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Caring and its ethical aspects—an empirical philosophical dialogue on caring

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Abstract
With a focus on caring ethics, the aim of this study was to see if and how experienced nurses in care for the elderly described caring and whether they included any theoretical basis to their caring acts. Questions that guided the research were: Does ethical caring theory have any relevance in nurses’ clinical work? How do experienced nurses describe care in general, their intentions and motives in particular? In order to enter into the meanings of caring, a reflective lifeworld research approach based on phenomenology was utilized. Eleven experienced nurses were interviewed and the resulting transcripts were analysed for meaning. The findings revealed caring as a seamless integration of different levels, or embodied moments, of knowledge. In caring that is understood as a practical, aesthetical and ethical field of force, there is room for “being”, “becoming” and “doing”. Theory and practice can and must intertwine to enable the caring goal of health as well-being. A conclusion that may be drawn from this study is that there is a potential for connecting ethical caring concepts and theories into practical everyday care. Nurses’ basic intentions for a care-giving profession, as well as hidden/forgotten theory and concepts, are viewed in this study as a possibility of turning from a pre-reflective state to a more conscious level. This study may contribute to the development of a more consciously ethical and individualized caring culture.

Key words: Lifeworld-led care, phenomenological philosophy, theory-practice, embodied care, aesthetics, ethics

Introduction and aim
The phenomenon of caring has interested nursing researchers and many have successfully described “caring”. Nursing theories have been developed from experiences of practice as well as from theoretical reasoning, ideals and ideas (e.g. Swanson, 1999; Cody, 2003; Parker, 2006; Tomey & Alligood, 2006). A general statement is that nursing and caring belongs to the human science domain with its source in a complex tapestry of aspects of knowledge. Several studies state that nursing and caring are philosophic in their nature, and therefore preferably should be answered philosophically (e.g. Nortvedt, 2003a,b; Kikuchi, 2004; Lavoie et al., 2006). These and other authors also note that even if much research already is being done, caring (and nursing) is complex and further studies are needed.

With a particular focus on caring ethics, the aim of the study was to see if and how experienced nurses described caring and whether they included any theoretical basis to their caring acts. Questions that guided the research were: Does caring theories have any relevance in nurses’ clinical work? How do experienced nurses describe care in general, their intentions and motives in care for the elderly in particular?

Background
In a report on the development of caring science in Sweden, the Swedish Research Council (2006) indicates that caring science research has changed over the last years and that “caring science disciplines are showing increasing signs of fragmentation in the sense that sub-disciplines are evolving” (p. 37). This...
is probably appropriate for an established but still young scientific field, but at the same time there is a risk that general questions are overlooked, such as general understandings of the phenomenon of caring. As the report also asserts, the development of nursing and its funding seems to stay linked to medicine, underlining the ambiguous nature of caring. The practical and technical aspects of nursing still seem to be dominant (Källerwald, 2007). This raises one serious question: Does caring in practise, i.e. the general field of health care, need any caring theory at all?

An argument promoting theoretical reflection might be to suggest that it grounds or deepens ethical caring attitudes, intentions or values, and makes them more conscious (Nortvedt, 2003a; Cody, 2003). However, to allow for such grounding and a true impact of theory in nursing, caring in theory must be sensitive enough to how caring is enacted in actual practice.

Ideally, theory and practice fuse in the caring activities carried out by nurses and other professional carers. However, for some reason the theoretical basis and coherence for providing care seems to evaporate with time in clinical practices. Ekebergh (2001) is critical that caring science as an academic subject is yet not implemented in practice. The Swedish Agency of Higher Education (Högskoleverket, 2000) has similarly highlighted this idea a few years ago with their intention to bridge the gap between theory and practice in nursing education. With this interest in mind, the analysis of caring as a phenomenon with theoretical and practical as well as ethical aspects, in the care of elderly was carried out.

Study approach

Entering into the deeper lying meanings of caring, a reflective lifeworld research approach (RLR) was utilized (Dahlberg, Drew & Nyström, 2001; Dahlberg, Dahlberg & Nyström, 2008). The RLR approach is based in the philosophy of phenomenology, as it was developed and described by the continental philosophers Husserl, Merleau-Ponty and Gadamer. With the phenomenological approach we are scientifically challenged to return to the things themselves, that is to say we use an open approach to understand phenomena and their meanings as lived. The focus is on detecting particular experiences of a phenomenon in focus with the aim on describing its structure of meaning, i.e. that pattern of meanings that makes the phenomenon that very phenomenon.

In this study, the RLR approach was utilized in two ways. First, it directed the empirical work consisting of the interviews and the analysis of data. Second, philosophical as well as empirical insights from the field of phenomenology were used in order to illuminate shadowy places of the findings; implicit meanings were made explicit. Talking with Gadamer (2003), the goal was to see “the otherness”, and something more, of the already well-researched phenomenon of caring.

Interviews

Eleven interviews with eight nurses and three assistant nurses (here called ‘nurses’), all working in seven units of elderly care in central Sweden, were conducted. The criteria for informant selection were determined through purposeful sampling (Kvale, 1996) for age, years working, social background, sex and geographical spread (see Table I). The median length of time in working practice was relatively high at 17.5 years.

The interviews were enacted as everyday dialogues, allowing the informants to talk freely about their experiences of an environment that was familiar to them (Kvale, 1996). The audiotaped interviews, conducted by the author, were transcribed verbatim after completion. The conversations lasted 45–60 minutes. The initial open question was, “What does caring mean to you?” The interviews differed from everyday conversations in the way that they, in line with the RLR approach, included many following-up questions from the interviewer, such as, “What do you mean?”, “Can you give an example?” or, “Could you please tell me more”. These questions had two main aims: to encourage the interviewees to deepen their narratives, and to “bridle” the interviewer, ensuring her own assumptions did not cover up the lived experiences of the interviewees.

Analysis

The interviews were analysed in the manner described by RLR (Dahlberg et al., 2001, 2008). Identified meaning units were “unpacked” of meanings and

| Caregivers | Age (years) | Years in caring |
|------------|-------------|-----------------|
| A          | 40          | 17              |
| B          | 63          | 35              |
| C          | 32          | 4               |
| D          | 58          | 20              |
| E          | 41          | 15              |
| F          | 38          | 12              |
| G          | 35          | 13              |
| H          | 26          | 3               |
| I          | 56          | 20              |
| J          | 62          | 41              |
| K          | 48          | 12              |
| Mean       | 45.4        | 17.5            |

*Sample consisted of 11 nurses working with elderly patients.
subsequently organized into several “clusters of meaning”, by which a structure of meaning could be found and illuminated.

The analysis used an open, sensitive and “bridled” attitude to the described lived experiences. This interrogative work—a synthesis as much as an analysis—can be seen as a way of approaching the various descriptions of the phenomenon of caring dynamically. One cluster of meanings is temporarily understood as being a figure against the rest of the material as the background. Another meaning might be figural at another time, with the previously figural meanings now part of the background. By using this approach, a structure of meaning can be described.

In the result section below, the description of the essence of the phenomenon with its most invariant meanings is first presented. These essential and invariant meanings characterize the phenomenon in general. Without these meanings, it would not be this but another phenomenon. After this description, further meanings are offered, highlighting contextual variations as well as variations between the individuals’ experiences, illuminated by excerpts from the interviews. Throughout this analysis, the informants’ descriptions are placed within quotation marks.

After the presentation of the empirical results, the essential aspects of the phenomenon “caring” are further illuminated by a discussion of ideas stemming from phenomenological philosophy and empirical research outcomes.

Ethical considerations

The regional ethical review board of the University of Linköping, Sweden, provided an advisory statement for the study (Dnr Ö 5–2006), and informed permission to conduct and tape the interviews was obtained from each participant.

Findings

The findings overall display caring as a fine integration of different levels, or embodied moments, of knowledge. In every caring act, an intention of “being there” and “at hand” is intertwined with an intention of “becoming”. There is neither a distinct beginning nor distinct ending of caring—it “is” or “happens” to support the medical treatment or to more autonomously support the patients’ health processes.

There is room for “being”, “becoming” and “doing” in caring showing its seamlessness as a practical, aesthetical and ethical field of force. An essential meaning of caring, which was illuminated in these interviews, is the importance of sense making. Carers, e.g. nurses, may make use of their alert senses and thus show an “awakeness”, which offers an opening for the patient’s lifeworld in caring. Such positioning in the patient world supports the seamlessness and avoids dichotomies between “doing” and “being/becoming”, or between “being” and “becoming”. Instead, “being”, “becoming” and “doing” presuppose each other as figure and background: Caring as “doing” is empowered by caring as “being” and “becoming”, and vice versa. If, for example, “doing” is to support the health processes, it needs to be intertwined with the dimensions of “being”, and “doing” may be what opens the senses up for “being” and a glimpse of “becoming”.

Accordingly, the seamlessness applies equally to the relation between theory and practice. Caring that enables the caring goal of health as well-being does not split theory and practice, which are intertwined when caring functions in the intended way.

The essential meanings that were found in the empirical analysis of the phenomenon of care are concretized below through a description of three elements of meaning: Sense making as movement of embodied reflection; Gaining meaningfulness; and Caring in distress. Finally, some meanings of the Input of caring theory in nursing practice are described.

Sense making as movement of embodied reflection

The nurses described themselves being caring as embodied moments when they were, for instance, “being a detective of the senses”, “creating a sphere of confidence”, “grasping the healing forces” or when they were “finding the tune in a harmony”. Caring as sense making was described in terms of sensibility, sensitivity and of being alert, as well as in terms of vulnerability. The terms used here display qualities that the nurses suggested as necessary for being able to understand the individual patient and to reach her/his lifeworld. They also described qualities that they need to remain centred and “calm” enough, for allowing “being” to take place. The terms also convey aspects of self-awareness that one needs as a nurse.

The interviewees explained how receiving an emotional response to a situation could instil patients’ motivation. They had recognized that patients’ need to feel they are being cared for with the appropriate sensitivity regarding the concern of one person for another. When asked to give an example of this sensitive non-verbal approach, a nurse working with elderly patients with dementia related her experience of an old woman who could not communicate with words. The patient spent many hours a day abandoned in her own screaming, also causing concern among the other residents. The
nurse sensed the patient’s fondness for singing and was thus able to communicate and create a safe space for the patient by singing for and with her, throughout the routines of the day. She explained that the singing affected her too: “You know you get kind of soft and gentle in your hands while singing and working at the same time.”

The singing example above illustrates how an aesthetic dimension enters into caring and how it together with sense making supports “being”, but also how close related “being” is to “doing”. In the example, sense making and the singing activity made up a temporal and spatial room for the nurse and her patient, and for their relationship; a room that was included in the everyday nursing activity.

The interviewees indicated that caring must include “being there”, i.e. that the nurses must be present in the moment of a caring encounter. “Being there” with intention and attention characterizes descriptions of a meeting between nurse and patient, and terms such as “being in tune with” the patient was used. The nurses described this attention as a state of mind that does not include thinking about or judging a situation; rather, it describes simply being there with full attention to what “is”. No one could describe what actually happened in such a meeting, but they did acknowledge that it required effort to be there. However, once there, it no longer felt like an effort—on the contrary, it was described as a positive experience.

When reflecting upon their experiences, the interviewees related both sense making, the ability of “being there” and their caring activities to empirical and experiential knowledge. However, even if a theoretical approach to their care more or less was missing, it was obvious to these interviewees that care that makes a difference cannot happen by chance.

Gaining meaningfulness

Sense making is connected with meaningfulness. The nurses described their intention to expand a kind of space between themselves and the patient—not a space of distance, but one in-between space, which makes room for the patients’ expressions and experiences. For care to be careful and comforting, according to the interviewees, it must make room for gaining meaningfulness.

Caring presupposes “responsiveness” and is “an emotive form of communication”, as one interviewee put it. Meaningfulness is given birth in communication that allows both carer and patient subjectivity: “Caring becomes creative when you are able to find individual solutions in the dialogue with the patient”, giving caring an aesthetical dimension. Meaningfulness does not develop that easily in care that is rule-bound and built on objective categories.

An expression that emerged from the interviews was that in all human beings, there exists a general need to experience meaningfulness in terms of contact with oneself as well as with others in life. Such “contact” may, at least partly, serve as a basic motive for patients to reach a state of well-being and for nurses being caring. Deep contact with oneself is not contradictory to helping others, but is an important foundation to help others realize this experience as well. Great satisfaction and pleasure is more likely to occur when one experiences meaningfulness where, despite suffering and pain, a person can still develop moments of well-being. Creating conditions for the patients to gain hold of their situation and strengthen their life forces was said to be an important element of the caring process. This would mean the creation of an inner space of freedom in which the patient is given the possibility to consider meaningfulness despite illness and suffering.

Caring in distress

The complexity of processes involved in caring as those illuminated by the interviews in this study, includes notions of sense making and “being there” together with demands of meaningfulness and care that supports “becoming”, may engender distress in the nurses. When time pressure pushes them out of balance and when the caring becomes purely “doing” or is experienced as mechanical, the nurses seem to feel dissatisfied. Instead of caring, they experience “non-caring” where there is an insufficient distance in the encounter with the patient. The interviewees also indicate that such experiences can occur if the vocation has been chosen merely as a means to earn a living.

In caring that inherits elements of non-intentional, non-existential and non-caring moments, when there is no true will or interest to initiate a caring relationship, the interviewees convey their inability to “be there” for the patient. An approach of “getting things done” takes over where the only motivation for caring becomes “performing duties”. Pressure on time was usually cited as creating these problems. The nurses described time management as problematic; they felt hounded by the constraints and sheer lack of time. Their organization demanded effective and productive work. Attentive caring can be neglected as it tends not to be noticed and not seen as productive. A consequence of this external pressure is that nurses may choose to handle quantifiable tasks because they are more easily
recognized by others. This dilemma is described as an ethical conflict in which external, formal obligations undermine the nurses’ inner obligations, which constitute caring. They “feel squeezed” between what they want to do and what they actually have to do. They maybe want to stay longer with the patients to observe and give comfort, but sense that they have to deal with all those practical matters before anything else.

Reflections and discussion

The empirical analysis of the interviews with experienced nurses illuminated caring as a phenomenon that has many layers and that its several meanings cannot be separated; all meanings connect. This is characteristic of lifeworld phenomena. As Todres (2007) note: The lifeworld “has a holistic quality in that it is full of interrelated horizons. Any qualitative moment or event is part of a larger story and place; every word is said in relation to other words and meanings” (p. 55–56). Seen in this way “the otherness of caring” can be seen as a phenomenon that should not be described in terms of dichotomies such as theory—practice, being—doing, or being—becoming. Caring exists in the dynamic movement of all these categories, and in a lifeworld perspective, all aspects of caring are understood as interrelated; all meanings are intertwined—and cannot be separated.

Lifeworld-led care—a caring ethical structure

The empirical analysis supports what has been previously described as lifeworld-led care (Todres, 2007). The core value of such care is a “humanizing force for health and social care that moderates technological progress” (p. 59), and is care that acknowledges human existence and, for example, the everyday living with illness. Further, the core perspective of lifeworld-led care means “an understanding of others’ worlds grounded in experiences of real people living through complex situations—the holistic context for understanding quality of life” (ibid). The touchstone of care is the acknowledgement of patients’ lifeworlds and the openness to the descriptions of others’ experiences—what things are like for them. “Such openness involves willingness to hear all the meanings and connections from others as lives that are lived” (ibid). This is the ethics that Husserl intended (Bengtsson, 1990). Husserl is clear that the call is absolute, meaning that the person to which the call is directed has an ethical duty to receive it. At the same time, the level of obligation goes with the opportunity to understand the ethical call. As Bengtsson (ibid.) clarifies, one cannot demand from a person who is not readable in Swedish to understand a text written in Swedish, and cannot consequently follow the intentions of that text. Likewise, one cannot demand from nurses or other professional carers, if they are educated in a narrow-minded form of medicine, to recognize patients’ whole suffering and their existential demands. Above all, it is up to health care communities, clinical as well as educational, to make visible these aspects of life, health, suffering and well-being.

Both philosophical and empirically derived texts indicate nurses’ vague awareness of the ethics of care and the outcomes of their untrained relationship with fundamental, substantial aspects of caring. However, these indications must not show an ethical ignorance in nurses. As Lögstrup (1992) states, human beings are given existential manifestations of life in terms of qualities such as trust, communication, openness of speech and compassion. These existentials belong to a person’s understanding of life. In care, named existential manifestations may be understood as the primary driving force in, but they may dwell at a taken-for-granted level. Nortvedt (2003a) and Martinsen (2003) among others label this approach “quiet and natural”, in other words, pre-reflected. It is, again, up to health care communities to release these and other pre-reflected assumptions.

The study illuminates the seamlessness of caring as a practical, aesthetical and ethical field of force, where there is room for “being”, “becoming” and “doing”. According to phenomenological existential philosophy, this seamlessness characterizes everyday life and gives it its qualitative character (Todres, 2007). For the seamlessness to explicitly embrace professional care and enable the caring goal of health as well-being, theory and practice must intertwine. However, the theory that is chosen to support caring must meet the ethical demands of caring and the patient lifeworld.

Lifeworld temporality

With an ontological lifeworld perspective, the interest is focused in the experience of time as it is lived (Ashworth, 2003; Todres, 2007). We all know how differently a particular amount of time can be felt. Five minutes at the dentist’s feels like an eternity, while a week on a holiday can be felt as if it only lasted two days.

Within healthcare, understandings of dementia may unreflectively mirror a quantitative temporal perspective, which includes seeing the problem as decreasing memory capability and a future closing down which limits the possibilities of living forward.
Caring encounters that have a lifeworld interest—with nurses “being there”—have the capacity of opening up for “becoming” in the way that they open up for possibilities, such as hope for moments of well-being that are experienced as long-lasting.

By relating to concept of lifeworld temporality, an enigmatic problem in care can be understood in a new way. Even when we know that nurses have “enough time” for their duties, they may still experience time pressures. The empirical data of this study show that the experienced pressure is about not finding opportunities to engage in true lifeworld encounters. Nurses may find time to carry out their concrete duties, such as giving drugs, but they do not “find the time” to deal with existential duties (Källerwald, 2007). To encounter patients in ways that give room for existence demands enough time, but also enough sensitive senses from the carers to recognize the “silent call” and self-awareness, self-strength, to encounter deeper lying concerns.

**Embodied existence and caring attention**

Caring as a lifeworld phenomenon further illustrates how we are to the world as embodied existence (Merleau-Ponty, 1995), an existential approach that intertwine ethics with aesthetics. When phenomenology talks about body it is always about the lived body; “one that is not best described by chemicals and neurons but by how we bodily live in meaningful ways in relation to the world and others” (Todres, 2007, p. 57). Adopting a lifeworld perspective, as described by Merleau-Ponty (1995), the importance of understanding the embodied “world of flesh” (Merleau-Ponty, 1968) is obvious. In particular, the descriptions of how we as humans relate to our world and co-exist with other embodied individuals and how our interaction becomes meaningful make demands on caring, if the goal is health and well-being in the other.

In illness, one’s identity is put on hold. As Toombs (1993) illuminates, illness sometimes replaces one’s everyday identity; one becomes one’s illness. It is for lifeworld sensitive care to restore this sense of identity. As Gadamer (1996) asserts, care must enable patients to take up their own way of living, before illness. For elderly, the findings illustrate that care can enable also them to take up their own way of living, even if being at homes for elderly. Here again ethics is intertwined with aesthetics, and there is a new interest in the relationship between cultural inputs in care, such as art, and health, which already Gadamer (ibid) emphasized.

The research findings draw attention to the meaning of sense making and “being there” as something ethical and aesthetical, a notion that is intertwined with the understanding of humans as embodied existence. Besides notions of language, the interviewees talked about “soft, gentle hands”, “using eyes and hands in the encounter”, and about the necessity of “being attentive in their senses”. These notions relate to Delmar (2006), who emphasizes caring as a continuous, never completed, task and the need to develop a sensory based, situational attention to the patient. Delmar argues that nurses easily get what she calls “need-orientated” (p. 242) on the expense of sensibility and focus on the situation. Mitchell and Cody (2002) is on the same lines, describing how caring should promote an attitude of thoughtful sensed contemplation as a tool for the nurse in caring.

Sense making is more or less an act of awareness and perception. Senses are our tentacles and connect us to our surroundings while allowing us to communicate experience (Løgstrup, 1992; Martinussen, 2003; Kabat-Zinn, 2005). Our senses can support our attention or close it down. In caring, we aim to attend to and be open to patients’ suffering. If we immerse ourselves in the sense making and engage our minds in the caring act, we may obtain the condition of a ‘sense of complete presence’ as a dimension of caring. One example of this is when a nurse expresses an awareness of herself while being attentive to the situation.

Much of our sense making goes unnoticed (Merleau-Ponty, 1995). The nursing informants showed uncertainty and struggled to express what they meant by the caring act, and they needed patiently support to find the words for the ‘sense-making’. However, Sa Cavalcante Schuback (2006) states that the attentive mind has the capability of not only register what exists “outside”, but also to discover itself in the middle of a world of experience. Through recognizing the dimensions of oneself in mindful or attentive sense making in caring practice, nurses may gain a reflective relationship with their caring acts and attitudes. Attention to sense making and reflection may therefore serve as a path to professional development.

**The input of caring science theory**

The explicit use of caring science theory in nursing practice in the context of elderly care seems minimal. Some interviewees spontaneously described how theoretical inputs were delivered in the way that the importance of “presence”, some notions of “caring relationships” and “the encounter with the patient” were mentioned. The idea previously mentioned that meaningfulness does not develop easily in rule-bound care and built on objective categories suggests a theoretical awareness of caring
science. However, no “theories” or theoretical references were related to these descriptions. It is still possible that theoretical knowledge is integrated in the nurses’ field of caring, even if it cannot be detected easily.

Conclusions

It is high time for ethical caring science theory to be visible in nursing and other care, and to form principles of practice and ethical action. Existence affects caring and caring affects existence. To grasp the meaning of and use this potential, carers such as nurses need to have the ability to “be there” for the patient in a way that opens up the lifeworld and makes room for embodied temporality. “Being there”, as other forms of “being” does not exist in opposite to “doing”. Consequently, “being there” can very well be the result of “doing”, and “doing” can be the result of some moments of “being there”. Actually, “being there” can characterize nurses’ doing, be they grounded in sound knowledge of caring. It is more about attention and the aim or doing, be they grounded in sound knowledge of caring science and the world of caring may lead to the development of a conscious ethical and individualized caring culture.

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