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Eliciting reflections on caring theory in elderly caring practice

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Abstract

Caring theories are the description and conceptualization of the care that is given in caring practise by nurses and other professional caregivers with the aim of verbalizing and communicating caring phenomena. Intermittently, a theory–practice gap is given expression- that theory does not go along with clinical practice in caring.

The aim of this study was an investigation into the possible disparity between theory and practice in caring by analysing nurses' lived experience of the understanding of caring theory in practice in the context of municipal elderly care.

Hermeneutical phenomenology was the research approach used to explore the lived experience of caring science theories in caring practice from the perspective of 12 nurses working in municipal care for elderly.

The findings shows that the nurses Impulsively described their experience of detachment to caring theory, but when describing their caring intentions, the relationship to theory became apparent, and even confirmed their practice. As such, a seedbed exists for caring theory to be reflected on and cultivated in caring praxis. However, as the nurses describe, the caring theory must be sensitive enough for the nursing practitioners to accept.

The gap revealed itself on an organisational level, as the nurses' commission in municipal care did not correspond with their caring intention.

We believe it is important to seriously consider what we want to achieve as a caring profession. We have to reflect on our responsibility as culture carriers and knowledge developers. We must make the disparate forces of intention and organisation become one intertwining force.

Key words: *Theory-practice, elderly care, phenomenological hermeneutics*

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This article focuses upon caring theory and caring as the main area of nursing. However, nursing and caring are difficult concepts to separate and define, and the definitions may seem unclear and even impossible to create (Meleis, 2007). In Swedish universities there are five different definitions of the discipline (Öhlen & Friberg, 2010). In international theory the conceptualisation of nursing and caring is even more unclear than in the Nordic countries (Tomey & Alligood, 2006).

The caring tradition emanates from explicit distinguishable principles of value for caring, which means a contemplative of caring as a phenomenon or existence. Caring can be defined as an ontological phenomenon (Heidegger, 1996). Heidegger's being (*Dasein*) reveals itself as the care (*Sorge*) that is relating to the "thrownness" in the world. Being "thrown" into an existence we did not choose in which death is the limiting end, makes humans vulnerable and in need of the primordial condition of care. Care includes taking care of objective things, taking care of things at hand and taking care of being itself. According to Heidegger, care takes things closer to being (*Dasein*).

Mayeroff (1972) gives caring the dimension of "helping the other grow" and actualise him/herself. This is viewed as a process of relating to someone that involves development, and in his/her thinking,

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the two concepts of "caring" and "being in place" are cornerstones of human existence.

Caring science that touches upon existence should consequently be the foundation and should guide nurses in their profession of nursing and, as such, in the nursing work itself (Dahlberg & Segesten, 2010; Watson, 2008). Caring is situated in the existential region of understanding and knowledge, and to make the distinction clearer between caring and nursing one may claim that it is possible to manage nursing without being caring (Pearcey, 2010). Nursing is confined to the profession and as such to the nursing work itself. Caring embraces more than the nurses' work, and departs from a distinguished basic value that comprises the core question of caring, namely, what is the deeper meaning of caring (Dahlberg & Segesten, 2010; Eriksson, 2002).

Through the long series of research results on the phenomenon of caring that have appeared over the years, one might claim that caring comprises context-specific situations where openness, authenticity, and sensibility appear to be involved qualities (Dahlberg, Todres, & Galvin, 2009; Nortvedt, 2003; Watson, 2008). Caring may further be defined as context-specific inter-relational processes between a caring person and the human being as patient. Within the discipline, caring has been used extensively to describe all aspects of, for example, patient and nursing encounters (Benner & Wrubel, 1989; Dahlberg & Segesten, 2010; Eriksson, 2002; Watson, 2008). Caring proceeds according to the needs and openness to receive care of the one who is being cared for, and by the carers' professional and personal maturity and ethical foundation (Dahlberg, 1999; Dahlberg & Segesten, 2010). Caring is further described as being an attitude, ability, a capacity, or characteristic of various inter-related accomplishments (Finfgeld-Connet, 2008).

Caring in theory and practice

Caring science has progressed over the last 20 years and is rooted in a phenomenological and hermeneutical epistemology as developed in the USA by, among others, Watson (2008) and Ray (1989). In Europe it is represented by, among others, Eriksson's (1995) theory of caritative caring and Dahlberg et al.'s lifeworld led health care (2009).

Caring characterises the discipline by four fundamental patterns of knowing, namely empirics, ethics, aesthetics, and personal knowledge in interaction (Carper, 1975; Chinn & Kramer, 2008). From this perspective, caring embodies several dimensions that cannot be separated; rather, caring must be comprehended holistically. Each qualitative part is incorporated into a whole; leading to an understanding that caring cannot be understood as a dichotomy between theory and practice, but rather as a dynamic movement of all dimensions, interrelated and inseparable (Galvin & Todres, 2007).

Theories are intended to be reflective builders of the practice (Chinn & Kramer, 2008; Cody, 2003; Fawcett, 2005). Through the use of theory, nurses may find ways of looking at and assessing phenomena that are different from unreflective (tacit) and taken-for-granted assumptions. With an explicit theory base, nurses have a better rationale both for their practice and for the evaluated outcomes (Cody, 2003). Extensive research experience in Sweden illustrates that caring theory can energise creative thinking and make communication easier (Ekebergh, et el., 2004; Ekebergh, 2009). Reasons for the caring professions being grounded in theory include, amongst others, the ethical ones. As an example, Cody (2003) states that practical nurses have an ethical responsibility to develop a knowledge base that is specific to practice.

Nurses have reported that they have experienced a theory-practice gap in clinical practice in which theory does not correspond to their clinical practice (Gallagher, 2004; Holmgren & Eriksson, 2009; Maben, Latter, & McLeod Clark, 2006, 2007). Do nurses experience this "theory-practice gap" when caring for the elderly? In this context, the patient is often suffering from multiple incurable illnesses and central existential questions become dominant.

Working as a municipal nurse in elderly care does not demand any specialist competency, as for example within geriatric care, and the nurses mainly work alone in their function that comprises medical guidance and treatment, counselling, supervision, and caring that demands their authorisation (Tunedal & Fagerberg, 2001). Municipal elderly care is characterised as comprising the norms of social services such as safety, community, and caring values and the medical ones such as treatment, technique, and pharmacology, all gathered in their homes (Gustafsson, 2009).

Aim

With the objective of investigating the possible disparity between theory and practice in caring, the present study inquires into nurses' lived experience of the understanding of caring theory in practice in the context of municipal elderly care.

Method

The data analysis was conducted in accordance with the phenomenological–hermeneutical approach developed by Lindseth and Norberg (2004). This

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method for interpreting interview texts was inspired by the philosophy of Ricoeur (1976). The purpose of using this method was to uncover the meaning of caring theory for nurses working in elderly care and, as such, phenomenological hermeneutics were considered as being a suitable approach.

Phenomenological hermeneutics hold that all "taken-for-grantedness" needs to be alienated to become visible (Bornemark, 2010). The reality is not observed; rather it shows itself as understanding and meaning, and this process of understanding and meaning is both phenomenological and hermeneutical (Gadamer, 1989). Due to this reasoning, theory is not an abstract description of an outer reality, of an empiric on the outside; rather, it is related to the knowledge of lived experience.

Interpretation of the text constitutes a dialectic movement between understanding and explanation. The scope of the research encompasses experienced registered nurses (RN) working in governmental hospitals, primary care units, and homes for the elderly.

Setting and sample

The management and responsibility of caring in municipal elderly settings rests with the nurses (Carlström, 2005). This work does not demand any specialist competency such as, for example, within geriatric care, and for the most part the nurses work solely alone as they carry out their function of providing medical guidance, counselling, and supervision (SFS, 1998: 531). The nurses in this study had gone through 3 years of an academic nursing program and were as such registered nurses (RN), with a bachelor degree of 160 points in caring/nursing theory. Contact with the township's chief of staff was conducted, and arrangements made for information gathering with interested nurses.

Thirty nurses were employed in this setting, all RN with qualifications from Swedish universities. Of these, 12 responded positively regarding participation in the study. A new meeting with the participants was arranged where questions about the research project were discussed in detail. The nurses gave informed consent to their participation in the study and were free to choose the date and location of the interview.

Permission to conduct the interviews was obtained from all levels: the township's chief of staff, the local administrator, and each contributing participant. According to the law of research ethics (SFS, 2003: 460), which concerns the ethical cornerstones of empirical research, approval is not required for this kind of research. The 12 nurses were women between 28 and 64 years of age. Their mean age was 49; their medium experience as a nurse was 19 years, with an average of 8 years in elderly care. According to Kvale (1996), an acceptable number of interviews are due to the approach 15 ± 10.

Data collection

The study took place during the summer and autumn of 2009 and the data were collected through digitally recorded narrative interviews, one per participant. The interviews were broad and open-ended, with the same initial question; the nurses were asked to narrate their relation to and experiences of caring theory in practice (Kvale, 1996). They were encouraged to provide examples from everyday caring situations. The interviews differed from everyday conversations in that they included many follow-up questions, such as "What do you mean?" or "Interesting—can you give an example?" These questions were intended to encourage the participants to deepen their narratives and to "bridle" the interviewers' process of understanding, to prevent the interviewer's assumptions from interfering (Dahlberg et al., 2008). The interviews lasted between 50 and 75 min and were transcribed verbatim. A comprehensive 362 pages of text forms the data material. All interviews were performed by the first author (Albertine Ranheim).

Data analysis

This phenomenological–hermeneutical method required that the material be analysed for patterns of meaning. The interview texts were read and discussed by all three authors of the study. The interpretation and analysis of texts involved three methodological phases. The analysis began with the dialectic phase, involving a naïve reading of the text as a whole, to gain an initial impression. The transcripts were read several times with an open mind, allowing the text to speak to and affect the reader. A phenomenological approach to the text necessitates setting aside one's own pre-conceptions as much as possible, to alienate what is familiar, and become capable of surprise. Thus, a primary understanding of the phenomenon is gained.

From the formulation of the naïve reading, questions emerged that guided the next phase of the analysis; the thematic structural analysis. The entire text was "unpacked" of meaning from the meaning units, then condensed and abstracted to build subthemes and main themes. One theme of meaning was temporarily understood as a figure against the rest of the material as the background (Dahlberg et al., 2008). Examples of structure analysis are presented in Table I. The themes from this structural

Table I. Examples of structural analysis. Theme: Confirmations and abstractions.

Meaning units	Condensation	Sub-themes	Theme
Then I understood what I was reading! But I could not imagine how persons that had not actually worked in health care could understand those theories.	Must have worked in health care to understand caring theory	Theory confirming praxis	Confirmations and abstractions
[N]ow I was able to place it into the right context, so to speak.	Theory and practice in a significant context		
[I]t described what we were actually doing!	. . . confirming caring through the theory		
Theory gives words to what I do—instead of me doing the theory . . . so . . .	Confirming practice		
Sometimes I say that our patients are living in cyber-space . . . in the computer. . . . That is how theoretical systems can fragmentise the patients' world . . .we sometimes do that when we split the patient's world in the patient records.	Theory as fragmentising and alienating—the patient is bundled off into cyber-space	Narrow and abstract systems or theories	
[T]his tacit knowledge is clarified . . .and one could conceptualise better . . . yes, that's the thing.	Conceptualising tacit knowledge	Theories denominate tacit knowledge	

Examples of structural analysis. Theme: caring efficacy

Meaning units	Condensation	Sub-themes	Theme
If the patient gets worried, it may be your responsibility and I ask myself what I can do. Am I the tool or instrument . . . for the patient to feel comfortable . . . it is this kind of training that is needed.	To understand what the patient experiences and how this is expressed	Cultivation of caring insights	Caring efficacy
This is the challenge—if I am able to help the worried, demented, or scared patient in a confirmating way, then I have succeeded in my using my caring, healing ability,	Training in caring—healing abilities	Self-reflexion and confirmation	

analysis were mirrored against the naïve understanding to validate the understanding (Lindseth & Norberg, 2004).

The last phase involved a comprehensive understanding. This was a critical in-depth interpretation based on naïve understanding, structural analysis, the researcher's pre-understanding, and the theoretical framework. The comprehensive understanding disclosed new possibilities for being in the prefigured world of the nurses as narrated in the interviews and refigured in the researcher's interpretation and in the interpretation of the readers of the research paper (Ricoeur, 1976).

Findings

The three main themes and sub-themes of meaning that arose from the analysis are interrelated and cannot be separated. They should be understood as intertwined. Table II

Confirmations and abstractions

Theory that confirms practice

The participating nurses argued that they had learned most in their profession through practical experience, through several years of working in elderly care without, as they expressed it, "any explicit or obvious foundation in caring or nursing theory." They did not, however, completely dismiss theory, to which they related with different levels of understanding. While they ranked empirical experience higher than theory, certain theories played a role in that they confirmed and verified their practical experience. These caring theories could

Table II. Main themes and sub-themes.

Confirmations and abstractions	The marginalisation of caring	The intention of caring
Theory that confirms praxis	Being medical consultants	Caring experienced as health
Narrow and abstract structures	Caring is neglected	Caring efficacy
Theory and practice intertwined		

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put into words their lived experience and illuminate and explain what happened in their professional capacity. As such, theoretical knowledge supported their personal knowledge and understanding of caring for elderly, and could become explicit.

> Some caring theory can confirm what I have experienced through a long period of praxis ... the theory is like a reflective wall.

Certain theories (knowledge) could be supportive of their personal knowledge and understanding of caring, and of an all-embracing notion of caring. Knowledge that was seen as a kind of common sense and obvious and, thus, tacit, could in this sense be verbalised and reflected upon. As a consequence, it became contextualised and the nurses became more aware of the implicit caring knowledge.

> [T]heories of caring can be experienced as reflected knowledge, and then the practical work is like an extension of this or moves with it ... without templates.

There came forth an expression of theoretical knowledge as an integral part of the nurses' knowledge, enunciated as being a "sounding board" or being the shoulders whereupon knowledge rests. In the expression of the deeper meaning of caring, it became clear that foundational and overall bridging was the aspects of health and well-being for the patients.

Narrow and abstract structures/theories

However, the difficulty in finding any obvious relationship between theory and daily caring was immediately pointed out. An instinctive revulsion towards theory became apparent—the nurses said it was like stepping on a sore foot.

Theory was instantly identified as a weak, unreflecting body of knowledge, even if the theoretical bases were seen as opportunities for reflection. Depending on the understanding of theory and its utilisations, theory had diverse meanings that were integrated into the nurses' practice.

The difficulties in relating to caring theory were described as resulting from conflicting elements of recognition. Nursing models felt unrealistic or narrow and seemed to dictate and constrain the nurses' work, rather than being contributing to the caring process. Using a nursing model as a kind of checklist obstructed more or less the individualised care and was seen as complicated to do.

> It does not work to follow a model—thinking from period to period ... all human beings and conditions are individually experienced ... and we encounter them in different ways.

Documentation was described as offering theoretical structures that were experienced as both enlightening and limiting. The enlightening experience came from the fact that such structures made visible what the nurses had actually performed; a quality assurance program for instance. Even if the nurses understood that these systems aimed to visualise, describe, and structure the elderly patient's complex caring situation, they experienced them as fragmentising and trivialising. It was even said that the system had a purpose of its own, creating a rift between what was documented and the lived experience of and with the elderly. Such theory or structure thus created two different ways of gaining knowledge that were not intertwined but colliding:

> [T]oo many theories and documentation and then the patient is situated somewhere out there ... they seem to live in a cyber world.

These structures were experienced as predetermined, preventing an open and uncompelled encounter with the elderly patient. Of course, the systems of documentation also represented a kind of diary for the nurses—what they had done and were about to do, medical reports, etc. The documented files were called patient records but they should be called nursing records.

Theory and practice intertwined

The nurses expressed that when reflecting on their caring goals or intentions, they became aware of the overall basis of caring theory. They described this as a background for their caring activities and functions, and as an all-embracing notion of caring for the elderly—an idea or vision or guiding light—closely connected to their own goals and visions of health and well-being. There was a need for reflecting on these foundational goals or the intention of caring, to renew or re-establish the deeper meaning or intent in an everyday situation. This came as an expression of re-establishing a connection to theoretical foundations for their work; to enlighten underlying meanings of caring that had gone lost in the wilderness of daily routines of doing.

> [F]ind it important with a connection to caring theory ... it may give a key to what we are working with and how we think ... it might improve quality

> in a way ... that there is a thought behind the caring ... a guiding light ... an ideal.

Certain theoretical aspects that could embrace the idea of caring as a guiding light were revealed as enlightening, as if by reflecting on them the participant nurses reconnected to their overall caring intention and anchoring.

The marginalisation of caring

Regarding caring theory in the nursing profession, the structure of the organisation in which the nurses work is of importance. As the nurses in municipal care for the elderly described it, their mission had drifted away from their obligations as caring professionals. As such, it was no longer in accordance with their discipline and intentions. In their work they now took the role of medical consultants and they were no longer situated in the wards with the elderly, involved in the caring encounter. Instead, they were prepared for any medical situation that might arise, at the same time functioning as a control body of medical and caring functions delegated to the staff. The profession or role was experienced as having drifted away from the intentional caring profession.

> Now I delegate all medical and caring tasks and I am not present during the nursing care anymore ... not even as a team-leader as I was before.
> [A]ctually I am not a nurse anymore.
> I am transformed into an administrator and have no use for my knowledge of nursing care.

Medical consultants

The nurses said that they functioned as medical consultants or administrators. The nurses did not experience benefits from caring theory; only medical theory was now seen as relevant as their activities had turned in that direction. Frustration and sorrow were experienced about the fact that they were no longer fully responsible for the care of the elderly patients. The demands for the nurses' professional skills principally came from a medical perspective, while the mission or intention from the nurses' caring perspective was lost. They felt caught between two forces, two demands—where the medical demands had subsumed the deeper involvement in caring for the whole person that corresponded to their inner caring intention.

The citation below illustrates the frustration this sometimes caused:

> That you give painkillers instead of finding new shoes if someone has sore feet.

Neglected caring

In the nurses' experience, caring had been superseded; since they were no longer participating in the nursing care of the elderly patients and were no longer part of the caring team, they felt that the knowledge cultivated through their encounters with patients and staff was jeopardised. The nurses felt that this influenced the refinement and development of their clinical judgment, since they no longer shared the "caring scene" and had to make secondary judgments from staff reports without having seen the patient.

> Sometimes I don't even meet the patient ... it's like taking responsibility for a soup you didn't cook yourself.

Working as medical assistants or consultants was not unfamiliar to the nurses, as medical knowledge is an important aspect of their profession, but they were not happy about being unable to take part in the caring itself and thereby build a foundation for making assessments. The structure of the organisation was described as undermining opportunities for the observation and cultivation of health and well-being amongst the elderly patients that implicitly guides nursing care.

The intention of caring

The interviewees explicitly expressed that promoting health and well-being is an unreflected core motive of their care. The concept of health appeared to be consistent with an intertwining of dimensions—an individual experience as well as a guideline for the elderly patient's situation of life. Health and well-being appeared to be a goal for those in the nursing profession; indeed, it was expressed as the central perspective in caring:

> I think medical attendance is the wrong concept from the beginning ... it should be called health care ... and we should be called health carers.

Caring experienced as health

It was seen as fundamental to be able to help the elderly to manage day-to-day living and to experience health and well-being despite tough medical conditions. Health was more significant and comprised more dimensions than the absence of illness. This was elucidated in statements such as helping the patient experience well-being despite illness. The caring milieu contributed to the experience of health and well-being, and was expressed as the collectively created atmosphere of the ward:

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> [A] poor milieu of caring may engender bodily symptoms like pain or eczema … and a bad experience of health.

This perspective of health and well-being as fundamental to the caring culture was seen as being created by how caring is established—what meaning caring has. Opinions were expressed that the caring culture emanates from this establishment and is nurtured by how it is cultivated.

To the nurses, caring has rich meanings and nuances. The most substantial and central meanings are focused around listening to the patients and being sensitive and perceptive regarding their needs. This meant being initially open-hearted and passive, engaging in an open-minded interaction to grasp the needs of the patients. This demanded an open awareness and sense of the totality of the situation that could be lost if not trained and maintained.

Caring efficacy

An orientation towards health and well-being and alleviating suffering is significant for the nurses. Caring efficacy is mediated through why the nurses act and think as they do, what basic values rule their intentions, and the meaning of their caring actions from a deeper existential level.

Implicit in these goals was the ability to have an open and accommodative awareness of the whole human being. Optimum care required the ability to see the entirety of the elderly person in his/her situation. In elderly care many patients have severe dementia, and the nurses found that they needed to develop a deeper knowledge of the world in which these people lived. It is described as important for the nurses to have the ability to see the healthy human being—the core of humanity, despite the severe changes and dementia, which may have overtaken the patients. This demanded self-perception and a consciousness of one's own efficacy as a nurse in the caring process. The participating nurses expressed a need for integrated knowledge on many topics and in many ways in their intentional caring, and said that single-minded knowledge represented single-minded care.

> [Y]ou need an open mind … open senses … and an observational self-reflection.
> The caregiver uses himself/herself as a tool and cannot be unconscious/unaware of this.

Medical demands excluded time to meet existential demands to recognise the "silent call" and develop the self-awareness and self-strength necessary to deal with deeper concerns in caring. As such, a frustration was described because the nurses felt their caring efficacy was reduced or narrowed because they were not present in the caring scene to a great extent.

> [T]he care we give mirrors our view of man.

Caring for and about people demands both constant and intermittent work, as well as self-reflection and flexibility. There is always the possibility of seeing or developing something new or the possibility of withering into routines. This is visible through our caring efficacy.

Discussion

Theory and practice

In ancient Greek understanding, "theoria" means beholding or looking at and refers to contemplation (Hellkvist, 1922). Pythagoras gave "theoria" the meaning leading to the modern term of it as a distanced, non-contextual neutral form of thinking. Theories are grounded in empirical phenomena, consistent with scientific methods or approaches. In human sciences the scientific approaches are grounded epistemologically in, for example, philosophies of phenomenology or hermeneutics, where understanding of being is intertwined in a historical and temporal context and shows itself as understanding and meaning. In this reasoning, theory is not an abstract description of an outer reality; it is related to the knowledge of lived experience (Gadamer, 1989; Hansen, 2009).

In regard to the nurses in our study, their values and visions for their profession and their caring ambitions became clearer and more pronounced, as they said, by reflecting on concepts from caring theory. Reflection on caring theories and their applicability to practice has been described from an educational perspective (Freshwater & Johns, 2005), from clinical educative perspectives (Bulfin, 2005; Ekebergh et al., 2004), and from instrumentation- and evidence-based practice from caring theory (cf. Sumner & Fischer, 2008; Watson, 2002). In a hermeneutical enquiry on nursing care, Austgard (2008) stated that caring requires a capacity for different levels of abstraction in the context of the patient, in other words, awareness at an advanced level, in situations that are often complex and unpredictable. This may be regarded as a paradox, since caring for the elderly in our study is often described as common sense and practical training. Here we may relate to the philosophy of tacit knowledge, meaning that the human being knows more than he/she can verbalise.

One way for tacit knowledge to become visible is by open awareness and reflection. In a Swedish study, Ekebergh et al. (2004, 2007) tried out methods of supervision in practice in which theoretical caring concepts could "come to life" and involve the practitioners. In those projects, the focus was upon the patients and their expressed experiences. The nurses or student nurses brought the cases and the stories to the supervision meetings. The supervisors contributed with educational tools, for example educational drama, and included theoretical concepts of caring in the reflections. By this, the practitioners could illuminate previously unseen areas of care and be more aware of what happened between them and the patients.

Confirmations and abstractions

The nurses in the study spontaneously identified caring theory as abstract or narrow knowledge. The abstract knowledge could serve as confirmation of their practical experience in caring for the elderly, like a mirror, but then again their caring practice did not correspond with their commission and as such became abstract. The nurses expressed the importance of having the freedom to form their own opinions and practical approaches in an unobstructed way. Narrow theoretical models could not serve as sources for their own creative care but were expressed as being shackles or experienced as injunctions. The nurses in the study mediated that reflection on caring concepts from existential caring theories might be a way to create a higher level of awareness of the common caring goals and the caring culture in the elderly care. An assumption is that caring concepts and theory represent an arena in which nurses are confronted with their own prejudices and pre-understandings. As the nurses made explicit, theory must appeal to their everyday caring world for elderly and be thorough if it is not to be alienating, abstract, narrow, or limiting in relation to caring practice. Thus, caring theory must be sensitive and open enough for nurses to relate to and it must correspond even to the deeper aims of caring (Galvin & Todres, 2007).

Through "caring practice-sensitive" theories that are anchored in a phenomenological existential view, the nurses must face to what extent they have the courage to encounter and witness the situations of patients in a way that touches deeper layers and may lead to transformation in suffering. Caring embodies several dimensions that cannot be separated; instead, caring must be comprehended holistically. As for the nurses in this study, this body of knowledge was expressed as caring for the health and well-being of the patients and in this several ways of knowledge were integrated in, and composed, an embodied sense of the patient. In this sense one may say with Todres (2007) that each qualitative part is integrated into a whole and this may lead to an understanding of care that cannot be understood as a dichotomy between theory and practice, but rather as a dynamic movement of all dimensions, interrelated and inseparable. Following this, the choice of an epistemological starting point has consequences for the relationship between theory and practice. In a Gadamerian (1989) sense, understanding is the ontology of being in the world. It is an understanding that in a deeper meaning seeks possibilities of doing—it is intentional. Understanding is, as such, shackled to practice, to intention.

Reflection is a way in which professionals can bridge the theory–practice gap (Ekebergh, 2007). Reflections on one's own pre-understandings with the help of sound caring theory creates a possible openness and pliability to the patient's world, which is essential in a caring profession. Pre-conception and pre-understanding prejudice may be an inner guide that can make the dialogue with the patient fruitful and meaningful, but may also lead the wrong way. The benefit of persistently challenging the movement between practice and the pre-conceived thought behind may represent an expanded awareness on what consequences actions have on the patients, on colleagues, and on the milieu. Caring intentionality is described by theorists as being the basis for an expanding ontology (Dahlberg & Segesten, 2010; Watson, 2008). Incorporating and reflecting on the dynamic between theory and practice means that we are caring for, and cultivating our caring consciousness and the meaning and significance of our intentions. An assumption is that through this effort we are constantly challenged in our meaning and intention of why we act and think as we do, and in what basic values rule our intentions and the meaning of our caring actions from a deeper existential level.

The nurses in the present study expressed that they considered the meaning of caring to be the health and well-being of their patients. In such a milieu as home for the elderly, which is usually the last home for an elderly person, being becomes pregnant with the possibilities of existential questions of how to obtain health when often multiple health problems exist. Health means an experience of well-being, despite illness, and the power to carry out one's life projects, both big and small, said Gadamer (1993/1996). Such understanding of caring acknowledges the same complexity of health and illness that the interviewees convey. For them to find a theory useful, it must include these qualities. If

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not, the theory cannot be seen as anything other than an external error.

Marginalisation of caring

In our study, the nurses mentioned that their everyday caring world was almost solely of a medical character, and at the same time they said that caring comprised a greater and more complex range of human existence. They were, so to speak, stuck between two forces. By being loyal and accepting their organisation's claims on them as "medical consultants," they scarcely took part in the practice of caring, and thus were alienated from their profession. One might claim that the organisation was attacking the notion of caring instead of underpinning it, thereby undermining the nurses' intentions of caring. In a study on caring culture (Rytterström, Cedersund, & Arman, 2009), the authors claim that a care culture seems to depend on how care is interpreted and given meaning by the personnel as well as the organisation. Caring occurs within a culture or society: this may include personal culture, hospital organisational culture, or societal and global culture (Ray, 1989). In our study the nurses described what caring for someone meant to them, saying that the elderly patients' individual health and well-being were the most important aspects of their work. Relating to this, caring theory is not unfamiliar to them—rather, it becomes unfamiliar as the organisation becomes dominated by a rational, medical way of acting and thinking. This may be a key reason that caring theory is not visible and is felt as alien.

We suggest that the integration of caring theory into practice in elderly care requires organisational consent to the caring intentions put forward both by the nurses and in political documents. Of course, this also means that nurses have a responsibility to bring forth their propositions and the aims of their profession. Organisational cultures are both humanistic and bureaucratic, and the humanistic aspects of professional nursing care within bureaucratic organisations must be given visibility in a caring culture.

Conclusion

The nurses' reflections on caring theory in practice show that their relation to caring theory was very much on an unreflected level. As they verbalised their intentions of caring in elderly care, they realised that theory was an integral part of their knowledge in one way or another. It is obvious that there are not two opposite sides of the phenomenon of caring as exist in theory and practice; rather, theory and praxis must be seen as an intertwining structure of knowledge. Otherwise, there will be a lived experience of disparity. Impulsively, the nurses described their experience of detachment to caring theory, but when describing their caring intentions in elderly care, the relationship to theory became apparent, and even confirmed their practice. As such, a seedbed exists for caring theory to be reflected on and cultivated in elderly caring practice. However, as the nurses describe, the caring theory must be sensitive enough for the nursing practitioners to accept.

We believe it is more important than ever to seriously consider achievements for a caring profession. At the same time, we have to reflect on our responsibility as knowledge developers. We must make the disparate forces acting within the caring profession become one intertwining force.

Clinical application is an incorporation of caring theory as a philosophical–ethical base that can offer a humanistic worldview and extended practices. This could constitute a possibility of transforming the nursing work from its ethical core, transforming practices by offering inspired theoretical philosophical visions in order to mediate high quality care.

Reflection on the existential aspects of caring phenomena may provide for an expansion of caring intentionality, which again may affect the mediation of caring. This is perishable knowledge that has to be rediscovered. These findings are found in elderly care context but could be applicable for other contexts.

The integration of caring theory into practice in elderly care requires organisational consent to the caring intentions put forward both by the nurses and in political documents.

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