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**EMPIRICAL STUDIES**

# Emotional knowing in nursing practice: In the encounter between life and death

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**Abstract**

Patients, next of kin and nurses in surgical wards often raise existential questions in the encounter between life and death. Nurses' emotional knowing at this encounter is crucial. Consequently, this study's purpose was to analyse and describe nurses' emotional knowing to reveal (a) how this knowing is expressed in daily work and (b) what emotions, thoughts and actions this knowing includes. This study used combined ethnographic and hermeneutic methodologies. Data were collected using participant observations, informal conversations and interviews. We found that nurses' emotional knowing could be interpreted in relation to various rooms of emotions, thoughts and actions. Nurses' judgements formed these rooms. They strived to do things correctly in the normative room; created a safe, secure milieu for patients and next of kin in the safety–security room; and questioned their actions in the critical room. They created affinity for co-operation that benefitted encounters with patients in their affinity room. And they demonstrated sensitivity and compassion to patients and next of kin; sensitivity and compassion were particularly evident in the closeness room. In our main interpretation, we found that nurses' judgements in various rooms (emotional knowing) constitute an expression of practical wisdom (*phronesis*) in nursing practice.

**Key words:** *Emotional knowing, ethnography, critical hermeneutics, nurses, assistant nurses, nursing practice, phronesis*

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In contrast to the previous emphasis on emotional distance (Savage, 1995; Schuster, 2006; Williams, 2000), emotional intelligence (EI) within nursing practice is increasingly coming into focus (Akerjordet & Severinsson, 2007; Freshwater & Stickley, 2004; McQueen, 2004; Savage, 1995; Schuster, 2006; Williams, 2000).

EI is considered meaningful for developing caring relationships (Akerjordet & Severinsson, 2004; McQueen, 2004; O'Connell, 2008) and for understanding patients' needs (Kooker, Schoultz, & Codier, 2007; McQueen, 2004), moods and emotions (Akerjordet & Severinsson, 2004; Freshwater & Strickley, 2004). EI is important during problem-solving, decision-making (Akerjordet & Severinsson, 2004; Freshwater & Strickley, 2004) and management of negative feelings for patients (McQueen, 2004; see also Sandgren, Thulesius, Fridlund, & Petersson, 2006). EI has been described as having these effects, namely it can: mitigate stress at work, facilitate cohesion within teams (Feather, 2009; McQueen, 2004) and constitute *the heart of the art* within nursing education (Freshwater & Stickley, 2004).

Most EI-related research is based on a natural science perspective. Few studies illustrate emotions, communication and behaviour from a humanistic perspective (Akerjordet & Severinsson, 2007).

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The natural science tradition (i.e., a western culture-dominated knowledge tradition) strictly differentiates between the rational and the emotional. In another philosophical track, with roots in Aristotelian thinking, this differentiation is not made. The rational and emotional are linked and they strengthen each other in the knowledge-generating process, expressed, for example, as emotional acuity and thought sensitivity (Nussbaum, 1995). We use our intelligence of emotions to orient ourselves in the world, to form judgements and to take decisions and actions (Nussbaum, 2001; see also Benner, Tanner, & Chesla, 1996). Emotions, thoughts, judgements and actions are woven together. Emotions intensify thoughts—and vice versa; the combination of emotions and thoughts increases abilities to demonstrate sensitivity and compassion.

Through our emotions and thoughts we can understand other human beings as human beings, namely, via our own emotions and thoughts we can understand others and ourselves (Nussbaum, 2001; Svenaeus, 2009). Emotions are also embodied and have intention (Nussbaum, 2001; see also Chinn & Kramer, 2008), i.e., they are always directed towards something. For example, we can feel another person's suffering in our bodies, and it's difficult to watch someone suffer without immediately trying to ease the suffering (Svenaeus, 2009). But emotions must be reflected if a caregiver is to be able to take the right decision at the right time (Nussbaum, 2001; Svenaeus, 2009). Emotions cannot be separated from thoughts about something, i.e., our beliefs about something. Personal histories and social norms shape emotions (Nussbaum, 2001). Ways in which we use our intelligence of emotions in nursing practice become important. For this study, we chose to use the *knowing* concept rather than the *intelligence* concept because (a) *knowing* "refers to ways of perceiving and understanding the self and the world" (Chinn & Kramer, 2008, p. 2) and (b) *intelligence* might generate ideas about something that is measurable.

Some authors (Bradbury, 2001; Goldsteen et al., 2006; Sandman, 2001, 2005) provide criticism of traditionally normative beliefs regarding how one should die a good death. They question whether or not dying humans go through various stages with acceptance as a goal. They also question whether or not death must ideally be encountered with information and open, honest communication (Goldsteen et al., 2006; Sandman, 2001, 2005). These norms also exist in modern hospice philosophy in which a natural death is preferred. The normative perspective might, however, become reductionistic; here, patients' personal needs and wishes are overlooked due to the assumption that rules and regulations are proper and correct (Goldsteen et al., 2006). Standardisation of care content and a one-sided view of knowledge, which allow no room for emotions, reinforce this risk.

The places of death vary and do not always occur in hospice or palliative care units. People also die in surgical wards at hospitals in which some patients have severe cancer and others have curable diseases.

Patients, next of kin and nurses in surgical wards can raise existential questions among themselves in the encounter between life and death. Nurses' emotional knowing—in an existential situation, such as the encounter between life and death—is crucial (see also Svenaeus, 2009). Emotional knowing constitutes care that patients and families have access to, i.e., the content in nursing.

The question is whether or not nurses use their emotional knowing in their daily work. Consequently, this study's purpose was to analyse and describe nurses' emotional knowing to reveal (a) how this knowing is expressed in daily work and (b) what emotions, thoughts and actions this knowing includes.

This study's analysis and description are based on Nussbaum's (2001) description of the intelligence of emotions: by using our emotions, we form judgements, take decisions and act. The *self-understanding* and *understanding* concepts are also used; from a hermeneutic perspective, this means that humans always find themselves in an interpreting position in which they interpret the world, others and themselves (Gustavsson, 2007). This study included registered nurses and assistant nurses (hereafter referred to as *nurses* when differentiation is inconsequential), because they are expected to interact with patients and with one another in their daily work. It is reasonable to assume that nurses and assistant nurses used emotional knowing in various ways because their training varies in length and content. This issue, however, is beyond the aim of the present study.

## Method

This study combines ethnographic and hermeneutics methodologies (see also Dalton, 2005; Erdner, Magnusson, & Nyström, 2005; James, Andershed, Gustavsson, & Ternestedt, 2010). Openness and sensitivity for how people experience and interpret their everyday practice characterise both methodologies (Dahlberg, Dahlberg, & Nyström, 2008; Dalton, 2005). Ethnographic and hermeneutic methodologies build on co-operation between closeness and distance. This closeness and distance relationship was applied during field work. When investigating the research topic, the first author (IJ)



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strived for (a) openness, sensitivity and closeness and for (b) maintaining distance to be able to describe embodied and embedded meanings in daily work on the ward (see also Dahlberg et al., 2008). Ethnography was mainly used during data collection and hermeneutics were applied during interpretation (see also Erdner et al., 2005). Dahlberg et al.'s (2008) reflective, lifeworld research and Ricoeur's (1976) critical hermeneutics inspired the interpretations.

Data were collected between 2003 and 2007. In this study, pre-understanding was managed with openness, whereby during the entire research process, we were open—and not judgemental—about what we observed. Consequently, we did not force meanings into linguistic categories, so we did not make definite what is indefinite (see also Dahlberg et al., 2008). The study's intention was to learn from nurses' experiences. From this perspective, we tried to be open for explanations to better understand their experiences. And with a critical outlook, we tried to distance ourselves from the self-evident in our interpretations (Gustavsson, 1996). The first (IJ), second (BA) and fourth (BT) authors are nurses and researchers who have contextual field knowledge. The third (BG) author is an expert on the history of ideas and has conducted research on various forms of knowledge and their meanings.

### *Participants and data collection*

Twenty-five nurses and 18 assistant nurses participated in this study. The field work was done in a surgical ward at a university hospital in Sweden. Data were collected by using participant observations (285 h), informal conversations (120 h) and interviews (25 h). At the study's start, one nurse served as a key informant and oriented the first author (IJ) to the ward's organisation and procedures. Before each 3–7-h observation, the first author (IJ) requested permission to follow a nurse or an assistant nurse during the shift. To obtain as variation-rich data as possible the observations were carried out during all weekdays: mornings, afternoons and evenings, and during a few nights. The first author (IJ) dressed as a nurse during participant observations and carried out simple tasks such as washing patients, changing bed linens and light cleaning. The observations focused on nursing actions, namely: *what* nurses do and *how* they do it.

The informal conversations were captured in moments that lasted 2–15 min; the conversations mainly focused on (a) how nurses thought, (b) how and why they performed an action in a certain way and (b) what was going on behind the procedures. The 20–90-min-long interviews were based on the observations, informal conversations and nurses' reflections and beliefs about their work. Data from interviews and informal conversations supported the observations. All but four interviews were recorded (the others were documented on paper). The interviews occurred at suitable times and in private rooms that were in or near the ward. During field work, the first author (IJ) documented reflections in a diary and then raised questions and discussed assumptions with the nurses; in other words, data were collected in creative collaboration with the nurses.

### *Data analysis—process and procedures*

Data analysis consisted of three *phases* as follows:

(I) Analysis that applied a hermeneutic method (Dahlberg, Dahlberg & Nyström; see also Erdner et al., 2005).
(II) Extensive interpretation inspired by critical hermeneutics (Dahlberg et al., 2008; Ricoeur, 1976).
(III) Main interpretation (Dahlberg et al., 2008).

*Phase I—hermeneutics*: Data analysis began in conjunction with data collection. When the field work ended, the analysis continued by using a hermeneutic method (Dahlberg et al., 2008), i.e., closely reading (several times) all transcribed data from the observations, informal conversations and interviews. This analysis consisted of the following steps in which we:

(1) Switched between closeness and distance reading to get preliminary understanding of what the data, as a whole, described.
(2) Alternated between reading and understanding each part of the text in relation to the whole—at the same time that we attempted to understand the whole in relation to the parts.
(3) Identified and looked for similarities and differences in relation to meanings in emotional knowing, i.e., emotions, thoughts and actions based on judgement. Similar meanings of emotional knowing were divided into various themes.

This procedure resulted in a merger of the data into a first sorting, which provide "rough" themes that in various ways describe nurses' daily work.

*Phase II—extensive interpretation*: Comprehensive efforts were made to disengage from the tradition of normative discourse on how one should die a good death. So this analysis consisted of a procedure

in which we shifted between inductive and deductive interpretation, namely, we:

(1) Investigated what other authors wrote about normative discourse, because interpretation develops (Schuster, 2006) by reading the research literature with another perspective, for example, by reading research that challenges our tradition (Bradbury, 2001; Goldsteen et al., 2006; Sandman, 2001, 2005), i.e., research that criticises the normative discourse of how one should die a good death.
(2) Developed a critical eye to be able to get below the surface during comparisons of similarities and differences regarding what our text said—compared to the research literature. This critical analysis is a way to strive towards self-awareness and self-reflection to be able to understand how we are embedded in tradition and the scientific paradigm (Dahlberg et al., 2008, p. 159; Ricoeur, 1976). If pre-understanding is not overcome, then circle reasoning results and nothing new can be seen (Dahlberg et al., 2008; Riceour, 1993; Schuster, 2006). A critical analysis enables creation of new interpretation, thus enabling progress in pre-understanding (Gustavsson, 1996; Kristensson Uggla, 1994; Schuster, 2006; see also Jaspers, 1970, p. 60).
(3) Raised questions to further create distance and find out what was behind the obvious:
    (a) How is this knowing—which includes emotions, thoughts and actions, and is based on judgement—used in daily work; specifically, how is it expressed in self-understanding and understanding of others?
    (b) What does this knowing contribute to the daily work of patient care?

    During the analysis, the data were processed and interpreted—based on these questions.
(4) Used quotations from study participants (somewhat edited) to:
    (a) Create more distance from our pre-understanding.
    (b) Establish the preliminary themes, thus avoiding use of abstract concepts that can be infused in our pre-understanding. The selected quotations were used to form judgements and the judgements represented many participants' statements.

Results from Phase II are thus presented as preliminary interpretations of emotional knowing; the interpretations are described in this article via five themes with sub-themes, which consist of judgements described as normative, safe–secure, critical, affinity and closeness. During analysis, the preliminary interpretations were called into question using counterarguments (Dahlberg et al., 2008).

*Phase III—main interpretation*: To derive the main interpretation, we:

(1) Carried out the main interpretation (or a new whole that explains all preliminary themes). Here, we critically tested other possible theoretical interpretations that best explained all data until we found the one that could best explain all the data; here, we also tried too see something in a new way (see also Dahlberg et al., 2008).
(2) Discovered that nurses' emotional knowing could be interpreted in relation to various rooms of emotions, thoughts and actions. We used Svenaeus' description (2009, p. 93) of the meaning of room. He claims that emotion exists in our bodies and that we experience the world via emotion as an emotional room.

The emotional room thus also becomes an action and a thought room—in other words, emotion is embodied and we create the rooms. The various rooms thus formed nurses' judgements that created the normative room, the safe–secure room, the affinity room, the critical room and the closeness room. Emotional knowing is about feeling the right emotion for the right reason, at the right moment—to act in a wise way and adapt to the situation you are in (Aristotle, 2000; Svenaeus, 2009). This could be described as practical wisdom or phronesis (Svenaeus, 2003, 2009). The nurses' creation of different rooms could then be described as practical wisdom. Together, these rooms comprise the main interpretation in this study (see also Dahlberg et al., 2008).

Note that in Phases II and III, we used the critical hermeneutic analysis with self-reflection, which is also a way to continuously validate data that were retained during all interpretation procedures in which the interpretations were critically examined. If the interpretations are believed to be invalid, then they were further interpreted (developed) or removed (see also Dahlberg et al., 2008, p. 286).

## Ethical considerations

Clinic and ward managers were informed about the study, which they subsequently approved. This study was explained to the nurses in a group and they were told that (a) participation was voluntary, (b) they could leave the study at any time and (c) they could


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decline observations of specific tasks. They also received written information. Patients were told about the first author (IJ, the observer) and that nurses were being studied during their daily work. Patient consent was sought at this time.

Situations judged to be ethically sensitive were avoided, for example, if the author believed that uncertainty existed among patients or nurses. The University Hospital Research Ethics Committee (Case No. 208/03) granted permission for this study.

## Results

In our main interpretation, we found that nurses' judgements in various rooms (emotional knowing) constitute an expression of practical wisdom (*phronesis*) in nursing practice. Combinations of emotions, thoughts and actions characterise various rooms, and the nurses expressed these emotions, thoughts and actions in their daily work as practical wisdom. The rooms contained self-understanding and understanding of others that were demonstrated via various actions. We found that nurses' emotional knowing could be interpreted in relation to various rooms of emotions, thoughts and actions. Nurses' judgements formed these rooms. They strived to do things correctly in the normative room; created a safe, secure milieu for patients and next of kin in the safety–security room; and questioned their actions in the critical room. They created affinity for co-operation that benefited encounters with patients in their affinity room. And they demonstrated sensitivity and compassion to patients and next of kin; sensitivity and compassion were particularly evident in the closeness room.

### *Context*

Patients in the surgical ward received highly specialised gastrointestinal care. Some had severe cancer; others had curable diseases. The registered nurse and an assistant nurse worked together. The work in the ward could vary several times during a 24-h period and the pace ranged from calm to very fast. Several quality projects had been implemented in the ward: one involved inclusion of palliative care. Another strived to improve ward operations via new thinking and breaking away from ingrained procedures, giving each other positive feedback and constructive criticism, and putting patients first. The nurses described the hospital social worker as being particularly important regarding conversations and support for patients, who were in a palliative phase and their next of kin.

*The normative room.* In this room of emotions, thoughts and actions, emotional knowing was related to nurses' feelings of inadequacy and responsibility. Feelings of inadequacy could be related to shortages of time and to not being able to provide satisfactory care for patients at life's end. These feelings could also be related to patients with curable illnesses. The nurses used emotions and thoughts of inadequacy and responsibility to create a normative room in which they strived to do things properly—based on prevailing norms associated with a good death and good palliative care.

*Maybe we're not enough.* The nurses on the ward moved among (a) patients whose conditions were critical—patients who needed fast, highly professional care, (b) patients who were near life's end and (c) next of kin who needed time, peace and quiet, and someone to talk to:

> No. It's like two different cultures. // It's a fast culture // one came in with bleeding. You must go up to // Operation ... Next room you must sit on the edge of the bed, be calm and talk with relatives because you feel that they want to talk.

The nurses expressed that periodically it could be hard to balance patients' curative and palliative care. Feelings of inadequacy were described to be associated with insufficient time for patients who needed curative care and patients who were at life's end. Nurses wished that they had more time to fulfil patients' need for closeness—especially when a patient was at life's end and was judged to be in need of extra care, for example, to fix his/her hair: "Maybe we're not enough. // You want to make more effort but there is // no time." The nurses experienced a conflict between what they felt and thought that they wanted to do and what they *could* do. This formed the judgement that they weren't enough.

*No one should die alone.* The nurses complied with and followed the norm that no one should have to die alone. They felt inadequate when they did not have time to be with patients who were dying and who had no next of kin beside them. This was judged to be not right because the patient might have been frightened and might have needed someone for support: "Certainly there's a law that says that no one needs to die alone". This formed the judgement that no one should have to die alone.

*Special atmosphere in the hospice ward.* The nurses believed that a surgical ward was not the right place for care of dying persons. The norm and the ideal that prevailed among nurses was that the best care is given in a hospice or in a palliative care

unit or in nursing homes within the municipality. Their emotions and thoughts were dominated by the fact that hospice care represents a special atmosphere that provides peace and quiet—where nurses have more time for patients. This formed the judgement that patients who received hospice care also received the best care:

> Special atmosphere [hospice] in which it's really calm and relaxing. They [the nurses] go in and sit with patients and // give them more care // they can get a gentle bath.

*We will provide the best care possible*. When nurses planned care so that the patient would get care at life's end somewhere other than their ward, they also knew that they would not be able to plan death away from the ward:

> There will always be some who will die with us. But our intention is that they will not // But then there will always be some who are here and one must then provide the best possible care.

The nurses felt responsibility for ensuring that the dying patients received good care. They strived to ease symptoms as best as possible, for example, by providing good nutrition, pain relievers and nausea treatment. These emotions and thoughts formed the judgement that nurses should provide the best care possible at life's end.

*Patients are aware of their incurable diagnosis*. Based on the judgement that nurses should provide the best care possible, they tried to achieve what was considered right and proper within palliative care, i.e., prevailing norms. Emotions and thoughts drove them on the right path towards what was considered a good death. The nurses felt and thought that the best for seriously ill patients was that they received clear information about their cancer and prognosis:

> I rethink if someone says tumour and cancer. // You get used to it being OK in any case. // You get some sort of confirmation that you know that they are aware of it. [The diagnosis]

It was important that the patient became aware because it could be a maturation process and lead to acceptance. If the patient did not talk about the cancer, then it could be interpreted that the patient was denying that the illness was incurable. In this respect, it was evident that nurses have a need to check what patients know. This formed the judgement that patients should be aware of their diagnoses.

*Patients must be able to die*. The nurses empathised with patients in their suffering. Carrying out painful examinations and treatments—especially if patients were older—did not feel right. It was better for nature to take its course:

> I can understand when someone is old and sick and needs to die. I think that many examinations are absurd—testing just for the sake of testing. People must be able to die in peace and quiet if they are 90, 95.

This formed the judgement that one must allow patients to die. The nurses also judged that it was better to stop all treatments—especially for older patients—that just led to more pain: "You shouldn't give treatment without effect".

The judgement to not treat unnecessarily was strong. That's why clear cut-off points were requested, for example, for administering cardiopulmonary resuscitation (CPR) on a patient who is seriously ill and dying. The nurses felt and thought that decision-making help from next of kin and patients was inadequate. They thought that they fought for life, and they did not see that a better alternative was to stop unnecessary treatment and instead, be at home at the end of life.

*So the patients should decide*. To do the right thing, based on the care that they considered that they had an opportunity to give, the nurses based their actions on the normative—the good death embraced by the palliative care philosophy. Patients, who were in a palliative phase of disease, were allowed to make their own choices. The nurses judged: "Then they should decide for themselves; they do so in hospice". If patients were dying, they could get their own rooms (if possible) and sleep later in the morning—compared with those who had curable diseases. The patients could also choose if they wanted to get up and go to the dining room and eat—or have food served in their rooms. If the patients had poor appetites, they choose whatever they wanted to eat.

*The safe–secure room*. In this room of emotions, thoughts and actions, emotional knowing was related to the nurses internalising and recognising the next of kin's feelings of powerlessness and insecurity. They used emotions and thoughts about powerlessness and insecurity to create a safe–secure room for patients, next of kin and themselves—where they thought about the approach's meaning and where they created a safe–secure milieu for patients and next of kin.



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*Next of kin are worse off than patients.* The nurses internalised and recognised the powerlessness that next of kin might experience, because some of the nurses had been through the same experience. They imagined what family members might be going through if they could no longer help the person who was sick: "Just to stand there and not be able to do anything". The nurses thought and felt that it would be nice for seriously ill patients to be able to avoid suffering and death. But it could be even more difficult for the family member who is the only one left—particularly for those who have small social networks and would be "alone in their loneliness". Daily routines also changed and the nurses thought about difficulties that could arise when trying to do practical tasks in daily life: "It's not a given that you can pay the bills if you've never done it before". Nurses' emotions and thoughts about next of kin's powerlessness formed the judgement that the next of kin lived in difficult situations: "They're worse off than the patients".

*I perceive next of kin to be a resource.* The nurses felt that they could not provide sufficient security for patients at life's end. That is why next of kin were described as extra important. They knew the patients, could interpret the patients' needs and wishes, participate in judgement regarding how patients felt, repeat information from nurses to patients and ask nurses questions on behalf of the patients. This formed the judgement: "I see them as a resource, as helpful".

*It's a relief if next of kin can be present.* The nurses felt powerless about their own work when they did not have opportunities to be with patients when they died. When family members were with the patients, the patients were less worried: "Someone is sitting with them and holding their hand". Possible worry and anxiety could be lessened. That way, patients were more secure, which led to feelings of security among the nurses. This formed the judgement that it was a relief if the next of kin could be there when patients died: "It's a relief if family members can be there".

*I try to think about how I would want to be received.* The nurses recognised family members' powerlessness—that they could be insecure and have more questions about patients' illnesses than the patients had. Consequently, the nurses gave out the ward's phone number so that next of kin could call and talk if they were worried. The nurses said that their approach was meaningful for the next of kin, for example, ways in which the nurses answered the phone or took time and participated in meetings with the next of kin so that they could ask questions.

> I try to think about how I would want to be received. When a family member has been admitted to the hospital. The way in which the ward's phone is answered is SO meaningful or // if there's time for questions.

Nurses' emotions and thought about how *they* would want to be received affected the way in which they received patients. They judged that "I try to think about how I would want to be received".

*Next of kin must feel safe and secure in this milieu.* Through the care that they provided, the nurses strived to create security for the next of kin. It could be a comfort, and enhance the feeling of security if, for example, patients got their own rooms so that patients and family members could talk without being disturbed. When family members watched over patients, the nurses told them about procedures such as how to buy food on the ward, how they could call for help using the bell or the alarm so that the nurses could come quickly if patients got worse and family members needed help. That way, the nurses tried to create a safe–secure room and formed the judgement: "Just so that next of kin feel really secure in this milieu".

*The critical room.* In this room of emotions, thoughts and actions, emotional knowing was related to feelings of uncertainty about things that could be perceived as *wrong*—that led to an understanding that they, as nurses, could have done something differently. They used emotions and thoughts about suspiciousness to create a critical room in which they thought about (a) other possible approaches that perhaps do not always remind the patient of death and (b) not acting mechanically in encounters with patients.

*Staff perhaps need not remind about death.* The nurses did not always agree with certain norms, which they felt were inconsistent with how patients and next of kin might feel and think. They challenged the norm, which states that it is best if patients receive straightforward information on their illnesses and that this information is repeated as needed. The nurses thought *and* felt that this information could be emotionally difficult for patients and next of kin and that it was unnecessary because they judged that patients and next of kin were aware of the situation anyway: "Obviously the patient and family members are aware that the patient is going to die and maybe the staff need not remind them". Instead the patient might need hope: "Perhaps we could cushion the information a little more". The nurses suspected that the normative ideal overshadowed patients' needs.

And perhaps hospice was not always the best choice because it could be perceived as the last station.

*Following rules and regulations to the point of absurdity.* The nurses criticised their care procedures and tasks when they had a feeling that they perhaps had acted in an incorrect manner. Performing care procedures and tasks without reflection could lead to the nurses not seeing the patient as a person, which formed the judgement: "This is getting to the point of absurdity". They suspected that some patients might simply want to die alone—without nurses and family members. An observation concerning a patient's care after death revealed the nurses' suspicions that they might have acted incorrectly. The nurses criticised the care, saying that there had been too many nurses in the room, voices had been raised too high in conversation and there had been too much talk with each other about how to make things nice for family members who would come to say good-bye to the dead person. The criticism concerned whether or not this was dignified: "Dignity is important. (Int.: What does this mean?) It's about being quiet—not talking about other things. It must be quiet; the focus should be on the patient". The focus of their actions had been to make things nice for the family—a feeling for what the situation required—but treating the patient with dignity had been "forgotten". Based on this, the nurses' judgement was to put the patient in focus.

*Action need not be so mechanical.* The nurses were critical about the fast work pace that could contribute to improper encounters with patients. The observations revealed several examples in which the nurses tried to stay calm—even when they had a hard time keeping up with the work. One such example comes from a situation in which a nurse was supposed to give a patient a pain-killing injection. The nurse purposely remained calm, spending time and talking with the patient. Another observation revealed how a relaxed attitude was conveyed via body language; here, one of the nurses walked in a relaxed manner beside a patient who was using a walker and slowly heading towards the dining room. They spoke with each other like two persons who knew each other well. When asked how she could be so calm, the nurse replied: "I don't think you need to get stressed // and say that it's time for dinner // being mechanical is unnecessary". The nurses used their embodied understanding in encounters with patients. They broke up a stressful situation and, instead of mechanical encounters, created closeness with the patients. The nurses' emotions and thoughts formed the judgement that care is not about mechanics—even if time is at a premium.

*The affinity room.* In this room of emotions, thoughts and actions, emotional knowing was related to a feeling of affinity, which provided understanding for the nurses' and their colleagues' emotions and thoughts. They used emotions and thoughts about affinity to create an affinity room, i.e., emotional knowing, whereby they spoke with each other and shared negative emotions and thoughts so that their approach and actions would benefit patients in the best possible way.

*I'm at ease in the ward—I think we have fun.* The staff room was a gathering place during the shifts. The nurses met there to take breaks, drink coffee and plan their work. They were involved with decorating the room; they changed curtains and cushions, and they bought new porcelain and repainted. Besides paintings, the walls were graced with bulletin boards that held lecture and party announcements, quality achievement awards and thank-you cards from patients and their families. The nurses recognised and shared their emotions and thoughts in the staff room (for example, "do you remember the conversation. . .") in conjunction with reading an obituary or a thank-you announcement that appeared in the newspaper. They reminisced with each other about patients and family members without violating the confidentiality law. They also shared emotions and thoughts concerning aspects of their private lives, for example, future plans and family life. During breaks, they could also plan various parties and trips that they planned to do together when they were not working. Feelings of affinity and understanding of each other were created in the affinity room. Nurses judged: "I'm at ease in the ward—I think we have fun!"

*Sharing thoughts and feelings with colleagues.* Feelings of affinity enabled the nurses to be able to share their emotions and thoughts about difficult events; this, in turn, created self-understanding and understanding for each other. This sharing occurred, for example, when a young person died, when someone died unexpectedly or when something traumatic happened. Those involved in the event spoke spontaneously with each other "It's a good thing. // Relieves the pressure". Regular meetings with, for example, trained professionals also facilitated sharing. These meetings were perceived as good, but the nurses received the most support by talking with each other, which is why they recognised each other's emotions and could thus share them. This led to emotional relief. Dialogue with each other formed the judgement that you can share with colleagues: "And then the feeling that you can share yourself with your colleagues".

*Chatting is good—it's necessary for co-operation.* The affinity room had an atmosphere of close


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communion; the nurses shared emotions and thoughts with each other—about work and about the personal and private. An informal conversation revealed the meaning of "daily chat" and of being with each other in the staff room: "It's a type of personal care; we get to know each other". This formed the judgement that chat is good for co-operation: "Well-functioning co-operation is a good thing". Informal personal and private chatting was assumed to have created feelings of affinity among the nurses; they became united, which benefited co-operation during work.

*It's good to talk about difficult issues—to facilitate encounters with patients.* When the nurses had negative feelings for a patient, the feeling of affinity led them talk to each other in privacy before they went to the patient and performed various care tasks. The difference between the way nurses spoke about patients and the way an encounter with a patient subsequently occurred became clear during the field work in which these observations were made:

> Nurse A and nurse B are talking about troublesome patients and that certain patients expect the hospital to fulfil their extensive requirements for help: "They manage at home but here they want comprehensive help". A moment later, both nurses are teasing and joking with a patient. One nurse then hugs the patient. The patient smiles and teases back. They appear to be genuine and to be having fun. How the nurses thought, felt and acted were illustrated in an informal, follow-up conversation with nurse B: "But of course I usually try to pat and hug and show that I care. Empathy is necessary, that you stroke and embrace. [the patient]"
>
> An informal conversation with nurse C, who was somewhat involved in the above situation, clarified the difference between how nurses talked and then acted. Nurse C pointed out the importance of sharing emotions and thoughts about difficult matters and troublesome patients—before encounters with patients. The chatting functioned as a safety valve that gave the nurses perspective and reduced risk that patients were harmed by the nurses' earlier negative judgement: "It's good that NN takes it. That she gets it out so that she can then face the patients".

This formed the judgement that it is good to talk about difficult situations so that the nurses can properly greet and meet the patients.

*The closeness room.* In this room of emotions, thoughts and actions, emotional knowing was related to the nurses' sensitivity and compassion for patients, next of kin and themselves. They used sensitivity and compassion to create a room of closeness in which they put patients first and used their embodied understanding to diminish patients' powerlessness and to give next of kin a picture to remember.

*One day healthy, the next day you're not.* The nurses' sensitivity and compassion were awakened when they saw how cancer could afflict patients without warning and that the course of the disease could be rapid:

> One day they're healthy, the next day they wake up with yellow skin and // we discover they have cancer of the bile ducts // about three months to live.

Patients with cancer could also develop severe stigmatising symptoms such as intense jaundice. Consequently it was hard to look at the patients. The nurses' sensitivity, compassion and recognition resulted in them identifying with patients. They gained insight and understood that the patients' situations could also be their situations. Most were of the opinion that they would also get cancer. They would reflect on the type of cancer that they might get. Neither could life be taken for granted. Their emotions and thoughts formed the judgement: "One day you're healthy, the next day you're not".

*It's even worse when young persons are afflicted.* Encountering young persons who were dying was particularly difficult. The nurses saw themselves or their children in the patients' situations. They understood that next time, it could be their turn:

> You become your own frame of reference—especially with younger patients who are a little younger. Makes you think that it's perhaps worse than when you're older // 70, 75 years // It's sad enough but I think it's even worse ... when someone younger is afflicted // They are like me, I think.

In some ways, the nurses found themselves in a shared existential situation with the patients. They judged that it was worse when young persons were afflicted.

*Suffer with patients and next of kin.* The nurses used their sensitivity and compassion and lived with the patients and next of kin in their suffering and hope. For example, hope could arise when a patient was supposed to take a trip or go home one last time. When hope about taking a trip went unfulfilled, they endured with the patient and family members: "Yes. He had to be about 75. So he wasn't that old // and

so full of life. Then you suffer with him and his family". This formed the judgement that the nurses suffer with patients and relatives. That way, they gained an understanding of patients and family members and could share the existential situation in which patients and relatives found themselves.

*I constantly give of myself.* Sensitivity, compassion, the fact that they liked their work and the patients, resulted in the nurses becoming involved, and they created close relationships with patients. This was the motivation in their daily work: "But I believe that you must be involved to be able to help. You can't burn yourself out, and you must have a cruising speed. You have to be involved and to have feelings for what you're doing". The nurses gave of themselves during encounters with patients: "But in the end, I believe // encounters with them are what are important". The nurses liked the patients, thought about them and remembered them—especially if they had been on the ward for a long time. This was nothing the nurses talked about in an explicit way. But it emerged in the observations and became clear when they were questioned: "It happens that you like them (the patients), well that's unprofessional but I like them". During observations in the corridors and patients' rooms, the nurses talked to patients and to each other. For example, the nurses would be sitting on the beds beside patients with their arms around patients' shoulders. The closeness was mutual, for example, to express gratitude, a patient would bend forward and stroke the nurse's cheek. The nurses' sensitivity and fond feelings for patients led to an approach and formed the judgement that they give of themselves in encounters with patients: "I constantly give of myself".

*I put patients first.* The nurses' sensitivity and compassion are often based on worry for patients, which led to them protecting patients in various situations in which they looked out for patients' best interests. They represented patients in various situations, as advocates; for example, they might monitor physicians and try to get an examination or treatment scheduled earlier. Another example could be when they saw that just "their" patient got a private room. In addition, they could protect patients, if possible, by declining to participate in a round in which patients would be surrounded by many people. These emotions and thoughts led to the judgement "I put patients first // How would you feel if a bunch of people stood around and stared at you? Makes you want to cry".

*She is so vulnerable.* Patients' situations wakened nurses' sensitivity and compassion, which were visible in their bodies. In encounters with patients, nurses' voices and posture softened. They leaned closer to patients as if offering them a protective enclosure. They touched the patients more often and caressed their arms or cheeks. When touching patients, their movements were slower, careful and protective—like when they would help patients stand up.

> (Int.: *Why does your voice soften and why do you touch her so much?*) "It might be because she is vulnerable // She won't eat or drink, and maybe did it consciously or unconsciously".

The nurses' emotions and thoughts regarding patients' situations led to the judgement that patient were in a vulnerable situation. Emotion was clearly evident when, in a care situation, they used themselves, their bodies, to convey tenderness and closeness to patients—to try to ease patients' powerlessness. But the nurses were aware that physical contact is perhaps not always appreciated. Sometimes presence was sufficient—that someone was just in the room with a patient. Patients' powerlessness could be diminished by offering food and beverages, for example, the nurses could take extra time to prepare porridge because a patient liked it. Diminishing patients' powerlessness was particularly clear when providing personal care, which this observation illustrates:

> Several persons are in the room, and nurse A, after talking with the patient, provided personal care that included washing. She stood close and leaned over the patient who was lying on her back in bed. Nurse A had a washbowl on her right. She moved her entire body in sync with the washing. She washed the patient's face with soft, sweeping movements. She watched the patient the entire time she was washing and drying. Her movements were soft yet firm, secure and customary; she was one with her movements. Her body and hands reflected sureness, confidence. When she finished washing, she backed away somewhat and studied how the patient was lying in bed. She twisted her own body where she stood to reflect the patient's position. She thought out loud about whether or not the patient was in a comfortable position. Nurse A and another nurse who was in the room conferred with each other and with the patient about what might be best for the patient. They decided that it would be best if the patient could lie facing the direction that they thought family members might take so that they can see the patient. When the personal care session ended, nurse A patted the patient's forehead and cheeks.

*Last image.* Sensitivity and compassion also existed in relation to family members' sorrow: "You're losing



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someone who means a lot to you". The nurses used this understanding when they created another atmosphere while providing care. They walked more quietly, opened doors more carefully and lowered their voices. Rooms could be dark and crowded with extra beds, chairs with blankets, coffee cups and magazines. The nurses often squatted close to family members; they had physical contact, listened and held hands. Due to their sensitivity and compassion, the nurses wanted to give family members a beautiful image to remember when patients died. The nurses' final tasks—washing and dressing them in their own clothes—if that was the next of kin's wishes—were performed carefully. The image must be pure: if equipment remained in the room, then the moment of death might appear to have been chaotic—but that was not the case. The nurses had sewn a quilt that they used as a bedspread. Sometimes they strewed flower petals on the quilt. The room also had candles and a bible:

> We have this lovely quilt and // meet, try to make it as memorable as possible. // The last thing, the last image someone really remembers in any case // You remember this better than you remember the funeral.

These emotions and thoughts form the approach and the judgement that the last image of a loved one was the image that family members retained and remembered.

## Discussion

This study's results describe how nurses' emotional knowing is used and expressed during encounters between life and death while providing care in a surgical ward. Ways in which nurses used emotions, thoughts and actions, which are based on judgements, were described via five rooms: *the normative room*, *the safe–secure room*, *the critical room*, *the affinity room* and *the closeness room*. In nursing practice, judgement is essential (Benner et al., 1996), and we concluded that the various rooms (with judgement) can be seen as expressions of nursing in daily work—based on nurses' and assistant nurses' practical wisdom (phronesis). Metaphorically, the rooms could be various sizes and they stood in relation to each other via doors that could be partially or fully open. During their daily work, the nurses moved among various rooms and could be in several rooms at the same time.

Feelings of responsibility drove the nurses to provide good care at life's end, while they bore a feeling that care was insufficient and that patients would be better off if they received hospice care. In this situation, the nurses judged that they should still strive to do the best they could. The will to provide good palliative care at life's end, while doing things right in relation to prevailing norms, was a motivational factor in their work. The normative room's values drove the nurses' emotions, thoughts and actions. For example, patients should be aware of deadly diseases and unnecessary treatment should be stopped and patients should be allowed to die. Nurses' adherence to norms, however, can lead to standardised care in which insufficient consideration is given to individual patient's or family's needs. Norms can be similar to manuals in which various measures are checked off to assure quality care (see also Ellershaw & Wilkinson, 2003). The nurses also sought clear cut-off points that identified when patients' illnesses entered a palliative phase—to be able to end unnecessary treatments and to increase patients' opportunities to take more decisions, for example, about their food. Giving treatment without effect could be perceived as torture for all involved (Beckstrand, Callister, & Kirshoff, 2006; Sorensen & Iedema, 2007). This led to a moral obligation to alleviate suffering (Oberle & Hughes, 2001). But when it comes to treatment cessation, it is important to be open-minded about patients' and family members' wishes and the power that nurses can have. The dependency situation that patients and family members find themselves in can make it difficult to decide what they want and to understand what they are permitted to do. Nurses' need for straightforward information and cut-offs (Thompson, McClement, & Daeninck, 2006) can also be a way to prioritise various curative and palliative care requirements. The balance between various types of care has contributed to stressful work environments (Sandgren et al., 2006).

Care that strictly follows norms and manuals creates risk for paternalism—a power relationship in which nurses have decision prerogative (Nikku, 1997). Nurses can hide in the normative room—use their profession as a protective shield (cold shielding)—to avoid emotional strain (Sandgren et al., 2006). There is risk that nurses will exclude themselves as persons, whereby their knowledge and creativity are negatively affected, when they strictly follow manuals and guidelines, for example, the Liverpool Integrated Care Pathway for the Dying Patient (LCP) (Ellershaw & Wilkinson, 2003). Sometimes, the door to the normative room must be shut and the door to the critical room opened.

In the critical room, nurses acquired understanding of the existentially exposed situations in which patients and family members find themselves—situations that the normative room can obscure. So the critical room is one of the most important rooms

and should be larger. Normative care tasks and alternative approaches are criticised and balanced in the critical room. Via critical review and reflection over possible mistakes, the nurses strived for a deeper understanding of the patients' and family members' situations from their perspectives. Nurses increased their self-understanding in the critical room when they reflected and questioned themselves and each other about whether they could have done something differently (Akerjordet & Severinsson, 2004). The nurses criticised the norm about needing to remind patients and relatives about death—as if they didn't already have this knowledge and wanted to live with hope, which is called creative illusion (Salander, 2003). The nurses' assessment was that it was unreasonable to follow poorly thought-out procedures.

To preserve a critical perspective and to facilitate self-understanding and understanding for others, it was also meaningful that the door to the affinity room remained open. Here, feelings of affinity were developed, contentment was created and nurses could share difficult incidents with their colleagues (Sandgren et al., 2006; Torjuul, Elstad, & Sorlie, 2007), which was also a way to validate each other (Sandgren et al., 2006; Torjuul et al., 2006) and each other's various perspectives. The affinity room contained the glue, chat and breathing space in daily life. It facilitated co-operation (see also McQueen, 2004). By sharing the personal and private of daily living, the nurses created a feeling of affinity and opportunities for managing negative emotions regarding patients. Emotions are not always harmonious; they have built-in ambivalence and require reflection (Nussbaum, 2001). This illustrates the importance of having an open door to the critical and affinity rooms—for reflecting and critical reviewing. That way, patients and family members experience the best possible encounters and care (Schuster, 2006).

Nurses' recognition of powerlessness, exposure and insecurity emotions occurred in the safe–secure room. They understood that they may one day be in the patients' and family members' situations. Family members' presence was judged to be meaningful for patients and nurses. This room constituted a safe, secure place, i.e., a safe haven for patients and family members (Thompson et al., 2006). The safe–secure room, however, can be represented as an ideal and can give false security, which is why the critical door must be opened. Even if patients' and relatives' situations were emphasised, no nurses described them as having natural participation in care. Clear, family-focused care is not there (Wright, Watson, & Bell, 1996)—care in which patients and families participate in the care in partnership (Andershed & Ternestedt, 2001) and in which relatives' practical knowledge is requested (James, Andershed, & Ternestedt, 2009). The door to the closeness room should be open so that existentially vulnerable situations can be shared.

Understanding of patients was central in the closeness room. This room was the largest in a sense, but it was less well-defined in relation to the normative room. The nurses identified with patients and relatives in this room. This might have contributed to increased self-understanding and understanding of others. The nurses' sensitivity and compassion—plus the fact that they liked the patients—contributed to them giving of themselves and to protecting patients in an advocate-like way (Sorensen & Iedema, 2007; Stickely & Freshwater, 2002). This is reminiscent of the Torjuul et al. (2007) study in which compassion within the encounter between nurses and patients was described as central. What is meaningful to critically reflect on is that compassion often awakens intuitively and here, it is the object of our emotions as well as our care (Nussbaum, 2001, p. 13). Major emotions are also concerned with value. This might mean that we make an assessment: whatever afflicted the person is serious and has *size*, for example, disease, death or lack of friends. Compassion often takes on the onlooker's viewpoint (Nussbaum, 2001). In this study, compassion was more prevalent for patients who were younger and dying than for patients who were older, which might mean that the nurses more easily identified with the younger patients than with the older. This, in turn, could affect encounters with younger and older patients.

Our results revealed that emotional knowing, i.e., phronesis includes judgements. One risk is that judgements become one-sided and out of alignment with patients' and family members' opinions. Many judgements about others' suffering can be wrong, depending, for example, on factors such as inattentiveness (on the part of the person doing the judging) and use of theory that is not aligned with the situation (Nussbaum, 2001). When making judgements, people must have the ability to (a) remove themselves from their situations—to put themselves out of play, which is the basis for understanding and insight (Gadamer, 2004)—and to (b) be suspicious about what they once believed to be true (Gustavsson, 1998; Kristensson Uggla, 1994; see also James et al., 2010). The essence of wisdom is to know that you maybe don't know (Meacham, 1990; see also Benner, 2000). So only the individual really knows—only the patient or the next of kin can decide if the judgement is based on practical wisdom.


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The nurses' movement among the various rooms clarified how emotions, thoughts and actions are reflected in self-understanding and understanding for patients and family members; this was particularly clear in the critical and affinity rooms.

They posed thought-provoking questions in the critical room: "Could I or we have done things differently? What is in patients' and family members' best interests?" Nussbaum (2001) and Svenaeus (2009) contend that reflection is important for making the right judgement at the right time.

Reflection occurred in the affinity room when the nurses shared emotions and thoughts with colleagues. In some ways, the affinity room functioned as a safety valve, which in turn influenced self-understanding. Self-reflection with the goal of achieving self-understanding—plus development of self-awareness—is important for nurses because their judgements affect others' lives, health and well-being (Dahlberg, et al., 2008, p. 164).

Note that emotions that may be perceived as negative (insecurity, powerlessness and the feeling of being wrong) created what might be perceived as fruitful care content in the safe–secure and critical rooms. It is also crucial to affirm and recognise negative emotions and not dismiss them as irrelevant or an expression of stress. The nurses' emotional knowing must be clarified and recognised because:

> ... theoretical people, proud of their intellectual abilities and confident in their possession of techniques for the solution of practical problems, are led by their theoretical commitments to become inattentive to the concrete responses of emotion and imagination that would be essentials constituents of correct perception. (Nussbaum, 1990, p. 81)

## Conclusion

To strengthen patients' and family members' positions in the care system—as well as nurses' knowledge—emotional knowing, i.e., practical wisdom (phronesis) must have an obvious place. Risk exists that emotional knowing is not taken seriously enough in western culture in which the knowledge tradition builds on strict differentiation between rational and emotional knowledge. And rational knowledge—visibly measurable knowledge—is assigned another weight. Today's society demands evidence (traditionally based on randomised controlled trials [RCT] studies in many areas). This type of view about knowledge and science can close the door on emotional knowledge (Freshwater & Stickley, 2004; Stickley & Freshwater, 2002; see also Benner et al., 1996). In the present study, the nurses clearly expressed that, due to shortages of time, they could not always provide the care that they wanted to provide. Other studies also reported that insufficient time is a barrier to good care (Beckstrand et al., 2006; Freshwater & Stickley, 2004; Liu, 2008; Mohan, Wilkes, Ogunsiji, & Walker, 2005; Sandgren et al., 2006; Torjuul & Sorlie, 2006).

In this study, we began to open the door to nurses' daily work. We do not claim that we provide a comprehensive picture of emotional knowing. The study lacked interaction with patients, which observational ethnographic studies should describe. To counter this, video recording would have been excellent.

The study's main advantage was its application of a combination of ethnographic and hermeneutic methodologies with Dahlberg et al.'s (2008) reflective lifeworld research and Ricoeur's (1976) critical hermeneutic analysis. The participants' observations enabled further questioning of participants regarding why they did and what they did. These observations, informal conversations and interviews—combined with critical hermeneutic analysis—enabled us to go below the surface, namely, beyond what is taken for granted and describe a knowledge that can be difficult to verbalise.

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