The Nordic Tradition of Caring Science: The Works of Three Theorists

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Abstract
The Nordic tradition of caring science has had a significant influence on healthcare research, healthcare education and clinical development in the Nordic countries from 1990 to the present. Theoretical contributions from the professors and scientists Katie Eriksson, Kari Martinsen and Karin Dahlberg form the basis for this paper. The tradition has established a paradigm of ethics, ontology and epistemology for the caring science domain. Short introductions present the scientific background of Eriksson, Martinsen, and Dahlberg, and show how interpretive teamwork has led to the formation of an intertwining of the essential qualities of the theories. The synthesis emphasizes caring science as a human science, and views caring as a natural phenomenon where the patient’s world, vulnerability, health, and suffering are primary. In the art and act of caring, relationships and dialogue are essential; they provide parameters where caring becomes visible in its absence.

Keywords
caring science, health and suffering, Nordic tradition, patient’s world, theories

For about 25 years, a unique knowledge tradition has developed in caring science in the Nordic countries (Sweden, Norway and Finland). The authors of this paper attempt to intertwine the work of three theorists and professors in caring science from three different Nordic countries, aiming to describe and bring together information on the current status of caring science in the Nordic countries in 2014. Examples are given of approaches that are common to the three researchers, as well as the individual variations in their theories. Theoretical contributions from professors-scientists Katie Eriksson, Kari Martinsen, and Karin Dahlberg are the originators of the Nordic tradition, and Dahlberg is a later follower, all with a background in caring ontology. The extensive development of caring science by these three scholars in the Nordic region is unique and has had considerable influence worldwide. They have all worked individually, but not without contact or cooperation. Without doubt, they have supported and inspired each other, but have also disagreed on a number of issues. The work of each one has been more prominent than that of the others at certain times. For example, the concept of suffering was developed into caring science by Eriksson, the concept of vocation developed by Martinsen, and the meaning of the concept of life-world-led caring by Dahlberg.

The search for the core and essence of caring has by these three Nordic scholars incorporated philosophy and concepts from the history of ideas. Ontological, epistemological, methodological and ethical bases for caregiving have been formulated and developed in relation to what it means to be a patient. The fact that caring science has developed as a human science means that it can be regarded as a supplement and extension to the bio-medical paradigm. The theories interact in an intricate way and their metaphoric fabric attempts to give the Nordic tapestry its own unique content.

The project to form this paper involves an interpretive teamwork by five scholars. The themes emerged from our readings and discussions in a year of regular joint meetings, discussions and analysis work. The fundamental question for the project was: what is the nature and essence of the Nordic caring science tradition? The result is presented as an attempt at synthesis within a hermeneutic framework. The research does not focus on the content of the theories, but rather how their shared perspective can clarify the substance of caring and caring science as it is theorized in a Nordic context. The result presents a descriptive synthesis for the current Nordic caring perspective.
Three Caring Science Theorists

Katie Eriksson was born in 1943. She is a Finnish registered nurse (RN), PhD and Professor Emerita at Åbo Akademi University, Finland. The development of Erikson’s theory was inspired by the history of ideas, and further developed with the help of conceptual and semantic analysis. In a departure from the Greek classics of Plato and Aristotle, her inspirations included Nygren, Gadamer, Kierkegaard and some Swedish and Finnish philosophers. She began her theory-building with the book, The Care Process (Eriksson, 1979), a version of her doctoral dissertation in pedagogy 1976. It was followed by The Idea of Health (Eriksson, 1984) and Caring Didactics in (Eriksson, 1985). The Idea of Caring (Eriksson, 1987b) is the work that has received the most attention. In this book she introduced tending, playing, and learning as the substances of caring. She suggested that the caring relationship develops through the concepts of communion and sharing in care, and that caregiving is an act of healing. She also discussed the concept of natural caregiving in relation to professional care. The concept of “caring care”, or caring in nursing, was introduced in this book, and was contrasted with technically-oriented and medical care. In the same year, she continued to develop the theory in The Pause (Eriksson, 1987a). She effectively introduced a scientific theory and argumentation which came to be accepted as standard in caring science. In these works, she introduced caritas as a concretization of love and charity. Love for one’s neighbor and a desire to serve became the basis for the caritative caring theory. Faith, hope and love were highlighted in caring, as was a new holistic approach to human beings involving requesting, experiencing, and creating. Perhaps this can be understood as the seed of the ontological health model, in which human health and suffering are understood as problems, needs, and desires (Lindström, Lindholm Nyström, & Zetterlund, 2014). Another key concept of the human was suffering. In The Suffering Human Being (Eriksson, 1994, 2006), Eriksson showed how the concept of suffering is the main element in caregiving and caring science. She stated that, “Suffering is the key motif of all caring.” This work presented three forms of suffering in healthcare: suffering from illness, the suffering of life and suffering related to healthcare.

From an early stage, Eriksson worked toward developing a theory of caring science outside the professional context, viewing it as an autonomous discipline defined by its ontology. She consciously developed the basis of caring science through concepts and assumptions, and is seen as a basic researcher. In an article Eriksson pronounced her development of caring science as “a new key” where the sounding board is to be found in its ontological core (Eriksson, 2002). In 2007 the drama of suffering was communicated internationally as Becoming through suffering – the path to health and holiness (Eriksson, 2007). Hermeneutic epistemology and hermeneutically-based methods were being developed simultaneously. The semantic analysis (Eriksson, 2010a), which is central to basic research and hermeneutic methodology was inspired by Gadamer. An alternative view of evidence was developed and described in 2010 (Eriksson, 2010b).

Today, Eriksson’s theory is known as “The theory of caritative caring”, as noted in “Nursing Theorists” (Lindström et al., 2014). Key concepts are: caritas, caring communion, the act of caring, caritative caring ethics, dignity, invitation, suffering, suffering related to illness, care and life, the suffering human being, reconciliation and caring culture.

Kari Martinsen was born in 1943. She is a Norwegian nurse (RN), PhD and Professor Emerita at the University College of Harstad, Norway. Martinsen studied psychology, philosophy, and history, and completed a PhD in philosophy in 1984. The development of her theory was inspired by the philosophers Heidegger, Foucault and Logstrup. Her thesis was a dissertation in philosophy and nursing, resting on Marxist theory as well as phenomenology. This thesis provoked a debate in Norway, as it offered a critical perspective on the nursing profession’s lack of social responsibility and lack of independence. Following this, Martinsen remained within a historical discipline and undertook a project on the social history of the nursing profession and its ties to feminist theory. Martinsen was initially critical of the lack of caring in healthcare, and declared in 1990 that “moral practice consists of caring, which is also a foundation for our lives.” Martinsen then worked for a period in Denmark. She developed her basic concepts of care from two philosophical, ontological ideas: Heidegger’s Sorge, in which caring is seen as ontological and a prerequisite for human life, and Logstrup’s concept of understanding of life, one expression of which is that human beings are naturally and universally interdependent. Martinsen’s essays further developed her thoughts on human encounters, vulnerable bodies, and power relations in healthcare.

Her important works include From Marx to Logstrup (Martinsen, 1993) a historical philosophical introduction to caring as ethical and natural. As a framework for searching for knowledge, she went on to develop a phenomenological methodology for caring in Phenomenology and caring (Martinsen, 1996). The call or vocation as a secular quality in caring was developed in The eye and the vocation (Martinsen, 2000) and in the English essay collection Care and Vulnerability (Martinsen, 2006). The book, Dialogue, Professional Judgement and Evidence (Martinsen, 2005), integrated into her theory of caring the concepts of vulnerability, dialogue, and untouchable zones, seen from an existential perspective. In her essay on the subject of encountering a suffering fellow being, she suggested the concept seeing “with the heart’s eye”, and she often returned to the importance of philosophy and an understanding of life in caring. Martinsen’s interest and knowledge in Logstrups philosophy has been a constant companion in her scientific work which 2012 resulted in the book Logstrup and the nurse (Martinsen, 2012). Martinsen has collaborated
with Patricia Benner and maintains an on-going dialogue with Katie Eriksson.

An early interest in evidence for caregiving, in cooperation with Katie Eriksson, led to publication of a book on evidence in caring science, To See and to Have Insight in the Understanding of Evidence (Martinsen & Eriksson, 2009). In the book traditional forms of evidence-based research are criticized in favor of evidence drawn more from a human science tradition.

"Today" Martinsen's theory is known as "The philosophy of caring", as noted in "Nursing Theorists and Their Work", and the key concepts (Alsvåg, 2014) are: care / caring, professional judgement and discernment, moral practice as founded on care, person-oriented professionalism, sovereign life utterances, vocation and the registering eye.

Karin Dahlberg was born in 1952. She is a Swedish nurse (RN) who specialized in psychiatry, and is a professor of caring sciences at Linnaeus University in Växjö, Sweden. Dahlberg received her PhD in pedagogy in 1993. She is best known in Sweden through her development of the phenomenological and life-world- led perspective in caring sciences. She has become recognized for her book, Reflective life-world research (2001) introducing a new method for phenomenologic research in healthcare (Dahlberg, Dahlberg, & Nyström, 2008; Dahlberg, Drew, & Nyström, 2001), and has given several graduate courses on her successful phenomenological methodology for healthcare science. Dahlberg's scientific development is rooted in continental philosophy, where the life-world approach and the concept of the lived body are based on the works of scholars such as Husserl, Merleau-Ponty and Gadamer. Sartre's existential worldview has also been a source of inspiration. In her book, Understanding caring science (Dahlberg, Segesten, Nyström, Suserud, & Fagerberg, 2003), caring science is described as an autonomous discipline, a discussion which later became a defining characteristic of her academic work in Sweden. From 2007 onward, Dahlberg wrote philosophically-oriented articles in partnership with and among others, Les Todres. These include "Life-world-led healthcare is more than patient-led care: an existential view of well-being" (Dahlberg, Todres, & Galvin, 2008). Dahlberg's thinking focused on health and well-being, on patients' life-worlds and on their participation in their own health and caregiving processes.

In 2010, Dahlberg in collaboration with Kerstin Segesten, published a book in Swedish that is a synthesis of her thirty years of research into a theory of caring, Health and caring. In theory and practice (Dahlberg & Segesten, 2010). In this theory of a life-world-led health care, Dahlberg claimed that caring can never be reduced to a specific technique or measure, but is a health-promoting action created in the encounter between a professional caregiver and the patient. The essential idea and purpose of caring is to support and enhance health processes of human beings, and the patient perspective is fundamental in this attempt. Dahlberg described good caring as “open and pliable caring” that includes nurturing encounters, caring conversation, and a caring presence, and

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she stated that it requires both openness and reflection on preconceptions from the caregiver. Participation means that caregivers have listened to and confirmed back to their patients what is understood (Dahlberg & Segesten, 2010).

An integrated view of the Nordic caring tradition follows. The table shows the theories thematically in a descriptive synthesis.

### Caring Science as a Human Science

The Nordic tradition is unique in that it is deeply rooted in basic issues of life and human existence. With a philosophical perspective on health, healthcare and caregiving, it is characterized as a human scientific discipline. A starting point is therefore existence itself.

### Caring Science is an Autonomous Science

The academic subject is not bound to profession, but can be studied by all caregivers, irrespective of profession, or by anyone interested in the scientific perspective. Caring science is a human science (Dahlberg & Segesten, 2010; Eriksson, 2001, 2002; Martinsen & Eriksson, 2009) and an autonomous academic discipline. The rationale for this is that a scientific discipline must have its own unique set of values, concepts, and theories in order to qualify as a discipline (Eriksson, 2001). Eriksson even said that caring science as an autonomous scientific discipline is defined by its ontology (Eriksson, 2001). This ontology is made explicit by statements on the nature of reality (Dahlberg & Segesten, 2010).

### Existence as a Starting Point for Caring Science

In general, it can be said that existence itself, that is what it means to be a human being, as a universal phenomenon is a decisive issue in the Nordic caring tradition. Three positions
can be observed, based on the work of the three scholars. However, they have more common ground than opposing issues, which is briefly illustrated by nuances within each perspective.

As a result of her research, Eriksson presented an ontology in which she developed the concept of a world based on ideas. Ideas and ideals are the basic substance, and human beings approach these through appropriation of knowledge. For example, suffering is part of human existence. People can experience authenticity by opening up to suffering and not avoiding it. Another example is the idea that love (caritas) is the basis of caring, and that there is a core, a basic substance that is timeless and eternal within which the essence of caring is hidden.

Martinsen similarly sees existence as a universal idea, that is, that there are universal phenomena that are embedded in the human essence. This is in accordance with the Danish philosopher Logstrup’s thinking, that is essential in the theory of Martinsen. Logstrup has developed a universal understanding of being human from a phenomenological position, seeing it as a universal understanding of life. For example, human trust and natural compassion, which are the most prominent utterances of life, can be interpreted as expressions of universal interdependency. Interdependency and mercy are ethical prerequisites for taking care of the life of others, and also are requirements in every encounter between people.

Dahlberg’s position on existence involves a serious interest in existential questions and their concern with caring. Departing from Husserl and his philosophical and epistemological theories, she developed caring science from a life-world- led perspective, anchoring it in “the lived body”, suggested by Merleau-Ponty. The freedom of will (free will), alongside human vulnerability and mortality, are universal conditions in the definition of being and existence in caring and caring science. Anchored in existential philosophy, Dahlberg has developed knowledge of existence in health and well-being through a life-world perspective.

**Evidence for Caring**

The concept of evidence has been the subject of critical and open discussions by all three theorists. Eriksson and Martinsen claimed in “To see or to have insight” (Martinsen & Eriksson, 2009) that evidence from a human science perspective means to unveil in order to see and understand age-old values or meanings, such as how to interpret the truth, the beautiful, the good, and eternity. Dahlberg argued that it is unscientific to force caring phenomena, which are epistemologically understood as immeasurable, into matrices that reduce them to measurable entities, sometimes beyond recognition. Similarly, Martinsen and Eriksson suggested that the concept of evidence in natural science is too narrow in relation to caring phenomena, and that it is, in fact, multifaceted and also must involve ontological evidence (Eriksson, 2010b). Dahlberg, Martinsen, and Eriksson proposed that when the focus of research is on the world of experience, descriptions are better than numbers, and by looking for both explicit and implicit meanings in descriptions of caring phenomena, one can come closer to the essence of a phenomenon. Dahlberg (2008) implied that scientific research needs to be interpreted and transformed in order to establish validity and evidence. All research results have an original context from which the results are re-contextualized into other situations and give rise to new questions. The meaning of research results for patients depends on how practitioners understand and use such knowledge. By using only medical statistical methods and the statistically significant concept of evidence, it is more than likely that those non-measurable phenomena such as hope, pain, confidence or well-being will be completely left out of the field of knowledge and evidence.

**The Essence of Caring**

The perspective of caring as a unique and foundational phenomenon is deeply rooted in these three theories. Since 2000, the concept of caring has been developed in Sweden as “vårdande”(caring) and in Norwegian as “omsorg”(caring). It has been considered important to stress new concepts for the characteristics of caring in both the Swedish and Norwegian languages, which could enhance the definition of what it means to care for another human being, a concept not bound to the nursing profession. The new concept “vårdande”(caring) uses the present participle (ing- form), linguistically-speaking, and aims to define caring as an ongoing action and state of being (being and becoming).

**The Human Being as an Entity**

The three theoreticians agree on the significance of having a holistic perspective. A common view is that the patient’s physical, psychological, existential and spiritual dimensions form a unity. Eriksson noted that the human being is an integrated entity that unites body, mind, and spirit, and when a person becomes a patient, he or she has to be considered in accordance with this. Strictly speaking, it is inconsistent to speak about parts of a human being, as a human being is always an indivisible entity. Martinsen suggested that developments in medicine have managed to make the body measurable in an unnatural way. With particular reference to Foucault, she believed that this is one of society’s ways of controlling people. Categorizing people as sick or healthy, or defining what is normal and what is abnormal, differs from how the patient is conceived from a caring science perspective. The idea that human beings live and experience wholeness leads to questions about what patients lack or what hinders their health processes. With the life-world theory as a basis, Dahlberg suggested that the concept of the lived body is a way of seeing the body as a subject that is going through lived experiences.
To shift the focus from a pathogenetic view toward health resources or salutogenetic powers is central to the perspective. The Nordic tradition places the patient at the centre, regarding disease or illness as patients’ contexts. From this perspective, diagnoses are secondary. No illnesses are mentioned by Eriksson or Martinsen in their writings or lectures. Instead, the patient is presented as a suffering human being by both of them. The human being, the patient has problems, needs, and desires; these are essential factors to take into account in caring science.

**Health and Suffering**

Basic concepts of caring are important and have been developed in the caring science of the Nordic tradition. Health was an early point of departure and this central concept has evolved to include a co-dependency in the dyad health and suffering. Human suffering is seen by Eriksson and Martinsen as natural and as part of health. They claimed that suffering is an unavoidable part of life, as well as interacting with fellow human beings, and of developing as a person. Eriksson argued that suffering as a basic concept for caring describes human beings’ struggle between good and evil. Dahlberg emphasized health as connected to well-being, rather than to suffering, and as a central concept and phenomenon. The tradition emphasizes human vulnerability and the patient’s exposure and lack of power as important considerations since caring has the purpose of alleviating human suffering and promoting the patient’s health.

**Caring as a Natural Phenomenon**

A common element in the tradition is to emphasize elements that are of a natural character in caring, a phenomenon known as *natural caring*. Eriksson emphasized “mercy”, “compassion” and “love” as natural elements in human beings, which makes caring acts a part of being human. Martinsen combined Heidegger’s concept of *Sorge* with Løgstrup’s *Understanding of life* and spontaneous life utterances, to create the concept of sovereign life utterances. The importance of human universal interdependence is another cornerstone of Martinsen’s ideas on life utterances. Dahlberg departed from the life-world perspective and the lived body. Natural caring is characterized by a natural approach and by demands from others, and could be unreflective or influenced by personal preconception, including *tacit knowledge*. Another common factor in caring is what Eriksson called “the creation of a caring act”. Both Martinsen and Dahlberg name this activity “the caring interspace.”

**Openness and Pliability: Seeing with the Heart’s Eye**

Eriksson and Martinsen discussed charity and the ability to show compassion, and how these are manifested in caring for a patient (Alsvåg, 2014; Lindström et al., 2014). Caritas is a union of compassion and mercy, and according to Eriksson, the core of all caring, education in caring, and the interrelations between human beings. Martinsen described compassion as implicit in the caregiver’s ability to “see with the heart’s eye”. “Caring for life and neighbourhood” are cornerstones of caring, illustrated by the apologue of the Good Samaritan. Dahlberg is anchored in a life-world perspective (Dahlberg, Todres, et al., 2008), and as such she describes caring as grounded in an understanding of the worlds of others, and based on experiences of how people are living through complex situations, a contextual understanding of the qualities of life.

The Nordic tradition has developed or expanded caring abilities by adopting a hermeneutical, phenomenological or life-world approach. With acuity of the senses, self-awareness and knowledge-based self-development, caregivers are more likely to recognize their patients’ unspoken needs and discover deeper, existential concerns. Development of “bildung” as open-minded sensibility, self-reflection, openness and pliability implies that caring from a life-world perspective is a challenge for the caregiver. In comparison, Eriksson accentuated the concept of “bildung” in terms of an invitation to the patient, an invitation to a caritative and caring communion. According to Martinsen, and Dahlberg “bildung” introduced an ethical demand that involves openness and responsibility toward the other.

**The Patient’s World at the Center**

The “patient’s world” is a basic consideration in the Nordic caring tradition (Dahlberg, Todres, et al., 2008; Eriksson, 2002; Martinsen, 2006). This understanding of caring is based on an interest in, respect for and understanding of the patient’s problems, needs, and desires, and the patient’s world as it is lived. The patients’ world is a world of suffering and vulnerability, but also of wellbeing and development in health. To give a “caring care” is a skill which must be understood and applied from the point of view of those involved: the patient and her next of kin.

Empirical research along the lines of these Nordic theories of Eriksson, Martinsen, and Dahlberg has largely focused on the patient’s world. The research has developed broad knowledge on variations and idiographic patterns of caring for patients in different healthcare contexts. Studies of lived experiences have been of interest, and have investigated how people deal and develop with boundary situations or important decisions in life, as well as what it means to be cared for or to live as a patient with different challenges and needs.

**Ethics and Caring Science**

Philosophy and ethics are the inspirational building blocks for the Nordic theorists’ framework. Relational, -virtue and ontological ethics have been keys to their ideas, and they
have referred to the ethics-based texts of, among others, Lévinas (1985) and Løgstrup (1997). Eriksson adopted the concept of “ethos” from Aristotle, and developed the term “caring ethos.” Ethos is understood as the motif or inner value in the caregiver, what the caregiver is mediating and carrying in his or her heart. This involves Lévinas’ relational ethics. Essentials to relational ethics are respect and openness for each patient’s world, and as such, ethics is involved in every patient encounter. The caregiver’s presence and seeing and listening in a reflective and sensitive way to the patient’s needs is a responsibility emphasized over and over again in this tradition. Dignity for the patient is related to respect and autonomy in care.

Martinsen has contributed extensive work on integrating Løgstrup’s ontological ethics with caring (Martinsen, 1993, 2012). Løgstrup’s phenomenological worldview considers people’s understanding of life as essential. An ethical demand involves a call from the vulnerable and dependent person that requires caregivers’ sensitivity. Interdependency is considered a natural, spontaneous, and basic universal attitude in people and a basis for all caregiving encounters.

The phenomenological approach is characterized by the fact that it always departs from the lived experience. It does not recognize the metaphysical reality behind phenomena if they are not experienced. Thus, Dahlberg suggested that the phenomenological researcher is not concerned with a worldview but with the lived and experienced world. Within Dahlberg’s framework, ethics does not precede the ontological, if the fundamental features of phenomenology are considered. Instead, they require one another; the one precedes or mirrors the other. This is in line with Martinsen’s theory inspired by Løgstrup. Løgstrup started with the phenomenological world and interpreted it in universal terms such as an understanding of life or interdependence.

The Art and Act of Caring

The art and act of caring form the scientific cradle of Nordic healthcare research (Dahlberg & Segesten, 2010; Eriksson & Lindström, 2003; Martinsen, 2006). Caring for others is seen as natural in the Nordic tradition; it is an example of the interdependency of human beings. The relationship between caregiver and patients aims to relieve the patient’s suffering and support health and well-being, which are vital cornerstones of the discipline of caring science. Eriksson called the caring relationship the substance of caring science or “Die Sache”. Martinsen referred to caring as a person-oriented professionalism in response to the ethical demand arising from a patient’s vulnerable situation. For Dahlberg, caring and the human life-world approach toward health, wellbeing, and disease are of central interest.

In the Nordic tradition, the person as a patient is conceptualized as a suffering fellow human being for whom the caregiver can care, and who’s suffering can be alleviated. Qualities beyond technical performance and actions are clarified in terms of concepts and theories. Martinsen is clear that caring is the primary concern of caregivers. Eriksson used the concepts of caring care or caritative care, but increasingly speaks only of caring, a form of tenderness that invites the patient into a caring relationship. Dahlberg used the concept of life-world-led caring to refer to responsive attention to the patient’s life-world and needs. Concepts such as the caring relationship, communion, interpersonal relationships and encounters mirror essential phenomena in the art of caring.

Relationships and Dialogue are Central for Caring

The concept and phenomenon of the caring relationship are central to the Nordic caring science perspective, and have been problematised and elaborated by both Eriksson and Martinsen (Eriksson, 1987b; Martinsen, 2000). Martinsen emphasized the importance of an open listening dialogue, where aspects of vulnerability, trust, and relational power are disclosed. Anchored in the work of Løgstrup, Martinsen pointed to aspects of dialogue such as “getting in tune” and caring situations that are “pregnant with meaning.” This implies that what is expressed is intimately related to how it is said, performed, and received. The music of the language, the tune of the words, and their authenticity are brought to light. A caregiver needs to understand the vulnerability and personal disclosure that may be involved in a caring dialogue. The challenge in caring is rooted in the art of the dialogue and finding the tune and the music of the language in it.

This relationship is central, even in Eriksson’s theory. She defined the relationship between caregiver and patient as existential and called it a caring communion (Eriksson, 1987b). In the caring communion, the caregiver is touched or shattered by the vulnerability of the suffering human being. A “room” can be created where both parties have the opportunity to be transformed by the caring relation. Dahlberg (Dahlberg, Todres, et al., 2008) stated that the caring encounter is characterized by the caregiver’s sense of responsibility and sensitivity toward the interaction, as well as its beneficial aspects. This responsibility involves responding to the needs of patients, and to their tone of voice and facial expression, which leads to an obligation toward their life-world. It implies an openness and responsiveness to the patient’s life-world, and its ambiguities and it is described as supporting patients’ health processes in a way that affirms the life-world and participation in it.

Caring Becomes Visible in Its Absence

Within the caring tradition, it has become clear through clinical research that the fundamental characteristics of caring become visible when they are absent. Deficiencies in care experienced by patients have been taken seriously, and have been analysed within a scientific framework. In 1994, Eriksson introduced the concept “suffering related to healthcare” as one
of three main forms of suffering in the field, the other two being suffering through illness and the suffering of life (Eriksson, 2006). People experience healthcare-related suffering when care causes more suffering than relief. Such suffering is caused by violations, abuse of power or a failure in caring. It is noticeable when caregivers are part of an organization and culture that fail in this responsibility. From an early stage, Martinsen criticized how insufficiencies in caregiving affect the vulnerable patient (Martinsen, 2000). From the point of view of vulnerability and dependence, Martinsen kept a persistently critical eye on power configurations in healthcare. She generally considered healthcare-related suffering in terms of an understanding of life in which spontaneous compassion is rejected. A caregiver has to be “touched” by the other to be able to understand and take action in caring. To be able to “see with the heart’s eye” is the start of a person-oriented professional approach. As an example, Martinsen claimed that caregivers today are more judgmentally tuned to emotions, closeness, and presence than to distance in their relations with patients. Dahlberg took this further, referring to humanizing as opposed to de-humanizing care (Dahlberg & Segesten, 2010; Dahlberg, Todres, et al., 2008). Suffering related to healthcare is understood by Dahlberg as a lack of caring consciousness from the caregiver and the organization. In philosophical terms, the caregiver is either immersed in or blind to the needs of the other, the patient.

The Meaning of Context and Environment

A common thread for all three theorists involves a departure from the idea that caring reflects the individual’s perception and environment. The context for caring is different, and is described from a number of standpoints. Eriksson used the concept of a “caring culture” rather than the metaparadigm of environment used in nursing science (Lindström et al., 2014). The core of the culture is its ethos or values, which can be seen as the essence of the culture. Ethos is an inner imperative in caregiving, and is closely connected to the ethical virtue theory. The caring culture should, according to Eriksson’s theory, reveal caritative caring, where compassion and love are the main motives and ethos. In Martinsen’s theory, the person, the patient, is always positioned in a “room” of power, time, and spatiality (Alsvåg, 2014; Martinsen, 2014). These rooms bring universal meaning, but as they are inhabited by people, patients or groups, a cultural room for caring is created. These rooms need to be permeated with dignity, and caregivers have to be given the opportunity to be open and to be sensitive to patients and their vulnerability. Dahlberg’s position is the life-world perspective, which defines patients in terms of self, others, and their worlds (Dahlberg, Todres, et al., 2008). Even if the life-world is individual and unique, it is simultaneously shared with others, both living beings and things. The person’s lived experience of caring embraces a more common dimension of the experience. According to the phenomenologist Merleau-Ponty, the lived body is not only the entity that carries the person’s being, it also comprises other living beings, a phenomenon he called the “inter-body” experience. People are, for example, intertwined in a common understanding or tapestry of language that connects them (Dahlberg & Segesten, 2010).

Development of a Methodology for Caring Science

The development of a methodology for an autonomous discipline of caring science has been important in the Nordic tradition. The epistemological question, of which form of knowledge and data are relevant, is essential if the results of caring science are to have credibility. Eriksson has called for basic research to address this. She has devised a method for semantic analysis and concept development based on the works of Peep Koort (Eriksson, 2010a), as a way of conducting basic research in a human science tradition, and to find rich and founding concepts for the science at different levels of abstraction. Furthermore, her epistemological framework for caring science as an autonomous discipline based on hermeneutic tradition is founded on the history of ideas and the philosophy of researchers such as Kierkegaard and Gadamer. According to Gadamer (Gadamer, 1989), hermeneutic epistemology and its approaches are characterized by openness and flexibility in the search for knowledge. This led Eriksson to formulate a scientific theory for caring science. Fundamental values, axioms, and presuppositions were formulated, which created a basis for furthering theoretical and clinical research.

The aim of caring science research is always to understand what is good for the patient. This focus is present in the epistemology of all three theorists. The substratum in the encounter with the patient is, as Dahlberg frames it, one of openness, pliability and dialogue. Martinsen has written texts and philosophical papers on phenomenology (Martinsen, 1996), while Dahlberg has developed salient phenomenological methodologies like “reflective life-world research” (Dahlberg, Dahlberg, et al., 2008). This methodology has been used internationally as well as on a national basis.

For the three Nordic scholars, it is important that the development of methodology and the methods used are related to the basic ontology and epistemology of caring science, in order to understand more of what Eriksson called “Die Sache” and what Dahlberg called the phenomenon of caring, and what Martinsen called presence in caring.

Discussion

In spite of moments of scepticism and resistance, the Nordic caring science has from 1990 to the present had a significant influence on the development of research, education and clinical
practice in caring and nursing in the Nordic countries. All of the nursing and caring sciences in these countries have been influenced by the approach in some way or another. There are health professionals across the Nordic region carrying greater or smaller fragments of this caring tradition, integrating them in head, heart, and hand. The tradition has established a caring paradigm of ethics, ontology and epistemology. This means that there is an understanding of caring that has become implemented and permeates the clinical healthcare culture with a focus on the patients’ needs.

The Nordic attitude toward caring, which involves facing core issues and questions in life, is mirrored in the research that followed in the tradition. This is considered in a number of articles and dissertations. It is noticeable how regularly philosophical, ontological and existential aspects have been discussed with the clinical and empirical phenomena presented by Nordic researchers since 2000. Empirical research with the perspectives of these three Nordic theorists, Eriksson, Martinsen, and Dahlberg has largely focused on the patient’s world. Doctoral and postdoctoral research has developed broad knowledge on variations and idiographic patterns of caring in different healthcare contexts. The essence of this tradition of caring science has been applied and developed in clinical contexts and approached in clinical practice and other work.

Conclusion

We have highlighted in the project how caring science in a Nordic tradition is argued to be an autonomous and human science discipline where questions of life and existence are the basis for healthcare. Caring essence starts with human beings, and their health and suffering are integrated. The patient as a human being is the first priority and the patient’s world determines the way of caring. Caregiving acts include developing awareness, opening up by reflection to what the unique patient shows, and reveals, and thus confirming the patient’s individual situation, although from a universal horizon. Through the development of theories and concepts, caring science in the Nordic countries has moved toward a deeper understanding of the essence of caring and its potential for the patients’ health and wellbeing and for alleviating suffering. Caring science and evident caring acts in a Nordic tradition begins in a perception of the lived experience of the patient, still reflected with a theoretical horizon of philosophy, values, concepts and ideals.

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**MARTHA E. ROGERS, RN; ScD; FAAN**

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