COACTION PUBLISHING

EMPIRICAL STUDIES

The encounter with the unknown: Nurses lived experiences of their responsibility for the care of the patient in the Swedish ambulance service

MATS HOLMBERG, RN MNS[1] & INGEGERD FAGERBERG, Professor[2,3]

[1]*Ambulance Service Department, Sörmland County Council, Katrineholm, Sweden,* [2]*Department of Health Care Sciences, Ersta Sköndal University College, Stockholm, Sweden, and* [3]*School of Health, Care and Social Welfare, Mälardalen University, Västerås, Sweden*

Abstract
Registered nurses (RNs) have, according to the Swedish National Board of Health and Welfare, the overall responsibility for the medical care in the ambulance care setting. Bringing RNs into the ambulance service are judged, according to earlier studies, to lead to a degree of professionalism with a higher quality of medical care. Implicitly in earlier studies, the work in the ambulance service involves interpersonal skills. The aim of this study was to describe RNs' experiences of being responsible for the care of the patient in the Swedish ambulance service. A reflective lifeworld approach within the perspective of caring science was used. Five RNs with at least five years experience from care in the ambulance care setting were interviewed. The findings show that the essence of the phenomenon is to prepare and create conditions for care and to accomplish care close to the patient. Three meaning constituents emerged in the descriptions: *prepare and create conditions for the nursing care, to be there for the patient and significant others* and *create comfort for the patient and significant others*. The responsibility is a complex phenomenon, with a caring perspective, emerging from the encounter with the unique human being.

Key words: *Ambulance care, prehospital care, caring science, responsibility, encounter, phenomenology*

(Accepted: 20 February 2010; Published: 22 March 2010)

Introduction

According to the Swedish National Board of Health and Welfare, there is at least one registered nurse (RN) in each ambulance in the Swedish ambulance service, and the RN has the overall responsibility for the medical care of the patient (SOSFS 2000:1). According to earlier studies, RNs in the ambulance service will bring a degree of professionalism into the ambulance care (Melby & Ryan, 2005; Suserud & Haljamäe, 1997). Physicians and emergency medical technicians (EMTs) in the Swedish ambulance service hold the opinion that RNs will lead to higher quality of care, based on their medical skills and ability to perform medical care (Suserud & Haljamäe, 1997, 1999). Working as an RN in the ambulance service is a combination of care in acute emergency situations and care in situations with lower medical priority (Ahl et al., 2005; Hjälte, Suserud, Herlitz, & Karlberg, 2007; Marks, Daniel, Afolabi, Spiers, & Nguyen-Van-Tam, 2002). The RN in the Swedish ambulance service acts as a team with usually one additional care provider with another educational level, EMT or assistant nurse. The partnership and the ambulance team are important to provide good care in the prehospital emergency and ambulance care setting (Ahl et al., 2005; Weiss, 1998).

Because of its emergency and accident character, care in the ambulance service is developed and managed with focus on emergency medical skills and treatment, and has a predominant focus on the physical aspects (Gentil, Ramos, & Whitaker, 2008; Melby & Ryan, 2005; Wahlin, Wieslander & Fridlund, 1995). Bruce, Suserud, and Dahlberg (2003) found that abilities to have an open attitude to and

Correspondence: M. Holmberg, Ambulance Service Department, Sörmland County Council, Kullbergska Hospital, Box 110, 641 22 Katrineholm, Sweden. Tel: +46 70 557 30 69. E-mail: mats@methos.se

Citation: Int J Qualitative Stud Health Well-being 2010, **5**: 5098 - DOI: 10.3402/qhw.v5i2.5098
(page number not for citation purpose)

maintaining meaningful relationships with the patients is necessary for RNs in the prehospital emergency care. Accomplishing care in the prehospital emergency care setting, involves being flexible, creative and humble in how to approach their tasks, and possessing inner strength and stability (Ahl et al., 2005). Studies in the prehospital emergency care area show a context more complex and in need of more capabilities than limited to medical skills and care (Ahl et al., 2005; Melby, 2000; Wahlin et al., 1995).

Both medical and nursing care is central in the RN's profession. Even though cognitive and medical technical skills are required in nursing practice, the nursing profession cannot be reduced to that level. The caring aspect of nursing involves the encounter with the patient as a unique human being (Gastmas, 1999). This caring encounter focuses on several ethical and moral dimensions emerging from closeness to the patient, and goes beyond the ethical boundaries that are related to medical care and nursing skills (Liaschenko & Peter, 2004; Myhrvold, 2003).

The concept of responsibility, according to the medical and nursing care, can be understood in two different ways. From a task-orientated nursing perspective, it can be understood as that the RNs in the ambulance service are responsible to follow the guidelines in care, e.g., Pre Hospital Trauma Life Support (The National Association of Emergency Medical Technicians, 2003) or the Advance Medical Life Support guidelines (Dalton, Limmer, Mistovich, & Werman, 2007). There are also several local directions for the care in the Swedish ambulance service, aiming to help RNs to treat the patient from a medical perspective. However, these guidelines cannot guide the RN in the personal encounter with the unique patients and their individual needs. Gastman (1999) means that in order to encounter a patient's unique situation, a caring attitude, integrated in the caring activities, is required. The caring attitude comprises the ability to step out of one's own personal preferences and put the patient first. This requires the ability to be open and encounter each patient as a human being.

Studies show that responsibility in the encounter within the prehospital emergency care setting can lead to several ethical conflicts, for example, if a patient refuses to co-operate with the ambulance team, even if their opinion is that transportation to an emergency ward is necessary (Adams, Arnold, Siminoff, & Wolfson, 1992; Sandman & Nordmark, 2006). The ethical difficulty is related to how the patient's right of self-determination can be respected. Ethical conflict can also arise when a difficulty to decide which care options are the best for the patient. The RN's responsibility, according to Nordtvedt (2001), is related to the encounter with the patient and the significant other. Nordtvedt holds that the RN is being placed in a moral responsibility situation. Responsibility in relation to the encounter can also be understood from a philosophical view. Lögstrup (1994) writes that in each encounter an ethical demand emerges that justifies our responsibility. To be responsible means to respond to this demand. Levinas (1996) understands responsibility as something that emanates from the presence of the other. In both Lögstrup's and Levinas' view, the responsibility is connected to the encounter and the closeness of the other, which has a central position in caring. The encounter is where the care takes place.

Rationale and aim of the study

Since the prehospital emergency care and ambulance setting has a predominant physical focus, where medical skills and treatment has been high valued, the RNs' responsibility can be seen from a medical perspective. According to the Swedish National Board of Health and Welfare, the RNs in the ambulance service are overall responsible for the medical care. At the same time, studies show the importance of interpersonal skills in the ambulance care setting and responsibility as emanating from the encounter with the patient.

Summarised, there is no uniform understanding of how the RNs responsibility for the care of the patient in the ambulance care setting shall be understood. Therefore, the understanding of the phenomena, responsibility for the care of the patient in the ambulance care setting, has to be questioned and described. The RNs' lived experience can generate descriptions of the phenomenon. The aim of this study is to describe the RNs' experience of being responsible for the care of the patient in the ambulance care setting.

Method

In accordance with this study's aim, a reflective lifeworld perspective based on phenomenological philosophy was chosen (Dahlberg, Dahlberg, & Nyström, 2008). This perspective has its epistemological foundation as described by Husserl (1913/2004), and the aim of the reflective lifeworld research is to illuminate and describe events of the lifeworld, i.e., phenomena, in their most original meaning (Dahlberg et al., 2008).

Informants and data gathering

Data was gathered in 2006 with interviews by the first author. The inclusion criteria were RNs in the

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5098 - DOI: 10.3402/qhw.v5i2.5098

ambulance service with at least five years of ambulance care experience. Permission was applied for one ambulance central in western Sweden. Contact was made with the manager at the ambulance central, who posted a general invitation to participate in the study, along with the inclusion criteria on a notice board. Seven RNs were interested in participating in the study. An introduction letter was sent to them and after two weeks the first author called them and asked if they still were interested. Five nurses declared their interest to participate and arrangements for the interviews were set. The participants received both written and verbal information about the study. Four interviews took place at the informants' work and one was carried out at the informant's home. The interviews lasted between 60 and 90 minutes, and were audiotape recorded. Three pre-made questions were used: "Can you tell me about an ordinary day at your work as an RN in the ambulance service?", "How do you experience care, as an RN in the ambulance service?" and "Can you in detail describe one situation when you, as an RN in the ambulance service has taken responsibility for the care of a patient?" To get deeper descriptions, the interviewer posed questions as: "Can you elaborate a bit more on when you said that you gave good care?"

Data analysis

The interviews were transcribed verbatim and read by the authors. Each interview was divided into meaning units, with similar meanings merged together to clusters. After our careful and detailed reading, the most invariant parts emerged, and the writing of the essence started. The essence is the essential meaning and general structure of the actual phenomena (Dahlberg, 2006). The analysis was carefully done to maintain actual descriptions of the phenomenon and without personal interpretation. Both authors took part in this phase. While writing the essence, variations emerged in the descriptions. Those variations formed meaning constituents. The essence of the phenomenon is described in the *Findings* section, followed by descriptions of the meaning constituents, further elucidating the meaning of the phenomenon. To clarify the particulars of the phenomenon, quotes from the interviews are provided as examples of explicit meanings.

Ethical considerations

The study took place in Sweden 2006. Before July 2008, ethical permission was not needed for this kind of research in Sweden (SFS, 2003:460). The supervisor of the ambulance central approved the study. The informants had the opportunity to pose questions and they signed an informed consent form before interviews started. During the transcription of the interviews the authors were careful to not alter the original text. Quotations have not been labelled with participant numbers or pseudonyms in order to protect informant identity. When a slash // appears within a quote, a part has been left out, as those parts are not considered essential for the reader's understanding of the text.

Findings

The essence of the studied phenomenon is described as to *prepare and create conditions for the care and accomplish care close to the patient*.

The meaning of preparation is to create general conditions for the care and to prepare the care in the actual situation. The preparation is experienced as to encounter the unique human being as someone unknown. The RNs encounter the patient unprejudiced, but at the same time have a plan for how to accomplish the care. In the encounter, respect for the patient's lived experience of the situation is important and the patient's experiences are superior and is the foundation for the RNs' care. To prepare care and gather information in the actual situation, means to create a picture of the patient's experience and use this in the following care. The RNs' experiences of the care close to the patient, means to be open-minded and have a broad outlook at the situation. They experience the importance of being careful in the assessment of the patient situation, and never take anything for granted. The RNs care is accomplished based on the needs of the patient and based on both medical and nursing care. Initially the RNs create an image of the medical conditions and needs, based on intuition and experience. Thereafter they decide the subsequent care, accomplished with a medical or nursing care focus. The nursing care is a general concept that frames the medical care. It means that there is no explicit boundary between the medical and nursing care, even though the RNs initially can have either of them as a focus. The RNs care is an ambition to confirm and understand the patient's situation and to create comfort for the patient and significant others. One foundation for the ability to create good care is the team and collaboration with colleagues and other healthcare authorities. This collaboration is important in every step in the ambulance care, creating conditions to accomplish care based on the patient's specific needs.

The three meaning constituents are: prepare and create conditions for the nursing care, to be there for

the patient and significant others and create comfort for the patient and significant others.

Prepare and create conditions for the nursing care

The meaning of preparation is to create general conditions for the care close to the patient. It begins when the working day starts and the RNs gather general information that can be important for the workday. It continues when the RN together with the ambulance team members check that the equipment and ambulance car are working correctly.

The preparation of the actual care situation begins when the RNs get the first information from the Emergency Medical Dispatch (EMD). This information is general and focused on how to reach the patient and could sometimes include general information about the patient's situation. When the RNs are not satisfied with the given information, they call the EMD for additional information. The collaboration with the team members is central. One RN experiences that he shares with the team member the information he collects:

> If I sit and read FASS (Swedish Pharmacy information) for example, I do not read it to myself in silence. I read it out loud and listen to my team member's point of view, to inform him.

In situations that involve more than one ambulance team, the RN in the first ambulance takes responsibility to check with the EMD that the right numbers of ambulances are called. That RN also takes responsibility to forward the information to the other ambulance teams.

The starting point is to reach the patient as fast as possible when the RNs get their call. They do not want to loose important time, which motivates them to ensure that they find the way to the patient. At the scene they just bring the most important equipment for the first emergency response, so the time reaching the patient is not delayed. When an emergency acute mission occurs, the RNs plan more how to accomplish care at the scenery, during the drive. This can be understood as the RNs create a mental image or gather more information from the EMD, general guidelines or by contact some other healthcare authority:

> If you get called to a car accident you often have an apprehension, you create an image of the place because you often know where it is and you think; OK they have probably crashed like that. And then you often have got information if someone is jammed and how serious it is. The more serious it is you prepare yourself by thinking of what to do when you arrive at the scene. If it is not that serious you think less about what to do. In those situations it gets more natural. If it is more serious things you haven't prepared for often come up.

Some of the RNs would prefer to encounter the patient with no pre-made assumptions especially in low-priority calls, in their ambition to do correct assessments. In these instances they do not collect complementary information until they encounter the patient. They do not want to be influenced by premade images of the patient's situation:

> My opinion is that I have learned throughout the years not to create so many images of how it is, even if the image is good since it often is incorrect when you reach the patient. And then I am hindered, because my image was incorrect. It is better, in this case, to be guided by what I actually see.

At the scene, close to the patient the RNs continue to create conditions in order to accomplish the care. The caring situation is experienced as to dare to encounter the patient. The RNs goal is to make a good first impression on the patient by plainly say "hello" to the patient and further present themselves and their mission. This does not always result in response from the patient, but the RNs mean that they at least tried to begin the encounter.

Before the care can take place the RNs create conditions to accomplish care, like collecting information from the patient and significant others. If there is a larger trauma scene the RNs must lead and cooperate with colleagues and other first responders, for example, the fire department, to accomplish care for the patient. This can also mean that the RNs in large scenarios must prioritise among the patients:

> You examine every reason for the accident and what the injuries are. You make quick decisions to release or not release someone who is stuck in a car, depending on the suspected injuries and if the patient's condition is critical or not. You need to lead the fire brigade or your colleagues, and then it is a big responsibility you have out there. To make the right priorities if there are many patients; Who should go first to hospital? Who needs to get the most qualified help?

Sometimes it means that the RNs consult other healthcare authorities to decide how they can solve the patient's situation. This means that they inform the hospital so they are prepared to receive the patient. In emergency situations the RNs prepare the hospital so care can be accomplished without

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5098 - DOI: 10.3402/qhw.v5i2.5098

interruptions, but also if they need help with moving of the patient, from stretcher to bed.

To be there for the patient and significant others

The primary starting-point in the encounter with the patient is experienced as having a medical focus. The RNs initially make a medical assessment to clarify if any emergency medical treatment needs to be done. The assessment is based on earlier experiences and intuition. The RNs often establish contact with the patient by putting their hand on the patient's wrist. The purpose of this gesture is to create comfort at the same time as it helps the RNs to get an apprehension of the patients' pulse and body temperature.

If the situation is judged as not acute from a medical perspective, the RNs have to come up with a different way to find out if there is another reason for the patient's situation. The RNs feel that they take on a lot of responsibility, sometimes more than they need to. It means that they take responsibility for measures that according to the RNs should be managed by other healthcare authorities or the social welfare. The RNs have an ambition to help and experience it as that they have expectations from the society that they will solve the situations. The needs are judged from a holistic view of the patients and their situation. It means that the RNs make an assessment and decide which care that is best according to the patient's needs. The RNs are careful in their assessments, which are based on a physical, psychological and social perspective. The social assessment is mentioned as an important factor. The RNs make sure:

> . . . that the doors are locked and the oven is switched off if the patient is alone in the apartment. You always have in mind if there are pets, younger people or children in the apartment.

The meaning of the phenomenon is also to encounter the patient in the actual situation as a unique human being with unique needs. The ambition is that the patient shall feel that the situation is taken care of by the RNs:

> . . . if I meet a girl who cries and thinks her life is struck. In these instances my care will be that I sit and hold her for about one hour or so, it is a kind of care that I listen to her, that I am there for her. . .

In some situations the patient will remain at home. If the patients' needs are not of emergency character then bringing the patient to a crowded emergency ward would not be considered accomplishing good care. The RNs' experiences are to find the best solution in the patient's situation at all times. It is described as putting the patient's needs first and try to take care of them in the best way possible:

> I will assess the patient's condition and give treatment or not, but they must always feel comfort with my decisions. When I leave a patient at home, they must feel that they have received good care and treatment from me, according to their needs. And that I have approached them in a good way.

The RNs use their competence and their abilities to establish contact with other authorities, to solve the situation for the patient and significant others in the best way. This can be understood as establishing contact and co-operate with social authorities, non-institutional or psychiatric care. When the contact fails, the RNs experience it as a dilemma, since the patient cannot get the care the RNs assess as best according to the patient's needs, meaning that the RNs are responsible since they have been called to the patient. In some cases the patient ends up at the emergency ward, because it is open around the clock, even if it is not the best alternative. In other instances the RNs use their authority to solve the patient's situation in the best way, meaning they stand up and defend the patient's rights to be cared for. This is depending on the RNs self-confidence and a conviction that they know what is best for the patient:

> We can't occupy one ambulance a whole night because of a patient who needs a psychologist or something similar. Maybe a major bus accident will occur on the highway. But we are called to the place and therefore it is our responsibility. Our mission is to prevent this patient to commit suicide and to take him or her to the right healthcare authorities, so it becomes our responsibility anyway. . .

The RNs experiences of the process of handover the patient to the receiving healthcare authority means to be careful and clear. It means to be careful with the information that is important for the following care and respect the patient as a unique human being. The RNs are clear while handover the responsibility for the care of the patient. "I am very clear when I say; Now we are done, now it is your responsibility".

It means not just to handover the responsibility, but also to assure that the patient's needs will be taken care of. It can involve that the observations from the patient's home, necessary when the patient

will return home, are reported to the receiving healthcare authority.

Create comfort for the patient and significant others

Creating comfort is common in the RNs experiences of being responsible for the care. It means that the situation of the patient and significant other is taken care of by the RNs, and that they with different approaches try to create comfort. This can influence the result of medical treatment and care. Even in emergency situations requiring immediate response, the RNs try to keep the patients comfortable. The patient needs to be kept aware not only of what is currently being done, but also of what is going to happen next. Therefore, the RN needs to communicate with the patient and significant others during the whole process:

> In a practical way I try to tell the patient what my thoughts are. What will happen next. // So that not a lot of things happen that the patient doesn't understand. You might touch the patient, try to move him or her, pull // Put a blanket over or under, or pull, hold, without informing the patient ahead of time.

The RNs inform the patient to prepare them for the next step in the care. This preparation also includes making the patient aware of how serious the situation is, but not to supply unsecure assumptions made by the RNs. Comfort can according to the RNs in some situations be described as establishing physical contact: "I grab them. Stroke the cheek. Try to calm them. Tell them that there are only nice people around you and nothing bad will happen".

The RNs experience that there is, as for comfort, a reciprocal relation between the medical and the nursing care. It means that if the patient is comfortable in the caring situation, the medical treatment will have a better effect. "If the patient can feel comfort and be relaxed in the situation, you get better effect of the analgesia, close to the effect you expected".

There are situations when the ambition to create comfort is directed towards the significant others. One RN's experience is that he tries to calm children by making the parents comfortable. In some situations creating comfort is naturally directed to the significant others, for example in situations with death and dying. The comfort also means that the patient shall experience that the situation is managed by the RNs and that they know what is to be done. The RNs try to understand the patient's point of view:

> Sometimes you can say; I can see that you have difficulties breathing, we'll fix it. You will get oxygen and medications, and we will help you to feel better′. Sometimes just by saying; I can see that it is difficult to breathe, but you don't need to say anything, we'll talk later.

The RNs' ambition is to create comfort for the patient even after they have ended their mission and the patient is in the hands of the next healthcare authority. That means to have the capacity to imagine what the patient's needs will be, and report it.

The RNs experience their ambition to create comfort as trying to show the patient empathy, even if they do not experience the situation in the same ways. Their starting-point is the patient's own experience of the situation. The RNs strive to be careful in their ambition to understand the patient's experience. It means that if the RNs suspect that they do not have a correct picture of the patient's situation they ask more questions or take in more information from significant others:

> He will answer what he thinks you expect him to, but you can see in his eyes or his body language that he means something completely different. In this situation you ask the same question but in a different way, and then you get a different answer.

If the RNs do not think that they experienced the situation in the same way as the patient and significant others, they subordinate themselves to them. The RNs experience that it is important to have the patient to describe the situation with their own words. This means that the patient is welcome to participate in the handover process and to fill in what the RN has missed. Sometimes these ambitions, to get the patient describe their experience, means that the RNs have to dare to ask delicate questions and not to be afraid of the answer:

> If you ask delicate questions as: Are you tired of living? Why do you feel this way? Is there something in your life that makes you feel this way? That you dare to ask tough questions that others close to patient don't dare, because they are afraid of the answer or don't want to be obtrusive. It is our duty and responsibility to actually dare to manage these unpleasant questions, and then you get a lot of information.:

To respect and confirm the patient's own experience means that the RNs enter the patient's lifeworld.

As a part of the ambition to create comfort, the RNs strive to understand their own way of acting and how it can influence the patient and the

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5098 - DOI: 10.3402/qhw.v5i2.5098

significant others. It means that the RNs have trust in themselves, and that the care can be accomplished in a calm and safe environment.

Discussion

The result of this study reveals that the meaning of the phenomena is to prepare and create conditions for the care, and accomplish care close to the patient. This means to encounter the unknown. It means to sometimes have an unprejudiced encounter with the patient and sometimes prepare for the encounter. In the encounter the patient's and the significant others' lifeworld is the foundation for how the RN will accomplish the following care (Dahlberg et al., 2008). The RNs have a holistic perspective on the care, and in the encounter with the patient the RNs ambition is to be there for the patient and significant others to give comfort. The collaboration with their colleagues' and other healthcare authorities is the foundation as well as the condition for the RN's responsibility.

The medical and nursing care

According to the medical and nursing care, it can be understood as that the RNs take responsibility from a medical perspective. They create conditions for the care with their medical and other technical equipment. This understanding of the phenomenon is close to the technical skills and abilities that the RNs must be able to perform. This is understood as the medical treatment being involved in the care. It can also be understood as a classic professional nursing perspective. On the other hand, it can have its foundation in the specific ambulance care setting and its preconditions. Is it depending on a caring culture, the nursing profession or something else? These questions prompt further studies.

From a deeper understanding, this responsibility for the medical treatment and equipment can also be a responsibility for the care from a caring perspective. The medical assessment is the beginning of the encounter with the patient. The encounter starts during the RNs first assessment of the patient's physical needs. According to Elmqvist, Fridlund, and Ekebergh (2008), an image of the inseparable relation between the medical and nursing care perspective in the ambulance care setting emerges. From this emanates an understanding that the RNs through their responsibility for the medical care also create opportunities for the patient to be responsible. Elmqvist et al. (2008) show that the patients in the prehospital context, experience a feeling of being confirmed and "being someone" while the prehospital crew takes responsibility for the medical treatment and guide the patient through this, constituting a way of regaining the control of their own life. We understand it as, when the RNs takes responsibility for the medical treatment the patient experience that their autonomy is taken care of, they need not to take care of their vital functions and can instead concentrate on being someone. Even if the vital functions are unstable, the patients still have some level of autonomy, they can "be someone". It is still a unique human being that the RNs encounter, even if the patient is in total need of the RNs' care. In some situations the RNs invite the patient to participate in the care, even if the patient is badly injured or has a serious disease. The RNs take from this understanding responsibility for the patient's responsibility. The patient can be responsible to mediate his or her own experiences.

The encounter with the unique human being

The RNs' experience of the phenomena is that they have a great responsibility and to take responsibility while accomplishing care close to the patient involves the patient. Their ambition is to encounter the unique human being. The patient and the significant other are encountered as persons (Buber, 1997) whose experiences are important for the following care. The RNs try to assess and accomplish care based on the patients' individual needs. This can be understood as Gastmas (1999) points out, that the caring aspect of nursing involves the encounter with the patient as a unique human being but also to integrate a caring attitude where the patient's need is put first. The present study emphasises the meaning of the RNs' responsibility, as emerging from the patient's experiences, even if it is not shared or fully understood by the RN. The patients have their own lifeworld and the RN respects it. This can be understood as an ability to step out of their own personal preference and put the unique patient or significant other first (Gastmas, 1999), in line with bracketing in the phenomenological view expressed by Husserl (1913/2004). Husserl means that the way to understand something is through the lived experience, and that this need a capability to put your earlier assumptions and apprehensions in parenthesis. The present study points in this direction within the RNs where it is important to unprejudiced encounter the patient, and the patient's lived experiences are the RNs starting point. The RN tries to reveal the patient's own experiences, and when they do this they confirm the uniqueness of the patient. This lived experience is protected by the RNs and they take responsibility for treating the patient with respect. When the RNs have the ambition from

this understanding to take responsibility they sometimes experience it as difficult (cf. Sandman & Nordmark, 2006).

A responsibility with elusive boundaries

The present study points at an understanding, that the responsibility for the care is based on the actual care situation. At the same time, the responsibility is greater than being limited to this. The understanding of the extent of the RNs' responsibility is that it goes beyond the boundaries of the emergency ambulance care setting.

The present study reveals that the RNs care from a dynamic approach, and that they cannot leave the responsibility if another healthcare or a social authority is not taking over. This can be understood from both Lögstrup (1994) and Levinas (1996), and their understandings of the relation to the other. The RNs' responsibility is new and understood in a unique way in every encounter with the patient or significant other. The actual care situation sets the boundaries for the responsibility, which cannot be reduced to any kind of treatment or setting. This gives us new understandings of the complexity of the responsibility in the ambulance care setting. To work in the ambulance care setting often means to solve the situation with one colleague. The RNs experience that they have to take the responsibility or otherwise no one will. An understanding in line with Lögstrup (1994), while he holds that the responsibility is constant and someone must take it. In the ambulance care setting this is different from other care settings (e.g., in hospitals). In other settings the responsibility for the patient can be shared with other healthcare professions, but in the ambulance care setting the RN alone has the highest responsibility (Suserud, 2005). Through the light of the present study this can be understood as the RNs experiencing a responsibility that sometimes goes beyond their profession. We understand it as that the RNs do not primarily take responsibility as professionals but take responsibility because they are humans who encounter another human being in need of support and therefore the limits for their responsibility are not so clear. This can be understood from studies of the nurse–patient encounter in the psychiatric care setting (Sjöstedt, Dahlstrand, Severinsson, & Lützén, 2001; Walsh, 1999). While the encounter becomes a human-to-human act (Buber, 1997), we understand it as the boundaries becoming more elusive. The experience of the responsibility in this understanding is subjective and difficult to manage with general guidelines. The RNs' experiences of responsibility are strongly connected to the encounter with the patient at hand. At the same time it goes beyond the present and reaches into an unknown future.

Methodological reflections

Phenomenological studies are always contextual and the outcome of the actual study is a general structure of the phenomenon (Dahlberg et al., 2008). The meaning of the phenomenon can be used to generate an understanding of the complexity of working as an RN in the ambulance service, sparsely researched before. This knowledge can be used in developing the RNs' profession in the ambulance care setting, and education, not at least in the specialist nurse education in the ambulance and prehospital context.

In the present study we have studied RNs' lived experiences and in the interview situations the first author was rigorous, and asked sometimes naïve questions in order to not take anything for granted. This was maintained according to be aware of the influence of intersubjectivity and to put the scientific attitude in front (Dahlberg et al., 2008). Validity can be questioned in this kind of research, if validity is equal to the ambition to remain objective. Validity has been maintained through our ambition to remain open for the studied phenomenon and a true willingness to understand it (Dahlberg et al., 2008). To eliminate subjectivity in any kind of research, qualitative or quantitative, is a utopia according to Giorgi (2002). Instead of trying to eliminate it we have tried to acquire knowledge with the subjectivity as a resource, while we have executed the interviews as well as the following analysis. Hence subjectivity has been used in that way, we have been aware of and tried to bridle our pre-understandings. This means that the results have been critically questioned and discussed over and over again until the studied phenomenon through the RNs descriptions emerged. Both authors were active in the analysis and careful not to subjectively interpret the material, a process that required a rigorous and self-critical attitude. Despite this there is always a risk that the final findings convey traces of the researchers own pre-understanding.

The findings of the present study can be used to describe the experiences of RNs according to their responsibility. The care setting in the ambulance is in many ways unique, so the findings are related to this context. Even if the RNs' experiences in some ways are similar with other contexts, this study only represents one ambulance care setting. Other RNs with focus on autonomous work can find some of the present findings meaningful. In order not to step out of the ambulance care setting, we have not named this context, the prehospital emergency care setting,

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5098 - DOI: 10.3402/qhw.v5i2.5098

since it involves several other authorities than the ambulance service.

Acknowledgements

The authors would like to thank the RNs who participated in the study, Sörmlands County Council the R&D Center/Center for Clinical Research and Mrs. Bodil Bergman Hughes, Mr. Michael Hughes and Mr. Ola Sonmark for helpful linguistic revision.

Conflict of interest and funding

The authors have not received any funding or benefits from industry to conduct this study.

References

Adams, J. G., Arnold, R., Siminoff, L., & Wolfson, A. B. (1992). Ethical conflicts in the prehospital setting. *Annals of Emergency Medicine*, *21*(10), 1259–1265.

Ahl, C., Hjälte, L., Johansson, C., Wireklint-Sundström, B., Jonsson, A., & Suserud, B.-O. (2005). Culture and care in the Swedish ambulance service. *Emergency Nurse*, *13*(8), 30–36.

Bruce, K., Suserud, B.-O., & Dahlberg, K. (2003). Initial assessment in ambulance nursing. Part two. *Emergency Nurse*, *11*(1), 14–18.

Buber, M. (1997). *Du och jag* [You and I]. Ludvika, Sweden: Dualis.

Dahlberg, K. (2006). The essence of the essences – the search for meaning structures in phenomenological analysis of lifeworld phenomena. *International Journal of Qualitative Studies on Health and Well-being*, *1*(1), 11–19.

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research*. Lund, Sweden: Studentlitteratur.

Dalton, A. L., Limmer, D., Mistovich, J. J., & Werman, H. A. (2007). *Advanced medical life support. A practical approach to adult medical emergencies*. Upper Saddle River, NJ: Pearson Prentice Hall.

Elmqvist, C., Fridlund, B., & Ekebergh, M. (2008). More than medical treatment: The patient's first encounter with prehospital emergency care. *International Emergency Nursing*, *16*, 185–192.

Gastmas, C. (1999). Care as a moral attitude in nursing. *Nursing Ethics*, *6*, 214–223.

Gentil, R. C., Ramos, L. H., & Whitaker, I. Y. (2008). Nurses' training in prehospital care. *Revista Latino-Americana de Enfermagem, 16*(2), 192–197.

Giorgi, A. (2002). The question of validity in qualitative research. *Journal of Phenomenological Psychology*, *33*(1), 1–8.

Hjälte, L., Suserud, B.-O., Herlitz, J., & Karlberg, I. (2007). Why are people without medical needs transported by ambulance? A study of indications for pre-hospital care. *European Journal of Emergency Medicine*, *14*, 151–156.

Husserl, E. (1913/2004). *Idéer till en ren fenomenologi och fenomenologisk filosofi* [Ideas pertaining to a pure phenomenology and to a phenomenological philosophy]. Stockholm, Sweden: Bokförlaget Thales.

Levinas, E. (1996). *Basic philosophical writings*. In: A. T. Peperzak, S. Critchly, & R. Bernasconi (Eds.), (pp. 33–64). Bloomington, IN: Indiana University Press.

Liaschenko, J., & Peter, E. (2004). Nursing ethics and conceptualizations of nursing: Profession, practice and work. *Journal of Advanced Nursing*, *46*(5), 488–495.

Lögstrup, K. E. (1994). *Det etiska kravet* [The ethical demand]. Göteborg, Sweden: Daidalos AB.

Marks, P. J., Daniel, T. D., Afolabi, O., Spiers, G., & Nguyen-Van-Tam, J. S. (2002). Emergency (999) calls to the ambulance service that do not result in the patient being transported to hospital: An epidemiological study. *Emergency Medicine Journal*, *19*, 449–452.

Melby, V. (2000). Experimental learning in pre-hospital emergency care. *Nurse Education Today*, *20*, 638–645.

Melby, V., & Ryan, R. (2005). Caring for older people in prehospital emergency care: Can nurses make a difference? *Journal of Clinical Nursing*, *14*, 1141–1150.

Myhrvold, T. (2003). The exclusion of the other: Challenges to the ethics of closeness. *Nursing Philosophy*, *4*, 33–43.

Nordvedt, P. (2001). An inquiry into some rival moral considerations in nursing care. *Nursing Philosophy*, *2*, 112–121.

Sandman, L., & Nordmark, A. (2006). Ethical conflicts in prehospital emergency care. *Nursing Ethics*, *13*(6), 592–607.

SFS (2003:460). The act concerning the ethical review of research involving humans. *The Ministry of Education and Cultural Affairs*. Retreived April 2, 2009, from http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=2003:460

Sjöstedt, E., Dahlstrand, A., Severinsson, E., & Lützén, K. (2001). The first nurse–patient encounter in a psychiatric setting: Discovering a moral commitment in nursing. *Nursing Ethics*, *8*(4), 313–327.

SOSFS (2000:1). *Socialstyrelsens föreskrifter och allmänna råd om läkemedelshantering i hälso- och sjukvården* [The Swedish national board of health and welfare: Regulations and general advices according to medicine management in health- and medical services]. Stockholm, Sweden: Socialstyrelsen.

Suserud, B.-O. (2005). A new profession in the pre-hospital care field – the ambulance nurse. *Nursing in Critical Care*, *10*(6), 269–271.

Suserud, B.-O., & Haljamäe, H. (1997). Role of nurses in prehospital emergency care. *Accident and Emergency Nursing*, *5*, 145–151.

Suserud, B.-O., & Haljamäe, H. (1999). Nurse competence: Advantageous in pre-hospital emergency care? *Accident & Emergency Nursing*, *7*, 18–25.

The National Association of Emergency Medical Technicians (2003). *PHTLS – basic and advanced prehospital trauma life support*. St. Louis, MO: Mosby.

Wahlin, U., Wieslander, I., & Fridlund, B. (1995). Loving care in the ambulance service. *Intensive and Critical Care Nursing*, *11*, 306–313.

Walsh, K. (1999). Shared humanity and the psychiatric nurse–patient encounter. *Australian and New Zealand Journal of Mental Health Nursing*, *8*(1), 2–8.

Weiss, P. B. (1998). Fire/EMS: An examination of cultural differences. *Fire Engineering*, *151*(9), 73–79.