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From Practice to Theory – How the Basic Concepts Appears in a Perioperative Practice

Lillemor Lindwall, PhD, RN

Associate Professor, Department of Nursing, Karlstad University, Karlstad, Sweden
Professor, Oslo and Akershus University College of Applied Sciences, Oslo, Norway

Irène von Post, PhD, RN

Department of Caring Science, Åbo Akademi University, Vasa, Finland

Correspondence : Lillemor Lindwall, Department of Nursing, Karlstad University, 651 88 Karlstad, Sweden E-mail: Lillemor.Lindwall@kau.se

Abstract

Aim: *The aim* of the study was to describe how the basic concepts, human being, health, suffering, caring and culture appear in perioperative practice in order to obtain an understanding of the concepts in practice.

Methods: A hermeneutic text interpretation of results from ten previous studies and reports from perioperative research meetings with co-researchers was conducted in order to gain an understanding of the concepts in practice.

Results: The basic concepts were understood as; *The human being – the patient and the nurse.* Patient is a suffering human being who has been betrayed by the body; a body that needs to undergo surgery. Nurse - the caring human being, whose ethos is embedded in human dignity and emerges in their caring acts. *Health – to be a unique human being:* someone who wants to be taken seriously wants to become involved, to be considered a resource and to establish a communion. *Suffering – a struggle between good and evil:* Suffering exists in different forms. Suffering in care can be a result of the staff behaviour towards the patient and towards each other, how caring/the work is organized, or how the nurses' time with the patients is planned. *Caring – to be there for the patient;* the nurses' care for the patient, taking the patient seriously and safeguarding the patient's dignity. *The culture – material and spiritual culture:* human dignity is the ethos of the perioperative culture and appears as confirmed or violated dignity and value conflicts.

Key words: basic concepts, caring theory, perioperative practice, hermeneutic

Introduction

Developing concepts is essential and important for caring research and for developing of new knowledge in caring science and praxis (Fawcett 1984). To think about concepts is to strive towards gaining new knowledge about the reality we live in, irrespective of whether it concerns the world of practice or science. Concepts link science,

the theoretical knowledge, through thinking, with the practical, resulting in the art of caring (Eriksson 2010). According to Gadamer (1989) concepts and language are closely related. Gadamer utilizes the term concept formation for the natural formation of concepts taking place within the language and also as part of the scientific conception of reason in pure thinking. The search for

epistemological and basic concepts in practice is expected to provide a special meaning to caring and a depth to reality. With the help of reflection on concepts, horizons can be widened and new depths detected (Lindström et al 2010). The basic concepts evolved from Fawcett (1984) and later presented to the international nurse organization ICN (2012) are; human being, health, caring and culture. The basic concepts have been developed through a central interest in creating caring science knowledge (Alligood & Marriner Tomey 2012) but they give no guidance for research or clinical practice. Eriksson (2008) has also described suffering as a basic concept, because health care aims to alleviate suffering and restore health. On this basis the basic concepts will be described as they have shown in previous results from research in perioperative practice.

In Eriksson's (2010) caritative theory the basic concepts are described as; the human being is an entity of body, soul and spirit. Every human being is unique and vulnerable with different abilities, creating, thinking and reflecting. The body is seen as a carrier of health and suffering, an abode for the soul and spirit. In the body there is a movement between health and suffering (Lindwall 2004). Health is perceived as becoming – a movement towards a more profound wholeness, multi-dimensional and relative as well as being more of an absence of sickness. Suffering and health belongs together and the ultimate purpose of caring is to alleviate suffering (Eriksson 2008). Suffering is described as; Suffering related to illness, to nursing and suffering related to life. *Caring* has been described as playing and learning through faith, hope and love (Lindström et al 2010). In caring science, the world/environment is described as culture (Eriksson 2010; Lindström et al 2010; Alligood & Marriner Tomey 2012). The culture is created by the humans that are part of and have been part of a given practice. The basic concepts have been described based on the characteristics of each practice. The characteristics of caring in practice have

earlier been described as a patient's illness, treatment methods, prognosis, and demands for competence of the nurses as well as the patient's ability to recover but are not founded on basic concepts (Marriner Tomey & Alligood 2012). This study tries to bring clarity about the basic concepts how they appear in a perioperative practice. How the concepts are used in the development of knowledge and research in its broadest sense and seen in theories and theoretical models (Eriksson 2010).

Previous perioperative research has focused on breast cancer surgery and women's worry (Metsälä et al 2011), on patients' experiences of soothing music (Nilsson 2009), and also on patients' experiences after ostomy surgery (Persson & Hellström 2002). Some research shows operating theatre nurses' intraoperative nursing (Kilvered et al 2011) procedures to create confidence based relationships to guarantee patient safety (Gustafsson et al 2007) and Liaschenko & Fisher's (2003) described typology of knowledge used in perioperative practice. It has been difficult to find unique descriptions of the basic concepts as they appear within perioperative research. According to Bond et al. (2011) there is a lack of useful nursing theories in nursing research.

Eriksson's theory (Lindström et al 2010) have been implemented in perioperative practice and described caring in practice (Lindwall & von Post 2009). Perioperative nursing was introduced in the U.S. in the 1970s (AORN 1985) and in Scandinavia by Panelius & Varisto (1989). In the early 1990s our interest in perioperative care arose as we became aware that it is something more than carrying out the ordinations as a nurse anaesthetist or operating theatre nurse (in the following named nurses). Since perioperative practice is organized and managed differently in Sweden compared to the U.S, perioperative nursing had to be defined in relation to Swedish conditions as: *Perioperative nursing includes the perioperative caring of the nurse anaesthetist or operating theatre nurse, as well as the perioperative dialogue in the caring process, i.e. the nurse's pre-, intra-*

and postoperative dialogue with the patient, as well as surgical treatment and techniques, i.e. the practical methods the patient is exposed to in order to improve health and save life. Perioperative nursing can also be seen as a way to lead and organize the work performed within an operating theatre (Lindwall & von Post 2008 p 13).

Aim

The aim of the study was to describe how the basic concepts, human being, health, suffering, caring and culture appear in perioperative practice in order to obtain an understanding of the concepts in practice.

Methodology

In order to describe the basic concepts a secondary analysis was chosen (Thorne 1994). Secondary analysis is a hermeneutic circle where researchers through hermeneutic text interpretation, re-interpret previous research and gain new pre-understanding, an understanding that leads to new questions being asked in order to create new knowledge (Gadamer 1989). Secondary analysis involves the re-use of pre-existing qualitative data and can be used to verify findings of previous research (Allgood & Marriner Tomey 2012). The hermeneutic circle where the interpretation moves from the whole to parts and back to the whole can be understood as a secondary analysis of previous results (Thorne 1994). Gadamer focus on pre-understanding, fusion of horizons and emphasized that those who express themselves and those who understand are connected by a common human consciousness that makes understanding possible.

Ethical considerations

Good scientific practice according to the National Advisory Board Ethics (2002) was the guideline through the entire research process. All participants in previous studies (table1) were given adequate information throughout the entire research process and ethical principles were taken into consideration in accordance with the Helsinki

Declaration (MFR 2002) which consists of research ethics that safeguard anonymity and integrity.

Data collection

The data, the text was the findings from the authors previous research conducted between 1995 -2010 (table 1) and notes from research meetings with co-researchers, nurses from practice. The scientific leader was interpreter of the caritativa caring science theory (Eriksson 2002, 2008). The co-researchers professional pre-understanding are based on caring science, encompassing nursing as nurse anaesthetists and operating theatre nurses, the clinical context experiences, ethical value, and medical knowledge.

Hermeneutic text interpretation

Gadamer (1989) highlighted the meaning of language for creating the world in which reality can be revealed and interpreted. The text should be understood not the author's intention. In this case the text is results from previous research (table 1) and notes from reaches meetings. The text was interpreted by help of hermeneutical text interpretation (Lindwall & von Post 2010a) based on Gadamer's hermeneutics. Understanding of a text is based on the reader's professional pre-understanding. According to Gadamer, all people have an existential pre-understanding of life. However, professional pre-understanding should not be understood as existential pre-understanding but rather as pre-understanding arising from the profession one investigates. The researcher's professional pre-understanding is made up of a caring science perspective encompassing nursing as nurse anaesthetists, medical knowledge and ethical values. The profession can aid or veil seeing. It is a process designed to push aside the "Maya's veil", i.e. to chase away the prejudices that block one's vision and see what actually appears in practice. Pushing the veil aside means that researchers and co-researchers use each other and theory to try to go beyond the obvious and reflect on what they really saw and what they overlooked (Lindwall et al 2010a).

Integrating the text with the reader. In order for the approach to the text to be as unprejudiced as possible it was not read or interpreted until the data collection was completed and compiled as a single text. The text was allowed to 'express itself' (Gadamer 1989). The first reading was an open reading exercise, which means that the reader asked what the text has to say. While reading, questions emerged such as; *Are there descriptions of the basic concepts in the text? – Yes there are. Fusion of horizons.* The text was read with an open mind so that the text could 'speak for itself'. Gadamer (1989) states that having a dialogue with a text leads to a 'fusion of horizons', that is the horizon of the text and the horizon of the reader are brought into relation with each other. From this fusion of horizons it became obvious that the basic concepts would be described in the results. *Putting new questions to the text.* The following questions arose when the researcher transcended the horizon of the text as well as their horizon: How are the basic concepts human being health, suffering, caring and culture described in the text? Movements back and forth throughout the text took place to discover answers to the questions with common and distinguishing qualities (Lindwall et al 2010a). *Summarizing the main and subthemes.* The text with the expressions was carefully read through to search for the common feature of all significant descriptions of the basic concepts human being, health, suffering, caring and culture. *The new understanding,* presentation and descriptions of the basic concepts. The process of understanding involved abstraction of the concepts to form a new understanding; a coherent whole which was deemed valid and free from contradictions (Lindwall et al 2010a).

Results

The basic concepts as they appear in a perioperative practice describes as: The human being – the patient and the nurse; Health – being allowed to be a unique human being; Suffering – a struggle

between good and evil; Caring – to be there for the patient; and environment as we have chosen to describe as Culture – material and spiritual culture.

The human being, the patient and the nurse

The patient - the suffering human being who is about to undergo surgery

The patients could be children, young or older human beings. In perioperative practice the patients have been betrayed by their body, and the body needs to undergo surgery. Some elderly patients are worried before surgery and will need help from family and friends after surgery. Patients who are given the time, will tell their stories about hopes, joys and sorrows in everyday life, memories of the life they have lived and experiences from previous surgery and anaesthesia. The patient becomes his/her story, present and future, memories that have given power and courage in everyday life, but also fears, loneliness and despondency. The patient will be allowed to be somebody, a unique human being with their own identity and integrity. Patients wish to talk about their early life, now as well as life after surgery. The body is the dwelling for life-giving forces, and limitations of the human being. When everyday life is changed abruptly, the situation erodes the person's energy. When the body is changed, undergoes surgery or is seen as an object, the patient sees it as mysterious and vulnerable. The body, which through its unique language tells the surrounding world how it feels. The body fights a constant battle in order to preserve the human being as an entity and strives to be whole again. In connection to surgery, the patients have to surrender the body and the control of it to others, which makes them lose power and control of their body.

Table 1. Previous perioperative care research

Author and title	Methods
1. von Post, I. (1995) Den perioperativa dialogen – Kontinuitet i vården. (The perioperative dialogue – continuity in caring)	Narrative method, nurses' narrative descriptions
2. von Post, I. (1996) Exploring Ethical Dilemmas in Perioperative Nursing Practice, Through Critical Incidents.	Hermeneutical design, Critical incident method
3. von Post, I. (1998) Perioperative nurses' encounter with value conflicts. A descriptive study.	Critical incident method and hermeneutical text interpretation
4. Lindwall, L. von Post I. & Bergbom I. (2003) Patients' and nurses' experiences of perioperative dialogues.	Hermeneutical design, interviews with patients and nurses.
5. Lindwall, L. (2004) The body as a carrier of health and suffering.	Hermeneutic and phenomenological design, interviews with patients and nurses.
6. Lindwall, L. von Post I. & Eriksson K. (2007) Caring Perioperative Culture, its Ethos and Ethic.	Hermeneutical approach
7. Lindwall, L. & von Post I. (2008) Habits in perioperative nursing culture.	Hermeneutical approach, Focus group discussions and hermeneutical text interpretation
8. Lindwall, L. & Bergbom I. (2009) The altered body after breast cancer surgery.	A phenomenological approach, interviews with patients
9. Lindwall, L. Lindberg AC. Daleskog I. & von Post, I. (2010b) Older patients undergoing surgery - a hermeneutical study.	A hermeneutic approach and applications research
10. Sundin, Y. von Post I. & Lindwall L. (2010) Perioperative care for older patients: a hermeneutical study.	A hermeneutic approach and applications research

The nurse – the caring human being

The professional nurses whose ethos, the profoundly ethical, is embedded in dignity and appears through the caring acts of the nurses when they have confidence, are there for the patient, have courage to take the patient seriously, take responsibility, take on someone else's burden, want to protect and safeguard and take the patient under their wings to tend and care for the patient's body. A professional nurse has the ability, the will and the courage to use their natural ability to care for another human being, someone other than a close relative. Being professional means having a profession, having knowledge based on science and empiric experience, an ethical

code which controls actions and demands that the nurse approaches the patient with dignity irrespective of who the patient is or what the patient has done. A professional nurse has an ethical approach, suffers in silence and is compassionate towards the patient, listens to the patient's cry for help and acts as the patient's spokesperson. What the nurses do, they do for the patient. They are the patient's protection. The nurses have the courage to see the patient being humiliated and feel their own humiliation, the courage to stop and prevent further humiliation. The nurses feel guilty and are ashamed when the patient's dignity is violated, when other healthcare

professionals behave in an impolite way, when others expose the patient's body and when they cannot provide the standard of care they want to. In these cases the nurses will be in conflict with themselves.

Health – being allowed to be a unique human being

The basic concept health in perioperative practice means being a unique human being and, as a patient, being allowed to be by their nurse who wants to make time for the patient, someone who takes the patient seriously, who creates a calm atmosphere and someone to whom the patient can hand over responsibility. For the patient, health means becoming involved, being considered a resource, establishing a sense of communion, making others feel that I am a human being. The patient experiences well-being when the body is resting comfortably and is touched by the soft, loving and confident hands of the nurses. Health means being received by a familiar face, a trusting nurse in the operating theatre. Well-being means being allowed to quietly speak to a nurse before the surgery about things that cannot be mentioned to just anyone, the small but very important details. Being allowed to tell one's story and being listened to, and also, through the postoperative dialogue, being allowed to thank the nurse who spoke for the patient, and controlled and safeguarded the body during surgery. This is related to health and dignity.

Suffering – a struggle between good and evil

In perioperative practice, the suffering of the patient emerges as fear of the unknown, that the body will not be controlled, of waking up during surgery or of not waking up afterwards. Being dependent on others can be seen as

suffering, as well as the feeling of losing control over the body and its functions during surgery. Suffering becomes pain when the body is struck by injury or illness, when anaesthesia is to be used or is not working and if no one believes the patient that talks about pain. Suffering can be waiting for one's turn to undergo surgery or being taken off the operating list to wait even more. In the postoperative phase suffering can arise when the body is injured or is infected after an operation. The patient is exposed to suffering if the body is exposed in a careless way or rendered nude during preoperative preparations. Suffering could be caused by staff when they are rude to the patient, or when they argue or correct one another in front of the patient. It could also happen when someone on the staff is rude to the patient's nurse, who is someone they trust. The patient has to endure this kind of suffering, as it is impossible to escape the situation. Having to listen to the private talk of staff in the operating room and not feeling part of the conversation when the patient is awake creates a sense of alienation. The nurses experience suffering when they are caught in ethical conflicts, ethical dilemmas or value conflicts or when they become conflicted with themselves against their own will. The nurses' freedom to choose has been eliminated and they stay silent and suffer. They suffer alone with the patient and feel bad, guilty and ashamed.

Caring – being there for the patient

The basic concept caring emerges in a perioperative practice as; caring for – having room in one's heart for the patient; trust – approaching the patient with respect; responsibility – taking on and taking the patient seriously; safeguard – taking under one's wings; bodily care – nursing the body and having the courage

and the will to be there for the patient. Every caring act is an ethical act that can be carried out if the organization creates continuity that makes it possible for the nurse and the patient to be there for one another. The perioperative dialogue is seen as a caring act that creates the prerequisites for the patient and nurse to meet in a professional way. The nurse has the courage to care for and take the patient seriously, approaching the patient with respect and protecting them against the unknown.

The perioperative dialogue

From a caring science perspective (Eriksson 2002) 'the perioperative dialogue' was developed; as an ideal working model (Lindwall & von Post 2009) for how perioperative caring could be organized so the caring process could guide the nurses. The ideal model is based on ethics and its ethos is human dignity, the duty to think and act correctly (von Post & Eriksson 2000). The idea of the perioperative dialogue has been expanded in Buber's (1989) thoughts about the dialogue, an interpersonal meeting between two human beings who want to share experiences. The perioperative dialogue has been defined as: *The perioperative dialogue is the operating theatre nurse's pre-, intra- and postoperative dialogue with the patient that she is caring for at the time of a surgical procedure and aims to alleviate the patient's suffering, safe-guard the patient's dignity, create well-being and become a life-giving event that the patient will remember as good. The purpose is also to make the perioperative dialogue useful as a guide for the operating theatre nurse's future caring work and a guide for the nursing managers as they plan and organize the perioperative caring work* (Lindwall & von Post 2009 p 396).

Through the nurses dialogues the responsibility goes longer than pure duty, as trust is ethical and cannot be transferred to anyone else (Levinas 1988).

The preoperative dialogue creates the prerequisites for the patient and the nurse to meet before the surgery. Caring as making time for the patients means that they are given time to tell their story in peace and quiet, to talk about what they hope for in everyday life and about their worries about how their body will be able to handle the surgery and about life after surgery in a changed body. The nurse and the patient have time to plan the care together (Rudolfsson et al 2003). *The intraoperative dialogue* starts when the patient is received by a familiar face in the operating room, i.e. by the nurse who has promised to be there for the patient during surgery and anaesthesia. The nurse has prepared the operating room so that the patient feels welcome. The patient shows trust and surrenders the body to the safe hands of the nurse. *The postoperative dialogue*, the final dialogue, gives the patient the opportunity to talk to the nurse who was present during the process and might fill in the gaps. The patient is also given the opportunity to thank the nurse that was there the whole time. The perioperative dialogue will be carried on within each of them as an event to remember with joy.

The culture – material and spiritual culture

Culture is described as material and spiritual culture and is characterized by the habits that have shaped the culture. The habits of perioperative culture have been shaped and are shaped through the values of nurses, values that are nurtured through practice. Habits are predominant, unreflecting and quiet, but not always allowed to be spoken about. Some habits

give room for development, while others limit the ability for change and create a non-permitting atmosphere. The cultural spirit is repressed through language. In perioperative culture, habits have been shaped through the different ethos of the material and spiritual culture.

The perioperative *material culture* is characterized by the empty walls of the operating room, advanced technical equipment, green and blue textiles, hissing and cooling ventilation and fluorescent lighting. Today, the material culture seems to be productivity. Traditions and habits that characterize the material culture alienate the nurse from the patient, as technology competes for her attention. Habits that set the tone in the material culture can be understood as the hidden power structure, achieving more in less time. Ideas controlling how caring work is organized and managed are taken from the habits of industry, the assembly line principle, with an ethos of productivity. In the material culture the patient is seen as a diagnosis, a procedure or something to be produced as quickly as possible.

In *the perioperative spiritual culture*, education (Gadamer 1989) emerges, as well as the humanities through ideals, upbringing, morals and habits of persons which are active and promoted in the culture. It is the spirit, the nurse's will to be there for another person that gives rise to the spiritual culture. Human dignity is the ethos and the core of the perioperative culture and its ethic is the good moral character of the nurse. Good sense and good will, caring acts that the nurse performs for the sake of the patient's well-being. Human dignity emerges through the spiritual culture as confirmed dignity, violated dignity and value conflicts. Habits in the perioperative culture promote ethical values, when a temporary

friendship evolves between the patient and the nurse, when they show mutual respect and when the nurses are given time for reflection about ethics and caring. Habits that hinder progress are seeing the patient as a surgical case, not acknowledging each other and not talking about ethics and caring. Dignity, the ethos of the spiritual culture, becomes evident through the behaviour of the nurses and through the values that control the choice of caring acts. In a caring culture, a human being does not acquire knowledge in a critical fashion, but as a participant. The results from previous studies (Lindwall & von Post 2009, see table 1 study 1-10)) can help us to understand the basic concepts in a new way and develop a perioperative theory in the future.

Reflections

The results make us aware of the importance of reflecting on the basic concepts that exist in a perioperative practice and its culture. The healthcare professionals are responsible for the habits created in perioperative culture and thereby for how to understand the human being, health, suffering and caring. In the operating room, a material and spiritual culture exists in the same room and time (Lindwall & von Post 2008). Through the demands of technological equipment, the material culture often takes over and competes with the patient for the attention of the nurse. The spiritual culture awards some space for the nurse to have the will to be there for the patient and preserve the patient's dignity. When the material culture takes over practice, the patient is rendered as an object or a symptom, and is no longer a unique human being. The material culture shall not be seen as opposed to the spiritual culture, but rather as a complement. But on the other hand, the spiritual culture must not be seen as a

complement to the material culture, but as a necessary and effective part of the culture. The human beings in the culture decided whether the ethos of the spiritual culture should be given room or whether the ethos of the material culture should prevail in practice (Lindwall & von Post 2008). When the values in the material culture take over, the nurses feel that they are caught in a conflict of values, a personal inner conflict (von Post 1998). Nurses should have the courage to put and stop to the spread of the material culture and make room for the spiritual culture which strives for a loving atmosphere which gives the culture meaning and is seen as ethical, aesthetic and safe (Lindström et al 2010, Lindwall & von Post 2008). If dignity, the ethos of perioperative care, is excluded, the patient might be exposed to suffering in care and the nurses end up in ethical dilemmas. Vulnerability becomes evident in the perioperative culture, when both patients and nurses have to make difficult choices, when experiencing unbearable suffering or rude behaviour of other human beings (von Post, 1998). The description of basic concepts is the responsibility of clinical caring science, partly to carry research forward and partly to create innovation within clinical research (Alligood & Marriner Tomey 2012). Contextual research is a necessary prerequisite for the development of fruitful applied research and theories.

Co-researchers were nurse who participating in the research with experiences and reflections from perioperative practice. They came from hospitals in Middle Sweden and were interest in perioperative care. However, we have not been able to talk to those nurses who are more interested in advanced technological equipment, which

can be seen as a limitation. The pre-understanding of both researchers and co-researchers has offered opportunities as well as limitations when observing practice and developing the major concepts from practice to theory. Secondary analysis (Thorne 1994) can be conducted from new questions, if the data is still current, both with the same researchers and new. This offers an opportunity for rich data but also comes with limitations as data can be produced with another purpose or data collection and analysis methods can be incongruous. Furthermore, previous data can have already created a rich pre-understanding in the researcher.

Conclusion

The basic concepts from perioperative practice have been presented by the following axiom;

The human being – the patient and the nurse. Patient is a suffering human being, who has been betrayed by the body, a body that needs to undergo surgery. *The nurse*, a professional human being whose ethos, is embedded in human dignity and appears through caring acts when nurses have courage to take the patient seriously and care for them. *Health – to be a unique human being:* someone who wants to be taken seriously wants to become involved, to be considered a resource and to establish a communion. *Suffering – a struggle between good and evil.* Suffering exists in different forms in a perioperative practice. Suffering in care can be a result of the healthcare professionals' behaviour towards the patient and towards each other, how caring/the work is organized, or how the nurses' time with the patients is planned. *Caring – to be there for the patient, in the perioperative dialogue.* The nurses care for the patient, by meeting the patient with respect, take the patient

seriously, safeguarding the patient's dignity and are the patients' voice. *Culture – material and spiritual culture* and human dignity should be the ethos of the perioperative culture. Human dignity emerges through the perioperative culture as confirmed dignity, violated dignity and value conflicts. Habits in the perioperative culture promote ethical values, when a friendship evolves between the patient and the nurse and when the nurses are given time for reflection about ethics.

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