

ORIGINAL PAPER**To Care for the Patient: a Theory Based Clinical Application Research****Maud Karlsson RN, MNsc, PhD student**

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Correspondence: Maud Karlsson Medical Clinic Falu Lasarett 791 82 FALUN SWEDEN. Phone number +46(0)23492562, +46(0)702895801. E - mail: maud.e.karlsson@ltdalarna.se**Abstract****Background:** The research is a theory based clinical application research with a participant orientation.**Aims:** The aim of the study is to describe meaning of the concepts 'care for' and 'not care for' from the carer's perspective.**Methodology:** The critical incident method was chosen as data collection. The interpretation of data was made using hermeneutic text interpretation in four readings.**Results:** To 'care for' means seeing the patient as a fellow human being which is understood as; to see the patient, to allow the immediately given and to think about the patient.

To 'not care for' means seeing the patient as an object which is understood as not listening to the patient and closing the eyes to the patient's wishes.

Conclusions To 'care for' as an aspect of caring is understood as an inner ethical attitude that includes responsibility and respect for the human being, an inner ethical attitude in the meaning of seeing your fellow being with love and mercy. Seeing the patient as an object means that caring has been reduced to actions and work tasks without a deeper meaning.**Key words:** Theorybased research, clinical application research, evidence based practice, care for, not care for, carer's perspective, critical incident, hermeneutic text interpretation.**Introduction**

Most of earlier clinical caring science research has often started from a specific clinical context, e.g. intensive care (Cronqvist et al 2004), emergency department (Wiman & Wikblad 2004), from a patient's specific diagnosis, e.g. stroke (Widar, Ek & Ahlström 2007) and cancer (Halldorsdottir & Hamrin 1997, Liu, Mok & Wong 2006), or specific symptoms, e.g. pain (Samuels & Fetzer 2009, Gélinas 2010). Furthermore, research within clinical caring science is often limited to a certain profession, e.g. the nurse (Gustafson, Asp, & Fagerberg 2009, Pearcey 2010), or the physician (Quirk M et.al.2008). A greater emphasis should be placed on theory based research into clinical caring science which is theory based.

This caring science research is based on Eriksson's caritative caring theory (Eriksson 2006a). Eriksson (1987) describes caring as a form of tending, playing and learning. She says that tending is 'to dare to sometimes go further than the already expressed, but most of all it means to dare to go outside yourself, to show that you really 'care for' the other through different small actions' (page 26). To 'care for' is fundamental into any kind of care; independent of health care speciality or where it is conducted. There is a lack of theory based clinical research and about of what it really means to 'care for' the patient. Based on this it is of interest for clinical caring science, to make 'care fo'r and 'not care for' visible from the caregiver's perspective.

Aim

The aim of the study is to describe the meaning of 'care for' and 'not care for' from the carer's perspective.

Methodology**Clinical application**

Clinical caring science application research has its roots in hermeneutics and includes both basic research and applied research where ontology, context, appropriation and hermeneutic understanding are the supporting cornerstones (Lindholm 2003; Lindholm et al., 2006). Clinical application research contains an opportunity to reveal and show tracks of caring science theory core, ontology, basic presumptions and ethos within different contexts. Application research contains the following: creation of the hermeneutic room, extension of understanding and reflection over the importance of dedication (Lindholm, et al., 2006). Clinical application research has a participant-orientated approach and in accordance with this a research group was formed (Lindholm, et al., 2006, Lindwall, von Post & Eriksson 2010). The research group consisted of scientific researchers and clinical co-researchers. Being a co-researcher means participating in the research by reading caring science literature, leaving incidents and actively participating in the interpretation movement. The clinical co-researchers represented four different professions: nurse, assistant nurse, and dietician and autopsy technician. It was the scientific researcher's responsibility to guarantee scientific stringency and also to represent caring science and its theoretical anchorage. The clinical co-researchers' responsibility was to contribute with reflections from clinical practice.

Making the common ontological starting point clear

The movement from the introductory conversation concerning caring science as an academic discipline with an ontological starting point, data collection and the interpretation of data consisted of 13 meetings over the years 2006 - 2009. All the co-researchers studied caring science literature and then reflected on their findings together with the responsible researcher. The caring science literature consisted of Eriksson's caritative caring theory (Eriksson 1987, 2001, 2002, 2006a). The dialogue was characterised by reflections concerning what it means to see caring science as

an academic discipline. Earlier published research material was also discussed and valued within the research group. It was stated that 'care for' and 'not care for' often occur in earlier research results, although it have not been clarified in detail with caritative caring science theory as a fundament.

Ethical considerations

Good scientific practice according to the National Advisory Board on Ethics (2002) was the guideline through the entire research process. Honesty and caution have been the basic idea throughout the research process, both when meeting co-researchers and towards the material that they created together. Based upon a written request, the head of the department gave the permission to the co-researchers to participate.

Data collection

The 'critical incident' method (Flanagan 1954) was chosen for the data collection. The motive for choosing the critical incident was to give the co-researchers an opportunity to describe concrete situations containing 'care for and not care for' experienced as practitioners in clinical care settings which was medical-geriatric inpatient, outpatient, home care, ambulance and autopsy. Each of the co-researchers was given written instructions where it was explained that they should write down and describe real incidents that they had been involved in or witnessed. After the co-researchers had read caring science literature, a reflective dialogue based upon the incidents, within the hermeneutic room took part. Another motive for asking the co-researchers to write down incidents containing 'not care for' was to try to understand the meaning of caring when 'care for' is limited and/or is absent. It was assessed that this could increase the understanding of the ideal of good caring according to Roach (1997) and Eriksson (2006b). A total number of 34 written incidents and 31 oral incidents were described, and all members of the research group were able to take part (Table 1). The data collection was finished by the end of 2008.

Interpretation of data

During the interpretation phase, both the researcher and the four co-researchers participated. All participants contributed and told about their own pre-understanding. The scientific leader was interpreter of the caritative caring science theory (Eriksson 2002, 2006a) and the co-researchers' responsibility was to contribute with

their own unique experiences of what 'care for and not care for' could mean in clinical daily life.

Table 1. Number of incidents, distribution between main themes and between data collection.

	Care for	Not care for	Total
Incidents in writing	15	19	34
Tape recorded incidents	16	15	31
Total	31	34	65

Everybody's unique understanding was reflected regarding the caritative caring theory and the suppositions made concerning human beings and caring. A hermeneutic text interpretation was used which is described in four readings (von Post & Eriksson 1999). This process of interpretation was characterized as a hermeneutic movement including questions and answers. At the first reading the entire text was read through in the research group in order to reach a first common understanding of what the text as a unit says (Gadamer 1997). During the second reading our ontological understanding in relation to the text was tested and new questions were also made. - 'Is this care for, is this not care for, the way it is, is this reality'? During the third reading new questions came up based on the text, which in turn gave new answers. Our new understanding was created based on the following question: What do care for and not care for mean from caregiver's perspective? During the fourth reading the text was read carefully again with the aim of finding basic characteristics for care for and not care for. Two basic themes could be separated and they were as follows: Care for – to see the patient as a fellow human being and not care for - to see the patient as an object. Based on every basic theme the interpretation continued with the aim of finding sub-themes that each characterised the meaning of the overall themes.

Results

'Care for' – To see the patient as a fellow being

Seeing the patient as a fellow being has three sub-themes: To see the patient, To allow the immediately given, and To think about the patient.

To see the patient

Seeing the patient is to see and take responsibility for their exposure by changing the plans and for example allowing the patient to have his breakfast with his roommates, since that had a personal meaning for the patient. As a caregiver it is important to reconsider earlier planned caring in order to do the right thing for the human being. The caregiver goes one step further than to simply take care of the patient according to the routines connected to the patient's diagnosis and need for rehabilitation.

"It was ambiguous since I knew that he didn't get the therapy he actually needed, but I saw his exposure of not being allowed to have breakfast with his roommates as larger. It felt good afterwards to be able to reconsider a situation and try to make the best for the patient. With that I mean to consider different situations, to see the human, and not only routines as a caregiver."

Seeing the patient as a fellow being can be seen in the fact that the caregiver's encourage the patient because they want to protect and allow him to do the things he still has the ability for, and things that are of personal importance for both the patient and the caregiver. Such caregiver's are longed for, since they bring about thoughtfulness, dignity and joy within caring. They see the patient as a fellow being that needs to be the person he/she is and wish to be.

"But then sometimes they came, 'the angels' that happily greeted daddy, talked about sport, cars and joked with him. They helped him so he could do the things he was still able to do himself, gave him time and social stimulation. When they had gone he always said: hope it's them next time I get a visitor."

To 'care for', in the meaning of seeing the patient, is when the caregiver has the responsibility, courage and will to see the patient as a fellow being and not only as a patient with a specific diagnosis, whereby the caregiver only bases his/her treatment on earlier planned general routines.

To allow the immediately given

According to the caregiver's, allowing the immediately given means when something

spontaneous and unplanned is allowed to happen. The caregiver sees himself/herself as a human being, and allows things that have not been planned before to happen because they are experienced as being good. The caregiver allows the things that immediately feel right to happen.

“That has never been planned, it is something instinctive, you can analyse it later but when it happens, then it just happens, the right thing, doesn't it? - Yes, there must be some routines, but then it is there, it just has to come when needed, spontaneously, of free will.”

To 'care for' in the meaning of allowing the immediately given is based on the courage and will to see and allow the instantaneous in the moment to happen. The immediately given has not been planned beforehand, it is something that is decided in the situation and that is generated because the caregiver allows himself/herself to see the patient as a fellow being. The unreserved spontaneous are allowed coming before the earlier planned.

To think about the patient

Thinking about the patient can mean making the patient's room look nice. This thoughtfulness is made visible when the caregiver makes the room ready by switching on the patient's own lamp making it welcoming when the patient returns from a hard treatment.

“A woman who was our patient was also a patient within specialist care and she had been treated at different hospitals for more than eight months. When she went for these treatments she was away for more than seven hours each time. She was mostly very tired and exhausted. In her room she had a small lamp that was her own. When she was away for the day we tried to make her room ready and light her lamp so it was on when she came back. She sparkled with joy, we caregiver's had thought about making it look nice and she said that it was the small things that meant the most for her.”

The caregiver means that thinking about the patient can be to think about the small things that are meaningful to the patient. The situation in the following example was when one of the

caregiver's started to sing for the patients and their depression was replaced by joy.

“Two gentlemen were on a ward. Both of them had a cancer diagnosis. They were feeling down and it was a very low-spirited atmosphere in the room when I and another caregiver came in. My colleague looked at both gentlemen and started to sing. Their depression was replaced by joy. It was the situation that made the caregiver to do the little extra for a fellow being.”

To 'care for' in the context of thinking about the patient is based on the courage to dare to see the patient as a fellow being and allow the situation to decide about the caring. The caregiver's courage to do the small everyday things is of great importance for the patient.

‘Not care for’ – To see the patient as an object

To see the patient as an object has two sub-themes: *To not listen to the patient* and *To close your eyes to the patient's wishes*.

To not listen to the patient

Not listening to the patient is when the caregiver's stand by the bed, showing no interest for what the patient has to say; they just interrupt by making completely different questions that have nothing to do with what the patient wished to say.

“A woman comes to the hospital for treatment. She talks about what has happened, which was a strong and tragic event. The personnel she was telling this to were standing by the bed, didn't look at the patient, showed no compassion and just answered aha and interrupted the patient with questions that didn't concern the things she was talking about.”

When the caregiver does not listen to the patient, the patient is reduced to an object that is exposed to careless treatment. The caregiver's are in a hurry and sulky during the morning washing and helping with clothes, they don't listen to the patient; they just talk to each other. The caregivers don't see the patient's vulnerability; they just do a number of predetermined tasks in a hurry without considering the human being.

“We noticed how he suffered from not being able to take care of himself and it became worse depending on which team came. They

were in a hurry, were sulky, hardly talked to him, put him up, washed him and "pulled" off and on clothes, toilet errands more than quickly while they were talking to each other as if he was just a package. They made him sad and even more confused."

To 'not care for', in the meaning of not listening to what the patient has to say, means that the patient is reduced to an object that is being "cared about" only based on a specific diagnosis and routine. Not being listened to and being an object that has to be taken care, efficiently handled creates suffering.

To close your eyes to the patient's wishes

Closing your eyes to the patient's wishes can be when the caregiver's ignore the patient's wishes and allow other things to be prioritised. A terminally-ill patient had asked for permission to go home for his final days. At an early stage, relatives had said that they needed help to carry the patient up the stairs to his home. Despite this request, the patient had to try to walk up the stairs himself, which led to a quick deterioration of his health; subsequently the patient had to be taken back to the hospital. The patient died the following day and his wish to come home for his final days could not be fulfilled.

"How a terminally- ill patient came in contact with care during his last hours alive: After a request from the patient to get the permission to stay at home, the clinic decided that ambulance transport should be arranged. The terminally ill patient needed all the caring you could ask for. When arriving at his home it turned out that carrying help was needed up to his apartment (which had been mentioned before by a relative). However, the ambulance personnel thought that the patient should try to walk up the stairs himself! This resulted in a total collapse and the ambulance personnel had to give him oxygen. Then the patient had to be taken back to the hospital. At the hospital they met a nurse, who told them how inappropriate this behaviour was (according to her view) that the patient should have been taken to his home under these circumstances. The nurse said all this in front of the terminally ill patient, who died the following day at the hospital."

Closing your eyes to the patient's wishes for care, according to the caregivers, is when a patient tells his/her doctor that he/she has felt some lumps and feels that something is wrong in the body and the doctor answers in a nonchalant way that what she feels is probably nothing serious.

"One patient, who has been treated for cancer had now felt lumps and felt that something was wrong. She cried and asked to be investigated, but the answer she got was "there are so many women on the waiting list and what you feel is probably nothing serious."

To 'not care for' in the meaning of closing the eyes to the patient's wishes is when a caregiver does not recognize the need for caring. The caregiver does not believe the patient either, and has a very uncaring attitude by clearly showing that it is caregiver who knows best about the patient's needs and not the patient. The caregiver prioritises completely different things than the things that the patient has asked for, and this can be interpreted as the caregiver seeing the patient as an object.

The findings in relation to Eriksson's Caritative caring theory

The patient as a fellow being – the caritative ethics

To explore 'care for' in the light of the caritative caring theory has opened up and made visible the ethical dimensions of caring. The findings are dedication in the sense that a glimpse of the caritative caring theory core has got a concrete meaning, which is a movement towards a synthesis of theory and praxis. This opens opportunities to see more than the already finish formulated about caring. Eriksson (1995) means that: - "the first ethical fundament can be seen in our view of human beings, i.e. our basic attitude towards the human being and her suffering" (page 24). Seeing the patient as a fellow being includes being a fellow being and to believe in your own strength. To see is to realise and know something, which is connected to evidence (Martinsen & Eriksson 2009). The evident has a meaning and it is true, beauty, good and forever (Eriksson & Nordman 2004). Gadamer (1997) emphasises that the evidence is something that has to be made visible and ruling.

The patient as an object

In contrast to 'care for', the findings also relieved that 'not care for' meant to see the patient as an object and not as a unique person and a unit of body, soul and spirit Eriksson (1995). This means that 'to not see' has its origin in the non-ethical (page 24). The non-ethical starts when the caregiver does not permit his/her ethos, the inner ethics to be present within the caring. Seeing the patient as an object means that the caring has been reduced to actions and work tasks without a deeper meaning. As a summary 'not care for' is understood as a routine pre-planned care with a lack of any ability to see the human being and to lack awareness of the motive for caring.

Reflection over the meaning of application

The discovery that 'care for' means to see the fellow being is understood as a human responsibility which is connected to the caregiver's inner ethic and ethos. This inner ethic is seen to be alive and acting and expressed in the caring act which is dedicated to the suffering other. The discoveries within research show the importance of dedication, where the ethical dimension of caring has become alive and acting. Dedication is the deduction towards a synthesis of theory and praxis and means that the theory core and the theoretical knowledge have been translated, by the carers together with the scientific leader, so that it has got a concrete meaning and has been connected to an experience of importance (Eriksson & Lindström 2000). Seeing the patient as a human being is an expression for inner caring ethics, where the caregiver allows caritas, love and charity to be present within caring (Eriksson 1995). Caritative caring ethical thinking requires that the caregiver gives more of himself/herself and ends up in situations as a fellow being on a deeper level (Näsman, Lindholm & Eriksson 2008). Roach (1997) supports this and means that one cares in a variety of ways and that we care is what we share as human beings. It is interesting to see how clearly it shows that the caregiver has the ability to be a fellow being, not to be reduced to acting a role. Instead, being able to be a fellow being reflects real professionalism and professional caring. In contrast to 'care for' 'not care for', seeing the patient as an object has made a kind of caring visible, where the caregiver does not allow himself/herself to be a human being and is hiding behind some kind of professional role. Omitted caring or non-caring can be due to a lack of ability

to see and determine what the patient needs (Eriksson 2006b). Halldorsdottir (1996) supports this and means that the lack of caring – uncaring leads to inhumane caring. 'Not care for' has too little of or completely lacks the inner ethical presence and preparedness that is present within 'care for'. According to Lindholm (2003), "we are always prepared to use ethical knowledge, but we don't have ethical knowledge in the way that we already possess it and then apply it in a specific situation. It is necessary to see what the situation requires from us" (page 51). In this study the co-researchers' creation of 'care for' was descriptions of caring where the situation was crucial. At this stage an ethical knowledge was created in the reflection between the universal caring theory and the individual clinical situation. Lindholm (ibid.) means that this understanding can be expressed in the form of a revision of clinical practice, a dedication in the form of a new understanding.

Method discussion

Clinical application research whereby co-researchers form a research group together with a scientific researcher is uncommon within clinical caring science. Through interpretation and understanding it has been possible for the clinical co-researchers, with the help of application research, to understand caring in a new way through a constant movement between theory and practice. Gadamer (1997) says; "understanding always is application" (page 309).

The innovative features of this research method have made it possible for the co-researchers to discover and concretise the theory of caring science as a form of evidence based practice. The research questions about what 'care for' and 'not to care for' are and how it is expressed within clinical praxis are of universal character.

This is the reason why it was an advantage that the co-researchers were working within different contexts and professions. The creation of the hermeneutic room where Eriksson's caritative theory is studied was of basic importance, since 'care for' was supposed to be understood from a specific theoretical caring perspective. The co-researchers were able to understand, through theoretical studies, the already known clinical phenomenon 'care for' in a new and different way than before and even to discover new sides and nuances of caring.

Researching 'care for' has made an inner ethical dimension visible within caring. The new understanding of the inner ethical dimension, an

awareness of the motive for caring, has consequences both for caritative caring theory and for evidence based practice. This means that the caregiver who care for 'always is prepared' to apply ethical knowledge depending on what he/she is confronted with in the specific situation.

Conclusion

This research about 'care for' and 'not care for' has uncovered and shown traces of caritative caring theory through the discovery of an ethical dimension in caring. This dimension includes respect and responsibility for the patient in the meaning of body, soul and spirit in protecting and keeping away from hurt and injury. To 'care for' the patient from the caregivers perspective is to see the patient as a human being and also to be a human being. The result is relevant both for caring theory and evidence based practice which has been concluded in the two following theses:

- To care for, as an aspect of caring, is understood as an inner ethical attitude that includes responsibility and respect for the human being.
- To care for, as an aspect of caring, is understood as an expression for caritative ethics, an inner ethical attitude in the meaning of seeing your fellow being with love and mercy.

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