The meaning of caring as narrated, lived, moral experience

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ABSTRACT

The purpose of this research was to understand the meaning of caring as narrated, lived, moral experience. Forty-five good nurses experienced in the care of patients in surgical, medical and geriatric wards were interviewed. They described their experience of; caring, caring abilities, the worthwhile of caring, the strength related to caring and narrated situations (n=88) in which they had experienced that their caring had made a difference to the patient. Surgical nurses described care and cure as an integrated whole, medical nurses described care as integrated with the patients' social context and geriatric nurses described care as enhancing the autonomy of patients (I). The nurses' narrated, lived, experiences of caring situations revealed ways of intervening and interacting with the patient including caring actions (II).

Eighteen good nurses experienced in the care of cancer patients were also interviewed. Their narrated, lived experiences of morally difficult care situations i.e. situations where it had been hard to know what was the right and good thing to do for the patient (n=60), revealed that relationships with their co-workers were very important for their possibility to act according to their moral reasoning and feelings (III). The situations for the nurses were either disclosed as overwhelming or possible to grasp. When narrating about these situations the nurses used different terms about themselves and their co-workers (One, They, I and We). The nurses viewed the patients either as a task to be accomplished or as a valuable unique person. In the latter situations ethical demands were interpreted, judged and acted upon (IV). Interpretations of these nurses' skills in managing morally difficult care situations disclosed two levels; one group of nurses who described positive paradigm cases, liberating maxims and disclosed open minds, while the other group described negative paradigm cases, restrictive maxims and revealed closed minds. The latter nurses were mostly the nurses who disclosed in Paper III that they used the term "one" about themselves and "they" about their co-workers (V).

Ten patients recently cared for at surgical and medical wards were interviewed (IV). They narrated lived experiences of receiving/not receiving the help they needed or wanted when suffering from pain and anxiety/fear. The patients revealed that the most important thing for them to feel cared for in these situations was to be listened to, taken seriously and trusted, if they were not treated in this way the patients revealed that they felt they were in the hands of somebody who was uncaring.

The findings are interpreted within the framework of Paul Tillich's philosophy concerning love, power, justice and courage, thereby showing the tension between these phenomena in the narrated, lived, moral experience. Light is also thrown on the dynamics of openness, vulnerability, fallibility, forgiveness, affirmation as well as powerlessness, meaninglessness, insufficiency, dissociation and exclusion. Reflections are made concerning practical wisdom.

Key words: Caring, lived moral experience, difficult caring situations, nurses, patients, narration, Paul Tillich.
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Dissertations from the Department of Advanced Nursing, Umeå University
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ABSTRACT

The purpose of this research was to understand the meaning of caring as narrated, lived, moral experience. Forty-five good nurses experienced in the care of patients in surgical, medical and geriatric wards were interviewed. They described their experience of; caring, caring abilities, the worthwhile of caring, the strength related to caring and narrated situations (n=88) in which they had experienced that their caring had made a difference to the patient. Surgical nurses described care and cure as an integrated whole, medical nurses described care as integrated with the patients' social context and geriatric nurses described care as enhancing the autonomy of patients (I). The nurses' narrated, lived, experiences of caring situations revealed ways of intervening and interacting with the patient including caring actions (II).

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Key words: Caring, lived moral experience, difficult caring situations, nurses, patients, narration, Paul Tillich.
ORIGINAL PAPERS

This dissertation is based on the following papers which will be referred to in the text by their Roman numerals:


VI Åström G, Hallberg IR. Patients' experiences of situations when receiving and not receiving the help they wanted and/or needed. Interviews with patients who had had pain and anxiety/fear. Manuscript, submitted.

The papers have been reprinted with the kind permission of the respective journal.
INTRODUCTION

Nurses at medical, surgical, geriatric and oncological wards care for patients in diverse states of illness, for example, fractured legs, dementia, hip replacements, ileus, angina pectoris, cancer with or without metastases, heart infarcts, strokes, diabetes, pulmonary oedema, trauma and infections. The patients' care needs fluctuate with the degree of the difficulty of the illness, but also with the patients' age, psychological and existential situation. In the caring situations nurses and patients are often faced with suffering, pain, the ending of life and difficult decisions. The suffering can be seen as a state of mind in which people wish violently or obsessively that their situation were otherwise, for example, situations including elements of despair, guilt, embarrassment, the loss of a loved one, the sense of failure and the inability to preserve one's own existence. Suffering may arise from elements such as fear of permanent disability or of death, anxiety about one's family, or one's finances, humiliation of helplessness and dependence on others. Suffering differs from physical pain in that it goes beyond the present moment. Intensive pain can, however, dominate consciousness and constitute a situation of suffering (cf. Hick 1991 pp. 318-320). Facing the end of life means facing existential questions and becoming aware of one's own mortality (cf. Gray 1965 pp. 442-443). A positive solution of this last crises presuppose that man can accept his previous and present life, death and future (cf. Erikson 1982 pp. 61-66). The difficult decisions nurses and patients face often concern the right and good thing to do in situations including suffering, pain and dying. Patients need to receive help in these situations and to see a meaning with suffering. Only through perceiving a meaning in life, is it possible to achieve mental health (cf. Frankl 1993 pp. 123-126). In some situations only short glimpses of meaning are possible (cf. Kihlgren 1992 pp. 37-38).

The focus of this study was the existential meaning (cf. Stack 1967 p. 262) of nurses' caring for patients, in medical, surgical, geriatric and oncological wards. Investigations were made into narration of nurses' lived experience of caring, i.e. of the reality which was there for them and which they had reflexive awareness of, because they possessed it immediately as belonging to them in some sense (cf. Dilthey 1985 p. 223). The investigation concerned both situations where the nurses thought caring made a difference to their patients and situations where they found it hard to know the right and good thing to do for their patients. The narrated lived experiences of patients about situations where they had experienced that they had received/not received the help they wanted or needed were also investigated.

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The particular reason for focusing on situations, where nurses found it hard to know the right and good thing to do for their patients, was to investigate the meaning of the statement; "It depends on the situation at hand how I act" expressed by good nurses experienced in the care of cancer patients when reflecting on a hypothetical case of caring for a patient (Jansson & Norberg 1989 pp. 354-355). These nurses reasoned mainly in a narrative context-dependent way and described difficulties in acting in accordance with their convictions when caring (Jansson 1993 p. 21). To understand the meaning of caring as lived experience, an illumination of the meaning of the nurses' expression seemed appropriate.

Caring

Heidegger (1962) tried to clarify the basic structures of human existence in an effort to see it as a whole. Dasein is always already in, amidst and ahead of itself (past, present and future) and makes itself an issue. Heidegger described this making oneself an issue as care (Sorge). All ontic senses of caring (care) can be seen as modes of this ontological care. Heidegger described concern (Besorge, i.e. dealing with equipment) and solicitude (Fürsorge, i.e. dealing with people) (Heidegger 1962 p. 157; Dreyfus 1991 pp. 150, 238-245). Solicitude appears in different modes; "being for, against, or without one another, passing one another, not 'mattering' to one another". The last modes are deficient and indifferent modes that are common in everyday average being-with-one-another (Heidegger 1962 p. 158).

Heidegger (1962 pp. 156-159) described two modes of positive solicitude (caring): 1. the kind that leaps in and takes over for the other that with which she/he is to concern her/himself and 2. the kind that leaps ahead of the other not in order to take away her/his "care" but rather to give it back to her/him authentically. When someone is extremely ill and dependent there is no choice but to "leap in" and take over. However, this kind of solicitude can extend past the point of necessity and man may find it difficult to take up her/his "care" again. The kind of solicitude that "leaps ahead" is a form of advocacy and facilitation. It empowers the other to be what she or he wants to be and this is an important goal in the nursing care relationship (cf. Benner & Wrubel 1989 pp. 48-49). Levin (1988 pp. 438-441) described this kind of caring as helping other people to be true to themselves by practising truth in the meaning of opening up and not concealing i.e. seeing from a multiplicity of perspectives, with an awareness of contextuality, of field and horizon, of situational
complexity and with a corresponding openness to the possibility of different positions.

Gaylin (1979 pp. 19-20) thought that it is the nature of human beings to care. The human species would never survive if this were not the case. Furthermore, we feel hurt by signs of uncaring and touched by signs of caring. Mayeroff (1965 pp. 462-464) regarded caring as a way of relating to another person in her/his uniqueness within "identity-in-difference" i.e. to experience the other person as apart from us and at the same time as one with us. He also regarded caring as helping others to grow and realise themselves, to help them to come to take care of themselves. This involves a rhythm of intervention and receptiveness on the carer's part and implies a whole-hearted devotion. The person who cares trusts her/his judgement and her/his ability to learn from mistakes and is genuinely humble in being ready to learn more about the other person. In helping others the carers also realise themselves.

Watson (1985) emphasised the process of human caring for individuals, families and groups as a major focus for nursing. Caring in nursing is related to, concerning and providing for the other, allowing the other to be what she/he is and could be (Gaut 1993). Caring is recognised as helping and assisting others (Leininger 1981 pp. 9-10; 1988). Caring requires recognition of the potential of the people cared for by empowering them and not by having power over them (Nyberg 1993). The "caring one" can feel the loss of care when wanting to care about and for, but not managing to be caring enough (cf. Noddings 1984 p. 38).

Jecker and Self (1991) postulated that "caring about" indicates an attitude, feeling or state of mind directed toward a person or circumstance and that "caring for" involves the exercise of a skill with or without a particular feeling or attitude toward the object upon which this skill is exercised. The caring about others may be more or less deep, and there may be more or less skill in caring for the others. A health professional who cares about a patient makes a cognitive and/or emotional appraisal that the welfare of a patient is of great importance. Caring about is shown in the manner in which the nurse cares for the patient, a manner which expresses concern and involves an effort to reassure and gain the patient's confidence.

Furthermore, Jecker and Self (1991) meant that a health professional who cares for a patient engages in a deliberate and on-going activity of responding to the patient's needs. Caring for involves deciphering the patient's particular condition and needs. This calls upon the verbal skills of questioning and listening and requires attention to and response to non-verbal cues. Caring for thus requires cultivating a capacity to understand others' experiences. Caring
for draws upon and teaches a way of knowing that involves awareness of the complexities of a particular situation and inner resources that have been garnered through experience of life (Benoliel 1987). Thus the content of the caring for and the caring about presumably becomes coloured by the nurses' outlooks on life (cf. Asplund 1991 p. 32).

Caring about does not imply caring for nor does caring for entail caring about. While it is rather easy to tell who cares for a patient it can be extremely difficult to construe who cares about a patient. There are four possible modes of caring about and caring for; Caring about and for a patient, Not caring about but caring for a patient, Caring about but not for a patient, Caring neither about nor for a patient (Jecker & Self 1991).

Caring about can become visible as a quality marker of caring for during the nurses' interaction with her or his patient, i.e. caring about is seen as the relationship aspect and caring for is seen as the task aspect of care (Griffin 1980; Egidius & Norberg 1983 pp. 99-100; Athlin 1988 p. 38; Norberg et al. 1992 pp. 73-81). Caring about and for the welfare of the other is love (cf. Lanara 1981 p. 160). Brotherly love in Greek is *adelphe*, which is also the word for "nurse". Erikson (1982 pp. 53-65) meant that love and care are virtues acquired through solving crises in life. Patience, gentleness, tolerance and thoughtfulness are expressions of love and morality and of the physiological virtues necessary for caring (Eriksson & Barbosa da Silva 1991 p. 91). Caring is also seen as a source to both love and will (May 1969 p. 307) and care, responsibility, respect and competence are mutually interdependent (Fromm 1962 p. 29).

Excellence in caring for particular patients typically requires contact and skill in ascertaining each patient's particular needs. Thus, carers learn through repeated experiences with others to perceive the particular rather than the typical (cf. Molander 1993 p. 49; Morgensen 1994 pp. 173-174). Care becomes individualised rather than standardised and planning becomes anticipatory of change rather than simply responsive to change (cf. Benner & Wrubel 1989 p. 382). Knowing more about some one's life is, however, not only a matter of the mere accumulation of information; it is a matter also of a perspective within which that information can be understood (cf. Grimshaw 1986 p. 238). Benner (1984) found that the thinking of the nurses changed from reliance on abstract principles, to the use of concrete past experience as paradigms, from seeing the situation less and less as a compilation of equally relevant bits and more and more as a complete whole, in which only certain parts are relevant, and from detached observer to involved performer (pp. 13-28). Knowledge in this form is practical and personal (pp. 1-9). Nurses' caring
demands several kinds of knowledge; factual, interpretational, judgmental, knowledge of measures, and knowledge of virtue and honour (cf. Pöm 1990).

Caring from the patients' perspectives

When investigating American patients' narrative descriptions it was found that they felt vulnerable and desired a closeness to the nurse in times of need, change and challenge. The patients wanted their feelings of nervousness, tension, fear, worry and lack of control to be perceived and respected and not judged as a deficit and/or a character weakness that needed to be eliminated. They expected competent nursing care (Appleton 1993). When asked to describe when they had felt cared for by a nurse, medical and surgical patients in the USA spoke clearly of the importance of the nurses meeting their treatment needs in a way that protected and enhanced their unique identity. They also stressed that the most important quality was the reassuring presence of the nurse who helps the patient medically with her/his pain or helps the patient manage the pain her/himself (Brown 1986). A description of patients, living in Texas, concerning noncaring interactions with nurses produced a picture of "a patient in a cold rough environment hearing unconcerned voices and feeling as though he was physically stuck. He felt helpless, uncomfortable and of no value" (Riemen 1986 p. 31).

Swedish patients, in a clinic for infectious diseases, described their perceptions of quality of care within four dimensions; the medical-technical competence of the carers; the physical-technical conditions of the care organisation; the degree of identity-orientation in the attitude and actions of the carers and the socio-cultural atmosphere of the care organisation (Wilde et al. 1993). Engström and co-workers (in manuscript) reported, that stories from different kinds of Swedish patients about good and bad caring revealed the presence and/or the absence of the same phenomena; e.g. being attentive, seeing, listening, taking seriously, understanding, and showing respect. Caring actions were interpreted as confirming actions and non-caring actions were interpreted as disconfirming actions. Swedish cancer patients describing experiences concerning hopes and expectations of the professional health care sector, revealed that patients actively avoided dissatisfaction through taking responsibility for themselves and through accepting the unarticulated as a form of discourse (Tishelman et al. 1992). Swedish patients with leukaemia described experiences of losing control, of being isolated and feelings that their life was threatened and having to live in uncertainty at the same time as
they were experiencing physical problems such as vomiting, loss of appetite and bleeding (Person et al. submitted).

Caring from the nurses' perspectives

Pålsson and co-workers (1994) analysed district nurses' descriptions of the negative and positive experience of caring for breast cancer patients. The nurses reported some satisfaction but mainly dissatisfaction and strong feelings of mental strain. Especially trying situations were connected with dressing bad smelling wounds, being too close to the patient, not being allowed to communicate openly, and patients' trust in alternative medicine. Positive experiences were described when the nurses were accepted as helpers.

Forrest (1989) interviewed staff nurses from medical, surgical, psychiatric and paediatric wards, about the meaning of caring as a lived experience. The nurses described their experiences of caring as meaning first and foremost being mentally and emotionally present, a presence evolved from deep feelings for the patients' experience and a deep interest in humanity. Registered nurses from acute medicine, urology and acute surgery cited real-life examples to explain their experiences of caring. Caring was emphasised as a response to patients' needs, experienced through the giving of oneself and through friendship, trust and love (Clarke & Wheeler 1992).

Nurses experienced in intensive care, revealed in narrative accounts from their practice two interrelated aspects; first that practitioners with different levels of skill literally live in different clinical worlds, noticing and responding to different directives for action; second that a sense of agency is determined by one's clinical world and shows up as an expression of responsibility for what happens with the patient (Benner et al. 1992). Registered nurses in medical and oncological care, who were assigned a certain number of patients, revealed in narratives about ethically problematic care situations that they emphasised their patients' wishes and quality of life when doing all they could do to provide good care (Udén et al. 1992).

When oncology nurses described their experiences of caring about and for patients, it appeared that they were motivated by a deep concern for patients and families which created tremendous stress when conditions such as poor staffing, excessive use of registered nurses and unexpected crises arose (Cohen & Sarter 1992). Registered nurses were asked to speak freely about risks in the clinical role and they described as risks situations characterised by high unpredictability and negative or hostile overtones, dependency on others, high
performance expectations from self and others, and unpleasant emotions (Dobos 1992). Registered nurses revealed when describing lived experiences of caring that "only a nurse" with whom one works can understand the emotional burden that arises as a result of caring for acutely ill patients and anxious families (Forrest 1989).

The meaning of caring for patients in medical, surgical, geriatric and oncological wards, facing the patients' pain, suffering and dying was found to be scarcely investigated. It seemed therefore important to throw light on this area with the help of nurses' lived experience completed with patients' lived experiences of situations where they needed help.

**Nurses' caring as lived moral experience**

Nurses' lived experiences of caring realities, which are there for them and they have reflexive awareness of, can be seen as a lived, moral experience, as caring means facing another human being, her/his demands, difficulties, and choices.

The terms morals and ethics are sometimes used as synonyms (e.g. Nilstun 1994 pp. 124-125). The term morality is sometimes used to refer to the practice of a person and the word ethics is used to refer to the rules or principles explicitly held or stated by that person (Fox & DeMarco 1990 p. 6). According to Kemp (1991 pp. 34-37) we live morals while ethics is the moral theory, which can be descriptive or normative. This is also how moral and ethics are viewed in this study. The study's view of moral can further be illuminated by Dilthey's work (1977 pp. 70-74) which states that moral thinking and moral feeling both influence moral action and also that moral action influences both moral thinking and moral feeling.


Murdoch (1970 pp. 40-43) highlighted the importance of being able to perceive the good in a certain situation as the good cannot be defined. The good is good and has no parts. It is a simple notion, like the notion of "yellow"
is a simple notion. She stated also that the good life becomes increasingly selfless through an increased awareness of and sensibility to the world beyond the self (Murdoch 1992 pp. 44, 53). Nerheim (1991 pp. 150) pointed to the importance of understanding the situation in which one is acting. Larmore (1987) stated that judgements and examples must play a substantial role in concrete cases and in moral deliberation. Moral judgements must steer us between the twin dangers of timidity and over zealousness, of doing too little to uphold our commitments and of rushing headlong into extravagance. The importance of moral examples lies in their suitability for exemplifying the exercise of moral judgement. By applying general moral rules to particular circumstances, moral judgement consists in our ability to go beyond what the schematic rules alone can tell us (cf. Lamore 1987 pp. 5-9).

Aristotle has described the ability to apply general rules to cases as a kind of practical wisdom, *phronesis*. This wisdom cannot be learnt through formal education only through experience (Louden 1992 pp. 99-124). Kant (1991 pp. 71-75) also emphasised the importance of judgement for deciding about cases. Judgement is a talent that can be improved through experience, for example through reflecting on hypothetical cases, on one's own experience and through moral exemplars. Kant agreed with Aristotle that judgement cannot be learnt through schooling but in practical activity an individual can first imitate the use of a maxim. Later the individual makes it her or his own. To know when a maxim should be applied it is necessary to be able to decide the relative significance of details and compare the situation at hand with previous situations. To be able to perceive the good in various situations it is important to have continuous discussions among co-workers about understandings and misunderstandings, agreements and disagreements. This enjoins on those involved a broadened reasoning in a situation of dialogue, through making the perspectives of all participants necessary (cf. Benhabib 1994 pp. 159, 220).

Caring presupposes that the carer can perceive and judge the situation, can feel compassion and concern about the patient, wishes to care for the patient, is able and has the opportunity to carry out proper caring actions (Norberg *et al*. 1994 pp. 10-19). Caring can occur spontaneously or deliberately. Vocational caring is focused on certain special aspects of another person although perception of the person in her or his totality is needed (cf. Blum 1994 pp. 108-111). The nurse is especially focused on the patient's health-related daily life matters (cf. Axelsson 1988 pp. 33-37; Carnevali 1993 pp. 253-257; Lundman 1990 pp. 9-34; Norberg *et al*. 1992 pp. 58-71). The special focus of a nurse's caring implies a demand for special types of moral sensitivity and virtues. Caring, for example, for patients that are especially
vulnerable and dependent makes demands on sensitivity, on "issues of trust, confidentiality, and betrayal" and demands responsibility for others (cf. Blum 1994 pp. 108-111).

When comparing the reasoning of good and experienced nurses in dementia care and cancer care, Jansson and co-workers (1995) elucidated caring phenomena such as; interpretation and understanding of the patient's wish, respecting the patient and oneself, transcending experience, imagining oneself in the patients' shoes and advocating for the patient. Lindseth and co-workers (1994), found that the nurses described meeting death, balancing between being open to one's own and other's reactions and being sheltered, handling advanced medical technology and grasping care as a whole as significant experience. Cooper (1991 p. 25) found that the moral decision-making of critical care nurses went beyond what would be dictated by a rational weighing of competing moral principles to encompass a complex, uncertain, and emotionally loaded process of moral struggle.

This kind of reasoning resembles casuistry art i.e. the practical resolution of particular moral perplexities or cases of conscience, as described by Jonsen and Toulmin (1988 pp. 12-13). According to them casuistry is unavoidable and moral knowledge is essentially particular. Sound resolutions to moral problems must be rooted in a concrete understanding of specific cases and circumstances. Moral understanding lies in the recognition of paradigmatic examples of good and evil, right and wrong. Man discerns a morality that develops from case to case and reveals maxims. This moral discernment has to be applied to new and more complex cases in order for moral knowledge to develop. Moral knowledge consists of the ability to put moral discernment to work, cultivate an eye for subtle and far from obvious considerations, which may be morally crucial in difficult situations (Jonsen & Toulmin 1988 pp. 329-331).

Lived experience represents the direct encounter with the world that might be called "immediate" experience (cf. Palmer 1969 p. 108). It is something that is lived in and lived through, it is the very attitude taken toward life as it is lived in the moment (cf. Tappan 1990). Morality begins when two people meet face to face and becomes more complicated when the third party appears (Bauman 1993 pp. 110-116). Caring as lived moral experience captures, for example, the lived experience of an individual faced with a situation that requires a moral decision and a moral action in response to that situation i.e. a situation in which an individual is faced with the question; "What is the right and the good thing to do?" (cf. Tappan 1990).
It seems logical that the ability to make moral judgements about situations is an integral part of the practical wisdom that was described by Benner (1984 p. 78). Benner followed Dreyfus' and Dreyfus' (1986) model of skill acquisition in unstructured problem areas when analysing nurses' experience of care situations which stood out for them and the clinical knowledge the nurses had found particularly difficult to teach or to learn. She found that it was possible to describe the characteristics of nurses' performance within five levels of skill acquisition; the nurse as a novice, an advanced beginner, competent, proficient and an expert. This can be interpreted to mean that nurses develop practical wisdom (*phronesis* as described by Aristotle). Thus it seemed essential to investigate skilled and experienced nurses' caring as lived, moral experience.

**Narration as a means to achieve understanding about the meaning of caring as lived moral experience**

Experience regarded within a phenomenological perspective refers to the turning around, the adding of nuance, the amending or changing of preconceived notions or perceptions of the situation (cf. Gadamer 1975 pp. 318-323). Lived experience is defined by Dilthey (in Palmer 1969 p. 107) as a unit held together by common meanings and he used the term expression to capture the move from lived experience to the symbolic representation of that experience. Expressions can for example be stories, ideas, or poems (cf. Brown *et al.* 1989; Tappan & Brown 1989, 186; Parry 1991).

Ricoeur (1976 pp. 20-21) wrote; "Because we are in the world, because we are affected by situations and because we orient ourselves comprehensively in those situations, we have something to say, we have experience to bring to language". MacIntyre (1985) argued that "man is essentially a story-telling animal" hence narration is "the basic and the essential ground for the characterisation of human action". "It is, because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out, that the form of narrative is appropriate for understanding the actions of others" (pp. 194-197). A narrative is a scheme by means of which human beings give meaning to their experience of temporality and personal actions (Polkinghorne 1988 p. 11). One of the functions of the narrative is to hold cognition, emotion and action together (cf. Tappan & Brown 1989).
In caring, the carers have responsibility for the cared one; for their caring attitudes, for using their power to decide what is good and right for the patient and for acting in a caring way, in varying situations. To achieve an understanding of the meaning of being in these often difficult care situations, one has to hear about the experiences afterwards, as it is difficult to shadow a nurse and a patient until the nurse is involved with a significant lived, moral experience and then ask what the nurse is thinking, how she/he is feeling and what she/he is going to do. "We must be content to hear about her/his experiences after the fact and as she/he chooses to report it - in its narrative form" (Tappan & Brown 1989).

Benner and Wrubel (1982), Benner and Tanner (1987), Benner and her co-workers (1992) have used narration as a means of uncovering knowledge embedded in clinical nursing practice and Benner (1991) emphasised the role of experience and narrative in skilled ethical comportment. Dobos (1992) used narration when investigating nurses' experience of caring situations to define risks in clinical roles and Cooper (1991) when investigating the role of principle-oriented ethics and the ethics of care as they affected critical care nurses. The ethical reasoning of nurses working in intensive care (Söderberg & Norberg 1993), in medical and oncological care (Udén et al. 1992) and in health care and social services (Saveman et al. 1994) has been studied with help of narrations. When investigated patients' experiences of caring (Engström et al. manuscript) and patients' and nurses' experiences of caring as an art (Appelton 1993) narrations were also used. Parker (1990) emphasised that when a patient's difficulties in life touch the nurse's life it makes it a nurse's experience of moral conflict and moral distress. She also stressed the necessity of searching for answers about what the boundaries or limits of care are and considered that nurses' stories of moral experiences are important sources for this purpose.

Thus it was assumed that nurses' narration of lived moral experience and patients' narrated experiences of situations where they needed help would provide an important window through which to view various caring situations and thereby be a means to achieving an understanding of the meaning of caring as lived, moral experience.
THE AIM OF THE STUDY

The aim of this dissertation was to understand the meaning of caring as narrated, lived, moral experience of medical, surgical, geriatric and oncological care and of patients within the context of surgical and medical care.

Health care in Sweden

The fundamental political principle in Sweden is that all citizens are entitled to good health and equal access to health care, regardless of their place of residence and their economic circumstances. Health care is seen as a public sector responsibility which is supported by a national health insurance system and by other social welfare services. Swedish health care legislation provides for the protection of the patient’s integrity (Health and Medical Services Act 1984). All health and medical personnel are supervised by the National Board of Health and Welfare (The Law about Supervision of Health- and Carers 1980). The state is responsible for ensuring that the health care system develops efficiently and in keeping with its overall objectives, based on the goals and the constraints of social welfare policy and macroeconomic factors (The Swedish Institute 1993).

The health care service in Sweden has undergone and is undergoing changes. The length of hospital stays in the acute surgical and medical wards has been shortened. Increasing demands have been made on the carer to work in more flexible organisations. New organisations directed to specific groups of patients within an interdisciplinary perspective are becoming predominant (County Councils 1994).

During the period 1980-1990 the number of employed carers has increased from 350.000 to 440.000. However, this development trade was broken in 1990. The number of employees was lower in 1993 (320 000) than in 1980 (350 000). This entails a change in age structure within the profession. In 1993 5 % of the carer employed were less than 25 years old and 40 % of the employees were more than 44 years old in comparison with the fact that in 1980 22 % of the employees were less than 22 years old and 25 % were more than 44 years old (County Councils 1994).
Caring in hospital wards in Sweden

The management of caring in hospital wards has changed from a functional organisation of the tasks to an arrangement where the care is given by carers working in small groups or in a modified primary nursing system (Swedish Institute for Health Services Development 1989). This has increased the carers' chances of perceiving the patients' situations, of experiencing their needs and understanding them better and thus also of providing the patients with care that can make a difference to them (County Councils 1994).

Education of registered nurses in Sweden

The Swedish nursing schools were made part of the system for higher education in 1977. Since 1982 the content of the nursing curriculum has been adapted to include requirements for combining research, theoretical and "scientific" study with basic nursing preparation. The education of nurses was extended from two to three years in 1992. A bold attempt was made to develop the theoretical part of the education while the practical education of nurse students remained unaffected (Morgensen 1994 p. 19).

Research into caring has developed in Sweden over the last 15 years. Separate departments of nursing/caring sciences have been established. Dissertations on nursing research have been produced within the six seats of learning in Sweden (Swedish Medical Research Council 1993).

The background of the author

The author has worked as a nurse aid at a surgical ward for one year, and as a registered nurse for six years in surgical, medical, and emergency wards and in an intensive care unit. She has also worked as a nurse teacher for 11 years. The author has been a hospitalised patient once as a child and twice as an adult for curable illnesses. She is the mother of one child and had a father who received a lot of care at the hospital at the end of his life. The author has an humanistic view of life seeing man as equal, valued unconditionally and as having the potentialities to grow and take responsibility. Solidarity and justice are important values. "The good" is seen as something given but also as something to care about and for.
METHODOLOGICAL FRAMEWORK

A phenomenological-hermeneutic method inspired by Ricoeur (1970, 1971, 1976, 1984; Klemm 1983) was chosen. The guiding theme of phenomenology is to go "back to the things themselves" i.e. to go to the everyday world where people live through various phenomena in actual situations (Giorgi 1988 p. 8). Phenomenology is concerned with the concealed meaning in lived experience and hermeneutics attempts to seek meaning through deciphering life expressions (cf. Ricoeur 1970 p. 33). According to Ricoeur phenomenology and hermeneutics are interdependent and have in this sense equal rights. For Ricoeur phenomenology is the inescapable presupposition of hermeneutics and hermeneutics is the necessary presupposition of phenomenology (Spiegelberg 1982 pp. 597-599). A phenomenological-hermeneutic method is attentive to both terms: it is a descriptive (phenomenological) methodology as it wants to be attentive to how things appear and it is an interpretative (hermeneutic) methodology as it claims that there are no such things as uninterpreted phenomena (cf. van Manen 1990 p. 180).

The word hermeneutics comes from a Greek word *hermeneia* the Latin corresponding latin word is *interpretatio*. In accordance with this and Jeanrond's description (1994 p. 72) of Ricoeur's theory of interpretation "understanding and explanation are seen as necessary steps in every act of interpretation". Ricoeur himself, however, seems to use the word interpretation in various ways, as synonymous with hermeneutic (1976 p. 74) and as part of understanding (1981b, p. 212; 1991, pp. 60-61). The latter meaning of interpretation is used by Croatti (1987 p. 21). In this study understanding and interpretation are treated as a complex and highly mediated dialectic. The term interpretation is applied to the whole process that encompasses explanation and understanding (cf. Ricoeur 1976 p. 74).

It was assumed that meanings are not subjectively held but already present in shared language and everyday practice (cf. Heidegger 1962 pp. 400-423). One way to make these meanings available for investigation is in-depth, open-ended interviews (cf. Patton 1990 p. 10) e.g. request narration about particular topics. The interview is then a shared task and purpose for the interviewee and the interviewer as the interviewee is informed about the interest, for example, in the meaning of caring in various situations and asked to talk about her/his experience (cf. Mishler 1990 p. 427). Interviewers and interviewees strive to arrive together at meanings that both can understand and thereby the discourse of the interviews is more or less jointly constructed (cf. Mishler 1986 pp. 52-65). To courage the interviewees to narrate lived
experience the interviewer listens and asks questions about particular aspects. This means that the interviewer and the interviewee produce narration together (cf. Riessman 1993 p. 10). An important issue is how pseudo-communication can be revealed and how it should be handled (Ricoeur 1981a pp. 63-100).

Human speech can be converted into texts by fixations which thereby become open to phenomenological-hermeneutical interpretation (cf. Ricoeur 1992a pp. 32-64). The interest in the language is the movement of thought which addresses itself to the reader and makes the reader a subject who is spoken to. This makes the reader a participant in what is announced. Thus the neutrality of phenomenology is broken as the meaning in the text is interpreted (cf. Ricoeur 1970 p. 31). Interpretation of a text is a cumulative holistic process, a move from a naive understanding via an explorative explanation, to a comprehensive understanding (cf. Ricoeur 1976 pp. 74-76). Interpretation can disclose the utterer's meaning, i.e. the intended meaning of the interviewee and the utterance meaning, i.e. the meaning in the text (cf. Ricoeur 1976 pp. 12; Klemm 1983 pp. 80). What is to be understood in a text is the sort of world that the text lays out i.e. the world emerging in front of the text (cf. Ricoeur 1978 p. 155). The text has an intention and a meaning about something. The interpreter receives the sense of the work and, through its sense, its reference. The reference is the experience it brings to language and the world and the temporality it unfolds in the face of its experience (Ricoeur 1984 pp. 78-79). To understand the text is to expose oneself to the text. The understanding concerns the possible worlds which the interpreting unfolds (cf. Ricoeur 1992a pp. 151-156).

SUBJECTS

Good and experienced registered nurses working at geriatric, medical and surgical wards (I, II) and at wards providing specialised care for cancer patients (III-V) (Table 1) at two large hospitals in northern Sweden were approached and asked to narrate their lived, moral experience of caring situations. So also were patients (VI) who had had a period of treatment at surgical (n=5) or medical wards (n=5) at the same hospital as the nurses in Papers I and II. The patients' ages varied between 33-78 years (Md=56.5) and there were four women and six men. The patients had been hospitalised previously on a varying number of occasions.
Table 1. Characteristics of the registered nurses (n=45+18)

<table>
<thead>
<tr>
<th>Paper</th>
<th>Nurses' Field of Work</th>
<th>Sex Female/Male</th>
<th>Age M (range)</th>
<th>Years in Nursing Care M (range)</th>
<th>Years at Present Clinic M (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and II</td>
<td>Surgical Care</td>
<td>13/2</td>
<td>36 (27-57)</td>
<td>13.6 (5-23)</td>
<td>8 (1-16.5)</td>
</tr>
<tr>
<td></td>
<td>Medical Care</td>
<td>14/1</td>
<td>35.5 (25-47)</td>
<td>11.8 (3-25)</td>
<td>7.9 (2-20)</td>
</tr>
<tr>
<td></td>
<td>Geriatric Care</td>
<td>15/0</td>
<td>41.5 (24-64)</td>
<td>11.9 (2-23)</td>
<td>7 (1.5-15)</td>
</tr>
<tr>
<td>III-V</td>
<td>Cancer Care</td>
<td>18/0</td>
<td>42.5 (29-63)</td>
<td>17.3 (8-39)</td>
<td>8.5 (4-25)</td>
</tr>
</tbody>
</table>

Selection of the subjects

The phenomenon in focus was the meaning of caring as narrated, lived, moral experience at medical, surgical and geriatric wards and at wards providing specialised care for cancer patients. Good/skilled nurses experienced in caring in these settings and patients who had received care at medical and surgical wards were selected as the phenomenon in focus was supposed to be based in these people's experiences of living through different caring situations (cf. Giorgi 1988 p. 8).

The nurses were selected by their nurse managers according to the criteria for being good and experienced nurses (I-V) in the care of medical, surgical and geriatric patients (I-II) or in the care of cancer patients (III-V). The Swedish word used when the nurses were selected was good, however, in paper I-II the nurses were labelled with the word skilled as skill was seen as an important component of good. The nurses' knowledge of/familiarity with the situations in focus was assumed to be greater than that of inexperienced nurses. No criteria were given for the qualities skilled/good or experienced, the nurse managers used their own criteria for selection in accordance with the specific tradition of their clinics. The nurse managers (n=3+3) had been educated during approximately the same period of time, and met regularly to discuss nursing. It was assumed that their explicit and implicit general understanding of a good nurse was fairly similar.
The nurses in Papers III-V had already been selected as being good and experienced in cancer care in Jansson's and Norberg's study (1989 p. 353).

The patients (VI) were selected by the head nurses in three surgical and four medical wards. They asked patients to participate who in their experience had pain and anxiety/fear. The reason for this demarcation was that the nurses' narrated lived experiences (II, III) contained a lot of situations where the patients had pain and anxiety/fear. It therefore seemed important to investigate patients' perception of situations when they had had a lived experience of pain and anxiety/fear and needed and/or wanted help. The head nurses did not ask patients to participate who were suffering severely, had a prognosis of immanent death or had communication problems to participate.

The studies were carried out in 1989 (I, II), 1990/91 (III-V) and in 1994 (VI).

Non-participants

The selection of the nurses focused on participants who were believed to have experiences of the phenomena of interest. Good nurses experienced in caring were chosen and non-participants were replaced with other similar nurses. Six nurses did not want to participate in the study presented in Paper I and II. The nurses replacing them were judged good and experienced in medical (3), surgical (2) and geriatric care (1) respectively by their nurse managers. In Janson's and Norberg's study (1989) all twenty selected nurses participated. Two of these moved and were not interviewed in this study (III-V).

It was planned to interview ten patients in the study presented in Paper VI. To achieve this number, sixteen patients were asked to participate. Six patients said that they did not want to participate and this decision was accepted without further question.

INTERVIEWS

Papers I-II

The following questions and requests were made during the tape-recorded interview; "What does caring really mean to you?", "Please, narrate a situation where you as a nurse experienced that caring made a difference to your patient!", "Please, narrate one more situation!", "Where did you learn to cope
in this way?", "Where did you get your strength from?", "What made it worth the effort?". Further clarifying questions were asked in order to understand the narration. The interviews lasted for about 45 minutes and were conducted at the nurses' wards or their homes by the author. The interviews were typed out verbatim. All in all there were 88 narrated caring situations.

Papers III-V

The interviews consisted of two parts: a) the nurses reflected on and gave their opinions about an account of the results from Jansson's and Norberg's study (1989) b) the nurses narrated care situations where they had experienced it hard to know the right and good thing to do for the patients. During the narration questions were asked in order to understand and encourage the narration. The interviews varied in length from 50 to 90 minutes and were conducted in an undisturbed room at the nurses' wards. Two interviews took place in the nurses' homes on the request of the interviewees. The interviews were tape-recorded and typed out verbatim by the author who had also conducted the interviews. Sighing, crying, laughter and pauses were marked in the text. All in all there were 60 narrated caring situations.

Paper VI

The patients were invited to talk about their illness and to narrate situations where they had experienced pain and anxiety/fear and received or had not received the help they wanted or needed. Questions were asked during the narration to enhance understanding of the situations narrated. The interviewer was trained in theology and psychotherapy and had not practised nursing care. The interviews were conducted after the patients' visits to the hospital in the patients' homes except two which were conducted at the interviewer's office on the patient's request. The interviews varied from 40 to 60 minutes. The interviews were tape-recorded and transcribed verbatim with sighing, laughter and pauses marked. All in all there were 36 narrated situations.

Ethical considerations

The nurses' narrated lived experience of caring situations included information about patients which had to be dealt with carefully. The anonymity of patients as well as nurses was guaranteed. The patients' narrated
lived experiences included information about specific carers whom the patients would probably want to rely on the next time they became ill. It was very important to guarantee that the patients' narration should not negatively influence any care needed in the future. Permission to ask the nurses and the patients to participate in the studies was granted by the head physicians. The study was approved by the Ethics Committee at the Medical Faculty, Umeå University.

INTERPRETATION OF THE INTERVIEWS

The process of interpretation already started in the interview situation as to narrate or listen to a story already is to reflect upon the meaning of the event narrated (cf. Ricoeur 1986 p. 61). There were, however, no deliberate notes taken during or after the interviews but an on-going reflection over the narrated situations emerged.

The interpretation of the interviews as texts started with naive readings i.e. a naive grasp of the meaning of the text as a whole, as openly as possible. This was done in order to see what was in the text and to obtain a cursory sense of the whole expressed as guesses and questions (cf. Ricoeur 1970 pp. 60-61).

The texts were searched through for expressions answering the questions raised (structural analysis). It was assumed that meanings were passed through to the interpreter as the expressions were seen as events holding messages (cf. Ricoeur 1976 p. 16). The focus was on the utterance meaning although unfolding the utterance meaning and the utterer's meaning is a circular process (cf. Ricoeur 1976 p. 74) i.e. the utterance meaning points back towards the utterer's meaning (cf. Ricoeur 1976 p. 13). The task of the structural analysis consisted in performing a segmentation and in establishing various levels of integration of parts into the whole (cf. Ricoeur 1976 p. 84) in order to identify patterns of meaningful connections.

Finally, the sense from the naive reading, the findings from the structural analyses and the text as a whole were reflected upon. The reflections as well as the interpretations were founded in the researchers' pre-understanding i.e. their fore-having practical familiarity from their own fields, their fore-sights, points of view and their fore-conceptions as they had some expectations of what they might anticipate in an interpretation (cf. Heidegger 1962 p. 191). The parts of the narratives were assembled to form a whole; a comprehensive understanding and restored to a narrative communication (cf. Ricoeur 1976
pp. 74, 85; Klemm 1983 p. 95). Several angles were viewed in the same text, so several interpretations were made, but not at the same time as also these prescriptions of meanings had to be sensed before they could govern the work of interpretation (cf. Ricoeur 1976 p. 78).

FINDINGS

The nurses working at surgical, medical and geriatric care wards felt that the important thing was to act in the patient's best interest regarding the patient as a person (I). The narrated experience focused on caring for patients with anxiety/fear and pain, on support of patients' insufficient vital functions and support of psycho social and spiritual needs. The abilities needed for caring were explained in terms of supporting, enhancing, seeing, meeting, listening, and comforting and were seen as a matter of maturity gained through life experience. The co-workers, the patients, the nurse's own family, and faith in God were sources of the nurses' strength to go on caring. The care was experienced as worthwhile, related to the gratitude, happiness, and comfort expressed by the patients and feelings of being useful. The caring in itself was a source of satisfaction to the nurse.

The nurses' experience of caring that had made a difference to the patients (II) revealed three approaches of interaction and intervention including eight caring actions when caring for the patients in different situations. The approaches and the caring actions were 1. Deliberate distanced interaction and intervention with the patient; the nurse observed the patient from close in order not to intrude on her/him or stimulated the patient through others. 2. Deliberate providing of prerequisites for interaction and intervention with the patient; the nurse was present for the patient in order to understand, made her/himself available when needed by the patient or created possibilities for starting an intervening process for the patient. 3. Deliberate deep interaction with the patient when intervening with her/him; the nurse shared/exchanged life experiences with the patient; contained the patient's emotional strain or was deeply committed to the patient. The comprehensive understanding was that the nurses narrated different ways of caring for the patients in a manner that made it clear that their choice of strategy was based on a conscious and accurate judgement of what would be best for the patients.

The narrated experience of caring situations where it had been hard to know the right and good thing to do for the patient (III) were all difficult complex situations. The situations concerned the difficulties in participating; when patients received information about their cancer diagnosis; in the
patients' treatment, in the patients' pain relief; in patients' dying and in advocating the patients' autonomy. The collaboration with co-workers was shown to be very important for the nurses' ability to follow their moral reasoning and feelings in the morally difficult care situations. Four kinds of situations were narrated; 1. Overwhelming situations where the nurses seemed lonely and alienated from their co-workers and where the patient was perceived only vaguely. 2. Overwhelming situations where the nurses experienced a restricting togetherness which made it hard for them to meet the demands of the situation and where the patient was perceived as a separate, but vague person. 3. Situations which were possible to grasp where the nurses knew what they wanted and needed to do and tried to do it but exhibited some sort of loneliness when they found themselves in an intermediate position between the physician and the patient and when they themselves had to be a strong leader. The patient was an obvious commitment and quite clearly perceived. 4. Situations which were possible to grasp where the nurses experienced a togetherness with their co-workers, i.e. a kind of involved-addition, which made it possible for them to draw conclusions that were more than the sum of the parts. The patient was perceived as a unique and valuable person.

Furthermore, the nurses, used different terms about themselves and their co-workers when narrating experiences (III). The interviewees, who revealed that the situations were overwhelming and themselves alienated, mostly used the term "One" about themselves although they narrated their own feelings, actions and thoughts. These nurses also viewed their co-workers as "They" who did not accede recognition, while the nurses revealing restricting togetherness, viewed themselves as a weak "I" and used the term "They" about their co-workers who did not want to talk. The nurses who saw the caring situations as possible to grasp and themselves as knowing what they needed to do, but exhibited loneliness, used the term "I" and revealed themselves as strong nurses who viewed their co-workers as "They" whom they had to fight with. The nurses who showed an involved togetherness in the caring situation used the term "We" about their co-workers and viewed themselves as an "I" who was a part of this "We", a "We" which gave support. The nurses' use of different terms relating to themselves and to their co-workers was interpreted as the use could be genuine expressions of their experience of being in these situations and as an expression of that their relationship with their co-workers influenced them in their care of their patients.

The findings from Paper III suggested that there was a connection between the experience of the situation, of oneself and of one's co-workers
and the perception of the patient. Lögstrup’s (1971) relationship ethics emphasises that by our very attitude to one another we help to shape one another’s worlds (p. 19) and that perspective must be found in the contexts, contradictions, and conflicts of our own existence if we want to understand the ethical demand of the situation (p. 7). Lögstrup’s (1971) ethics was used as the theoretical framework in the structural analysis in Paper IV. Sovereign and perverted (locked in) utterances of life, ethical demands, interdependence, and power in the overwhelming situations versus the situations possible to grasp were focused on. The nurses’ ways of relating to the ethical demands i.e. to the right and good thing to do, related to their use of terms about themselves and their co-workers in the different situations were also analysed. The understanding was that the nurses wished to meet their patients’ demands but could not do so in the overwhelming care situations. They saw the tasks to be accomplished but revealed no conscious interpretation of the ethical demands of the situation. The nurses revealed that they were met by indifference, reserve and unresponsive attitudes from their co-workers. The narrated experience did not reveal if the nurses found new solutions to the situations through their own powers. In the situations interpreted as being possible to grasp the nurses made efforts to interpret and to act in accordance with their interpretation of the ethical demands of the situation. These nurses’ trust in their co-workers was met with sensitiveness and the interdependence between the nurses and their co-workers seemed constructive for the care of the patients. More complex ethical demands seemed to be perceived and met by these nurses. The question, was raised whether there were any differences between the nurses’ ways of revealing themselves as individuals in their narration concerning their dealing with morally difficult care situations.

The nurses’ management of morally difficult care situations (IV) was analysed with the help of Dreyfus’ and Dreyfus’ (1986) theory of skill acquisition in unstructured problem areas. The theory describes five levels of skill acquisition; novice, advanced beginner, competent, proficient and expert. Dreyfus’ and Dreyfus’ criteria for these levels were used in the structural analysis of the same interviews as in Papers III and IV. The nurses’ skills in managing morally difficult care situations were dichotomised into two extremes; "limited skills" and "extensive skills".

The nurses labelled as having limited skills revealed circumstances that were too much for them, narrated experiences with negative outcomes, used maxims characterised as limiting and showed themselves to be subordinated to the situations. They had learnt to protect themselves and to avoid deep
involvement. They seemed frozen and trapped in their situation and their approaches were reserved. This was seemingly a means of defence.

The nurses with extensive skills revealed complex circumstances but they looked upon the circumstances within a perspective of possibilities. These nurses' experiences had positive outcomes and their maxims were characterised as liberating. They showed courage i.e. they did not follow the rules when important values were threatened and were able to act on their own. The revealed security, open-mindedness and that they were prepared to take the risk of being hurt. They appeared involved in their situation and committed to care though they seemed aware of the risk of failure.

When the narrated lived experiences interpreted as revealing limited and extensive skills in managing morally difficult care situations respectively (V), were related to the interpretation which disclosed the different use of terms concerning the nurses themselves and their co-workers (III) the following was found; the nurses who used the term "One" about themselves and "They" about others and the nurses who used the term "They" about others and viewed themselves as a weak "I" were also mostly the nurses who had narrated lived experiences interpreted as revealing a limited skill in managing morally difficult care situations. The nurses who showed themselves as a strong "I" against their co-workers, called "They", and the nurses who showed themselves as an "I" as a part of a "We"-group were the nurses who revealed extensive skills in managing morally difficult care situations in their narration (Table 2).

Table 2. Relation between the nurses' use of terms about themselves and co-workers in narration about morally difficult care situations and the nurses' revealed levels of skill in managing the morally difficult care situations narrated.

<table>
<thead>
<tr>
<th>Morally difficult care situations (n=60) where the nurses talked about themselves and their co-workers as;</th>
<th>&quot;We&quot; (&quot;I&quot;)*</th>
<th>&quot;I&quot; (&quot;They&quot;)</th>
<th>&quot;They&quot; (&quot;They&quot;)</th>
<th>&quot;One&quot; (&quot;They&quot;)</th>
<th>&quot;I&quot; and &quot;We&quot;</th>
<th>&quot;One&quot;</th>
<th>&quot;They&quot;</th>
<th>&quot;I&quot; and &quot;We&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Extensive skills (n=11)</td>
<td>17</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Limited skills (n=7)</td>
<td></td>
<td>7</td>
<td>10</td>
<td>4</td>
<td></td>
<td></td>
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</table>

* Pronouns within brackets seldom used.
The patients' narration about receiving/not receiving the help they needed or wanted being in pain and anxiety/fear (VI), disclosed similar experiences about what was of help and of no help to them in spite of differences in age, sex, illness and earlier stays in hospital. The important thing was to be listened to, trusted and believed in as a person by physicians, registered nurses and enrolled nurses. Feelings of severe pain, of being left out, of dependency and disappointment were explored when the patient did not feel she/he had received help. In these situations the patients revealed that they felt they were in the hands of somebody who was uncaring. The patients then either stayed and fought with the staff, went to others in order to fight for themselves or resigned themselves and obeyed the staff. Furthermore, the understanding was that the patients thought it very important to "be seen" by the staff i.e. to be seen in their existential situations when in pain and anxiety/fear. "Being seen" was experienced when staff took the time to stop and listen with an open mind to the patients' experiences of their situation, showing that they had a knowledge of the unique patient and of the disease. "Being seen" was also experienced when the staff did what was in their power to help the patients in their situations of pain and anxiety/fear. This feeling was explained in terms of the staff knowing and doing their best to help the patient. It did not necessarily mean that the staff had to succeed in all that they did but it meant that they had to try to do their best and that they had to communicate that they "saw and that they wanted to help" the patient. The narration about good caring also indicated that the patients had felt that the staff's actions were performed with compassion and involvement. This was interpreted as meaning that the patients wanted to be helped through loving caring.

Understanding the findings

Caring about and for patients within the context of medical, surgical, geriatric and oncological care means that the nurse meets pain, suffering and death but also gratitude, happiness and involvement.

The nurse tries to see and understand both the patient's situation and the patient's emotions as she/he wishes to meet the patient as a person, as her/his fellow-being and care for the best interest of the patient i.e. she/he tries to do good. She/he tries to care and does care for the patient in a just way i.e. she/he tries to do right. To care in a good and right way can sometimes mean running fast, spreading oneself as a nurse among several patients at the same time and
co-operating with other carers. To carry out this caring means that power and courage but also knowledge and time are required.

To care about and for the best of the patients means that the nurse can act wrongly and/or badly. The nurse can hurt the patient if she/he misjudges the situation or if she/he has insufficient understanding of the patient's situation (cf. Norberg et al. 1994 pp. 91-95). The human being is fallible (cf. Kristensson Ugga 1994 p. 201). The nurses are responsible when doing wrong. The possibilities to do wrong at the same time as the nurses experience the pain, the suffering and the dying of patients make the nurses vulnerable. The vulnerability seems to be the other side of caring about and for the patient as a fellow-being. It also seems that a "We" can help nurses to accept and live with the fallibility of human beings, help to protect them against vulnerability and instil fresh courage into the nurse, to act in spite of the possibility of acting wrongly and badly. When nurses in a "We" group realise that their caring is not the best for their patient they can rejudge and in a way forgive each other and themselves (cf. Bråkenhielm 1987 p. 28) and they are prepared to understand the patient's situation in a better/new way.

When the nurse cares for the patient without seeing him/her as a person and when there is caring without emotional involvement, the nurse may give care in a just way by routine. This caring means accomplishing the task of caring by doing things with/to/for the patient but not together with the patient. Here there is also a risk of misjudgements occurring, but as the nurse is not emotionally involved her/his vulnerability is probably less apparent. To go beyond the routines and not subordinate oneself to the situation requires knowledge of practice, the courage as well as skill to see the whole situation for the patient but also the ability to reflect on the situation with the help of an awareness of one's own as well as the patient's fundamental outlook on life. The nurse is also responsible for aiding and abetting in caring ordered by others (cf. Arendt 1994 p. 246). A living and continually discussed philosophy of caring as well as a liberating togetherness with co-workers can probably help the nurse to use her/his courage to see and become involved in the situation of the patient; involved in the sense that the nurse judges the need of the patient and respects the patients' integrity.

The nurse who cares about a patient emotionally, seeing her/him as an important fellow being, but without doing something for the patient probably feels insufficient and powerless. Perhaps, this happens because her/his courage to see her/his own insufficiency in this situation fails. To have the courage to see one's insufficiency requires discernment, humility, self-esteem and security. Without feeling secure with one's co-workers in the caring situation
it is difficult to have the kind of courage required for the right and good care of the patient. The patient can then receive uncaring caring. It seems very important for the nurse's ability to meet the patient's wishes to be seen, to be taken seriously, listened to and trusted, that the nurse her/himself is affirmed by their co-worker.

To further understand the meaning of lived moral experience in caring situations Paul Tillich's books *Love, Power and Justice* (1954) and *Courage to Be* (1952) were used as a theoretical framework. Summaries of these books, the interpretation of the findings in the light of the Tillich framework and a comprehensive understanding of the findings will be presented below. Lastly reflections of the findings with the help of various relevant literature are presented.

*Love, Power and Justice*

Life has love in itself as one of its fundamental elements. Love is the moving power of life. Love is the reunion of the estranged (cf. p. 25). Love creates participation in the concrete situation. Participation and communion point to the *Eros* quality in personal relations i.e. the transpersonal pole. *Philia* represents the personal pole. They are interdependent. Love and life together are *Agape* which is the highest form of love (cf. p. 33).

Power is the drive of everything living to realise itself. Life includes continuous decisions in the encounter between power and power. The more centred a being is the more power she/he has as long as she/he does not use it for a particular purpose. Power can be resisted by a being which negates everything. Another's power is either weakened or strengthened by one's own power (cf. p. 42). Power needs compulsion to destroy what is against love, but the power has to be united with love. Whether one loses or gains power is never decided *a priori*, but is a matter of continuous concrete decision in every moment of life, in all relations.

Justice is the form in which the power of being actualises itself. Justice can be proportional, calculating or creative. The latter is the form of reuniting love. Love is the principle of justice. Principles that mediate between love and the concrete situation are the principles of adequacy, liberty, personality and community/solidarity (cf. pp. 60-62). The content of these principles is given from the cultural process, provided by the human experience, embodied in
laws, tradition and authorities as well as the individual conscience. The problem of justice is the fact that it is impossible to say before the encounters happen what the power relation will be.

The valid formal principle of justice in personal encounters is the acknowledgement of the other person as a person through listening, giving and forgiving. Giving is an expression of creative justice when it serves the purpose of reuniting. Love united with justice is forgiving (cf. p. 86). Love recognises what justice demands.

In existence love, power and justice are separated and conflicting. Essentially they are united.

**Courage to Be**

Courage is the power of life to affirm oneself in spite of life's ambiguity, while it is cowardice to negate life because of its negative sides (cf. pp. 32-35, 151-156). In order to achieve courage one has to obey and command and command whilst obeying. The obeying in command is the opposite of submissiveness (cf. p. 29).

Courage is self-affirmation "in spite of" all that wish to stop the "I" from self-affirmation. Courage is one key to understanding being and to overcoming fear. Fear and anxiety have the same ontological roots but yet are not the same. Fear instils anxiety and anxiety tries to become fear. Fear is to be afraid of something, of a pain, of being rejected by another person or a group, of losing someone or something, of the moment of death, losing everything. The object of anxiety is the unknown after death, i.e., the definite non-being. In anxiety there is also anxiety for the situation of man as such. Anxiety is to be unable to preserve one's own existence (cf. pp. 30-39).

Anxiety about meaninglessness is an anxiety about losing the meaning of one's existence. Anxiety about emptiness occurs when the thing one earlier affirmed with passion, has lost its ability to give life meaning. Human beings sometimes try to escape the situation. They escape their freedom to ask questions of and reply to the situation on their own. They offer themselves, their "I". They offer freedom of personality, as human beings are human beings only through understanding and forming their reality and themselves and themselves in relation to meaningfulness and the world (cf. pp. 46-51).

The human beings' self-affirmness to realise oneself is threatened by non-being. Despair comes when human beings become aware of their insufficiency to affirm themselves and others because of the power of the non-being. The
despair is also a despair of debt and damnation. The anxiety about destiny and death evokes a striving for security in order to be able to affirm oneself (cf. pp. 54-56).

Vitality is an ability to create without losing oneself. Courage is a function of the vitality. The courage to be as a part is in some way exposing difficulties. The will to be as a part can be seen as a lack of courage, a weakness which pushes us to affirm ourselves as a part. But the courage to be is always in its essence the courage to be as a part and the courage to be an "I" in interdependence with others. The self-affirmation in a group includes the courage to bear a guilt and its consequences irrespective of whether the responsibility is laid on oneself or the others. The courage to be a part means a threat to the individual "I". The risk of losing oneself evokes the protest and arouses the courage to be oneself (cf. pp. 86-89, 116).

Interpretation of findings in the light of the Tillich framework

The nurse cares via different approaches related to the patient and her/his situation. These approaches seem to be filled with "good and right" thoughts, feelings and actions i.e. love and justice. The nurse's caring can be viewed as caring with the help of principles mediating between love and justice, principles such as adequacy, freedom, personality and communion. This can mean that the nurse does not know what the relevant thing to do for the patient is until she/he is actually in the encounter with the patient, because the nurse wishes, to meet the patient as a person, to interpret and decide what action is adequate, to give space to the patient's freedom and to make it possible for the patient to take part her/himself in caring. The nurse's striving i.e. power, to do the good and right thing for the patient can be seen as creative justice.

When caring about and for the patient the nurse works together with her/his co-workers. This can be seen as the nurse having courage to be a part of a group and to be an "I". Being a part of a group includes the courage to accept guilt and its consequences irrespective of whether the responsibility is laid on oneself or on the others. The nurse experiences caring as worthwhile, she/he feels useful and her/his discernment is valued. This can be seen as the nurse being affirmed by her/his co-workers and by the patients. The nurse sometimes experiences powerlessness and feels insufficient. In this situation she/he needs courage to see her/his own insufficiency to affirm her/himself.
The nurse's abilities to listen, to support, and to affirm patients can be seen as learning "listening love", the first step towards justice in person-to-person encounters. To acknowledge the other person as a person by listening, supporting and confirming her/him in her/his situation can be seen as an act out of justice based in love.

The nurse meets death, pain and suffering when caring about and for patients. She/he sees that the patient struggles with her/his situation and needs to be cared about and for. This can be seen as the nurse facing meaninglessness, and emptiness, but it can also be that she/he is facing wisdom and insights. She/he may realise that she/he her/himself is threatened by non-being. Anxiety about destiny and death can evoke a longing for security. When a nurse cares about and for patients it means taking the risk of making mistakes. Some nurses have the vitality to rejudge the care situation when they realise that their caring is going in the wrong direction. Forgiving oneself and others can be seen as love united with justice, through striving to find new solutions. The vulnerable nurse can be helped by affirmation from others and others can also be supportive by giving of their own experience, by listening to the nurse's experience and by forgiving bad and unjust actions. Creative justice, a form of the power founded in love, can thereby also be seen as necessary for the nurse.

When the nurse's caring means merely accomplishing the task of caring not sharing the caring actions with the patient it can be seen as a good and right action but it can also be the inability of the nurse to relate her/his "I" to a "Thou" or it can be an expression of she/he having difficulties knowing what is good and right in the caring. The nurse also sometimes subordinates her/himself to the situations which can mean that she/he is not making her/his standpoint clear to her/his co-workers. Other times the nurse experiences powerlessness and feels insufficient. In this situation she/he also needs the courage to see her/his own insufficiency in order to affirm her/himself.

The nurse's co-workers sometimes limit her/his caring and restrict her/his involvement with the patient. Her/his encounter with the patient then does not affirm her/him as a person as "injustice against the other one is always injustice against oneself" and "the master who treats the slave not as an ego but as a thing endangers his own quality as an ego" (Tillich 1954 pp. 78-79). The nurse fights for the patient's best with her/his co-workers when she/he is in an intermediary position. She/he discloses a readiness to cross her/his boundaries and to dare to risk her/his own 'I'. This can be seen as the nurse having the courage to affirm her/himself in spite of the ambiguity of life.
Comprehensive understanding of the findings

The comprehensive understanding of the meaning of caring as narrated, lived, moral experience is that there are interacting phenomena which influence nurses' caring. This is described in the text below and shown in Figure 1.

Figure 1. The meaning of caring as narrated, lived, moral experience

The good nurses experienced in surgical, medical, geriatric care and the care of cancer patients revealed in their narrated lived experience that they wanted to care for the patients' best interest, they saw the patient as a person whom they wanted to encounter as a fellow human being i.e. their care seemed to be based in love for their patients. This love seemed to give them the power and courage to care for their patients in a creative just way while remaining open to the patients' existential situations. They tried to listen and to give to the patients the care they judged was best for them. Being open to the patients' situations and open to co-operation with other professionals meant that the nurses were also open for the possibilities that they could do both right and wrong, good and bad things. To do fault when wanting to do right can mean that the nurse feels hurt. The vulnerability and the fallibility seem to be close phenomena. To be listened to, to be cared for and to be affirmed as an individual nurse in these situations i.e. to receive love from co-workers means that the nurse can continue to care for the patient's best.
However, these interactive phenomena were threatened by phenomena which limited the giving/listening caring. These phenomena could be evoked when the caring situation was very difficult i.e. when feelings of powerlessness and meaninglessness arouse in the individual nurse or in the group of carers. If this was not discussed and dealt with in a way that suited the nurse or the group as soon as it appeared, feelings of insufficiency, dissociation and exclusion took the place of power, courage and creative justice. It seems important that the carers in these situations should be helped, as meeting the patient's expectations of receiving help means that the patient wants to be seen by someone who both wants to help and really does help to the best of her/his ability and with both an open mind and competence.

The factors in situations that influenced the nurses' moral judgement and moral actions concerning the care of the patients, as narrated, also seemed to be interacting factors. These factors are described in the text below and shown in Figure 2.

![Figure 2. Situational factors of significance for moral judgement and actions when caring for patients.](image)

The narrated, lived experience revealed that to perceive the patient's spoken and unspoken demands, to interpret and understand, to judge what is best for the patient and to act according to this judgement demanded a nurse with "eyes open" to the patient's best as the patient wanted to be seen in her/his threatened existential situation. This also meant that the nurse had to trust both the patient and her/his co-workers at the same time as she/he was trusted...
her/himself. To achieve this her/his relation to her/himself and her/his ability to affirm her/himself seemed important. This however, was influenced by relating to earlier experience, for example, from earlier participation in difficult care situations. These interacting factors influenced each other, in both positive and negative directions. Earlier experience, with positive outcomes, for example, could produce attitudes to others and reflections in the situations filled with loving caring thoughts. Experience with negative outcomes and destructive interdependence with co-workers could produce mistrust and reflections on the situation filled with disappointments, insufficiency and exclusion.

The nurses' expression that "It depends on the situation at hand how I act" in moral difficult care situations is illuminated by the above mentioned circumstances but Tillich's (1954) statements "It is impossible to say before an encounter happens, what the power relation will be within an encounter"(p. 56) and "one can never know a priori what the outcome of an encounter of power with power will be" (p. 64) can also provide enlightenment. In the moral difficult care situation the nurses meet both the power of the patient and the power of their co-workers. Then the nurse needs to be simultaneously a separate, self-determining self and a part of the staff group which also makes it difficult to say in advance what the decision will be. The fact that the mediating principles between love and justice i.e. personality and freedom, communion and adequacy have to be judged in the situation, before a decision on how to act is made, can also contribute to the nurses' way of expressing their argumentation's. The nurses' expressions appear to be pronouncements of mature human beings.

METHODOLOGICAL CONSIDERATIONS

The method, interpretation of narration of lived experience within a phenomenological-hermeneutic approach, made it possible to gain access to the good and experienced nurses' thoughts, feelings and narrated actions related to the meaning of caring as lived moral experience. In the interviews the nurses had the freedom to choose how and what to narrate within the area of the research question.

There are limits related to the method which need to be borne in mind. Firstly, the interviewees were asked to participate in an interview with a time-span of one to one and a half hours which means that they narrated their lived experiences with the time limit in mind. It is therefore possible that they
consciously or unconsciously left out the most complex lived moral experiences of caring. Secondly, the nurses should perhaps have been contacted again later in order to gain access to the thoughts the interviews evoked. These thoughts might have contributed to the depth of the interview and to a feeling in the nurses that they had had the chance to explain things they had thought about (cf. Lindseth et al. 1994). Thirdly, to narrate a story is to reflect upon the event narrated (cf. Ricoeur 1986 p. 61) and as people’s reflections are individual, for example, in the time they need, this can also be an argument for calling the interviewees again later.

The interviewer her/himself might contribute another limit i.e. if she/he does not allow the interviewee space, thereby limiting the interviewee the freedom to narrate in her/his own way. This is a delicate subject as awareness of influencing factors can be hard to achieve. However, the interviewers made conscious efforts to listen to the narrated experiences as the nurses and the patients chose to narrate them.

The relevance of the narrated situations, in illuminating the phenomena studied, is connected with the questions which encouraged the narrations. The nurses were asked to narrate situations where they had experienced that their caring had made a difference to their patients and situations where they had found it hard to know what was the right and good thing to do for their patients. The patients were asked to narrate experiences of receiving/not receiving help. The requests thus focused the attention on situations where the interviewee had been involved her/himself. This was seen as one way of revealing the meaning of caring as a lived experience.

The sample of the nurses consisted of 60 women and three men, thereby the findings of the study mainly reflect women’s moral experience of caring. The nurses were chosen as good and experienced. This means that the findings do not capture the experience of bad and less experienced nurses. If a the sample of the study had been randomised, probably both bad and good, experienced and less experienced nurses had been mixed. The focus of this study was to understand the meaning of caring, not uncaring, therefore a sample of good and experienced nurses seemed appropriate.

The expressions of the nurses' lived experience were judged trustworthy by the interviewer (cf. Dilthey 1977 p. 125). Although the narration of the lived experience may not have been the direct expression and representation of what really happened, it was seen having a meaning that deserved to be interpreted and understood (cf. Tappan 1990; Saveman et al. 1995).
To view the result of a study as sufficiently trustworthy, validation is needed. Validation is the social construction of a discourse through which the result comes to be viewed as trustworthy enough for other investigators to rely on in their own work (cf. Mishler 1990 p. 429). According to Heidegger (1962 pp. 257-268) truth is the agreement of knowledge with the object itself. Every agreement, and therefore a truth as well, is a relation. This agreement has the relational character of the just as. Knowledge is supposed to give the thing just as it is. Knowledge is judging; a judging as a real psychical process or a judging as an ideal content. In the phenomenal context of demonstration, the relationship of agreement must become visible. What is to be confirmed is that the being in which the assertion is made uncovers the entity towards which it is. The truth of the assertion must be understood as being-uncovering. Being-true means being-uncovering; taking entities out of their hiddenness and letting them be seen in their unhiddenness (cf. Heidegger 1962 pp. 258-266). Truth requires that things will be disclosed (cf. Dreyfus 1991 pp. 265-270). The interviews were fixed as texts to make it possible to uncover the embedded meaning.

The critical moment in interpretation is when one arbitrates between various possible interpretations in an attempt to arrive to the most valid meaning of the experience (cf. Madison 1990 p. 4). What makes one interpretation more acceptable than others is that it seems more fruitful, more promising and to make more and better sense of the text than other interpretations. It opens up greater horizons of meaning (cf. Madison 1990 pp. 11-15).

It is possible to validate the utterer's meaning with the author but not the utterance meaning (Ricoeur 1976 p. 12; Klemm 1983 p. 80). The utterance meaning can be validated with other texts by the same author; by different interpreters within the same reference of interpretation; and through comparisons with other researchers' findings in their work of interpretation of the same or similar things. This is a closed validation as it is very difficult to validate between various references of interpretation. It may be easier to invalidate an interpretation than to validate it (Ricoeur 1981b p. 213). The meaning of the reader, can conceal other meanings, as a text can always have several meanings which are disclosed in interaction with the reader's pre-understanding (cf. Heidegger 1962 p. 191). The problem of validation is then concerned with whether or not it is possible for the reader to see the achieved meanings in the text. However, it is always possible to argue for or against an interpretation, to confront interpretations, to arbitrate between them and to seek agreement (Ricoeur 1976 p. 79). The meaning of the reference i.e. "about
what" (cf. Ricoeur 1976 p. 19) can only be partly validated, for example, by observations, by written diaries or by asking some others involved in the situation narrate their experiences.

Beside the need of a detailed examination of a text's features *i.e.* validation through structural analysis (cf. Ricoeur 1976 pp. 75-79) there are needs for critical and self-critical acts of interpretation as there are radically differing perspectives through which a text can be approached (Jeanrond 1994 p. 73). The interpreter's presupposition must be recognised and taken into account when studying a text. The text must have priority over the interpreter (Osborne 1991 p. 413). Therefore a thorough examination is needed of the individual interpreter's perspective *i.e.* critical checks by testing the interpreter's presuppositions from the perspectives of the text (cf. Jeanrond 1994 pp. 71-74) within a critical distanciation (cf. Ricoeur 1981a pp. 87-95).

Validation is an argumentative discipline. It is a logic of uncertainty and of qualitative probability (Ricoeur 1981b p. 212). The process of validation is closer to a logic of probability than to a logic of empirical verification as it is possible to relate the same sentence in various ways (cf. Ricoeur 1971 p. 459). The interpretations produced are connected with the community of which the interpreter is a member (cf. Gadamer 1975 pp. 245-274; Tappan & Brown 1992). Interpretative agreement, is seen as holding the key to the validity of a given interpretation of what a text means until a new interpretation is offered and the members of the community agree that the new interpretation is better (cf. Tappan & Brown 1992).

The interpretative agreement was construed as follows in the different papers:

In Paper I the structural analysis was checked by the second author and the relevance of the analysis of the similarities and differences in the findings was discussed by all authors.

In Paper II an interpretation was performed by the third author who read and coded 33 out of 88 narratives. Agreement was obtained in 29 out of 33 cases. The disagreements, concerning whether the nurse-patient relationship or the problem of solving the content dominated the narrations, were discussed by the authors until a consensus was achieved. All authors reflected, firstly alone and then together, on the text as a whole taking their pre-understanding, the naive grasping and the findings from the structural analysis into account and arriving at an overall reflection.

In Papers III and IV the first author analysed and interpreted the text and the co-authors checked that there was agreement about the interpretation of the parts of each analysis. All of the authors reflected together on the findings.
In Paper V the first and the second authors made the interpretation together. The third author discussed the findings and reflected upon them through the process of interpretation. All the authors together reflected on the overall interpretation.

In Paper VI the interviewer was not familiar with caring in hospitals and thus influences from the first author who had conducted the other interviews was avoided. The focus of the interpretation was the meaning of the reference *i.e.* "about what" (cf. Ricoeur 1976 p. 19) as the patients' lived experiences were seen as a reference to the nurses' narrated experience; to value the trustworthiness of the nurses' narration in the light of the patients' narration. The interpretation was made by the first author but there was continuous communication all the way with the co-authors. At the beginning of the interpretation process the authors read and analysed the structure of four interviews. The overall reflections were made by the authors together. Validation of the reference as such was not done. It could partly have been done with help of diaries written by the patients or observations of their received care.

**REFLECTIONS OF THE FINDINGS RELATED TO VARIOUS RELEVANT LITERATURE**

The patients want openness, competence and to be seen by the nurses who want to help and who do try to help as much as they can. The nurses want to view patients as people and care about and for them in a loving and just way. The two positive modes of solicitude (caring) described by Heidegger (1962 pp. 156-159) (leaping ahead or leaping in and taking over) seem to accord with the nurses' narrated lived moral experience of caring. However, some of the nurses' lived experience revealed that they had not been able to care in the way they wanted to or had judged necessary *i.e.* good and right, and this seemed to make the nurses suffer. Ricoeur (1992a p. 190) thought that suffering is not defined solely by physical pain or even by mental pain, but also by a reduction of the capacity to act. Furthermore, he meant that from the suffering of another there also comes a giving, a giving that is no longer drawn from the power to act *i.e.* when unequal power finds compensation in an authentic reciprocity of exchange (p. 191). The narration of situations when the nurses felt that they were not able to care about and for the patients revealed that they suffered from this inability, but also that the nurses lacked receiving the
strength from caring about and for the suffering patients *i.e.* they lacked the giving that comes from meeting the other's weakness.

For nurses to care for patients means to care for the patients together with other carers. This togetherness was sometimes experienced as restricting and at other times as involving *i.e.* sometimes it was easy to act in a caring way other times it was not. For Ricoeur (1992a) the fact that the self and the being-in-the-world are basically correlated is indisputable (p. 313) but also that "I" cannot myself have self-esteem unless "I" esteem others as myself. Solicitude adds the dimensions of value whereby each person is irreplaceable in her/his affection and her/his esteem (p. 193). This study shows that the nurses caring is affected by their caring world *i.e.* a caring world with support, trust and creative co-working helps the nurses to develop their moral judgements and their moral actions while the opposite hinders the nurses both in developing their moral thinking and moral actions.

The narration of the nurses' experienced in the care of cancer patients revealed that the nurses had learnt from their experience in various ways. Some narrations revealed that the nurses had learnt that they have to protect themselves. Other narrations showed the nurses as developing competence and the intention of doing something for the other, and of developing their power to implement actions judged as good and right for the other (cf. Gaut 1983 p. 318). Locke (1983) stressed that moral reasoning is only one factor which determines moral action. Aristotle (1976 pp. 102-110) said that learning and wisdom about the good and right in life can be achieved over a long period of step by step learning in practice, balancing between extremes, searching for the golden mean and the right attitude in the concrete situation of life. Kemp (1991 pp. 44-49) thought that it is important how man sees the life of exemplary models and how she/he works with her/himself in order to manage to walk the good way in life (p. 53). To gain further understanding of the connections that contribute to learning from one's own caring experience seems to be an important issue for research.

In their narration the nurses experienced in the care of cancer patients also revealed more or less courage in acting in the patient's best interest. The nurses who had the courage to care for the patient with an open mind also revealed their own vulnerability (cf. Ricoeur 1992b pp. 306-307). This open mind is both vulnerable itself and a source of vulnerability for the person's *eudaimonia*, for trusting people are more easily betrayed than the self-enclosed people and it is the experience of betrayal that slowly erodes the foundation of the virtues (Nussbaum 1986 p. 339). Aristotle (in Nussbaum 1986 p. 338) stated that virtues that require openness or guidelessness rather than
defensiveness, that trust in other people and the world rather than in self-protection are virtues that the circumstances of life can impede thereby making them difficult to retain. This means that in certain ways the good is more at risk than the bad. The person who trusts in uncertain things risks the pain of disillusion. It can mean that the nurse who revealed less courage and a reserved approach to the patients and her/his co-workers may once have been the one who trusted the uncertain and cared with an open mind.

Moral virtues are the qualities that enable one to play an acceptable part in an acceptable network of social roles to relate to people in the variety of ways that a decent society requires, facilitates, encourages or merely permits. A good person is the one who is a safe companion, an easy friend, a gentle master (Kemp 1991 p. 43). Shiber and Larson (1991) as well as Kurtz and Wang (1991) subscribed to the fact that nurses need to feel cared for and valued by their colleagues and the institution in which they work. A major source of burn out for nurses is being unable to give care in the fullest way desired, to receive positive rewards or recognition for their caring activities and effort. Nurses need to identify ways to support one another and "care for the caregiver" (Albright 1988). One way to do this might be to narrate and reflect on lived, moral experiences of caring (cf. Jansson 1993 p. 29).

According to Griffin (1980) the exercise of our freedom is a small piecemeal business which goes on all the time and not a grandiose leaping about unimpeded in important moments. It seems important, however, to exercise this freedom as "I" can only choose within the world "I" can see in the moral sense of "see", The reason a nurse looks is that she/he cares and the habit of looking may engender caring (cf. Griffin 1980). The interpretation of what one is seeing and/or hearing or feeling in relation to another person requires more than awareness, one must also know that something could be done for the other to improve her/his situation. Narration of caring that made a difference for patients showed that the nurses knew what to do for their patients; to be present, to participate, to share, to contain and to be with the patient when caring about and for her/him. Caring in situations when it was hard to know the right and good thing to do showed that the nurses strove to achieve the best for the patient, alone or together with co-workers. It meant also that sometimes the nurses failed while at other times they succeeded. Many of these narrated situations revealed that the nurses exercised their freedom, they saw, knew what to do and cared for their patients.

The meaning of the nurses' expression "It depends on the situation at hand how I act" in morally difficult care situations (Jansson & Norberg 1989 pp. 354-355) can be reflected on against the background of reasoning about
how to make decisions in moral matters, especially how to judge. Judgements require virtues. Aristotle insisted that virtue requires *phronesis* i.e. practical wisdom (Sorabji 1980 pp. 205-209). A man of practical wisdom deliberates with a view, not merely towards achieving particular goals, but to the good in life in general, with a view to the best and to happiness. The man with practical wisdom is not only concerned with the good life in general but also with particular actions (pp. 205-206). Practical wisdom enables man to perceive what virtue requires of her/him in the particular case and instructs her/him to act accordingly. Practical wisdom is concerned with what ought to be done and involves the knowing of what is required in that particular case. According to Ricoeur (1992b p. 269) practical wisdom consists in inventing conduct that will best satisfy the exception required by solicitude, by betraying the rule to the smallest extent possible.

Most of the nurses experienced in cancer care revealed in their narration that they had practical wisdom; they tried to see the patient as a person, to judge what was best for the patient in her/his situation and they cared about and for the patient in numerous ways with the intention of caring for the patient's best interests. The virtue disclosed in most of the narrations was the courage to care "in spite of" life's ambiguity. Some narrations revealed, however, that the nurses had understanding, but not always enough power to do what ought to be done. These narrations revealed a vague picture of the patient as a person and also a vague picture of "the good". There is a need for us to have a concept of the good life in general in order to be virtuous as, for example, we cannot know what courage requires from us without imaging what the good life in general is. Applying a conception of the good life in the situations can presumably be seen as applying a general ethical principle to cases. The nurses' narrations were interpreted as showing love as the ethical principle for power and creative justice when viewing the findings in the light of the Tillich framework (1954 pp. 41-42). Love, power and justice, however, are not principles one refers to, they are principles one lives by and derives attitudes and maxims from.

"A maxim is a principle upon which we act. It is a purely personal principle - not a copy-book maxim - and it may be good or it may be bad". A maxim is a subjective principle that is "manifested in actions that are in fact performed". Maxims do not need to be formulated in words (Paton 1991). The expressions in the nurses' narrations that were interpreted as liberating or restricting maxims were not emphasised as maxims by the nurses themselves. They were expressions used when the nurses narrated their feelings, thoughts and actions in the difficult care situations. The question is why nurses, who
clearly showed that they cared about and for the patients' best, used restricting expressions and disclosed reserved attitudes when judging the situation. The interacting situational factors that influenced the nurses' moral judgement and moral actions concerning the care of the patient, illuminated in this study - trust in other people, relations to the co-workers, to self and to earlier experience - may constitute one answer. It seems important that the carer is cared for by concrete human fellowships when, for example, the carer has done wrong or bad things or experienced very difficult care situations. Armgard (1990) meant that if the carer is cared for through authentic care for her/his own sake then caring will also be enhanced.

The fact that the same nurses (III-IV) took part in this study as took part in the study reported in Jansson and Norberg (1989) and Jansson and co-workers (1995) makes a comparison of the findings from the studies meaningful. Jansson and Norberg (1989) asked the nurses about their decision to feed a several ill, mentally alert, elderly woman with cancer who refused food. The findings gave at hand that the nurses reasoned on the bases of the ethical principle of autonomy when the question was whether or not to force the patient to eat. When the situation was complicated all nurses had problem to explain their ethical choices and said that their decisions depended on the situation at hand. When the question concerned the use of active euthanasia the nurses seemed to reason as if the ethical principle of sanctity of life were the most important. Furthermore, two nurses spontaneously admitted that they could consider participating in active euthanasia and some narrated that in practice active euthanasia (high doses of analgesics) was sometimes used although no one confessed that it was given. The purpose was not to kill but to relieve suffering. Then it seemed that the first ethical principle was the principle of beneficence. Jansson (1993 p. 21) concluded that the question whether or not to feed he patient was not as urgent as the question of whether or not to accept active euthanasia. The findings were interpreted as showing that the nurses acted in accordance with the Golden Rule: "Whatever you have people do to you, do the same for them" (Matthew 7:12). Thus it seemed that the Jansson study (1993) showed the meaning of the expression "it depends on the situation at hand how I act" as connected to various contents of care.

The present findings from nurses' narrated lived, moral experiences of situations when it had been hard to know the right and good thing to do for the patient showed situational factors that enhanced or hindered the nurses to act according to their thoughts and feelings. These factors were trust in others, relation to co-workers, relation to self, and relation to earlier experiences. The nurses disclosed in their narration that they wanted to care for the patients
best with love as the basic principle and freedom, adequacy, solidarity and communion as mediating principles between love and justice. It seems reasonable to assume that the use of the Golden Rule as maxim, is close to love as the basic principle for caring, maybe identical.

Implication for nursing practice and further research

The implication of the present study for nursing practice and education is the importance of really making room in everyday work for dialogues and reflections concerning morally difficult care situations and support for the nurses who involves themselves heavily in the patients' best.

This dissertation concerns the meaning of caring as narrated lived moral experience through focusing on caring situations where the caring made the difference for the patient and on situations where it had been hard for the good and experienced nurses to do the right and good thing for the patients. Further research is suggested on caring situations where the nurses' caring failed in contrast to the situations where the caring made the difference to the patients. Research on less experienced and not particularly good nurses' narration of caring situations also seems important in order to understand the total range of caring, from bad to good, from wrong to right.
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