeling of being understood.

Sense of solidarity. The participants felt that the nurse perceived as caring was ‘on their side’ which was extremely helpful to them in their circumstances.
Sense of well-being and health. Experiencing caring seems to increase the subjective sense of well-being in the recipients of caring, which positively affects their disposition -- they feel empowered.

Key Statements on Uncaring

*The Essential Structure of an Uncaring Encounter*

Perception of the uncaring encounter is threefold: The nurse perceived as uncaring; the resulting lack of trust and disconnection; and finally, the patient’s perception of the uncaring encounter -- a sense of being discouraged.

*The nurse perceived as uncaring* is perceived as indifferent to the recipient as a person, involving ‘indifferent incompetence’, ‘indifference to the recipient of health care as a person’ and finally, ‘coldness or closure of heart’.

*Lack of trust and perceived disconnection.* The participants said that they had not trusted the nurse or nurse perceived as uncaring. Furthermore it was their perception that they had not connected with that nurse.

*Perceived consequences of the uncaring encounter* are very negative and can be summarized as discouragement and a sense of being broken down.

Key Concepts on Uncaring

*Indifferent incompetence* is when the recipient perceives that the nurse doesn’t seem to care if mistakes happen, that if there is incompetence it is as if the nurse does not mind the incompetence and how it affects the recipient of health care.

*Indifference to the recipient of health care as a person* is when the recipient perceives that the nurse does not care for him or her as a person, does not listen and does not respect the recipient.

*Coldness or closure of heart* is when the nurse is perceived as a rather cold person with a ‘closed heart’ unwilling or unable to open up and connect with other people.
Key Statement and Key Concepts in Paper III [See Figure 2, p. 24]

Key Statement
The lived experience of having cancer is many-sided. Among the different aspects of this experience is the feeling of uncertainty, isolation, vulnerability, discomfort and of redefinition.

Key Concepts
Uncertainty, which all the participants experienced in all the stages of cancer: In the diagnostic phase (is it cancer?), in the treatment phase (will the treatment work?), during the post-treatment phase (will I get cancer again?), and in the terminal phase (when will I die?);

Vulnerability, which all the participants felt because of the cancer experience. They all felt that because of this vulnerability encounters with health professionals have much greater effect on them than when they are well;

Isolation, most of the participants felt isolated and alone at some point in time, either because of withdrawal or because of perceived or actual rejection in the environment;

Discomfort. Physical, mental or emotional discomfort, which was the common experience of all the participants, caused e.g. by appetite and eating problems, nausea and vomiting, constipation or diarrhoea, fatigue, pain, or disturbances in their sleeping patterns;

Redefinition. All the participants felt that the cancer experience had changed them. They had redefined their goals and roles or their environment had redefined them for them.
Key Statements and Key Concepts in Paper IV [See Figure 3, p. 26].

Key Statements on Caring
The nurse/midwife perceived as caring has some qualifications that make her different from the nurse/midwife perceived as uncaring i.e. competence, genuine concern and respect for the childbearing woman (and her partner), as well as a positive mental attitude. The nurse/midwife perceived as caring is perceived as an indispensable companion on the journey through labour and delivery, through competence, caring and connection.

Perceived positive effects of the caring encounter are many-sided: a sense of trust and connection, feeling safe and at ease and finally, a sense of a successful birth. The perceived positive effects of the caring encounter can be summarized as the sense of being empowered.

Key Concepts on Caring
Competence: Having the necessary knowledge and skills needed to coach a woman through labour and delivery. It involves attentiveness, responsibility, deliberation, sensitivity to each woman's needs, as well as communication skills.

Genuine concern and respect for the childbearing woman (and her partner) involves showing solidarity and sharing in the course of events, encouraging and supporting the woman (and her partner) and being benevolent. It also involves creating a quiet and comfortable environment and allowing participation of the woman's mate. Furthermore, the nurse/midwife perceived as caring seems to have a positive personality, being considerate and understanding, cheerful and positive, reliable and trustworthy.

Key Statements on Uncaring
The nurse/midwife perceived as uncaring seems to have many unfortunate characteristics. In some cases the woman perceived a 'lack of competence', in other cases the problem was a sense of 'indifference or a lack of respect for the woman as a person and as a childbearing woman'. Finally, in some cases the problem seemed to stem from a 'negative mental attitude'.

Perceived negative effects of the uncaring encounter are many-sided. All the women felt that uncaring in their situation as women giving birth, had very negative effects on them. The woman is sometimes left feeling unconnected and alone as well as feeling abandoned by the nurse/midwife. Most of the women said that the uncaring had increased their anxiety, had left them feeling insecure and afraid.
distressed and out-of-control, which in some situations made them feel hurt, bitter and angry. Feeling uncared for during labour and delivery sometimes seems to result in the feeling of being a failure as a woman giving birth and often there is long-term negative feelings toward the nurse/midwife. Sometimes the woman is determined not to go through birth again.

**Key Concepts on Uncaring**

*Lack of competence* can be many-sided in the labour and delivery context, e.g. being rough when giving care to the woman, ineffective communication, not taking initiative when needed, as well as lacking in understanding and flexibility.

*Lack of genuine concern and respect* involves many different aspects in this context, e.g. being thoughtless, strict on routine and rules (domineering -coercive), not taking notice of woman (and mate), lack of co-operation and carelessness. In some cases the women perceived the nurse/midwife as gloomy and brusque, cold, inconsiderate, unkind or harsh.
Key Statement and Key Concepts in Paper V  [See Figure 3, p. 26].

Key Statement
The lived experience of journeying through labour and delivery is a many-sided reality. It is composed of the woman's perceived circumstances and expectations before the birth, a sense of vulnerability and a sense of being in a private world during the birth experience, perceived needs during labour and delivery, as well as a sense of self while going through labour and delivery including the rough journey through labour and the triumphant joy of delivering a healthy baby, the first sensitive hours of motherhood, and finally, the perceived uniqueness of birth as a life experience.

Key Concepts
Circumstances in life: whether the woman is a primipara or multipara, married, engaged or single, child wanted or not, perceived support from the environment or not.

Expectations: whether the birth experience is expected to be easier than it is or more difficult than it is.

Sense of being in a private world: comprises a sense of unreality and of loosing a sense of timing.

Sense of vulnerability: part of the lived experience of being in labour. A woman giving birth perceives herself to be more sensitive and vulnerable than at other times.

Perceived needs: a need to feel in safe hands, a strong need for connection, encouragement and caring, as well as a need to be able to be herself. Furthermore, a need for some-one's understanding of what she is going through, as well as a need for assistance and help, information and explanation.

Sense of self while going through labour and delivery: The woman's perception of the rough journey through labour seems to be comprised of the perception of pain, of loosing a sense of timing, and for many there comes a time when they feel at the point of exhaustion and the labour seems to be never-ending. On the other hand, the triumphant joy of delivering a healthy baby is a time filled with relief, joy, as well as a sense of amazement and gratitude.
In the *first sensitive hours of motherhood*: the woman seems to examine the child very quickly in order to see whether the baby is all right and sometimes there is a perception of changes of self following the new experience of being a mother.

*Uniqueness of birth as a life experience* was recounted by most of the women in that they felt it was a unique, powerful life experience unlike other experiences, creating a sense of victory and ecstasy, at least in those without medication.
Key Statements and Concept in Study VI

Key Statements
There are three major statements of study VI that are relevant for the theory construction:

1. **Health is a broad, complicated and multifaceted concept that is comprised of several other concepts, e.g. 'feeling in control of own life and work', 'happiness', 'to be able to...', 'a sense of vitality', 'a sense of possibility', 'equilibrium', 'peace', 'harmony', 'sense of fairness' and 'having no pain'.**

2. **Health has many dimensions, e.g. physical, social, emotional, mental, spiritual and societal.**

3. **The personal level of health can be increased or decreased by actions of the individual, actions of other people or things happening in the environment.**

Key Concept
The key concept in study V is health, which is defined in the following way:

Health is a contextual multifaceted lived reality involving a physical, mental, emotional, spiritual, social and societal dimensions, the personal perception of which can be increased or decreased by actions of the individual or others. The lived experience of health can be summarized as the feeling of empowerment where the individual has the ability to achieve his or her vital goals that are connected with his or her long-term happiness.