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Metaphysics of love as moral responsibility in nursing and midwifery

Submitted by
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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy.

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November 2005
I certify that the thesis entitled ‘Metaphysics of love as moral responsibility in nursing and midwifery’ submitted for the degree of Doctor of Philosophy is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any university or institution is identified in the text.

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Date: 14-6-2006
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Publications, Presentations and Placement

Publications
Nursing Ethics. 7 (6): 481-491.


Presentations
Key note presentation (International conference):

Podium presentations (International Conferences):


International Discourse Placements

Department of Caring Science, 
Abo Akademi University, 
Finland. 
September/October 1998, (4-week visitation)

Researcher(s), staff or supervisor(s) with whom you worked
Professor Katie Eriksson PhD, (scholar and nurse theorist on caring science) 
Lisbert Lindholm PhD, Carola Warna, Maj-Britt Raholm, Terese Bondas-Salonen, Ingegerd Bergbom, academics specialising in human caring science.

Lecture:
Fitzgerald, L (1998) ‘The essence of love is the human desire for wholeness’, a research seminar to PhD students and academic staff at the Department of Caring Science, Abo Akademi University.

Centre for Human Caring 
University of Colorado 
Denver USA 
October/November 1998, (2-week visitation)

Researcher(s), staff or supervisor(s) with whom you worked
Professor Jean Watson PhD, (scholar and nurse theorist on human caring) 
Professor Sally Gadow PhD, philosopher 
Professor Marilyn Dee Ray PhD, (scholar and nurse theorist on human caring) 
Marlaine Smith PhD, Fran Reeder PhD, Amy Barton PhD, Phyllis Updike PhD specialists in human caring

Lectures:
Fitzgerald, L (1998) ‘Love and the caring relationship’ PhD students, School of Nursing, Health Sciences Centre, University of Colorado, Denver, 21 October.

Fitzgerald, L (1998) ‘Essences of love’ to PhD students and academic staff, a research colloquium and video-conference presentation, School of Nursing, Health Sciences Centre, University of Colorado, Denver, 27 October.

Fitzgerald, L (1998) ‘What is the difference between caring and love in human relatedness,’ PhD student presentation at the School of Nursing, Health Sciences Centre, University of Colorado, Denver, 28 October.
Summary

This study used a qualitative research design incorporating principles of social constructionism, hermeneutic dialectic method, Neo-Socratic dialogue and philosophy for reporting the tacit and social knowledge constructions underlying particular ways of knowing that inform the experiential reality of love in the practice of nursing and midwifery. The philosophy of Emmanuel Levinas, that culminated in his magnum opus of the ‘metaphysics of otherness’, provided the theoretical underpinning for the interpretation of the experiences nurses and midwives believed were examples of love in their clinical practice in Australia, Singapore and Bhutan.

What is love in nursing and midwifery? The answer is moral responsibility. The relational context has a nurse and midwife constantly exposed to patient situations that give rise to expressions of love as moral responsibility. It is a form of love that centres on the ability of our being, or at least the possibility of our being, to transcend its everyday form to a metaphysical state of being moral. It enables a nurse and midwife to transcend the isolation associated with their personal being as a self-project, to be ‘for’ the patient as a first priority. But while the ‘Goodness’ of the ‘Good’ assigns the nurse and midwife responsible and is expressed to their personal being in the form of the ‘urge to do’, ‘what to do’ in caring for the patient is a matter of living out the command to be responsible and will be different for each nurse and midwife. However, no matter the outcome, love as moral responsibility will always leave a nurse and midwife feeling there is still more to be done in being responsible.
Chapter 1: Introduction and Background.

1.0 Introduction.

This dissertation provides an answer to the question of what is love in nursing and midwifery. While the background to this study demonstrates that nurses and midwives believe their professional practice contains expressions of love, there is uncertainty about the relation of love to caring. In acknowledgment of the link between love and caring, the dissertation explores the extant literature on caring and its relation to the concept of love. Next, the study design describes the framework used to enable nurses and midwives to explicate their understanding of the love embedded in their clinical practice. The conclusions drawn by nurses and midwives, regarding love in nursing and midwifery, are then subjected to a philosophical analysis using Emmanuel Levinas’s philosophy of the ‘metaphysics of otherness’. In the final analysis it is my thesis that the form of love that is exemplified in the practice of nursing and midwifery is moral responsibility.

The demography of the study shows that 56 nurses and midwives participated in 6 Neo-Socratic dialogues that were held in Australia, Singapore and Bhutan. The background and professional experience of participants was varied and reflective of the diverse specialty fields of nursing and midwifery that included Aged Care, Child and Adolescent Nursing, Accident & Emergency, High Dependency, Critical & Coronary Care, Intensive Care, Acute Medical and Surgical Nursing, Operating Theatre & Recovery Room, Day Surgery, Oncology, Rehabilitation Nursing, Palliative Care, Midwifery, Women’s Health, Mental Health Nursing, Community Nursing, Naturopathy, Nurse Administration and Nurse Education, in urban and remote area locations. Each of the 6 Neo-Socratic dialogues is reported and used as data for construction of the thesis.
1.1 Background to the Study.

In 1992 the then Liberal State Government of Victoria, Australia implemented a mechanism for determining the financial resourcing of the acute health care sector called ‘Casemix Funding and Diagnostic Related Groupings’ (DRGS). The implementation of ‘Casemix Funding and DRGS’ resulted in the quantification of health care. While the effects of this policy have been widespread, the principle change has been to the way in which health care is delivered and health service costs controlled.

Given registered nurses are the people charged with the provision of care and represent the largest body of health care professionals within any acute hospital and community setting, it is easy to understand why this group was the prime target for change. With human resources comprising approximately 80% of all hospital and health agency budgets, the registered nurse population at this time was an easy target for budgetary reduction. While there was a fear that the introduction of ‘Casemix Funding and DRGS’ would result in a reduction of the number of registered nurses, this was not the case. Instead, the number of registered nurses across the State of Victoria slowly increased (2005). However, the introduction of ‘Casemix Funding and DRGS’, did give rise to the casualization of the nursing workforce, which peaked in 2001 with 60.2% of registered nurses working part-time in the State of Victoria (Australian et al., 2005). Because of the introduction of ‘Casemix Funding and DRGS’ the hospital environment where acute care nursing occurs changed. Today, nurses must care for a more debilitated and complex patient population in a shorter timeframe than ever before.
However, little serious attention has been given to the other side of the ledger with regard to the impact these paradigmatic changes have had on the human caring role within this new system of health care delivery; specifically, the impact these changes have had on the human caring role of nurses in the acute care hospital sector.

Anecdotal discussions with nurses since the introduction of ‘Casemix Funding and DRGS’ have shown that the nurses are highly critical of the changes these funding models have imposed on their caring practices. Without exception they openly express their concern at the quantification of health care and consequently nursing. Nursing has long been identified as both an art and a science. Nurses say that Casemix Funding and DRG models support the science of nursing and have impacted in negative ways on their practice of the art of nursing. The process of learning an art requires both mastery of theory and practice. If a nurse is to learn the art of nursing, that individual is not only required to learn the theoretical knowledge related to nursing (the science of nursing), but must also become competent in the practice of nursing where the blend of the two (art and science) gives rise to the development of the intuitive nurse practitioner, which is central to nursing as an art. Anecdotally, many nurses see the quantification of nursing as detracting from an individual nurse’s capacity to practice nursing as both an art and a science. For many nurses, Casemix Funding and DRG models have upset the balance of nursing as both an art and a science. The shift of nursing more toward a science of health care has resulted in them feeling distressed, confused and aggrieved at what they believe is the undervaluing of the human act of caring.

In addition, the community has voiced, and continues to voice, its concern about the standards of care expected from hospitals and community caring agencies. Since the introduction of ‘Casemix Funding and DRGS’ the press has been littered with articles addressing a variety of concerns, including for
example, the downsizing of the health care sector, unreasonable waiting times in accident and emergency departments, the severity of health funding budget cuts, closure of rural hospitals, health professional retrenchments, difficulty in accessing suitable health care services, problems with early discharge and the resultant increased morbidity, increased readmission rates, the increased stress health care professionals face in providing health care within a ever declining budget and environment, the difficulties of recruiting nurses with a general nurse shortage, and the premature retirement of nurses from the nursing profession.

This said, is it any wonder that it is difficult to engage registered nurses in dialogue about anything else but that which they identify as helping them with ‘getting all the work done’. It is a perception that is supported by my current experience of teaching registered nurses’ at the Post Graduate level, where nurses who work in specialities that involve ‘high’ science find it difficult to focus their thinking on nursing as an art and, in fact, actively resist it. Nurses do not devalue the tenets of holistic care, but find that, the increased acuity and medicalization of acute care, the short stay of the patient population, and the changing nature of the nursing workforce, have caused nurses to focus more on the ‘work tasks’ of nursing (involved in the science of nursing) as opposed to the holistic care needs of the patient (involving, in part, the art of nursing). Given this environment, the responsibility for the holistic care of the patient has been distributed among nurses and other health care workers to the point where a nurse’s individual responsibility for, and management of, the total care of the patient has been lessened. Consequently it comes as no surprise that nurses report that they hold in high esteem those of their colleagues who are able to embrace the responsibility of the patient as if the patient was them. But what is the quality of this nursing care that enables these people to engage another person in this way? For me, listening to my colleagues and discussing these ideas, the term ‘caring’ fails to capture the essence of what I and other
nurses appear to experience when in a relationship of the type just described, whereas the term ‘love’ seems more apt; not that the relations spoken about here occur everyday by every nurse because clearly this is not the case. While there are some nurses who are uncaring, equally there other nurses who are able to enact the role of a registered nurse and midwife in a way that is more than caring.

While the concept of ‘love’ appears in some literature and theories of caring (Watson, 1985, 2003, Ray, 1988, Eriksson, 1990, Eriksson, 1994), it remains to the most part poorly described. In discussions with nurses and midwives about ‘what it is to care’, all believed love was an integral component of their caring yet were unable to articulate the basis on which these beliefs were founded. From these anecdotal discussions it could be postulated that while nurses and midwives may intuitively understand that many of the feelings and actions inherent in the caring relationship are expressions of love, conscious recognition does not occur. The literature provides some explanation for why expressions of love in caring remain largely hidden from view in nursing and midwifery. Montgomery (1991) argues that nursing is in a paradoxical position. On the one hand nurses as caregivers are supposed to care deeply for the patients in their care but on the other-hand are not to become ‘too involved’ with these same people. Montgomery (1991) claims actual nursing practice may in fact be more caring and more involved than orthodox theory and formal professional discourse indicate. Furthermore, Jacono (1993) suggests that while caring may be central to the discipline of nursing, feminist thinking has caused nurses to fear caring. As a result, this fear has resulted in a shift in the orientation of nursing from a ‘caring for’ or providing direct hands on care role toward a ‘caring about’ or providing resources role (Jacono, 1993). Jacono (1993) captures one important reason as to why the exploration of love is largely absent from the literature; ‘... nursing is searching for a way of practicing (i.e. a definition of caring) that serves others without being subservient’. Linking
the concepts love, caring and what it is to be a nurse and midwife appears to support a subservient view of the nurse and midwife role in a profession trying to rid itself of subservient images. Thus, the exploration of the concept of love and its relationship to caring is important for the emancipation of nursing and midwifery and also the identification of what nurses and midwives understand to be an expression of love that is specific to their professional practice.

1.2 Study Question

‘What is love in nursing and midwifery?’
Chapter 2: Discursive Analysis of the Extant Literature on Caring in Nursing and Midwifery

2.0 Introduction

Given that love and caring would seem to be closely linked concepts, I will begin by exploring the literature on caring to see what light it might throw on the research question. While some of this literature will not be obviously linked to the idea of love in the contemporary use of the term it is none-the-less important to the construct of love as presented in this thesis. There is an abundance of literature on caring in nursing, and therefore scholarship that is repeatedly cited in the literature, and generally accepted as the primary literature on caring as it relates to the idea of love, is the focus of this review. Accordingly, the challenge here is to present the philosophical ideas of the many authors in a way that presents mainstream thinking about caring and love in a way that offers more than a cursory glance. Some scholarship about caring and love in general is included because it has been cited in the literature in nursing and midwifery. Only that literature published in English or translated has been used. As stated, not all the scholarship on caring in nursing and midwifery or love is reported on here, nor is literature that relates to the ‘non-caring’ practice of nursing and midwifery. Of note is the seminal work of Janice Morse, Joan Bottorif, Wendy Neader, and Shirley Solberg (Morse et al., 1990), Kristen Swanson (1999), and John Paley (2001) which has been used to background this overview. With this in mind, a report of the thesis of each of 21 scholars Margaret Dunlop, Simone Roach, Anne Griffin, Madeleine Leininger, Marilyn Ray, Patricia Benner, Judith Wrubel, Sara Fry, Howard Curzer, Anne Boykin,
Savina O. Schoenhofer, Milton Mayeroff, Jean Watson, Katie Eriksson, Sally Gadow, Rosemarie Rizzo Parse, Nel Noddings, Stan van Hooft, Olivia Bevis, Delores Gaut, and Kristen Swanson, forms the foundation for this discursive analysis.

2.1 Discursive analysis

Margaret Dunlop (1986), in her seminal work which explores the possibility of caring being a science, offers insight into the concept of caring and its relationship to love. This work commences with the identification of the socio-historical construction of caring and love as part of the role of middle class Victorian women where the usage of the word caring involved a form of love; love as personalized affection (1986, 1992). It includes a view that the socialization of women in general, in the private domain, has love as an integral part of caring (Dunlop, 1986).

Dunlop (1986) demonstrated that nursing has taken upon itself to translate love into the public domain. She noted that the depersonalization of health care is witness of the separation of caring from love, in the traditional usage of these terms (Dunlop, 1986). However, Dunlop (1992) later noted that the problems associated with the separation of caring and love are, in part, resolved by that scholarship which gives rich meaning to caring.

Accordingly, the translation of love to the public domain has resulted in love becoming indirect in that the nurse ‘. . . acts as if they were the one who greatly loved the patient’ (Dunlop, 1992: 24). ‘The as if is important in marking a transition from the “love” of the private domain to the “caring” (in the emergent sense) of the public domain’ (1986: 663, 1992: 24). Thus Dunlop (1992, 1986), says ‘as if” provides the means for both the closeness and the distance of the nurse to the patient that is present in the practice of nursing. Because caring has become institutionalized and public, love as personalized affection is no
longer present in it. The separation of the self from the patient by way of the ‘as if’ suggests that the closeness and distance chosen in the nurse-patient relation is a conscious decision and a reflection of ethical norms. However, is it possible that decisions about the degree of involvement in the project of the patient is something that is not always consciously thought about? What is more, is it also possible that the limits of the closeness, which Dunlop (1992, 1986) speaks about, is more than caring and different to her definition of love as personalized affection. Dunlop’s identification of ‘as if’ suggests that there is a moral component to love that is translated into the physical act of caring, but this is an idea that is not taken up in her thesis.

Simone Roach, like Margaret Dunlop, was one of the early scholars who contributed to thinking about ethics and human caring in nursing in the 1970’s, 80’s and to a lesser extent in the 1990’s. Roach’s (1984, 1992) conceptualization of caring accepts the Hiedeggerian idea that care is primordial and while it can only be associated with identified personal attributes such as Roach’s five C’s (compassion, competence, conscience, confidence and commitment), it cannot be reduced to some form of specific action (Roach, 1984, 1991, 1992, 1998). As a result, the professional skills, knowledge, and experience that a nurse brings to bear on their relationship with the patient is what makes caring unique in nursing and thus enables the identification of certain activities as ‘caring’ (Morse et al., 1991). In this sense caring is ‘expressed in specific moments as particularized in concrete behaviors’ (Roach, 1992: 47).

An important point of Roach’s (1984, 1992) conceptualization of caring in nursing is that caring is not identified as unique to nursing but instead is made unique in nursing through its application. Accordingly, caring is understood to be unique in nursing only in that it is developed in people who fulfill the role of nurse (Roach, 1991, 1992). For Roach (1984, 1991, 1992), harnessing the
human ‘desire to care’ and its application to the professional roles and responsibilities of nursing, is what makes caring in nursing unique.

To this end, Roach (1 984, 1 991 , 1 992, 1 998) has identified five attributes of professional caring, or put another way, five things nurses do when they are caring in nursing. The first is ‘compassion’ which is derived from the Latin, paticum, meaning to suffer with. Roach (1992) says this involves the sharing with another their feelings of brokenness, fear, confusion, anguish and the like that occurs by full immersion in the condition by being present to the other person. It is understood to be a person’s awareness of their relationship with another, which makes possible the nurse sharing in the suffering of the patient (Roach, 1984).

The second trait is ‘competence’, and is defined as the ‘state of having the knowledge, judgment, skills, energy, experience and the motivation required to respond adequately to the demands of one’s professional responsibilities’ (Roach, I 984: 22, I 992: 61). In nursing, as with any health related profession, compassion operates from the competency appropriate to the needs of the patient (Roach, 1984, 1991, 1992, 1998). The two traits are central to any conceptualization of professional caring because, as Roach 1984: 22, 1992: 61) says, ‘competence without compassion can be brutal and inhumane, [and] compassion without competence may be no more than a meaningless, if not harmful, intrusion into the life of a person or persons needing help’. Clearly, Roach (1984, 1992) understands caring in nursing is only made possible by the compassion that is lived out in the competent response of the nurse to the human needs of the patient. However, this conceptualization suggests that even though it is not desirable, it is possible to be compassionate at the same time as being incompetent, but that, according to this model, this would not be professional caring because caring in nursing requires both competence and also compassion.
The third attribute in Roach’s schema is ‘confidence’ and is defined as ‘the quality which fosters trusting relationships’ (Roach, 1984: 23, 1992: 62). Here Roach is making the point that the relationship between the patient and the nurse comprises respect and trust to act in their good. The role of the nurse is understood by the patient to require professional standards and moral attributes that enable them to know that the nurse will always act in ways that foster their wellbeing. Roach (1984: 24, 1992: 63) says that ‘caring confidence fosters trust without dependency; communicates truth without violence; and creates a relationship of respect without paternalism or without engendering a response born out of fear or powerlessness’. However, while Roach has identified the idea that an act of caring requires the patient to have trust that the nurse will act for their good, there is no explanation for why this should be the case.

‘Conscience’, the fourth attribute, is understood by Roach (1984, 1991, 1992, 1998) as a state of moral awareness in the nurse that causes them to intentionally respond in a deliberate, meaningful, and rational way to what matters. However, there are also occasions where a nurse may respond to what matters without rational thought because should they have rationalized their intention they may not have responded at all. Can our moral awareness, or human desire to respond to what matters, also occur preconsciously? For Roach (1984, 1992) conscience is the call of care that manifests itself as care. What makes one person respond to the call and another not or in a different way, however, is what makes the conscience moral as opposed to innate. In this context the conscience can only be innate in that everyone possesses one, but each person’s response is different, which is the ground of the moral person. However this raises a question regarding the response of nurses where the call to action is not something they thought about; where in fact they have no recollection of considering the matter at all?
The fifth and final attribute of caring in nursing is identified as ‘commitment’. Roach describes commitment as ‘a complex affective response characterized by a convergence between one’s desires and one’s obligations, and by a deliberate choice to act in accordance with them’ (Roach, 1984: 25, 1992: 65). It is where choosing is relegated to second priority because the commitment one has is synonymous with what would be chosen. It is where a person is drawn consciously and willingly to a course of action (Roach, 1984), that is, the commitment is such that whatever is required for the patients’ good is never considered a burden because it is not identified as burdensome. But how can this be so when the self is its project? What is this form of commitment that potentially would enable a burden, while not considered a burden, to be so burdensome that it could result in the demise of the nurse’s self-project? Is it commitment that would enable such a state of being as a nurse, particularly when Roach herself hints at this state of being as the state of being moral?

While Roach (1992) speaks about caring in terms of the calling forth of the innate ability to care she also alludes to the idea that caring has a moral element to its nature. In her schema of caring the concept of ‘conscience’ is used to describe the primordial call to care and, while it is a call that requires a response, different people respond in different ways thus making the desire a moral one (Roach, 1984, 1992). For Roach (1984: 27), ‘caring is living in the context of relational responsibilities - responsibilities to self and to the other’; a responsibility that is moral. The postulate is that there exists a primordial call to care but the definition of this motivation is not hypothesized.

**Anne Griffin** (1980), an educationalist, offers insights into caring in nursing that are consistent with Roach’s beliefs. They both understand caring as a primary mode of being human (Griffin, 1980, 1983, Roach, 1984, 1992). The two authors also explain caring from the perspective of the ‘context’ of nursing, and both seek an understanding of professional caring that is effected in the
performance of the specific roles and responsibilities of being a nurse (Griffin, 1983, Roach, 1984, 1992). While Roach identifies 5 activities of caring, Griffin identifies two broad categories called, ‘activities’ and ‘attitude and feelings’ (Griffin, 1980, 1983).

However, other than a brief commentary, Griffin (1983) offers no explanation about the activities of caring in nursing other than to say they comprise of ‘assisting’, ‘helping’, and ‘serving’. More though is said about the attitudes and feelings component of her postulate. Like Roach, Griffin (1980, 1983) understands that caring is made known not by the specific activities nurses undertake as part of their role and responsibilities, but in the ‘way’ they are undertaken, that is, ‘a nurse’s activities in relation to a patient may be called caring only because those acts are performed in a certain way; as expressions of particular emotions’ (Griffin, 1983: 291). For Griffin (1980), the category ‘attitudes and feelings’ relates primarily to the moral attitude of respect for the person of the patient which is given expression though the implementation of various nursing activities which she describes as assisting, helping and serving during the provision of health care. According to Griffin (1980), these caring acts are underpinned by the moral emotion of ‘respect’ for the dignity and autonomy of the patient. Unfortunately, Griffin (1980) offers no description that makes clear the extent of the respect for another person’s dignity. Just how far a nurse or midwife is willing to go out of respect for the dignity of the patient that is defined as caring is unknown.

Although much of the content of Griffin’s thinking about caring relates to innate human drive and moral attributes, it also contains views about the impact of emotion on the caring relationship. More particularly, Griffin (1983) believes that the emotional component of caring is what energizes and licenses the interpretation of the nursing activity as caring. The view taken is that emotions are conceptually linked to reason and appraisal of situations, where the degree
of exposure a nurse has to the plight of the patient impacts on the way the nurse feels toward that particular patient (Griffin, 1983).

One type of emotion identified by Griffin (1983) is affection. Affection ‘refers to the desire for another’s welfare and happiness as a particular individual - not from a sense of duty or benevolence’ (Griffin, 1983: 292). In this conception of affection, affection is interpreted as being ‘concerned’ for the person of the patient, which is different to being concerned for every patient. It is about individuating the caring relationship. The concept of affection, as offered by Griffin (1983), does not require the nurse to ‘like’ the person nor is it reliant upon the character of the individual being amenable to the nurse. In fact affection is not a prerequisite for caring at all because of the irrational nature of its content. More notable is the point that affection and liking may be present in a caring relationship, can effect the kind of a relationship a nurse has with a patient, and that these emotions exist in the caring of nursing outside any sense of duty or feelings of benevolence. As Griffin (1983: 293) writes, ‘. . . in the caring act of nursing, one sees a person in a reactive (subjective) way. . . ‘ which is to identify emotion as a component of caring in nursing. Here, Griffin (1983) adopts the Heideggerian view of care (Sorge) in that things matter to us because mattering structures our world. It determines our interest in things and our relations with people. While Heidegger’s ideas around mattering are not fully explained, Griffin (1983) believes it to be the foundation of caring, that is, mattering gives rise to the emotional component of caring and is what energizes and licenses the interpretation of the nursing activity as caring.

Next, Griffin (1983) links the idea of affection to the emotion of mattering, with affection being the desire for a person’s welfare and happiness. It is what individuates our mattering, and in this case, identifies the person from the patient. Consequently, Griffin (1983) feels that on occasion it is our mattering that gives rise to a deep connection between the nurse and the patient and
hence could be interpreted as a ‘kind of love’. This idea suggests there is a quality to mattering that gives rise to the human response known as love. It is not love in the romantic sense and it is not caring because it is a form of love and a love that is specific to the practice of nursing. However, the content of this mattering that is a kind of love is not explained.

While Griffin understands caring as consisting of two main aspects, an activity or technical component and an attitudinal and feelings component, she also identifies the impact of the relationship of the nurse on the patient. Griffin (1980, 1983) says that the moral principle of respect for the dignity and autonomy of a person is what gives rise to the emotional component of caring that energizes, motivates and enables a nurse to ‘see’ what a patient needs. It is where a nurse continually uses ‘perception’ and ‘judgment’ to understand the reality of the patient’s situation (Griffin, 1983).

Although Griffin identifies a moral component to caring in nursing she acknowledges that there is still much to be learnt about the quality of the relationship between the nurse and the patient (Griffin, 1980). She believes that because nurses are increasingly confronted by more complex and integrated ways of responding to patient needs, and on occasions connecting deeply with patients, the ‘. . . dominant emotion in caring is in fact a kind of love’ (Griffin, 1983: 294). Other than this overview little more can be said about how Griffin conceptualizes the concept love and its relationship to caring except that it contains both an emotion and moral quality to its character.
Madeleine Leininger is a nurse anthropologist who offers a theory of cultural care diversity and universality that represents much of her thinking about the concept of ‘caring’ over an approximate 50 year period (Leininger, 1991a). Similar to Roach and Griffin, Leininger (1988a, 1988b, 1991a) also understands care as a trait that all humans share (generic care). Specifically, she believes caring is an essential human need that is necessary for the full development, health maintenance, and survival of the species (Leininger, 1981c, 1988a, 1988b, 1991a). Leininger (1988a, 1991a, 2002) postulates that while caring exists in all the peoples of the world it is culturally unique.

Leininger uses an ‘ethnonursing’ research method, ‘ethno’ referring to a people centered approach, or a particular culture, with a focus on worldview, ideas, and cultural practices related to ‘nursing’ phenomena (Leininger, 1991a). She identified the cultural meanings, interpretations, expressions and behaviors of people from a range of cultural backgrounds about care and identified three different types of care, ‘generic care’, ‘professional care’ and ‘professional nursing care’ (Leininger, 1991a).

Leininger suggests that in order to deliver ‘culturally congruent care’ nurses need to understand the different individual and group cultural interpretations of care that she has labeled ‘generic care’ (Leininger, 1988a, 1991a). Once this is understood, this ‘cultural care knowledge’ can be combined with the nurse’s individual ‘professional knowledge’ to deliver nursing care that better meets the needs of the individual or group (Leininger, 1988a, 1991a). In this way ‘professional nursing care’ is understood to be the;

‘cognitively learned humanistic and scientific mode of helping or enabling an individual, family, or community to receive personalized services through specific culturally defined or ascribed modes of caring processes, techniques, and patterns to improve or maintain a favorably healthy condition for life or death’ (Leininger, 1988a: 9).
Given this perspective, it would seem that Leininger like Roach and Griffin identifies the ‘context’ of nursing to be critical in defining caring.

All three authors (Leininger, Roach and Griffin), seek an understanding of professional caring as it relates to the performance of the specific roles and responsibilities of being a nurse. However, Leininger specifically focuses on ‘cultural care knowledge’ and its place in the professional care dimension of nursing. As she states, ‘the goal of the theory is to improve and to provide culturally congruent care to people of different or similar cultures in order to maintain or regain their well being, health, or face death in a culturally appropriate way’ (Leininger, 1991 b: 39).

For Leininger, the phenomenon of human caring is both universal and culturally expressed and therefore caring patterns are transculturally different. In developing an understanding of ethnonursing as it relates to caring, Leininger (1988c) found professional caring behaviors, activities and processes were interpreted differently among nurses of different cultural backgrounds. Equally she found nurses shared similarities in their understanding of the concept of helping or assisting others in need, or anticipating the needs of ‘care recipients’. Plus, she also found that most care recipients expected nurses to help them or anticipate their caring needs. However, any philosophical explanation for the goodness that would underpin such expectations is absent from this theory.

Leininger’s ‘ethnocaring’ and nursing care data revealed 28 constructs related to caring, namely, comfort, compassion, concern, coping behaviors, empathy, enabling, facilitating, interest, involvement, health consultative acts, health instruction acts, health maintenance acts, helping behaviors, love, nurturance, presence, protecting behaviors, restorative behaviors, sharing, stimulating behaviors, stress alleviation, succurance, support, surveillance, tenderness, touching, trust, and one called ‘others’ to complete the list (Leininger, 1981a,
For Leininger, these concepts represent the basis for understanding ‘professional nursing care’ and the development of theory about nursing and human caring. However, this list of concepts presented by Leininger (1981a, 1988c) is little more than a list because there is no theoretical exploration of the concepts offered or how they relate to ‘professional nursing care’. In Leininger’s (1991b) publication of her ‘theory of culture care diversity and universality’, these concepts are not included, which is suggestive of the fact that their exact relationship to caring in nursing remains unclear. It would therefore seem that ‘caring’ is little more than a summative term used to cover all or most of the behaviors identified by Leininger. More specifically, Leininger’s postulates around the concept of love and the related ideas of compassion, concern, interest, involvement, presence and so on, as listed above, have no content that enable a more incisive exploration of her theoretical ideas.

This said, Leininger (1991a) does attempt to make known the general tenets that underpin her perspectives about caring in nursing.

‘Care is nursing, care is healing, care is the nurse’s way of being with and helping people, care is the heart and soul of nursing, care makes the difference in wellness or illness states, and care can cure’. (Leininger, 1991a: 40)

What is Leininger’s rationale for adopting these concepts? Again, Leininger offers no substantive philosophical explanation about these ideas that are central to her theory. For example, in brief, it appears that she is saying firstly that because ‘care is nursing’ whenever a person is caring they are by inference nursing and this is clearly not the case. Secondly, that because ‘care is the essence of nursing and the central, dominant, and unifying focus of nursing’ (Leininger, 1991a: 35), nursing does not occur without caring. However, it is general knowledge that not all nursing activities are done in a caring way, if this is correct then, according to Leininger, such activities would not be considered nursing, which is also not correct. Thirdly, that ‘care is the nurse’s way of being
with and helping people’, which suggests there is a moral component to all nursing interactions. Just what is this way of being that is caring exactly, and just how far a nurse is will to go in helping a person, is for the most part unknown. Thus, it is difficult to explore Leininger’s thoughts on caring, and in particular love and morality, in any substantive way because she does not provide philosophical explanations about the tenets on which she has built her theory (Leininger, 1981a, 1981b, 1988a, 1988c, 1988b, 1990a, 1990b, 1991b, 1991a, 2002).

Madeline Leininger was not alone in exploring the concept of culture as it relates to nursing. While Leininger sought to understand culture as the wider context of care in nursing Marilyn Ray has focused on the impact of the cultural systems that operate within bureaucratic health care organizations on caring in nursing. In particular, Ray (1988a, 1988b, 1989) explores the meanings and values of human caring (as a trait) in health care organizations and has developed a ‘Caring Classification System’, a substantive theory of ‘Differential Caring’, and a formal ‘Theory of Bureaucratic Caring’, the later two acknowledged but not examined in this review.

Ray’s ‘Caring Classification System’ of bureaucratic caring (Ray, 1988a) is the result of the exploration of the cognitive perceptions of both health care workers/professionals and patients about caring in nursing in hospital. She identified four categories of caring behaviors, ‘psychologic’, ‘practical’, ‘interactional’, and ‘philosophic’ (Ray, 1988a). In brief, the ‘psychologic’ category consists of both affective (e.g. empathy, concern, feeling, loving, compassion), and cognitive (e.g. teaching, meeting needs, knowledge, observation, decisions, assessment, evaluation, problem solving) caring characteristics (Ray, 1988a). From her description it would appear that when a nurse expresses an attitude of love in professional nursing they are exhibiting a behavior that is caring, but what is the content of the psychologic category that
includes love as an affect of caring? The second category is described as ‘practical’ and is related to both the social organizational system (e.g. economic/money! budget, organization/coordination), and the technical notion of caring (e.g. skill) (Ray, 1988a). The third category of caring characteristics was the ‘interactional’ group with communication (talking) the most significant feature (Ray, 1988a). The physical subset of the ‘interactional’ category is associated with ‘doing for’ comfort (physical, and touch), while the social subset related to ‘doing with’ communication (e.g. talking, interacting (sharing), listening, helping, involving, reassuring, supporting) (Ray, 1988a). The last category in the taxonomy was ‘philosophic’ and consists of three characteristics, spiritual (e.g. concern, faith), ethical (e.g. attitude, responsibility, holistic care, trust, individual care, respect), and cultural caring (e.g. some understanding of cultural care, equity in cultural care) (Ray, 1988a).

The significance of this early research was that it made known the effect of the modern health care bureaucratic system on caring in nursing. In particular, it identified the changes to the beliefs of nurses about caring in Western styled health systems. For example, it revealed that health care workers/professionals understood the use of technology as caring (Ray, 1988a). This said, Ray also identified the ethical shift of caring in nursing from an ‘other-orientation’ to more a ‘self-centered’ orientation, with nurses no longer seeing themselves as completely dedicated to the causes of patients, physicians and the organization (Ray, 1988a). Hence Ray (1988a: 110) believes that ‘the political, legal, and economic systems of bureaucracy, although not negative in themselves, dwarf the more universal, positive elements of ethico-spiritual-humanistic caring’. To this, Ray (1988a: 111) herself makes the call for nurses to ‘work toward the construction of deeper levels of meaning of caring knowledge within contemporary institutional cultures’.
Patricia Benner and Judith Wrubel, are two nursing scholars who have featured in the literature on caring in nursing for several decades. Of note is their development of a theory of caring in nursing titled ‘the primacy of caring’ (Benner and Wrubel, 1989). At the outset of their discussion Benner and Wrubel (1989: 1) clarify their definition of caring as, ‘caring ... means that persons, events, projects, and things matter to people’. They say that ‘caring is a word for being connected and having things matter . . . ‘; it ‘. . . sets up the conditions that something or someone outside the person matters and creates personal concerns’ (Benner and Wrubel, 1989: 1). In this description of caring, Benner and Wrubel (1989) make the assertion that caring is primary. It is what gives rise to what matters, and what matters gives rise to the response of stress and resultant coping. However, Benner and Wrubel (1989) offer no explanation about the motive for caring or its individuated quality; caring simply exists. If caring gives rise to what matters, why do different things matter differently to different people? While linking caring and mattering seems appropriate, their explanation of the ideas does not enable the reader to understand the origin of caring as they present it, nor the degree of mattering possible nor, moreover, that part of mattering that can be considered caring. What is the philosophy underlying their position on caring?

It would seem that a more plausible explanation would be that caring and mattering exist in a dialectical relationship, that is, ‘mattering’ gives rise to the motivation required ‘to care’, and caring involves having an effect on what matters. Mattering is what gives rise to stress and coping is the response. Moreover, that something matters is what gives care its impetus and force, that is, a person cares about or for something or someone because those things matter to them. In this way mattering points toward the self while caring points away from the self. A person cares about X because X matters to them, and, because X matters to a person they are vulnerable to X’s fortunes. For these reasons, ‘mattering’ can be considered a prerequisite of caring and that different
‘mattering’ gives rise to different types of caring. However, Benner and Wrubel do not engage in this type of idea exploration and so it is difficult to fully understand their postulates with regard to caring and mattering. Even in this epigrammatic examination of the ideas the foundation of mattering remains unexplained by them.

Care and caring as described by Benner and Wrubel (1989, Benner, 1994), is a requirement of human being, a part of ‘what it is’ to be human. So caring is ontological. It is a point also made by Edwards (2001: 168) who states that Benner’s and Wrubel’s (1989: 68) claim that ‘caring is the most basic human way of being in the world’ supports the interpretation that they are speaking of care in terms of an ontological view. These ideas stem from the thinking of the philosopher Martin Heidegger (1962) and his concept of ‘Dasein’ which is about being-in-the-world, the inescapable reality of being situated in a world that has to be dealt with, and that things in that reality matter (Benner and Wrubel, 1989, Edwards, 2001). Thus Benner’s and Wrubel’s (1989: xi) claim that ‘caring is a basic way of being in the world…’ supports the interpretation that what they are speaking about is ontological care which is basic to ‘what it is’ to be human.

As a human trait, caring makes possible people being connected in different ways to different things. To this end, Benner and Wrubel (1989: 1) say that caring is a term that is used to describe a variety of ‘. . . involvements from romantic love to parental love to friendship, from caring for one’s garden to caring about one’s work to caring for and about one’s patients’ (Benner and Wrubel, 1989: 1). This description suggests they understand care to be an all encompassing term, one that describes a range of things that matter to people and the different relationships (involvements) they have (Benner and Wrubel, 1989). The suggestion here is that because the mattering of things differs, so the caring that follows also differs; that because things matter to a person and that a person cares for and about things, the person caring is vulnerable to the
fortunes of these things that matter to them. As stated above, Benner and Wrubel (1989) believe that caring creates the possibility that things outside of a person are of concern, and that this concern gives rise to all sorts of involvements (relationships) that create new possibilities, including the vulnerability and risk associated with the concern for the fortunes of another. They explain this by saying that ‘mattering’ establishes what is meaningful to a person, what concerns a person, and what then provides the motivation to act in a particular way in the situation that confronts them (Benner and Wrubel, 1989). Accordingly, caring is understood to be specific and relational, each relationship unique in terms of the perceived care required and offered (Benner, 1984, Benner and Wrubel, 1989). Is it possible that specificity takes their concept of caring away from the institutional form to that of love?

At a practical level, Benner and Wrubel (1989) believe that because caring is about what matters, it gives birth to stress, the response of coping, and the consequence of risk and vulnerability to the self. While there is little discourse about their ideas of risk and vulnerability to the self, what is said relates to self preservation and the need to moderate one’s responses in order to reduce the felt vulnerability and risk. Benner and Wrubel (1989: 2) refer to this as ‘controlled caring’, where ‘. . . the person dictates fully what matters and exercises the freedom to stop caring when the person or project is threatened’. As ‘. . . caring is the essential requisite for all coping’, it appears the more something ‘matters’ to a person the greater the ability to respond to the associated stress, vulnerability and risk to the self (Benner and Wrubel, 1989: 2). There is an acknowledgement that caring has consequences for the nurse, in that the possibilities that caring creates give rise to many and varied feelings, from pain and loss to moments of joy and fulfillment (Benner and Wrubel, 1989).
However, contrary to the idea of self preservation as described above, Benner and Wrubel (1989) say that, because caring is specific and relational, it enables the nurse to focus on the event or person rather than the threat to the self-project. This connection and concern for another is what they say is primary in caring because it ‘. . . sets up the possibility of giving help and receiving help’, and it sets up the conditions for a relationship of trust and feeling of being cared for (Benner and Wrubel, 1989: 4). What they appear to be saying is that in some situations, a person, by not concentrating on the threat to the self, is able to forgo their own good for the sake of another. It is not that the threat to the self is not real but simply not acknowledged as a threat. The threat therefore could be quite real and result in harm to the self, yet the ability of a person to sacrifice their own good is not explicated by Benner and Wrubel (1989), except to say that it appears to be dependent on the perceived risk and vulnerability to the self. What is more, the relationship one person has with another brings about a variety of cares (mattering) that are unique and have significance to those involved. Therefore the response of the person caring is dependent on the type of relationship, the perceived threat to the self-project, and the possibilities of giving and receiving help, which together make explicit what is required by the one caring. While this is one explanation, is it equally possible that what matters to a person comes from outside of their everyday being in another form?

**Sara T. Fry** is a nurse academic who a has postulated a view that the value foundations of nursing are located within the existential phenomena of human caring in the nurse-patient relationship (Fry, 1989a, 1989b). Her scholarship on caring incorporates elements of both caring as a human trait and caring as a moral imperative (Fry, 1989a, 1989b). Reporting on her early thinking about caring, Fry (1989a, 1989b) claims that caring ought to be the foundational value of ethics in nursing, and that caring ought to be considered from the moral-point-of-view of people, as opposed to some idealized conception of moral action, behavior or system of justification.
To support her opinion, Fry (1989b) turns to the scholarship of Nel Noddings (1984), who says that ethical caring arises from the relation where the nurse and patient meet each other morally. It is a relation that is motivated by the ideal of caring itself and not an appeal to ethical principals. As such, caring represents the attitude of being moral and is not an attitude that begins with moral reasoning (Fry, 1989b). Continuing with the ideas of Noddings (1984), Fry says, that ethical caring is based on the notions of ‘receptivity’ (confirmation by the caregiver of the one cared for), ‘relatedness’ (the relation of the caregiver to the other person as a fact of human existence), and ‘responsiveness’ (commitment of the caregiver to the one being cared for). For these reasons, Fry (1989a, 1989b) supports Noddings’ (1984) belief that an ethic of caring represents a theoretical framework that is able to address the realistic nature of the nurse-patient relationship; a relationship that is characterized by a nurse’s caring being inseparably linked to the patient’s status as a human being (Fry, 1989a, Fry, 1989b). Together, Fry (1989a, 1989b) and Noddings (1984) claim that ethical caring is the relation in which one person meets another morally. What is the moral state of being that enables two independent beings to have a relation that motivates an ideal of caring? Could love play a part in this relation?

In order to further her thinking about caring, Fry (1989a, 1989b) turns to the ideas set out in the moral-point-of-view model (Frankena, 1983). In this model caring is understood to be the basis of all normative human judgments (Fry, 1989b, 1991), that is, caring requires a person to not only accept a particular view of morality but to also enter the moral arena itself. It requires a person to live out the morality in their life rather than simply accepting a particular view (Fry, 1989a, 1989b).
The moral-point-of-view model is based on the idea that a person not only subscribes to a particular moral perspective but that the attitude or the precondition that underlies that perspective is what motivates the taking of the moral point of view (Fry, 1989a, 1989b). As such, there is always something that moves a person to approve or disapprove of another, which is the attitude or precondition that serves to motivate a person, in this case, a nurse (Fry, 1989a). However, exactly what is meant by the attitude or precondition that generates the moral-point-of-view is not explained, a point also made by Fry (1989a, 1989b). What is said is that the attitude or precondition ‘. . . generates a moral-point-of-view of caring or. (Fry, 1989a: 97), as Frankena (1983: 71) in Fry (1989a: 97, 1989b: 19, 1991: 164) puts it, ‘a Non-Indifference about what happens to persons and conscious sentient beings as such’.

The idea that the attitude or precondition of a person serves to motivate a moral point of view seems consistent with the notion postulated earlier that ‘mattering’ motivates caring. So there exists in a person an attitude or precondition that gives rise to a moral point of view where things, events and persons outside of the self matter and thus give rise to differentiated caring. However, this thought-provoking analysis does raise some further questions, namely; is it possible that a patient may matter to the nurse to the extent that they would give up their own welfare for that of the patient; what is the attitude or precondition that would enable the nurse or midwife to place the welfare of the patient first; what is the extent of the mattering that would enable this to occur; just how far would a nurse or midwife go with the things, events and persons outside themselves that matter; and, as I repeat, what is the moral state of being of a nurse or midwife, the precondition that is able to motivate this ideal of caring?
Fry (1989a, 1989b) holds the view that, given the context of nursing practice, any theory of nursing ethics must incorporate a recognition of the uniqueness of the nurse-patient relationship. Moreover, ‘... it should adopt a moral point of view that focuses directly on this relationship. ...’ a relationship where caring is understood to arise from an attitude of respect for the dignity of the patient rather than an appeal to moral principles (Fry, 1989b: 20). However, in her later scholarship, Fry (1991) acknowledges that she has rethought her ideas on caring, which has resulted in an acknowledgment that there is valid reason for incorporating ideas about autonomy and beneficence, that dominate medical ethics, in a model for nursing, which in her early scholarship she rejected. To this end, Fry (1991, 1993) proposes a pluralistic model of caring that includes both an obligation and covenant models of caring in nursing.

Specifically, Fry (1991) says that an obligation model of care makes clear the types of behavior that can be expected in the nurse-patient relationship. It also defines the compassion and the acts of caring in nursing. As she (Fry, 1991: 165) states, ‘one cares in order to produce some good or to create some benefit for another individual’. However, in a note of caution, Fry (1991) says that such a model has the limitation of relegating care to an interpretation of human good, when, in fact, there are occasions where what is good for a patient is undetermined. While there is an acknowledgment that elements of the obligation model have relevance to the caring of nursing, it only offers a limited explanation (Fry, 1991).

Different to the obligation model is the covenant model. The covenant model features the ‘fidelity’ that arises from the covenant made between people who stand in particular relationships to one another (Fry, 1991). Accordingly, Fry (1991, 1993) claims that authentic nurse caring is not based on what is good for a patient, but on the maintenance of the fidelity between them.
In proposing a pluralistic model, Fry (1991) is able to incorporate elements of each model, the compassion and doing for others of the obligation model and respect for persons and protection of human dignity contained in the nurse-patient relationship of the covenant model (Fry, 1991). Combining these ideas, Fry (1991) says, makes possible the development of theory about caring in nursing, that is, theory that acknowledges caring as a mode of being and part of the natural state of human existence and human relatedness, theory that acknowledges the attitude or precondition of caring, which gives rise to a moral point of view, and theory that acknowledges the moral and social ideals of caring that are embedded in the health care context in which nursing functions (Fry, 1989a, 1989b, 1991, 1993). Thus, according to Fry (1991, 1993), caring is both a moral phenomenon and also a human phenomenon, that if brought together in a practical ethic of human caring, will provide guidance for nursing practice. While on the surface this may seem plausible the philosophy underpinning these views has not been forthcoming by Fry. The moral and human phenomenon that enables caring in nursing and midwifery is little more than an interesting idea.

A more specific critique of the thesis of Fry (1989a) is offered by the philosopher Howard Curzer (1993). While not reporting here on the entirety of his critique, of particular note is his belief that Fry fails to present a plausible argument for how the concept of care can be used as a foundation on which to build an ethics of nursing that is different to ethics in general and also the ethics of specific disciplines, such as medicine. What is more, he says that Fry’s use of the thinking of Noddings (1984) and Frankena (1983) is misguided and, rather than supporting her basic thesis, they work against it. Especially when Frankena (1983), speaks about care as universal care which is consistent with mainstream ethics as opposed to a specific discipline. What is more, Curzer (1993) says that if care means non-indifference, it does not support Fry’s thesis that care is a central concept for nursing ethics.
Care, as spoken of by Frankena (1983), is a universal concept and one that is familiar to any branch of ethics. While the role of care in each branch of ethics would differ, the central concept would be the same. Curzer (1993) says that this trivializes Fry’s thesis that care is a central concept for nursing ethics. Second, care as described by Noddings (1984) involves emotional attachment, which Curzer (1993) says presents nursing with significant problems, because if accepted, it could be argued that care is a vice rather than a virtue because it can foster favoritism, injustice, inefficiency, lack of objectivity, and burnout. Curzer (1993) suggests that it is perhaps more accurate to understand care as a virtue and a disposition that enables relationships to be formed and maintained with the ‘right people’, with the ‘right feeling’, for the ‘right reason’. Here the ‘right people’ means those patients who the nurse has a relationship (Curzer, 1993). The ‘right feeling’ is not related to equal, minimal, or massive emotional attachment of a patient to a nurse, it is less (Curzer, 1993). The ‘right reason’ for caring is neither merely a means to an end but rather both a means and an end (Curzer, 1993). Thus Curzer (1993) believes that rather than applying the ideas of Noddings (1984), which involve emotional attachment in caring, it would be more accurate to speak of a caring relationship as something that involves friendship. Curzer (1993) suggests that the concept of friendship, rather than caring, is central to nursing ethics. With these thoughts in mind, perhaps it would be more plausible to develop an understanding of the moral and human phenomenon that enables caring in nursing and midwifery, as opposed to an ethics of nursing.
Anne Boykin and Savina 0. Schoenhofer are two nurse scholars who have developed a theory of Nursing as Caring, which is premised on the idea that ‘. all persons are caring’ (Boykin and Schoenhofer, 2001b: 1). They say ‘caring is an altruistic, active expression of love, and is the intentional and embodied recognition of value and connectedness’ (Boykin and Schoenhofer, 2001a: 392). While much of their discourse relates to this definition there is no obvious explanation that says how caring is altruistic or an active expression of love; nor do they explain the nature of human connectedness that is caring.

Boykin and Schoenhofer (2001b, 2003) write that caring is an essential characteristic and an expression of being human. The idea postulated is that being a person means living caring, because they say that it is through caring that our being becomes known (Schoenhofer and Boykin, 1998b, Boykin and Schoenhofer, 2001b, 2003). In this conception of caring, caring is said to be a process where over time each of us grows in our innate ability to express our self (fundamentally, potentially, and actually) as caring (Boykin and Schoenhofer, 2001b, Schoenhofer and Boykin, 1998b). It is an ideal to which we aspire and one that has its origins in our commitments, or more fundamentally our beliefs, to which we are devoted (Boykin and Schoenhofer, 2001b). For Boykin and Schoenhofer (2001b), it is our commitments as a caring person, or at least an awareness of them, that directs the ‘oughts’ of our actions and makes caring as presented here, ethical (Boykin and Schoenhofer, 2001b).

Caring is understood to involve the authenticity of the carer, which is who I am as a caring person in the moment of the relation, and encapsulates the relational responsibilities understood in living caring (Boykin and Schoenhofer, 2001b). According to Boykin and Schoenhofer (2001b: 4), ‘when being with self and others is approached from a desire to know the person as living caring, the human potential for actualizing caring directs the moment’. Therefore, the more a person develops knowledge of their caring, or put another way, the more they
authentically care about themselves and others, the more they are able to be aware of the interconnectedness of caring persons and truly be with the another person in the fullness of their being (Boykin and Schoenhofer, 2001b).

If caring is, as they say, an ideal to which we aspire and one that has its origins in our commitments and beliefs to which we are devoted, is there a limit to what I would do as a nurse in acting out my devotion to caring for another? It is unclear what the interconnectedness of humans is that has one person committed to the extent of having relational responsibilities for another person. This description of caring hints at there being no limits to the responsibility one person has for another. Should this be the case, would that responsibility equate to caring or would it be something else, that is, not only what I as a caring person may feel I ought to do as a response to my commitment to another person but also what I must do? So, where the interconnectedness of the nurse and the patient is of the quality of being present to each other in the fullness of their being, what their responsibility is to each other is less than obvious.

In applying these ideas to the nursing context, Boykin and Schoenhofer (2001b) say that the relationships of nursing are of a covenant nature and emphasize personal engagement and the freedom of the individuals to choose their commitments. Such relations, they claim, authentically represent the bond between the nurse and patient because ‘nursing as caring reflects an appreciation of persons in the fullness of personhood within the context of the nursing situation’ (Boykin and Schoenhofer, 2001b: 8).
Nursing as caring gives rise to nurturing relationships, where both the nurse and the patient engage in living out their caring as whole beings, and in doing so, create new possibilities for their growth (Boykin and Schoenhofer, 2001a, 2001b, Schoenhofer and Boykin, 1998b). In other words, the nurse engages a relation with the patient with the intention of knowing them as a caring person and then responds by creating appropriate ways of knowing and of offering nurturance that are consistent with their uniqueness and the situation at hand (Schoenhofer et al., 1998a, Schoenhofer and Boykin, 1998b, Boykin and Schoenhofer, 2001a, 2003). Using Boykin’s and Scheonhofer’s (2001b, 2001a) terminology, it is through the nurse and the patient ‘living caring and growing in caring’ that the nurse is able to know the patient and therefore better able to identify the ‘call for nursing’. As Boykin and Scheonhofer (2001a, 2001b) write, the call for nursing is a call for ‘caring nurturance’, which gives rise to specific caring responses that are aimed at improving the situation of the patient. While the idea of ‘living out caring’ suggests there is a moral quality to it, this is not identified.

According to Boykin and Schoenhofer (2001b, 1998), in order to achieve such ‘caring nurturance’, the nurse must be willing to risk entering the patient’s world and equally the patient must be willing to allow the nurse into their world if the nurse is to come to understand how they can be supported, sustained, and strengthened in their unique ways of living and growing in caring. It is where the nurse brings to the relation their knowledge of the person as a unique being that is then applied to the situation in which the person is located so making the caring unique (Boykin and Schoenhofer, 2001a, 2001b). ‘A call to nursing is for specific forms of caring that acknowledge, affirm, and sustain the other as they strive to live caring uniquely’ (Boykin and Schoenhofer, 2001b: 18). As a result, the nurse comes to know the patient in ever deepening ways that enable the caring to be specifically tailored to their situation (Boykin and Schoenhofer, 2001b). However, in this explanation one is left to speculate on what is the
content of the ‘call’ to nursing.

In such a relation there is a presence that develops between the nurse and patient, which Boykin and Schoenhofer (2001a, 2001b) call ‘authentic presence’ because it captures the idea that the nurse is intentionally being with the patient in the fullness of their personhood. The caring that results through ‘authentic presence’ is said to be the initiating and sustaining medium of nursing the person of the patient (Boykin and Schoenhofer, 2001b). It results in a specific expression of caring nurturance that is aimed at sustaining and enhancing the welfare of the patient. This response evolves as the nurse clarifies their understanding of the call to nursing through presence and dialogue (Boykin and Schoenhofer, 2001a). While the activity of ‘authentic presence’ is spoken about, the foundation that makes possible this type of relation is not. In this theory of caring, why does a nurse seek out this type of a relation with the patient when they are first a self-project?

According to this view of caring, the nurse’s responses are unique and created for the moment and involve sensitivity and skill in communicating caring (Boykin and Schoenhofer, 2001a). The nurse-patient relation is one in which each encounters the other, which Boykin and Schoenhofer (2001a, 2001b) say is the ground for nursing, what they label ‘caring between’. This ‘caring between’, they believe ‘is the loving relation into which nurse and nursed enter and cocreate by living the intention to care’. Where expressing self and recognizing the other as a caring person occurs, it is what enables nursing to be lived out in its fullest sense (Boykin and Schoenhofer, 2001a: 394). However, the relation of love to caring is ill-defined. Furthermore, it seems ‘caring between’ requires two people who are willing and able to establish a relation that is of love but there is no clear description of the loving relation that is made possible by a ‘caring intention’. While the theory involves the idea of reciprocity this also is not discussed.
So not to be confused, their claim is not that caring is unique to nursing but that caring is uniquely expressed in nursing because of the relation and the context in which it occurs (Boykin and Schoenhofer, 2001b). As Boykin and Schoenhofer (2001b: 19) say, ‘nursing another means living out a commitment to knowing the other as caring person and responding to the caring other as someone of value’. All in all, their theory of Nursing as Caring focuses on the idea of personal theorizing about caring experiences, trusting that each person will examine the content of those experiences as they come to know themselves as caring person’s (Boykin and Schoenhofer, 2001b). While this description of caring places the relation between the nurse and patient centre stage it seems to rely on there being a reciprocity of caring. However, there are occasions in nursing and midwifery where the relation between the nurse and midwife and patient will not be reciprocal instead it will be one-sided such as in a case where the patient is unconscious, uncooperative, or unable to participate because of some type of debility such as a mental health problem. Nonetheless caring is still said to have occurred. Together these ideas suggest there is a moral element that underpins caring in nursing and midwifery. The question that remains is what might this moral foundation be that enables a relation to be one-sided where there is no reciprocity; might it be love?
Milton Mayeroff is an intellectual who is often cited in the early scholarship of caring in nursing but it is to be noted that his theory of caring is a generalized description and not specific to nursing. For Mayeroff (1971), caring is considered a process of which its content is in the present. It is a way of relating to another person that helps them grow and actualize their self. In this view, caring is a means to an end in that it is specifically aimed at helping another grow, that is, in order to be caring a person one must be able to relate to another person in such a way that the other person is seen as an extension of their self (Mayeroff, 1971). However, this union of self and other that Mayeroff (1971) speaks about is a union of separate beings and one that is respectful of their integrity. It is a respectfulness that is characterized by a focus on the other person’s growth, and while bound up with ones own sense of well-being, is not the motivation for ones action nor is it the source of ones satisfaction because the focus is on the other person.

In terms of nursing, the relatedness of caring has the nurse identify the potential in the patient for growth and the nurse’s need to satisfy those growth needs. It is as though the nurse has been entrusted with the care of the patient, which causes the nurse to respond to the needs of the patient in a way that is guided by those needs for growth and not the nurse’s interpretation of them (Mayeroff, 1971 ). As Mayeroff (1971 : 5) states;

‘any direction that I may give the other is governed by my respect for its integrity and is intended to further its growth, and I show that respect by the interest I take in determining whether my actions do in fact further growth and by being guided by what I find’.

Hence caring requires commitment to an unforeseeable future. It requires our devotion because devotion, Mayeroff (1971: 5-6) believes, is shown by our being ‘there’ for the other, which expresses itself in our willingness and our persistence to overcome difficulties and is an expression of our will.
What is more, this devotion that Mayeroff (1971: 6) speaks about, gives rise to a particular type of obligation. It is;

‘a constituent element in caring, and I do not experience them as forced on me or as necessary evils; there is convergence between what I feel I am supposed to do and what I want to do’.

To exemplify this point, Mayeroff (1971) says, it is like the father who takes his child to the doctor in the middle of the night; he does not see it as a burden because he is simply caring for his child. Thus Mayeroff believes that in order for a nurse to care for a person they must be able to engage in a relationship that is motivated out of respect for the integrity of that person and one that is characterized by the nurse’s commitment, perseverance, selflessness, devotion and willingness to do what is required in order to respond to their needs for growth.

From this description it appears that there is no limit to how far a nurse may go in acting out their commitment, perseverance, selflessness, devotion and willingness to do whatever is needed to assist the growth of another. It is different for each person because how far the nurse will go is governed by the nurse’s respect for the integrity of the patient. While the example above of the father caring for his child supports these ideas, it also hints at there being something more to the relation that is other than caring. In the example offered by Mayeroff, where it is stated that the father is simply caring for his child, an alternative perspective can be postulated; it equally could be said that the father cares for his child because he loves his child. Loving his child is the reason that he is able to care the way that he does, he cares for his child in a way that is without limit — there is nothing he would not do for his child in fostering its growth, even the sacrifice of his own welfare. What is not spoken of here is the relationship of love to caring, in this case, the respect of the integrity of the
other that love requires.

At a more practical level, Mayeroff (1971) believes that because caring involves helping another person to grow, it therefore requires encouragement and assistance for them to care for themselves. It requires help for that other person to become responsive to their own needs and to be responsible for their own life (Mayeroff, 1971). In nursing it requires the nurse to know something about themselves and the patient such as their needs, strengths, and limitations. It requires the nurse to possess the ability to be reflective of their success or failure in helping the patient, so in the future they can better help the patient (Mayeroff, 1971). To this end, Mayeroff (1971: 12-20) identifies several ingredients he believes are necessary for caring, they comprise;

- Patience: ‘Patience is not waiting passively for something to happen, but is a kind of participation with the other in which we give fully of ourselves’ (Mayeroff, 1971: 12).

- Honesty: ‘Honesty is present in caring as something positive, and not as a matter of not doing something, not telling lies or not deliberately deceiving others.’ ‘To be honest with oneself. To care for the other I must see the other as it is and not as I would like it to be or feel it must be. If I am to help the other grow, I must respond to its changing needs’. (Mayeroff, 1971: 13)

- Trust: ‘Caring involves trusting the other to grow in its own time and in its own way. It appreciates the independent existence of the other, that the other is other’ ‘Trusting the other is to let go; it includes an element of risk and a leap into the unknown, both of which take courage’. (Mayeroff, 1971: 14-15)

- Humility: ‘Being always ready to learn about the other. That an others existence is for them and not for our purposes’. (Mayeroff, 1971 : 17)
Hope: ‘... it is rather an expression of the plenitude of the present, a present alive with a sense of the possible’. ‘It is hope for the realization of the other through my caring...’. (Mayeroff, 1971: 19)

Courage: ‘Trust in the other to grow and in my own ability to care gives me courage to go into the unknown, but it is also true that without the courage to go into the unknown such trust would be impossible’ (Mayeroff, 1971: 20).

It is these personal qualities, Mayeroff (1971) suggests, that are central to successful caring for another person. Nonetheless how they relate to nursing is a matter of interpretation.

Mayeroff (1971) also believes that for caring to exist there must be selflessness on the part of the carer. This is not a selflessness that is typified by a demise of one’s own project but ‘a selflessness that goes with being absorbed in something I find genuinely interesting, that goes with being more myself’ (Mayeroff, 1971). It is a selflessness that is characterized by a heightened awareness, a greater responsiveness to both the other person and oneself, and the fuller use of one’s distinctive powers that help the other person grow, which at the same time, also helps one’s own growth (Mayeroff, 1971). Or, put differently;

‘by using powers like trust, understanding, courage, responsibility, devotion, and honesty I grow also; and I am able to bring such powers into play because my interest is focused on the other’. (Mayeroff, 1971: 21-22)
Of note is that the selflessness inherent in caring is made possible because of the ability of a person to be absorbed in something outside of their own project. While the selflessness Mayeroff speaks about may result in a cost to the self, because of their absorption in the other, it is not interpreted by them as something lost, but just the opposite. It is something gained, for it enables them to do what they want to do in being more themselves. It appears that the selflessness of caring has a net benefit for both the self and the other. How does this explain those actions of a person where their selflessness or absorption in the other is to a level where there is a demise of their own being? Is this still caring? For example, is it caring if a person jumps off a bridge into the raging water to save a person when they cannot swim, or is it something else? Can the selflessness of caring be of this quality, where there is neither an expectation of reciprocity nor concern for their own welfare? How is it possible to place the welfare of another before the self as its project?

However, given Mayeroff is not theorizing specifically about nursing, application of these ideas is cautioned, as Mayeroff suggests that caring requires a degree of competency on the part of the one caring. For example;

‘if I am to care for the other, I must be able to cope with it; I must be up to caring for it… I must be capable of caring for this other’. (Mayeroff, 1971:24)

This is a point that would sit comfortably with any professional nurse or midwife in that a prerequisite of caring is professional competency. On the other hand, Mayeroff (1971) contends that a necessary prerequisite of caring is the capacity for the other person to ‘grow’ and if this is not possible then the suggestion is that caring may also not be possible.
‘If caring is to take place, not only are certain actions and attitudes on my part necessary, but there must also be developmental changes in the other as a result of what I do; I must actually help the other grow’. (Mayeroff, 1971: 28)

While the term ‘growth’ is not specifically defined, it would appear that it is related to developmental growth, which is supported by his offering of the example of tending a person with extensive brain damage who is ‘unable to grow in any meaningful sense’. The claim is that while the nurse may be interested in helping this person’s welfare, they cannot care for him in the sense of helping him grow, therefore caring cannot take place. While consistent with his idea that caring is helping a person grow toward self-actualization, it seems that this definition limits caring to a physical helping role that has no existential capacity.

Although tenets of Mayeroffs theory on caring may have relevance to a profession like nursing and midwifery, other components, as mentioned above, do not apply. Mayeroff’s theory is about caring in general and therefore the application of the ideas contained within this theory to nursing and midwifery should be seen in this light. In terms of this theory of caring, little can be said about how it makes known caring that is specific to nursing and midwifery because some of its elements fall short of offering an adequate explanation of the situations confronting nurses and midwives.

Jean Watson is a nursing scholar who offers a ‘Theory of Human Care’ that has as its central tenet, caring as an intersubjective human process and the moral ideal of nursing (Watson, 1985). In response to this belief, Watson (1979, 1985, 1988, 2001, 2003) identified 10 ‘carative factors’ that were later restructured to include more the spiritual dimension and an overt evocation of love and caring that is now labelled ‘clinical caritas processes’. It is ‘clinical
caritas’ or ‘caritas processes’ that Watson (2001) believes better attends to the intersubjectivity of human-to-human relatedness and the infinity and mystery of the human condition, but more on this later. As an overview, Watson’s (1996, 2001) ‘Theory of Human Care’ consists of three essential elements, (1) the transpersonal caring relationship, (2) ‘clinical caritas process’ (formerly ‘carative factors’), and (3) the caring occasion/caring moment that together focus on the human-to-human encounter between the nurse and the patient that reflects their shared humanity. As Watson says, ‘the theory is about a different way of being human, a different way of being present, attentive, conscious, and intentional as the nurse works with another person’ (Fawcett, 2002: 215).

More specifically, Watson’s (1985) conception of transpersonal caring holds that all humans are in relationship to each other and morally committed to the protection and enhancement of each others dignity. It is a relationship that has an individual move beyond their ego self and the specific moment to deeper connections of a more spiritual type (Watson, 1999, 2001, 2003). As Watson (2001: 347) says;

‘transpersonal caring seeks to connect with and embrace the spirit or soul of the other, through the processes of caring and healing and being in authentic relation, in the moment’.

In other words, people engage in what Watson (1996: 151) describes as a ‘special kind of relationship’ that is typified by high regard for the whole person and their being-in-the-world. It is a ‘spontaneous’ relationship, one characterised by what is called a ‘caring moment’, which is where the nurse and the patient enter the ‘lived experience’ of each other and connect with the infinity of their humanity (Watson, 1990, 1996, 2001, 2003), that is, the nurse forms a;

‘... union with the other person on a level that transcends the physical, and that preserves the subjectivity and physicality of persons without
reducing them to the moral status of object’. (Watson, 1985: 68)

Watson (1996) says that in the ‘caring moment’ there is a ‘caring consciousness’ where the nurse is able to detect the patient’s condition and so respond. Hence transpersonal caring not only influences the caring consciousness of the nurse, a consciousness that focuses on the uniqueness of self and other, it goes beyond the ego-self and the present to a deeper, spiritual and cosmic level of concern and connectedness that Watson (1996, 2001, Watson, 2003) believes makes possible alternative or new forms of healing. However, one is left to question the accord of a consciousness of caring that enables a nurse and midwife to have a say in caring as dictated by an ego concerned about its self and the caring that issues from beyond the ego-self where the self is not a concern.

Equally, the ideas contained in transpersonal caring could help explain existing nursing encounters that appear on the surface to be something different to the general conceptualisation of everyday caring. What is more, it is postulated that the uniting or the coming together of people through transpersonal caring frees them from the feeling of isolation and separation, because the union of feelings enables self-healing, discovery of inner power and control, and the personal meaning of existence (Watson, 1985). Watson (1990) believes that it is essential that the inseparable connections between people and nature be acknowledged if expanding the ontology of personhood beyond identifying the other as object and as separate from others and nature is to be achieved. Accordingly, Watson has identified that the transpersonal relation of the nurse and the patient is more than a relation of caring for it also includes love, but exactly what Watson understands as love is at this point not fully explained in her theory. Notable though is the fact that she has restructured her theory of transpersonal caring and has care and love on an equal footing in the description of the nurse-patient relation.
In view of this, the second element to the ‘Theory of Human Care’ is what was originally called the ‘carative factors’ now reconceptualised and presented as ‘clinical caritas processes’ and the means for achieving transpersonal caring (Watson, 1985, 1996, 2001). While in her original work Watson (1996) does not claim the ‘carative factors’ as new, she does claim her model offers a language and structure for practising transpersonal caring. Both the original ‘carative factors’ and newly defined ‘clinical caritas processes’ characterise the human caring and loving process that occurs during a caring occasion; where the nurse and patient share an intention, a will, a relationship and actions that demonstrate their commitment to caring and loving as a moral ideal aiming to preserve humanity (Watson, 1979, 1985, 1988, 1996, 2001).

In her new conception of the ‘Theory of Human Care’, Watson (2001) says that the replacement of the carative factors with ‘clinical caritas’ or ‘caritas processes’ enables ideas of love and caring to come together in a new understanding of transpersonal caring. It harnesses the idea that nursing is a life-giving and life-receiving enterprise and one that invites us into new relationships with ourselves, thinking about life, nursing, and our relationships with others (Watson, 2001). Thus the ‘clinical caritas processes’ represent the ‘core’ of nursing and the utility of the caring-loving process. They are those aspects of nursing that actually potentiate therapeutic healing processes and relationships affecting both the one caring and the one-being-cared-for that are actualised in the moment where the nurse is being with the patient (Watson, 1997, 1985, 1988, 2001).
Watson’s (2001) ‘clinical caritas processes’ differs from her original ‘carative factors’ in that they contain an obvious spiritual dimension and overt evocation of love that the ‘carative factors’ did not. However, similar to comment made above, further elaboration of the content of the ‘clinical caritas processes’, in particular, the caring-loving process, is needed if they are to provide nurses and midwives with a clear account of how these ideas of caring and love apply to the practice of nursing and midwifery.

Watson’s (2001: 347) 10 ‘clinical caritas processes’ comprise:

1. The practice of loving kindness and equanimity within the context of caring consciousness.
2. Being authentically present, and enabling and sustaining the deep belief system and subjective life world of self and one-being-cared-for.
3. The cultivation of one’s own spiritual practices and transpersonal self, going beyond ego self, opening to others with sensitivity and compassion.
4. The development and sustenance of a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with the deeper spirit of self and the one-being-cared-for.
6. The creative use of self and all ways of knowing as part of the caring process; to engage in the artistry of caring-healing practices.
7. Engaging in a genuine teaching-learning experience that attends to unity of being and meaning; attempting to stay within others’ frame of reference.
8. Creating a healing environment at all levels (physical as well as non-physical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentate).
9. Assisting with basic needs, with an intentional caring consciousness, administering “human care essentials,” which potentate alignment of mindbodyspirit, wholeness, and unity of being in all aspects of care, tending to both embodied spirit and evolving spiritual emergence.

10. Opening and attending to the spiritual-mysterious, and existential dimensions of one’s own life-death; soul care for self and the one-being-cared-for.

The third element to Watson’s ‘Theory of Human Care’ embodies ideas that surround the concept of ‘human care transactions’ and includes the ‘actual caring occasion’, ‘intersubjective caring occasion’, and ‘transpersonal caring moment’ (Sourial, 1996). As Watson (1985: 58) states:

‘transpersonal human care and caring transactions are those scientific, professional, ethical, yet aesthetic, creative and personalized giving-receiving behaviors and responses between two people (nurse and other) that allow for contact between the subjective world of the experiencing persons (through physical, mental, or spiritual routes or some combination thereof)’.

It is these human care processes that make possible human care transactions, or to use Watson’s language, the engagement of ‘caritas processes’ in an ‘actual caring occasion’ makes possible an ‘intersubjective caring occasion’ where a ‘transpersonal caring moment’ can occur (Watson, 1985, 2001). As Watson (2001 : 348) says;

‘the nurse seeks to recognise, accurately detect and connect with the inner condition of spirit of another through genuine presencing and being centered in the caring moment; actions, words, behaviours, cognition, body language, feelings, intuition, thought, senses, the energy field and so on, all contribute to transpersonal caring connection’.
It is where the nurse and patient come together and present each other with the opportunity to choose how to be in the relationship - what to do with and in the moment of their meeting (Watson, 1985, 2001). The suggestion here is that there is a consciousness associated with the meeting of the subjectivity of the nurse and the patient. While this may be true, it does not help explain the proposal of a primordial relation where as a consequence of the nurse-patient relation the nurse acts without thinking or being aware of a choice about what to do with and in the moment of their meeting. Watson (2001, 2003) also says that should the caring occasion be transpersonal, the nurse and the patient will feel a connection at the spiritual level of their being which enables deeper levels of love and caring than that of mere physical interaction. The time of nurse-patient coming together and the subsequent decision regarding the type of relationship to be formed is the time when a transpersonal caring moment can occur (Watson, 2001). As such, transpersonal human care is said to happen from person to person in an I-Thou relationship that is based on the notion of reciprocity where there is symmetry of attitudes, and responsibilities (Watson, 1985, 2001). For the nurse the task becomes one of responding to the humanity of the patient, which Watson (2002) says is the ultimate goal of nursing and nurses. Transpersonal human caring enables both the nurse and the patient to engage each other’s subjectivity, but should they not wish to do this they run the risk of being reduced to the level of object (Watson, 1985). While the motive of reciprocity underpins the mutuality involved in the nurse-patient relationship, the motive underpinning the quality of the relationship decided on between the nurse and the patient is unclear. Does the connection at the spiritual level, for example, have to be something felt and is the basis of the relation necessarily always one of reciprocity with symmetry of attitudes and responsibilities or could it also be a primordial meeting of our being’s subjectivity where there is asymmetry of responsibility and no expectation of reciprocity? Could this primordial responsibility be a form of love?
As mentioned above, in her later work, Watson (1999) extends her theorizing about transpersonal caring to focus more on the spiritual aspect of caring, in particular, ‘being-in-relation and its associated multi-dimensions and planes of existence in the universe’ (Watson, 1999: 97). In this expanded conception of transpersonal caring Watson (1999) says that caring is an explicit global ontology of being-in-relation and the moral starting point to caring for self, others, nature and the universe. What is more, it requires a unity of caring consciousness that comprises mind-body-spirit and nature, and ‘cosmology of oneness of consciousness’ (Watson, 1999: 97). It is where both the nurse and the patient are able to use the universal energy field or universal spirit and its associated healing potentials and wholeness (Watson, 1999). To this end Watson (1999: 111) believes that;

- ‘The whole caring-healing consciousness is contained within a single caring moment.
- The one-caring and the one-being-cared-for are interconnected; caring and healing are connected to other humans and to the higher/deeper energy of the universe.
- Human caring-healing processes (or the non-caring, non-healing consciousness of the nurses or other practitioner) are communicated to the one-being-cared-for.
- Caring-healing consciousness is spatially extended; such consciousness exists through space.
- Caring-healing consciousness is temporally extended; such consciousness exists through time.
- Caring-healing consciousness is dominant over physical illness and treatment’.
Accordingly, Watson’s (1999) ideas about ‘transpersonal caring-healing’ are more than that which occurs between people, it goes beyond the individual to a unitary connectedness that incorporates both the metaphysical and spiritual dimension, transcends time and space and physicality and can result in new possibilities for healing and wholeness. However, given the somewhat nebulous nature of her theory it is not surprising that this work has attracted some criticism. Critics make various observations of the ideals postulated by Watson saying that the language used is often unclear and the linkage of ideals not easy to follow, which together make the notions contained within the theory hard for clinicians to understand, apply, and achieve (Barker and Reynolds, 1994, Cohen, 1991, Kuhse, 1993, Morse et al., 1991, Sourial, 1996). Perhaps Watson herself acknowledges that there is some validity in these criticisms as her new scholarship is directed toward developing trans-theoretical discourse that, in her words, will allow ‘for some necessary convergence of extant theories to better solidify and inform nursing’s metaparadigm’ (Fawcett, 2002: 219, Watson and Smith, 2002: 460). Whether this will provide more clarity of ideas about her theory and scholarship is yet to be seen.

However, in terms of this scholarship a further criticism can be made of Watson’s ‘Theory of Human Care’ as it relates to the use of the terms ‘love and caring’ as presented in one of the basic premises on which her theory has been developed. Watson (1985:50) states that she believes;

‘People need each other in a caring, loving way. Love and caring are two universal givens. To paraphrase Teilhard de Chardin, “Love (and care) are the most universal, the most tremendous, and the most mysterious of cosmic forces. . . It is the primal and universal psychic energy.” These needs are often overlooked, or even though we know we need one another in a loving and caring way, we do not behave well toward each other. If our humanness is to survive we need to become more loving, caring, and moral to nourish our humanity, advance as a civilisation, and
live together. As a beginning we have to impose our own will to love, care, and be moral upon our own behaviour, not on others’ behaviour. We need to love, respect, care for ourselves, and treat ourselves with dignity, before we can respect, love and care for others and treat them with dignity’.

As illustrated in this seminal work, Watson (1985) does not explain in any depth the meaning behind the use of the terms care and love. For example, the word love has numerous meanings and forms of common use that make it a concept that is easily misinterpreted when applied to the ideas presented in this theory. This problem is further exacerbated when two such confusable terms (love and care) are used together. In the later development of her theory, where Watson (2001) introduced the idea of ‘clinical caritas processes’, and placed love on an equal footing to caring, the concept of love and its relation to care or loving caring processes remain subject to this potential confusion. For example, in the ‘clinical caritas process’ ‘practicing loving kindness’ suggests that love may be linked to the idea of goodness which leads one to question the origin of the kindness that is practiced as loving by a professional nurse or midwife. Similarly, in her (Watson, 2003) more recent scholarship, the terms ‘love and caring’ continue to be used together suggesting they are inseparable; one cannot be caring without being loving and visa versa. For example, Watson (Watson, 2003: 199) says ‘by attending to, honoring, entering into, [and] connecting with our deep humanity, we find the ethic and artistry of being, loving, and caring’. In this conception, love and caring are presented as the means for living out our humanity, but again, just what the content of love and caring is at this point in time is not fully explained.
These criticisms aside, this scholarship provides a general explanation of the inclusion of ‘love and caring’ in nursing and midwifery, as for example, the;

‘…relationship between love and caring connotes inner healing for self and others, extending to nature and the larger universe, unfolding and evolving within a cosmology that is both metaphysical and transcendent with the coevolving human in the universe’. (Watson, 2001: 345)

Given that these ideas are new to Watson’s thinking, it is reasonable to expect that they will be explicated in further detail in the future, which in part, has begun (Watson, 2003). In this later publication, Watson (Watson, 2003) clarifies her thinking about love by suggesting that love is something that occurs as part of the process of caring, such as a ‘loving presence’ in caring. Here, love is presented as a way of being in the caring moment and an expression of our humanity (Watson, 2003), but her statement ‘perhaps it is love that underpins and connects us. . . ‘ is yet more evidence that her ideas about love as they relate to her theory of caring are still evolving (Watson, 2003: 200).

**Katie Eriksson** is a nurse scholar who has developed a theory of caring in nursing that takes the view that caring is the essence and central focus of nursing practice (Eriksson, 1990a, 1991, 1992e, 1992d, 1997b, 1997a). Explicating Eriksson’s theory is made somewhat difficult because much of her scholarship is reported in the Scandinavian literature with only a small amount published in the English language. However, it is clear from available writings that she promotes the search for knowledge that looks for answers to ontological questions that surround what is the ‘… inmost being of caring reality’ (Eriksson, 2002: 62). She (Eriksson, 1990b, 1991 , 1992e,1992b) uses motive research to identify the ontology of caring, for as she says, ontology deals with exiting entities in a certain reality that makes possible the identification of the fundamental characteristics of caring, and in this case, caring in nursing. To this end, Eriksson supports the development of ‘caring science’ and has postulated
a theory of caring (incorporating ideas about love), that is based on the
assumption that the aim of caring is to alleviate the suffering of the other person
through the promotion of healing and health (Eriksson, 1990b, 1992a, 1994,

What is more, her theory of caring is situated in an ontological model of health
which consists of three dimensions, ‘health as behaviour’, ‘health as being’, and
‘health as becoming’ (Eriksson, 1994). ‘Health as behavior’ relates to the idea of
having health, where to be healthy is to have some objective criteria applied to
oneself that enables judgment to be made about the state of being alive
(Eriksson, 1994). For example, living in a healthy way by demonstrating health
supporting behaviors that are aimed at ‘having health’, such as regular health
assessments to check against problems of illness. Eriksson (1994) comments
that the extreme of this dimension of health is that people can become totally
focused on illness prevention to the point of avoiding anything that could
threaten their health.

The concept of ‘health as being’ is different to health as behavior’. ‘Health as
being’ centers on the notion that a person desires fulfillment of their needs and
is in search of a state of equilibrium, of harmony of their physiological,
psychological and social selves, of harmony between their body and soul, and
of harmony between the internal and external forces that constantly impact on
them (Eriksson, 1994). Eriksson (1992d) says people functioning in the
dimension of health concentrate on the fulfillment of their human needs in order
to reach a state of harmony and balance in their life. Yet different again is the
idea of ‘health as becoming’. Here health is postulated as the ‘. . . growing
toward a deeper oneness’ and is based on the assumption that a person is
always in a state of becoming something and as a consequence is constantly
being shaped and reshaped by both internal and external forces (Eriksson,
1994: 9). To this end, the dimension of ‘health as becoming’ requires people to
Thus for Eriksson (1992d: 5), ‘health is motion, a dynamic movement, and man (sic) is not constantly in the same dimension, at the same level of health, but moves between them’. It is a conception of health that is situated in a holistic model that focuses on the interrelated nature of a person that has both a physical and spiritual component to their being where to be healthy is equated with physical, mental and spiritual wholeness (Eriksson, 1992d). To this end Eriksson (1992d) claims that such a multidimensional view of health challenges ideas of caring in nursing.

Consistent with her conception of health Eriksson’s theory of caring in nursing centers on an ontological belief that a human being is a whole of body, soul, and spirit, and is basically religious and in suffering (Eriksson, 1989, 1991, 1992e, 1994, 2002, Naden and Eriksson, 2000). The theory is made up of five intertwined concepts which include; what it is to be a human being - patient, carer/nurse; the nature of suffering and health; caritas motive and the ethics of caring; caring as compassion, invitation, commitment, faith, hope and love; and caring as a communion (Eriksson, 1990a, 1992e, 1994). In this conception of caring, caring is seen as something that is both natural and primordial; and something that results in the unselfish relation of one with another where there is a genuine desire to alleviate the suffering of that other (Eriksson, 2002).

Eriksson (1994: 12) makes the point that ‘caring is in itself ethics’, which comes to life in the relationship one person has with another, and that a person’s ethical foundation combined with their disposition establishes their ethical standpoint and reflects the different depths of human relations and caring for people (Eriksson, 1994). Equally it is also acknowledged that, while a fundamental ethical standpoint is central to a person’s integrity, different motives such as the social motive, humanistic motive, and the caritas motive,
result in different relationships that include how far a person is prepared to go in sacrificing their own selves in caring for another person (Eriksson, 1994).

In short, the social motive centers on social responsibilities and the desire to intervene to correct unacceptable behavior but it does not extend to taking care of another person (Eriksson, 1994). As distinct from the social motive, the humanistic motive is based upon humanity and goodness, and for example, enables a nurse to take responsibility for meeting the basic human needs required to sustain life but stops at the nurse being prepared to take responsibility for the person’s life (Eriksson, 1994). Different again is the caritas motive which urges the nurse to act from love and compassion and urges, for example, the nurse to take responsibility for the good of the other (Eriksson, 1994). It is the caritas motive that Eriksson (1994) says is ‘the core of caring’.

Her views about caring in nursing are built on the premise that there is ‘caritative caring’, which Eriksson (1990a, 1990b, 1991, 1992e, 1992b, 1994, 2002) says has its origins in human love and the idea of mercy and charity, which are the basic motives for caring. Thus ‘caritative caring’ is the application of the motive of ‘caritas’ in the conduct of caring, in this case, caring in nursing (Eriksson, 1990a). Put another way, the basic motive of caring can be no other than the caritas motive, for it is the core of caring (Eriksson, 1991, 1992e, 1994, 2002). As to what is the ‘human love’ that underpins ‘caritative caring’; it is not fully explained.

The caritas motive invites a person to care and includes the ethical motive of respect for the absolute dignity of the human being, and is that which gives rise to a person being responsible for both their own and others’ lives (Eriksson, 1994). In this view (using Eriksson’s language) the ‘mission’ of a person is to serve the other, to exist for the sake of the other that is only realized when their suffering has been responded to in a way that restores them to their ‘mission’
(Eriksson, 2002). Yet, what is the state of our being that has a person, or in this case a nurse, ‘exist for the sake of the other’? What makes this possible?

The starting point for the caritas motive is compassion, which is given birth in meeting the suffering of the other person and the responsibility and the desire to do good (Eriksson, 1992e, 1994, 2002). Where does this good that a person desires come from? What is its form and why is the good a desire of mine? While the idea of the good is a premise on which Eriksson’s theory is built there is little by way of a description that makes known what this good is that a person desires.

Compassion, according to Eriksson (1994: 13-14) ‘emerges in the meeting between suffering and love’ and is the force that motivates a person to care. It involves the invitation to a relationship where the nurse’s attitude is ‘I am here for you’, which Eriksson (1994: 14) says causes the ethical to appear as a result of the correlation between the invitation offered to the patient and the way in which the patient is accepted into this relationship. It is a relationship that is characterized by what Eriksson (1991, 1992e, 1992c, 1994, 1997a) calls the ‘caring communion’.

While all forms of caring are understood to be variations of human communion, ‘caring communion’ gives caring its context, source of power and meaning (Eriksson, 1991, 1992e, 1992c, 1994). The central point is that joining in communion means creating possibilities for the other as though they were your own possibilities. It is the ability of the nurse to do good for another person, to minister and give the whole of their self (Eriksson, 1991, 1992e, 1992d, 1992c, 1994, 1997a). ‘Caring communion is a creative act which can imply different forms and contents, but it is characterized by intensity, openness and possibilities’ (Eriksson, 1991: 14). How is this possible? What is the communion that would enable a nurse to have a relation with a patient that would enable
them to give the whole of their self to the good of another? As stated above, why should I desire to do this good? How is it possible that I am able to sacrifice my self-project for the good of the patient and is this something that is desirable of a nurse?

Given the significance of the commitment, it is not surprising that Eriksson has identified the pre-requisites needed for a caring communion. They include a genuine, mature, and professional attitude that is characterized by responsibility, genuineness, courage and wisdom and the ability to presence themselves with the patient (Eriksson, 1990a, 1991, 1992e, 1992d, 1994, 1997a). From the nurse’s point of view, there is meaning in being present and giving something of oneself for the purpose of something very important in the actual situation (Eriksson, 1991). From the patient’s point of view, it means being special, someone important to another person, someone’s responsibility, a willingness for them to do good for me (Eriksson, 1991). Thus for Eriksson (1992e) true caring is not a form of behavior, nor is it a feeling or a state; it is an ontology. It is a way of living, for as she says, it is not enough to just be there or to share. Caring is more; it is the way and the spirit in which it is done. However, as to why it should be done is not fully explained.

The verb caring is used here to also encapsulate the idea ‘to respond’; that is, caring is a response that is triggered by the identification of the suffering of another person (Eriksson, 1991, 1992e). In this conception of caring, suffering is understood to be the point at which caring begins (Eriksson, 1992e). According to Eriksson (Lindstrom and Eriksson, 1993, Eriksson, 1993, 1994, 1997a, Eriksson and Lindstrom, 1993), suffering is a state of being that incorporates a sense of dying and has neither meaning nor purpose. Regardless of the perspective, there is only one common denominator to all suffering and that is that a human being is to some degree cut off from their personal identity and the experience of wholeness (Eriksson, 1991, 1993,
Eriksson (1997a) says that to suffer is to be estranged from oneself, both one’s inner demands and possibilities. It results in a person being driven by external contradictions amongst the search for a harmony where ‘to become in suffering is a struggle between hope and hopelessness, between life and death’ (Eriksson, 1997a: 77).

Added to this idea of suffering is the notion of love, where Eriksson (1993, 1994, 1997a) says that in order to experience suffering a person must know love because love is a condition for human growth and development, and it is through suffering that a human being is able to be in contact with the basic conditions of life and thus grow to understand the meaning of suffering as a feeling. For Eriksson (1992a, 1992e, 1993), living through suffering is what enables a person to find purpose and meaning in their suffering, and is what is at the heart of all forms of caring in nursing. Here suffering is understood to be the basic category of all caring for according to Eriksson (1992a: 123), ‘suffering gives caring its own character and identity and all forms of caring aim in one way or another to alleviate it’. ‘True caring is not just an abstract thought, philosophy or ideology: it is work of the most concrete kind, encountering suffering in true situations’ (Eriksson, 1992a: 123).

As stated above, Eriksson (2002) regards the patient as a unique being that comprises body, soul and spirit; spirit meaning spiritually existential, spiritually religious, and spiritually Christian. The claim is that ontologically, every human being and therefore every patient, fundamentally longs for something beyond their own selves, be it a god or abstract other (Eriksson, 2002). In explicating this idea as it relates to nursing, Eriksson (1987, 1990c, 1991, 1992e, 1994, Naden and Eriksson, 2000) says the core of caring comprises of nurturing, purging, playing, and learning in a spirit of faith, hope, and love, which together form the content of what she calls ‘caritative caring’.
of specific note, the verb ‘purging’ is interpreted to mean to nourish, to clean, to see to, and show interest in, presence and shelter (Eriksson, 1990a). Also the verbs ‘to nourish’ and ‘to clean’ capture the belief that caring is to engage in activities that support being human, a being that has physical, mental and spiritual needs (Eriksson, 1990a).

What is more, Eriksson (1994) holds that health is faith, hope, and love and that in order for a person to grow they require faith, hope, and love. Faith assists in adopting a trustful position towards existence, hope is the motion between hope and hopelessness and is related to ‘not giving up’ and belief in the future, and love is devoted claimless care and caring of one for another (Eriksson, 1994). Together these ideas represent the basic assumptions of Eriksson’s theory of caring in nursing.

Basic assumptions of Eriksson’s theory are that:

1. The human being is fundamentally an entity of body, soul, and spirit.
2. The human being is fundamentally a religious being, but not all human beings have recognised this dimension.
3. The human being is fundamentally holy. Human dignity means accepting the human obligation of serving with love, of existing for the sake of others.
4. Health means a movement in becoming, being and dying, and striving for integrity and holiness which is compatible with bearable suffering.
5. The basic category of caring is suffering.
6. The basic motive of caring is the caritas motive.
7. Caring implies alleviating suffering in charity, love, faith, and hope.

Natural basic caring is expressed through tending, playing, and teaching in a sustained caring relationship.

Of note is Eriksson’s (1990a) claims that the concept love has in recent times been reduced to mean just the need of an individual to get satisfaction from love, predominately sexual needs gratification or love as an expression of empathy from the nurse’s side. Rather, Eriksson (1992e: 204) says ‘... caring is based on human love’, or put another way, ‘caring is naturally human, a concrete form of human love’ (Eriksson, 1992d: 2). For Eriksson, the term love has a far deeper meaning than that which is commonly understood and, to this end, her position on love accords with the philosopher Emmanuel Levinas’ view that the word love has been corrupted to the point that it is better to say ‘responsibility for the other’ in order to make clear the idea (Eriksson, 1990a: 4, 1992b: 9) that ‘man’s essence is love’ (Eriksson, 1990d: 4). In short, Eriksson (1990a, 1992b) claims that Levinas’ notion of ‘responsibility for the other’ is in fact what combines love with caring, highlighting the point that love is totally ethical. Accordingly, developing an understanding of the concept love as the responsibility for the other and its link to caring is something that will be explored in this thesis.

Eriksson (1990a) claims that the concept ‘love’ applies to nursing and is given expression through the caritas motive, caritative caring and caring communion. In this conception love is said to ‘just exist’ in a caring culture with the central dimensions of love being honour, generosity, genuineness, affirmation, understanding, freedom, not abandoning (Eriksson, 1990a). The point made is that ‘... caring is love’ (Eriksson, 1990a: 206, 1992e: 206), and therefore it is legitimate to ask question what is the love that is caring or more specifically what is the love that is love in nursing and midwifery?
In summary, Eriksson (1992e: 204) claims that ‘caring is based on love’ and that ‘the basic structure for all kinds of caring is the relationship between the patient and the nurses’ (Eriksson, 1994: 17-18). Thus caring is a natural manifestation of human love and is based on the motive of caritas, through which compassion awakens a desire to alleviate another’s suffering (Eriksson, 1994). The basis of every kind of caring is, therefore, unconditional caritative ethics, a responsibility and a desire to do what is good (Eriksson, 1994). The question that emerges from this scholarship is what kind of love is it that is specific to nursing and midwifery?

Sally Gadow’s theory of ‘existential advocacy’ embraces the notion that caring as the moral ideal of nursing is concerned with the protection and enhancement of the dignity of the patient (Gadow, 1985). Here, dignity is used to capture the idea of a being having integrity, that is, ‘... a being has dignity when it gives to itself its meaning and so creates for itself integrity’, integrity implying ‘... both the coherence which meaning gives to experience and the origin of that meaning within, rather than outside, the individual’ (Gadow, 1985: 32-33).

To achieve this, Gadow (1979, 1985, 1989) says, requires embodiment of both the nurse and the patient, because embodiment enables intersubjectivity and thus regard for the patient as subject rather than just object, which means to respect their freedom to transcend all the forms of categorization and expectation that would cause their objectification. Thus the ideal of existential advocacy is expressed when a nurse assists a patient to authentically exercise their freedom of self-determination (Gadow, 1979). As Gadow (1979: 82) says, it is where a nurse helps a patient to be;

‘... clear about what they want to do, by helping them to discern and clarify their values in the situation and, on the basis of that self-examination, to reach decisions that express their reaffirmed, perhaps
recreated, values’.

Here, the nurse attends to the patient as a whole, a person of unity, a person that is more than a definition of a single problem, categorization or system (Gadow, 1979, 1995).

In this context, caring in nursing is understood as a commitment to protecting and enhancing the dignity of the patient. It is attending to what Gadow (1985) calls their ‘objectness’ without reducing them to the status of object. Here, objectness means that which has been ‘lifted out of the lived immediacy of experience’ or that which is objectified as is the case of a disease type or type of a disease (Gadow, 1985). Gadow’s (1985) point is that objectification in this way is aimed at overcoming the indignity of the problem for the patient so enabling the restoration of the patient’s integrity which has been compromised. Importantly though, Gadow (1985) makes clear the object-subject relationship in caring for a patient when she says that therapeutic activities aimed at dealing with the objectness of the person if linked with activities that are aimed at protecting the patient from being treated as an object, constitutes a caring relationship.

Equally she notes that, in the modern clinical context, the objectification of the patient is often so complete that the subjectivity of the patient is almost extinguished. It is a point powerfully made in her quoting of a patient’s experience of health care exemplified in the dictum of my body becoming the body (Gadow, 1989, 1995). The patient describes his experience with a leg that wouldn’t move and a surgeon who considered himself a carpenter. ‘I regarded my leg as a thing, and he regarded me as a thing. Thus I was doubly thinged, a thing with a thing’ (Gadow, 1989: 539). The view put is that objectification of the patient can be so complete that the person is reduced to the status of object with little acknowledgement of the subject. In this case, the surgeon saw only a
‘thing with a thing’ (Gadow, 1989: 539).

What is more, Gadow (1995) makes clear that the disengagement can extend to also include the patient, that is, the patient can adopt the same disengagement that is used to maintain a reflective distance from subjectivity as, in the example above, the surgeon or for that matter a nurse. In this way the patient and the nurse can collaborate in the translation of experience into categories to the point where both the nurse and the patient talk about, using the example above, the patient’s leg as if they were engaging in a discussion about an inanimate object, a ‘thing’. In this type of;

‘. . disengagement the force of immediacy is countered by a new force, the power of objectification - a force so strong that experience itself can be objectified, reduced to its simplest parts’. (Gadow, 1995: 28)

In the health industry Gadow (1984, 1985), identifies the impact of technology on the dignity of the patient, what she refers to as the technologizing of care. The claim is that technology and its required professional application, particularly that which is highly sophisticated, serves to reduce the person to their objectness. The technologizing of care thus poses a dilemma for the nurse, as in how to enact moral commitment to the dignity of the patient at the same time as attending to their objectness. In response, Gadow (1985) poses two solutions, the use of truth telling and also touch, which she says requires the participation of both the patient and the nurse in the expression of their subjectivity. More precisely, ‘the ideal of caring is an ideal of intersubjectivity, in which both nurse and patient are involved’ (Gadow, 1985: 38-39).
The embodiment of the nurse and the patient makes possible access to their subjectivity, which is the basis for moral commitment to act as an advocate in order to enhance autonomy (Gadow, 1989). Here, the nurse and the patient exchange in a sharing of values and views and so enable bridging of both the objectivity of the patient being treated as an object and also the isolation associated with pure subjectivity. For Gadow (1985), the empathetic or caring ideal, means that mutuality becomes the moral foundation of nursing: that it is commitment to the dignity that distinguishes persons from objects. In the modern clinical context where objectness can so easily undermine dignity, understanding caring as the moral ideal of intersubjectivity makes possible the restoration and maintenance of the patient’s dignity (Gadow, 1985). It provides insight into the realm of human intersubjectivity and the relation that enables a person to rise above their own subjective isolation and be concerned with more than just their self. This ability of our being to transcend its subjective isolation is an idea that will be further explored in this thesis.

Gadow’s (1988, 1995) theory of existential advocacy also includes the belief that care is the alleviation of vulnerability. In particular, care is identified as the moral end and cure as the means to that end (Gadow, 1988). The view postulated is that the alleviation of a patient’s vulnerability is only made possible when both the nurse and patient have a relationship that includes an expression of their embodied selves, their shared subjective reality (Gadow, 1988, 1995). In practical terms it may be the sharing of their body’s significance, disclosing their own anguish, fear and bewilderment as a testimony to the body’s subjectivity (Gadow, 1988). As Gadow (1995) notes, the relational narrative engaged in by both the nurse and the patient extends beyond their particularity as a person concerned only with itself, but not beyond their relationship which she says ‘. . . creates a new objectivity in the form of intersubjectivity, an advance beyond the subjectivity of vulnerability and the antisubjectivity of objectivism’ (Gadow, 1995: 33). Therefore, as long as the nurse and patient ‘...
remain engaged in each other’s vulnerability and its alleviation, the existential
distance between them diminishes’ and caring is possible (Gadow, 1988: 13).
The theory of existential advocacy suggests that in the moral party of two the
nurse and midwife respond to the vulnerability of the patient. It requires them to
be concerned with more than themselves and instead be committed to protect
and enhance the dignity of the patient. The view presented suggests morality is
at the centre of the nurse-patient relation and is what makes it possible for a
nurse and midwife to be concerned for more than their own project.

Rosemarie Rizzo Parse’s original scholarship in the 1970’s centered on the
formulation of a theory of nursing called man-living-health which has continued
development to the point where Parse (1998: ix) herself now refers to these
ideas as a ‘school of thought’. While it is not a specific theory of caring, it is a
type of nursing which contains easily identifiable elements that relate to the
moral imperative of caring in nursing. To this end, this account is not a thorough
description of Parse’s theory of nursing but a brief acknowledgment of her
contribution to the understanding of caring in nursing or more specifically, the
relation between the nurse and the patient.

Of note in her theory is the inclusion of tenets and concepts derived from
existential-phenomenology, that is, the concepts of intentionality, and human
subjectivity, and the concepts of coconstitution, coexistence, and situated
freedom that inform her thinking about nursing and in particular, caring in
adopts the view that a person is by nature an intentional being that is open,
knows and is present to the world in the creation of the self as a project of
personal becoming. Here, being situated in the world consists of two
components, a presence as a being and a not-yet but open presence to the
world, which it is claimed is evidence of the freedom and desire of a being to
says that, ‘man experiences existence as coexistence’, that is, a person exists with others in their becoming as a self-project and that without such others it would be impossible to know about oneself.

As a self-project, a person is responsible for both their choices and their omissions about the situations in which they find themselves. In these situations, the freedom to choose and the responsibility that comes with it, exist because of the need to take a stand about a way of being. It is a stand that is representative of one’s values, feelings, and desires (Parse, 1981, 1998). However, Parse (1981: 21, 1998: 18) equally acknowledges the risk that comes with such situated freedom and the accompanying responsibility; one always chooses and such ‘… choices are made without full knowledge of the outcomes yet with full responsibility for the consequences’.

Next, the tenet of human subjectivity holds that ‘. . . conscious man (sic) by nature is no-thing but, rather, a unity of being and non-being’ (Parse, 1981: 19), ‘. . . living what is and what is not-yet all-at-once’ (Parse, 1998: 15). As Parse (1981, 1998) notes, it is a Heideggerian view of subjectivity. The claim is that a, human can only be present with the world by means of a dialectical relationship, which makes possible the cocreation of personal becoming by way of the meaning given to the projects that emerge during the process of choosing to live in a particular way as an expression of one’s values, beliefs and desires. Thus living in relation to others or coconstitution, is what makes possible meaning. It is a meaning that is reliant on the constituents of that situation. It is a meaning that arises from the human-world dialectic, the mutual process with its various perspectives on situations, others and one’s own presence, which results in the cocreation of the world (1981, 1998). It is these postulates about human becoming that provide the foundation for understanding the interrelationship of the nurse and the patient that are encapsulated in Parse’s definition of caring and description of ‘true presence’ (Parse, 1981).
However, as stated above, while not a specific theory of caring, Parse’s work is premised on a foundation that has as its central tenet the interrelationship of the nurse and others (Parse, 1998). More particularly, it focuses on the concern of the nurse with the patient’s lived experience of health as is reflected in patterns of expression and the idea of ‘true presence’ as an intentional reflective love (Parse, 1978, 1981, 2001).

Specifically, Parse (1978: 130) says ‘…caring is risking being with someone towards a moment of joy’. Here the term risk is used to capture the idea of threat to the self-project. In coconstituting, the nurse and the patient engage in a relationship of authenticity through which both have the potential to grow, but while the patient’s values, beliefs and desires may not necessarily be those of the nurse, the subject-to-subject relationship, Parse (1978) says, has the nurse reach out to the patient’s call even though the reaching out exposes the nurse to change and the possibility of negative consequences to the self. Thus, the term ‘risk’ as is used here, is related to the chance of the nurse and the patient ‘…growing toward the possible, as well as in the possibility for rejection’ (Parse, 1978: 131). From this description it appears that intentional reflective love is what enables the nurse and the patient to be truly present to each other and is of the quality that enables the nurse to risk and therefore potentially sacrifice their own welfare for the sake of another. What exactly the love is then, that Parse speaks about, that enables such commitment and responsibility to another person that is also specific to the profession of nursing and midwifery, is unclear.

The second element of Parse’s (1978) definition of caring is linked to the concept of ‘being with’ or authentic and open engagement, and has the nurse reach out to understand the patient’s experience. Here ‘being with’ relates to the subject-to-subject relationship which is said to be unique in nursing. While both the patient and nurse have the possibility of growth as a self-project, in nursing,
Parse (1978) says, the nurse takes the responsibility for their choosing to participate with the patient in the health-related situation. It is a choosing that arises from the responsibility the nurse feels toward the patient, making the responsibility chosen, moral, but what is the explanation for why a nurse should feel morally responsible. What makes the nurse feel this way?

Notably, Parse (1978: 131) states, that ‘each experience of participation is a source of self revelation toward growth for both nurse and client’. Here, Parse (1978) identifies that there is reciprocity involved in the nurse-patient relation but she does not speak about its effect on the motive of responsibility felt by the nurse. What is the relationship of the responsibility the nurse feels for the patient on reciprocity? For example, is the motive for risking the nurse’s self-project first about the possibility of self improvement and can this be otherwise?

While the dialectical relationship makes possible the coocreation of personal becoming, if the nurse’s self-project is their first priority and the project of the other is second, caring is simply the means to their collective ends. It appears that the responsibility felt by the nurse in the nurse-patient relation is of two distinct types, one is where the nurse’s self-project is their first priority and the second is where the patient’s self-project comes first. What determines the responsibility the nurse has for the patient and how is it possible that a nurse or midwife is able to sacrifice their own good for the patient?

The idea of ‘true presence’ is described by Parse (1992, 1995, 1997, 1998) as a special way of ‘being with’ a patient, an attentiveness to the patient in the moment-to-moment changes of their living of their value priorities as they relate to their changing health patterns. Thus, ‘true presence is an intentional reflective love, an interpersonal art grounded in a strong knowledge base. . . ‘ that respects the uniqueness of the personal way of being of the patient (Parse, 1998: 71). It requires of the nurse ‘free-flowing attentiveness’ to the patient and
is not something that arises from effort or a focus of attention, because trying would be a distraction that would take the focus off the patient (Parse, 1998). To this end, ‘true presence’ is described as requiring ‘preparation’ and ‘attention’ (Parse, 1998). ‘Preparation’ means that the nurse empties themself in order to be available to bear witness, to be flexible, and to be gracefully present from their centre (Parse, 1998: 71). However, given this brief description, it is difficult to understand Parse’s ideas about the concept ‘preparation’ (Parse, 1992, 1995, 1997, 1998). Similar to comment made earlier, perhaps she is suggesting that in order to have a chance at being truly present to a patient, a nurse and midwife requires moral commitment of a quality that enables them to be concerned with more than just their self.

The second concept, ‘attention’, is easier to comprehend and means to focus on the moment at hand, to be immersed in the moment, and so cocreate attentiveness to the patient’s situation (Parse, 1998). Thus according to Parse (Parse, 1998), this coming-to-be-present moment that incorporates the ideas of ‘preparation’ and ‘attention’, is what enables the nurse to enter the patient’s world. It enables the patient to share with the nurse only that which they desire, the nurse working with that version of reality in the belief that each person knows ‘the way’ somewhere within themself (Parse, 1992, 1998). Parse (1992: 40) makes clear her ideas when she says, ‘it is essential to go with the person where the person is rather than attempting to judge, change, or control the person’. Here Parse concentrates on what appears to be a conscious relation, where the nurse and midwife focuses on the moment at hand and is attentive to that situation, but, should she be speaking about attention that is other than conscious, her description is incomplete.
The third concept that Parse (1978) identifies as an essence of caring in nursing, in addition to ‘risking’, and ‘being with’, is called ‘moment of joy’, that is, the quality of ‘being with’ in the subject-to-subject relationship Parse (1978) says gives rise to the dynamic of ‘suffering-joying’. She (Parse, 1978) calls this a ‘moment of joy’. It is where the nurse risking being with the patient in a health-related situation shares in the patient’s suffering-joying. As Parse (1978) says, when the nurse realizes the meaning of the risk associated with the position taken, the witness of the patient’s suffering-joying and their attention to that, coconstitutes moving toward the possible with the patient. All this said, Parse (1990: 139) says the focus of nursing practice is the ‘... subject-to-subject interrelationship, a loving, true presence with the other to enhance the quality of life’. Notable in this summation is the use of the term love as opposed to caring. It would appear that for Parse love best identifies the motive that underpins the subject-to-subject interrelationship from which caring emanates. Yet throughout her text Parse offers little by way of an extant description of love.

Nel Noddings is an educational philosopher who offers a theoretical exposition of caring that has contributed significantly to the general scholarship on caring and is often cited in the literature of nursing. Explicating Noddings’ (1984) ideas in some detail is a worthy task because she is one of a handful of scholars that offer such a comprehensive perspective of the content of caring that is able to be applied to nursing. Noddings’ (1984) thesis presents a feminine perspective of practical ethics that requires a person to place themselves in a concrete situation, or as close as possible to it, so as to assume personal responsibility for the choices made from the relation (Noddings, 1984).
In view of that, Noddings (1984) believes that human caring and the memory of caring and being cared for form the foundation of our ethical responses. Caring involves a psychic relatedness that in a feminine view is understood to be rooted in the ideas of receptivity, relatedness, and responsiveness that begin with a moral attitude and a longing for goodness (Noddings, 1984). She seeks an understanding of what it means to care and to be cared for, and in doing so explores the concept of relations, which is interpreted as ontologically basic, and the caring relation, as ethically basic.

Here the term relation is defined by Noddings (1984: 3&4) as ‘a set of ordered pairs generated by some rule that describes the affect - or subjective experience - of the members’. As for relation as ontologically basic, Noddings (1984) says, it simply means that the human encounter and affective response is a basic fact of human existence. Thus what it means to care and to be cared for involves two parties in relation, where my caring can only be completed in the other if the relation is a caring relation. As can be seen, the reciprocity of the relation is important, for it defines how we meet the other morally (Noddings, 1984).

This said, Noddings (1984) is of the view that ethical caring is the relation in which we meet the other morally. It arises from our natural caring, the relation where a person responds as one-caring (one-caring is the term used to describe the feminine perspective of caring), out of love or natural inclination. Here the relation of natural caring is perceived (consciously or unconsciously), in the human condition, as ‘good’ and is a condition that a person strives and longs for (Noddings, 1984). It is a longing in the sense of wanting to be in that special caring relation, a relation that motivates a person to be moral.
To be moral is our aim because it enables a person to be in a caring relation and so enhances the ideal of ourselves as one-caring (Noddings, 1984). It is this ethical ideal that enables a person to form a realistic impression of themself as one-caring, which is what guides the meeting of the other person morally (Noddings, 1984). For Noddings (1984), everything depends on the ethical ideal because it, and not absolute principles, is what guides people. To this end, Noddings (1984) rejects the notion of universalizability because her focus is not on judgment and the particular acts performed but on how a person meets the other morally in each unique human encounter.

Specifically, caring from the ‘inside’ or locating oneself in a relation, where the responsibility for decisions about caring is accepted, enables the one-caring to displace interest in their own reality to the reality of the other (Noddings, 1984). To explain how this may be possible, Noddings (1984: 14) appeals to the ideas of Søren Kierkegaard (Kierkegaard, 1941) saying that ‘...we apprehend another’s reality as possibility’. Applied to nursing, the possibility of the patient’s reality arouses the nurse in such a way that it disrupts their ethical reality because it enables the nurse to understand that the patient’s reality could possibly be theirs (Noddings, 1984). The relation is not only about the nurses’ self improvement but an acknowledgment of the feeling that is aroused; an acknowledgment of the feeling that says ‘I must do something’ (Noddings, 1984).

The reality of the other, when understood to be possibly one’s own reality, evokes responses that are aimed at the elimination of the problem encountered (Noddings, 1984). For example, the implementation of activities aimed at reducing the pain and suffering of a person (Noddings, 1984). In view of this Noddings (1984: 14) says, ‘when I am in this sort of relationship with another, when the other’s reality becomes a real possibility for me, I care’. In this way ‘all caring involves engrossment’, as this is about endurance and not intensity as is
the case in romantic love (Noddings, 1984: 17).

Ethical caring as the response to the feeling that one must do something, Noddings (1984) says, has many forms. It can be short or long-lasting, visible for all to see, depending on the ability of the relation to be sustained, or it can be invisible where one simply acts out of a concern for one’s own ethicality. But even in the latter case, where the relation is not sustained, the striving to attain or regain the relation results in a person experiencing genuine caring for their self (Noddings, 1984). Accordingly, ‘caring for self, for the ethical self, can emerge only from a caring for others’ (Noddings, 1984: 14).

What is more, the caring Noddings (1984) speaks of is not universal because, as she says, we do not care equally for everyone. For example, in nursing I may encounter a patient whom I find repugnant, which may elicit feelings in me of disgust and revulsion, and require me to withdraw because I simply do not care for this person (Noddings, 1984). Noddings (1984) uses the basis of this nursing applied example to explain the idea that should I do something, no matter how small, on this person’s behalf, such as an acknowledgment in me that this person has a legal right to medical treatment, the same as any other person, then it is because I care about my own ethical self which dictates that I must try to care.

However, while we may ‘care about’ everyone in the sense of being at the ‘ready to try’ to care, it is not the same thing as ‘caring-for’ to which she refers when using the word ‘care’ (Noddings, 1984). It is a point Noddings (1984: 18) makes clear when stating that the caring being referring to is ‘. . . an actuality; in the other, it refers to a verbal commitment to the possibility of caring’. It is a relation which makes possible the apprehension of an other’s reality as if it were possibly one’s own. Applied to nursing, it enables a nurse to feel, as close as it is possible, what the patient is feeling. It arouses in the nurse a feeling that ‘I
must’ act as though it was for the nurses own good that they were acting (Noddings, 1984). But the nurse’s acting is on behalf of the patient. It requires of the nurse a commitment to do something that is more than just responding to a feeling for it may require the nurse to be committed to act on behalf of the other for a long period of time (Noddings, 1984).

However, Noddings (1984) says that while ‘feeling’ is essentially involved with caring, there is more. She (Noddings, 1984) uses the term ‘receptivity’ to describe the relation that is characterized by one receiving the other and being totally with the other. Here receiving the other describes the relation in terms of the response to the feeling ‘I must do something’. It is about responding to the ‘feeling’ (being in a receptive mode), which does not necessarily require knowledge of the object because at the time of the responding one is not thinking of the other as an object nor is one making a claim of any knowledge of the other (Noddings, 1984). She (Noddings, 1984: 33) adds that responding to the feeling that ‘I must do something’, involves a shift of motivation. It is not a relinquishment of the self, but rather that, ‘allow my motive energy to be shared; I put it at the service of the other’. Such a shift in the focus of the motive energy makes one vulnerable because one’s good is now partly in the hands of the other (Noddings, 1984).

Given Noddings’ (1984: 33) claims ‘that the one-caring is engrossed in the other’, is not only about endurance, as was spoken about earlier, but also about the ‘... appropriate mode of consciousness in caring’. Precisely, the response to the feeling that ‘I must do something’ shifts the motivational energy from a concentration on the self to the other and so is shared with the other, which is what enables one to be engrossed in the other.
It results in a particular characteristic and an appropriate mode of thinking that is different to an emotional response in caring, it is what Noddings (1984: 33) says ‘. . . is a thinking mode that moves the self toward the object’. In other words, one uses the various modes of thinking, from rational objectivism to irrational emotivism in responding to the situation that is before them. One moves between the various modes of cognition and at any given point in time there will be one mode dominating the mind giving rise to responses that could be classified as appropriate or inappropriate (Noddings, 1984).

In responding, ‘. . . my rational powers are not diminished but they are enrolled in the service of my engrossment in the other’ (Noddings, 1984: 35). As Noddings (1984) says, it is in this subjective mode that one sees what they have received from the other, it is for them to decide what to do because the choices are theirs, they can either precede in a state of truth or they can deny the other and so talk themselves into feeling comfortable as opposed to feeling guilty. Thus, caring according to Noddings (1984: 40), ‘. . . is to be partly responsible for the other’. But can one’s engrossment in the other be so complete that they are wholly responsible for them and, if this were possible, what would this state be, because it would be different to caring?

Here caring is understood to involve the idea that ‘I ought’ to respond to the other, which means that one can equally accept or reject the other (Noddings, 1984). A central tenet of Noddings’ (1984: 4) thesis is that ‘each of us is dependent of the other in caring and moral relationships’. She (Noddings, 1984) summaries her ideas about our dependence on each other and our fundamental relatedness to each other in the sentence, ‘we are both free - that which I do, I do - and bound - I might do far better if you reach out to help me and far, far worse if you abuse, taunt, or ignore me’ (Noddings, 1984: 49).
Noddings (1984) also says, what is more, that the ethical ideal to which she refers is incomplete if it only relies on one’s engrossment in the other, the shift of one’s motivational energies toward the other and their projects. It is only half of the picture, which is a half that is made up of one’s understanding of oneself as a caring person, with the other half being located in one’s desire to be ‘received, understood, and accepted’ by an other (Noddings, 1984).

Noddings (1984: 49) says, ‘I see that when I am as I need the other to be toward me, I am the way I want to be - that is, I am closest to goodness when I accept and affirm the internal I “must”, which is integral to one’s ethical self. Here Noddings (1984: 49) identifies the idea of ‘goodness’, which she says is „. . . an assessment of the state of natural caring’. This goodness, to which she (Noddings, 1984) refers, is felt, is what guides one’s thinking implicitly, and is thus an essential part of the picture of one’s ethical self. As with comments made earlier about Eriksson’s use of the term goodness, there is no description of what exactly it is and why it is sought.

The ethical self is the active relation between the picture of one’s ideal self and one’s actual self as both the one-caring and the cared-for (Noddings, 1984). It arises from the natural relation that is founded on goodness. It connects one through the other to oneself, that is to say, as one cares for an other they are equally cared for by them and so one becomes able to care for oneself, the ethical self (Noddings, 1984). Accordingly, the ‘I must’ arises from the ethical ideal of myself, which is what sustains one in times where caring for the other fails, it also helps rise above moments of uncaring towards caring (Noddings, 1984). Thus, caring is the picture of the ethical self. It is what caring can be, and is what gives rise to the feeling ‘I must’, which is about the struggle toward the other over, what Noddings (1984) says, is one’s own apathy, aversion and doubts.
For Noddings (1984: 51), ‘my very individuality is defined in a set of relations. This is my basic reality’. Thus, the caring relation requires of the one-caring, engrossment and motivational displacement, and it requires of the cared-for a receptivity of caring that results in authentic recognition and a spontaneous response to the one-caring (Noddings, 1984). When caring is not perceived as caring by the cared-for, or its absence is felt, the cared-for may still, by an act of ethical heroism, respond and contribute to the caring relation. However, such responses compromise the quality of the relation (Noddings, 1984).

As thorough as Noddings’ (1984) explanation is about caring, there are several ideas that require further elaboration. While a central tenet of Noddings’ (1984) theory of caring involves the ability of the one-caring to displace their motive energy from a caring about self to a caring for an other, she offers little discourse on the quality of the sacrifice that is able to be made in such a shift of focus. For example, how far is a nurse willing and able to go in shifting their motive energy from a concentration of their self-project to the interest of the patient when such a shift will place them at risk?

A second tenet of Noddings’ (1984) theory of caring involves the idea of the one-caring responding to the feeling ‘I must’, which Noddings says operates at the level of one’s reflective consciousness for it is something that must be given consideration. What is more, the ‘I must’ is linked to the idea that in some situations one not only feel that they must do something but that they also want to do something (Noddings, 1984). Here the ‘I want’ to which Noddings (1984) refers, is about relatedness and is a must that is born of desire. As Noddings (1984) states, the most intimate situations of caring, such as taking care of one’s own child, is natural. However, the impulse to act in such a situation is innate and may be overwhelming; it still requires a response of the reflective consciousness (Noddings, 1984). As a nurse (myself), there have been occasions where relations with patients have operated at the preconscious
level. Namely, when an event has resulted in my immediate reaction that was not a response to the feeling ‘I must’. There was no feeling to which I was to respond and there was no choice because it was something I did not have any say about. I found myself responding in a relation before my conscious consideration, but what is more, that should I have had an opportunity to have thought about the way I was to respond, before I responded, I may well have responded differently. In hindsight, it seemed that it was something I had to do, I had no choice, for it just happened. At the time, it was as though I was a hostage to the needs of the patient where my own project was not a consideration. In this example there appears an asymmetry in the relation that is not fully explained by Noddings’ (1984) theory. Perhaps the event described is more akin to Noddings (1984: 5) concept of ‘natural caring’, which she says is ‘... that relation in which we respond as one-caring out of love or natural inclination’.

Similar to Nel Noddings the philosopher Stan van Hooft presents a considered explanation of the content of caring and also caring as it relates to the practice of nursing (van Hooft, 1987, 1988, 1995, 1999a, 1999c). Specifically, van Hooft’s (1995) theory of caring is based on the belief that our attitudes to other people and toward the world in general take their character from being the determinable formation of our own deep caring. In citing Aristotle, van Hooft (1995: 2) makes the point that in order ‘... to act well we must not only reason truly but also desire rightly’, desiring rightly or feeling rightly van Hooft (1995, van Hooft, 1999a) claims, are dependent upon our cares, cares that lie deep within us and are given their content in our commitments. For van Hooft (1995) our cares and our commitments are an expression of our primordial motivational field called ‘deep caring’.
Deep caring as conceptualized by van Hooft (1995), is a motivational comportment that has both an inward function, in that it is responsible for defining the self (caring as self-project), and an outwards function, in that it defines how our self relates to others and the world in general (caring-about-others). It is a motivational comportment that operates at various levels of our human existence; at the biological level, where the focus is on our interaction with the physical environment; at a perceptual and reactive level that is concerned with a cognitive understanding of reality; at an evaluative and proactive level where we define our place in the world in which we live as reflective, purposive and active beings; and at a spiritual level where we live out our hopes, loves, and faith in order to make our life meaningful as relational beings (van Hooft, 1995). As a unified being, all levels operate together to form the basis of the attitudes and commitments in the various expressions of our being as deep caring about caring for the self as a project and a caring-about-others (van Hooft, 1995).

Accordingly, van Hooft (1995) claims that morality is directed by what we as individuals find important, which of course will vary in significance because of how these various things accord with our being as a self-project and caring-about-others. Consequently, van Hooft (1995) believes, ethics is an expression of our deep caring. However, in his thesis van Hooft does not speculate on the origin of the primordial motivational field he calls deep caring. What is at the root of deep caring remains a mystery?

The idea of commitment is central to van Hooft’s (1995) thinking about caring. The claim is that people care about a variety of matters at a deep level in their character, and that these cares, in various ways, are given expression in our commitments to our self-project and care-about-others (van Hooft, 1987, 1988, 1995). Here, the commitment to self and other arise from deep within people and forms the foundation on which they make moral decisions about what are
their cares (van Hooft, 1995). Put simply, commitment as an attitude gives its object a positive and practical importance, in that, we invest ourselves in what we are committed to (van Hooft, 1996). In this view, commitment is intentional because it is directed at something or someone (van Hooft, 1987, 1995, 1996).

What is more, the force of the commitment of one’s cares is revealed in the dedication that comes with professing one’s commitments, and the commitment that comes with being called to respond to something outside of one’s self that is identified as important (van Hooft, 1995). Commitment, van Hooft (1995: 16) believes, comprises both ‘. . . the subjective connotation of to profess and the objective connotation of vocation’. It is an intentional and dynamic two-way relationship where a person is committed to something or someone (van Hooft, 1995). It may arise from that to which a person is dedicated and devoted or it may arise from a person’s personality or character that is engaged by the object through attention to it (van Hooft, 1995). Hence commitment is understood to be a relationship that has both objective and subjective content and is based on a person’s character (van Hooft, 1987, 1995).

In other words, commitment arises from a ‘given way of life’, which means that a person has commitments and is committed to persons and things based on that way of life, which itself can give rise to more self conscious commitments (van Hooft, 1995). As van Hooft (1995: 18) points out in his model of care, ‘it is out of what we are, as described by the way of life to which we are committed, that our more focused and specific commitments arise’.

What is more, van Hooft (van Hooft, 1995) makes an important distinction about determinate and nondeterminate commitments, such as, for example, the difference in commitment to people in general versus a commitment to a particular person. Clarifying this view, van Hooft (1995) says that should commitment be understood to be a function of subjectivity it is always
undetermined (nondescript and vague, a general commitment), but becomes focused and determined (commitment that is specific, tangible and has form), just to the degree that its intentional object is focused and determined. For example, in being committed to a person one is not committed to any particular course of action, but to whatever action or actions are necessary to secure the well-being of the one to whom we are committed (van Hooft, 1995). In this way, commitment may lay dormant and one may not know what one is committed to until faced with a choice where the commitment is tested, the testing revealing the commitment and what one cares about (van Hooft, 1995).

As van Hooft (1995) says, a person has to care about something or be attracted to it if they are to be committed to it. In living a moral life, a way of life, our commitments are made, discovered, and rediscovered, and are given their content in the decisions made and stance taken about what one cares (van Hooft, 1995). He (van Hooft, 1995) makes the point, that a person cares about a variety of things at a deep level in their character and that one or another of these cares comes to expression in commitment. Put another way, commitment is the articulation and specification of deep caring which is grounded in a person’s character and is given expression in what a person finds important and what they come to care about (van Hooft, 1995). Accordingly, ‘deep caring is a mode of our being from which commitment springs’ (van Hooft, 1995).

In applying these ideas to nursing, the professional commitment of the nurse has their attention focused on the object of health rather than the person of the patient (van Hooft, 1987). The commitment of the nurse is to the health of the person and the cares required in preventing, restoring or maintaining that health (van Hooft, 1987). Here the ideal of health is the object of the nurse’s professional commitment; the patient is the vehicle for the nurse’s general commitment to health, which is not to say that the person of the patient is not important to the nurse because it is (van Hooft, 1987). However, more important
to the nurse is the health of the patient because this is what the nurse cares for (van Hooft, 1987, 1999a). But is this postulate over simplistic; is it always the case that the health of the patient is the nurse’s first priority and the person of the patient second? Is it not equally plausible that what the nurse and midwife actually cares for is the welfare of the person who is a patient in need of professional health care in order for their welfare to be secured? Is what the nurse and midwife cares for as health is only the means to the achievement of the end that is the welfare of the person? It is questions like these that lead to speculation about the commitment of the professional nurse and midwife to the patient.

Continuing, van Hooft (1995) claims that, for the reasons given above, caring as a motivational structure has the concepts of caring and commitment intertwined. In describing this motivational structure, van Hooft (1995) coined the term ‘deep caring’, which acknowledges the existence of an inchoate level of commitment in our motivational sets that, when applied to the objects of one’s world, changes them to focused commitments of which one is reflexively aware and which become one’s intentional forms of caring. In daily living one’s cares are object-directed and are determinable, which means that while one may care for all one’s cares in a determinate way, when focused to the object of one’s caring, one’s caring becomes determinable, it becomes the focus of one’s now determinable commitment (van Hooft, 1995).

To explain these ideas further van Hooft (1995) suggests caring can be spoken of in three ways. First, caring as a mental state occurs when in the activity of caring for something or someone, the caring and the object of one’s caring attention are present to one’s mind and serve as a source of motivation (van Hooft, 1995). Second, caring as a mental disposition embraces the idea that each of us possesses determinable sets of concerns that become conscious only as the situation demands. Although the object of one’s caring may be
specifiable, it is not usually determinable unless it is reflected on (van Hooft, 1995). At best, reflection on one’s thoughts, feelings and actions is the only way one is able to reveal the objects of their cares (van Hooft, 1995). Third, caring as a mental activity relates to the idea that one tries to be careful in what one does, which can be either the outward expression of caring as a mental disposition or it may itself bring about a mental disposition of caring (van Hooft, 1995).

In other words, mental activities occur spontaneously from the commitments of our deep caring. However as one might expect, they are not preceded by volitions or intentions. Rather, the commitment spoken of by van Hooft (1995: 43) ‘. . . is an act of will determinable by any occasion apt for the enactment of that commitment . . .’, thus, while it is a stance taken it is one that is not one preceded by an intention (van Hooft, 1995: 43). So a commitment is made before we decide to make it, and therefore we can find ourselves either making a commitment or having made a commitment, which we only become aware of as we enact it (van Hooft, 1995). As van Hooft (1995: 43) writes, ‘it has no phenomenological volume, but is itself directed upon objects and projects of the world’.

Accordingly, the commitment to which van Hooft (1995) refers is expressed in our caring without putting that caring into effect deliberately or intentionally for it is an activity that is not an action (van Hooft, 1995). What is more, once a commitment has been made it continues as a mental disposition that in making the commitment and then acting on it, inaugurates the mental disposition. In this way, the mental activity has given rise to a mental disposition (van Hooft, 1995). Therefore in the course of conducting ourselves in a careful or caring way and where we are aware of this quality we may experience a mental state of caring that has originated from the mental activity of making of a commitment (van Hooft, 1995). Accordingly, the mental disposition of which van Hooft (1995)
speaks about is determinably intentional and already an expression of our deep caring which is neither determinable nor intentional.

An important feature of van Hooft’s (1995) view is that the commitment of ‘deep caring’ is not intentional nor is it determinable because no object can be specified for it. For van Hooft (1995: 45) ‘deep caring is present to us as a horizon rather than a content of consciousness or an a priori postulate’. Here the term horizon is used to explain the idea that interpretation of the inchoate commitment of our deep caring is manifest through the commitments of our mental activities of caring which give rise to our mental state of caring and thus our mental disposition of caring (van Hooft, 1995). Like Noddings (1984), van Hooft (1995) holds that caring is reflexive. It is focused inwards toward the self as the self is an implicit object of caring and even when determinable caring is focused outward toward an object, it is at the same time focused inwards towards the self. In deep caring, however, caring is not intentional and therefore no distinction can be made within it between self and other because it is sheer motivation. It does not have an object on which to act (van Hooft, 1995).

While deep caring is without object it is not without function. The function of deep caring is that it constitutes the self; it provides the horizon against which caring can be interpreted and so enables the integrity of our commitments and the caring that issues from them (van Hooft, 1995). So the primary expression of our primordial care that is situated deep within us and called ‘deep caring’ is our own being as a self-project (van Hooft, 1995). Besides caring, however, what other forms do our commitments take that arise from the motivational field that van Hooft (1995) has labeled ‘deep caring’?
In van Hooft’s (1995) model of caring, deep caring is said to exist at all four levels of being human, that is, the ontology of being human functions at the biological, perceptual and reactive, evaluative and proactive, and the spiritual levels of which deep caring is diffused (van Hooft, 1995). At the biological level, deep caring is the motivational impetus to our intentional and purposeful lives that enables basic survival and the determinable care required of the self as a project (van Hooft, 1995).

The perceptual and reactive level entails the preconscious apprehension of the world through the cultural meanings made available to us and so is a perception (van Hooft, 1995). Equal to perception is the idea that existence also entails reaction, which makes possible practical understanding that is then assimilated into the perceptual and cognitive level of our lives as it is lived (van Hooft, 1995). It is not a two stage process of perception followed by reaction; rather, the things that matter to us, such as our determinable cares, are noticed more, and therefore reaction is better understood to be a schema through which what is perceptually given in the world has significance (van Hooft, 1995). At this level of our being, deep caring is postulated to be our ontological relatedness to the world that enables development of our self-project (van Hooft, 1995).

Next, the evaluation and proactive level of being human is about praxis (van Hooft, 1995). It entails the ways in which we express our attitudes and our desires as shaped and motivated by our inchoate deeper level of needs and wants that constitute our determinable and determined instances of caring that form the reasons for action (van Hooft, 1995). So it is through reflection that we bring our reasons for action to our consciousness, actively and self-consciously assessing and pursuing the motivations involved in living out our self-project (van Hooft, 1995). For van Hooft (1995), our projects and activities are important to us because they form part of our life as it is lived, past, present and future, which we care about in a deep and inchoate way (van Hooft, 1995).
Finally, the fourth level of van Hooft’s (1995) model of caring consists of the spiritual level, which embodies the idea of our self-project as an integrated, whole (van Hooft, 1995). The spiritual level is where our being is constituted whole, wholeness as a person, the wholeness of our life as it is lived, and the wholeness of our attitudes and view of the world in which we live (van Hooft, 1995). It is where our sense of ourselves, as unique individuals and projects in the world in which we live, is articulated (van Hooft, 1995).

All this said, intentional caring occurs at all four levels of the caring model, but while the objects of our attention and the degree of reflexivity differ, together they are expressive of our deep caring as a self-project (van Hooft, 1995). While our deep caring always remains intimate and inchoate, it comes to light in the cultural form of communication which can only ever be historically and therefore reflexively available to us (van Hooft, 1995). As van Hooft (1995: 64) says, ‘deep caring is the prereflexive basis of our self-projects which become focused as determinable caring and determinate projects and intentions as we engage our world’.

What is more, the content of deep caring also takes the form of caring-about-others because others matter to us (van Hooft, 1995). Van Hooft (1995) holds the view that being as a self-project and also being as a caring-about-others provide a preconscious dynamism that forms the projects and commitments which constitute our ontological being as it is focused and determined by the intentional objects which make up our world. Here caring-about-others and the self as a project are equally primordial because as pre-intentional structures of our being, they have no determinate content that separates them. At this level of our being they are the same (van Hooft, 1995). Our attitudes towards other people take their character from being the determinable formation of our deep caring and so others matter to us the same as our selves matter (van Hooft,
As a result, in van Hooft’s (1995) model of caring at the biological level, caring-about-others is purely bodily and is directed outward towards others. It is where there is a prereflexive physical rapport between two people that gives rise to a focused desire and affection for the other. At the perceptual and reactive level, caring-about-others consists of the spontaneous, preconscious, nondeterminable solidarity that is demonstrated through the positive and basic cooperative attitude of people toward each other and society in general that is shown in the willingness of people to help each other (van Hooft, 1995). This level is characterized by the intentions and attitudes of our sociability. It is where the equality of our primordial caring-about-others and our self-project is so complete that relationships are the only difference, because at this level of our deep caring there are no true selves or others (van Hooft, 1995). So it is through our sociability or more specifically, our relationships, by which our identity is constantly formed and reformed (van Hooft, 1995). While the content of our relational reactions may be either positive or negative, because these feelings arise preconsciously in our awareness, they are not yet subject to our moral judgment for they are not yet something to which we are consciously aware or able to deliberate upon. What these feelings do, however, is represent the basic mode of our orientation towards the not-self and therefore reflect our deep caring as caring-about-others (van Hooft, 1995).

Next, the evaluative and proactive level of van Hooft’s (1995) model is marked by praxis. It entails that which we are conscious of as we go about our everyday life and is characterized by our culturally formed attitudes and intentions (van Hooft, 1995). As van Hooft (1995: 83) says, this level comprises ‘. . . the determination of a preconscious determinable comportment arising from our being as deep caring effected by suitable objects’. It is at this level we choose to cooperate with others in the conduct of living, it requires cooperation,
commitment, trust, and other examples of the way we enact our sociability and counter the isolation and independence which is not consistent with living or reflective of our deep caring as caring-about-others (van Hooft, 1995).

Finally, the fourth level of van Hooft’s (1995) model of caring, the spiritual level of our being, is where we live our faith, which centers on positive regard and commitment to the ideals that we aspire to in the course of seeking a meaningful life. Caring-about-others involves the sharing of this ideal with another and so involves interpersonal love (van Hooft, 1995). Interpersonal love as spoken of here, is a form of intimate rapport that has its foundation in the most profound feelings and commitments of one to another (van Hooft, 1995). It is love as consonance of spiritual commitment, shared attitude about the things that are important to us, shared faith or stance toward life in general, and the passion that comes from a shared spiritual rapport in the living out of our deepest commitments and attitudes (van Hooft, 1995).

Given our deep caring does not individuate us, our identity can only be made known to us through our commitments, actions, or reactions to the world and people with whom we interact in the course of living our life (van Hooft, 1995). Deep caring, according to van Hooft (1995), is what makes possible our individuality because it is only through our relations that our individuality is formed. Thus, ‘our deep caring is our being as a self-project and as a caring-about-others ‘... and is expressed at all four levels of van Hooft’s (1995: 90) model of caring.

Of note, is van Hooft’s (1995) elaboration of the spiritual dimension to his model of caring-about-others where he explains his use of the term love, meaning interpersonal love. For van Hooft (van Hooft, 1995), love represents the most intimate and intense form of caring-about-others because it is the passionate expression of our most deeply held attitudes and commitments which arise from
our deep caring and become determinable when they are focused upon an object or persons in the formation of our identity. In this way, love is understood to define our self-project, because as van Hooft (1995) explains, it is like the mythical being of Aristophanes (in Plato’s Symposium). We are looking for our other half, because caring-about-others is equiprimordial and we need the love of another to individuate us. In this way, van Hooft (1995: 91) says that ‘our loves establish who we are’ because they enable our particularity and our individuality.

Caring-about-others also has another dimension to it and one that was primarily articulated by the philosopher Emmanuel Levinas (1981) and explicated here by van Hooft (1995). The idea theorized is that both the other and the self are infinities, which when applied to van Hooft’s (1995) model of caring as a self-project and caring-about-others, means the self and the other are without limits. The term infinity is used to capture the idea that we cannot contain our being because there are no limits on its aspirations or ideals or on the scope and degree of the caring able to be generated because of it (van Hooft, 1995). While our relations may vary, the infinity of the other is ever present to us as a limitless possibility and is so powerful a presence, that should the other be requiring it, we would give up our life for their good (van Hooft, 1995).

When applied to van Hooft’s (van Hooft, 1995) model, deep caring as a caring-about-others enables a relation that particularizes an other and so supports the development of our self-project, but also, our caring-about-others makes possible our acknowledgment of their radical otherness. It is an otherness that through my caring-about-others has us reach out to them without reservation so as to allow them to be, which also enables recognition of one’s own infinity (van Hooft, 1995). As van Hooft (1995: 95) says;

‘it is because there is limitless depth on the call of the other on my infinity, in this appeal of the other to my being as a caring-about-others,
that I realize the limitless dimension of my being as deep caring’.

It is a calling that seeks caring-about-others at all four levels of existence and so as the other calls to us with their needs equally we are present to them in the same way (van Hooft, 1995).

While caring-about-others at the first three levels of van Hooft’s (1995) model involves one’s self-project and will to communicate with others based on one’s own needs and purposes, the fourth level, the spiritual level, is where we are drawn to the other out of the pure fascination of their humanity. In van Hooft’s (1995) model of caring, the spiritual level includes Levinas’ idea of infinity, or our shared humanity, which helps explain how the limitless commitment of caring-about-others is possible.

All this said, deep caring as described by van Hooft (1995) is a prereflexive mental disposition that incorporates a pre-intentional motivational structure through which our cares for our self as a project and caring-about-others acquire their importance. The ideas presented by van Hooft about caring-about-others and the self as a project, identify the primordial motivational field from which our commitments and therefore our cares arise; that when combined with Levinas’ views about infinity, enable a relation with an other that is characterized by a limitless commitment to their wellbeing.

While the thesis of both van Hooft and Levinas are significant to thinking about the concept of caring in general, how these ideas relate to the profession of nursing and midwifery where much of the work of a nurse and midwife is in fact tied to the protection of the humanity of the patient is still to be explicated. To make this point clearer, by transposing ‘I’ with ‘nurse’ and ‘other’ with ‘patient’, infinity makes it possible for a nurse and midwife to sacrifice their self for the patient even give their life for the good of the patient, the point being, these
ideas allude to a quality of the nurse-patient relation that is beyond the scope of the professional duty of care. However, the relation that is beyond that which a nurse and midwife may find themselves in is not known yet, except that it is a relation that can cause them to sacrifice their life for the patient. What gives rise to the commitment that would ultimately enable a professional nurse and midwife to sacrifice their life for a patient? Is it, as van Hooft (1995) hints, a form of love?

**Olivia Bevis** is another nurse scholar who has attempted to explicate the meaning of caring for nursing. She bases her theoretical position of caring on the thinking of two philosophers, Rollo May and Martin Heidegger, who understand care as a response to ‘something that matters’ and is the ‘basic driving force of life’ (Heidegger, 1962: 237, May, 1969: 289). Adding to these ideas, May (1969) claims that ‘care’ is a state in which something does *matter* and is the opposite of apathy. Adopting this position Bevis (1988: 50) understands caring to be ‘... a feeling denoting a relationship of concern, when the other’s existence matters to you; a relationship of dedication, taking the ultimate terms, to suffer for, the other.’

While caring may begin with a feeling it cannot stay as such if it is to be caring because caring compels a person to respond, in a thoughtful way, to the feeling that ‘something matters’ (May, 1969, Bevis, 1988). To this Bevis (1988: 50) adds the thinking of Heidegger who believes that ‘conscience manifests itself as care’ and is the motivating force of life. To this end, caring is presented as a ‘... feeling of dedication to another to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual self-actualization’ (Bevis, 1988: 50).
For Bevis (1988), the goal of caring is mutual self-actualization, which can only be achieved through developing personal capabilities of patience, kindness, compassion, love, trust, and creativity that enable one person to know and experience the other person. According to this view, caring is a response to something outside of ourselves that matters to us. Here, the mattering is our concern and is initiated by us with our response to it also our concern in that it matters to the extent that we are moved by it to respond in a particular way. However, the extent to which the other’s existence matters to us, which ultimately could be more than our life matters to us, that is caring, is unclear. For example, the sacrifice of self in suffering for another involves the altruism attributed to love. This being the case, what is the relation of caring where both persons must be served (egalitarianism), to love (altruism) that would enable a nurse and midwife to sacrifice their own well being for the good of the patient?

Bevis (1988) goes on to identify the ideas that embody the concepts of love, sex, intimacy, concern and duty as confused with caring. In summary, love, while a component of caring, is different to caring because caring is egalitarian whereas love is altruistic, (Bevis, 1988). Sex is understood to be intertwined with caring because it offers the possibility of overcoming the sense of isolation and separateness of being human (Bevis, 1988). However, according to Bevis (1988), the concept of ‘concern’ (if personalized) is the one closest to being synonymous with caring because concern captures the unmistakable feeling that one must take action. Intimacy though is identified as a stage of the process of caring and hence a part of caring (Bevis, 1988).

Finally, the concept of duty, while identified as a feeling of responsibility is presented more as an external governing factor rather than something germane to caring (Bevis, 1988). What is noteworthy is that Bevis (1988) offers a discourse that attempts to explain the idea that caring is a life force that compels a person to action. It is what she (Bevis, 1988) calls a ‘feeling
mandating relationship’ because the ‘feeling compels the caring person to take action for that person’s good. However, the egalitarian nature of Bevis’ view of caring, that is linked to notions of reciprocity, seems incompatible with the idea that a nurse responds to what matters because it is what matters to them, which may or may not include what matters to the patient, or visa versa. Is it possible that a relation with a patient does not require reciprocity and if so is it caring or something else?

The nurse scholar Delores Gaut (1983, 1986, 1988) sought to develop a theoretic description of caring as action as a practical activity that included explication of the conditions necessary for the accurate use of the term. The description offered by Gaut (1988) goes further than just the identification of observable performative skills to include ideas around the intention, choices, and judgments which underlie the performance of the activity called caring. In view of that Gaut (1988) says that because caring is an intentional human activity it is best understood as action rather than behaviour.

As a result, Gaut (1983, 1986, 1988) identified five conditions necessary if caring in nursing was to occur. These are awareness, knowledge, intention, means for positive change, and the welfare-of-x criterion, which she then regrouped and presented as three distinct conditions necessary for caring. Condition one states that the person undertaking the caring must have knowledge about the person for whom they are intending to care in order to identify the needs of the person and the activities that can best improve their situation (Gaut, 1983, 1986, 1988). But there are occasions where the non-specific knowledge about the patient is sufficient such as in the case of emergency care where the need to know the patient as a person is secondary to responding to their destitute state in order to secure their life. If a requirement of caring is knowledge of the patient, then responding to the needs of a patient as described here, is not caring. So what is it?
Continuing, Gaut (1986, 1988) says that the carer must not only possess knowledge of the recipient but also knowledge about what to do in order to be able to meet the practical goals identified. What is more, because the goals chosen are not static they may continually affect the activities planned (Gaut, 1986, 1988). Condition two says that, based on this knowledge, the carer implements actions that have the best chance of improving the situation of the recipient (Gaut, 1983, 1986, 1988). It involves the carer making considered choices about what ‘tactic’ is to be taken that will enable the practical goals to be met (Gaut, 1986, 1988). Nevertheless, as Gaut (1988) points out, because caring is not a basic action that can be directly applied but a mediated action delivered through other practical activities, what is considered competent is a matter of degrees and related to the achievement of the goals set. Condition three is about the evaluation of the success of the improvement in the condition of the person which is judged purely on the nonarbitrary welfare-of-x (Gaut, 1983, 1986, 1988). Success at meeting the care goal is based on two factors, the likelihood that the activities planned will meet the set goal and the expertise of the carer in being able to carry out the planned activities (Gaut, 1986, 1988). Together these ideas support the view that for caring to be considered as an action the activities of nursing must be related to the need for care to be able to bring about a positive change directly related to the need for care that is justified on by the nonarbitrary welfare-of-x (Gaut, 1983, 1986, 1988). However, Gaut’s thesis, like that of some other scholars listed above, offers no commentary about the degree to which a nurse and midwife will go in acting on the caring needed to secure the welfare of the patient. While caring as action helps describe what the caring is that is specific to nursing and midwifery, the description provided does not delineate the range of possible actions that they may take to secure the welfare of the patient, nor does it explain why a nurse and midwife should care in these ways.
The scholarship of Kristen Swanson has recently come to the forefront of those following the development of caring in nursing by way of her seminal work that focuses on a literary meta-analysis of caring. This work, plus her own thinking about caring, is aimed at clarifying the concept of caring which she says has existed as a ‘Tower of Babel’ (Swanson, 1999: 31). For her part Swanson (1991, 1993, 1999) presents a mid range factor-naming theory consisting of five categories, namely ‘maintaining belief’, ‘knowing’, ‘being with’, ‘doing for’, and ‘enabling’, that are structured in such a way as to demonstrate a caring process. Swanson (1991: 165, 1993: 354, 1999: 49) defined caring as ‘a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility’.

The first category of her theory is ‘maintaining belief’, ‘... in the other’s capacity to get through an event or transition and face a future with meaning’ (Swanson, 1991: 165, 1993: 354). Swanson (1993) holds that this is at the base of nursing because here is where what matters is defined. Second, the ‘knowing’ category is based on the idea that the nurse desires knowledge of the events as they impact on the life of the patient, which requires a willingness to recognize the other as important (Swanson, 1991, 1993). Third, the ‘being with’ category or being emotionally present attempts to capture the idea of being there, being present to the patient in a way that has the nurse open to their reality and that matters to the nurse (Swanson, 1991, 1993). It is being with, not only side-by-side, but available and able to engage with the suffering of the patient. It identifies the responsibility the nurse has toward the patient (Swanson, 1993). ‘Doing for’, the fourth category, entails all those activities that a person would normally do for themselves should they possess the capacity being undertaken by the nurse (Swanson, 1991, 1993). Citing Noddings (Swanson, 1991), she makes the point that it is the doing for the other what we would want them to do for us, which is also linked to the fifth and final category, ‘enabling’. ‘Enabling’ is where the nurse brings to bear their expertise on the situation for the betterment
of the patient.

Of the three research projects that underpin Swanson’s theory of caring and category development, the findings that related to the attachment of the nurses in the neonatal intensive care unit, in one of the projects, hint at their being more to the idea than has been able to be presented. Swanson (1990) identified that nurses working in the neonatal intensive care unit were prone to falling in love with the neonates for whom they had primary care. Her postulate was that love explains the attachment of the nurses to the neonates but this is all that is said about this idea except to add that it was a view that was also validated by the parents involved in this research, namely that there was a lot of love in the neonatal intensive care unit (Swanson, 1990). This leaves us with the question as to what is the love that is specific to the nurses who worked in the neonate intensive care unit and therefore what is the love that is specific to nursing in general?
2.2 Conclusion
This chapter has explored some of the extant literature for definitions of caring in nursing and midwifery, and looked for links between these definitions and the idea of love. The recent seminal papers of Morse, Bottorff, Neader, and Solberg (Morse et al., 1990), and Swanson (1999), which offer a schema for conceptualising the literature on caring, combined with Paley’s (2001) critique of the content of the literature on caring in nursing, has provided the foundation for this analysis. The examination of the contribution of each scholar on the concept of caring as it is applied to nursing and midwifery has resulted in the identification of the idea of love in nursing and midwifery, and supported the introductory and background observation made in chapter one.

Notably, this analysis revealed that much of the scholarship on caring does not provide an exact explanation of the concept caring or caring as it applies to the practice of professional nursing and midwifery. It is a view that is also shared by the philosopher John Paley (2001) who observed that the scholarship on caring in nursing and midwifery is little more than an aggregation of ‘things said’ about caring, which gives rise to an endless list of associations and attributes of caring in nursing and midwifery that through different permutations give rise to yet further endless descriptions that together do little more than provide confirmation of things already said, repeated over and over again. What is more, some literature on caring also includes the concept of love as something that is qualitatively different to caring. Like so much of the literature on caring, the literature that speaks about love as it relates to caring also does not make clear exactly what is meant by the term or its application to the profession of nursing and midwifery.
While Martin Heidegger’s (1962) notion of ‘mattering’ is used to explain the origin of caring, this same literature, which also identified the existence of love, does not explain the content of ‘mattering’ as it relates to love. The extent of the ‘mattering’ and just how far a nurse would be prepared to go in responding to the things, events, and people outside of them self as both caring and loving is unclear. The question posed here is, is it possible for a patient to matter to a nurse to the extent that they would forgo their own good for that patient, and if this were to be the case, what would be the extent of the foregoing and what would it be called, care, love, or something else?

What is more, the literature also shows that caring and ideas about love in nursing and midwifery involve risk to their self-project. Because a patient’s values, beliefs and desires may be different to those of the nurse and midwife, the nurse and midwife in responding to the destitute state of the patient exposes themselves to change and the possibility of negative consequences. While ‘mattering’ gives rise to different forms of commitment and therefore different nurse-patient relations, none of the nurse scholars sampled explained the type of devotion that arises from their form of commitment and the relational responsibility of another person as something they desire or feel they must do. What the premotivational comportment is that enables a professional nurse and midwife to rise above their own subjective isolation and move their motive energy from a concern about their own self-project as a first priority to that of the patient remains unclear. Although the selflessness of the nurse’s and midwife’s caring acts have a net benefit for both the nurse and midwife and the patient, what of those nursing and midwifery actions where the selflessness or absorption of the nurse and midwife in the other is to a level where there is a demise of their own being. Is this still caring? Is it caring if a person jumps off a bridge into the raging water to save a person when they cannot swim, or is it caring if a nurse gives mouth-to-mouth resuscitation to a patient who could be HIV positive, or are these examples, examples of some other form of nurse-
patient relation? Can the selflessness of caring be of the quality where a person is able to shift their motive energy from a concentration on their own self-project as their first priority to another person, where there is asymmetry of the relation and no expectation of reciprocity nor concern for their own welfare?

When examining the concept of love as it applies to the nurse-patient relation, the literature reveals it to have a far deeper meaning than that attributed to it in popular western culture. Love in nursing and midwifery is more than personalized affection; it is reported as a form of intimate rapport that has its foundations in the most profound feeling and commitments of one caring about another, but the intimate rapport of a professional nurse and midwife that is love is still to be fully explained. What is more, caring is reported as being the active expression of love but what is this form of love? Instead of care, the term love is repeatedly used to portray the quality that is possible of the nurse-patient relation. General depictions of caring suggest caring is understood to be an all encompassing term and one that describes a range of different nurse-patient relations. While various scholars allude to the idea that love is the motivation for caring there is no mention of the motivation of love. If caring is the activity of love what is love that is caring or more specifically what is love that is love in nursing and midwifery?
Chapter 3:  Study Design

3.0  Introduction
Embarking on study about a topic area as nebulous as ‘love’ is not without its challenges, one of which was the identification of a study design that would enable the deeply held beliefs of nurses and midwives about love, as it related to their professional practice, to be exposed. A reconnaissance about the topic question of ‘what is love in nursing and midwifery’ showed that nurses and midwives understood their practice to incorporate elements of love but were unable to articulate, in any meaningful way, what that was. As a result, the design developed for this study incorporated the principles of social constructionism, hermeneutic dialectic method, incorporated real case focus groups called ‘Neo-Socratic dialogue’, and philosophical inquiry. The combination of approaches enabled the researcher to elicit through language the tacit and social knowledge constructions (understandings) of nurses and midwives about the topic as data for analysis and the subsequent development of a thesis about love in nursing and midwifery that is reflective of the complexities of real life.

3.1  Social constructionism and Neo-Socratic dialogue
In this study, principles of social constructionism are combined with a Neo-Socratic dialogue process to reveal nurses and midwives understandings of love as it is experienced in the practice of nursing and midwifery. Social constructionism as articulated by Gergen (1994: 68), ‘... traces the sources of human action to relationships and the very understanding of ‘individual functioning’ to communal interchange’. Gergen (1994: 253) believes that conceptions of self and others are derived from and sustained by patterns of relationship from which language is born and it is language that makes possible
the capacity to render ourselves intelligible. For this reason, relationship replaces the individual as the fundamental unit of social life (Gergen, 1994: 263). As such, Gergen (1994: 263) says, commence with individual subjectivity and then work in a deductive way toward an account of human understanding through language. This makes possible analysis of the human relationship because it is the human relationship that generates both language and understanding.

‘An individual’s utterances in themselves possess no meaning. In the intersubjective account of meaning, the mind of the individual serves as an originary source. Meaning is generated within the mind and transmitted via words or gestures. In the relational case, however, there is no proper beginning, no originary source, no specific region in which meaning takes wing, for we are always already in a relational standing with others and the world ‘ (Gergen, 1994: 264).

While social constructionism focuses on the micro-social processes of interchange as the basis for knowledge generation, the principles that underlie Neo-Socratic dialogue reveal the implicit ‘knowing’ of the individual and community of others that occurs as a result of social interchange. The Neo-Socratic dialogue process enables the researcher to reveal the logical reason, for instance, as to what nurses and midwives understand as love in the practice of nursing and midwifery. Neo-Socratic dialogue seeks to prove nothing but make known the logical reasons for acknowledged consequences that are accepted conclusions and evaluations of nurses and midwives about their clinical practice. It employs a dialogue strategy for the interchange of group ideas about love in the practice of nursing and midwifery that support a skeptical view of the assumptions that underpin individual understandings; that new ways of understanding are generated by active and cooperative interpersonal relations; and that conclusions reached are never complete in that they can always be improved upon with further social interaction (Gergen,
So what does the social constructionist and the Neo-Socratic dialogue perspectives offer this research? They support a relational orientation to knowledge generation and the belief that the processes of understanding are not natural but rather the result of the active and cooperative engagement of people in relationship (Gergen, 1985: 267). The combined approach enables this study to focus on the meanings and significances of nurses’ and midwives’ relational experiences of love in the practice of nursing and midwifery. Specifically, the principles of social constructionism as postulated by Gergen (1982, 1985, 1991, 1994, 1995), and applied to this study:

- Support the development of understandings about the relational experiences of registered nurses and midwives as understood by those nurses and midwives. The emphasis being on the meanings generated by nurses and midwives as they collectively generate descriptions and explanations in language as opposed to that being in their individual minds.
- View knowledge (understandings as represented in language) as a product of the coordinated activities of individuals, the emphasis being on the inter-dependence of understandings that are generated for locally-agreed-upon purposes as embedded in the experience of nurses and midwives.
- Recognize that the quality of knowledge constructions (understandings) is dependent on the range, scope and sophistication of information able to be communicated by nurses and midwives participating in the research. It is accepted that constructions (understanding) are always in a state of becoming more informed as a result of new information, time and negotiation.
- Identify the researcher as an integral participant in the generation of understanding about the research question.
3.2 Social Constructionism and hermeneutic-dialectic method

Methodologically, social constructionism and Neo-Socratic dialogue are congruent with the hermeneutic-dialectic approach which uses the art, skill and theory of interpretation to gain insight into human existence (Appleton and King, 1997, Bullock et al, 1977). When hermeneutic method is applied to the social constructionists’ perspective, the focus is on the reconstruction of previously and currently held understanding about a phenomenon in order to generate new insight. In social constructionism the foundational unit of analysis is not the individual and the understanding of this person. Rather the starting point for meaning is the linguistic relational understandings of people (Gergen, 1994: 263).

For this reason individual knowledge constructions (understandings) are explored and refined hermeneutically, and compared and contrasted dialectically to generate new consensus constructs about a phenomenon (Guba, 1990: 27, Cuba and Lincoln, 1994: 112). In this way, my use of hermeneutics is to make public the constructions (understandings) of the registered nurses and midwives as accurately as possible, which includes them formulating answers to the study question. Furthermore, the dialectic aspect focuses on a relational exploration of nurses and midwives constructions (understandings) by having them engage in a process of comparing and contrasting each with the other in an attempt to reach a more informed level of knowing (individual and group) about the phenomenon (Cuba, 1990: 26). Accordingly, all knowledge constructions (understandings) are understood to become more informed over time, and can only ever be considered the most plausible view of the moment that is reflective of the registered nurses’ and midwives’ experiential reality (von Glasersfeld, 1993: 3).
More particularly, the adoption of a hermeneutic-dialectic method and principles of social constructionism and Neo-Socratic dialogue supports the implementation of a dialogue strategy that uses the continuing dialectic circle of iteration, analysis, critique, reiteration, and reanalysis, to develop joint consensus constructions about the phenomenon of love in nursing and midwifery. Specifically, the method requires participants to come together in a group and iterate real life examples of the study phenomena that are then analysed in a way that makes the underlying understandings about the examples offered understandable to others. Each example offered is critiqued by all participants who may either hold similar or different understandings about the example. The example is then reiterated in light of this new information or new level of sophistication. This may be then subjected to reanalysis and so on until consensus of understanding about the phenomena amongst the group is reached or as close to consensus as possible (Guba and Lincoln, 1989: 89).

The method requires participants to:

- Share a commitment to work from a position of integrity.
- Communicate their beliefs and possess a willingness to share their thinking about the topic.
- Share equitably the power within the group so as not to dominate group-working processes.
- Possess a willingness to change individual thinking on a topic as a response to reasoned argument.
- Commit the time and energy required to develop an understanding about the topic. (Guba and Lincoln, 1989: 149)

In addition, hermeneutic-dialectic method combined with the subjective epistemology of social constructionism and Neo-Socratic dialogue includes the relationship of the researcher and the participants in the cyclic dialectic process of knowledge construction. The method identifies the researcher and the participant as intrinsically linked to the outcomes of the study inquiry and
acknowledges that the outcomes are a literal co-creation of the inquiry process. Interactions are identified as best arising from among and between the researcher and participant/s in the natural setting where increased opportunities exist for inquiry of a hermeneutical and dialectical nature. Thus hermeneutic dialectic method, social constructionism and Neo-Socratic dialogue acknowledge the relationship of the researcher and the participant in the study process where the aim is ‘the collective generation of meaning as shaped by convention of language and other social processes’ (Schwandt, 1994: 127).

3.3 Neo-Socratic dialogue method

Neo-Socratic dialogue enables the study of the tacit knowledge (understandings) of participants and therefore requires the researcher to instigate a data sampling strategy that enables tacit meaning to be clarified. Further, Neo-Socratic dialogue, as I will explain below, exemplifies the hermeneutic-dialectical method and embodies principles of social constructionism. Specifically, Neo-Socratic dialogue is the art of philosophizing about a topic and was originally developed as an educative process and based on the ideas of the German Philosopher Leonard Nelson (1882-1927), and by the Philosophical-Political Academy in Germany, the Society for the Furtherance of critical Philosophy in the U.K., and Dutch Association for Philosophical Practice (Fitzgerald and van Hooft, 2000, van Hooft, 2001). Neo-Socratic dialogue is a process that elicits explicitly from participants their implicit ‘knowing’ (Marinoff, 2000: 262). It attempts to impart to reasoning a practical form by reflecting upon it together with other people (Boele, 1997). To do this Neo-Socratic dialogue uses the process of regressive abstraction to find a collective answer to a fundamental question, in this case, ‘what is love in nursing and midwifery?’ (Boele, 1997: 49-51 , Curnow, 2001 : 235, Fitzgerald and van Hooft, 2000: 483, Nelson, 1949: 1, van Hooft, 1999d: 2). Regressive abstraction reverses the usual method of objective establishment, which derives consequences from their reason and rather seeks to identify logical reasons for
consequences. Nelson (1949) claims that the Neo-Socratic method enables the researcher to prove nothing but make known the logical reasons for acknowledged consequences that are accepted conclusions and evaluations. It is these accepted conclusions and evaluations that are the focus of Neo-Socratic dialogue analysis and which serve as data for the construction of a thesis about the concept ‘love’ as it relates to the clinical practice of nursing and midwifery.

‘If we choose from the experience of daily life those judgements and evaluations on which there is agreement, we can analyse them and thus, by a regressive procedure, search out the philosophical principles that have been applied in these judgements and evaluations and are presupposed in all of them. By a process of continuous analysis and abstraction from the specific applications we must eventually reach some essential and ultimate assumptions, which we can then separately denote’. (Nelson, 1949: 106-107)

In this study Neo-Socratic dialogue was identified as the method best able to provide data for an answer to the fundamental question of ‘what is love in nursing and midwifery’. The Neo-Socratic dialogue method used in this study consisted of three principal components as outlined below by (Boele, 1997, Fitzgerald and van Hooft, 2000, van Hooft, 2000, 1999d, 1999b).

- Step 1: Broad question requiring a specific example. The researcher presented the question to the group — what is love in nursing and midwifery. Next, each participant provided one personal clinical practice example of love in nursing and midwifery. The group then chose one example from the list that they believed best-reflected love in nursing and midwifery.
• Step 2: Specific question of the example. Once the best example of love in nursing and midwifery was accepted, the group set about formulating an answer to the question; ‘If this example is an example of love in nursing and midwifery, then what in this example did this nurse do that exemplified love?’

• Step 3: Broad question related to specific answer. The group were then asked to formulate an answer to the question; ‘If what you have articulated to date is what you consider to be love in nursing and midwifery in this example, then what is love that is specific to nursing and midwifery’?

What is more, during the course of the Neo-Socratic dialogue the facilitator or any participant is able to initiate a metadialogue. A metadialogue is dialogue that is not directly about the formulation of an answer to the questions posed but about the dialogue processes itself. In particular, the facilitator or any participant, at any time, can call a kind of ‘time out’ in order to temporarily stop the dialogue about the topic question and instead initiate dialogue about any issue that is hindering the formulation of a group-consensus answer to the Neo-Socratic dialogue question. For example, a metadialogue can be initiated if either the facilitator or the participant feels they have lost track of the discussion, is unable to understand what others are saying, is upset with the current line of discussion, feels they are not being heard, wishes to clarify group processes, or wishes to identify strategies for resolution of conflict (van Hooft, 1999d). All this said, the group should not return to the dialogue until all the reasons for initiating the metadialogue have been resolved or strategies for moving ahead have been identified (van Hooft, 1999d).
3.3.1 Neo-Socratic dialogue method: The sample

This study used a criterion-based non-probability purposive sampling method. This sampling method enabled the researcher to obtain data from a specific group of people titled Registered Nurse and Registered Midwife. The criteria applied to the selection of participants for inclusion in the study was that all the participants were required to be:

- Registered as a nurse and midwife with the Nursing authority of their country or endorsed on the nurses register as a midwife.
- Practicing nursing and midwifery.
- Interacting with patients at the ‘bedside’ on either a full-time, part-time or casual basis.
- Able to provide an example from their nursing and midwifery practice where they believed they used love and be willing to share that example with other participants.

Purposive sampling is a sampling method that is congruent with social constructionism, hermeneutic dialectic method and Neo-Socratic dialogue because the object of purposive sampling is to identify ‘information-rich cases’ for in-depth examination (Appleton and King, 1997). In this study, the researcher embarked on a process of recruiting registered nurses and midwives who were able to provide a specific example from their clinical practice of love in nursing and midwifery and were willing to share that example with others. Purposive sampling enabled the sampling of both typical and divergent cases in order to promote discovery of different constructions about love in nursing and midwifery. To this end this study recruited participants from Australia, Singapore and Bhutan. In addition, Neo-Socratic dialogue (as explained above) requires all participants to share their example of love in nursing and midwifery with others in the group and in doing so causes exploration of the examples so as to purposively trigger discourse on the typical and divergent views about the
phenomenon that are inherent in the various examples.

Snowball technique was used to recruit participants into the study. The researcher used four different strategies for recruitment of participants.

- The study proposal was presented to various groups of nurses and midwives inviting them to make contact should they like to participate in the study.
- A handout sheet was provided to Unit Managers of various health care settings, titled ‘Research Invitation’, inviting interested participants to provide their contact details for the provision of additional information about the study and possible inclusion (Appendix I: Research Invitation).
- ‘Word of mouth’, where various nurses and midwives heard about the study from a work colleague or friend who had either attended a proposal presentation or had participated in a Neo-Socratic dialogue focus group or had seen the Research Invitation flyer.
- A clinician who could identify both registered nurses and midwives who would possibly be interested in the topic for the researcher to then follow-up.

The demography of the sample population showed registered nurses and midwives recruited to the study were very different in that they lived and worked in three countries with different cultural backgrounds and possessed different levels of education and clinical experience. Some nurses had as little as one year postgraduate registered nurse experience, while others had a large amount of specialty registered nurse expertise that included; accident and emergency nursing, aged care nursing, acute medical and surgical nursing, cancer nursing, community nursing, critical care nursing, hospice nursing, midwifery, naturopathy, nurse administration, nurse education, palliative care nursing, pediatrics/child and adolescent nursing, psychiatric nursing, and renal
nursing. Registered Nurse’s (Division 2) were Australian and a second level nurse who provide basic nursing care. The Registered Nurse’s (Division 2) had large amounts of clinical experience in aged care and acute medical and surgical nursing. There were a total of fifty-six registered nurses and midwives who participated in the study, eleven were Registered Nurses’ (Division 2) and forty-five were Registered Nurses’, (Table I: Demography of the participant population). Eight of the eleven Registered Nurses’ (Division 2) were undertaking a Bachelor of Nursing (Conversion) program. Of this population there were forty-four women and twelve men, which was not reflective of the percentage gender mix of registered nurse in any of the countries where this study was conducted.

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Female</th>
<th>Male</th>
<th>Registered Nurse and/or midwife (Division 1)</th>
<th>Registered Nurse (Division 2)</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
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<td>7</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Group 2</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Group 3</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Group 4</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Group 5</td>
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<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Group 6</td>
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<td>2</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>12</td>
<td>45</td>
<td>11</td>
<td>56</td>
</tr>
</tbody>
</table>
3.3.2 Neo-Socratic dialogue method: Focus group

This study used the Neo-Socratic dialogue method, which requires use of a focus group for the development of knowledge constructions (understandings) about love in nursing and midwifery as data for building a thesis about love as it applies to the practice of nurses and midwives. The hallmark of a focus group is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group (Morgan, 1988).

The formation of a focus group to conduct a Neo-Socratic dialogue enabled me to facilitate group interaction where participants engaged in active thinking about what is love in nursing and midwifery. Each focus group enabled six to twelve registered nurses and midwives from different backgrounds to come together and dialogue on the topic question of ‘what is love in nursing and midwifery’. Given the nebulous nature of the topic question, the focus group, by using the Neo-Socratic dialogue method, provided participants with a less threatening environment in which to express their views and considered responses to others. Unlike the conduct of a traditional focus group, which may last from between 60 to 90 minutes, each focus group using the Neo-Socratic dialogue method normally lasts between 6 to 8 hours, which is the time preferred to investigate the topic question in depth. However some were shorter.

The dialogue required participants to verbalize in a thoughtful way their specific thinking about the question at hand. Participants were required to generate reflection, which in turn, required awareness on their part of what they were saying and hence gave rise to abstraction. Because each contribution to the dialogue required a clearly articulate statement, participants were able to identify inconsistencies in their thinking. Social constructionist thinking supports the requirement of participants to engage in both interactive and subjective dialogue about social reality, revealing meanings, intentions, and purposes in
their constructions, and to reach a group consensus position, in this case, about love in nursing and midwifery.

The cyclic process of iteration, analysis, critique, reiteration and reanalysis achieving group consensus on a knowledge construction (understanding) about a topic required significant time. Von Glaserfeld (1993) argues that in constructivism (in general), establishment of such a consensus position is difficult and what one aims for is more that another’s perspective is at best compatible. To this end, I as the researcher encouraged exploration of the ideas participants raised in the course of the Neo-Socratic dialogue, supported diversity of opinion and fostered shared insight into the different perspectives about the study question. Each Neo-Socratic dialogue was able to develop a consensus position on an answer to the study question of what is love in nursing and midwifery.

Each of the four Neo-Socratic dialogue focus groups conducted in Australia was held in a location close to the participants’ place of living. Three were conducted at the university and one in the home of one of the participants. All locations provided me with central locations to assist recruitment, neutral territory away from the politics of the participants’ workplace, and venues suited to serious and purposeful dialogue about the study topic. Similarly, the Neo-Socratic dialogue conducted in Singaporean was held at the Singapore Nurses Association and the Neo-Socratic dialogue conducted in Bhutan was held at the Royal Institute of Health Sciences. Both venues enabled the participants to be away from the demands of the clinical setting and able to focus on the task at hand.
Approximately 6-12 registered nurses and midwives participated in each of the six Neo-Socratic dialogues. Two of the Neo-Socratic dialogue focus group meetings lasted between 6-8 hours and four went for 3-4 hours. I as the researcher found it difficult to recruit nurses and midwives able to donate 6-8 hours of their time. Many potential participants said they would be able to provide ‘a couple of hours but not a day’. Requiring 6-8 hours for the conduct of a Neo-Socratic dialogue limited the available population base and saw only those nurses and midwives who felt strongly about the topic question agreeing to participate even for 3-4 hours. For the four Neo-Socratic dialogue focus group sessions of 3-4 hours duration, changes to the format were made. Participants were prepared before the dialogue session on the process of Neo-Socratic dialogue, informed consent was obtained prior to the session, and participants undertook preparatory reflective thinking about the question posed and came prepared with a clinical example of love in nursing or midwifery ready to share with the group. With the shorter duration came less need for prolonged breaks and during the dialogue, I as the facilitator, increased my interaction to ensure the discussion remained ‘on track’. Neo-Socratic dialogue and constructionism allows for such facilitator focus group interaction acknowledging the facilitator as an integral part of the Neo-Socratic dialogue (Barbour and Kitzinger, 1999). This said all groups developed answers to all the components of the Neo-Socratic dialogue on the question of ‘what is love in nursing and midwifery’.

All focus group meetings were audio taped to assist the accuracy of data collection.
3.3.3 Neo-Socratic dialogue method: Role of the researcher as facilitator

In the constructivist paradigm the relationship of the researcher and participants is acknowledged as connected, in that the researcher is identified as being intrinsically linked to the constructions developed. The Neo-Socratic dialogue method also acknowledges the connected relationship of the researcher and participants. While the researcher/facilitator does not actively participate in the ‘content’ of the dialogue, they nonetheless input via a facilitative role that requires the dialogue to adhere to a strict format concentrating on identifying inconsistencies or the limitations of the conceptions posed.

Regressive abstraction, as applied in this study, sought to reveal individual and group constructions about love in nursing and midwifery as exemplified in a specific nursing and midwifery example and then applied to nursing and midwifery in general. Systematic reflection upon the example was the basis of the group’s search for shared judgments about the question. The dialogue aimed at consensus and to these ends each participant’s thoughts were clarified as the dialogue progressed so as to ensure participants understood each other fully. The phases of the dialogue move from describing an actual example of love in nursing and midwifery, to drawing out the principles in the light of which judgments were made and decisions taken in that example, and from there, to the articulation of more general principles which might be applicable in other cases. In this way, Neo-Socratic dialogue is congruent with social constructionism and the hermeneutic dialectic method (Figure 1: Study design).

In order to achieve the outcomes stated above, it was imperative that I as the facilitator conducted myself in a particular way especially given the time able to be offered by participants to explore the question at hand. As Barbour (1999) states, focus groups have their own momentum, and the facilitators role is to promote interaction between participants unencumbered by heavy-handed
interventions, to be open and prepared to assist ‘sensitive moments’, painful exchanges and revelations, yet at the same time provide a safe environment where appropriate disclosure is promoted.

Furthermore, given the study topic is about love, I as researcher was particularly aware of the potential for very personal disclosures and hence established ‘ground rules’ with each group prior to the commencement of each Neo-Socratic dialogue session. ‘Ground rules’ focused on providing a safe environment for the conduct of the dialogue and made sure all participants understood the question. Participants were told that all disclosures would be confidential to the group, and that no person was obliged to disclose personal information about themselves or their patients that would compromise their own wellbeing or the identification of the patient. However, should a participant become emotionally distressed by the content of the Neo-Socratic dialogue, a process for debriefing and referral to a professional counsellor aware of the conduct of the study was established (Appendix 2: Deakin University Ethics Committee Plain Language Statement). Owen (2001) supports this initiative, making clear that researchers have a moral duty to provide safety mechanisms in their conduct of focus groups that protect vulnerable people.

3.3.4 Neo-Socratic dialogue method: Role of the participant

Neo-Socratic dialogue makes certain requirements of participants (van Hooft, 1999d). First the facilitator is required to set a well-formulated, general question, or statement, before the discourse commences. In this case the question set was ‘what is love in nursing and midwifery?’ It is from this point that participants are required to collect concrete examples of their experience in which the topic plays a key role. Here participants were asked to offer actual examples of where love has been used in their practice of their nursing and midwifery. It was made clear to participants that the examples were not to be about romantic love. The following criteria were provided to participants (Appendix 3: How Do I
Participate In A Neo-Socratic Dialogue?).

3.3.4.1 Criteria for suitable examples

1. The example has been derived from your own experience; ‘hypothetical’ or ‘generalized’ examples (quite often it happens to me that . . .’) are not suitable.

2. Examples should not be very complicated one’s; simple examples are often the best. Where a sequence of events has been presented, it would be best for the group to concentrate on one aspect or one event.

3. The example has to be relevant for the topic of the dialogue and of interest to the other participants. Furthermore, all participants must be able to put themselves into the shoes of the person giving the example.

4. The example should deal with an experience that has already come to an end. If the participant is still immersed in the experience it is not suitable. For example, if decisions are still to be taken, there is a risk that group members might be judgmental or offer advice; and if there is still an emotional involvement, the discussion might re-open emotional wounds.

5. The participant giving the example has to be willing to present it fully and provide all the relevant actual information and answer questions so that the other participants are able to understand the example and its relevance to the central question.

6. Positive examples: i.e., examples that affirm the question or statement are preferred.
Next, participants came together as a group to engage in the Neo-Socratic dialogue. At this point the group was reminded of the rules for the conduct of the Neo-Socratic dialogue (Appendix 3: How Do I Participate In A Neo-Socratic Dialogue?), they include:

3.3.4.2 Rules of participants

There are eight basic rules for participants in the Socratic Dialogue:

1. Each participant’s contribution is based upon what s/he has experienced, not upon what s/he has read or heard.

2. The thinking and questioning is honest. This means that all and only genuine doubts about what has been said should be expressed.

3. It is the responsibility of all participants to express their thoughts as clearly and concisely as possible, so that everyone is able to build on the ideas contributed by others earlier in the dialogue.

4. Participants should not concentrate exclusively on their own thoughts but should make every effort to understand those of other participants. To assist with this, the facilitator may ask one participant to express in his or her own words what another participant has said.

5. Anyone who has lost sight of the question or of the thread of the discussion should seek the help of others to clarify where the group stands.

6. Abstract statements should be grounded in concrete experience or in the example, which is central to the discussion in order to illuminate such statements.
7. Inquiry into relevant questions continues as long as participants either hold conflicting views or have not yet reached clarity.

8. It is important and rewarding to participate in the whole of a dialogue even if there is disagreement. Everyone should endeavor not to leave early or cease participating before consensus is reached.

Furthermore, I as the facilitator reiterated the information that describes the concept of a metadialogue that was provided in the ‘How Do I Participate In A Neo-Socratic Dialogue?’ sheet.

### 3.3.4.3 Metadialogue

It is permissible at any time within the dialogue for the facilitator or for any participant to call ‘timeout’ in order to direct the attention of the group to any problems that may have arisen. It may be that a participant has lost track of the discussion, is unable to understand what others are saying, or feels excluded, or it may be that one or more participants have become upset with the way the dialogue has developed. Alternatively, it may be that the group has lost its way and needs to review the structure or content of the dialogues, or the group may want to discuss the strategies it is using to seek a consensus of the question. Whatever the reason, a discussion about the dialogue, or a ‘metadialogue’, can be called for at anytime. If it is thought appropriate, someone from the group other than the facilitator may be asked to chair the metadialogue. The group should not return to the content dialogue until all the difficulties that led to the calling of a ‘timeout’ have been resolved or until strategies for proceeding with the content dialogue have been formulated.
In addition to the explanation about a metadialogue I as the facilitator identified the ‘ground rules’ to apply to the conduct of the dialogue. The ground rules for each Neo-Socratic dialogue were established in negotiation with each group and focused on the maintenance of confidentiality. The following statement on confidentiality contained in the ‘How Do I Participate In A Neo-Socratic Dialogue?’ sheet acted as a trigger for discussion and identification of group specific ground rules.

### 3.3.4.4 Confidentiality

All the content of the dialogue is bound by the rules of research confidentiality. Notwithstanding this requirement, it is pointed out to the nurses and midwives that their participation in the dialogue bound them to that confidentiality.

In summary, Neo-Socratic dialogue as used here required each participant’s contribution to be based on his or her clinical experience, not upon what may have been read, heard or postulated about the topic (theory is to be set aside). Importantly each contribution and the questioning of others were always to be honest and related to understanding the concepts presented. This means that only genuine doubts about what has been said were to be expressed. As a result each participant was asked to express their thoughts as clearly and concisely as possible, so that everyone was able to build on the ideas contributed by others earlier in the dialogue. Moreover, participants were asked not to concentrate exclusively on their own thoughts but to make every effort to understand those of their colleagues. To assist with this, participants understood that I as the facilitator, from time to time, may ask a participant to express in his or her own words what another participant has said. Furthermore it was made clear to participants that should they lose sight of the question or of the thread of the discussion they should seek the help of others to clarify where the group stands. Another requirement of participants was that any abstract statement/s offered was to be grounded in concrete experience or in the example focused on in the dialogue. Inquiry into relevant questions continued
as long as participants either held conflicting views or had not yet reached clarity. Notwithstanding it was a requirement of the dialogue that all participants remain for the whole of a dialogue even if there was disagreement. Everyone was asked to participate in the entire dialogue and not leave early or cease participating before consensus was reached.

Once the above items had been finalized the Neo-Socratic dialogue commenced. I as the facilitator put the broad question to the group that required of them a specific example, that is, I presented the question to the group — what is love in nursing and midwifery. To which each participant provided one personal clinical practice example of love in nursing and midwifery. Each example that was provided was explored in detail by the group to the point of them feeling they have a clear understanding of that example. Once all participants had offered their examples the group then chose one example from the list that they believed best-reflected love in nursing and midwifery. After the specific example was chosen the group embarked on a detailed exploration of that example. Participants continued to explore the specific example until they believed they had a comprehensive understanding of it and could then consider the example to be their example. Hence, the example moved from being the participant’s personal example to where it was now considered the groups’.

It is at this point that the Neo-Socratic dialogue enters its second phase, entailing the specific question of the example. Participants now focused on the formulation of an answer to the question; ‘If this example is an example of love in nursing and midwifery, then what in this example did this nurse or midwife do that exemplified love?’ This phase of the dialogue process proved to be most intense and required, from time-to-time, the restatement of the rules of conduct to ensure the group remained focused on formulating an answer to the question and did not become sidetracked. This phase particularly challenged participants, because it required them to engage in abstract thinking that had to be grounded in concrete experiences or in the example itself. It required doubts
about what was said by others to be expressed, it required the resolution of conflicting views, and it required that they follow a path of inquiry in order to reach clarity and group consensus which was challenging. During this phase, both participants and I had cause to engage in metadialogues to address a variety of issues that included resolution of conflicting views, a focus on the question at hand, and a clarification of progress.

In the final phase of the Neo-Socratic dialogue, I as the facilitator put to the group the broad question that related to a specific answer. In other words, the group were asked to formulate an answer to the question; ‘If what you have articulated to date is what you consider to be love in nursing and midwifery in this example, then what is love that is specific to nursing and midwifery?’ On each occasion participants began with summarizing their thinking to date about what they understood to be the love that was practiced in nursing and midwifery in the example and then began to clarify their beliefs about how those concepts apply to nursing and midwifery in general. The temptation for each group was to formulate an answer to the question that was so broad that it was not specific to nursing and midwifery. Hence, with each Neo-Socratic dialogue, a metadialogue was initiated by me as the facilitator to help the group to remain focused on the question to be answered, to provide clarification of the various positions of participants, to illuminate strengths and weaknesses of the argument and to assist in the summation of the final position and answer to this last question. This said, each group was able to formulate a broad answer that was specific to nursing and midwifery.
It can be readily seen that this dialogue process fulfils the requirements of the hermeneutic-dialectical method and is in accord with the theoretical framework of social constructionism, which are further developed in the chapters on reporting the data.

3.3.5 Neo-Socratic dialogue method: Data collection

Data collection using Neo-Socratic dialogue took place over a twelve-month period and was complicated by the difficulty of recruiting participants willing and able to offer such a large portion of their time to a Neo-Socratic dialogue session and the difficulty in coordinating the shift roster allocations of the participants in order that they could attend. Six Neo-Socratic dialogue sessions were conducted and each was audio taped to ensure an accurate transcription of the content of each session.

3.3.5.1 Data collection process

Each Neo-Socratic dialogue followed the three basic steps as outlined by Fitzgerald and van Hooft (2000), van Hooft (2000, 1999d, 1999b) and Boele (1997) and the study supervisor attended a session to validate my conduct as a facilitator of a Neo-Socratic dialogue. Data for this study were collected using the following format.

- Introduction:
  At the beginning of each session, participants were introduced to each other.
  A) 3-4 hour Neo-Socratic dialogue sessions
  Participants in these sessions were each given information about the conduct of a Neo-Socratic dialogue and a ‘How Do I Participate In A Neo-Socratic Dialogue?’ sheet. After participant introductions, questions were taken on the process of Neo-Socratic dialogue as a final check to ensure all participants were comfortable with the process. At this time I as the facilitator also collected
each of the participant’s signed ‘Deakin University Research Ethics Committee Consent Forms’ and again checked with individuals that all their questions and concerns about the study had been addressed (knowing that each participant had been spoken with prior to the Neo-Socratic dialogue session about the study as it related to being informed). It was at this time that I as the facilitator also set the ‘ground rules’ for the conduct of the session, that is, reiterated the content of the ‘How Do I Participate In A Neo-Socratic Dialogue?’, ‘Rules of participants’ and ‘Confidentiality’ statements along with information provided on the ‘Deakin University Ethics Committee Plain Language Statement’ sheet that made clear the process for assisting any participant who may be distressed by any of the content of the Neo-Socratic dialogue.

B) 6-8 hour Neo-Socratic dialogue sessions
In these sessions the introductory phase was less rushed and participants were afforded the time to get to know each other in a relaxed way. Participants were educated about the study using the same information as described in the 3—4 hour sessions. However, given there was less pressure on time, much of the questioning about the study in general, and the Neo-Socratic dialogue process, took place in the introductory phase of these longer sessions.

- Step 1: Broad question requiring a specific example.
Each Neo-Socratic dialogue group was presented with the question; ‘What is love in nursing and midwifery?’ Each participant of each group provided one personal clinical example of love in nursing and midwifery. The group then engaged in discussion with the relevant participant about the example in order to fully understand the example. On completion of this discussion the group then chose one example from the presented list that they believed best-reflected love in nursing and midwifery. The time taken by participants to deliberate on the best example varied between the four groups. However given the time constraint of 3-4 hours, it required that I facilitated an expedient
outcome. Each group reached unanimous agreement on what they considered the best example.

- Step 2: Specific question of the example. Once the best example of love in nursing and midwifery was accepted, the group set about formulating an answer to the question; ‘If this example is an example of love in nursing and midwifery, then what in this example did this nurse and midwife do that was love?’ All groups developed several answers to the question that were reflective of group discourse. It must be acknowledged that the two groups of 6-8 hours duration produced more answers to the question than did the groups of 3-4 hours duration. The groups of 3-4 hours duration focused on articulating thorough responses to a smaller number of answers whereas the groups of 6-8 hours duration produced several answers and over a longer time developed argument to support their responses. Equally the quality of argument in support of answers to the question varied both within each group and across all groups.

- Step 3: Broad question related to specific answer. Each group was then asked to formulate an answer to the question; ‘If what you have articulated to date is what you consider to be love in nursing and midwifery in this example, then what is love that is specific to nursing and midwifery?’ All groups found this part of the Neo-Socratic dialogue difficult and required the use of the metadialogue strategy to help keep the group focused on the question to be answered, to provide clarification of the various positions of participants, to illuminate strengths and weaknesses of argument and to assist in summation of the final position and an answer to this last question.
3.3.5.2 Record of the data

All Neo-Socratic dialogue sessions were audiotaped and transcribed in full-text. Audiotaping enabled access to the full-text of conversations. It provided information about how conclusions were reached, the identification of concepts overlooked or not adequately explained, and ideas not logically argued. Given that the Neo-Socratic dialogue sessions were lengthy (3-4 hours and 6-8 hours duration), audiotaping was essential to enable accurate exploration of the concepts and conclusions drawn from the Neo-Socratic dialogue. Audiotaping also enabled me to concentrate on the facilitative role, without having to worry about trying to record the content of the dialogue as well as facilitate the dialogue process.

3.4 Data Analysis

This thesis used two methods of data analysis; Neo-Socratic dialogue and philosophical inquiry. Data analysis in the Neo-Socratic dialogue phase of the study was undertaken by the participants, and in the philosophical data analysis phase by the researcher.

3.4.1 Data analysis: Neo-Socratic dialogue

Neo-Socratic dialogue is more than a simple method for the collection of data because it requires of the participants some analysis of their own and others’ experiences of the phenomena in question. However, unlike other methods of data collection and analysis, Neo-Socratic dialogue requires the participants, as opposed to the researcher, to engage in the process of constant comparative analysis and reflection through hermeneutic dialectic. Appleton and King (1997) make clear that both hermeneutic-dialectic and constant comparative analysis focus on searching out alternate views, convergent and divergent opinion and look for explanations for identified discrepancies.
What is more, Neo-Socratic dialogue enables the implementation of a dialogue strategy that used the continuing dialectic circle of iteration, analysis, critique, reiteration, and reanalysis, to develop joint consensus construction about the phenomenon of love in nursing and midwifery (Guba and Lincoln, 1989). The regressive procedure used in Neo-Socratic dialogue searches out the philosophical principles that underlie the judgements and evaluations of the everyday actions and the tacit knowledge that nurses and midwives bring to bear in their decision-making (Nelson, 1949, van Hooft, 1999d). Moreover, group discourse using the process of continuous analysis and abstraction from the specific experiences of nurses and midwives make it possible to reveal essential and ultimate assumptions which underlie the practice of nursing and midwifery as they related to ‘love’ (Nelson, 1949). By doing this the researcher seeks to prove nothing, but rather to expose the logical reasons for acknowledged judgements of nurses and midwives in relation to love (Nelson, 1949). While participants were able to engage in rigorous debate about the topic as it related to their own and others’ experiences of love in nursing and midwifery, as the abstract nature of the discourse increased so too did the difficulty for participants to offer new insights into the questions posed. To this end, the process of Neo-Socratic dialogue challenged the ability of some participants to think in critical and reflective ways. However this said, all Neo-Socratic dialogue groups offered answers to all the questions of the dialogue.

3.4.2 Data analysis: Philosophical inquiry
In this study the focus was on the development of a thesis of love as it applies to nursing and midwifery. Given the nebulous nature of the topic, however, the study required a data analysis strategy that enabled critical exploration of the data collected. Philosophical inquiry was chosen as a data analysis strategy because philosophy focuses on thinking about thinking, or more specifically, ‘philosophy is rationally critical thinking, of a more or less systematic kind about the general nature of the world (metaphysics or theory of existence), the
justification of belief (epistemology or theory of knowledge), and the conduct of life (ethics or theory of value)’ (Honderich, 1995: 666). It enables exposure of the conclusions about what lies behind ‘appearance’ or the ultimate reality that transcends appearance (Honderich, 1995). Applying philosophical inquiry, therefore, to what nurses and midwives understand to be love in their practice, and that of nursing and midwifery in general, makes known the reality that transcends the clinical appearance. Thus the outcome of this study is a thesis about the nature of love in nursing and midwifery, as understood by clinicians.

3.5 Quality of the study inquiry
Given this study uses a qualitative research approach that incorporates a social constructionist, hermeneutic-dialectic method and a Neo-Socratic dialogue, a criteria of ‘authenticity’ was accepted as the vehicle for demonstrating the quality of the study inquiry process (Nelson, 1949, Guba and Lincoln, 1989, Lincoln, 1995, Seale, 1999, Lincoln and Guba, 2000). Here the claim is that authenticity is the most appropriate measure for assessing quality in research that uses a qualitative approach. Specifically, this study uses the authenticity criteria of fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Guba and Lincoln, 1989, Lincoln, 1995, Seale, 1999, Lincoln and Guba, 2000).

3.5.1 Authenticity criteria of fairness.
The authenticity criteria of fairness require the study to place in the report participants’ perspectives, claims, concerns, and voices so ensuring direct inclusion of the participants (Lincoln, 1995, Seale, 1999, Lincoln and Guba, 2000). In this study, the chapters that report the Neo-Socratic dialogues present the different perspectives and realities of the participants. These reports enable the reader to authenticate the researcher’s representation of both the data and the theoretical insights about the conclusions of participants in regard to the question of ‘What is love in nursing and midwifery’.
3.5.2 Authenticity criteria of ontological authenticity and educative authenticity.

Seale (1999: 3) states that, in order to meet the authenticity criteria of ontological and educative authenticity, the study design must engage the participants in such a way that they gain a ‘...more sophisticated understanding of the phenomenon being studied ...‘ and ‘ ... appreciate the viewpoints of people other than themselves’. Neo-Socratic dialogue as implemented in this study, required participants to engage in reflective thinking about the question as it specifically related to their practice and also the practice of nursing and midwifery in general. It required dialogue that searched for alternate views, convergent and divergent opinion and looked for explanations for identified discrepancies and in this way fostered in participants more sophisticated understanding of the phenomena and others’ points of view.

3.5.3 Authenticity criteria of catalytic authenticity and tactical authenticity.

Lincoln and Guba (2000: 181) claim that catalytic and tactical authenticities require the ‘… inquiry to prompt, first, action on the part of study participants, and second, the involvement of the researcher/evaluator in training participants in specific forms of social and political action if participants desire such training.’ To these ends, this study made possible insights into the question of ‘what is love in nursing and midwifery’ and as such caused participants to develop a stance on what they understood to be ‘love’ as it related to their practice and also that of nursing and midwifery in general. The development of this insight better enabled participants to acknowledge ‘love’ as a component of the practice of nursing and midwifery that up until this study has not been reported in this way in the literature of nursing and midwifery. The generation of new understandings in participants about ‘love’ as it applies to nursing and midwifery has made possible the acknowledgement of ‘love’ as a genuine component of
the practice of nursing and midwifery and to this end, should the participants be so committed, create change to their own practice of nursing and midwifery and to nursing and midwifery in general.

3.6 Ethical issues
Given this study combines the doctrine of empirical research and philosophy, issues related to the ethical conduct of the study with regard to the safeguarding of participants, health care organizations, patients, and the quality of the study and philosophical inquiry have been addressed. The study obtained human research ethics committee approval from organizations, participant disclosure and informed consent, and established study conduct procedures for the maintenance of confidentiality and the safeguard of participants. The study design also enabled the implementation of data collection methods that both benefited the participants and the development of a thesis on love in nursing and midwifery.

3.6.1 Human Research Ethics Committee Approval
Approval for this study was obtained from Deakin University Human Research Ethics Committee: Project EC 197-2001 (Appendix 4: Deakin University Human Research Ethics Committee Approval). In addition, the researcher sought approval from various health care organizations to circulate an invitation to registered nurses and midwives to participate in the study.

One health care organization required approval of their research ethics committee prior to the circulation of the invitation, which was obtained. The research ethics committee of this organization expressed concern about the possibility of nurses and midwives providing examples of romantic love that could lead to the disclosure of professional misconduct. In order to meet this concern and as directed by this research ethics committee, I as the researcher
moderated all proposed examples to ensure that no example was of a romantic or professional misconduct type. To this end, all documents that were provided to participants, and on each occasion where discussion took place about the example of love in nursing and midwifery, it was made clear that this study was not about romantic love. In addition, information was included on the ‘Plain Language Statement’ and the ‘Consent Form’ about confidentiality and this romantic love exception. This information also identified my legal and professional obligations in regard to the nurses’ code of ethics and those of the nurse and midwife participants should an incident of professional misconduct be made public that placed a patient at immediate risk of harm. However, at no point did any nurse or midwife interpret the research question to mean romantic love nor was there any occasion where an example of romantic love was posed, discussed informally with myself, or offered as an example of love in nursing and midwifery. No example of love in nursing and midwifery was offered that could be identified as an example of professional misconduct.

3.6.2 Disclosure and informed consent

All participants were provided with:

- Information in verbal and written format about the study (Appendix 2: Deakin University Ethics Committee Plain Language Statement);
- The Neo-Socratic dialogue process and their role in that process (Appendix 3: How Do I Participate In A Neo-Socratic Dialogue?);
- The means for ensuring confidentiality and the need to maintaining confidentiality (Appendix 3: How Do I Participate In A Neo-Socratic Dialogue? and Appendix 5: Deakin University Human Research Ethics Committee Consent Form);
- The process to be implemented should a participant become distressed at the content of the Neo-Socratic dialogue (Appendix 2: Deakin University Ethics Committee Plain Language Statement);
• The safe storage, content use, and destruction of the audio-tapes of the Neo-Socratic dialogue sessions (Appendix 2: Deakin University Ethics Committee Plain Language Statement);
• The voluntary nature of their participation which included the opportunity to withdraw from the study at anytime without malice or prejudice (Appendix 2: Deakin University Ethics Committee Plain Language Statement, and Appendix 5: Deakin University Human Research Ethics Committee Consent Form); and
• The benefits of the study and the dissemination of results (Appendix 2: Deakin University Ethics Committee Plain Language Statement).

Prior to the commencement of the Neo-Socratic dialogue, each participant was asked to provide his or her informed consent (Appendix 5: Deakin University Committee Ethics Committee Consent Form). A documented record of consent has been kept in a locked filing cabinet dedicated to this study, so maintaining confidentiality and the safe storage of consent approvals.

### 3.6.3 Confidentiality and safeguard of participants

In addition to the confidentiality clauses listed in the informed consent and plain language statement, the nature of a Neo-Socratic dialogue necessitates the sharing of information that may be personal and of a sensitive or confidential nature and therefore at the commencement of each Neo-Socratic dialogue, I as the facilitator establish ‘ground rules’ for maintenance of confidentiality and respect for the comments of other participants. All participants were required to abide by the confidentiality rules established by the group otherwise they would not be included in the dialogue. As the dialogue facilitator I acted as a gatekeeper with regard to issues of a sensitive or confidential nature, maintaining the right to stop discussion on such matters and where necessary, to provide the participant/s with an opportunity to obtain counselling support. At the commencement of this study a counselling team was established, made
aware of the project, and invited to act as a referral source should it be required. Participants were made aware of the strategy for dealing with any distress should it eventuate verbally at the commencement of the Neo-Socratic dialogue session as part of obtaining informed consent (Appendix 5: Deakin University Committee Ethics Committee Consent Form).

3.6.4 Confidentiality of audiotapes and records
All group conversations were audio taped and transcribed and have been stored in a locked filing cabinet in the research office. The researcher and supervisor were the only two people with access to the audio tapes and transcription file. Pseudonyms have been used to disguise the participant’s identity in the transcription file. The supervisor has checked the transcription file for analytical thinking about the concepts raised but has not had access to participant identifying schema. On completion of the study all materials that identify people or places will be destroyed once the six-year data holding rules for Deakin University have been fulfilled.

3.6.5 Benefits and obligations to the study participants
Neo-Socratic dialogue conversations about love in nursing and midwifery and the human relatedness issues it has raised provided nurses and midwives with a forum that was sensitive to their practical experiences that would otherwise have remained hidden from the discourse of nursing and midwifery. The study has also given nurses and midwives the opportunity to identify (in their group) others of a like mind, and the opportunity to share their thinking about the topic, to explore inconsistencies in their own thinking, and given the opportunity to move toward a greater personal understanding of ‘love’ as it applies to their practice of nursing and midwifery. At the time of writing this report there was no significant research on love in nursing and midwifery that is not related to romantic love. This study offers an explanation of what is love in nursing and midwifery that has not been reported in this way before.
3.7 Conclusion

This study aimed to gather data from nurses and midwives on their perceptions, understandings and responses to the concept of love in nursing and midwifery. The study also gathered participants’ judgments about love in nursing and midwifery and about those of their actions, which were seen to put love in nursing and midwifery into effect. The method rested on the belief that the processes of understanding are not natural but rather the result of active and cooperative engagement of people in relationship (Figure 1: Study design) (Gergen, 1985: 267). The conclusions drawn were the result of philosophical analysis that resulted in the development of a thesis of ‘What is love in nursing and midwifery?’
Figure 1: Study design (adapted from the authors Guba and Lincoln (Guba and Lincoln, 1989: 174, Lincoln and Guba, 1985: 188)).
Chapter 4: Group 1: Report on a Neo-Socratic dialogue on the question of what is love in nursing? (Australia)

4.0 Introduction
This was the first Neo-Socratic dialogue undertaken on the question of ‘what is love in nursing’. It is presented in a way that allows the reader to follow the progress of the participants thinking and the development of their answers to the question posed. The group of nine nurses and midwives together developed four answers to the specific question of what is love in nursing in the example offered, from which they develop a universal statement that makes clear their answer to the question in general. In particular, the group understood that love in nursing requires of them a willingness, commitment, and intention to place the good of the other before the self without reciprocity. The dialogue makes clear that these qualities are given expression through an act of nursing in which the intention is to nurture a relationship of understanding of people which accepts or tolerates the will of the other where that other’s choice is based on a well informed health belief. What is more, the dialogue shows that nurses understand that they bring their own self to a relationship of understanding and feeling with the patient in order to nurture a state of health, well-being and comfort. It is an intention that expresses the nurse’s own health beliefs in the light of the desires of the other. The following is a description of the Neo-Socratic dialogue about this content.
4.1 The sample group: setting the scene
The Neo-Socratic dialogue on ‘what is love in nursing?’ was conducted in one six hour block of time with nine participants, seven of them being registered nurses (Division I) and two second year students undertaking a Bachelor of Nursing who were also Registered Nurses (Division 2). One participant was both a Registered Naturopath and a Registered Nurse (Division 1). All participants were currently practicing nursing on a part-time, casual or full-time basis. The background of participants was purposefully varied in an attempt to elicit a greater range of views about the topic. They included acute care, oncology and palliative care, aged care, mental health nursing, naturopathy, women’s health, nurse education, midwifery and student undergraduate clinical experience. Seven participants were women and two were men. The Neo-Socratic dialogue was undertaken at the university, which provided an environment conducive to serious discussion about the topic. Light refreshments and a luncheon were provided to help keep participants focused on the purposes of coming together and also to assist with the creation of a friendly atmosphere that was conducive to a thoughtful discussion about the topic. The following is a report of the Neo-Socratic dialogue.

4.2 Dialogue question
The focus of the Neo-Socratic dialogue was on the question ‘what is love in nursing?’

4.3 Phase 1: Dialogue example
In this Neo-Socratic dialogue, rather than each participant identifying an experience that related to the question, one participant (whom we will call Lee) offered an example, which was accepted by the group as an example of love in nursing and as the focus of the dialogue. What is more, rather than offering a
specific example that described one single nursing event that was identified as love in nursing, the example offered spanned a period of weeks that together was understood, in this example, to be an example of love in nursing.

It was obvious from the example offered that Lee had thought seriously about the question prior to the Neo-Socratic dialogue and came prepared to offer a detailed account of the example of love in nursing. Not only did Lee provide the group with a detailed oral account, she also provided newspaper articles about the event, a personal diary record, and photographs of the nursing home residents, family and other nurses involved in the event, which together helped create a clear image of the experience in the minds of all participants. The event described below was accepted as an example of love in nursing because of the prima facie plausibility of seeing that action as an expression of love in nursing.

Lee: ‘We took a group of nursing home residents with varying degrees of debility on a five day holiday to the seaside’.

4.4 Phase 2: Exploring the selected example

4.4.1 The example:
Lee: ‘We took a group of nursing home residents with varying degrees of debility on a five day holiday to the seaside’.
4.4.2 Further details of the example:
Next, the example was described in detail to the point where all participants could imagine themselves participating in Lee’s example of love in nursing. In order to make progress in the dialogue, all members of the group have to come to ‘own’ the example as if it was their own experience. Only in this way can they come to understand Lee’s intuition that this was an example of love in nursing. To this end, Lee now provided a detailed account of the episode, circulated a set of photos of the holiday that showed examples of people in relationship and a personal diary that outlined what Lee thought were the important experiences.

During the description of the event Lee said the motivation for initiating the event arose out of a concern that the residents in the nursing home where she worked were denied many of the normalized features of independent community living which she believed impact in significant ways on the health and wellbeing of the residents. It became clear from this and other similar comments made by Lee that something inside her demanded that she act.

More specific details about the chosen example were disclosed:

- ‘I saw a publication in the Australian Nurses Journal about a holiday that was had by a group of nursing home residents and thought that this was something that we must do’.
- ‘Approval to take the residents out of the nursing home and on a holiday was obtained from the hospital executive and each resident’s family’.
- The invitation to participate in the activity was open to all residents and family members without prejudice to the degree of mental or physical debility.
- No person was coerced into participating. Lee explained the frailty of the residents was such that of the originally 10 people wishing to participate, 3 died before the event was initiated.
• ‘Because anyone could come, we had several residents wanting to participate who had serious problems. One person suffered dementia, another was mentally retarded and prone to aggressive outbursts, another was a very heavy man who had suffered a CVA and was very debilitated and a couple of others were very frail.’

• ‘Several of the very frail residents died before the holiday took place, but they had the enjoyment of helping plan it and looking forward to it’.

• ‘Three other nurses thought it a good idea and were prepared to help’.

• ‘In all seven residents came on the holiday, plus one resident’s wife and their little dog’.

• The holiday consisted of a mini bus trip of 200kms with a trailer loaded with the equipment need to care for the residents.

• Accommodation was at a beach house designed for disabled people and close to the seaside and shops, but 30 kilometers from a hospital.

• ‘About four days before the holiday the idea was really Poo Who’d by a lot of the nursing staff that weren’t interested...’

• ‘The hospital was good and paid for the beach apartment and provided the hospital bus and trailer’.

• ‘Beside myself, One Registered Nurse (Division 1) and Two Registered Nurses (Division 2) volunteered their time’.

• ‘I had never driven a minibus before, and never packed up a trailer with a mountain of equipment’.

• Residents dictated their wake up, meal times and choices, evening bedtime, bath and showering preferences, clothing, activity program and sleeping arrangements.

• ‘Together we shared the night cover’.
• We took the residents:
  o On the Queenscliff Ferry and had chips in paper on the deck.
  o Went to the hotel and had a counter lunch and played the pokies.
  o Went shopping.
  o One resident just wanted to put his feet in the sand at the beach, so we pulled his wheelchair down to the beach and put his feet in the sand and sat some seaweed on his head.
  o Along the coast road for a short drive.
  o Sat up late in the evening and sat around the kitchen table drinking coffee and biscuits with a couple of residents just talking about everything and planning the next day.

• We had to:
  o Toilet residents at the back of the minibus.
  o Give out medications on the run in different circumstances.
  o Be aware of the effects of the public on the residents especially the people with dementia, aggression and antisocial behaviour.
  o Lift and move people around in difficult places, which was physically hard.
  o Monitor one resident’s diabetes.
  o Had to push beds against walls at night to reduce risk of falls in a strange environment.
  o Keep a constant watch on the residents with dementia so they didn’t wander off from the house or get harmed.

• ‘There was a bit of anxiety from the hospital’s point of view and a little bit of anxiety from the nurses’ point of view that something might go wrong’.
• The residents changed in that:
  o One resident hardly used his oxygen.
  o There was less incontinence.
  o Less dementia and no aggressive outbursts.
  o Residents talked to each other, were more tolerant of each other and respected each other’s needs more.
• ‘Everyone was sad on return’.
• ‘On return I was crying because I felt as though now I have opened up all these new ways of being for the residents and us as nurses are going to be changed as a result of this. And I feel as if I’ve let people down, I’ve just put them back in to how it always was.’
• ‘We took a video of the trip so all the residents and nurses could watch it later’.
• ‘We made a photo album up of the holiday and gave it to the residents’.

4.5 Phase 3: Exploring the question in the light of the example
Phase 3 of the dialogue: ‘What is love in nursing in this example?’ In asking the question, the respondent group offered four answers.

Question: What is love in nursing in this example?
Answer 1: ‘It is going beyond the traditional duty of care’.
Answer 2: ‘Being prepared to take a risk’.
Answer 3: ‘She was prepared to put herself up to have to think differently’.
Answer 4: ‘Respecting the choice of the other’.
4.5.1 Answer 1: It is going beyond the traditional duty of care

The first answer saw one nurse reply immediately with, ‘it is going beyond the traditional duty of care’. In this statement the respondent identified two important notions namely, ‘duty of care’ and love as ‘going beyond’. In legal terms, the group understood duty of care to relate to the provision of a minimum standard of nursing care, a standard that is measured by what one can reasonably expect, in this case, of all similar nurses. The measure of duty is benchmarked at the level of the group called registered nurse, that is, individual nurses may offer a level of care that exceeds the minimum standard expected, but they are not to fall below it. All this said, the group concluded that ‘duty’ can only have a tangible measure if the caring is outcome based, able to be demanded of the other, and then able to be compared to some criterion or standard. Given this position, it would seem that these nurses identify love in nursing as something outside of these parameters, something that is unquantifiable and therefore unable to be demanded. It is, in their words, ‘going beyond’ the traditional duty of care.

Adding to this view, the group also identified the norms of professional health care practice, as defined by Australia’s health care system and supporting health care bureaucracy, to be the result of the development of a system of health care founded on a duty of care that places boundaries on the role of the nurse, and in their words, ‘limits the possibilities of human caring’. This, along with what was described as the community’s increased awareness of the legal obligations of health professionals, resulted in the view that many nurses base their practice on what was labeled as the ‘safe ground’; the ground that protects a person from legal liability, professional critique, and personal harm. It was felt that to step outside the norms of professional practice was to move away from the ‘safe ground’ and place oneself at risk. While it was not disputed that the practice of nursing should be none other than safe, the group were of the opinion that the parameters set by the term ‘professional’ define safe practice in
such a way as to focus caring on the accepted minimum. It was postulated that duty of care has caused caring in nursing to be benchmarked at the level of what is reasonable rather than of what is admirable; of what is observable and measurable, not of what is invisible and unpredictable. As a consequence, the group felt that it was difficult for love in nursing to emerge in such a professionally constrained setting.

The second part of the first answer to the question of ‘what is love in nursing in this example’ suggested it is ‘going beyond’, and is something that is offered outside the current definition of duty of care. In fact, to ‘go beyond’, it was stated, was to ‘give of yourself’. It was to do something that was ‘not asked’. It was ‘to give freely to another something of yourself’ in the act of professional caring that ‘cannot be asked nor paid for’, and is more than the minimum standard of care because it is, as the participants described, where the nurse goes ‘out of her way’. Group responses suggested that love in nursing involves ‘going outside yourself’ or a ‘personal commitment outside that for which one is paid’. But what is ‘giving of your self’ and what then is the further quality that marks this example as an example of love in nursing? The question of what this extra element is remained unanswered. At this point of the dialogue, however, the group had not fully realized that it was opening such deep questions and it did not pursue that line of inquiry further.

4.5.2 Answer 2: Being prepared to take a risk.

Returning to the question of the definition of love in nursing in this example, the group formulated a second response. It was suggested that love in nursing in this example, involved the nurse ‘being prepared to take a risk’. Again, two notions were identified in this second answer, namely ‘being prepared’ and ‘to take a risk’. The ensuing discussion focused on two points of view about ‘being prepared’. The first point related to competency and the second related to motivation. The group understood that the registered nurse in this example, like
all nurses, was prepared formally for the challenges of caring for people who are in the traditional sense ill or unable to care for themselves. Put another way, ‘all the registered nurse’s caring actions arose from a foundation of her being a competent registered nurse’. In this example ‘being prepared’ meant this nurse was identified as competent. Also bedded in the discussion was the idea that in ‘being prepared’ this nurse was motivated by her moral condition to take action. In other words, as one respondent stated, ‘something inside her demanded she act in accordance with her belief where that belief was for the betterment of the residents in her care’. ‘As a registered nurse she willingly chose this action even though she knew it could result in professional critique of her caring’, not that the demand to act was either binding or something she could ignore. It was just the opposite. The group understood this to be an example of love because this nurse chose to respond to her deepest motive. The group decided that those nurses who enact professional caring, like the nurse in this example, are those motivated by something deep inside them that then results in a response that places the other before their own self. What in this example is love in nursing? The group concluded that love in nursing requires, on the part of the nurse, the ability to place another before them self. More particularly, what constitutes this, as an example of love in nursing was that, not only could it not be paid for or demanded by another, it was not even felt by the nurse herself as a sacrifice.

At this point the group introduced two new ideas that related to the risk associated with the conduct of the event. The suggestion focused on the belief that the self-sacrifice associated with taking the residents on the beach holiday was in itself a quality of love in nursing, but what is more, the foregoing of self interest was seen to be particularly significant because it showed this nurse did not feature at all in the motive to act. Specifically, participants understood the term sacrifice to relate to the idea that while taking residents on a beach holiday was a risky business, one that contained both a risk that she was professionally
prepared for and also risk she could not be fully prepared for, in that she could not predict what would transpire in each and every situation, the event required more. It required her to forgo personal activities that would benefit herself. As the group explained, she sacrificed the enjoyment of her family by being away from home. She sacrificed her own relaxation by being professionally responsible for the welfare of the residents 24 hours a day while she would have otherwise been off duty. She sacrificed her physical rest by being at the residents constant call 24 hours a day, and she risked her personal safety by driving the bus and trailer, with which she was unfamiliar. The opinion was that this nurse did all this and more because the motive to act was not out of self-interest, which was exemplified in the fact that no reciprocity was considered. This was an act of love in nursing not because the nurse was able to forgo personal benefits to herself but because her welfare did not feature at all in the motive to act. As interpreted by the group, love required something of this nurse that caring did not. It required the ability to put the welfare of the other person before her own without consideration of her own needs. All this said, the group did not continue with this line of inquiry and therefore no discussion was had about the limits of the sacrifice the nurse was prepared to take. The group now turned its attention to a third answer to the question of what is love in nursing in this example.
4.5.3 Answer 3: She was prepared to put herself up to have to think differently.

Discussion in the Neo-Socratic dialogue continued about the motive for the beach holiday, and resulted in a third answer to the question namely, ‘she was prepared to put herself up to have to think differently’. In this answer, being ‘prepared’ was not related to competence (as discussed above) but rather volition, or as one respondent replied, ‘she was willing to put herself up to think differently’. The introduction of the term ‘willing’ was an attempt to capture the notion that this was a voluntary act. Respondents held the view that it is one thing to have a ‘good idea’ as in the beach holiday, but entirely another matter to ‘live out’ the motive. The beach holiday was only a good thing to do if the residents wanted it. What made this an example of love in nursing was that, while this nurse was committed to the idea, she was able to empower the residents to decide whether or not it was good for them and then act on that outcome. The group believed that love in nursing requires, on the part of the nurse, the ability to empower the other to direct their care even in situations where the nurse may not agree with the outcomes. The issue as to whether a nurse could do this in all situations was only given brief consideration.

The final part to this third answer read, being prepared to put herself up ‘to think differently’. Participants were of the opinion that the nurse in this example was, in a prepared way, initiating nursing care of a type different from that normally offered to these nursing home residents, that is, the decontextualization or de-institutionalization of the nursing experience required this nurse to reorient her thinking about the provision of nursing care to the residents. The residents had the full attention of the nurses. In this example, the group understood the residents to be the focus of the experience, as opposed to being residents in a nursing home where they share the focus of orientation with the demands of institutional care. As one respondent reported, ‘the ability to think differently required her (the nurse) to blend the normal everyday goals of a holiday with
the provision of professional care to severely debilitated people’. To ‘think differently’, it was suggested, was an indicator of her willingness to put the care of the other before herself. What in this example was love in nursing? It was said that this was an example of love in nursing because the focus of nursing was on meeting the needs of the residents in ways that challenged thinking about nursing. Love in nursing requires flexible thinking about what constitutes care in nursing.

4.5.4 Answer 4: Respecting the choice of the other

Finally, a fourth answer to the question of ‘what is love in nursing in this example’ arose from discussions regarding the previous two answers and culminated in the statement, ‘respecting the choice of the other’. In the example offered, the nursing home residents and their families were consulted as to their views on the proposal of a nursing home resident beach holiday. It was explained that the invitation was open to any person in the nursing home and nobody was to be rejected on the grounds that they would not be suitable because of severe cognitive disability or physical debility. As was reported, ‘if a nursing home resident or family member wanted to participate they would be included, no pressure was placed on any resident by nursing staff or their families, thinking the holiday would benefit a particular resident where the resident refused or was reluctant’. The view expressed by this nurse in organizing the venture was that if this was to be a holiday in the true sense of the term holiday then that included participation in planning and the anticipation associated with the forthcoming event. Respondents saw these and other descriptions of the event as evidence of her ability to accept the will of the other person even if she did not agree with their decision. The idea expressed was not about the legal rights of residents and their authority in the control of their nursing home care but on the nurse’s preparedness to accept the outcome of their decision and its impact on her. While the decision to go on a beach holiday was a decision that could safely be left to the discretion of the residents, this was not the point. The point was that this was an act of love in nursing not
only because this nurse was able to accept the desires of the residents about
their participation in a beach holiday but also because she did this without
feeling any loss to herself. As one participant commented, ‘the act is loving
when the will of the other is accepted despite your distress’, that is, while the
beach holiday was an idea she was committed to it was only a good idea if the
resident also thought it was. As with the previous answers, the focus of the
nurse was not on her self and her feelings but on the feelings, thoughts and
desires of the residents. What is more, the comment ‘. . .despite your distress’,
alluded to the idea that love in the example required this nurse to do for the
other person something that ‘cost’ her. The nurse, in respecting the will of the
residents, was also willing to sacrifice her own beliefs about the value of the
event. Peter (a participant) made this point clear when he said, ‘it is putting
aside your own belief system and respecting the belief system of the other
person, and I consider this to be the ultimate sacrifice’; respect, as a component
of love that puts the other person first.

4.6 Phase 4: The general question

The next stage of the Neo-Socratic dialogue required broadening the question
from the specific form of, ‘what is love in nursing in this example?’ to the more
general form of the question: namely, ‘if this is what we understand to be love
in nursing in this example, then what is love in nursing in more general terms?’

The group found this a formidable task since the dialogue had now reached the
point of saying that nurses are only able to do their ‘job properly when they go
beyond duty. . . and nurse in a loving way’. It was not disputed that one can
nurse without being loving in that one ‘might be able to get through the day of
work and draw a salary’ and care for patients in a way that meets the formal
duty of care. However, the new claim was that, for one to be an ‘effective’
nurse, one needs to go beyond the legalist view of the duty of care and to love
in the act of professional caring. What is to be identified here is what the love is
that is specific to nursing, as opposed to other caring professions, and how this can be seen as being beyond duty.

In an attempt to answer this question, discussion commenced from the participants’ own understanding of their professional nurse roles. Peter offered a broad statement to begin this portion of the dialogue, the content of which is a blend of Peter’s understanding about his role as a nurse and what he saw to be love in nursing. For Peter ‘the intention of nursing is to benefit the health and wellbeing of patients where the nurse is able to accept the views of the other despite their own belief system’. Yet how is this statement related to the identification of what love is in nursing? It seemed the group first needed to come to some general consensus about the role of the professional nurse since only then could they look to identify what love is in nursing, if love involves going beyond the strict requirements of the role. Consequently, as it developed, the answer moved from a depersonalized statement about the nursing role to one that took on a more connected view. For example, the group in responding to Peter’s statement changed the word ‘benefit’ to ‘promote’, and then from promote to ‘nurture’. Participants believed that the earlier terms were not specific enough to nursing and failed to capture the human relations that are reflective of nursing and love.

Similarly, the group changed the term ‘health’ in favor of ‘people’ and then from ‘people’ to ‘understanding of people’. In this way the statement came to read: ‘the intention of nursing is to nurture an understanding of people where the nurse is able to accept the views of the other despite their own belief system’. This more personalized statement suggests that nurses nurture people in a relationship, but more, that they nurture in a relationship of ‘understanding with people’. Of course, the objective of health should not be lost sight of. The group came to the view that love in nursing is evidenced in the relationship a nurse has with the patient where the nurse is able to express a personal value system
as it relates to health and life in the light of understanding, respecting, and accepting the will of the other. One participant commented that ‘it is a relationship of respect for the self-expression of the other’s value system and of accepting that value system despite yourself’. While it is obvious that love requires, on the part of the nurse, competence, personal commitment, openness to the other, and the ability to place the other before oneself, the key point here is that the nurse should overcome an insistence on their own point of view so as to accept that of the patient. However, this raised the difficulty of a possible clash between the views of the patient on such matters as their own treatment on the one hand, and the professional view of the nurse of that treatment on the other. Is it really a requirement of love that the nurse should suspend personal professional judgment in favor of the views of the patient - especially in such cases where the patient is suffering from some degree of dementia? The group concluded that there is room for a nurse’s professional judgments about the wellbeing of the patient. Accordingly, love is an act in which the intention is to nurture a relationship of understanding of people where that intention implies acceptance or tolerance of the will of the other where the other’s choice is based on a well informed health belief. It is bringing the nurse’s own self to a relationship of understanding and feeling with the patient in order to nurture a state of health, wellbeing and comfort. It is an intention that expresses the nurse’s own health beliefs in the light of the desires of the other.

I felt at this point that the discussion had moved to a general level too quickly. The group was now grappling with the question of what love is in nursing without making reference back to the example. The insights that had been won during the earlier phase of the discussion: namely, that love in the example involved going beyond the duty of care, giving of oneself, preparedness, risk taking, sacrificing oneself, and taking the point of view of the other seriously, should now have been absorbed into a more general understanding of what love is in nursing. However, given the time constraint on this dialogue all that
could be articulated related to the notions of willingness, commitment, intention, and sacrifice of the self for the other, that is, love in nursing was seen as the willingness and commitment of the nurse to want the good of the other before the self without reciprocity. This is a complex statement requiring still further analysis.

One thing that does seem clear about this statement is that ‘love’ as understood by the group is something qualitatively different from ‘caring’. Whereas caring is seen as the fundamental professional and ethical stance of nurses towards their patients, love was seen as something more. This is not to suggest that the concept of caring is not rich in moral dimensions and deep in its levels of engagement and rapport with patients, but it does suggest that love is a supererogatory level of such caring which takes nurses beyond what caring indicates and into a further dimension of commitment and dedication. Just what this means and whether it can be morally demanded of nurses is a question yet to be explored.

4.7 Commentary on the dialogue
The format and structure of the dialogue ensured that every participant’s contributions were thoroughly explored and tested against the insights of others. Nevertheless, there were a number of assumptions that were not called into question or made explicit. As a result the dialogue raised a number of questions that could not be explored in the context of this dialogue.
4.7.1 If love is something beyond the duty of care, what is this extra element?
While all the participants agreed that love in nursing is something that is offered outside the current definition of duty of care in that it is to go beyond the duty of care and give of yourself that which cannot be asked nor paid for, no answer was provided.

4.7.2 Is it acceptable for a health professional to knowingly place the good of another at risk?
Significantly, the notion of risk taking in the example provided, was only considered from the nurse’s point of view. No dialogue took place that sought an answer to reconcile as to whether or not it was an example of love if the patients were placed at risk even though the motive for such was admirable.

4.7.3 What is the quality of the sacrifice that makes an act of nursing loving?
Although sacrifice was identified as a prerequisite of love, little consideration was given to the nature or measure of such sacrifice. It was agreed that love in nursing requires, on the part of the nurse, action that places the other before themselves without conscious consideration of themselves and without consideration given to reciprocity. However, no one asked whether there were limits to the degree to which nurses should sacrifice their own interests in favour of their patients.

4.7.4 Is it a requirement of love in nursing that a patient be empowered to direct their own care in all situations?
The key point around the discussion of the patient being empowered to direct their own care was related to the overcoming of the nurses’ insistence on their own point of view. Little discussion occurred around the ability of the nurse to do this in all situations such as in dementia or possible clashes between the
views of the patient on such matters as their own treatment on the one hand, and the professional view of the nurse of that treatment on the other. The group concluded that there is room for a nurse’s professional judgments about the well-being of the patient. No discussion took place that sought to identify the parameters of empowerment that should be engendered by an act if it is to be considered loving.

4.8 Conclusion
The culmination of the four answers to the question what is love in nursing in this example showed that Lee gave more of herself than was asked or could be paid for, in that she went beyond the duty of care and in a prepared way placed the good of another before herself. In so doing, she placed her own well-being at risk. When translated to nursing in a more general sense, this suggests that the qualities of love in nursing require on the part of the nurse a willingness, commitment, and intention to place the good of the other before the self without consciously seeking something in return. These qualities are given expression through an act of nursing in which the intention is to nurture a relationship of understanding of people which accepts or tolerates the will of the other where that other’s choice is based on a well informed health belief. It is bringing the nurse’s own self to a relationship of understanding and feeling with the patient in order to nurture a state of health, well-being and comfort. It is an intention that expresses the nurse’s own health beliefs in the light of the desires of the other.
Chapter 5: Group 2: Report on a Neo-Socratic dialogue on the question of what is love in nursing? (Australia)

5.0 Introduction
This Neo-Socratic dialogue is a report of nine Registered Nurses’ (Division 2) answers to the question of what is love in nursing. The group offered three specific answers that together showed that the group believed love in nursing arises out of the conscious recognition of their subconscious connection to the patient, occurring as a response to witnessing the patient’s suffering. The dialogue describes the group’s understanding of how a nurse uses professional skills and judgment to respond in a selfless way to the needs of the patient, action that is not without its risk to either their own welfare or that of the patient’s. However, it is also explained that risk, if associated with nursing interventions that are considered acceptable, is itself acceptable when the motive for the action is for the ‘good’ of the patient. What is more, the dialogue shows the group understands that the level of the professional commitment required for nursing action to be considered love cannot be demanded because the commitment is in being morally responsible for the vulnerable patient.

5.1 The sample group: Setting the scene
Participants of the Neo-Socratic dialogue were Registered Nurses (Division 2) undertaking a Bachelor of Nursing (conversion program) to Registered Nurse (Division I). As a result of the invitation to participate in the study, eight (8) Registered Nurses (Division 2) agreed. By coincidence, all the participants were male. While the clinical experience of the participants varied, they all had currency of practice by way of either part-time or casual employment as a
Registered Nurse (Division 2). Two participants were employed in the acute health care sector, working on an acute medical or surgical ward, with the remainder working in aged care in nursing home areas. Because all the participants were enrolled in the third year of the Bachelor of Nursing (conversion program), they also had a wide range of clinical experiences of nursing in areas such as mental health, community nursing, palliative care, and a plethora of acute health care specialty areas. The Neo-Socratic dialogue reported on here was undertaken at La Trobe University campus and was conducted in a room conducive to discussion. Light refreshments and a luncheon were provided to assist with the creation of a stress-free environment but, at the same time, one that was favorable to serious discussion.

From the participants’ point of view their arrival at the Neo-Socratic dialogue session heralded the revelation that the group was all male. To participate in a group that was all male was seen by them as something of a novelty, given the population of men in nursing in Australia remains relatively constant at around 8% of the total population of nurses and midwives (Nurses et al., 2001). As a consequence of this revelation, an aura of camaraderie seemed to traverse the room. Most notably, the camaraderie of the group appeared almost instant with joking and laughing and general getting to know each other. The camaraderie evident in the group appeared to assist the creation of trust where these men felt safe to disclose information about the topic in a serious and very personal way. This Neo-Socratic dialogue lasted 3 hours, which was a little short. The group made significant insights into the topic and with more time could have further developed their final answer to the question. What was notable in this Neo-Socratic dialogue was that the group chose to construct a basic mind map of their ideas that were to be included in their final answer to the topic question. The following is a report of their Neo-Socratic dialogue.
5.2 Dialogue question
The focus of the Neo-Socratic dialogue was on the question of ‘what is love in nursing and midwifery’. Given the demographic of this group the question was modified to, ‘what is love in nursing?’

5.3 Phase 1: Dialogue example
The discussion began with participants offering an example from their practice of love in nursing. The following eight examples were offered:

Lincoln: ‘I was undertaking clinical placement in a child and adolescent unit. In answer to the question, I was sitting on the floor holding in a ‘bear type hug’ a deeply disturbed 9-year old boy, who was trying to harm himself and myself. While he was constantly hitting and punching me, pinching me, scratching me, spitting at me, and pulling the hair on my arms, I felt no anger toward him, just love.’

Brian: ‘I was nursing a man of Italian or Greek extraction who had a diagnosis of Alzheimer’s type dementia and who, on this day was becoming increasingly aggressive. At the time, I was physically restraining him so that he could be given an injection safely. When I let him go, he turned and punched me on the chin. While it hurt, I felt no anger towards him; rather I felt love, for it was not his fault. It was mine.’

Roy: ‘I had been allocated the care of a terminally ill woman who was near death. I had to make sure this lady would not die alone. I remained with her and held her hand and talked to her the whole time until she died. I think this was love.’
Ron: ‘We had this lady in our nursing home who was quite obese. She was bed ridden and she couldn’t move nor speak or communicate. On this particular day when she was having her health care assessment she was totally ignored by the team of doctors and nurses. I looked at her and she had tears in her eyes so I went over to her and all I did was stand there and have direct eye contact with her. This was how my love came out.’

Neil: ‘I was working in an aged care facility and had the care of a 31-year-old fellow who had sustained severe brain damage when he attempted suicide by jumping off a moving truck. This particular day I turned on some music that he had by his bed while we were caring for him and I just started chatting to him as if he was a person with whom I could communicate normally. For some reason the music, which I knew, caused in me a connection which I think was love.’

Ernie: ‘I was allocated the care of a woman who was diagnosed with cancer and she had a huge pressure sore on her buttock, which was infected, and resulted in her being isolated from the rest of the ward. One day she said to me, ‘I’ve had enough. I don’t want anything. I don’t want you to do my dressing. I don’t want you to wash me or anything’. Hearing this, I just sat down with her for about half an hour and chatted with her about her life. Nothing more was said but after that she improved dramatically and eventually went home. At the time I never thought anything of it but now, on reflection, I feel it was an example of love in my nursing.’

Daniel: ‘I came across a lady who was in an aged dementia unit, with moderate confusion. We built up a good relationship because she had run a milk bar for much of her life and similarly I had grown up in one. I felt she had been dealt a pretty hard hand when you see how she has ended up; worked hard all her life and now in a nursing home with dementia. On reflection, I found myself putting more into the care of this women and I always seemed to be a bit more
concerned about her. I liked to keep her mood up and when it was low I just wanted to be there ‘for’ her.’

Ryan: ‘I was on a nightshift with two Division I nurses and we had a patient who was dying and drifting in and out of chain stokes breathing. While she had her daughter present most of the time, her daughter left regularly to call family members, so when she was away, I made sure I was with her, just holding her hand so she knew that someone was there and that she wouldn’t be alone at death.’

At the conclusion of offering examples the group engaged in general discussion about all the examples. The group took approximately 15 minutes to reflect on each of the examples offered and after some discussion on each example they selected Lincoln’s example as the one that, in their collective opinion, best exemplified the concept of love as exemplified in their own clinical practice.

5.4 Phase 2: Exploring the selected example
The next stage of a Neo-Socratic dialogue is for the group to explore the chosen example in such detail that they are able to imagine themselves in the example. Hence, after the example has been explored in depth the group is sufficiently informed about the example that they are able to individually take ownership of the example. Thus at the conclusion of this phase the example is no longer ‘just’ Lincoln’s example but the group’s.

5.4.1 The example:
Lincoln: ‘I was undertaking clinical placement in a child and adolescent unit. In answer to the question, I was sitting on the floor holding in a ‘bear type hug’ a deeply disturbed 9-year old boy who was trying to harm himself and myself. While he was constantly hitting and punching me, pinching me, scratching me, spitting at me, and pulling the hair on my arms, I felt no anger toward him, just love.’
5.4.2 Further details of the example:
The following details about the chosen example were disclosed:

- ‘I arrived on the unit for an afternoon shift at this acute care hospital’.
- ‘The boy was fast tracked through accident and emergency to the child and adolescent unit because he was disruptive’.
- ‘I walked in and saw a room on the unit that was completely dismantled with a child in the room who was ‘deeply’ disturbed. The contents of the room were strewn all over the room.
- ‘There was a nurse holding the door closed looking in through the window at this boy’.
- ‘He was violently trashing around in his room trying to harm himself’.
- ‘He was having suicidal ideations and trying to abscond from the unit’.
- ‘Another student who had been caring for this child on day shift had a split and fat lip and bruises to the arms and legs’.
- ‘There was mayhem on the ward and they were doing their dampest to just keep the door to his room closed and keep him confined to that room’.
- ‘He has a fair bit of Diazepam and other sedatives but with no apparent effect’.
- ‘I could not just look in the window and watch on [sic]. I had to go into his room’.
- ‘Later, at handover, I was asked if I would take on the care of this child because I was a ‘bloke’ and bigger than all the females’.
- ‘Within 20 minutes of being with this child I could see that there was no way that this child could be left alone, not even for a minute’.
- ‘After handover we had to physically strip everything from the room because he was trying to use everything he could to harm himself. He was left with a mattress on the floor, that’s all.’
- ‘He had assaulted 3 or 4 of the staff, and for their own safety they simply refused to attend him’.
• ‘I was told, for my own safety, to stand outside the window and hold the door shut’.
• ‘I couldn’t stand the thought of this child running around the room like a moth at a light, at a plate glass window, which was cracked, trying to do himself harm’.
• ‘I wasn’t prepared to just sit and watch him harm himself’.
• ‘I sat on the floor with him hugging him for about two and half hours. He was so strong and he fought me, trying to injure me. I was absolutely knackered’.
• He constantly tried to spit on me, pinch me, scratch me, kick me, punch me, pull my hair, do anything he could to hurt me’.
• ‘I said to him nothing you can do would make me leave you’.
• ‘I couldn’t feel anger toward him, even though he was really hurting me. I could only feel love’.
• ‘After two and a half hours he calmed down and we began to talk about our pets’.
• ‘If staff came in and interrupted us he would jump up and begin his self-harming behaviors again’.
• ‘At the end of my shift I didn’t want to let him go but followed him to the Acute Psychiatric Unit where he was being transferred’.

5.5 Phase 3: Exploring the question in the light of the example

The group now confronted the question of ‘What is love in nursing in the example offered’. The group presented three answers to the question as listed below.

Question: ‘What is love in nursing in the example?’
Answer 1: ‘It’s a selfless, subconscious calling’.
Answer 2: ‘Love is more than duty’.
Answer 3: ‘Being content in your vulnerability’.
5.5.1 **Answer 1: It’s a selfless, subconscious calling**

The first answer that was offered had two components to its content, the first was the idea that love is a ‘subconscious calling’ and second was that love requires ‘selflessness’ on the part of, in this case, the nurse. With this answer, much discussion took place on the motive behind Lincoln’s reaction to his witness of the boy attempting self-harm where he stated ‘I could not, not go in’, to the boy. The group believed that this event had triggered something deep within Lincoln to cause him to not only take action, but action that both ignored personal warnings about his own safety, and action that had him place the other person’s welfare before his own. To this end, the group offered the following insights.

Participants shared a common view that there was some form of ‘connection’ between Lincoln and the boy. Moreover, they believed that the ‘connection’ between them was below their collective consciousness and only became conscious at the point of Lincoln’s witness of the ‘trauma’ suffered by the boy. As Daniel explained, it was ‘a selfless subconscious connection that he had, wasn’t it really, like a selfless act that would come out in his subconscious, he just went in’. Participants had introduced the idea that the reason Lincoln went into the room was that there was a metaphysical ‘connection’ between Lincoln and the boy and that this ‘connection’ was of an unconditional nature, that is, Lincoln’s consciousness had no part in the decision to go to the boy.

Lincoln: ‘... I really didn’t have a choice...
Daniel: ‘Do you think it was the right thing to do?’
Lincoln: ‘It was the only thing to do’.
The group though struggled to articulate the content of the metaphysical ‘connection’, except to say that it was something that only became conscious after the decision to act was already taken. Thus, Lincoln found himself ‘committed’ to going to the boy without a reason. As he stated, ‘I really didn’t have a choice’, ‘it was the only thing to do’, and ‘I could not, not go in’.

At this point of the dialogue there was general puzzlement at the reason for why Lincoln responded to the event in the way he did, which was very different to the rest of the nurses on the unit. To this, the group could only suggest that as people are different, so they respond differently. Why there was a ‘connection’ between Lincoln and the boy remained a mystery to the group. They suggested that it was perhaps because Lincoln had a young family of his own and so it was an instinctual response similar to a father trying to protect his child. However, the group remained perplexed and could not offer an explanation as to why only Lincoln responded to the situation in the way he did, which was very different to all the other nurses, including other men, on the unit.

Alternatively, the group believed the example made clear the unconditional nature of the commitment of Lincoln to the boy. Lincoln placed the welfare of the boy before his own but the decision to place the boy first was not a conscious consideration of Lincoln’s. The dialogue around the phrases, I really didn’t have a choice’, ‘it was the only thing to do’ and ‘I could not, not go in’ left the group in no doubt that Lincoln was compelled to respond to the boy and that this compulsion was a pre-requisite for this to be an act of love.

What is more, it was understood that the act of responding to the boy was a ‘selfless’ act. The group was of the view that for whatever reason, Lincoln’s witness of the boy attempting self-harm resulted in him taking action that placed the welfare of the boy before his own. This meant that Lincoln’s welfare by inference was no longer his priority. Hence entering the room of the violent boy
was identified as a selfless act because it was despite his own welfare and was something that he was not conscious of or could control. While the point of entry to the room, where he stated, he ‘could not, not go in’ was a decision of his subconscious, it was also the point at which he was conscious of the threat to his welfare. However, the group understood that Lincoln’s welfare was a separate matter to the welfare of the boy. While Lincoln could make conscious decisions about his entry to the room that would include nursing actions once in the room, he could not have input into the decision to enter. The suggestion was that love was exemplified in Lincoln not being able to moderate the unconditional nature of his selflessness. However, no discussion took place about the limits of Lincoln’s selflessness. While Lincoln would not speculate on how far he would have gone to help the boy, he stated that he was extremely committed to the welfare of the boy and explained that he ‘could only feel love for the boy not anger’ when he was being punched, scratched, spat on, kicked and the like. Love, it seemed, enabled Lincoln to rise above a primary concern for the preservation of himself to the good of the other person.

The group now introduced the idea of risk, risk associated with the welfare of both Lincoln and the boy. However, as explained above, the selflessness inherent in the response of Lincoln to the risk of being hurt was not a consideration, not even when he became conscious of it. Both Lincoln and the group spoke little about the event and the risk to Lincoln’s welfare. It was as though it was accepted that such events require selflessness on the part of the nurse. As Lincoln later disclosed, ‘I would say that I’ve never had so many physical assaults in all my life…‘. Neil added, ‘that physical danger isn’t deemed important. It’s putting yourself second to the needs of someone else’. This suggests that love acts in such a way as to have the respondent not identify any risk of possible danger to the self because the focus of attention is not on the self but on the other person. At this point the group were not aware that they had introduced the notion of altruism in nursing and no further discussion of this
concept took place.

Rather, the group identified the idea of ‘risk’, not only to Lincoln but also to the boy. In the example Lincoln risked not only his own welfare but also the welfare of the boy. For example, it was stated that Lincoln went into the room and held the boy in a ‘bear type hug’ for two and a half hours, but as Lincoln stated, at that time he had no idea the boy had had a history of sexual abuse and that the boy may have interpreted his actions as yet another abuse (restrained against his will). What is noteworthy is that the group appeared unconcerned with the possible negative implications of Lincoln’s restraint of the boy. It was as though the risk associated with Lincoln’s actions was acceptable because it was well intentioned. Thus, it is acceptable for a nurse to put another at risk when the motive for action is the ‘good’ of that other person. The group understood that the circumstances Lincoln found himself in were extreme and out of the ordinary and as such warranted action that was equally not of the normal or everyday nature of nursing. As a consequence the potential benefits to the boy of Lincoln’s actions outweighed the possible negative consequences for the boy and Lincoln and therefore were acceptable. The group however did not venture into an examination of what equates to an acceptable risk for a professional nurse and or midwife and what is the unacceptable risk that is associated with professional misconduct.

Finally, some discussion was had around the idea of the ‘connection’ made between Lincoln and the boy during the two and a half hour period when they sat on a mattress on the floor and Lincoln held the boy in a ‘bear type hug’. The group were of the view that the ‘bear type hug’, was not only the way Lincoln believed he could lessen the physical and psychological impact of the event on the boy but one in which he could establish a ‘connection’ with the boy. It appeared that the idea of connecting with the boy, or establishing a relatedness, was important. The example offered centered on ‘pets’. Both
Lincoln and the boy had a pet animal that had died and caused them to be very upset. From the discussion of the example it was obvious that their communication about the shared suffering of the death of their pet was the moment in which the relationship changed. Lincoln reported that from this time on the boy was more settled and the intensity of his physical assaults lessened. The group was of the opinion that Lincoln’s actions demonstrated his love because all of his energy was directed at the relief of the suffering of the boy through the establishment of a ‘connectedness’.

5.5.2 Answer 2: Love is more than duty
In this answer participants identified love as ‘something extra’. Discussion about the interaction between Lincoln and a nurse senior to him made it clear that placing the welfare of the boy before his own was something that was not expected of him. In fact, he was advised to the opposite when he was told, ‘I would be taking it on my own back if I went in there and sustained an injury because it’s not what is required of me’. While there was no professional requirement for Lincoln or any other nurse to place at risk their welfare or to act in a selfless way, Lincoln did so willingly. Professional duty cannot require the obligation that love can. The implication is that love as ‘something extra’ is ‘more than professional duty’ because it is something that cannot be expected or required but is at the same time respected and admired. This attitude was shown in the fact that, while Lincoln was advised against going into the room, when it was made clear to his superiors that he had gone in and wanted to care for the boy, his superiors supported his endeavors and encouraged his action. The group were of the view that, while Lincoln’s superiors could not compel him to go into the room and place his own welfare at risk, once he had made that decision he was supported, encouraged and respected for the decision.
Without articulating it clearly, the group were of the opinion that professional duty places boundaries on ‘compassion’ and so limits the participation of the nurse and/or midwife in the suffering of another whereas love does not. Love, it seemed, enabled the nurse to share the suffering of the other person, in this case with the boy, and as such is more than duty.

5.5.3 Answer 3: Being content in your vulnerability.

At this point in the dialogue, the group engaged in a reflection on the ideas that had been discussed to date which culminated in a third answer to the question of what is love in nursing. As mentioned above, significant discussion took place around the idea that there existed a ‘connection’ between Lincoln and the boy, in that, the group continued to believe that Lincoln was in relationship with the boy before they met. As Lincoln stated, the relationship ‘had no start nor finish’ because, ‘it was already happening’. Both Daniel and Lincoln understood this to be ‘a subconscious connection’ that ‘was already there’. The point being made was that this was an example of love because there existed in Lincoln a moral state of his being that had him connected to the boy before and after the event because they were always ‘connected’. Yet what exactly this connection was that went before and after them was not made clear but continued to be a significant theme of the dialogue.

Having again accepted the idea that there existed between Lincoln and the boy a ‘connection’ that made possible their relatedness, the group continued their interest in the nature of this relationship and the selflessness that accompanied it. As was earlier explained, Lincoln did not think about going to assist the boy because it was just something that he had to do. Lincoln understood this to mean that he was the one who was responsible for helping the boy in that the responsibility was his responsibility and it was a responsibility he could not ignore. The group understood nursing to be a unique profession; one where nurses encounter people with serious health related problems that affect their
life. The group believed Lincoln found himself in just such a situation; he was in the presence of a boy who was attempting self-harm. It was a situation that Lincoln understood called him to action.

Extending this idea further Daniel believed there exists among nurses ‘the willingness to accept that people almost put their lives in your hands and that’s a big responsibility… and we willingly take that responsibility, we accept it, we want to accept it’. The group again digressed momentarily and engaged in a discussion about the nursing profession in general and how nurses respond to situations with patients where their own welfare is threatened. A nurse may be called on to respond to a situation, which they feel they are not professionally prepared for but do so because they feel the responsibility of the patient. It was acknowledged that some nurses choose to not take up the responsibility, where others like Lincoln feel compelled; they feel a deep responsibility for the patient.

Returning to the example, the group held the view that Lincoln responded to his moral conviction. The fact that it may have caused him to respond in a less than a competent way and possibly threaten his own personal or professional wellbeing was something he was not concerned about. As Lincoln stated, ‘you are content in your vulnerability’, meaning his moral concern for the boy overrode any rational concern he had for himself. As he went on to say, he was not concerned that his actions may well have lead him to be, in his words, ‘open to degrees of criticism from your peers and hierarchy and the patients family…’ because he was more concerned for the boy. This was an example of love in nursing because Lincoln responded to his moral conviction to take responsibility for the suffering of the boy. While he brought all his professional skills to bear on the situation, he knew this may not have been enough and his actions would be open to professional critique. Lincoln’s vulnerability to professional critique was not something that concerned him because he was able to place the welfare of the boy as his first priority ahead of any concern for himself.
5.6 Phase 4: The general question

This phase of the Neo-Socratic dialogue requires broadening of the question from the specific example of love in nursing to the general. Therefore, the group was asked that if what had been identified in the example was love, then what was love in nursing in general? To this question, the group responded with a mixture of thoughts that, while related to the question in general, did not necessarily relate to each other in any logical form. It was at this point a Meta dialogue was undertaken with the group in order to implement a process strategy that would facilitate the development of an answer to the question, and that ensured each person’s contribution was considered. To this end, it was decided that agreed ideas would be incorporated into a mind-map of thinking about the answer to the question. Specifically, the group constructed a mind map of the concepts raised in the specific example that they wanted to include in their answer to the general question (Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing). Having said this, specific reference is made throughout this report that explains the content of the mind-map and the answer to the question.
Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing (as formulated by the group).

Question: What is love in nursing?
Answer: Love in nursing is the response of the nurse to the suffering person that is characterized by an unconditional subconscious connection of their respective beings that has neither start nor finish. It is where the nurse engages in selfless action as a response to the trauma, suffering, vulnerability and fear of the patient that no one else can bear because the responsibility of the vulnerable is my privilege.
Dialogue about the general question of ‘What is love in nursing’, started with the idea that the profession of nursing has nurses alert to the ‘trauma’ suffered by people or, reflecting the groups thinking more accurately, the ‘suffering’ of people (Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing). It was suggested that, unlike other professions, nurses spend long periods of time interacting with patients in ‘intimate’ and ‘intense’ ways and for that reason are immersed in their suffering. As such, suffering is the object of the attention of the nurse. While it was understood that any nurse, by way of professional education and clinical experience, might be able to identify the ‘trauma’ being suffered by another person and respond to it in a professional way, it is an entirely different thing to identify the ‘suffering’ of the sufferer.

While the group understood the witness of the ‘vulnerability’ and ‘fear’ of the suffering patient to be at the level of the ‘subconscious’, they were unable to clearly identify what causes this response in certain nurses and not others. However, earlier in phase 3 of the Neo-Socratic dialogue, participants identified the concept of responsibility. In the specific example offered, the nurse saw himself as being responsible for the other person, more responsible than any other nurse and that his responsibility for the patient was his responsibility alone. When applied to this part of the dialogue the answer to the question of what causes one nurse to respond to the suffering of a person and not another, must be the moral state of this particular nurse. In other words, this nurse’s ‘responsibility’ to the suffering of the patient is what triggered his moral state of being as a nurse with the outcome as was shown in the specific example. To put it simply, a nurse’s response to a clinical situation is both rational and moral. It would have been rational not to go in but moral to do so. The discussion to this point inferred that the appeal of the other person’s suffering, which is an appeal of their helplessness, is a moral appeal that each nurse can only respond to in their own way. As such, love in nursing is the expression of the
moral self of the nurse.

Yet does this mean Lincoln was more moral than the other nurses on the ward who also witnessed the event? While not a point specifically explored in the dialogue it is one that is nevertheless worthy of brief comment. It seemed that the group understood Lincoln’s moral response to be unique. Lincoln was no more moral than anyone else, but his moral state of being identified something of the suffering of the boy that required him to act in the way he did, which was different to others. Was Lincoln more moral than the other nurses? All that can be said at this point is that his morality required him to take the action he did, whereas the morality of the other nurses required of them something different.

Furthermore, the group also believed that while there is no choice in accepting or rejecting the responsibility of the other, there is a certain ‘contentment’ that comes in the ‘responsibility’. The group recognized that with the responsibility comes ‘trust’ of the patient’s life, which they understood as a ‘privilege’ (Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing). To be clear, the privilege was not identified as some type of feeling of satisfaction or honor, for this would compromise the selflessness of the moral response, just the opposite, the privilege highlights the depth of the selflessness. It was about the nurse responding to the trust of the patient who gives over their life to the nurse, the responsibility of their life, with the nurse responding to the trust of being entrusted with the responsibility of that patient’s life by selfless action. It is a privilege because the nurse responds to the trust with all that they are. They respond in a selfless way by willingly offering themselves for the good of the patient (Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing).
The idea that love in nursing is characterized by an ‘unconditional’ ‘subconscious’ ‘connection’ of the nurse’s and patient’s being that has ‘no start nor finish’ further added weight to the view that love in nursing is the moral response of human to human relatedness (Figure 2: Group 2 Mind-map of the concepts underpinning the answer to the general question of what is love in nursing). The group shared the view that there exists between all humans a state of constant relatedness. It seemed that without knowing it they had once again entered the field of metaphysics in articulating the idea that humans exist as more than subjective beings but as ‘connected’ beings concerned not only with their own welfare but also the welfare of others. What is more, they also held the view that this relatedness was ‘unconditional’. The participants harked back to the example where Lincoln believed he had no choice in the matter of going to the boy when he stated that ‘I really didn’t have a choice’, ‘it was the only thing to do’, and ‘I could not, not go in’. As was articulated, the unconditional nature of the relatedness has the nurse committed to responding to the other person without concern for his or her own welfare. However, as a professional nurse the limits to the selflessness remain unclear as explained by Lincoln whose last word about the event was:

‘. . . there is nothing I would have done I mean, it’s hard for me I did everything that I had to do like that was needed to be done and I was able to do and I don’t know about it, like I needed to jump out of a window to stop him from falling out of a window, I may have done that I don’t know, I don’t know I can’t say but I know of what I lived through in that shift um my own well being was of a very low priority so maybe it’s possible, I just don’t know’.
One postulate that arises from this dialogue is that the degree of selflessness is unclear because there is no way of knowing what a nurse’s moral response will be to the suffering of another person. The suggestion here is that love in nursing is unconditional and therefore unlimited.

5.7 Commentary on the dialogue:
This section provides a brief commentary on the dialogue and makes clear the questions that arose in the course of the dialogue that were unable to be explored, they included:

Answer 1: ‘It’s a selfless, subconscious calling’.
Answer 2: ‘Love is more than duty’.
Answer 3: ‘Being content in your vulnerability’.

The group understood that there exists between people a metaphysical connection that only becomes conscious after the commitment to the other person has been given. However, while the content of the relatedness that all humans share was identified as one person being responsible to another person, the exact nature of the responsibility was not broached. What is more, no explanation could be offered for what triggers this responsibility in one person and not another. Furthermore, no discussion was had on the moral nature of the relatedness given that the group held the view that the connectedness was something that was always present between them and the patient both before and after the event.
5.7.1 What is the limit to the unconditional nature of the selflessness of love in nursing?

While Lincoln made it clear the severely disturbed boy was his first priority, the level of his sacrifice of his self was neither tested nor able to be postulated about. Lincoln knew he was committed to the boy but just how far he would have gone in his selflessness remained a mystery to both him and the group.

5.7.2 Is it ever acceptable for a nurse to put a patient at risk even when the motive for action is the ‘good’ of that person?

What equates to an acceptable risk for a professional nurse and what is an unacceptable risk that is associated with professional misconduct was not explored. It seemed that the group understood risk if associated with a motive of charity was acceptable, even if the outcome of the action that risks the welfare of the patient was negative. Is it ever acceptable for a professional nurse to risk the welfare of a patient even when they believe it is in the patient’s best interest?

5.7.3 If love in nursing is ‘something extra’ what exactly is the extra element that cannot be demanded?

It was clear from the dialogue that the group understood love to be ‘something extra’ than professional duty and also something that cannot be demanded of the nurse. While the group identified the idea that obligation is a component of love in nursing and something different to the obligation of professional duty of care, exactly what the differences were remains unclear, except to say that the obligation associated with love appears to be an obligation without boundaries, and linked to notions of responsibility, whereas the obligation associated with professional duty is definable and something able to be demanded.
What is more, the group also touched on the idea that ‘compassion’ is an element of love in nursing that enables the nurse to share in a deeper way the suffering of the patient more than professional duty is able. However, just what the content of the shared suffering of love is, that is different to professional duty, was not discussed.

5.7.4 **Can a decision of our consciousness override a moral decision?**

While in the example Lincoln stated that he had no choice but to go to the aid of the boy, could he have changed his mind? While Lincoln suggested he could not have changed his mind because, using his words, ‘he could not, not go in’, the fact that he was advised to the opposite suggests there was an opportunity for him to opt out. While it was one thing to feel the way that he did, it was a different matter to act upon it. No discussion was had about what made Lincoln follow his moral judgment of the situation and not change his mind.

5.7.5 **Does feeling a sense of self-satisfaction after the event compromise the selflessness of the love act?**

The group momentarily spoke about Lincoln’s feelings at the end of his shift after the boy was transferred to the Acute Psychiatric Unit. Lincoln said that he felt good about what he had done and that it was all worth it. While it was believed that Lincoln’s feeling good about his actions and the outcome was not the motivation for what he had done, there was no discussion about how feeling good about the outcome related to the selflessness of the love spoken about. What is the relationship of self-satisfaction to the selflessness of love in nursing?
5.8 Conclusion

This group of nine male Registered Nurses (Division 2) offered three answers to the question of what is love in nursing. Their answers showed that the content of love in nursing, as revealed in the example offered by Lincoln and understood by the group, comes about by their conscious recognition of their subconscious connection to the patient as a response to their witness of the patient’s suffering. The group understood that love in nursing requires on the part of the nurse, use of his or her professional skills and judgment to respond in a selfless way to the needs of the patient. However, it was equally understood that a selfless response may not be without its risk to both their own welfare and also that of the patient’s. Yet it is a risk that is understood by them to be acceptable if the motive for the nursing action is for the ‘good’ of the patient. What is more, it is understood that the level of the professional commitment required for action of this type is more than can be required of the nurse, because the responsibility of the vulnerable patient is moral and not just rational.
Chapter 6: Group 3: Report on a Neo-Socratic dialogue on the question of what is love in midwifery? (Australia)

6.0 Introduction
Yet different again to previous dialogues, this Socratic dialogue was made up of nine registered midwives who sought to answer the specific question of ‘what is love in midwifery’ The dialogue went over one day with participants offering two answers to the question as it related to the specific example offered, plus the development of one answer to the general question of what is love in midwifery. The group understood that love in midwifery requires of the midwife both personal and professional commitment in advocating the health needs of the woman who, during child birth, cannot always advocate for themselves. It requires the midwife to willingly place their self at both considerable personal and professional risk during the management of birth that the woman desires and is able to achieve. As such, love in midwifery requires the midwife to place his or her needs second to those of the woman and hence requires of the midwife both personal and professional sacrifice. This said, a characteristic of love in midwifery is its selflessness. The following is a description of the Socratic dialogue about these ideas.

6.1 The sample group: Setting the scene
The participants of group 3 were all Registered Nurses (Division 1) and endorsed on the Nurse’s Board of Victoria Register to practice midwifery. When the initial invitation to participate in the study was made, midwives saw it as an opportunity to develop a midwifery perspective on the topic. As a result of the invitation to participate in the study, nine (9) midwives agreed. While the clinical experience of the participants varied greatly all participants had currency of
practice. Eight participants practiced midwifery in a midwifery unit in an acute care hospital and one participant was an independent practicing midwife. All midwives had varying degrees of experience across the range of midwifery that included; antenatal, labor ward, birth suite, postnatal, special care unit, and community midwifery. In addition, the midwife who was an independent practicing midwife had experience with home birthing that included antenatal and postnatal care. The Socratic dialogue reported on here was undertaken in the home of one of the participants and was conducted in a relaxed environment that encouraged a sharing of thoughts about midwifery. Similar to other dialogues, light refreshments and a luncheon were provided to help keep participants focused on the purposes of coming together and also to assist with the creation of a friendly atmosphere that was conducive to a thoughtful discussion about the topic. This Socratic dialogue was of six hours duration and concluded with what participants considered a well-articulated answer to the topic question. The following is a report of this Socratic dialogue.

6.2 Dialogue question
The focus of the Socratic dialogue was on the question: ‘what is love in nursing and midwifery’. This group consisted entirely of midwives practicing only midwifery, and therefore the question was rephrased to read ‘what is love in midwifery?’

6.3 Phase 1: Dialogue example
The dialogue commenced with participants offering an example from their practice of love in midwifery. The following nine examples were offered:

April: ‘This day I was caring for a couple, Loretta and Joe and we quickly established a rapport. It was the couple’s first baby and they where going to have the labor induced because she was of 42 weeks gestation. They originally
wanted a homebirth but that wasn’t to be. She labored really well and everything was fine. She ruptured her membranes and that heralded the onset of second stage, and there was meconium stained liquor. The Resident Medical Officer wanted to intervene and was edgy about the meconium (to him it indicated fetal distress). Again, my assessment showed everything to be fine. There was no bradycardia; there was nothing that made me feel that there was any need to intervene, as she was about to start pushing. I was happy to keep going but the doctor wasn’t and he was standing at the end of the bed clicking his fingers and the husband wasn’t amused. I thought ‘I’ve got to get rid of you’, so I just suggested that he perhaps go off and have some morning tea as it would be a little while. Everything’s fine. Just go. Off you go and have a cup of tea, and he did. He was quite happy about that. I knew she was going to be a couple of hours pushing, as it was a big baby. We had about 15 minute’s peace and quiet and he came back. He had rung the consultant and of course the consultant said get a scalp clip on if there’s meconium. That’s the only piece of information he took any notice of. . . I could not see any reason to do that, so I suggested that he go and have another cup of tea. I think I suggested he was dehydrated actually and he got the hint. He was someone I got on well with and he went out. I really think deep down he would have gone with it but he had the consultant in on it now. It put this guy in an awkward position. I talked to Loretta about the meconium and what it meant. . . she trusted that I would tell her if I thought something needed to be done. She would be quiet happy to do whatever I recommended or what the medical staff recommended, with good reason... She trusted my judgment... She had a large normal well baby.’

Lyn: ‘I got to know this couple late in the antenatal period. I came on duty on an evening shift and she was laboring and then when she presented in labor there was no fetal heart sound so the end result of that labor was a forceps delivery under epidural. I stayed in contact with this couple, got to know the family, went to the funeral and within a couple of months she was pregnant
again and I was at the delivery at theatre. I’ve stayed in contact with the family and my husband has also been included. I fully expect to be at their next birth.’

Helgar: ‘I was asked to go to theatre and collect a dead baby of 32 weeks gestation. I just walked into theatre and found out that there had been a horrific car accident. Their 4 year old son had been killed, father was practically unscathed, and the mother was critically injured and her uterus had ruptured resulting in the death of her baby. Here am I with this dead baby and I thought well what do I do? I took the baby in to a designated single room on the unit. I hadn’t had contact with the father at this stage. So I involved the Chaplin at the hospital and asked him to seek out the father and he duly arrived with the father carrying a pair of little boy’s shoes. He didn’t want to know about the baby. He was just so traumatized and in such deep shock, as you could all well imagine. So anyway we just sat down and we talked quietly about it and as I say, he didn’t want to see the baby. Another midwife who was experienced with stillbirth babies and neonatal deaths helped and we both realized the impact of our practice on these families. We used the single room to help the family come together and start the grieving process and the father gradually became involved. We eventually bathed the baby, took foot and hand prints, and got as much detail about the baby as we could and started their little book as a keepsake and we had the baby christened. At the end of the shift I felt somewhat, well certainly, traumatized by it, but I felt as though I did all in my power. I had done everything I could to perhaps set up the grieving process and make the situation the best it could be for this family. I look back on that and feel I could have walked away and just left the baby and did what I had to do as a midwife to the baby without involving the family, but I see my love for my midwifery that kept me and supported me through this time. I did have subsequent contact with the family and they have moved on.’
Sandra:  ‘I was attending a homebirth for a primigravida woman who wanted to birth in water. She had a history of sexual abuse, early death of a parent, and other significant health related problems. . . I could tell she was nearly full on labor. They’d nearly used up all their hot water system with showers, and she desperately wanted to have the baby, at least labor in water, have the baby in water, this was her dream. . . I did a fetal heart and its way down and I thought oh no we’ve got to move (go to hospital). I just did it again, to check that it was right and it really was what I heard and what it was in relation to the contractions . . . I said I think we’re going to have to go, you don’t feel like pushing. . . I rang the second midwife, got the oxygen and suction ready, and did a vaginal examination. . . I said you don’t think you could push do you, cos I’ didn’t really want her to push, cos there would have been no point if the baby’s distressed and I just said you couldn’t do that could you just by this look in her eye and she said, she just looked wide eyed and went ‘ARH’ and out came the baby, like I just had to grab it and just rescue it from falling in the water, literally and out it came.’

Sharnee:  ‘I was working in an antenatal clinic and got to know this woman who had a history of trauma. She had been a bank teller and experienced two separate armed robberies, which had affected her deeply and now she was very untrusting of people. She had previously had a caesarean section for fetal distress and desperately wanted a normal birth this time round. We met several times before she came into labor. Unfortunately she was in breach at 39 weeks and would have to have another caesarean section. What I wanted for her was what she wanted, a normal birth, but in the end all she wanted was a healthy baby. On this particular day, night staff told me that a girl was requesting me and she was not going to theatre unless I was there. So lucky I was on, and I went to theatre and she had a beautiful birth and just the look of trust, appreciation and gratitude was a reward for me.’
Julie: ‘I came into labor and I got the midwife I didn’t want, the midwife we had not got on with and I thought, that’s it. I’m going around to the labor ward but what happened was over night, the trust and, you know, the relationship that was formed in a short time and things went beautifully.’

Nina: ‘I had been on duty almost 3 consecutive shifts with this woman who was having a stillbirth fetus at 15 - 16 weeks. A relationship had certainly developed but in the night after working with her for many hours where she thought she was going to die, and there was this real intensity of stillbirth as you all know, it’s like the rest of the world is closed off and it’s just the midwife and the couple are just there, and it’s a very intense environment. They’d settled down to sleep and he was on the floor and she was on the bed and she was actually grabbing some sleep after many hours of tears and trauma and whatnot and it was a very profound moment when I was sitting in the room in the dark quietly listening. . . I was thinking of the processes the couple would have to still go through where everything stops and where the dead baby sits in the cervix for a time. . . I was thinking about my role as a midwife and birth and death and the whole thing with my particular job I love so much… So much emptiness there is in this sensation, this terrible sensation… There I was thinking of this woman’s life and my care as a midwife and it’s really love of my work and caring very much for this woman who I hardly knew at the time…’

Mandy: ‘Well, love exists within me of the unknown baby and mother. On this particular day I helped the mother through a difficult labor and the ‘freaking out stage’ and she turned to me and said, ‘I love you’. You don’t have to be with a woman long to have that level of trust.’
Madalya: ‘I was a first year midwifery student and came across a couple in antenatal classes. This particular day I was on duty in the birthing suite and there was this same couple and they were just wrapped to see me. I had my preceptor with me and they just had so much trust in me, with so little experience, and I just wanted to give them the best I could, with so little experience, because their trust was so unreal. The husband just about dogged every step that I took and I was thinking does he know how little experience I have? At the end of my shift I had to go off duty because I was on a day next day. I didn’t want to go. She had the baby at 2 am, but I couldn’t wait to get to work the next morning and they couldn’t wait to see me and it was just, it was so unreal, but I still see them and they actually live close to me. They worked out my home address, but it was just wanting to be the best you could that was important…’

With the completion of example offering, the group set about identifying the example they believed was the example that best exemplified love in the practice of midwifery. While each example was briefly reflected on, the group quickly concluded that the choice of one example was one out of two. The group found favour in Madalya’s example because of the commitment of Madalya to the woman and the ‘deep trust’ of the woman of a stranger. However, the group concluded that April’s example was the specific example they wanted to explore in depth.

6.4 Phase 2: Exploring the selected example

As with each Socratic dialogue the next stage required the group to explore the April’s example in such detail that they could place themselves in the example. That is, after the example has been explored in depth each member of the group should be able to take ownership of the example and imagine it as their own. Thus at the conclusion of this phase the example is no longer ‘just’ April’s example but everyone’s.
6.4.1 The example:

April: ‘This day I was caring for a couple, Loretta and Joe and we quickly established a rapport. It was the couple’s first baby and they where going to have the labor induced because she was of 42 weeks gestation. They originally wanted a homebirth but that wasn’t to be. She labored really well and everything was fine. She ruptured her membranes and that heralded the onset of second stage, and there was meconium stained liquor. The Resident Medical Officer wanted to intervene and was edgy about the meconium (to him it indicated fetal distress). Again, my assessment showed everything to be fine. There was no bradycardia; there was nothing that made me feel that there was any need to intervene, as she was about to start pushing. I was happy to keep going but the doctor wasn’t and he was standing at the end of the bed clicking his fingers and the husband wasn’t amused. I thought ‘I’ve got to get rid of you’, so I just suggested that he perhaps go off and have some morning tea as it would be a little while. Everything’s fine. Just go. Off you go and have a cup of tea, and he did. He was quite happy about that. I knew she was going to be a couple of hours pushing, as it was a big baby. We had about I 5 minute’s peace and quiet and he came back. He had rung the consultant and of course the consultant said get a scalp clip on if there’s meconium. That’s the only piece of information he took any notice of. . . I could not see any reason to do that, so I suggested that he go and have another cup of tea. I think I suggested he was dehydrated actually and he got the hint. He was someone I got on well with and he went out. I really think deep down he would have gone with it but he had the consultant in on it now. It put this guy in an awkward position. I talked to Loretta about the meconium and what it meant. . . she trusted that I would tell her if I thought something needed to be done. She would be quiet happy to do whatever I recommended or what the medical staff recommended, with good reason... She trusted my judgment... She had a large normal well baby.’
6.4.2 Further details of the example:

- ‘The mother was a primigravida (first birthing experience)’.
- ‘The couple wanted a home birth but were overdue (42 weeks) and the pregnancy needed to be induced’.
- ‘Both Loretta and Joe wanted a spontaneous non-interventionist birth’.
- ‘I did an assessment during first stage of labor and was happy everything was normal and happy to go with the mother’s wishes for a non-interventionist birth’.
- ‘I established a quick rapport with Loretta and Joe and was able to work pretty easily with them’.
- ‘The onset of second stage resulted in rupture of the membranes and lots of fluid with meconium stained liquor’.
- ‘I got rid of the meconium, just in case a doctor saw it, but he did’.
- ‘Assessment of the baby showed it to be fine’.
- ‘The medical staff were keen to intervene believing they had to monitor the fetus for fetal distress’.
- ‘The baby was obviously large and a long second stage was anticipated which bothered the medical team but did not bother me’.
- ‘The RMO (Resident Medical Officer) was hanging around creating a negative atmosphere so I had to get rid of him, nicely, but firmly, twice’.
- ‘The consultant physician said to the attending medico to place a scalp monitor on the baby to monitor the fetal distress’.
- ‘My assessment did not reveal fetal distress’.
- ‘I maintained the mother’s confidence that there was no need for technology’.
- ‘She felt secure that her baby was safe; she trusted I would tell her if I thought something was needed, she trusted my judgment’.
- ‘After 2 hours of pushing the Medical Officer wanted to do a forceps delivery, but there were no indications except the mother was becoming a little tired’.
Another half an hour passed and she was becoming tired so I suggest an episiotomy would help and she was happy to have the episiotomy. She trusted me, she was happy to go along with it because I suggested it was a good idea.’

‘I was later reprimanded for asking the Medical Officer to leave the room a couple of times and for also having a clash with one of the consultants’.

‘I base my practice on evidence and that gives me the confidence to stand my ground’.

‘I was told after the birth by the medical staff that I wasn’t fit to practice’.

‘The normality of birth is something that I love about my practice’.

6.5 Phase 3: Exploring the question in the light of the example
The group now confronted the question, ‘What is love in midwifery in the example offered?’ The group provided two answers to the question as listed below.

Question: What is love in midwifery in the example?
Answer 1: ‘When I asked the Medical Officer to leave the room’.
Answer 2: ‘Love in midwifery is being there for the woman and being with the woman doing what needs to be done to help her birth in a way she wants’.

6.5.1 Answer 1: When I asked the Medical Officer to leave the room
The conversation commenced with attempts to identify what in the example was love. However, the group strayed around this topic area for some time and rather than identifying what in the example did the midwife do that was love, participants spoke about professional commitment as love of midwifery. The midwives described their commitment to the ethos of woman-centered birthing and saw themselves as advocates of ‘natural birthing’ for women in an
environment dominated by medical obstetrics. Accordingly, these midwives found themselves in many situations making professional arguments against what they considered unnecessary obstetric interventions. The midwives believed April, knowing the woman’s desires for a natural birth, acted as an advocate for the woman who was in a compromised state by laboring. She acted as a mediator between the woman and the medical staff about the obstetric care required, so guarding against the use of what have become known as routine type interventions such as ‘scalp clip monitoring’ (electrocardiography), use of vaginal examination to assess progress of labor, use of forceps for delivery of the fetal head at birth, need for episiotomy, and the like. The professional bantering between the midwife and the medical staff of the competing beliefs saw the care of the laboring woman a matter of negotiation. However, the group understood April to be very committed to her beliefs about the practice of midwifery and as such agreed with her preparedness to put herself in a position of ‘risk’ of criticism of professional judgment about the obstetrics required, which was evidenced by her actions of asking the medical officer to leave the room and the resulting retort of the medical staff who stated she was not fit to practice midwifery.

However, was asking the medical officer to leave the room an example of love in midwifery? The group offered this as the first answer to the question because in asking the medical officer to leave the room where there was possible fetal distress was not only evidence of the high degree of professional commitment and skill of the midwife, but was also something she described she ‘had to do’. In other words, April had to take the action she did because if she did not her professional integrity would have been compromised. However, in answer to the question above, was asking the doctor to leave the room love in midwifery, it was suggested that it was not, it was love of midwifery. It was understood that the love of midwifery elicited in this midwife a level of professional commitment that saw her willingly ‘risk’ critique of her duty of care. What remained unclear
was the relationship of love of midwifery to love in midwifery. The group understood a requirement of the love of midwifery was a high level of professional commitment that made it possible for the midwife to risk critique of their professional practice in order to maintain her integrity as a midwife. While not directly articulating it, it seemed that the midwives were of the belief that the professional commitment of April was a prerequisite of love in midwifery. In other words, for love in midwifery to be present the midwife must be committed to the profession of midwifery. In light of this general acknowledgment the group offered a second very different answer.

6.5.2 Answer 2: Love in midwifery is being there for the woman and being with the woman doing what needs to be done to help her birth in a way she wants.

The group fleetingly but repeatedly spoke about the relationship of the midwife to the woman in labour. The relationship was described as one of ‘trust’, one that was built on the woman’s acknowledgement of the midwife being ‘present’ to her needs that was understood as ‘help to birth in a way that the woman wanted’. While April’s love of midwifery saw her committed to a particular ethos of midwifery (women centred birth), one that required a high degree of professional commitment, the group identified that love in midwifery required something different, that is, as April described it in the example, her professional integrity resulted in her being committed to using all her professional skills and judgement to help the woman birth in a way that she desired. However, what made this an example of love in midwifery was that it required her to not only commit herself as a professional midwife to the relationship, but also more. It required she respond to the woman’s trust of her by being responsible for her. The midwife by way of her professional commitment to midwifery used her skills and judgement in being responsible for the welfare of the labouring woman who was at that particular time not able to
be responsible for her own welfare. Furthermore, the midwife was also responsible for the accomplishment of the birth the woman desired and was able to achieve. As such, responsibility is understood to be a quality of love in midwifery.

However, the group was clear that ‘love in midwifery is not always doing what the woman wants’. For instance, in the example, April stated that the woman needed to know that there was meconium liquor present at the rupture of her membranes, which indicated amongst other things possible foetal distress, and the effect this complication could have on her labour and birth. The midwife in understanding the type of birth the woman wanted then applied each clinical decision about the labour to that model of birth. In this example the midwife made a clinical judgement about the type of obstetric care that best met with the woman’s desired model of birth and also her current circumstances. The midwife made the professional judgement that ‘scalp clip monitoring’ was not required and while she sought to inform the woman of both the positives and the negatives of this obstetric intervention she participated with the woman in the decision.

Moreover, what made this an example of love in midwifery was that the women trusted the midwife with her welfare and that of her baby, in that, she entrusted the midwife with the responsibility for the decision and the midwife responded with a response that required no less than the midwife placing the welfare of the woman before her own. As April stated, ‘it is putting our own needs second’. It seemed that April understood love to be expressed at the moment when she became responsible for the management of the clinical situation that now included the welfare of the woman as understood by the woman. As she described it, ‘love is in that snippet of time’ . . . ‘doing what needs to be done according to her circumstances’. This statement was part of the dialogue around the taking up of the responsibility, the revelation of the responsibility. Love in midwifery requires the use of professional skills and judgement on the
part of the midwife in being professionally accountable. It requires placing the concern of the woman first without even thinking about it.

However, at this point in the dialogue, the group did not pursue a discussion about the concept of responsibility and the selflessness that accompanies it but rather turned their attention to a discussion on the risk to the autonomy of the midwife. In taking the stand that she did on behalf of the woman, when she rejected the intervention of ‘scalp clip monitoring’ for possible foetal distress, she put at ‘risk’ her own welfare by way of critique of the decision, particularly in regard to the woman, should it have been a choice that was later proven to be the wrong choice, and critique on the part of the medical staff who disagreed with her professional judgement of the situation. As one participant stated, ‘we risk a lot making those sorts of decisions because we risk the trust of our colleagues, risk offending our colleagues and offending the woman. We risk trust, so in a sense we’re doing it out of love because it is not necessarily going to benefit us.’ Accepting this statement, the group acknowledged that love in midwifery requires on the part of the midwife action that is not inspired by a self-benefiting motive because there is no expectation of reciprocity. The midwife did not engage the clinical situation thinking about the risk to her own welfare, for if she did she may well have not done what she did. Rather, as April stated, it was something she had to do to maintain her integrity. The statement ‘we risk a lot. . . ‘ further supported the degree of selflessness associated with love in midwifery.

**6.6 Phase 4: The general question**

This phase of the Socratic dialogue requires broadening of the question from the specific example of love in nursing and midwifery to the general. The group was asked that if what had been identified in the example is love then what is love in midwifery in general?
Question: What is love in midwifery?

Answer: ‘Love in midwifery is empowering the woman to do as much as she can for herself by being there with and for her, doing what needs to be done, maintaining a balance between professional judgment and respect for the woman, including an understanding of her innate ability to give birth’.

Initial discussion focused on the professional commitment of the midwife group to midwifery. They spoke at length about their love of midwifery, which centered on a belief in a woman’s innate ability to give birth. The midwives believed this ethos often caused them to be at odds with their medical colleagues who use the medical model in the practice of obstetrics. This said, the picture painted was one of an environment laden with conflict. On the one hand there are midwives who advocate a non-interventionist approach to the practice of childbirth akin to natural birth and on the other hand medical practitioners, and also some midwives, who apply a medical interventionist approach to the practice of obstetrics. Consequently the group was of the opinion that to practice women centered birth required of them a high level of professional commitment. Without knowing it the discussion at this point centered on their professional autonomy and the commitment required of the midwife if they are to practice woman centered midwifery in the medically dominated environment of a maternity unit situated in a hospital.

However, the group eventually made the distinction between the commitment associated with ‘love of midwifery’ and the commitment associated with ‘love in midwifery’. While ‘love of midwifery’ and ‘love in midwifery’ were understood to require both a high degree of professional and personal commitment the attention of each was different. Discussion around love of midwifery focused on the midwife’s understanding of their personal and professional commitment to the practice of midwifery and associated professional autonomy, whereas love in midwifery focused the midwife’s attention on the relationship with the woman.
That is to say, love in midwifery was understood to be about the midwife’s personal-professional commitment to the woman giving birth, which requires something very personal of the midwife. While the commitment required to practice a particular model of midwifery can be professionally required, the commitment associated with love in midwifery cannot. While midwives use their professional judgment and skills to respond to the health needs of a woman in labor in a professionally committed way, the relationship they have with the woman may demand more of them to which they may or may not respond. Commitment was seen to be the outcome of the midwife’s identification of the trust of the woman in labor. As such, the group understood that a prerequisite of love in midwifery is the midwife being entrusted with the woman’s vulnerability caused by her labor. From this, it was postulated that the commitment of love in midwifery is a commitment to the woman and the responsibilities inherent in a relationship in trust of the midwife.

While it was understood that love in midwifery requires the midwife to respond to the trust of the woman in a responsible way, by using all his or her professional skills and judgments in the management of the labor, the response may require more; it may require the woman’s welfare to come first. It was a point iterated by different group members and is exemplified in April’s following comment, ‘. . . it comes back to us putting our own needs second. . .’ and ‘. . . act selflessly’. However, the implications of the idea of a midwife acting selflessly were only partially explored. For example, no discussion was had about what transpires between a woman and a midwife at the point of the midwife taking the responsibility for the woman’s welfare that would cause a midwife to adopt such a selfless attitude. Equally, there was little discussion about the content of the self-sacrifice to be made by a midwife, except to say that, the group understood that the requirement to be selfless places both themselves and women at risk. However, rather than discuss the idea of risk to the woman, the group turned its attention to the risk to themselves and the accompanying
selflessness. As was stated above, placing the welfare of the other person before your own necessitates a degree of self-sacrifice, and the dialogue around this point made it clear that it was something the midwives were prepared to do. As midwives they are prepared to do what is needed in order to help the woman birth in a way she wants from a professional point of view. To exemplify this idea further, the group harked back to the specific example of where April took a professional stand about the type of obstetric care she believed was in the best interest of the woman, which resulted in her later being both reprimanded and berated by the medical staff who told her she was not fit to practice midwifery. As she further explained, ‘we risk the trust of our colleagues, we risk offending our colleagues and we risk offending the woman too’. While there was general agreement that by responding to the woman by being ‘with’ and ‘for’ her, the midwife places herself or himself in a position where sacrifice of their own self may be required, just how far a midwife is willing to sacrifice themselves other than professionally, remained unclear. However, April provides a glimpse as to the level of personal-professional sacrifice midwives offer when she, in referring back to her specific example, stated, ‘I was prepared to put my head on the chopping block’ for the woman. This statement indicates the midwife was perhaps even prepared to do more that sacrifice her professional standing, but again, exactly what the content of the sacrifice would be remains unknown. The dialogue around the concept of risk and self-sacrifice culminated in the statement that appears in the final answer to the general question of what is love in midwifery. It is ‘doing what needs to be done’.

The culmination of opinion around the type of relationships midwives develop with women gave rise to the view that love in midwifery requires the midwife to be both ‘with’ and ‘for’ the woman. More precisely, ‘for’ is related to ‘doing for’ or, as expressed by the group, doing what needs to be done but maintaining a balance between professional judgment and her innate ability to give birth. In
this context, doing ‘for’ requires the midwife to advocate on behalf of the woman who is unable to advocate for herself. It is an advocacy that is based on the professional expertise of the midwife, where he or she does what needs to be done, but in doing so, understands the risk involved and the selflessness required. In regard to the use of the term ‘with’, it was understood to mean ‘being with’, or as expressed by the group, supporting the natural innate abilities of the woman to give birth. Together, these and the ideas above ended in the group understanding that, ‘love in midwifery is empowering the woman to do as much as she can for herself by being there with and for her, doing what needs to be done, maintaining a balance between professional judgment and respect for the woman including an understanding of her innate ability to give birth’.

6.7  Commentary on the dialogue:
The following commentary briefly identifies questions that were raised in the course of the dialogue but not answered, they included:

6.7.1  Is love of midwifery a requisite for love in midwifery?
During the course of the dialogue the midwives spoke at length about their ethos of midwifery and its effect on their practice and the relationships they have with women. Whilst it was not directly articulated, it seemed that the group was saying that if one was not committed and passionate about their profession they would not be able to engage in the selflessness required for love in midwifery. For example, is it possible for a midwife to approach the practice of midwifery as nothing more than a job for which she or he is paid and still engage in a relationship of love in midwifery?
6.7.2 What is the quality of the personal-professional sacrifice of a midwife?

April, in sharing her example of love in midwifery, identified several defining moments in the example that showed she placed at risk both her personal and professional self for what she believed was for the ‘good’ of the woman. As April later went on to say, she was prepared to put her head on the chopping block for the woman, but nobody questioned the measure of her sacrifice nor did they question why she should do this. What was the motive for April adopting the responsibility for the woman’s birthing that enabled her to put the woman’s welfare before her own, and is the taking of such risks on the basis of an intuitive judgment acting responsibly?

6.8 Conclusion

The group understood the principles of April’s example of love in midwifery to be centered on a belief about woman-centered birthing and the associated personal and professional commitment required of a midwife if she or he is to advocate on behalf of the woman who, it was understood, cannot always advocate for herself. It requires a midwife to willingly place their self at both considerable personal and professional risk during the management of a birth that the woman desires and is able to achieve. The group understood that love in midwifery requires on the part of the midwife a willingness to place one’s self at both personal and professional risk and, what is more, a preparedness to put oneself second to the needs of the birthing woman which may require both a personal and professional sacrifice. A characteristic of love in midwifery is its selflessness.
Chapter 7: Group 4: Report on a Socratic dialogue on the question of what is love in nursing and midwifery? (Australia)

7.0 Introduction

A notable feature of this Socratic dialogue was the diversity of the participant population in age, years of nursing and midwifery experience, areas of specialization, current work environments, and the personal belief systems of individuals and their ability to all share their thinking about the study question. As with previous dialogues, the question posed to the group was; ‘What is love in nursing and midwifery?’

In this dialogue, love in nursing and midwifery was understood to arise from the moral character of the nurse that enables the identification of the unique value of the person of the patient and so gives rise to the commitment that is required to respond to the destitute condition of the patient. In other words, the group understood that love in nursing and midwifery is present when the nurse-patient occasion elicits in the nurse a feeling of being deeply responsible for the patient’s welfare. It is a responsibility that causes the level of the nurse’s commitment to the patient to increase in response to perceived threats to the patient’s welfare, as is evidenced in the determination of the nurse to help. As such, the character of the responsibility that is felt by the nurse is something that cannot be transferred, shared or ignored. Furthermore, it is a responsibility that requires the nurse to place the welfare of the patient before his or her own. For these reasons love, in nursing and midwifery was understood to demand more than the simple performance of the professional duty of care. It requires the nurse to ‘go beyond’ the professional duty of care and enter a ‘special
relationsh that is evidenced in the commitment and the compassion shown. The following is a description of the Socratic dialogue about these beliefs.

7.1 The sample group: setting the scene
Six participants made up group 4, which comprised one Registered Nurse (Division I) who was endorsed on the Nurse’s Board of Victoria Register to practice midwifery, four Registered Nurses’ (Division I) and one Registered Nurse (Division 2). All participants were currently practicing nursing and midwifery on either a full-time or part-time basis. The professional experience of the group was diverse and included acute medical and surgical nursing, high dependency and critical care, aged care, accident and emergency, child and adolescent nursing, and gynecology and midwifery. In addition, it also became clear that participants had recent or concurrent experience in palliative care, nursing administration, nursing education, operating room and day surgery, and mental health nursing. Furthermore, it was notable that the group possessed a variety of different beliefs about health, healing and the nurse’s role in the contemporary health care system. In addition, different as the individuals were, they were also similar in that all the participants expressed their commitment to developing an answer to the study question and its importance to the practice of nursing and midwifery in general. All participants were equally represented in the expression of thinking about the study question. All the participants were women.

For this dialogue the participant sample was obtained by a random sampling technique. Invitations to participate in the study were sent to hospitals where Human Research Ethics Committee approval had been obtained or permission by hospital administration had been given. Each hospital circulated the invitations to all areas of their health service where Registered Nurses were employed. The area manager of each health service collected the responses to the invitation and returned them to the researcher. Each of the respondents was
then contacted by the researcher and provided with additional information about the study question that would enable them to make an informed decision about their participation in the study. Information provided to respondents included a ‘Deakin University Ethics Committee Plain Language Statement’, as information sheet on ‘How Do I Participate In A Socratic Dialogue’, and general information about the conduct of the Socratic dialogue session. Lastly, respondents were contacted and asked for their decision about possible participation. While fifteen participants consented to participate, attrition throughout the recruitment process resulted in six participants undertaking the Socratic Dialogue session.

The Socratic dialogue reported on here was undertaken at La Trobe University campus and was conducted in a room conducive to discussion. Light refreshments and a dinner were provided to assist with the creation of a relaxed environment favorable to serious thought on the topic. This Socratic dialogue was of three and a half hours duration plus time out for the short dinner and concluded with what participants considered was a well-articulated answer to the topic question.

7.2 Dialogue question
This Socratic Dialogue was on the question of ‘what is love in nursing and midwifery’.

7.3 Phase 1: Dialogue example
The dialogue commenced with participants offering an example from their practice of love in nursing and midwifery. The following six examples were presented:

Sue: ‘I work in a nursing home and the only love many of the residents get is from us nurses. This particular example of love in nursing is related to an
elderly woman who I regularly care for. She has no family to visit her. She is very alert to her circumstances. She is obese and has a large leg ulcer that has a purulent discharge and must be dressed daily. The daily dressing of her wound is very painful and because it has been going on for some time she suffers from clinical depression. The dressing is complex to care for and takes considerable time to do and she often cries throughout the procedure. The procedure is very distressing for everyone. To make things worse, we have to use the lifting machine to transport her to the treatment room, which she finds most undignified. I have made a ‘connection’ with this lady. I have felt her pain and how depressed she gets with the whole thing. To make her feel better, I bring in a rose or butterfly type clip to uplift her. That is what I consider my love in nursing.’

Rita: ‘I was caring for a 63 year old man with a history of mental illness and now some dementia. At this particular time, he was on IV morphine and he pulled out the IV drip and broke the cannula. He had to go off to x-ray, where in the process of locating the cannula tip, they revealed he had lymphoma. This man had no family and no friends. We nurses were the only people he had around him and he had been with us for a long time. The decision by the medical and nursing team to tell him of his situation fell to me. I had to tell him that he was not going to be with us for much longer, to which he replied that, he knew something was wrong, and he cried. Then I asked him, is there anything you would like to do? We both cried. He said; yes, I’d like to go for a ride in a ‘fast car’ and go to a ‘strip club’. While extremely difficult, we organized it and then escorted him. To me, my love in nursing was when I believed I had to tell him that he was going to die and I cried with him and against all the difficulties of organizing it, made his wish come true.’
Jan: ‘I was caring for a lovely elderly man who was in the unit dying of end stage cardiac failure. The medical team had identified that there was nothing else they could do for him and that he would die soon. It was left to us nurses to prepare him for his certain death. In the unit, we normally don’t get to care for people in this way. They are usually transferred to the ward, but on this occasion we were not busy and he was kept with us. We became very tolerant of his every wish, and we listened actively about how he had lived his life. We listened over and over again to ever aspect of his life. But nothing was ever said about how he wanted to die, but over this time we became one-with-him. My love for him was shown in the tolerance of his constant need to talk about his life and my feeling one-with-him and sharing his suffering (Jan crying as she recalled this event). Even when they wanted to transfer him to the ward, we did all we could to keep him with us and he wanted to be with us also. We wanted to protect him and make sure every thing was done the right way. We wanted to comfort him.’

Pam: ‘I am somewhat ashamed of this story, but here goes. This night I was in charge of hospital admission and was contacted by the Ambo’s (Ambulance Offices) about admitting an elderly man who was found unconscious, and I agreed. We had a spare bed in a four-bed room and I thought that would be ok. On arrival this man was in an appalling state. He was unkempt, filthy, his clothes were stuck together with vomit, urine and faeces, his hair was matted, he had not had a wash for a very long time and he smelt terrible. The other men in the ward were all middleclass type people and I thought it was wrong to inflict him on them, so I felt bad for them too. I did not want to care for this man. The other nurse I was working with was very busy so I could not palm him off onto her and I suddenly realised, in amongst all my middleclass prejudice, that if I did not respond to his need for care, which was his right, he may not get the care he should. I had to make a transition from seeing him as he was to seeing his uniqueness. Love was overcoming my initial repulsion of him in his unkempt state, then go beyond that to see him as a unique person, not that which was
on show to society. I was able to extend myself by overcoming my repulsion of him and care for him as a unique person, which I believe, was my love as a nurse.’

Cristal: ‘This particular day I was allocated the care of a 53 year old woman who had a history of repeated admissions related to alcohol abuse, drug abuse, and mental illness that included depression and personality disorder. On this occasion, she had taken an overdose of Diazepam and some type of antidepressant. The other nursing staff labelled her a ‘loser’ and, it was said to me that, if I could not care for her, they would get rid of her (discharge her). I couldn’t believe what I was hearing. Up until this time, I had great respect for these nurses and didn’t think they would say such a thing! I remember thinking to myself that I wanted to make a difference to this woman. I was determined to care for her in spite of the prejudice coming from my colleagues. So, besides all the prescribed care, I just sat and listened to her. I listened to her life story in between all the other patients and tasks I had to do. I just kept going back to her every moment I had and spent the time listening to her, made her coffee, held her hand, put my arms around her and held her close, and let her cry. I learnt about how she despised herself because of her life and problems and how she had tried to kill herself. We talked about what could be, so giving her hope. I believe I helped her try again to overcome some of her problems. She saw herself as a loser and we talked about that and the transition was amazing. On leaving, she just looked at me and at that moment something touched me deep inside and she held my hand and said thank you.’

Tam: ‘I was on the mid floor (midwifery ward) this night and a 40-year-old gravida 4 woman presented in labour with an unstable lie. It became obvious that she was a very nervous person and relied on her husband to cope and suffered poor self-esteem. She constantly asked the same questions over and over again while we were trying to organise her to go to theatre for a caesarean section. At this point, one of the midwifery staff grabbed me and said, we have
a problem, quick. She had ruptured her membranes and had a cord prolapse. We immediately went into emergency procedure mode and set about getting her to theatre while I tried to push the baby’s head back off the cord. Anyway, we got her up to theatre and she had a healthy normal baby. Because I had pushed back on the baby she connected with me, in that, I had played an intimate role in saving her baby. But later, when things had calmed down, she felt a loss of control and felt angry at what had happened to her. She wanted to blame everyone for the embarrassment of the way she was whisked to theatre and all the emergency activity that was associated with the birth. We spoke at length because she wanted me to fill in all the gaps with what had happened. We went over and over the sequence of events to help overcome her anger and make everything right, that she thought was wrong. Each night I spent between 1-2 hours talking through her emotions. From her behaviour, I knew she was not going to have counselling or have any professional assistance for her problem and I just knew that I had to ‘take it on’. I felt an overwhelming responsibility to help this woman.

With the completion of the offering of examples of love in nursing and midwifery, the group set about choosing the example they believed best captured their understanding of love in nursing and midwifery. To this end, the group settled on Cristal’s example because of the way she responded to the perceived hopelessness of the patient’s situation that was presented to her by both her colleagues and also the women.
7.4  Phase 2: Exploring the selected example

As with each Socratic dialogue, the next stage required the group to explore the Cristal’s example in detail to the point where they could see themselves in the example. At the completion of phase 2, the example became everyone’s.

7.4.1  The example:

Cristal: ‘This particular day I was allocated the care of a 53 year old woman who had a history of repeated admissions related to alcohol abuse, drug abuse, and mental illness that included depression and personality disorder. On this occasion, she had taken an overdose of Diazepam and some type of antidepressant. The other nursing staff labelled her a ‘loser’ and, it was said to me that, if I could not care for her, they would get rid of her (discharge her). I couldn’t believe what I was hearing. Up until this time, I had great respect for these nurses and didn’t think they would say such a thing! I remember thinking to myself that I wanted to make a difference to this woman. I was determined to care for her in spite of the prejudice coming from my colleagues. So, besides all the prescribed care, I just sat and listened to her. I listened to her life story in between all the other patients and tasks I had to do. I just kept going back to her every moment I had and spent the time listening to her, made her coffee, held her hand, put my arms around her and held her close, and let her cry. I learnt about how she despised herself because of her life and problems and how she had tried to kill herself. We talked about what could be, so giving her hope. I believe I helped her try again to overcome some of her problems. She saw herself as a loser and we talked about that and the transition was amazing. On leaving, she just looked at me and at that moment something touched me deep inside and she held my hand and said thank you.’
7.4.2 Further details of the example:

- ‘I was working in the Accident and Emergency Department’.
- ‘She was a regular visitor to the hospital’.
- ‘Her drug addiction had resulted in her losing touch with her family. She said she had no one close to her, and she was alone.’
- ‘People had given up on her and she had given up on herself’.
- ‘It seemed the medical and nursing profession had also given up on her. She was in and out all the time with no one helping her get off the merry-go-round.’
- ‘As she said, ‘she had nothing to live for’, and she described her living conditions as a pig sty’.
- ‘She had tried rehabilitation programs such as ‘detox’ but dropped out’.
- ‘On this day she had already received her initial treatments before I came along and started caring for her’.
- ‘She was crying constantly, buzzing, and wanting attention’.
- ‘The staff said she is an annoying lady, just comes in and wants attention’.
- ‘I was told, ‘look, if she is too much for you, I will take her over and get rid of her’. I had respect for this nurse up to this point, but no more.’
- ‘I was shocked and disappointed at this response. This person used language to describe her and to get her out. They were angry at her.’
- ‘I was not prepared to hear this from this nurse’.
- ‘This nurse was prepared to abandon her’.
- ‘My response was very quick. I wanted to see what I could do. I did not want to abandon her like this nurse had. I saw it as a challenge, to make a difference to this woman.’
- ‘I believe we have a duty of care, despite the ‘state’ in which some people present’.
- ‘I was very busy but in between my other patients and duties I kept going back to her and I always did what I said I would do for her, even if it was just making her a cup of coffee’.
• ‘Once I established a connectedness with her and sat down with her, she became willing to trust me and open up’.
• ‘I let her know I was willing to listen to her and let her finish her story’.
• ‘The other staff were looking at me and talking about me for giving her this time, and therefore it took some courage to continue, but in spite of the negative comments being made about my actions, which they showed by their body language, I continued. But I never saw it as courage as the time just something I had to do.’
• ‘I was not going to palm her off and just ignore her’.
• ‘But I do remember feeling very isolated and I did not have any peer support in all of it’.
• ‘They didn’t talk to me afterwards but I felt talked about’.
• ‘I felt victimized because of what I did’.
• ‘Staff told me that after I have been here for some time I would become like them, but I never will’.

7.5  **Phase 3: Exploring the question in the light of the example**

The group was very responsive to the question of ‘what is love in nursing and midwifery in the example offered’ and immediately replied with several answers to the question, which were then explored in more depth.

**Question:** What is love in nursing and midwifery in the example?

**Answer 1:** ‘She had the courage to go beyond her colleagues’ negative expectations in caring for this woman and beyond the duty of care’.

**Answer 2:** ‘Accepting the person unconditionally, and was non-judgmental’.

**Answer 3:** ‘Being determined to show compassion and not concerned with the consequences of her actions upon herself’.
Answer 4: ‘Love is a willingness to connect, be open, sensitive and show understanding of the patient’s plight by giving hope’.

Answer 5: ‘The nurse was prepared to form and enter a ‘special’ relationship that was characterized by her feeling deeply responsible for the woman’.

7.5.1 Answer 1: She had the courage to go beyond her colleagues’ negative expectations in caring for this woman and beyond the duty of care.

This answer was aimed at capturing the idea that this nurse placed the welfare of the woman before her own and this, it was concluded, took ‘courage’ because placing the others welfare before her own had a personal-professional cost which she was willing to bear. While it was understood that the professional code of ethics compels a nurse to act in a professional way, that is, a patient is able to expect that nursing staff will respect their need for health care and trust that nursing staff will act in their best interest, the example offered showed this was not the case. As one member of the group said, the woman was the recipient of prejudicial health care, or more particularly, while she was in receipt of nursing care that was aimed at meeting her immediate physiological health care needs, the prejudice shown her made it likely that her psychosocial needs would not be met. The group was of the opinion that, because the patient was labeled ‘a loser’, nursing staff willingly dismissed her care needs in favor of others they believed were more deserving. Specifically, the prejudicial attitudes of the nurses immediate to the situation resulted in an attitude that this patient was not deserving of their time and care. Evidence of this attitude was captured in the response of one nurse who said to Cristal ‘look, if she is too much for you I will take her over and get rid of her’. From this and other comments, Cristal believed her colleagues expected that she would share a similar view to them, and ‘tow the line, so to speak’, and when she did not, she too became a victim of their prejudice. As Cristal said, ‘I felt isolated... and
victimized’. To this the group concluded that Cristal also was the recipient of the nurses’ prejudice and it took ‘courage’ for her to act out her professional duty of care, let alone do what she did.

But why was this an example of love in nursing? The group believed that this was an example of love in nursing because Cristal was able to place the welfare of the women first, which did not change when she began to experience the disapproval of her colleagues about her response to the needs of the woman. The group were of the opinion that in this clinical situation it would have been easy for Cristal to have bowed to the pressure of the group and so conform to the prevailing attitude. It was thought Cristal could have provided nursing care that met the woman’s needs at the minimal level and so met her professional duty of care but Cristal did more. She, according to the group, went ‘…beyond the duty of care’ which they understood took ‘courage’. To place the welfare of the woman first, knowing the disapproval of her professional colleagues.

What triggered the ‘courage’ in Cristal to take the action she did? Throughout the dialogue Cristal made comments such as, ‘my response was very quick’, ‘I didn’t really think about it’, ‘it just happened’, ‘I found myself just wanting to see what I could do’, ‘I saw it as a challenge, make a difference’ to this woman. The group believed that something deep inside Cristal caused her to respond to the hopelessness of the patient, a hopelessness that was expressed by both the patient herself and also the nursing staff. It was a hopelessness that had culminated in the patient trying to commit suicide, and a hopelessness that was identified by the nursing staff who were prepared to abandon her. As Cristal said, ‘she had given up on herself and nursing staff had given up on her too’. To this the group concluded that the content of the hopelessness was ‘abandonment’. The patient had abandoned herself, as evidenced in her attempt to commit suicide and her disclosure about how she hated her life and
hated herself. Nursing staff had abandoned her in terms of improving her health situation, seeing any attempt to help her as a waste of time because, as Cristal explained, they had tried so many times before to help her without any success. Their abandonment was characterized by the label ‘looser’. However, Cristal’s identification of the hopelessness triggered not abandonment but the opposite. It triggered a commitment to the betterment of the patient’s condition and in doing was aimed at the restoration of hope. The group believed Cristal’s love in nursing was evidenced in the way she responded to the destitute woman, that is, she responded with the courage to commit herself to a course of nursing actions that would benefit the woman but knowingly cost her personal-professional self. It required her to commit herself to a course of action where the degree of self-sacrifice was not known and this required she ‘go beyond the duty of care’. To this end, the group understood that a quality of love in nursing is ‘commitment’, which can be interpreted by others as ‘courage’. It is to knowingly sacrifice one’s own self for the sake of another. However, as to the amount of say Cristal had in accepting or rejecting the commitment she felt toward the women, or the degree of sacrifice she would have made, was not discussed.

7.5.2 Answer 2: Accepting the person unconditionally, and was non-judgemental.

This answer followed immediately after the offering of the first answer and focused on Cristal’s identification of the sanctity of life and uniqueness of the other person without all its worldly encumbrances. As the participants commented, Cristal did not ‘label’ the person but rather accepted her for who and what she was. The group believed that Cristal was able see the person behind the label ‘patient’, a unique person, a person like any other, a person with a variety of personal problems that effected her health. To this end, the group agreed that, unlike the other nurses, Cristal showed love in nursing when she identified in the woman her uniqueness and value as a person per se that
other nurses could not and that this non-judgmental identification, and that uniqueness and value of this woman’s life and her destitute state resulted in Cristal being committed to nursing actions to better the patient’s condition. The group believed that, Cristal was able to identify in the woman what others could not, and that a quality of love in nursing is the ability to identify the unique value of the person and respond to their destitute condition. However, the idea of moral responsibility was not discussed.

7.5.3 Answer 3: Being determined to show compassion and not concerned with the consequences of her actions upon herself.

It was clear to the group that something happened between Cristal and the patient that resulted in Cristal being determined to show compassion toward the patient, and that this ‘something’ happened before they had time to form a relationship, or as Cristal said before they ‘established a connectedness’. Here the connection Cristal spoke of related to a reciprocal relationship, whereas, what the group had identified was the non-reciprocal relationship of Cristal to the women. As was shown in the answer above, it was Cristal’s identification of the value and uniqueness of the person of the patient that gave rise to her feeling committed to the betterment of the woman’s condition. To this, the group believed that commitment is a quality of love in nursing because commitment is what enabled Cristal to place the woman’s needs first, in that, Cristal’s first concern was with the welfare of the woman and not her own. However, the degree to which Cristal would have been able to sacrifice her own welfare for the woman’s remains, for the most part, unknown but for Cristal’s comment that she was determined to make a difference to the woman. The group thought this statement showed that she knowingly placed herself at odds with her colleagues about the care of the woman in spite of the effects it would have on her. Love in nursing is shown in this example by Cristal’s commitment to the woman that had no expectation of reciprocity. In fact, it was just the opposite. The quality of the commitment was such that it had Cristal place the welfare of
the other person before her own which did not change when the effects became known to her.

Moreover, the ‘commitment’ she had to the woman was given expression in her ‘being determined’. Here, ‘being determined’ explains Cristal’s unwavering commitment to the woman’s cause. As one participate pointed out, Cristal’s consciousness played little or no part in the establishment of her commitment. As Cristal said, ‘I didn’t really think about it’, ‘it just happened’, ‘I found myself just wanting to see what I could do’ for this woman. As Jan (a participant) pointed out, Cristal only became aware of her commitment to the woman after it was already made, which was evidenced in Cristal’s later comment ‘I remember thinking to myself that I wanted to make a difference’ to this woman. The group thought that Cristal’s ‘unconscious’ commitment to the woman’s welfare was a quality of love in nursing.

In addition, the group repeatedly raised the issue of Cristal not being concerned with the consequences of her stand upon herself. It was obvious that they thought that Cristal’s actions were admirable and that such selfless action on the part of any nurse is to be praised. However, what the group particularly noted was that, while Cristal’s commitment to the woman arose from her unconsciousness, when she eventually became conscious of how she felt toward the woman and the possible consequences to herself, she remained unwavering in her commitment. In addition, as she began to experience the negative consequences of her action, her commitment took the form of being ‘determined’. However, no further discussion was had about the concept of ‘determination’ and its relationship to love in nursing.
7.5.4 **Answer 4: Love is a willingness to connect, be open, sensitive and show understanding of the patient’s plight by giving hope.**

There was little dialogue around answer four except to say that it continued to support the groups’ general thinking about the specific example. The theme of this part of the dialogue was on the idea that love made it possible for Cristal to hear the call of the destitute woman. Here the group focused on Cristal’s good character as the means for identifying the destitute condition of the woman and did not speak about the woman’s call on Cristal, identifying Cristal’s moral character as making it possible for her to identify the destitute nature of the woman’s condition, which she could not ignore. The group believed that it was Cristal’s moral character that enabled her to be ‘open and listen’ and to respond to the woman. However, nothing further was added to the idea that love is a ‘willingness’ to connect, to be open, sensitive and show understanding and give hope. Likewise, there was no meaningful discussion about the idea that to be open, listen and give hope required a certain moral character, one that allowed Cristal to be ‘non judgmental and allowed her to listen to the woman’. Rather the group, without discussion, accepted the idea that ‘hope’ is the remedy of hopelessness and Cristal’s moral character made it possible for her to identify the destitute nature of the woman’s condition and so give hope. Cristal understood that her love in nursing was evidenced in the way she gave the hope. ‘Love was to give her hope’ and ‘I responded with hope the way I did and this is what made this love in nursing’. Hence, love in nursing in this example is where Cristal’s good character enabled her to respond to the destitute woman by way of a ‘willingness to connect, be open, sensitive and show understanding of the patient’s plight by giving hope’.
7.5.5 Answer 5: The nurse was prepared to form and enter a ‘special’ relationship that was characterised by her feeling deeply responsible for the woman.

Answer five arose from the group’s dialogue about the previous answers and represented a natural progression of their thinking. This said, in offering this answer the group understood the term ‘prepared’ was related to Cristal’s ‘willingness’ to respond to the destitute woman and to risk her own wellbeing. It was linked to the idea that it was the moral state of her being that had her obligated to the woman. It was as though being ‘prepared’ meant she possessed a moral state of being ‘ready-at-hand to the other person as a nurse and, what is more, being ‘prepared’ also meant she had no say in it, which was evidenced in her comment that it was not something that she thought about, it just happened.

Clearly the group had identified the thought that this was not an ordinary type of nurse-patient relationship. It was more because it was a ‘special relationship’. However, at this point in the dialogue what the group understood the phrase ‘a special relationship’ to mean remained largely unknown except to say that they saw the moral character of Cristal’s relationship to the woman central to what made this relationship ‘special’. Thus, Cristal’s concern was for the woman as a first priority and not for herself, which the group believed was a characteristic that is not ordinary to every nurse-patient relationship. Furthermore, the term ‘special’ acts as a marker for ‘exceptional’, in that, the relationship required Cristal to go ‘beyond the duty of care’ which is more than can be ordinarily or professionally asked of any nurse or midwife.
The group was clear that what made this relationship ‘special’ was the fact that Cristal felt ‘deeply responsible’ for this woman. Here the term ‘deeply’ was used to communicate the thought that the responsibility was moral. As the group said, it was a responsibility that was tied to who she was as a person, and that it required she take action to assist the woman. What is more, the group also identified a second element to the responsibility, which was that, as the clinical situation unfolded and Cristal became cognizant of her colleagues’ abandonment of the woman, her responsibility became known to her. As Cristal told the group, her knowledge of her colleagues’ abandonment of the woman made her fearful for the woman’s welfare. Cristal’s fear was related to the fact that she believed that it was very likely the woman would not obtain the care she needed or was entitled to. Therefore, if she did not advocate on behalf of the woman, the woman’s welfare would be compromised. Knowing this, Cristal’s responsibility for the woman took on the characteristic of being ‘determined to show compassion’, a compassion that was rooted in her feeling ‘deeply responsibility for the woman’, aresponsibility the group understood was her responsibility because it was tied to who she was as a fellow human being and then later a professional nurse. The responsibility inherent in the clinical situation was a responsibility that was Cristal’s, and Cristal’s alone, a responsibility that could not be transferred, shared or ignored. As Cristal came to realize, she was alone in her responsibility for the woman because it was her responsibility, which she said did not worry her, but the others’ prejudice did.

7.6 Phase 4: The general question
This phase of the Socratic dialogue requires broadening the question from the specific example that was provided to the general question ‘what is love in nursing and midwifery?’ The content of phase four was the culmination of the groups thinking about the specific example and its relationship to nursing and midwifery in general.
Question: What is love in nursing and midwifery?

Answer: ‘Love in nursing and midwifery is when the nurse is prepared to form and enter a special relationship that is characterised by feeling deeply responsible for a person and demonstrates compassion, and is beyond what is normally expected’.

Dialogue commenced around the idea that love in nursing and midwifery requires, on the part of the nurse, the ‘taking on a responsibility’, or more specifically, being responsible for your responsibility. Here the group was speaking about the moral responsibility of the nurse to the patient. As one participant said ‘it is where you feel deeply for them and their wellbeing, you feel a responsibility for them, a responsibility for that person and their entire family unit’. To be clear, what the group was speaking about was not the responsibility inherent in a nurse’s professional duty of care but the moral responsibility of the person of the nurse to another. The act of ‘taking on’ a responsibility was not about a ‘choice’. The group did not speak about it as though a nurse has a choice in whether they either accept of reject the responsibility, but rather, the impression given was that the ‘taking on’ related to the idea that the responsibility was already present and now it was more a matter of what the nurse does with the responsibility of the other person. This idea harked back to the groups’ earlier thinking about the concept of responsibility, where they spoke of the nurse being ‘determined’, the nurse being ‘prepared’ and the nurse having the ‘courage’ to act for the betterment of the patient as a first priority. However, as one participant said, ‘love can be simple, don’t have to be a huge sacrifice. . . ‘ It was at this point the group added the proviso that, while ‘courage’ may be required in being responsible, it is not always necessary for an act of love in nursing to occur. In summarizing their thinking to date, the group believed that ‘responsibility’ is a prerequisite for the ‘special relationship of love and caring in nursing’. As was stated, ‘it is that special thing that happens because you love and care’ and is something that can only be achieved by a ‘...
nurse who is prepared to accept people unconditionally, and does not judge others’. While there was no further discussion of these concluding remarks, it is noteworthy that the group in formulating their answer to the question what is love in nursing and midwifery, understood it to be the ‘special relationship’ they have with their patients. As one participant stated, it is a ‘special relationship’ that is characterized by both ‘love’ and ‘caring’. Given there was no discussion on this point, all that can be said is that the group understood that love in nursing is something that is qualitatively different to caring in nursing. What is more, love is a motivational force that is able to overcome a nurse’s own needs as a first priority that a caring cannot.

In reposing the question of what is love in nursing and midwifery in general, the group replied by continuing to summarize their thinking to this point in the dialogue. Participants all agreed that the health care system provides nurses with the unique opportunity to witness people in various situations of need that require a response, in that, the profession of nursing provides nurses with the occasion for identification of the destitute condition of the patient. More specifically, love in nursing is said to be present when the nurse-patient occasion elicits in the nurse a feeling of being deeply responsible for the patient’s welfare, to the point where if called on the nurse is able to place the welfare of the patient before their own, because the nurse is morally committed to the welfare of patient without reciprocity. Moreover, the commitment of the nurse to the patient increases with adversity because love in nursing requires more than the simple performance of the professional duty of care. It requires the nurse to ‘go beyond’ the professional duty of care and enter a ‘special relationship’ that is characterized by the nurse feeling deeply responsible for the patient as is evidenced in the compassion shown.
7.7 Commentary on the dialogue:
The following commentary briefly identifies questions that were raised in the course of the dialogue but not answered. They included:

7.7.1 What is the relationship of commitment to responsibility and rational choice?
In the specific example of love in nursing and midwifery, Cristal was adamant that she had no say in the commitment that she felt for the woman, which was partly evidenced in her statements ‘I didn’t really think about it’, and ‘it just happened’. This and other brief comments made by the group suggest that Cristal was committed to the benefit of the woman before she was conscious of this knowledge. What is more, when she became conscious of how she felt toward the welfare of the woman, which was in opposition to her colleagues, her commitment did not change. She was not concerned for herself as a first priority, which was demonstrated in the fact that when she became aware of her colleagues prejudice toward the woman and the associated negative consequences of her peers disapproval of her action, her commitment did not weaken, but in fact it increased, as can be seen in, ‘it made me more determined to make a difference’ to the woman.

Thus, without saying it, it seemed that the group believed commitment has two forms, that which arises from deep within a person and is linked to the idea of responsibility and initiation of actions before their conscious consideration, and the commitment that is known and subject to rational thought. In this clinical example, Cristal’s rationalization of the situation had her increase her commitment to the welfare of the woman, which overrode her own needs as a first priority as was evidenced in the selflessness that she demonstrated. While the full extent to Cristal’s selflessness remains largely unknown, it went beyond common friendship, collegiality and the professional duty of care. Thus, is it the case that, in human relations, commitment and responsibility are able to reorder
a person’s priorities from a motive of selfishness to selflessness? Is it also the case that commitment and responsibility changes the principle base from which a person rationalizes? What is more, ‘courage’, as a trait of commitment, appears to be something that is identified by others and not the person themselves. It acts as a signal to others of the personal risk associated with their commitment.

7.7.2 How can one person respond in a moral way to the destitute state of a patient and others not?

It was generally thought that Cristal responded to the needs of the woman where others were prepared to abandon her. However, the dialogue on this point was related largely to the conscious decision-making that went on between the nurses about the woman’s health care. The group did not explore the notion of the human response to the destitute other, not why this nurse responded and not other nurses or indeed all the nurses.

7.7.3 What is the character of the ‘special relationship’ that is described as love?

At the end of the dialogue the group, in formulating their answer to the general question, introduced the idea that the relationship of love in nursing is ‘special’, in that, ‘it is that special thing that happens because you love and care’, and ‘it is a special relationship’. However, no specific discussion was had about the character of the ‘special relationship’ except to say that it appeared to be used to capture the idea that the relationship of love in nursing is something out of the ordinary, because it causes the nurse to ‘go beyond the duty of care’. It seemed that the term ‘special’ acts as a flag to highlight the fact that love in nursing is different to care in nursing because love requires more than the everyday performance of the duty of care.
7.7.4 What is the content of the ‘beyond’ of the duty of care?
It was clear that the group believed that love in nursing and midwifery requires a nurse to ‘go beyond the duty of care’. While not discussed as an item in itself, the group identified courage, compassion and selflessness as three traits required of a nurse in order for them to go ‘beyond’ the duty of care. However, as to what was meant by each term, this was not discussed in any detail except to say that the term ‘courage’ appeared to be related to the idea that actions of love in nursing involve a ‘risk’ to the personal self of the nurse.

7.7.4 What is the difference between love in nursing and care in nursing?
It was clear from the group that love and care in nursing are different. The group was also observed to use the terms care and caring in two ways. The term care was used in relation to the ‘doing’ of nursing, such as, a ‘care plan’ directing nursing action, whereas the term caring was used to describe the emotional relatedness of the nurse to the patient. However, in this specific example, the nurse’s caring appeared to be motivated by more than some form of emotional relatedness, because the group understood that the clinical situation caused this nurse to place the welfare of the patient before her own. The motivation to act in this way is what the group called love in nursing, because love in nursing appears to arise from a moral foundation of one person being for the other person before they are for themselves. However, while the group was adamant that caring in nursing is different to love in nursing, they did not engage in any significant dialogue about the specific differences.
7.8 Conclusion

In this Socratic dialogue, love in nursing was understood to arise from the moral character of the nurse. It enables the identification of the unique value of the person of the patient which gives rise to the commitment needed to respond to the patient’s destitute condition. Thus, love in nursing is said to be present when the nurse-patient occasion elicits in the nurse a feeling of being deeply responsible for the patient’s welfare. It is a responsibility that causes the level of the nurse’s commitment to the patient to increase in response to perceived threats to the patient’s welfare, as is evidenced in the determination of the nurse to help. The character of the responsibility that is felt by the nurse is such that it cannot be transferred, shared or ignored. Moreover, it is a responsibility that requires the nurse to place the welfare of the patient before his or her own. Hence love in nursing requires more than the simple performance of the professional duty of care because it requires the nurse to ‘go beyond’ the professional duty of care and enter a ‘special relationship’ that is evidenced in the commitment and the compassion shown.
Chapter 8: Group 5: Report on a Neo-Socratic dialogue on the question of what is love in Nursing? (Singapore)

8.0 Introduction
Exploration of the study question has centered, up to this point, on the perspectives of nurses and midwives who work in the modern western styled health system of Australia. What the researcher had not done was obtain a sample of the views of nurses and midwives from countries other than Australia. This Neo-Socratic Dialogue is a report of twelve Registered Nurses who live in Singapore and work in the Singaporean health care system and their answers to the question what is love in nursing?

8.1 The sample group: setting the scene
This Neo-Socratic Dialogue took place in Singapore. As a result of the invitation to participate in the study, twelve (12) Registered Nurses agreed. At the commencement of the dialogue, when identifying themselves, the first few participants made reference to their religious belief system and this was a pattern the rest of the group followed. There were three Muslim, three Buddhist, four Christian, and two participants who described themselves as non religious. What is more, the participants also spoke about their education in their introduction to the rest of the group; one participant had attended pre-university education in the United States of America, one in Hong Kong, one in Singapore, two in Malaysia, and seven in China. Furthermore, the group described Singapore as a culturally diverse country and referred to themselves in the following way, one said she was Singaporean/Singaporean, three identified themselves as Malaysian/Singaporean, and eight said they were
Chinese/Singaporean. While the clinical experience of the participants varied they all worked full time as Registered Nurses in clinical practice in the Singaporean health care system. One participant was employed as a psychiatric nurse working in an inpatient acute psychiatric ward, two worked in theatre and recovery room, one in accident and emergency, one in pediatrics, two in an intensive care unit, three in the general medical and surgical wards of hospitals, and two in community clinics.

The Neo-Socratic Dialogue reported on here was undertaken at the Singapore Nurses Association in Singapore and lasted 4 hours. The first 30 minutes were taken up with an explanation of the conduct of a Neo-Socratic Dialogue and the importance of the example to be offered being an example of love in nursing as has been practiced by them. The conduct of the dialogue was made easy by the fact that the group used the available time efficiently staying on-task all of the time. The more difficult part of the dialogue was having participants volunteer their examples and talk about themselves. The outcome saw five examples offered.

8.2 Dialogue question
Because there were no midwives in the group the question posed was ‘what is love in nursing?’
8.3  Phase 1: Dialogue example

The question put to the group was, what is love in nursing in Singapore?

Five examples were volunteered:

Pricilla: ‘I work in a Community Clinic. One day an old single lady of 72 years of age visited my outpatient’s clinic needing medication but she had no money to buy it. She told me that she had no money for the medication or for food. She was dirty and frail and not in good physical health. I felt for this women and it was important for her health that she had her medication, so much so that I was going to buy the medications for her myself. I accompanied her to the pharmacy to get the medications and when I went to pay the Pharmacist said that if I sign a waiver form and then got the authorization section on the form signed by my superior she could have the medications free of charge. Given the Pharmacy was soon to the close for the evening and my superior had left work, he gave me the medications because I promised to get the authorization and return the form to him tomorrow. This was unusual but accepted. The next day when I went to the nurse manager to get authorization she was very angry with me for what I had done because procedure was not followed. While I was upset by her outburst and knowing this could go against me, it was more important that the lady got her medications and her health and living conditions were organized.’

Hong Fang: ‘On my pediatric ward one evening, an Indian child was crying for a long time. I (Chinese/Singaporean) responded by changing the child, singing to the child, carrying the child around while I did my other work, cuddling the child and patting and talking to the child. The child stopped crying. The family was initially untrusting of the nursing staff (they were Indian/Singaporean and we nurses were all Chinese/Singaporean), but when they could not stop the child from crying and I was successful they were most grateful and respectful. The parents, after this, felt we nurses could manage the child and they could
leave and go home. Given differences in cultures, this was an example of how love can cross the barriers between peoples.’

Jamaliah: ‘A young unmarried women who was pregnant with twins had difficulties in her relationships and was booked into theatre for a termination of the pregnancy. I was called to this theatre to attend her. On noting her situation I talked to her about her problems and how they may be able to be solved in other ways and recommended some solutions, like the help that was available to her. She was very worried and I held her hand all the time. We spoke for only about 15 minutes. It didn’t seem that long before she was to have the operation. Just before she was to go in to have the operation she changed her mind. She wanted to consider her situation further. I didn’t think that I did much, but we seemed to connect and straight away talked about what was really important to her. Staff wondered what I said that made her change her mind. It was obvious that they did not approve but nothing was said to me about that.’

Sam: ‘I was in the operating room and I was very busy with the needs of my room. Another nurse came to me for help because she could not communicate with a woman in her operating room and I could speak the language, so I could not refuse her request. I agreed to go to this woman and speak with her. She was shaking, her voice was trembling, and she was very, very frightened. I stayed with her and reassured her. I went and got blankets for her which no one had bothered to do (she was freezing). She was extremely grateful and wanted me to stay. Even though I had so much to do and people waiting on me I could not leave this woman I had to stay with her.’
Chinhula: ‘A women who was intubated and could not talk and was considered a difficult patient, what we nurse’s routinely called a FON (full of nonsense) patient. No nurse wanted to look after her. I was assigned to her for this shift and I took the time to communicate with her through writing and finding out what her needs were. I was able to tell from her writing how frightened she was and so responded to her. I spent a lot of time with her even though I had a lot of other work to do. The reward for me was the smiles on her face and later the less call bells.’

At this point it was obvious that the remaining participants were to shy to offer an example in public and therefore we moved to the next stage of the dialogue. The aim was to encourage interaction from those who had not offered examples. This said participants were quick to come to agreement on which example they preferred, it was Pricilla’s. The group believed ‘it was the best example because of how Pricilla responded to the old woman’.

8.4 Phase 2: Exploring the selected example

The group was asked to speak with Pricilla about the example and obtain information that would enable them to think of the example as their own.

8.4.1 The example:

Pricilla: ‘I work in a Community Clinic. One day an old single lady of 72 years of age visited my outpatient’s clinic needing medication but she had no money to buy it. She told me that she had no money for the medication or for food. She was dirty and frail and not in good physical health. I felt for this women and it was important for her health that she had her medication, so much so that I was going to buy the medications for her myself. I accompanied her to the pharmacy to get the medications and when I went to pay the Pharmacist said that if I sign a waiver form and then got the authorization section on the form signed by my superior she could have the medications free
of charge. Given the Pharmacy was soon to close for the evening and my superior had already left work, he gave me the medications because I promised to get the authorization and return the form to him the next day. This was unusual. The next day when I went to the nurse manager to get authorization she was very angry with me for what I had done because policy and procedure was not followed. While I was upset by her outburst and knowing this could go against me, it was more important that the lady got her medications and her health and living conditions were organized.’

8.4.2 Further details of the example:

Pricilla provided the following additional information about her example:

- ‘I have worked for a long time in community nursing’.
- ‘We have a lot of poor people in our clinic area’.
- ‘She was very old, frail, dirty and in poor physical health’.
- ‘She said that she was not well’.
- ‘She didn’t know what she was going to do’.
- ‘She had no family she was alone’.
- ‘I gave her some money to get a taxi home from the clinic which was about 15 minute’s way’.
- ‘My nurse manager was very angry with me and reprimanded me for my actions. She left me thinking that this was going to count against me in the future if I was to apply for a promotion. I was very upset by her response but I knew what I did was right and I would do it again if I needed to.’
- ‘The nurse manager eventually authorized the form for the free medications and I returned it to the pharmacist as I promised I would’.
- ‘The manager made me go to the woman’s flat in my lunch break to get her to also authorize the form that we did not have the night before, which did not bother me, in fact I was very happy with that because I wanted to see the woman again to make sure she was ok. I was going to go and see her
anyway.’
- ‘While in her one room flat I saw it was nearly empty of furniture, it was unclean, and there was only a little bit of food that was old and semi-spoiled’.
- ‘She would just take a little bit of food out of the refrigerator at a time and eat it each day’.
- ‘She had no money and could not get a job to buy her medications which were expensive’.
- ‘She went to her former employer and begged him for a job but he refused’.
- ‘After work I collected donations from other nurses to buy her some food’.
- ‘I went to her flat again and filled her cupboards with the food and gave her some money for other things she might need to buy’.
- ‘I helped the woman apply for social work support and tried to get her application considered quickly’.
- ‘I did all this in my own time’.
- ‘All I wanted to do was help this woman. I was worried about her, not about myself, not at any time. I just knew I had to help her.’

8.5 Phase 3: Exploring the question in the light of the example
Next, the question, ‘What is love in nursing in the example that Pricilla offered?’ was put to the group. Three answers to the question were obtained and are listed below.

Question: ‘What is love in nursing in the example?’
Answer 1: ‘Going the extra mile, putting the women before her self’.
Answer 2: ‘It is responding to the helplessness of the women’.
Answer 3: ‘There is no expectation of a reward’.
8.5.1 Answer 1: Going the extra mile, putting the women before her self

The person who offered this answer ‘going the extra mile … ‘ immediately went on to explain what she meant by the phrase to the rest of the group who then agreed with her answer. From the start the group were committed to the idea that Pricilla did more than is normally expected of a nurse in Singapore and that this was ‘special’. As they explained, it is very unusual, in fact, rare for a nurse in Singapore to behave in this way.

While Pricilla may have simply responded in a professional way and within the confines of her role as a community nurse by providing the health care services of the clinic, she did more because responding to the helplessness of the woman required a different response. It required a deep personal-professional response. ‘Going the extra mile’ was understood to explain the idea that Pricilla as a community nurse exceeded the Singaporean expectation of duty and role. ‘Going the extra mile’, also described the fact that Pricilla was prepared to do whatever she needed to do in order to overcome the woman’s helplessness. However, the extent of how far Pricilla would have gone was not able to be tested in the example offered. What the group identified was that Pricilla went as far as she thought was required to overcome the threat to the woman’s life, no more and no less. As the group stated, Pricilla went the extra mile which was evidenced in the things that she did, sacrificing her lunch break, collecting donations of money to buy the woman food and other items in her own time, and risking her professional credibility and standing by arranging the prescription of medications for which she was not authorized, and the devotion expressed in her statement ‘that she had to do whatever she could to help this woman’. The group understood this to mean that love in this example was demonstrated by Pricilla ‘going the extra mile’, a response to a motivation that was triggered from deep within her. At this point, the final word was left to Pricilla who said that ‘I was simply doing what I had to do to help the lady’.
The second part to this answer was ‘putting the woman before herself’ which is exemplified, in part, by Pricilla’s, above concluding remark, where she says, ‘I was simply doing what I had to do to help this lady’. Unfortunately no dialogue was had that directly related to this statement or the idea that she ‘had’ to respond in that there was no choice about to respond or not. Rather, the group focused on the second part of the first answer, ‘putting the woman before herself’, which they believed required sacrifice on the part of Pricilla, in that, they said that Pricilla ‘gave up’, which they later changed to, ‘sacrificed’, her lunch break, her own money, her own time, and her own wellbeing (in risking her professional standing and future opportunities for promotion). Notably, the group said that this ‘giving up’ or ‘sacrifice’ was not identified by Pricilla as such because, they said, ‘that is our perspective as outsiders looking on and giving it a label’. Rather, the group thought Pricilla’s response to the woman was in fact an opportunity, ‘she saw it as an opportunity’, ‘she was willing’, and ‘it was not difficult it just happened’. ‘There was no expectation of a reward’, and ‘it never crossed my mind that there would be any repercussions’, which they thought was just the opposite to ‘giving up’ or ‘sacrifice’ because she was not giving up anything she could identify for ‘it never crossed her mind’. These ideas expressed the thought that ‘something inside her’ (Pricilla), responded to the woman which was something that enabled Pricilla to put the woman before her self as something she wanted to do. However, the group had no idea as to what this ‘something’ might be and so moved on to the second answer to the question which was an answer that was offered almost at the same time as the first answer.
8.5.2 Answer 2: It is responding to the helplessness of the woman.

Questioning Pricilla further about the example the group honed in on the idea that when this woman fronted her at the clinic for help, Pricilla immediately identified in the woman her need for help, not help for a medical problem, but help to overcome a perceived helplessness. The group struggled with this idea because they thought that the helplessness Pricilla saw was the result of a conscious assessment when what had actually happened was at the level of Pricilla’s subconscious. Pricilla subconsciously identified the destitute woman’s life as important and at risk. As Pricilla said, ‘while on the surface she appeared to have a life of no value her life was valuable, she was someone’s daughter, mother, sister and perhaps wife’. It was felt that while the professional duty of the nurse may have centered on providing the professional services of the clinic to meet the woman’s health needs, overcoming her helplessness required more because it required responding to what the group called ‘all of the woman’. The phrase ‘all of the woman’ was used to identify her personal being. As Pricilla went on to say, ‘thinking back on it now I found myself just doing what I had to do to help this woman, it wasn’t something that I thought about’. The group believed the identification of the woman’s helplessness which was not something Pricilla was consciously knowledgeable of motivated her to respond by doing whatever was needed, routine or otherwise, to overcome the threat to this woman. It was thought that Pricilla’s response was a response of who she was as a person who was also a community nurse. Pricilla understood what was needed to restore the wellbeing of the woman which also included actions to restore her health. Responding to the health care needs of the woman was simply one of the means by which Pricilla was trying to ameliorate the threat to the well-being of the woman. Finally, the group concluded that the ‘things’ Pricilla did were examples of the physical manifestation of love that show this example to be an example of love in nursing. Love, they said, was not contained in the things Pricilla did, which were also more than her professional duty or role obligations required, but the reason she did them.
8.5.3 Answer 3: There is no expectation of a reward.

The group said that there was no expectation of a personal reward because Pricilla willingly ‘gave up’ or ‘sacrificed’ her lunch break, her own money, her time outside work, and risked her professional credibility with her nurse manager. To this, Pricilla and others followed with dialogue that made it clear that she did not see this as a sacrifice. In fact, Pricilla said that was the groups words and not hers. Using her lunch break, giving the woman some of her own money for a taxi, collecting donations in her own time, buying her food and other things and stocking up her cupboards were things she was happy to do. As Pricilla explained, if there was a reward to be had it probably was received by her being able to do what she desired to do which was to help this woman. It was concluded that while Pricilla may have obtained some personal satisfaction from doing what she did for the woman, it was not a reward in the sense that it was the motivation. The group believed that what motivated Pricilla to help the woman was the identification of her helplessness not this as an opportunity for personal gain. If there was a personal gain this was incidental because the woman’s self-project was Pricilla’s first priority. It was thought that Pricilla had ‘gone beyond herself’. In this they meant that she was not concerned with herself as her first priority and this is what enabled her to disregard her own self and risk her own well-being for the sake of the woman. In this example there was no expectation of a reward because Pricilla was focused on the woman as her first priority and not on herself or what she could gain from the situation. But as to what enabled Pricilla to move her motivation from a concentration on her own self-project to that of the woman’s was not able to be answered.
8.6 Phase 4: The general question

This phase of the Neo-Socratic dialogue requires broadening of the question from the specific example of love in nursing to the general. The group was asked that, if what has been identified in the example is love, then what is love in nursing in general?

Question: What is love in nursing?
Answer: Love in nursing is a self sacrificing intuitive act of responding to the helplessness of a fellow human being without expectation of self gain.

The group were quick to seize on the ideas that had already been identified in Pricilla’s specific example of love in nursing. The answer to this general question of what is love in nursing started with one participant saying ‘love in nursing is an act that helps a person go all the way, go beyond themself and respond intuitively to the helplessness of not only one, but to everybody, in order to promote their well-being.’ It was at this point that further discussion was had around the idea of going beyond oneself. By this they meant going beyond one’s normal everyday self, a self concerned with only its priorities. Pricilla’s example was important to the group, as they repeatedly said, it was an example of nursing that did not happen often in Singapore, because people in Singapore are on the whole self centered and tend to be only concerned with their own needs and do not normally do things for no gain. The idea of being able to go beyond self interest was seen as a highly desirable nursing attribute because the group thought that not all nurses could do this, meaning not every nurse is able to enact an expression of love in nursing. Accordingly, love in nursing is not something that is able to be controlled by conscious thought, nor is it something that every nurse is able to express.
Following this theme, the group added that ‘love requires commitment and sacrifice to enable a nurse to go the extra mile.’ Rather than ‘sacrifice’, it would have been more descriptive to have stayed with the first term they identified, ‘giving up’, which more accurately captured what they meant. Sacrifice indicates something lost whereas ‘giving up’ indicates that it was something the nurse desired. To freely give up something that is a priority for their own self is not seen as difficult, because their priority has shifted from a concern about them to a concern for the patient. Summarizing these ideas, participants said ‘love is responding to the helplessness of another person. It is putting the other person before oneself without any consideration of a benefit’.

Throughout this dialogue the group struggled with the idea of how a nurse is able to subconsciously identify the helplessness of a patient. In the process of formulating an answer to this question they incorporated, for the first time, the word ‘intuitively’, which they believed, best explains the subconscious act of identifying the helplessness of a patient. Their final answer to the general question of what is love in nursing was ‘love in nursing is a self sacrificing intuitive act of responding to the helplessness of a fellow human being without expectation of self gain’.

### 8.7 Commentary on the dialogue:

This section provides a brief commentary on the dialogue and makes clear the questions that arose in the course of the dialogue that were unable to be explored. They included:
8.7.1 What is the limit on going the extra mile?

From the example it seems that this nurse went as far as she identified was needed and did not appear to stop until she was satisfied with the outcome that resolved, in her mind, the threat to the woman’s wellbeing despite being warned by her supervisor to the contrary. Just how far a nurse will go in responding to the helplessness of their patient was not tested by the example nor challenged by the group and therefore remains unknown. All that can be said is that this nurse responded by using all her professional nursing knowledge, skills and personal attributes for the betterment of the woman. While it is hypothesized that there is no limit to what a professional nurse will do to assist a patient, the current example does not exemplify this. In the example, Pricilla stated that she did what she needed to do in order to get the medications for the woman, which in this case meant that she broke policy and procedural rules, albeit unknowingly. The question not explored in this dialogue was, is it every acceptable to act outside the professional boundaries of nursing when to do so may benefit a patient? Are the defining boundaries of what it is to be a professional nurse the same boundaries that define an act as an act of love in nursing? In this example, ‘going the extra mile’ was understood to be the phrase used to describe the motivation of love and was within the scope of practice of the professional nurse.

8.7.2 What is the responsibility Pricilla enacted on behalf of this woman?

Pricilla and the group struggled with providing a plausible explanation for what they believed happened in the relation between Pricilla and the woman where without thinking, Pricilla identified the helplessness of the woman as something she was compelled to respond to, without any consideration of her own needs and desires. As she said, ‘I was simply doing what I had to do to help this lady’, but the group were unable to explain the responsibility Pricilla assumed for the woman’s welfare or how this was affected in her having no choice about to be responsible or not. However, the idea of ‘responsibility’ was not specifically
identified in the dialogue.

8.7.3 To go beyond self interest is a desirable trait in nursing, or is it?
As stated above, the idea of being able to go beyond self interest was seen as a highly desirable attribute for a nurse to possess. The extreme of ‘to go beyond self interest’ though is death. Is sacrifice of oneself to the point of causing one’s own death the ultimate expression of love? If correct, the ultimate expression of love in nursing is the sacrifice of a nurse’s life for a patient, as in, for example, to give a HIV positive patient mouth-to-mouth resuscitation. From this dialogue the ability of a nurse to place a patient’s interest before their own is identified as a pre-requisite for an act of nursing to be also love. While not identified by the group, understanding the altruism involved in being able to go beyond self interest is relevant to the formulation of an answer to the question what is love in nursing.

8.7.4 Love in nursing is not something that is able to be controlled by conscious thought.
It is postulated that love arises from deep within a person and is not subject to thought because it is not available to a person’s consciousness. Accordingly, what exactly is the motivation of love is unknown and not speculated on except that, in the last moments of the dialogue, the group accepted a statement made by one participant who said, love is an intuitive act. Because the dialogue was ending, no discussion was able to be had about this new idea that was wholeheartedly accepted by the group.
8.8 Conclusion

This group of twelve Singaporean Registered Nurses offered three answers to the question what is love in nursing? Their answers showed that the content of love in nursing, as revealed in the example offered by Pricilla and understood by the group, is the ability of a nurse to go beyond concern only for their self-project and place the welfare of the patient first without any consideration of self gain. Love in nursing is not something that is able to be controlled by conscious thought because it is not privy to a person’s consciousness nor is it something that every nurse is able to express.
Chapter 9: Group 6: Report on a Neo-Socratic dialogue on the question of what is love in Nursing and Midwifery? (Bhutan)

9.0 Introduction

This Neo-Socratic Dialogue took place in Bhutan and offers an initial understanding of the views of twelve Bhutanese Registered Nurses’ about what is love in nursing and midwifery. The report is constrained because of the limited time available to conduct the dialogue, given the complexity of the ideas raised about the question what is love in nursing and midwifery, in a health system that incorporates a mixture of traditional Buddhist healing and western medicine.

9.1 The sample group: Setting the scene

The Bhutanese health care system incorporates a mixture of traditional Buddhist healing and western medicine to service the health care needs of its people. The presence of monks practicing traditional Buddhist healing in the health system is commonplace, particularly in rural and remote Bhutan. Participants stated that both traditional Buddhist healing and western medicine are equally respected as legitimate healing methods in Bhutan.

All participants were of Bhutanese origin and lived and worked in Bhutan. Originally eight male and ten female nurses agreed to participate but six of the male participants from the border regions of Bhutan withdrew due to being required by the minister for health to stay in the rural and remote hospitals and health clinics to receive casualties from insurgent terrorist activity. The final twelve participants were leaders of nursing from across Bhutan who came
together for their studies into nursing and midwifery and consented to participate in this study for their self-confessed enlightenment. Buddhism is central to life in Bhutan and all the participants said they practiced, to varying degrees, Buddhism. Six participants were from the capital Thimphu and worked at the major teaching and referral hospital of Bhutan, and six participants were from rural and remote areas and worked in small rural hospitals and remote area health clinics. The clinical experience of the participants was very similar for all of them in that they all worked full time as registered nurses and midwives and all but one were in clinical practice in senior positions of nursing such as in charge of a ward/area, hospital or health clinic. All six of the nurses working in the rural and remote areas routinely practiced both nursing and midwifery. Of the six participants who worked at the major referral hospital in Thimphu, one worked in and was responsible for operating and recovery room, one held a senior post in the accident and emergency department, three were in charge of or held a senior posts in the acute medical and surgical wards, and one was a nurse educator who worked with students of nursing in the major teaching hospital of Thimphu.

The Neo-Socratic Dialogue reported on here was undertaken at the Royal Institute of Health Sciences in Thimphu and was of 3 hours duration, which in hindsight was to short a time given the complexities of this dialogue. Participants were prepared the day before about the conduct of the dialogue and the importance of the example to be offered being an example of love in nursing and midwifery as had been practiced by them. While the conduct of the dialogue was made easy by the fact that the group were leaders of nursing and midwifery in Bhutan and spoke English, they were shy and hesitant to talk about their practical experience of love in nursing and midwifery. Similar to other dialogues, the challenging part of this dialogue was having participants volunteer their examples and then talk about themselves in public. Eight practical examples of love in nursing and midwifery were offered but only six
participants agreed to talk about their example. The following is a report on the six examples offered to the group.

9.2 Dialogue question
‘What is love in nursing and midwifery?’

9.3 Phase 1: Dialogue example
The question put to the group was, ‘what is Love in Nursing and Midwifery in Bhutan?’ Six examples were presented:

Honey: ‘A patient came into my hospital and was bleeding due to an abortion. She had no one with her to donate blood and she was in a serious condition and shocked. If she did not get the blood that she needed she probably would die. Without thinking of the consequences to myself I donated my blood to save this woman. After doing this, I felt weak and very tired as I kept working for the rest of my duty.’

Somana: ‘A woman came into hospital with intra fetal uterine death. I just finished my day duty and was called to attend to this woman. She wanted me to stay with her till delivery because she said I made her feel safe. I stayed all night until she delivered at 0730 hours the next day. At 8am I went and changed my uniform ready for day duty. I started day duty at 8.30 and was so tired that I vomited, I was so tired I felt sick all my duty but I could not leave this woman when she asked me to stay.’
Maya: ‘A female patient 68 years old came into hospital alone for hemodialysis. She had children but they were not able to be with her to help her while she was in hospital. Patients in hospital have a family person to help look after them. She was frightened and depressed about her condition. On seeing this I went to her bedside, held her hand, and talked and listened to her problems. I introduced her to other patients because she was lonely. I established a village person as a friend and then scheduled dialysis with her new village friend. The patient was happy.’

Lipnee: ‘I had finished my duty and was outside the emergency room about to go to a party with friends. While waiting for the ride, I noticed outside of the corner of my eye a boy with his mother standing at the pharmacy window. The boy began to collapse. Before I realized it, I was running toward the boy and grabbed him before he fell to the ground. We then took him to emergency where he was treated. I stayed with them to make sure everything was done and make them happy.’

Treen: ‘There was a nine year old boy in hospital who had no family in Thimphu and came from a village in a remote part of Bhutan. He had leukemia and required regular blood transfusions. He was kept separate (isolated) and he was worried and alone. So I went to him regularly and played and talked with him. I also took him home when well enough to play and give him a sense of a home. When we walked back to hospital he would get so tired we would sit beside the road till he felt well enough to continue to get back to the hospital. I took him home a lot which he enjoyed.’
Mana: ‘I was nursing a boy who was a case of leukemia. He was alone most of the time and sad so I use to go and talk to him often. Later he would ask for things and I would try to get them for him. He was very close to me and during my night duty hours he would come to the nurse’s station and be there with me. And one day during his ‘last breath’ I had some kind of feeling of loss.’

The participants agreed that Mana’s example was the one they thought best exemplified love in their practice of nursing and midwifery because of her commitment to the boy.

9.4 Phase 2: Exploring the selected example
The group was asked to speak with Mana about the example and obtain information that would enable them to think of the example as their own.

9.4.1 The example:
I was nursing a boy who was a case of leukemia. He was alone most of the time and sad so I use to go and talk to him often. Later he would ask for things and I would try to get them for him. He was very close to me and during my night duty hours he would come to the nurse’s station and be there with me. And one day during his ‘last breath’ I had some kind of feeling of loss.

9.4.2 Further details of the example:
Mana provided the following additional information about her example:

- ‘The boy had no family other than an older brother who lived far away’.
- ‘His older brother would rarely visit and when he went the boy was really all alone’.
- ‘I would visit him and talk with him often’.
- ‘We had 1 nurse to 36 patients and I only had I student to help but I would find time to be with him mainly by not having my rest but going to the boy’
and talking with him after my duty’.

- ‘He would ask for things, like a radio, which I would then get for him. He needed these things because he was alone.’
- ‘Sometimes I would bring him simple things like foods and things like that’.
- ‘Out of all the patients, he was in the most need’.
- ‘I had a previous life connection with this boy’.
- ‘Sometimes I felt that he was almost my child or like my younger brother and I was his big sister’.
- ‘He would come to the nurses’ station and sit with us and would have tea and talk with us’.
- ‘He was on chemotherapy and becoming very sick’.
- ‘I talked with the doctor to see how I could help him and check on his care’.
- ‘I became closer to him as he became sicker and I visited and stayed with him more and more’.
- ‘He died on my duty and I felt very sad and had a feeling of loss’.
- ‘I had some kind of attachment to this boy’.

9.5 **Phase 3: Exploring the question in the light of the example**

Next, the question, ‘What is love in nursing in the example that Mana offered?’ was put to the group. Two answers to the question were offered.

- **Question:** ‘What is love in nursing and midwifery in the example?’
- **Answer 1:** ‘A sense of responsibility for the boy as a big sister’.
- **Answer 2:** ‘Responding to the identification of the loneliness and isolation of the boy’.
9.5.1 Answer 1: A sense of responsibility for the boy as a big sister

In discussing this answer the group thought love was exemplified by Mana responding to the call by the boy, which they concluded was a call to be responsible for him and his need to be cared for at all levels of his being. Furthermore, the responsibility for him was not as a stranger but as a family relation, his ‘big sister’. As the group said, what a big sister does is to care for and protect her ‘little brother’ when he cannot take care of or protect himself. While not specifically stating it, the group were talking about the idea that the responsibility and the commitment that issues from a family relation is more than and different to that of a non-family relation.

In answer to the question of why she should be responsible in this way, Mana stated that she understood her response to the boy to be a response to a previous life connection with him (Buddhism). No explanation for this idea was offered. It was presented as a simple fact. All that was said was that her understanding of how she felt toward the boy was because of her previous life connection and was one that could not be ignored for it was her responsibility. As Mana explained, she was his ‘big sister’ and no body else could be this ‘big sister’ because she was. The responsibility that Mana was describing was a responsibility that was hers and nobody else’s. She was responsible and nobody could take her place, nor could she hand over her responsibility to anyone else. However, not only was Mana responsible for the boy, but the degree of responsibility was something that was dictated by the boy and not her. As was explained, ‘she didn’t stop doing what she believed she had to do until the boy was satisfied’. While not directly stated, it appeared that what Mana was saying was that the boy dictated how far she went. It was not her call because she went as far in caring for the boy as was required to satisfy his needs which he ultimately knew and she did not. Listening to the discussion about these ideas, it was as though Mana did whatever she thought the boy needed and as long as he needed it because, in effect, she was a hostage to
his needs. While the ideas raised were profound, the group did not explore them any further, which with more time may have been possible.

Continuing, one participant said that Mana made time for the boy; ‘you sacrifice your free time and instead of sitting down you use that time for the boy’. The responsibility Mana assumed for the boy was of the quality that enabled her to place the priorities of the boy before her own. As she stated, ‘I would go to the boy because his needs were greater than my own. It was more important to do these things for the boy than think of my own needs’. And as another participant said, ‘whatever the boy wants she tries to give ... there was a cost (financial) in meeting his needs but she still did those things’. Mana replied saying ‘the gifts made him feel happy’. The dialogue continued around the boy and his needs which were, for Mana, needs to make him happy. While the boy’s happiness was a priority no other discussion was had about what was meant by happiness or the degree Mana would have gone to (as a big sister) in placing the boy’s needs before her own as her first priority. As she stated, she didn’t stop doing what she believed she needed to do until the boy was satisfied. She sacrificed her free time and rest periods so that they could be used for the benefit of the boy. As another participant said, ‘this was not normal because we do not do this for every patient’, meaning it was not an everyday event.

In the course of the dialogue Mana said that when the boy died on her duty. She felt a sense of ‘loss’, ‘emptiness’, and ‘sadness’, and ‘a heaviness in the heart’. However, other than these brief comments, no explanation was offered by the group as to why Mana should feel the way that she did, except that Mana reiterated that it was ‘as his ‘big sister”, meaning his death meant she lost her little brother which made her feel the way she did. It was at this point that a brief but intense discussion was had by the group in Bhutanese that culminated in the response; it will take too long to explain in English, so we should move on. This was interpreted as a polite response and meant that Mana preferred not to
speak about it any further in public so we respectfully moved on.

9.5.2 Answer 2: ‘Responding to the identification of the loneliness and isolation of the boy’.

In responding to this second answer one participant said that ‘where you have previous experience of conditions this makes you sensitive to matters specific to the condition, not only the physical condition of the patient but also their self condition’. The ‘self condition’ related to the response of the boy to his illness, physical surrounds and his general spiritual being. It was felt that the boy’s loneliness and isolation was the outward manifestation of his ‘self condition’, a condition of his being that connected with Mana through a previous life connection. As they said, it was a connection that had her responsible for him as a ‘big sister’. While the loneliness and isolation of the boy were the physical manifestations of his state, what Mana saw, what she was responding to, was something far deeper in their beings connectedness. However, at this point the group found it difficult to articulate in English what they exactly meant and so again spoke in Bhutanese with each other, which after a short time resulted in the answer that it was too difficult to explain in English. They apologized, ending the dialogue with the statement, ‘it is our belief’.

9.6 Phase 4: The general question

This phase of the Neo-Socratic dialogue requires broadening of the question from the specific example of love in nursing to the general. The group was asked that if what had been identified in the example is love, then what is love in nursing in general?
Question: What is love in nursing and midwifery?
Answer: It is where the nurse identifies in the patient a connection which triggers a feeling of responsibility and a relationship with the patient that is characterized by closeness, honesty and frankness. It requires the nurse to be responsible for them, ‘take care of’, to protect, and to give of themselves till the patient is satisfied. Love requires the nurse to be concerned with the patient as their first priority and not themselves.

9.7 Commentary on the dialogue:
The format and structure of the dialogue ensured that every participant’s contributions were explored and tested against the insights of others. However, there were a number of assumptions that remained unclear. As a result the dialogue raised a numbers of questions that could not be explored in the context of this dialogue given the limited time and difficulties that surrounded the explanation in English of several complex ideas.

9.7.1 What is the motivation of the responsibility of love in nursing and midwifery that arises from a previous life connection?
From what Mana had said, the responsibility of the boy was not something she chose, for it was not for the choosing because it was related to a previous life connection and beyond her capacity to input. Mana said that the responsibility she felt was as a ‘big sister’, which is akin to the responsibility of a family relation, again, something that is not for the choosing or otherwise because it is a given. However, the group were unable to explain, in English, the origin of the responsibility that they said arises from a previous life connection’ and part of their Buddhist belief system. However, this aside, what was clear was that all members of the group did share the view that they experience from time to time ‘a previous life connection’ with patients for whom they care. Equally the group was also clear that this life connection also makes them responsible, a
responsibility that is acted out in different ways depending on the situation of the patient. However, the motivation for the responsibility that arises from ‘a previous life connection’ that is understood as love was not explained. Where does this type of responsibility originate and what impact it has on the practice of a professional nurse and midwife remains largely a mystery.

9.7.2 Is asymmetry and selflessness a requirement of love and therefore love in nursing and midwifery?

From Mana’s description of her relationship with the boy, it was clear that her focus was toward doing whatever she needed to do to make him happy. While the relationship was not all one-way and there were occasions where she received affection and the like from the boy, this she said was not her motivation. From what Mana said, her focus was on the boy and because it was on him it was not on her. What the motivation is, that enables a selflessness of the type that a person, in this case a nurse, is able to shift their focus from a concentration on their self-project to another person as their priority, was not discussed. Accordingly, what is the altruism of love in a nurse or midwife?

9.7.3 How can someone else dictate your responsibility to them, and is this a desirable quality of a professional nurse and midwife?

In the first instance, Mana spoke about her responsibility to the boy as a given. She was responsible for him because of ‘a previous life connection’. However, it appeared that while she had no say in the original call to be responsible, she did have a say in what she did when responding to his individual needs as part of acting out her responsibility. Without saying it, it appeared the group had identified two different levels of patient responsibility. At one level the nurse and midwife has no say about the responsibility they feel and at the other, they do. While the first seems beyond the nurse and midwife’s ability to comprehend, the second is subject to their professional judgment. However, if the original responsibility that was described by Mana for the boy was something she had
no say about, what the potential impact is on an individual nurse and midwife is not known.

9.7.4 What is the result of the death of a patient who a nurse and midwife loved?

At the death of the boy Mana said she felt a sense of ‘loss’, ‘emptiness’, and ‘sadness’, and ‘a heaviness in the heart’. While it was not discussed, it appears that the death of a patient a nurse and midwife loved leaves them with a similar feeling to that of the death of a family member. If this is the case, the impact of the death of a patient on a nurse and midwife will be significant and something that perhaps should be explored further.

9.8 Conclusion

The conclusion to this dialogue showed that Mana identified a deep connection between herself and the boy that resulted in her being responsible for his welfare. While the motivation for this responsibility remains unclear, it was a responsibility of the quality of a family relation and was characterized by closeness, honesty and frankness and the requirement, ‘to take care of’, to protect, and to give of herself to his needs. The dialogue showed that a requirement of love in nursing and midwifery is the ability of the nurse and midwife to have the welfare of the patient as their first priority and before a concern for themselves. While the extent of the selflessness of a nurse and midwife was not tested in this dialogue it was identified as a quality of love in nursing and midwifery.
Chapter 10: Theoretical framework: love as responsibility ‘for the other’

10.0. Introduction

In the previous chapter the report of the dialogues identified that nurses and midwives understood love to be an integral part of the moral character of a person. Love it was said is a response to the deep connection between the nurse or midwife and the patient that arises from the identification of the unique value of the person of the patient. The nurses and midwives believed this form of love results in a unique responsibility because it is characterized by a selflessness and a willingness to risk their own welfare in doing whatever is necessary for the ‘Good’ of the patient. The responsibility spoken of and understood to be a form of love is not open to conscious thought. It is not able to be commanded, nor is it expressed by every nurse or midwife because of the inordinate level of professional commitment and responsibility required. The question that now follows is what is this form of love that is a form of unique responsibility that these nurses and midwives speak about?

In this thesis, the philosophy of Emmanuel Levinas and, in particular but not exclusively, that set out in his text titled the ‘Otherwise than Being or Beyond Essence’ (1981) provide the theoretical framework for the interpretation of what nurses and midwives understood as the love that is specific to their practice of nursing and midwifery. Given that nurses and midwives understood this form of love to be a unique form of responsibility it is more accurate to say that what these nurses and midwives enacted was a ‘being-for-the-other’, or a ‘responsibility for the other’. This exchange of terminology is important because it more closely represents the views of the nurses and midwives in this study and is also a view that is shared by Emmanuel Levinas. Levinas (1985,
Levinas, 1998 #961) believes the word love has been compromised to the point that its myriad of meanings and common place usage serve only to confuse the explication of ideas that underlie the concept. Specifically, Levinas (1998: 103) is of the belief that it is ‘. . . responsibility for my neighbour, which is, no doubt, the harsh name for what we call love of one’s neighbour; love without Eros, charity, love in which the ethical aspect dominates the passionate aspect, love without concupiscence’. In this thesis nurses and midwives understood that the form of love that they were speaking about was a unique form of responsibility. In fact it was an ethical responsibility, a ‘being-for-the-other’, a being ‘responsible for the other’ or, as Levinas (1998) refers to it, a taking on of the fate of the other, which in its simplest form is a depiction of what nurses and midwives did.

10.1 Elucidation of Emmanuel Levinas metaphysics of Otherness

Emmanuel Levinas was a French philosopher, Jewish scholar and a survivor of the Holocaust of WWII, which I mention because it had a profound effect on his belief about the failure of ethics. According to Murray (Murray, 2003), Levinas took the view that ‘ethical’ categories can make possible moral justification for atrocities like the holocaust, where ethical rules and principles failed to prevent ‘normal’ everyday German people from engaging in torture and murder. In response to this experience and what he perceived as the failure of ethics, Levinas developed his philosophical work titled the ‘Otherwise than Being or Beyond Essence’, which is a part of his magnum opus on the ‘metaphysics of Otherness’. It incorporates theory that recaptures the summons to ethical obligation that traditional ethics fails to provide. In short, it is a work that articulates the original form of responsible subjectivity (Levinas, 1981). It is a phenomenological description of my relation with the ‘Other’ and the commandment ‘thou shalt not kill’ (Levinas, 1998), which is grounded in my ethical responsibility and the non-symmetrical relation that enables me to place the needs of another person first without any expectation of reciprocity. The
radical nature of Levinas’s philosophy of ethics is that relationship rather than existence, subjectivity, or Being itself, is what grounds everything (Murray, 2003). More specifically, my knowledge of the other by way of my perception and comprehension of them, is only part of who the other is because there is also an ethical dimension to the other, their ‘Otherness’ (alterity), an ‘Otherness’ that is outside my capacity to take possession of in knowledge. My relation with the ‘Other’ is a relationship of ethical responsibility. Moreover, the responsibility I have is not my responsibility because it belongs to the ‘Other’ who commands me to be ethically responsible. This ethical responsibility that is inside me, as though somebody had placed it there, does not originate from an act of subjectivity. Rather it originates from my incarnation as responsible. It requires I answer the question ‘am I my brother’s keeper’, with a ‘yes’. The philosophy of Emmanuel Levinas provides a foundation for understanding ethical responsibility that nurses and midwives interpret to be a form of love.

In scientific terms, humans exist as separate living entities, in that, as humans we are marked by our separation one from an other, where, at best, we can only ever be ‘with’ an other, side by side, and never able to share the same space. I am I and you are you. It is like the severed beings in Aristophanes’ myth in Plato’s Symposium (Plato, 1994). The Greek God Zeus split the original androgynous being into two separate beings. Although the two separated beings had an unfillable desire to be reunited into one being, no matter what they did they could not bridge their separation. Being human is like this, it is to be a separate living entity. At the level of our everyday life, the relationships we have can be no other than those of a ‘with’ nature, because the space that exists between our human being is a space that can only be bridged by relatedness activities that have one person’s being ‘for’ another as opposed to being ‘with’ an other. If Aristophanes’ account of love is accurate, relatedness activities that are of a ‘for’ nature are unachievable as an outcome of conscious human endeavour. Indeed, the experiences reported by nurses and midwives of
love also suggest this is the case.

What then is a relation of being ‘for’ another person as opposed to being ‘with’ them? Relationships that are characteristic of one person’s being ‘for’ another have their foundation embedded in what Emmanuel Levinas calls the ‘preontological territory of the otherwise than being’. What Levinas is describing is a metaphysical state, that is a state of our ‘being’s other’, a state different from ‘being otherwise’, and also different from both ‘being’ and ‘not being’ (Levinas, 1981).

Levinas’s idea of an ‘otherwise than being’ is radical because it suggests that consciousness emerges from the anonymity of ‘il y a’ (‘there is’ or more specifically ‘existing without existence), which is the impersonality of expression, of anonymous or impersonal existing. ‘Consciousness, along with subjectivity and identity, are secondary, emerging from the ‘il y a’ rather than pre-existing it’ (Davis, 1996: 23). In this view, consciousness is an event in which something as yet unidentified acquires a separate existence. Everything that comes to me from outside of myself is experienced by me as something of my making and therefore becomes part of the world as I construct it and so it becomes more of the ‘Same’. However, my being’s ‘Other’ is very different to this because it exists outside of what I have knowledge in the ‘otherwise than being’, the ‘yet unidentified’, and for that reason remains a mystery to me. In this territory of the ‘otherwise than being’, ‘to be or not to be’ is not the question because here Levinas is speaking of the ability of my being to transcend its physical form to a metaphysical state of ‘otherwise than being’. It is from this territory that my being ‘for’ arises in the form of moral responsibility. It is a form of responsibility that resides in me as though it has always been there and is a responsibility that commands me to act for the welfare of the other person. However, it is the personal act of taking responsibility ‘as if’ I was the one and only one responsible, more responsible than any one else is what makes my
responsibility moral. Thus, taking responsibility in this way is an act of creating the moral space. A mode of human ‘being’ that enables me to be ‘for’ an other person as my first priority, which is the only way I can bridge my isolation as a separate living entity.

More precisely, the realm that gives birth to moral responsibility is identified by Levinas as the ‘there is’ and describes existence without existents. His claim is that for creation to occur there had to be a ‘there is’, an anonymous space, a space not a space, a space devoid of our personal being (Levinas, 1985). Accordingly, the ‘there is’, is not referring to a there is this or that which would allude to some matter of form, but rather, the ‘there is’ refers to what Levinas (1985) describes as the ‘excluded middle’, in that it is neither nothing nor being. To help explain the concept of the ‘there is’ and the idea of ‘nothing being something’, Levinas (1985) applies two examples. First, Levinas (1985) says that the ‘there is’ is similar to the sound that is present in an empty shell, it is as though the emptiness is full. While I may understand the empty shell to be devoid of any objective contents, when it is placed to my ear I am able to identify the presence of something (noise) that is at the same time nothing. The existence of nothing that is at the same time not nothing is present in the shell. In the second example, Levinas (1985) describes the ‘there is’ as similar to the night. The ‘there is’ is like the dark of the night, in that in the darkness there seems to be no existence. There is nothing present in the moment but the darkness of nothing, yet the darkness itself is something that is at the same time nothing. Both the noise of the shell and the dark of the night that has no content is what Levinas (1985: 48) calls the ‘excluded middle’, ‘one can neither say that it is nothingness, even though there is nothing’.
Notably, Levinas’s ‘there is’ breaks apart the dichotomy of nothing or something. It enlightens me to the fact that there is no longer only this or that to which we attach our independent existence but also there is a ‘not something that is not nothing’. Lingis (1989: 30), in his interpretation and translation of Levinas, makes this ‘not nothing’ image clearer with the statement, ‘universal absence is in its turn a presence, an absolutely unavoidable presence’. What this means is that the nothingness of the ‘there is’ diffuses my existence as an independent being. Like the dark of the night in the example above, the nothingness of the dark is itself an unavoidable presence of something that is beyond my capacity to have knowledge of. The ‘there is’ is what Levinas (Lingis, 1989) describes as the impersonal form of being that submerges every subject, person or thing. It is the ‘there is’ in which my personal being is situated.

In Levinas’s text of the ‘otherwise than being or beyond essence’ the ‘Good’ is presented as an example of impersonal being, but the ‘Good’ spoken of here is not the same good as in good versus evil. The ‘Good’ to which Levinas is referring is a ‘Good’ that cannot become present or enter into a representation (Levinas, 1981). While my subjectivity by way of my personal being gives me freedom, that is, a consciousness and knowledge of being an ‘I’, the ‘Good’ is external to my personal being and beyond my comprehension. As Levinas (1981: 122) says, ‘the Good is before being’ and is what my personal being is submerged in. A responsibility that was given to me before I had a choice because as Levinas says, ‘it is as responsible that one is incarnated’ (Levinas, 1981: xiii). As the ‘Good’ is external to me and is what I cannot initiate by my own accord, access to the ‘Good’ is by way of the approach of the ‘Good’ to me and not me to it, but because of my submersion in the ‘Good’ of the ‘there is’, like the dark of the night in the above example, the ‘Good’ is already present. It is as though this ‘Good’ chose me before I was in a position to be able to choose because it is present to me in the ‘there is’ and therefore before my
personal being is realized. As Levinas (1981: 11) explains, ‘the present is a beginning in my freedom, whereas the ‘Good’ is not present to freedom; it has chosen me before I have chosen it’. As such, I have no access to the ‘Good’ because it is external to what I can ever think. But the ‘Good’ of the ‘there is’ is always present, even though I am not aware of it as such.

Does this mean that every person is ‘Good’? If I were to answer this question from Levinas’s ‘preontological’ perspective, which is before my personal being as an ‘I’ is realised, the answer would be yes. Thus, every person is ‘Good’ in the sense that the ‘Good’ spoken of here is before ‘I’ comes onto the scene and has the freedom to choose, and before good versus evil is presented as a choice. The claim is that my personal being arises from a foundation of ‘Good’, a ‘Good’ that is before choice in that the ‘Good’ chose me not me it (Levinas, 1981). As Levinas (1981: 11) says, ‘no one is ‘Good’ voluntarily’.

Moreover, the idea of the ‘Good’ is important because it offers an explanation for my yearning to be the support of an others’ being. The ‘Good’ is the susceptibility to being the one effected by an other’s personal being that is expressed in the ‘passivity of supporting’ (Levinas, 1981: 122). It assigns me to approach the other, what Levinas describes as a ‘non-erotic proximity’, a ‘desire of the non-desirable’ (Levinas, 1981: 123). In other words, the ‘Good’ is what I yearn for without knowing it, what I strive for but cannot ever attain, because the moment I try, I become sidetracked and the producer of some type of good, which is not the ‘Good’ spoken about here. For example, Levinas is not referring to a good that is initiated by me wanting to do ‘X’ as an opportunity to achieve some greater good. It is not a good of my making for, as I repeat, it is not me who makes the approach to the other person in order to do some matter of good. To the contrary, the direction of the approach to do good work is from the ‘Other’ who commands me by way of the expression of their personal being, which Levinas says is the approach of the ‘Face’ of the ‘Other’, an idea that is
explained later in this text. The ‘Good’ as it is conceived by Levinas is a ‘Good’ that does not emanate from my initiative nor can it become present or enter into a representation. It is a ‘Good’ that exists outside my personal being and is what I cannot have knowledge of, even though it impacts on me by way of the passivity of being the support of an other’s personal being.

Then how is the ‘Good’, as spoken of by Levinas, given personal expression? The ‘Good’ is found in the ‘passivity of supporting’ and is expressed in my love for my neighbour, which is being responsible for my neighbour. To be precise, the ‘Good’ is enigmatically suggested in the ‘Face’ of the ‘Other’ (Hutchens, 2004). In the ‘Face-to-Face’ encounter, which is the encounter of our personal being, the ‘Good’ seeks me out and desires a response to it and is the only place where it is possible to catch a glimpse of this type of ‘Good’. Thus, the ‘Good’ expressed in my ‘passivity of supporting’ an other’s personal being, my incarnation as responsible, is my love for my neighbour, a love without ‘eros’.

However, rather than use the term love, which has many different meanings, Levinas says use the word responsibility.

> ‘From the start, the encounter with the Other is my responsibility for him. That is the responsibility for my neighbour, which is, no doubt, the harsh name for what we call love of one’s neighbour; love without Eros, charity, love in which the ethical aspect dominate the passionate aspect, love without concupiscence. I don’t much like the word love, which is worn-out and debased. Let us speak instead of the taking upon oneself of the fate of the other. That is, the “vision” of the Face. . .’. (Levinas, 1998: 103)

Similarly, nurses and midwives in this study offered examples of love in their professional practice that were founded on the taking upon themselves the fate of their patients. Without stating it, each example of love was an expression of the responsibility of being ‘for’ the patient. In acknowledgement of this observation and Levinas’s claim about the corruption of the word love, the word
responsibility will instead be used. To be clear, the responsibility spoken of here is not the responsibility we associate with our everyday life, that is, a responsibility defined by societal laws and codified rules, nor is it a responsibility situated in time, place or object. Rather, the responsibility that Levinas speaks about is moral responsibility, a responsibility that arises because of the ‘Good’ of the ‘there is’ in which my personal being is submerged. While the ethical part of the self (the self based on societal codified rules and laws), allows me to either accept or reject the responsibility of an other, moral responsibility does not. Moral responsibility is where I am ‘for’ my neighbour as determined by chance proximity and not as something I am able to plan or have thought about. As Peperzak et al, (1996: 140) say, moral responsibility as spoken of by Levinas involves;

‘. . . an undoing of the nucleus of the transcendental subject, the transcendence of goodness, the nobility of a pure supporting, an ipseity of pure election. Such is love without Eros’, such is my responsibility’.

Replacing the term love with the concept of moral responsibility appears entirely consistent with the views reported by nurses and midwives in this study. Hence, the concept moral responsibility as opposed to love, offers a theoretical framework for the development of insight into the clinical experiences of nurses and midwives where their professional love was expressed in the form of being morally responsibility ‘for’ the patient’s in their care.

To recap, tying the ideas spoken about thus far to the unique language of Levinas, my human ‘being’ is submerged by the ‘Good’ of the ‘there is’ or ‘otherwise than being’ and has me responsible ‘for’ the ‘Other’ as a matter of fact. This statement contains one of the centrepieces of Levinas’s philosophy of ethics which is the relation of the ‘Other’ and the self. That is, the self, my self, is constituted by my ability to identify my self in an other as in all others even though the self I identify in an other is different in its many alterations to me. As
a human being I live as one among many. In contrast, the concept of the ‘Other’ is very different to the self. As was alluded to earlier, the ‘Other’ is not an other self it is ‘Other’, an ‘Otherness’ of an other. Levinas uses a capital ‘O’ in the word ‘Other’ to alert the reader to the fact that he is not referring to an other person in their everyday form but to an ‘Otherness’ of an other or what could be loosely referred to as a state of being different. This ‘Otherness’ that Levinas has identified is like the ‘Good’ also external to me and the world that I can know. Being external to me is another way of saying the ‘Other’ is outside what I understand to exist and so is what I do not and cannot have knowledge of. Therefore not only are the ‘Other’ and self completely different they are also completely separate to each other. To be separate, the ‘Other’ must not be able to be personalised. If it were, it would not be ‘Other’ because it would be a part of the world as I understand it and therefore part of the same. The ‘Other’, being so completely external to me, is what makes learning possible. If it were not, it would be learning that was constrained by my capacity to think and therefore be more of the same. rather, the ‘Other’ makes learning possible by way of the presence of something completely new to me, something completely foreign and something that I could not have possibly thought; a revelation. A learning that is only made possible when the self and the ‘Other’ come into contact, a point highlighted by Davis (1996: 44-45) who says:

‘…the self exists because the Other is irreconcilable with it. Otherwise, both self and Other would be parts of a greater whole or totality which would invade and invalidate their separateness. So, although the self may feel that its separateness ensures both its mastery and freedom in the world, that separateness depends upon the possibility of an encounter which will put both mastery and freedom into question…’.
What is more, Davis (1996) also makes the point that the difficulty for Levinas’s was to identify the way that the self and the ‘Other’ are able to come into contact with each other and yet still be able to preserve their independence and self-sufficiency. According to Levinas the contact of self and ‘Other’ is not a physical contact but a contact made by way of a relation that is not a relation as we would normally understand it. For Levinas, the relation of the self and the ‘Other’ cannot be a mechanism for making the ‘Other’ a part of my personal world which would diminish its mystery of what is external to me and unknowable. Instead, Levinas’s describes the relation of the self and the ‘Other’ as a ‘relation-without-relation’ (Levinas, 1979). His point is that my relation with the ‘Other’ is not something that I have a say about. I am passive with regard to the approach of the ‘Other’. I simply wait at the ready for the approach. As Levinas (1981: xvii) says, ‘the approach of the other is an initiative I undergo. . . It is then not to an apprehensive or comprehensive initiative that alterity is given, but to sensibility. One is passive with regard to the approach of alterity, one sustains its impact without being able to assimilate it, one is open to it, exposed in its direction, to its sense, susceptible to being affected…’.

Consequently the impact of the ‘Other’ on me is in its approach and results in my response as obedience. However, it is an obedience that is already active before any pronouncement or understanding of the effect of the ‘Other’. In this relation the effect of the ‘Other’ on me is ‘sensuality’, a susceptibility to be affected, a vulnerability that has me open to the ‘Other’ in a way that makes me responsible before I know it. As Levinas is often known to say, it is as responsible that I am incarnated (Levinas, 1981: xiii). This means that my personal being is given to be always open to the approach of the ‘Other’ and therefore to be responsible. This being the case, my responsibility for the ‘Other’ is what I have no say about. However, it is the next step, which is the personal act of taking responsibility ‘as if’ I was already responsible, which is
the act of creating the moral space, a point Bauman’s (1993) in his reading of Levinas says is the only foundation morality can have. Putting these ideas another way, responsibility is a relational bond that results from a non-cognizable recognition of the ‘Other’ effected in the expression of being that results in an exposure of oneself to the other, a giving of one’s subsistence to the other (substitution) in living out the unspoken command to be responsible, morally responsible. In this way ‘taking’ responsibility, that responsibility I already have, or as Bauman (1993) says, responding to the ‘urge to do’, is what founds me as a moral person.

At the level of my personal being, where at best, I can only be ‘with’ another, the I-thou relationship is symmetrical; I am ‘with’ them as they are ‘with’ me. Yet, at the level of Levinas’s ‘Otherwise than being’, the relationship of our respective beings is not symmetrical but asymmetrical. It is a relation that contains the hallmarks of a moral stance, in that the relation is one-sided, has no expectation of reciprocity and is not subject to reversal. It makes possible being ‘for’ as opposed to being ‘with’. In a note of caution, Bauman (Bauman, 1993): 50) also makes the point in his commentary on Levinas that ‘... in a moral relationship, I and Other are not exchangeable, and thus cannot be ‘added up’ to form a plural ‘we”, any codified rules or duties apply only to me. Therefore, being a moral person I am my brother’s keeper whether or not he is for me because his relation to me is his business and not mine. Being ‘for’ the ‘Other’ means I am ‘for’ the ‘Other’ whether or not the ‘Other’ is ‘for’ me. The impetus to be ‘for’ the ‘Other’ clearly lies with me because while my neighbour may change, nobody can take my neighbour from me, for it is not my neighbour who holds me fast. It is, in Levinas’s view, my responsibility which holds my neighbour fast. Here the notion of reciprocity does not exist because my being ‘for’ the ‘Other’ is not based on the Other’s being ‘for’ me. Levinas (Levinas, 1998); (cited in (Bauman, 1993) makes this point even clearer by using the example in the Christian faith where God asked Cain the question, ‘where is
your brother’. Cain answered from his own point of view with, ‘Am I my brothers keeper’. Personal being is the territory without morality, and therefore, at best, Cain’s relationship to his brother was of a ‘with’ nature, I am I and he is he (Levinas, 1998): 110). However, if Cain was able to respond from the ‘Otherwise than being’ (where I am ‘for’ the ‘Other’), the ground of morality, he may well have answered very differently. To be a moral person means Cain was his brothers keeper and therefore responsible for his brother. Cain’s responsibility for his brother was always more than any other person’s. Being a moral person means it would have been impossible for Cain not to have been responsible (Bauman, 1993). Cain was his brother’s keeper whether or not his brother saw his duties toward Cain in the same way. Being ‘for’ the other means, like Cain I am ‘for’ the ‘Other’ before I am ‘for’ myself, making my relationship to an ‘Other’ a moral one. Thus, the moral self comes into being by my ability to rise above a concern only for myself. It moves the focus of attention from the self to the other in a relational bond that, as previously explained, has me ‘for’ an ‘Other’ so creating the moral state of the self, or more specifically, moral responsibility. This explanation of moral responsibility is consistent with the experiences reported by both nurses and midwives, and is an idea that will be explored in more depth in the next chapter.

The mechanism that enables moral responsibility arises from my attention not on the other person as a specimen nor as an isolated being among other beings but on what Levinas identifies as the ‘Face’ (‘Call’) of the ‘Other’. The ‘Face’ of the ‘Other’ is that which is the same as me but is also different to me in that it is not me; it is them. The ‘not me’ spoken of here is not referring to my subjective status as an individual person but to my ‘Otherness’ which is not an other’s ‘Otherness’ by the simple fact that it is mine. The relation of the ‘Face’, the ‘Face-to-Face’ relation, is where the depth of the Other’s personal being is revealed to my ‘Other’. However, my relation to the ‘Face’ is not the relation we normally associate with the conduct of our everyday interpersonal life. The
‘Face’ cannot be seen, thematized or appropriated. A repeated phrase of Levinas is that the ‘Other’ always remains ‘Other’, meaning the ‘Other’ is always a mystery or unknowable to me. So the ‘Face’ of the ‘Other’ is not an object and it is not what I am able to experience because if it were it would be reducible to phenomena and therefore a product of my knowledge, ceasing it to be ‘Other’. Again, the ‘Face’ of the ‘Other’ is always external to my personal being and is what is irreducible to phenomena and therefore my knowledge. The ‘Face’ though is what enables the encounter our beings ‘Otherness’, the ‘Face-to-Face’ relation.

Furthermore, Levinas’s concept of the ‘Face’ is not referring to a surface or the physical attributes associated with the head of a person and all its expressive characteristics or for that matter the uniqueness of the other person as a being with physiological and psychosocial form. Rather, the ‘Face’ is a metaphor for the expression of the moral summons of the ‘Other’ to me. ‘The face is signification, and signification without context’ (Levinas, 1985: 86). It is what enables two beings to encounter each other without reducing that encounter to an experience and therefore an object of their making. It is from the first ethical, or put another way, the ‘Face’ that is revealed by way of its signification summons my ethical obligation. As Levinas (1985: 87) says, the epiphany revealed in the ‘Faces’ consists of saying ‘thou shall not kill’. This manifestation of the ‘Other’s’ right to be is a fact, a primordial command that is not open to my interpretation because it comes to me from outside what I am able to know. Thus, the moral summons of the ‘Other’ is an appeal that I cannot ignore. However, Murray (2003) in his analysis of Levinas’s philosophy makes the point that while the ‘Face’ appears to me by way of a moral summons, is not open to my personal interpretation and therefore any potential distortion or silencing of it, and is something that must be ‘heard’, I am able to refuse to respond to it’s appeal. The identification the difference between the appeal of the ‘Face’ and my response to it, will in the next chapter, help explain the different types of
nurse and midwife patient relations.

Typical of the relation with the ‘Other’ as a ‘Face’ is my at-the-ready obedience to the approach of the ‘Other’. This means that I am passive toward receiving the approach of the ‘Face’; I am at-the-ready to receive it and I am open and susceptible to being affected by it. I do nothing toward either receiving it or acting upon it. Thus, the ‘Face’ of the ‘Other’ is what impacts on me by way of its expression. The ‘Face’ is expression. The ‘Other’s’ personal being is expressed to me by way of the ‘Face’s’ approach; it is what is sensed. The source of meaning that comes to me by way of this sensing though is external to me and the world as I know it and to all that I could think. It is a sensing, a sensibility that first involves ‘sensuous affection’ which is then followed by ‘sense-ascription’ (Levinas, 1981). Levinas’s idea of ‘sensuous affection’ is comprised of contact, immediacy and assimilation, which is given to ‘sense ascription’, the act of perception that involves envisaging and viewing from a distance, and objectification. In ‘sensuous affection’ there is a sensuous contact with the material, which Levinas (1981) identifies as more like the ‘savouring’ that takes place prior to any ‘sense ascription’. Sensing the expression of the other’s personal being by way of the ‘Face’ is this savouring. It is a ‘savouring’ of the material being sensed which is then given meaning through ‘sense ascription’. But in a note of caution, Levinas (1981) says that sensibility or savouring is not an act in itself, rather it is a susceptibility to being affected. It is being open to being effected, a being passive toward the approach of the ‘Face’. Thus, ‘the face is a living presence; it is expression . . . a discourse, it speaks by its mere presence, to present oneself by signifying is to speak’ (Levinas, 1979: 66).
The ‘Face’ is a source of language or as Levinas says above, the ‘Face’ speaks because its manifestation is already discourse. But again, like much of the language used by Levinas, the discourse he is referring to here is not about reasoning or for that matter the spoken word, as the ‘Face’ speaks in that it is already discourse. Here, discourse is the ‘first word’, which is not communication as something given to a sign or an interpretation but communication by way of an exposure to being effected. Before the ‘Face’ of the ‘Other’ is presented to me I am at the ready to receive it, open to its approach. Levinas calls this state of openness, and hence passivity to being effected, the ‘Saying’. To be clear, he uses two main terms to explain his thinking around discourse, one is the ‘Saying’ and the other is the ‘Said’. The ‘...saying is a state of openness to the other’, a ‘here I am’ prior to any commitment being made (Hand, 1989: 6&7). The ‘Said’ is the giving of a sign to a communication. The meaning given to the ‘Saying’ is very different to anything communicated by the ‘Said’. In terms of the ‘Face’, the ‘Saying’ is a form of greeting the ‘Other’, which Levinas (1985) says is to already answer for him. It is the first word presented that says ‘here I am’ (Levinas, 1981: xxxiv), a passivity of being open, of being exposed to being effected by the expression of the depth of ‘Other’s’ personal being.

The ‘Saying’ by way of my passivity to being effected by an ‘Other’ also enlightens me to the fact that I exist as more than a separate living entity, an isolated person concerned only with mastery of its atomistic self. It ‘awakens’ me to the fact that I am more than a solitary being; I am a being that is in union with the ‘Other’ of all others (Levinas, 1998). As Bauman (Bauman, 1993: 76) succinctly puts it;

‘awakening is not in the ‘I am I’, but in the ‘I am for’. It makes it possible for my personal being to ‘awaken’ from its egology, from egoism and egotism to the realisation that I am I, a unique and irreplaceable I, only through my unity with the Other’.
The ‘Face’ by way of the ‘Saying’ awakens me to the responsibility I have for assisting the ‘Other’s’ personal being. This idea of awakening or at least the very chance to awaken from a concern only for my self to a responsibility for an ‘Other’ adds to a foundation for understanding why nurses and midwives were able to rise above a concern only for themselves and place the patient at the centre of all their professional endeavours.

Responsibility for the ‘Other’ is not the responsibility associated with everyday life where one is able to make certain choices about the responsibility that fronts them. For Levinas, responsibility for the ‘Other’ is exactly what I do not have any say about, because it is as responsible that I am incarnated, meaning I am responsible whether or not I like it because the responsibility that I have is not of my making, it chose me not me it. The fact is, I am responsible for the ‘Other’. This responsibility that I have, as though someone placed it inside me, is a form of recognition of the authority of the ‘Other’, an acknowledgement of a claim to arise and present oneself. To be precise, responsibility is the response to the concrete act of ‘Facing’ (Levinas, 1981). As was explained earlier, the act of ‘Facing’ is not a cognitive act. It is an act of expression. Meeting the ‘Other’ as a ‘Face’ involves the way one expresses oneself, exposes one’s being to the ‘Other’, exposes oneself to the ‘Other’ (Levinas, 1981). These incarnate concrete acts of the exposure of one’s being, of opening one’s self to the ‘Other’, of giving of one’s substance to the ‘Other’ are what Levinas (1981) says, is my responsibility. Responsibility communicated by way of the ‘Face’ is how our being’s ‘Otherness’ is able to come into contact. It breaks through the sphere of the exteriority associated with the ‘Otherness’ to the sphere of phenomena.
Levinas suggests that maternity is an authentic figure of responsibility (Levinas, 1981). In maternity one does not choose one’s responsibility to an other. One is chosen by the very nature of one’s being. As in maternity, the command to act for the ‘Good’ of the ‘Other’ is a preexisting command, a command that requires me to give something of my very being to the other in support of them. Here, my responsibility has me offer my being to the other without holding back and before it is asked. It is a passive giving, an openness of the quality that I give everything to them whatever they need for their sustenance even if it is at my own peril. As in maternity, my responsibility for the ‘Other’ is not what I initiate because it has always been the case, it is not something that is started or stopped nor is it something that I know I do. Like maternity, what signifies my responsibility is that I bear all the responsibility for the bearing. My exposedness to the other is so complete that I bear all the demands of their being and also the consequences of the bearing of their being. As in maternity, responsibility makes possible the life of an other, where the food from one’s own mouth is given for the betterment of the ‘Other’, something Levinas (1981) describes as the maternal support for the material destitution of an other. Thus, my responsibility is ‘for’ the ‘Other’s’ welfare and expressed in concrete acts that are for the support of their personal being. It is to make my subsistence the support of their order and needs for without responsibility our respective being would not be possible. As is the case with maternity, I have been chosen by this responsibility which I bear alone; it is a responsibility I cannot compare against any standard because the experience of being responsible is mine and mine alone. I am always responsible for the situation and what went on before it and more responsible than anyone else. What is more, like maternity, I am always haunted by the possibility that I am not being responsible enough.
Just how far does this responsibility of being ‘for’ the ‘Other’ extend? First, because my responsibility for the ‘Other’ is already in tow and not something I can have a say about, I am already responsible and therefore will always be responsible. My responsibility will not cease. Second, citing the Danish philosopher Knud Løgstrup, Bauman (Bauman, 1993) makes it clear that Levinas’s responsibility for the ‘Other’ is endless because ‘the moral self is a self always haunted by the suspicion that it is not moral enough’. That is to say, the moral self has to be the judge of what is ‘enough’, the interpreter of ‘could I have done more’ in the absence of codified rules, laws and the like that place boundaries on what is acceptable in a society and therefore of me. Here though the moral self is to answer to itself. There are no rules, conventions or parameters that necessarily apply. Each situation is unique, which makes the task of defining what is ‘moral enough’ difficult. Adding to this difficulty the ‘Other’ has no right to demand anything from me and so they cannot offer me any help in the decision of ‘what is enough’. The moral self is without appeal to anyone or anything. This moral anxiety and uncertainty that I experience is what underpins morality, a self always unsure if it has been moral enough.

In sum, while responsibility in the everyday sense of the word has me focus upon my own atomistic self and what it is to be human and ‘alive’, Levinas’s idea of responsibility embraces a self able to transcend its being as only concerned for itself to a caring ‘for’ an ‘Other’. In Levinas’s philosophy responsibility is moral. Moral responsibility involves the metaphysical ‘call’ of the ‘Other’ to me and it precedes any responsibility that my self, in its everyday form, is summoned to. It is a form of responsibility that does not issue from me but comes from the ‘Other’ in the form of a command to be ‘for’ the ‘Other’ as my first priority. It is a command that issues from the ‘Face-to-Face’ relation. It is a relation of moral responsibility and it has two communicative parts, what Levinas calls the ‘Saying’ and the ‘Said’, which were briefly touched on earlier and now to be explored in more detail.
The ‘Face’ speaks in that it is already discourse. Here, discourse is the ‘first word’, which is not communication as something given to a sign or an interpretation but communication by way of an exposure to being effected. Before the ‘Face’ of the ‘Other’ is presented to me I am at the ready to receive it, open to its approach. Levinas calls this state of openness and hence passivity to being effected, the ‘Saying’. To be clear, he uses two main concepts to explain his thinking around discourse, the ‘Saying’ and the ‘Said’. They represent a model that explains how ‘ethics signifies within ontological language’ (Critchley, 1992: 229&234). Specifically, the ‘Saying’ is a verb and is the ‘act’ of ‘Saying’ something. The ‘Said’, a noun, is ‘what’ is being said. More particularly, the ‘. . .saying is a state of openness to the other’, a ‘here I am’ prior to any commitment being made (Hand, 1989: 6-7). The ‘Said’ is the giving of a sign to a communication. The meaning given to the ‘Saying’ though is very different to anything communicated by the ‘Said’. In terms of the ‘Face’, the ‘Saying’ is a form of greeting the ‘Other’ which Levinas (Levinas, 1985): 88) says, is to already answer for him. As I reiterate, it is the first word presented that says ‘here I am’, a passivity of being open, of being exposed to being effected by the expression of the depth of ‘Other’s’ personal being and their demands on us.

The terms ‘Saying’ and ‘Said’ show how communication and language, which convey meaning, can be problematic for responding to the ‘Call’ of the ‘Other’. Levinas believes that ethics as a first philosophy occurs in the ‘approach’ the ‘Other’ makes to me which precedes any response I am able to make. The ‘approach’ made to me by the ‘Other’ is what he refers to as the ‘Saying’. The ‘Saying’ is the antecedent to verbal signs and linguistic systems, ‘. . . it is the proximity of one to the other the commitment of an approach, the one for the other, the very sign ifyingness of signification’ (Levinas, 1981: 5). The ‘Saying’ is a communicative event because the ‘approach’ of the ‘Other’ by way of the
‘Face’ is expression, a sense, a savouring, and a sensibility that is ‘sensuous affection’. A phenomenological encounter of the call of the ‘Other’, which ‘... can only be experienced genuinely through a non- or pre-discursive phenomenological encounter (the saying) and it is the movement toward discourse (the saying) rather than its content (the said) that assists in that disclosure’ (Murray, 2003: 57).

Because the content of communication cannot reveal the ‘Face’ of the ‘Other’ Levinas seeks a structure of communication that enables the ‘Saying’ to be heard. This means that to be able to respond ethically to the Face (call) of the ‘Other’ the communication of the ‘Saying’ must not be corrupted by the ‘Said’. The ‘Said’ is the move from phenomenology to ontology, or the ‘signifyingness’ or ‘significance’ of the expression of the ‘Other’ to my signification of that signifying expression. Significance (saying) is what lies behind signification (said) and is what makes it (said) possible. The ethical ‘Saying’ is given linguistic representation ‘as’ the personal interpretation expressed by the ‘Said’. The ‘Said’ is the content and form of communication that makes up the response to the ‘Saying’. Important in Levinas’s thinking is that the ‘Saying’ is dominated by the ‘Said’. For example, as soon as the other’s ‘Otherness’ is revealed by way of the expression of the ‘Face’ it becomes a response (the said) to the response (the saying), an interpretation that is subject to misrepresentation and distortion. The ‘Saying’ has its own meaning which is different from the ‘Said’. It is a point Murray (Murray, 2003) clarifies by way of yet another example of human behaviour in WWII; that if someone was to ask you to ‘please shoot me in the head’, Levinas would say there is no ethical requirement on you to follow this command. Hence, the ‘Said’ of discourse (the message conveyed in the ‘please shoot me in the head’) does not fully represent the true message of the ‘Other’ (the saying). In fact, it is a distortion.
The ‘Said’ is subject to distortion and misrepresentation. In the above example the rhetoric of the Nazis and the supporting ideology functioned to misrepresent the ‘Saying’ which resulted in a ‘Said’ that enabled normal everyday German people to commit atrocities and murder. The ethics of Levinas’s first philosophy insists that the ‘Saying’ as a response, a commitment of an approach, is what is required of my responsibility ‘for’ the ‘Other’. In short, Levinas’s ‘Saying’ means, to be responsible for the ‘Other’ before I know I am. This responsibility though is purely sense and is something that must be sensed prior to any interpretation of it. The conceptual apparatus that supports the interpretation and communication of my responsibility though may or may not be a response that is an accurate representation of that responsibility or obligation to respond.

Moreover, because ‘there is no saying that is not the saying of the said’ (Levinas, 1993: 141), the ‘Saying’ is not the original ‘Saying’. It is but an interpretation and a representation of it. The suggestion is that discourse and the straightforwardness of ‘everyday language’ and not rhetoric and eloquence are what best enables one person to communicate with another person in a way that is open and better able to represent the ‘Saying’ of the ‘Said’. Rhetoric and eloquence support a form of communication that is self-serving and contaminates the response to the call of the ‘Other’. Discourse and ‘everyday language’, on the other hand, is the form of communication that helps keep at bay the totalising of the other and is more akin to representing the ‘truth’. These ideas are particularly relevant for nurses and midwives who care for people in the health care environment that is laden with medical jargon and rhetoric burdened by the politics of health. As Levinas clarifies, ‘everyday language’ incorporates words whose meaning is due to ‘. . . their usage surrounding interhuman relations that are based on custom and tradition and the everyday repetitions they entail. Those are the meaning of words according to usage, as if the language were nothing but a ‘tool’” (Levinas, 1993: 137), a tool that can lessen distortion and misrepresentation. While the summons of the ‘Other’ is
something that is always heard as pure expression, communication by way of
the ‘Said’ is different, it is either the response to and therefore an interpretation
or a representation of the ‘Saying’ of the ‘Said’, or equally it may be the failure
to respond at all.

As an addition to the thinking of Levinas about the function of rhetoric, Murray
(Murray, 2003) posits the view that rhetoric can have a positive effect and thus
be used to either facilitate the disclosure or re-disclosure of the Face of the
‘Other’, which he labels a ‘rhetoric of disruption’ and a ‘rhetoric of supplication’.
Communicatively (re)disclosing the Face of the ‘Other’ is an additional
mechanism to Levinas’s Face as a phenomenological given, and is the product
and goal of ongoing discourse (Murray, 2003).

The rhetoric of disruption is a form of communication about the ‘Other’ that
challenges and redresses ideological assumptions that work to distort, mask or
silence the call of the ‘Other’. The idea is that, after the call of the ‘Other’ a
rhetoric of disruption is implemented by this other to work against ideology that
would disrupt, mask, or silence their phenomenological call to respond. It is a
targeted rhetoric in that it is implemented after the response to the call of this
‘Other’ is heard and responded to. It is at this point the rhetoric of disruption
takes effect by challenging communicated ideological assumptions, cultural
stereotypes and the like in an attempt to recover the original phenomenological
unsettling of discourse, by itself unsettling the discourse that settled that
unsettling (Murray, 2003). As Murray (Murray, 2003: 77) claims;

‘... I suggest that only through an ongoing dialogical engagement can
assumptions, beliefs, and values be kept under constant scrutiny, and
the potentially oppressive effects of cultural stereotypes and prejudices
be monitored’.
Murray’s idea is that dialogue enables the ‘Other’ to be, bit by bit, re-disclosed. However, in a point of note, Murray (Murray, 2003: 88) says that ‘there is an insurmountable and unavoidable risk here, because dialogue can never disclose the ‘Other’ in its absolute ‘Otherness’, in its purity. Instead, such a mode of communication can only work to recover the ‘Face’ one bit at a time, as it targets particular masking one at a time. As a consequence, this dialogue by way of a rhetoric that seeks and a rhetoric that reveals is never ending, never sure that it is a representation of the ‘Saying’.

For its part, a rhetoric of supplication is about the self’s role in practicing a dialogue that supports the ‘Other’s’ rhetoric of disruption (Murray, 2003). It is a targeted form of communication that uses a variety of communication strategies, such as active listening, to help reveal the ‘Face’ of the ‘Other’ by way of creating a communicative environment conducive to supporting the ‘Others’ investigation of ideas through their implementation of a rhetoric of disruption. A rhetoric of supplication assists the recovery of the ‘Face’ after the fact of its appearance and its masking or distortion (Murray, 2003). Again, this view purports that the dialogical form of communication with ‘Others’ is never ending because it is always haunted by the idea that we can never be certain that we have the content of the response to the original call of the ‘Other’ accurate enough. But as Bauman (Bauman, 1993: 80) says;

‘what makes the moral self is the urge to do, not the knowledge of what is to be done; the unfulfilled task, not the duty correctly performed. But it all adds up to the fact that a person can never be entirely sure that he has acted in a right manner’.

But being human means we are one among many. The relations we have are not only with one other but many different others who are called a ‘Third party’. What Levinas (Levinas, 1981: xxxv) describes as ‘... not simply a multiplication of the other, from the first the ‘Third party’ is simultaneously other than the
other, and makes me one among others’. What is more, the discovery of the ‘Third’, ‘tertiality’, only occurs after the encounter with the Face. That is to say, while the ‘Third party’ is also an ‘Other’ they are not an ‘Other’ of the ‘otherwise than being’ that has me responsible for them as a matter of fact. The ‘Third party’ is one step removed from me, so removed in fact that I can only encounter them when I leave the moral realm and enter the world of ‘Social Order’ ruled by a social form of justice and not morality (Bauman, 1993). Introduction of the ‘Third party’ is what disturbs the one to one relation and introduces a world outside of my relationship with the neighbour, that is, it introduces society and questions the limits of my responsibility.

‘I now live in a world populated by All, Some, Many and their companions. Similarly, there is Difference, Number, Knowledge, Now, Limit, Time, Space, also Freedom, Justice and Injustice, and certainly, Truth and Falsity’. (Bauman, 1993: 112)

Once the ‘Other’ is dissolved into the ‘Many’ their ‘Face’ is lost to me. This means that;

‘the third party is other than the neighbour, but also another neighbour, and also a neighbour of the other, and not simply his fellow. . . the other and the third party, my neighbours, contemporaries of one another, put distance between me and the other and the third party’. (Levinas, 1981: 157)

Although the ‘Third party’ is distant to me they can equally be present to me as an ‘Other’, or conversely the ‘Other’ is never only my ‘Other’ but an ‘Other’ to an other and therefore potentially a ‘Third party’ to me. Levinas’s point is that the possibility of the ‘Other’ being a ‘Third party’ to me has me realise that the ‘Other’ does not only exist for me because the ‘Other’, who is also my neighbour, is also an ‘Other’ to an other. They are never simply my ‘Other’. The other as a ‘Third party’ disturbs the closeness and the asymmetry of my
responsibility in the ‘Face-to-Face’ relation.

The appearance on the scene of the ‘Third party’ introduces a questioning into the relation which changes the nature of my responsibility. It means I am no longer a hostage to the needs of ‘Other’ but now can expect some form of reciprocity, as in, the asymmetry characterised in the moral relation of being ‘for’ the Other is all but lost in the other as a ‘Third party’, because now objective criteria are able to be applied to the relation that seeks just reasons for what they do. As such, ‘Third party’ relations are able to be thermatized. While the selves may be unique and irreplaceable in the moral party of two of the ‘otherwise than being’, in the social world of the ‘Third party’ the others, as in all others, are able to be compared and contrasted.

The other being a ‘Third party’ is what enables my deliberation on the relation which itself comes to form part of socially accepted standards and normative measures and what Levinas say’s makes the ‘Third party’ a judge. The ‘Third party’ is the personal form of the other because their ‘Face’ is hidden from my view or as it relates to nursing and midwifery, a patient, the persona that hides their ‘Face’, which is a topic that will be taken up in the next chapter. In other words, my relation to the other as a ‘Third party’ deals with either their persona or the presentation of themselves as they want everyone to see them. This means my relation to them is now tied up with responding to stereotypes and the like that determine how I am to act toward them; what Bauman (Bauman, 1993) refers to as a ‘Mask’ (persona) and not to their ‘Face’. Dissolving of the ‘Other’ into the ‘Many’ results in the loss of their individuality because my focus is on responding in an objective way to them as a group (one of many) and so sets up the demands of justice and impartiality.
‘The third party introduces a contradiction in the saying whose signification before the other until then went in one direction. It is of itself the limit of responsibility and the birth of the question: what do I have to do with justice? A question of consciousness. Justice is necessary, that is comparison, coexistence, contemporaneousness, assembling, order, thematization, the visibility of faces, and thus intentionality and the intellect, and in intentionality and the intellect, the intelligibility of a system, and thence also a copresence on an equal footing as before a court of justice’ (Levinas, 1981: 157).

As mentioned above, the appearance on the scene of the ‘Third party’ is the appearance of society. It encompasses the idea of justice because I am now responsible for an ‘Other’, as in many ‘Others’ and must weigh up all the competing ‘calls’ on my responsibility. It is to discover the necessity for justice, because the question becomes, who in this plurality comes first. What is the order of the responsibilities, which is also the birth of the demand for justice (Levinas, 1981, 1998)? As Levinas (Levinas, 1998) says, justice must therefore take precedence over the taking upon myself the fate of the other. I must judge where in the moral party of two I assumed responsibility as a given. This, he (Levinas, 1981) believes, is a question of consciousness, the birth of the theoretical. It starts from the responsibility ‘for’ the other and then requires judgement and a comparison of the unique other which is incomparable. As stated, this is the moment of knowledge, consciousness and intentionality (Levinas, 1998).

Levinas (Levinas, 1998) is of the belief that our ethical obligation, which arises from the ‘call’ of the ‘Other’, is the starting point for justice. As such, justice is not about the application of some external set of principles or laws. Instead, justice is made possible by way of the dialogical prioritisation of ‘calls’ that encompass the community of others in which each is responsible for all. For
his part, Murray (Murray, 2003) is of the view that the problem for justice is that the response to the ‘call’ of the ‘Other’ is subject to ideology which can give rise to a response that in no-way resembles a response equal to the original ‘call’ to be responsible, as revealed in the ‘Saying’. There is a potential for misrepresentation of the ‘Saying’ revealed in the ‘Said’. What is of note is that Murray (Murray, 2003) claims that, in order to overcome this problem, a rhetoric of ‘disruption’ and ‘supplication’ can facilitate the re-disclosure of the ‘Face’ by way of the development of a response that is more akin to the ‘Saying’. Complicating this idea however, is the fact that the ‘call’ of the ‘Other’ is most often part of a larger context where there are multiple ‘calls’ of many ‘Others’ to be responsible. It is a point that Levinas (Levinas, 1985: 90) responds to when he says;

‘If I am alone with the Other, I owe him everything; but there is someone else. Do I know what my neighbour is in relation to someone else? Do I know if someone else has an understanding with him or his victim? Who is my neighbour? It is consequently necessary to weigh, to think, to judge, in comparing the incomparable. The interpersonal relation I establish with the ‘Other’, I must also establish with other men; there is thus a necessity to moderate this privilege of the Other from whence comes justice. Justice, exercised through institutions, which are inevitable, must always be held in check by the initial interpersonal relation’.

Thus, ethical obligations arise from ‘Others’ as in each ‘Other’, not from situations involving numerous ‘Others’, nor from groups who possess the same or similar beliefs or, for that matter, a collective of others represented in an organisation. But as to how Levinas’s interpersonal account of ethics is translated to justice for the multiple ‘calls’ of ‘Others’ is unclear in his philosophy. As he (Levinas, 1985) says above, I do not only have a single interpersonal relation, I have many, and therefore it is necessary that I
moderate this privilege of the ‘Other’, and keep it in check by the initial interpersonal relation. Just how this is to be done is not explained. It is a point that Peperzak (1996) and Murray (2003) have also identified, with Murray suggesting that dialogue is a way of managing justice because it can enable one to ‘hear’ the ‘Call’ of the ‘Other’ as in all the ‘Others’. Dialogue makes possible the prioritisation of the ‘Calls’ of ‘Others’, in that, it enables the unsettling of ideology that can mask, distort and silence the ‘Call’ of ‘Others’. Moreover, dialogue, he argues, makes possible the unsettling of my own preconceptions, justifications, arguments, and rebuttals and thereby discloses and tests my prioritisation of the ‘Call’ of the ‘Other’. But equally it means that justice requires I always be at the ready to ‘hear’ the ‘Call’ of the ‘Other’ and in all ‘Others’, given those ‘Calls’ may be silenced by ideology. What this means for nurses and midwives is that dialogue can help reveal a ‘Said’ that is a more accurate representation of the ‘Saying’ of not only one ‘Other’ but many ‘Others’. In this way dialogue can assist the just prioritization of the multiple ethical summonses that I confront.

To summarise, the philosophy of Emmanuel Levinas morality is what makes possible the transcendence of being. It explains how a person is able to transcend their being as a separate living entity, concerned only with mastery of its atomistic self, to being ‘for’ the being of another person where the self is not a consideration. It is an asymmetrical relation where there is no expectation of reciprocity because it is founded on the ‘Good’, a ‘Good’ expressed in the ‘passivity of supporting’ an other’s personal being as a result of my incarnation as responsible or, put another way, my love for my neighbour. In a moral relation the ‘Good’ seeks me out and is presented to me in the form of the ‘urge to do’ that desires a response, and is the only place I am able to catch a glimpse of this ‘Good’. Like the example of maternity, the fact is I am responsible and could always be more responsible. My responsibility is to respond to being ‘for’ the ‘Other’. It is what I am obedient to before I know I am
because it is not privy to my conscious thought and therefore is not what I am able to have a say about. Instead, the approach of the other is an initiative that I undergo. I am passive with regard to its approach. As responsible I wait at the ready, open and exposed in its direction, susceptible to being affected, and make my subsistence the order of their support (substitution). This responsibility I have is lived out in the sensing of the ‘Face’ (expression) of the ‘Other’, which is a signifyingness that gives rise to my sensing of it as a significance. The first word in ethics is ‘Saying’ ‘here I am’, which is my exposure to being affected by the expression of the signifyingness of an other’s personal being. The giving of a sign (Said) to the significance of the ‘Other’ (Saying) is the point at which I enter the scene and is at best only an interpretation and representation and so is open to distortion and misrepresentation or it may be a failure to respond at all. A rhetoric of disruption and supplication is suggested as one way to help rediscover the original Saying. The introduction of the third party disturbs the one to one relation and changes the nature of my responsibility to one where I can expect some form of reciprocity. Now objective criteria are able to be applied to the relation that seeks just reasons for what they do. But equally justice means I stay at the ready to ‘hear’ the ‘Call’ of the ‘Other’ of the multiple ethical summonses I confront. It all adds up to the fact that a person can never be sure they have acted in the right manner. Notably, the personal act of responding to the ‘urge to do’, which is to take responsibility ‘as if’ I was already responsible and the one and only one responsible, is the act of creating the moral space and what grounds me as a moral person or, as is this case here, a moral nurse and midwife.
Chapter 11  Love as moral responsibility in Nursing and Midwifery

11.0 Introduction
In this chapter nurses and midwives answers to the general question of ‘what is love in nursing and midwifery’ are analyzed using Emmanuel Levinas’s philosophy of the ‘metaphysics of otherness’. Incorporated into this analysis are specific examples of love in nursing and midwifery from the Neo-Socratic dialogues plus discussion that addresses the various questions raised in the commentary section of each of the Neo-Socratic dialogues and those raised in the discursive analysis of the extant literature on caring in nursing and midwifery.

To recap, six Neo-Socratic dialogues were conducted in urban and remote area locations of Australia, Singapore and Bhutan, which resulted in 56 nurses and midwives agreeing to participate in this study. Participants came from across a variety of fields of nursing and midwifery that included Aged Care, Child and Adolescent Nursing, Accident & Emergency, High Dependency, Critical & Coronary Care, Intensive Care, Acute Medical and Surgical Nursing, Operating Theatre & Recovery Room, Day Surgery, Oncology, Rehabilitation Nursing, Palliative Care, Midwifery, Women’s Health, Mental Health Nursing, Community Nursing, Naturopathy, Nurse Administration and Nurse Education.
11.1 A case of what is love in Nursing and Midwifery

11.1.1 Participants general answer to the question of ‘what is love in nursing and midwifery’

The combination of the six groups’ general answers to the question what is love in nursing and midwifery plus the specific answers to the examples of love offered by participants (table 2) support the view that love is an integral part of the professional practice of a nurse and midwife. While it was thought love was something every nurse and midwife is able to express it is not something that is always obvious in the everyday practice of a nurse and midwife. Participants in this study believe that love in nursing and midwifery has its origin in the deep connections that exists between all people. Love it was thought arises from the moral character of the nurse and midwife in response to the witness of the destitute state and suffering of a patient. It is not something that is able to be controlled by conscious thought, because it is not privy to a person’s consciousness, nor is it something that every nurse and midwife responds to in the same way. But love is what makes possible the identification of the unique value of the person of the patient. It gives rise to the commitment needed by the nurse and midwife to do whatever is required for their good and is more than the simple performance of the professional duty of care because it requires the nurse and midwife to ‘go beyond’ the professional duty and enter a ‘special relationship’ that is evidenced in the commitment and the compassion shown. Love in nursing and midwifery is not something that is able to be mandated because the level of the professional commitment and responsibility is too great.
Love in nursing and midwifery is said to be present when the nurse and midwife-patient occasion elicits in the nurse and midwife a feeling of being deeply responsible for the patient’s welfare. It is a responsibility that requires a nurse and midwife to ‘go beyond’ a concern only for their self-project and instead place the welfare of the patient before their own without any consideration of reciprocity. It is a responsibility of the quality of a family relation, and is characterized by closeness, honesty and frankness and the requirement, willingness and commitment needed ‘to take care of’, to protect, and to give of their self to the patient, which may require both a personal and professional sacrifice. It is a responsibility that causes the level of the nurse’s and midwife’s commitment to the patient to increase in response to perceived threats to the patient’s welfare as is evidenced in the determination of the nurse and midwife to help. The nature of the responsibility that is felt by the nurse and midwife is unique; it cannot be transferred, shared or ignored.

A characteristic of love in nursing and midwifery is its selflessness. It is where a nurse and midwife use all their professional skills and judgment in responding in a selfless way to the needs of the patient. It is a selfless response that may not be without its risk to both their own personal and professional welfare and also that of the patient’s, but a risk that is understood by the nurse and midwife to be acceptable if the motive for the action is for the ‘good’ of the patient. Love in nursing and midwifery incorporates the nurturing of a relationship of understanding, where the will of the other is accepted when it is based on a sound health belief. It is an intention that expresses the nurse’s own health beliefs in the light of the desires of the other.
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<th>Group: 1</th>
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<tr>
<td>Answer 1:</td>
<td>‘It is going beyond the traditional duty of care’</td>
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<td>Answer 2:</td>
<td>‘Being prepared to take a risk’</td>
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<tr>
<td>Answer 3:</td>
<td>‘She was prepared to put herself up to have to think differently’</td>
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<td>Answer 4:</td>
<td>‘Respecting the choice of the other’</td>
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<th>Group: 2</th>
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<tbody>
<tr>
<td>Answer 1:</td>
<td>‘It’s a selfless, subconscious calling’</td>
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<tr>
<td>Answer 2:</td>
<td>‘Love is more than duty’</td>
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<td>Answer 3:</td>
<td>‘Being content in your vulnerability’</td>
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<th>Group: 3</th>
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<tr>
<td>Answer 1:</td>
<td>‘When I asked the Medical Officer to leave the room’</td>
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<tr>
<td>Answer 2:</td>
<td>‘Love in midwifery is being there for the woman and being with the woman doing what needs to be done to help her birth in a way she wants’</td>
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<th>Group: 4</th>
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<tr>
<td>Answer 1:</td>
<td>‘She had the courage to go beyond her colleagues’ negative expectations in caring for this woman and beyond the duty of care’</td>
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<td>Answer 2:</td>
<td>‘Accepting the person unconditionally, and was non-judgemental’</td>
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<tr>
<td>Answer 3:</td>
<td>‘Being determined to show compassion and not concerned with the consequences of her actions upon herself’</td>
</tr>
<tr>
<td>Answer 4:</td>
<td>‘Love is a willingness to connect, be open, sensitive and show understanding of the patient’s plight by giving hope’</td>
</tr>
<tr>
<td>Answer 5:</td>
<td>‘The nurse was prepared to form and enter a ‘special’ relationship that was characterized by her feeling deeply responsible for the woman’</td>
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<th>Group: 5</th>
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<tbody>
<tr>
<td>Answer 1:</td>
<td>‘Going the extra mile putting the women before her self’</td>
</tr>
<tr>
<td>Answer 2:</td>
<td>‘It is responding to the helplessness of the women’</td>
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<tr>
<td>Answer 3:</td>
<td>‘There is no exception of a reward’</td>
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<th>Group: 6</th>
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<tr>
<td>Answer 1:</td>
<td>‘A sense of responsibility for the boy as a big sister’</td>
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<tr>
<td>Answer 2:</td>
<td>‘Responding to the identification of the loneliness and isolation of the boy’</td>
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Table 2: Specific group answers to the group specific example of love in nursing and midwifery.
11.1.2 The analysis
What is love in nursing and midwifery as it was identified in the six Neo-Socratic dialogues of this study? Before offering an answer to this question and consistent with the rationale outlined in the previous chapter, the words love and responsibility are used interchangeably throughout this text. The view adopted is both that of the philosopher Emmanuel Levinas who says that my incarnation as responsible is my love for my neighbour, and that of nurses and midwives, who in this study, offered examples of love in their professional practice that were expressions of their ‘Goodness’ in being responsible ‘for’ their patient’s.

With this in mind, an initial examination of what nurses and midwives understood as love that is specific to their profession shows they believed that ‘love has its origins in the deep connections that exist between all people’. This part of their answer to the question of ‘what is love in nursing and midwifery’ is an acknowledgement that as humans we are born into a world of social relations that we have no say about and cannot ignore. Here our relationship to an other and to all others is of a ‘with’ type, in that, we are with them as they are with us but we are all the time separate beings similar to the severed beings in Aristophanes’ Myth in Plato’s Symposium (Plato, 1994). In Aristophanes’ account of love, the Greek God Zeus split the original androgynous being into two separate beings. Being as it were now a separate living entity, the two severed beings had an unfulfillable desired (an eros form of love) to be reunited into one being. As a result, they kludged together in an attempt to be reunited but no matter what they did they could not bridge their separation. Being human is like this. Each one of us is separate from the other and no matter what we do by ourselves we cannot bridge that separation. At best our relations can only ever be of a ‘with’ nature, side by side never able to inhabit the same space. Again, like the severed being, our being ‘with’ each other is what is humanly possible, a being among other beings, a social being.
As social beings there is an expectation on us to be responsible and to act in a responsible way toward each other. For example, in the modern Western styled health system the role of a nurse and midwife involves, at the most basic level, the responsibility of caring for another human being. The responsibility spoken of here is a part of what it is to be a ‘professional’ nurse and midwife as is mandated by a country’s government and managed by its statutory bodies.

Being a professional nurse or midwife has a legal requirement that dictates what I am obliged to be interested in and responsible for, that is, ‘to be responsible’ is what is straight-a-way expected of the nurse and midwife by another, be that other a patient, family member, doctor, paramedic, health administrator, or anyone who has call upon them in the conduct of their professional role. It is what can be expected of a nurse and midwife and is their duty to meet, what is owed another and is that person’s right to expect as a standard of performance. A feature of the duty of care in nursing and midwifery is that my responsibility is able to be stated in terms of expected performance standards and can be compared against specified performance criteria that results in an outcome measure of the duty that is owed.

While the patient may expect something of me, it is my responsibility in the form of my duty toward them that dictates what it is that I will and will not do in being responsible. My duty toward the patient as a measure of my responsibility is a matter of my business and, while it is what I owe, there is a limit to what can be expected of me. In this study several groups believed that love in nursing and midwifery requires a person to ‘go beyond the duty of care’ and therefore have a relationship with the patient that is more than that of a ‘with’ type. The responsibility that can be expected of me as a nurse and midwife in the performance of my professional duty of care is very different to the responsibility that arises from the deep connections between people that are
understood to be love.

Then, what is the form of responsibility that arises from the deep connections that exist between people? A general idea that was reported in several of the Neo-Socratic dialogues was that love requires a nurse or midwife to enter a realm not normally associated with the conduct of everyday life. Love, it was said, requires that you to ‘go beyond’ yourself. For example, group one concluded that love in nursing and midwifery involves an ability to ‘go outside of yourself’ in the act of professional caring, group two said it was a ‘subconscious calling’ and ‘deep connection’, group four, ‘beyond’ an everyday relationship, group five, a subconscious connection, and group six, understanding this deep connection in Buddhist terms, said it was responding to ‘a previous life connection’. What nurses and midwives were alluding to was a profound form of interhuman relationships and responsibility that can be explained by the application of Levinas’s philosophy of the ‘metaphysics of otherness’ or the ‘primordial’ state of interhuman relations.

According to nurses and midwives, love requires that you ‘go beyond’ or ‘go outside of yourself’, which in ontological terms, is an impossibility. The only way that a person can go outside of themselves without their being in another form is to be able to transcend being by being not another being but by being moral. It involves what Levinas refers to as the impersonal form of being, the impersonality of expression expressed in a realm that is different to that associate with everyday life and also different from the nothingness that is associated with death. The realm of impersonal expression where there is an existing without existence, is like Levinas’s (1985: 48) example of the dark of the night. In the darkness of the night there is nothing but the darkness, which is at the same time not nothing. The realm associated with this nothing that is not nothing, the realm different to being and not being, is the realm of the impersonal form of expression.
What nurses and midwives thought was the place that you go to when you ‘go outside of yourself’ is in fact a place that you’re personal being is not able to go. This place that is no place, like in the example above of the all encompassing presence of the nothingness of the dark of the night, is what your being is submerged in and is what Levinas calls ‘il y a’ (there is). It is from this realm called ‘there is’ (‘il y a’) that your personal being and consciousness emerges and where that which is unknowable to you gathers form and becomes your knowledge. Therefore, if love requires a nurse or midwife to ‘go beyond’ or outside of themselves, it is not an indication of a place to which they go but of an ability, the ability of their personal being to transcend its physical form to a metaphysical state, the state of being moral. It moves the nurse and midwife patient relation from a being ‘with’, which is characteristic of the relations of separate living entities, to a being ‘for’, where there exists an ability of the nurse and midwife to rise above a concern only for their self, and place the patient as their first priority. In this way, being ‘for’ is to be moral and is the only way a person can bridge their isolation as a separate living entity.

The initiative to be moral though is not an initiative that is of our own making. While the personal act of taking responsibility ‘as if’ I was already responsible, is the act of creating the moral space, the initiative that I undergo to be responsible comes to me from outside of myself and is beyond what I can know. In this study, love in nursing and midwifery is said to be present when the nurse-patient occasion elicits in the nurse and midwife a feeling of being deeply responsible for the patient’s welfare. It is a responsibility that requires a nurse and midwife to go beyond concern only for their self-project and instead place the welfare of the patient before their own without any consideration of reciprocity, that is, ‘... the responsibility for the others, the relationship with the non-ego, precedes any relationship with the ego with itself’ (Levinas, 1981: 119). If this were not the case and nurses and midwives were in the first
instance a self-project and second responsible for their patients, they could say no to the responsibility that ‘Faced’ them because they would be first an ego concerned for their own welfare. Love as moral responsibility is not something that is able to be controlled by conscious thought. Nurses and midwives reported that they were not conscious of any decision to open themselves up to the plight of their patients. Reflection on the examples of love showed these nurses and midwives were already responsible for their patients before they knew what that responsibility was. As such, love requires a nurse and midwife to be ‘for’ their patient before they are for themselves and this is what makes these examples of love examples of moral responsibility.

Notably, in all of the Neo-Socratic dialogues nurses and midwives repeatedly spoke about how, in their example of love, they could not recall ‘thinking’ about their response or the way of their response to the patient. For example, in Group two, Lincoln repeatedly stated that ‘he could not, not go’ to the aid of a boy who had a mental health problem and was engaging in self-harming behaviour, such as the hitting of his head on the wall of a locked psychiatric ward room, even though Lincoln was warned that to do so would pose a danger to himself. The double negative contained in the phrase ‘I could not, not go’ highlights this as a choice that was no choice, in that Lincoln felt that he had to go to the boy despite himself. He lead the way without consideration of himself and this was precisely what made this ‘I could not, not go’ an example of moral responsibility.

In Levinas’s philosophy, moral choices arise from conscious thought but moral responsibility is different because it is what a person has no say about at all. Therefore, this ‘I could not, not go’ phrase combined with the absence of any ‘thinking’ about the original ‘urge to do’ highlights this as an initiative that was presented to Lincoln for his consideration of ‘what to do’. The origin of the initiative ‘to do’, was not an initiative of Lincoln’s making or for that matter of the
other nurses and midwives who offered examples of love because the initiative ‘to do’ came from the direction of the patient, or more precisely, from the realm of impersonal being (there is) to them.

In this study, it was concluded that love is what ‘. . . makes possible the identification of the unique value of the person of the patient, which gives rise to the commitment needed by the nurse and midwife to do whatever is required for their good and is more than the simple performance of the professional duty of care because it requires the nurse and midwife to ‘go beyond’ the professional duty and enter a ‘special relationship’ that is evidenced in the commitment and the compassion shown.’ For example, in group four, nurses and midwives held the view that ‘love is a willingness to connect, be open, sensitive . . . ‘. However, this again was not something that any of the nurses and midwives could actually recall ‘thinking about’ or ‘doing’ in their example of love. What they had articulated in the dialogue was exactly what they did not do because the form of love they were speaking about was not an initiative of their making.

Instead, the form of love they had identified was what these nurses and midwives were ‘Called’ on to do as their moral responsibility in being ‘for’ their patients and what they later came to understand that responsibility to be. The second answer of group four, to the question of what is love in nursing and midwifery, shows the beginning of some insight into the idea of love being moral responsibility when they say, ‘the nurse was prepared to form and enter a ‘special’ relationship that was characterized by her feeling deeply responsible for the woman’. The feeling of deep responsibility is what follows the ‘Call’ to be responsible and is an interpretation of that responsibility they identified as ‘deep within’. The suggestion here is that this ‘deep within’ is not a place, but as spoken about earlier, an ability. It is the ability of our being to transcend itself, rise above a concern for itself and place the welfare of an other first, in this case the patient, and as such, it could be characterized as ‘a special relationship’ that
is the state of our being morally responsible. This form of love that is moral responsibility is ‘a special relationship’ and is what makes possible the identification of the unique value of the patient, or more specifically, the unique value of the person of the patient. While it is a separate matter to what is to be done in the performance of the professional duty of care, love as moral responsibility was understood to be ‘a special relationship’, and what makes possible the initiative to be responsible in a professional way.

Another characteristic of all the examples of love that were offered was the ability of the nurse and midwife to place the welfare of the patient as a first priority. While this was explained in different ways, it was a theme that was consistently expressed. For example, nurses and midwives were of the view that love requires; ‘selflessness’, ‘being content in your vulnerability’, ‘... not concerned with the consequences of her actions upon herself’, ‘... being there for the woman and being with the woman doing what needs to be done to help her birth in a way she wants’, ‘going the extra mile putting the women before her self’, and ‘a sense of responsibility for the boy as a big sister’.

So how is it possible for a nurse and midwife to place the welfare of a patient before their own self-project? In Levinas’s philosophy, the initiative of these nurses and midwives to be morally responsible for their patients comes from the ability of their being to arise above self interest and be ‘for’ the ‘Other’, which is the signifying of their ‘Goodness’.
‘This antecedence of responsibility to freedom would signify the Goodness of the Good: the necessity that the Good choose me first before I can be in a position to choose, that is, welcome its choice. That is my pre-originary susceptiveness. It is a passivity prior to all receptivity, it is transcendent. It is an antecedence prior to all representable antecedence: immemorial. The Good is before being. There is diachrony: an unbridgeable difference between the Good and me, without simultaneity, odd terms. But also a non-indifference in this difference. The Good assigns the subject, according to a susception that cannot be assumed, to approach the other, the neighbour. This is an assignation to a non-erotic proximity, to a desire of the non-desirable, to a desire of the stranger in the neighbour’. (Levinas, 1981: 122)

The visceral signifying of the ‘Goodness’ of the ‘Good’ is in the ‘desiring of desiring’; what Levinas refers to as ‘non-erotic proximity’. As a body of ‘Goodness’ ‘non-erotic proximity’ has nothing to do with distance, but rather refers to a restlessness or a state of permanent attention like a ready-at-hand alertness that does not arise from any initiative of mine. The desire of ‘non-erotic proximity’ is metaphysical and therefore is not a response to any need that I may have. This being the case, the responsibility inherent in this state of permanent attention is endless because it is not aimed at satisfying a need, there is no end in its sight. Hence, the more I take up my responsibility the more I become responsible. My responsibility circles on itself without end so I can never be sure that I have been responsible enough. Accordingly, my ‘proximity’ to the ‘Other’ is founded on the ‘Good’ and is the birthplace of moral responsibility. It explains why all the examples of love portrayed encounters with patients that sort their betterment. The ‘Good’ of impersonal being (‘there is’) is the foundation of moral responsibility and is before good and evil are presented to me as a choice. It is from a foundation of ‘Goodness’ that nurses and midwives enacted examples of love that were examples of moral
Contrary to the thinking of nurses and midwives, moral responsibility and hence metaphysical ‘Goodness’, does not require a personal and professional sacrifice as some nurses and midwives thought. Love it was said requires the ability to go beyond a concern for the self which may require both a personal and professional sacrifice. However, a feature of all the examples of love that were offered was that the nurses and midwives who offered their example of love saw the example the same way as the rest of their group who were trying to understand the example to the point of making it their own. While the particular group may have thought there was evidence of a personal and professional sacrifice on the part of the nurse or midwife, the originators of the examples thought there was no such sacrifice.

A sacrifice is the surrendering of something that is of worth to one’s self-project for the sake of the other who is held to be more important. When applied to the idea of love, the surrendering contained in the concept of sacrifice is not a ‘giving up’ of something as in a loss but rather a ‘giving over’ as in an offering. To consider something as a loss is to consider its effect on oneself, which is the situation of an onlooker. However, in a case of love in nursing and midwifery I am not a concern, do not come first and therefore there is no loss and no sacrifice. For example, it could be likened to that of the anticipation exemplified in group six where Mana, on encountering the boy with leukaemia, thought of him as being his ‘big sister’ and he being ‘almost her child’, a relationship that in the Buddhist belief system was characterised by a ‘previous life connection’.

Because a discussion on Buddhism is outside the scope of this analysis, the ideas communicated by Mana will instead be interpreted using Levinas’s philosophy. Being a ‘big sister’, ‘almost her child’, and having a ‘previous life connection’, as was explained by Mana, involved not so much what she could do to benefit the boy’s health in terms of medical therapies for the treatment of
Leukaemia but being ‘for’ the boy by being the substance of his support, which was to be a psychological support to him but moreover by being morally responsible. The metaphor of Mana being the boy’s ‘big sister’ expresses the idea that she was responsible for the boy in a way that had him come before herself. She anticipated his needs before she or he knew what his needs were. What the example of Mana shows is that nurses and midwives can experience a responsibility that is founded on ‘Goodness’. A responsibility that has them first for their patient’s before they are for themselves, because this responsibility requires them to offer their substance for the support of the patient, like in a case of maternity. If sacrifice is a consideration it is at best only an after thought.

Levinas (Levinas, 1981: xiii)} says, ‘the figure of maternity is an authentic figure of my responsibility’. In maternity one does not choose one’s responsibility to an other. It is a form of responsibility that chooses me by the very nature of my being and that being is a body of ‘Goodness’. The command to act for the ‘Good’ of the ‘Other’ is a pre-existing command, a command that requires me to give something of my very being to the support of the ‘Other’. Like in a case of maternity, the example of Mana, as described above, showed that her responsibility in being ‘for’ the boy involved a giving of her own substance for the betterment of the boy without any holding back and before it was asked. To onlookers, this giving of their own substance could be interpreted as a ‘giving up’, a sacrifice, because like maternity, she bore all the responsibility for the bearing of the being of the boy even if it was at her own peril. However, sacrifice here is not viewed as a ‘giving up’ but a ‘giving over’, a passive opening of oneself to being affected, an exposedness to the ‘Other’ that is so complete that in the example of Mana above, she bore all the demands of the being of the boy and also the consequences of the bearing of this being.
So what is love as a ‘sense’ of the patient? In this study it was concluded that ‘love in nursing and midwifery arises from the moral character of the nurse and midwife in response to the witness of the destitute state and suffering of a patient’. What is witnessed though is more than that seen by the eyes of a nurse or midwife or is able to be experienced because it is what is sensed prior to seeing or experiencing anything at all. Nurses and midwives encountered not only a patient as a physical entity or for that matter the mask that may be worn as a persona or the role played by the patient in a particular situation, or as a description of them like that which takes place in a conversation, they were exposed to the patient’s ‘Face’, which in ‘Otherwise than Being’, is a ‘significance’.

In the ‘Face-to-Face’ relation ‘significance’ is what is expressed. In the example of Lincoln and the boy, this ‘significance’, which was the expression of the ‘Otherness’ of the boy’s personal being, is a ‘pure act’ and not a type of a message. It is like the sensing that occurs in the metaphor of something being on the tip of your tongue which is not a something at all because it is an act that is the act of sensing. That which is on the tip of your tongue cannot be formulated into anything able to be explained because it remains elusive and beyond your immediate grasp. It is one step removed from you and is not what you are able to think about because there is no content that is able to be applied to the sensing. For his part, Levinas uses the term ‘savouring’ to describe this ‘pure act’ in that the sensing is more like the ‘savouring’ that takes place prior to any determination of it. Lincoln, without knowing it, encountered the boy’s ‘Otherness’ by way of the sensuous expressing of it and it had ‘significance’.
The expression of the ‘Face’ as a ‘significance’ was an initiative that each nurse and midwife in this study underwent and was not something they either instigated or could initiate. Instead, it came to them as a revelation, for the ‘signifyingness’ of the ‘Face’ of the ‘Other’ is not something that is able to be thought because it is a ‘signification without context’. Being ‘pure experience’ this expressive event (‘signifyingness’) that is a presence takes place in the realm of impersonal being (there is). It is a presence that cannot be experienced because it is beyond comprehension.

Moreover, the ‘Face’ of the ‘Other’ was presented to each nurse and midwife as an appeal. It was an appeal of ‘authority’ in that they were obedient and passive to being affected by its approach. The nurses and midwives were open to the ‘Face’s’ expression expressing a ‘significance’ signified as ‘thou shall not kill’ or ‘right to be’, or put another way, the impossibility of committing murder on the ‘Other’. As Levinas (1979) proclaims, this ‘significance’ is a revelation because it reveals the original relationship as one of peace (Good), that aroused in these nurses and midwives their ‘Goodness’. Using Levinas’s terms, the ‘Good’ or ‘God’ or ‘Other’ chose each nurse and midwife on the patient’s behalf and held them ‘hostage’. Like being a ‘hostage’, each nurse and midwife was inescapably assigned the one responsible for their patient. They were each held accountable ‘as if’ they were the one and only one responsible. It is a responsibility that was assigned them before their freedom as a subjective being and its obsession with its self-project. For his part, Levinas refers to this accountability as an ‘unavoidable assignation’. It was an unavoidable responsibility that had each nurse and midwife responsible for their patient as though they were the only one, the irreplaceable responsible one. This is how these nurses and midwives came to be responsible for the being of the patient before being responsible for their own self-project, the unavoidable responsibility assigned each of the nurses, and explains ‘why them’ and not another nurse or midwife.
The unavoidable responsibility of being moral is what enabled each of the nurses and midwives in this study to place the patient as their first priority. Translated to the delivery of nursing and midwifery care, this meant that what others witnessed of these nurses and midwives in the course of caring were various expressions of selflessness. Not surprisingly, in this study nurses and midwives concluded, ‘a characteristic of love in nursing and midwifery is its selflessness. It is where a nurse and midwife use all their professional skills and judgment in responding in a selfless way to the needs of the patient. A selfless response that may not be without its risk to both their own personal and professional welfare and also that of the patient’s but a risk that is understood by the nurse and midwife to be acceptable if the motive for the action is for the ‘good’ of the patient.’ The view postulated is that the selflessness of moral responsibility relates not to a self that can be known but to the before of the self, which by virtue of our being human, must be in the transcendence of being. This means that what each nurse and midwife first sensed as an expressed ‘significance’ of the patient was ‘goodness’. It was a ‘goodness’ that signified their responsibility which was to respond without any consideration of their own selves. This being the case, while onlookers identified these nurses and midwives enacting behaviour characteristic of selflessness, the nurses and midwives themselves did not see this the same way. For example, all of the nurses and midwives stated they did not believe they did anything special in terms of selfless acts. Contrary to the opinion of onlookers, they thought they were simply doing what they ‘had to do’ and in this they did not feature. The view of these nurses and midwives is consistent with the idea of them being morally responsible for their patients, where the patient was their first priority and therefore before any consideration of themselves. As they indicated, in moral responsibility the self does not come before the patient.
So what is the relation of the nurse and midwife to the patient? The example offered by Lincoln who was allocated the nursing care of a boy who had a mental health problem and was inflicting trauma upon himself shows that the relationship and communication between them was different to what is understood of these every day terms. What was communicated between Lincoln and the boy was not only language in the form of a spoken word or a summons that resulted from some form of interaction or something that Lincoln thought about the boy, or the situation that confronted him. Instead, communication was by way of the approach of the sensuous expression of the ‘Otherness’ of the boy’s personal being to Lincoln. Communication between Lincoln and the boy had it’s origin in what Levinas describes as the ‘relation without relation’. It identifies the fact that there is an encounter, in this case, between Lincoln and the boy, but it is not an encounter as an event that is situated in a time. The time of an encounter is when I understand what has arisen from the relation. At the level of our everyday being Lincoln encountered the boy and gained knowledge of him in terms of the characteristics that made him the unique and distinctive boy that he was, that was different to all other boys. However, the relationship of Lincoln and the boy was different to normal because it involved a time of an encounter where neither of them had knowledge of each other nor experience of each other in the way of an everyday relationship.

Levinas’s idea of the ‘relation without relation’ describes the encounter of the ‘Otherness’ of our personal being. For example, the encounter of Lincoln and the boy was not only an encounter with the boy as an other person it was also an encounter with his ‘Other’ in the sense of his Being that was different to the Being of Lincoln and is what is unknowable. In the ‘relation without relation’, communication is by the ‘Face-to-Face’ encounter. It involves a relation that neither Lincoln nor the boy was aware of, because it took place in the sphere of impersonal being (there is) and was not privy to conscious thought. The boy did
not ask for anything of Lincoln nor for that matter did any of the patients in the other examples of love that were offered by nurses and midwives. In fact, in the beginning of this example, the boy was unaware of Lincoln’s presence and did not have any knowledge of Lincoln at all. Nonetheless there was an approach made of Lincoln but it was outside of what Lincoln and the boy could have initiated or had knowledge because the encounter took place in the sphere of the ‘there is’ (‘il y a’) where, as explained above, personal being does not exist.

In the ‘relation without relation’, Lincoln was responsible for dealing the boy signifyingness (Levinas, 1981: 48). It involves the ‘Saying’, which is a form of communication that makes possible the phenomena associated with ‘alterity’ breaking into the sphere of the world of understanding. The ‘Saying’ is the extreme exposure expressed in the phrase ‘here I am’. Levinas often uses this phrase ‘here I am’ to exemplify the extreme passivity, openness and receptivity to being affected by the ‘Face’ or ‘significance’ of the ‘Otherness’ of an other’s being. Communication between Lincoln and the boy was not only communication of the type associated with the conduct of everyday life, it was also by way of the ‘Saying’, which is not about the utterance of a word, or a sign or anything that was of a wilful act or of Lincoln’s ego. Communication by way of the ‘Saying’ involved the extreme exposure of Lincoln, expressed in his passivity, openness and receptivity to being affected by the boy. As Levinas explains;

‘The saying signifies this passivity; in the saying this passivity signifies, becomes signifyingness, exposure in response to. . . , being at the question before any interrogation, any problem, without clothing, without a shell to protect oneself, stripped to the core. . . . ‘Saying is a denuding, of the unqualifiable one, the pure someone, unique and chosen; that is, it is an exposedness to the other where no slipping away is possible’. (Levinas, 1981 : 49-50)
Lincoln’s encounter with the boy was by way of the passivity of exposure in ‘Saying’ ‘here I am’; a sensitivity and exposed-ness to being affected that renders the approach of the ‘Other’ a ‘signifyingness’. The ‘Saying’ of Lincoln is this passivity and openness to being affected and not the activity involved in taking on the liability for the demands of the boy. In ‘Saying’, Lincoln was open to the approach of the boy and this is what made possible the signifying impression on him. It was his visceral response to the exposure of being and was the very start of language that is ‘Said’ as dialogue, interpretation and felt responsibility. In ‘Saying’, ‘here I am’, Lincoln was the one responding, a responsibility expressed in his being ‘for’ the boy’s demands. This visceral response of Lincoln to the boy was the beginning of language and did not need the boy to be aware of Lincoln because, in the ‘relation without relation’, Lincoln’s exposure to the boy, his exposed-ness, rendered the boy a ‘signifyingness’ and this was enough. What preceded the feeling, revealed in Lincoln’s statement ‘I could not, not go’ to the boy, was his ‘Saying’ ‘here I am’, which was to respond as the one chosen and was what he had no say about.

What Lincoln had a say about was a different matter to his ‘Saying, ‘here I am, in that, Lincoln’s encounter with the boy impacted on him in two ways. At the level of Lincoln’s personal being, he came to an understanding of the situation that confronted him as a nurse and what was his professional duty of care. He knew what his duty was and it was the same as other nurses. His response as an individual, though, was a different matter because it was not a shared response but one unique to him and was what he felt as his responsibility. However, what he felt as his responsibility was also different to the un-thematizable ‘Signifying’ impression of the ‘Face’ of the boy that was expressed to him in the ‘Saying’.
In Levinas’s philosophy, the ‘Saying and the ‘Said’ occur together (diachrony). The ‘Said’, though, can never be a true representation of the ‘Saying’ because the ‘Saying’ cannot be represented in language. The ‘Saying’ is a verb and is the ‘act’ of saying something, the ‘Said’, a noun, is ‘what’ is being said. The ‘Said’ is the giving of a sign to a communication and is, to repeat, dialogue, interpretation and felt responsibility. Therefore, the meaning given to the ‘Saying’ is different to anything communicated by the ‘Said’. What Lincoln ‘Said’ was his responsibility was what he felt his responsibility to be. It was at best his interpretation of his responsibility, which was not the ‘urge to’ be responsible, but rather, the content of his responsibility as to what he thought he was to do. Lincoln interpreted his responsibility as going to the boy and then sitting on the floor holding him in a ‘bear type hug’ so as to restrain the boy from injuring himself.

While it was the ‘Call’ of the ‘Other’ expressed by way of the ‘urge to do’ that commanded each of the nurses and midwives to be responsible, it was the nurses and midwives themselves who gave a voice to that command. The command of the ‘Other’ to not kill is not vulnerability or a command that can be commanded to be acted on because there is no means for its enforcement. Signifying ‘thou shall not kill’, or more precisely the signifying of the ‘Other’, is what I cannot kill because it does not belong to my world. The ‘Other’ is of the sphere of impersonal being (there is) and is therefore what I do not have access to and so cannot do it any harm. The ‘urge to do’ signifies my responsibility and that responsibility is in being ‘for’ the ‘Other’. The choosing of ‘what to do’ in being responsible is at best my interpretation of my moral responsibility.
In this study nurses and midwives spoke about how, in their examples of love they felt they had not done everything that they could have done for their patients. There was always a feeling that they could have done more in the interpretation of their moral responsibility. For example, Lincoln stated that he later was concerned about his action of sitting on the floor with the boy, restraining him in a ‘bear type hug’, when he found out that the boy had suffered from child abuse. The self reflection and questioning his actions around holding the boy in a ‘bear type hug’ were yet another response to an ‘urge to’ be responsible in a responsible way as a professional nurse, owing the boy a duty of care. It is an example of how the moral self is always haunted by the suspicion that it is not moral enough (Bauman, 1993). Lincoln’s example of love shows that a nurse is never sure that he has acted in the right manner or been moral enough. It explains how love in nursing and midwifery is not a ‘one off’ response to a need as is the case of caring. All the examples of love are elongated examples that show nurses and midwives repeatedly going back to the patient haunted by the suspicion that they had not done everything that they could have done for their patient’s betterment.

Being morally responsible means each nurse and midwife responded to the responsibility they felt in a professional way, which was fraught with uncertainty. For example, onlookers questioned the wisdom of Lee’s actions of taking the nursing home residents on a beach holiday that required the driving of a minibus with a trailer, and also a resident that was difficult to manage, when she had no experience of this type of enterprise. A question that followed this group dialogue was, ‘Is it acceptable for a health professional to knowingly place the good of another at risk?’ The obvious answer is no, but it is not this simple. While the professional duty of care is able to be quantified in terms of expected and measurable performance outcome standards, when meshed with moral responsibility Lee found she had to make an interpretation of both. At best, Lee’s interpretation of the ‘Saying’ of moral responsibility is exactly that. It is an
interpretation that can always be improved on because it is based on the desiring of the ‘Good’, but as a professional nurse her interpretation of the ‘Saying’ was carried out within the boundaries of the professional duty of care. The problem for Lee and other nurses and midwives is that they could never be sure that the interpretation of their moral responsibility (‘Saying’) and professional duty of care was accurate enough or would be seen by others in the same way. In group five, Pricilla responded to the elderly woman who was in need of medication and had no money. She came to an arrangement with the pharmacist to provide the woman with the medications that she required that, while legal, was outside the normal mechanisms for providing medications. Next day, Pricilla’s superior reprimanded her for this action because the supervisor did not feel morally responsible for the woman and was only responding to the encounter from the perspective of professional accountability which she interpreted differently to Pricilla. The mix of professional accountability and moral responsibility results in an interpretation that is different to those who only act out of a professional concern.

What exactly, then, is the ‘urge to do’ that nurses and midwives responded to as the responsibility they each felt? As explained above, the ‘Call’ of the ‘Other’ was expressed as a ‘significance’ and is a communicative event that exceeds my ability to contain it. If this were not the case, the ‘Other’ would be an object of my knowledge and experience and simply be more of the ‘Same’, that is, more of the world as I understand it. It would be of my knowledge and experience and therefore what I could have a say about, and that say could be no. However, the approach of the ‘Face’ is what I cannot say no to because it has no content that I am familiar with and therefore no way of being thematized.
‘The manifestation of the kath’auto in which a being concerns us without slipping away and without betraying itself does not consist in its being disclosed, its being exposed to the gaze that would take it as a theme for interpretation, and would command an absolute position dominating the object. Manifestation kath’auto consists in a being telling itself to us independently of every position we would have taken in its regard, expressing itself. Here, contrary to all the conditions for the visibility of objects, a being is not placed in the light of another but presents itself in the manifestation that should only announce it; it is present as directing this very manifestation-present before the manifestation, which only manifests it. *The absolute experience is not disclosure but revelation.* .. ‘ (Levinas, 1979: 65)

The ‘Call’ of the ‘Other’ is an expressive event, ‘pure experience’ that presences itself as a ‘signifyingness’, a ‘significance without context’. This ‘signifyingness’ arrives to me as a ‘revelation’ because it exceeds my ability to contain it. It is as though it immerses the temporal of my personal being and stops me in my track of thought. As an expressive event the ‘Call of the ‘Other’ is the only way the sphere of exteriority associated with the ‘Otherness’ of personal being is able to break into the sphere of phenomena and is the ‘urge to do’. Because the ‘urge to do’ is a ‘revelation’ it interrupts the obsession I have for my self-project. In this study all the nurses and midwives experienced an ‘urge to do’ that was demonstrated in the asymmetrical relation of their patient. A feature of all the examples of love that were offered was that the patient was a first priority, a relation where reciprocity was not a consideration.
As reported in the previous chapter, being ‘for’ the ‘Other’ means that each nurse and midwife was ‘for’ the ‘Other’ whether or not the ‘Other’ was ‘for’ them. The impetus to be ‘for’ the ‘Other’, their patients, clearly laid with each nurse and midwife, for while your (nurse or midwife) patient may change, nobody can take the patient from you (nurse or midwife) because it is not your (nurse or midwife) patient who holds you (nurse or midwife) fast. It is your responsibility that holds your (nurse or midwife) patient fast. In a relation of being ‘for’ the ‘Other’ the notion of reciprocity does not exist because the nurse’s and midwife’s being ‘for’ the patient was not predicated on the patient’s being for them. They did not feature in the ‘urge to do’. Thus, moral responsibility presents itself to each nurse and midwife in the form of the ‘urge to do’. It immersed their temporal being and stopped them in their track of thought, demanding a response which did not include any consideration of reciprocity.

In practical terms, because the responsibility of being ‘for’ originates in the realm of the ‘there is’ and is from where our personal being arises, the self is of no concern. The ‘Face-to-Face’ relation involves our impersonal form of being where ‘I’ do not feature, am not a consideration, which as an aside, is different to not being concerned about myself or ‘giving up’ something of myself as a decision ‘I’ make. To continue with the example of Lincoln and the boy with a mental health problem, while Lincoln was warned by other nurses not to go into the room with the boy because of the danger this posed to his welfare, he still did. Lincoln ignored the danger, not because he was brave, hardy or foolish, or had an attraction to violence or some type of altruistic motive, but because his being responsible ‘for’ the boy was affected in the ‘there is’ of impersonal being where his self-project did not figure. If Lincoln was able to think about himself and his responsibility, which he was not, his response may well have been very different. The moral self comes into being through our ability to rise above a concern only for ourself. It moves the focus of attention from the self to the other in a relational bond that, as previously explained, has me ‘for’ an ‘Other’
so creating the moral state of the self, or more specifically moral responsibility. Thus, in the conduct of nursing and midwifery, an act of love will be a product of the interpretation of what the nurse or midwife understands that responsibility to be (‘Said’), which to onlookers it may appear to include an act of selflessness. However, none of the nurses and midwives thought their response to the patient involved an act of selflessness. To the contrary, because, as they said, their focus was on the patient and not on themselves.

Being moral means each nurse and midwife had to give a voice to the command of the ‘Other’, but this is at the very point the ‘Face’ of the ‘Other’ disappears and each nurse’s and midwife’s personal interpretation takes over. As explained above, the ‘urge to do’, to be responsible, is different to what ‘I’ understand as an interpretation of my responsibility. Therefore, the command to be responsible that is expressed in the ‘urge to do’ can result in a number of different responses. Each nurse and midwife could have responded by doing nothing which is a refusal similar to an apology. As in an apology, there is a consideration of the request that is subsequently denied. So to do nothing is to do something. It is to do nothing, and is in itself a response to the ‘urge to do’. In this study, what makes the examples offered examples of love as responsibility is that each nurse and midwife gave a voice to the moral ‘urge to do’, not by saying no or for that matter an apology but by way of enacting their responsibility by inquiring into the condition of the patient and so responding in a responsible way as a professional nurse or midwife.

Applied to a practical example, the ‘urge to do’ was an initiative that Lee in group one underwent with a number of the elderly residents she was nursing. Lee was affected by the expression of the ‘Otherness of the residents personal being, impacted by the institutional living arrangements of the nursing home. She said, ‘something inside her demanded she act’. It shows that the relation of love as responsibility of being ‘for’ the ‘Other’ is not only a relation of one ‘Other’
but is a relation that can be had with all ‘Others’ whether physically present or not. In this case, it was a relation that was had with a number of nursing home residents around a common theme, the frailty of old age that resulted in institutionalised care, with the denial of many of the normalised features of independent community living, such as a change of surrounds and individualised routes, like in this example, a holiday. Lee responded to the ‘Saying’ and the ‘urge to do’, which Levinas describes as Lee being a ‘hostage’ to the ‘Other’. It is the putting of oneself in the others place, so moving the relation from a ‘with’ nature, where one is side by side and never able to inhabit the same space, to a being ‘for’ the ‘Other’, where the ‘Other’ becomes a first priority. Lee, by way of the ‘urge to do’, gave an interpretive voice to the ‘Saying’ of the nursing home residents as was captured in the ‘Said’ activity of going on a seaside holiday.

When applied to the other groups, the ‘urge to do’ shows that in group two, Lincoln responded to the destitute state of the boy with a mental health problem who was engaging in self harming behaviour by going to his assistance, which meant going into the room with the boy and sitting on the floor holding him in a ‘bear type hug’ to restrain him from self-harming behaviour. While the decision and action to restrain the boy in this way may be questionable, Lincoln responded to the urge to be responsible, which was his interpretation as a professional nurse.

In group three, April responded to the mother’s call to be responsible by being her advocate in birthing. April’s interpretation of this responsibility as the woman’s birthing advocate required that she use her professional judgement in determining what equated with a safe birth of the baby. Again, April’s response was her moral and professional response to be responsible for the birthing, which does not protect it from debate because at best it was only her interpretation of the ‘Call’ of the ‘Other’ (‘Said’) and she cannot ever be sure that
her response is an accurate interpretation of that ‘Call’.

In group four, Cristal responded to the ‘Call’ of the women who had taken an overdose of Diazepam and labelled by other nurses in the Accident and Emergency Department as a ‘looser’, which simply served to harden her resolve to help this woman. Cristal’s interpretation of her responsibility as an act of love was in her responding in a professional way with sensitivity and what appeared to be compassion for the woman’s plight.

In group five, Pricilla responded to the elderly woman who was in need of medication and had no money. On encountering the woman Pricilla responded to the ‘Call’ to be responsible by not abandoning her but ensuring she received the medications she required and more. Pricilla’s example is important because it shows how the interpretation to respond to the ‘Call’ of the ‘Other’, and the professional judgements that accompany the response, continue as long as is needed to respond to the repeating ‘Call’. In this example, Pricilla made several attempts to improve the plight of the woman in order to overcome any potential threat to her wellbeing.

In group six, Mana’s example is linked to Buddhism where on encountering the boy she was straight away responsible for him, a responsibility that was of the quality of a family relation, and in fact, a previous life connection. Without delving into the theology of Buddhism, from Mana’s description she had some form of metaphysical relation with the boy that had her engage in activities that were common to nurses and midwives in the other groups. Mana responded by being responsible ‘for’ the boy personally and professionally as best she could interpret it.
Responding though, for these nurses and midwives, was at best an interpretation of the responsibility of the ‘Saying’, which Bauman (1993: 80) says, ‘. . . all adds up to the fact that a person can never be entirely sure that he has acted in a right manner’. At one level the witness of the destitute state and suffering of a patient can be interpreted as the ‘Call’ of the ‘Other’ to be responsible that is revealed in the ‘Saying’. At the level of personal being, each nurse’s and midwife’s interpretation of the responsibility of the ‘Saying’ is what they ‘Said’ it was.

Given a person can never be sure that the responsibility they feel (‘Said’) is an accurate interpretation of the ‘Saying’, a rhetoric of disruption and supplication can be help. For example, it was through the planning and execution of the seaside holiday that Lee communicated with the residents, as well as possible given the level of resident debility, a dialogue that over time was aimed at revealing a more accurate interpretation of the ‘Saying’ of each resident. In other words, without knowing it, she employed a dialogue strategy that Murray (2003) identifies as a ‘rhetoric of disruption and supplication’ as a mechanism for ensuring the holiday was ‘their’ holiday and not Lee’s interpretation of what that should be. While the seaside holiday was an idea of Lee’s, the planning and the implementation of the holiday, and its significance for each resident was in the hands of the residents themselves. For Lee, her focus was on the implementation of, in the first place, a ‘rhetoric of disruption’ that aimed at working against communicated ideological assumptions and stereotypes that would mask the ‘saying’. Lee used ongoing dialogue to unsettle assumptions, beliefs and values that were representations of cultural stereotypes and prejudices held by individual nurses and family and supported by the western system of health, as for example, including a resident’s partner and dog on the holiday and them sleeping together in one bed, which they had not done for a very long time.
Next, ‘rhetoric of supplication’ was continually applied to the planning and implementation phases of the holiday as Lee sought to understand what the residents wanted from it. As she said, for example, we ‘sat up late in the evenings and sat around the kitchen table drinking coffee and eating biscuits with a couple of the residents, just talking about everything and planning the next day’. Lee’s example shows a dialogical form of communication that sort to refocus her interpretation of the ‘Others’ ‘Saying’ because she could never be quite sure that her response to the ‘Call’ of the ‘Other’ was accurate enough.

Nursing and midwifery is not a solitary practice and typically the patient situations reported in this study also involved other nurses and midwives providing care. It leads to the question as to why nurses and midwives respond in different ways to the same patient, or more specifically, as to how one nurse or midwife can have a relation with a patient that is characterised by love and another not. For example, in Group four, Cristal reported on a relation of love with a woman who was admitted to the Accident and Emergency Department with an overdose of Diazepam. In the example Cristal was but one of many nurses who were attending to this woman’s need for care yet she was the only nurse, from the information offered, who had a relation of love with the woman.

As Cristal pointed out, other nurses had a negative view of the woman. They saw her as an ‘annoying lady, [ just comes in and wants attention’. Cristal’s interpretation of this situation was that ‘people had given up on her and she had given up on herself’, ‘but I established a connectedness with her’. From the start and without any more information than that offered by Cristal, the other nurses in the Accident and Emergency Department appeared to have objectified the woman and therefore responded to her as a patient and not a person, and what is more, a troublesome patient at that, since the objective relationships other nurses had with this woman were governed by the rules, norms, stereotypes, prejudices and accepted practices associated with working in this Department.
As Cristal said, it seemed as though the medical and nursing staff had given up on her. She was in and out all the time. There was no one helping her get off the medical merry-go-round. Instead, the staff found her annoying and just wanted to get rid of her. Cristal responded differently however. She acknowledged the woman’s subjectivity and responded to her as the person of the patient. As she said, ‘my response was very quick, I wanted to see what I could do . . . to make a difference to this woman’.

The stark contrast of Cristal’s relationship with the woman compared to that of other nurses makes clear that while the expression of the ‘Other’s’ personal being is an initiative that I undergo (‘Saying’) and is unavoidable, the ‘Said’ as an interpretation of the ‘Saying’ and is at best an interpretation which can also be a distortion or even a failure to respond to the ‘Saying’ at all. Thus, the personal act of taking responsibility ‘as if’ I was already responsible is the act of creating the moral space but is also the point at which ‘I’ enter the scene and choose either to ignore the ‘urge to do’, or respond to it with some form of interpretation. The example of Cristal reinforces the point made above, that while the ‘Other’ commands my ‘Other’ by way of the ‘Saying’ it is not a command that can be commanded because it is each nurse and midwife who must give a voice to that command by acting on the ‘urge to do’. Notably, the divergence between Cristal’s response to the ‘Saying’ of the woman and the other nurses reveals the spectrum of possible responses to the ‘urge to do’. Should Cristal’s group have had access to the views of other nurses working in the Accident and Emergency Department there is no doubt that there would have been an even greater range of interpretative, distorted or ignored responses to the urge to be morally responsible for the woman.
In the above example, Cristal demonstrated a commitment to the welfare of the woman but it was a commitment that she believed she had no say about. As Cristal said, ‘I didn’t really think about it’, ‘it just happened’, and later ‘I wanted to see what I could do; I did not want to abandon her like this nurse had; I saw it as a challenge, to make a difference to this woman’. Similarly, all the examples of love showed evidence of the nurses and midwives being committed to a course of action in being morally responsible for their patients, even if it meant their actions could, and in some cases did, result in negative outcomes for themselves. Yet Cristal’s comments suggest she was committed at two levels of her being responsible. First, Cristal’s statements about ‘I didn’t really think about it’ and ‘it just happened’, is evidence that she found herself already committed to the woman. Here, commitment issued from the ‘Saying’, as the signifying impression on Cristal was as the one designated morally responsible for the woman more responsible than anyone else. Second, Cristal was also committed in a self-conscious way in living out her character as a professional nurse. What Cristal ‘Said’ was her responsibility was what she felt her responsibility to be as a professional nurse and the content of this responsibility was what she was committed to implement. Furthermore, the knowledge of the nurse abandoning the woman to whom she was committed resulted in an increase in Cristal’s commitment. In this way commitment also issues from the object or the person to who one is responsible and is what one is able to think about in an objective way.

11.1.3 The general answer to the question of ‘what is love in nursing and midwifery’
This study presents a case that love in nursing and midwifery is another name for moral responsibility. Applying the philosophy of Emmanuel Levinas’s metaphysics of ‘Otherness’ to the tacit knowledge of nurses and midwives clinical practice examples of love show it to be moral responsibility. It is the ability or more precisely, the possibility of the transcendence of personal being
in its everyday form that enables a nurse and midwife to be ‘for’ the patient before they are for themselves. It explains nurse and midwife patient relations that onlookers identify as expressions of love that are different to caring. Given that the philosophy of the metaphysics of ‘Otherness’ applies to the general condition of human being, love as moral responsibility is not unique ‘to’ nursing and midwifery but is made unique ‘in’ nursing and midwifery through the fulfillment of the professional roles of nurse and midwife. Specifically, the relational context has a nurse and midwife constantly exposed to patient situations that give rise to expressions of love as moral responsibility. While the reason a nurse and midwife is ‘Good’ in their responsibility is no different to any other person, the relational context in which the nurse and midwife-patient relation takes place is unique and different to the relations of other health professionals and the general population.

The various nursing scholars cited in the discursive analysis of the extant literature on caring, in different ways, locate caring as a central initiative of what it is to be a human being. But love as moral responsibility is not like this because it centres on the ability of our being to transcend its physical form to a metaphysical state, the state of being moral. Therefore to speak of love as moral responsibility is to speak about the ability of our being to ‘go beyond’ or outside of itself’, which is not about a place that you go but of an ability. It moves the nurse and midwife-patient relation from a being ‘with’, which is characteristic of the relations of separate living entities, such as in the case of a caring relation, to a being ‘for’, where there exists an ability of the nurse and midwife to rise above a concern only for their self, and place the patient as a first priority. Thus caring is ontological and love is metaphysical.
While every nurse and midwife is capable of an expression of love as moral responsibility, the response of every nurse and midwifery is different to the point that some responses are not identified as love at all. In a nurse and midwife patient relation the initiative of love as moral responsibility issues from the sphere of impersonal being (II y a) and is what a nurse and midwife has no say about because, in the transcendence of being, they do not feature. In this sphere of impersonal being (ii y a), a relationship with the non-ego comes before any relation of the ego of the nurse and the midwife and is what enables them to rise above their self-project as a first priority.

A central concept in Levinas’s philosophy is our incarnation as responsible. It is a moral responsibility that is founded on the ‘Good’ and from which our personal being arises. It is a ‘Good’ or ‘Goodness’ that is before choice in that the ‘Good’ chose me before I was in a position to choose. This ‘Good’ that is inside every person and therefore in every nurse and midwife, without them having knowledge of it, is what has them desire to be the support of the patient’s being. Thus, the ‘Good’ has a nurse and midwife susceptible to being effected by the patient’s condition of being and is expressed in the passivity and supporting of a nurse and midwife in being ‘for’ the patient. The signifying of this ‘Goodness’ is the desiring of desiring. It is what each and every nurse and midwife yearns for without knowing it, assigning them to approach the patient in that they are open and exposed to being affected by the condition of the ‘Otherness’ to the patient’s personal being. It is a metaphysical state of permanent attention that does not arise out of any need the nurse and midwife may have and therefore has no need that is to be satisfied. This being the case, the responsibility inherent in this state of permanent attention is endless because the nurse and midwife can never be sure they have been responsible enough. It explains how, in an example of love that a nurse and midwife feels, there is always more that they could have done in being morally responsible for the patient. For these reasons love as moral responsibility is analogous to maternity. Like maternity, a
nurse and midwife does not choose their responsibility to the patient. It has chosen them by the very nature of their being, and the foundation of that being is a body of ‘Goodness’.

In a relation of love between the nurse and midwife and the patient there is no conscious decision made to open themselves up to the plight of the patient because the initiative to be morally responsible comes not from the nurse or midwife. It comes from the direction of the patient or more specifically, from the sphere of impersonal being (ii y a) to them. The time of this encounter is when a nurse and midwife understands what has arisen from the relation. At the level of our everyday being a nurse and midwife will engage a patient and gain knowledge of them but equally it will also involve a time of an encounter where neither the nurse and midwife nor patient will have knowledge of each other, nor have experience of each other in the way of an everyday relationship. Thus, in an expression of love, the nurse and midwife will be morally responsible for the patient before they know it and before they understand what that responsibility requires of them. Moreover, they will not be able to recall any contemplation of the initiative to act because the initiative does not issue from their personal being but instead comes to them. All that a nurse and midwife will know is that the responsibility they have for the patient leaves them feeling they have not done enough.

What is love as a sense of the patient is more than that seen by the eyes, or that able to be experienced, because it is what a nurse and midwife senses prior to seeing or experiencing anything at all. As I repeat from the previous chapter, a nurse and midwife encounters not only a patient as a physical entity or for that matter the mask that may be worn as a persona or the role played by the patient in a particular situation, or as a description of them like that which takes place in a conversation, they are exposed to the patient’s being ‘Other’, which is a ‘significance’. In a nurse and midwife-patient relation of love,
communication is a pure act that involves the sensuous expression of the patient’s ‘Otherness’ to their personal being, signifying a ‘significance’. This ‘signification’ that is without a context comes to the nurse and midwife as an authoritative appeal. As such, it is what they are obedient to by way of a response which is to be open and exposed to being affected by an approach. What is signified in the approach is a ‘significance’ and it is a revelation because it reveals the original relationship between the nurse and midwife and the patient as one of peace (Good), as ‘thou shall not kill’ that arouses their ‘Goodness’.

In the moral party of two, this ‘Good’ or ‘God’ or ‘Other’, to again use Levinas’s terms, assigns the nurse and midwife to be the one responsible, like a hostage, inescapably responsible and more responsible than any other nurse and midwife could ever be for the patient. It is an unavoidable assignation of responsibility that is before their self-project is able to be realized. However, should the question be asked as to why it is that this nurse or midwife is the one chosen as a hostage of responsibility and not that one, is to miss the point of love as moral responsibility. In the moral party of two, the relation of a nurse and midwife to the patient is no different to the relation of another nurse and midwife to this same patient but that is their business and not mine. Love is a moral party of two.

In the sphere of impersonal being (Il y a), communication between the nurse and midwife and the patient is in the form of sensuous expression. It is where the nurse’s and midwife’s being ‘Other’ is made the support of the patient and is expressed as an extreme openness and receptivity to be affected by the ‘Otherness’ of the patient’s personal being. In everyday language it is to say ‘here I am’, which is a phrase Levinas often uses to make clear this extreme exposure to being affected. It is a sensitivity and exposed-ness to being affected that deals the ‘Otherness’ of the personal being of the patient a
‘signifyingness’. Importantly, in nursing and midwifery, this ability to be affected is what enables a signifying impression of the state of the patient’s being ‘Other’ that gives rise to a visceral response and so the start of language as dialogue, interpretation and felt responsibility, expressed as the ‘urge to do’. Levinas’s philosophy explains how emotion is the basis of action and before reason.

Notably, in the nurse and midwife-patient relation love as moral responsibility is presented to my personal being in the form of the ‘urge to do’. The ‘signifyingness’ of my responsibility is a ‘revelation’ for it exceeds my ability to contain it. As defibrillation is to the heart, the ‘urge to do’ is to the temporal of the brain. Hence, the ‘urge to do’ overwhelms the temporal of a nurse’s and midwife’s personal being and stops them in their track of thought. As an expressive event, it is how the ‘Otherness’ to a patient’s personal being, that is located in the sphere of impersonal being (Il y a), becomes phenomena as the ‘urge to do’, and like defibrillation of the heart, interrupts the obsession a nurse and midwife has with their self-project thus enabling the patient to be a first priority.

The ‘urge to do’ commands each and every nurse and midwife to be morally responsible but it is each nurse and midwife that then must give a voice to that command in deciding ‘what to do’. While the ‘urge to do’ is a command that cannot be ignored, it is a command that has no means of enforcement. Thus, the ‘urge to do’ signifies the responsibility of a nurse and midwife in being ‘for’ the ‘Otherness’ of the patient’s personal being, but the choosing of ‘what to do’ is an act of interpretation and representation of their love as moral responsibility. This being the case, choosing ‘what to do’ can result in a number of different responses. A nurse and midwife may respond by doing nothing, which is in itself to do something that is nothing, or it is to respond by inquiring into the condition of the patient in a responsible way as a professional nurse and midwife that is based on an interpretation and representation of their love.
Love as moral responsibility means a nurse and midwife has to live with the feeling that they have never quite got it right. However, the mix of professional accountability and moral responsibility results in an interpretation that is different to those who only act out of a professional concern.

As the ‘urge to do’ the self is not a consideration, a nurse and midwife will make an interpretation of their moral responsibility that would be different should they have been able to think about themselves. This explains why it is possible for a nurse and midwife to place their own welfare second to that of a patient. It explains for example, why a person is able to jump off a bridge in a raging river in order to save the life of a person when they cannot swim and it equally explains how it is possible for a nurse and midwife to give mouth-to-mouth resuscitation to a patient who could be HIV positive. Nevertheless, while the moral self comes into being by our ability to rise above a concern only for ourself, different nurses and midwives will make different interpretations and representations of that moral responsibility. Returning to the above examples it means that some people will jump off the bridge into the raging water as an expression of ‘what to do’ or will participate in mouth-to-mouth resuscitation of a patient who could be HIV positive, and others will call for help and the like and still others look to someone else to do something. Being committed to a greater or lesser extent to a course of action is a product of conscious thought in living out their personal character as a professional nurse and midwife. This commitment that also issues from the patient to who the nurse and midwife feels responsible and is what they think about in an objective way when deciding what that responsibility means in terms of caring about what they do.
While in caring for a patient a nurse and midwife may be called on to ‘give up’ something of their self-project for the betterment of the patient that is understood to be a sacrifice, this is not the case with love, which shows there is no personal and professional sacrifice. Because love issues from the sphere of impersonal being (i.e., the self as its project does not exist and so there is nothing for a nurse and midwife to ‘give up’ nor for that matter is there any expectation of something from the patient in return. In a relation of love there is no ‘giving up’ of anything, rather it is more like a ‘giving over’ as in an offering of oneself in the support of the patient. A characteristic of love is the asymmetry of the relation between the nurse and midwife and the patient where there is no expectation of reciprocity. Therefore, the nurse and midwife expects nothing from the patient in return for what they do in being ‘for’ them. The asymmetry of reciprocity that is characteristic of a relation of love is yet another point that differentiates love from caring. While in a relation of love as moral responsibility, there is no expectation of reciprocity, whereas in a caring relation there is.

The unavoidable responsibility of being moral is what enables a nurse and midwife to place the patient as their first priority, that from an onlooker’s perspective may be interpreted as a form of selflessness. From the perspective of the onlooker, what is seen as an expression of love is the caring activities of a nurse and midwife. These activities show that the self-project of the nurse and midwife is second to the project of the patient, which may also involve a degree of risk to their welfare and add support for the identification of these acts as selflessness acts of love. However, from the perspective of the nurse and midwife in the moral party of two, the self as its project is not a concern and hence there is no regard or thought about their self because it does not exist.
As it is impossible to know if the responsibility a nurse and midwife feels (‘Said’) is an accurate interpretation of the ‘significance’ of the ‘Otherness to a patient’s personal being (Saying), a rhetoric of disruption and supplication (Murray, 2003) can help overcome distractions that can make such interpretation even more difficult. The dialogue strategy proposed by Murray (2003) enables a nurse and midwife to challenge the assumptions, beliefs and values inherent in the cultural stereotypes and prejudices of nurses and midwives and others within the health system that mask moral responsibility. Objective relationships are governed by rules, norms, stereotypes, prejudices and accepted practices that are associated with working in a system of health care and can work to hide moral relations and mask or distort moral responsibility. If the subjectivity of the patient is lost to only an objective view, the patient becomes an object subject to objectification, like a repeated presenter to an Accident and Emergency Department for substance abuse who is labelled a ‘troublesome patient and a waste of time’. It all adds up to the fact that competing interests for a nurse and midwife can serve to mask love as moral responsibility that, if not challenged, leads to the objectification of the patient as a thing that has things done to it in the name of caring.

The entry of a third person such as another nurse or midwife onto the scene disturbs the moral party of two because it introduces the social world and so changes the nature of their responsibility. In this new relation a nurse and midwife ceases to be a hostage because now there is the potential for another nurse or midwife to also be responsible for the patient but this is what they cannot know. At this point the relation ceases to be metaphysical because now some objective criteria can be applied to the relation that seeks just reason for what they do as professional nurses and midwives. Thus, the introduction of the third party means that a nurse and midwife must judge among the competing ‘Calls’ where in the moral party of two they assume responsibility as a given. To this end, and as suggested above, a rhetoric of disruption and supplication
(Murray, 2003) can assist a nurse and midwife to peel away ideology that can further mask, distort and misrepresent the approach of the ‘Otherness’ to a patient’s personal being. In this way, dialogue combined with, for example, the professional codes of ethics for nurses and midwives, gives expression to the need to adjudicate between the conflicting calls to responsibility and the need for just prioritization of the multiple ethical summonses that they confront.

Moral responsibility is then the answer to the question of ‘what is love in nursing and midwifery’. Moral responsibility is a form of love that centres on the ability of our being, or at least the possibility of our being, to transcend its everyday form to a metaphysical state of being moral. It enables a nurse and midwife to transcend the isolation associated with their personal being as a self-project, to be ‘for’ the patient as a first priority. Yet while the ‘Goodness’ of the ‘Good’ assigns the nurse and midwife responsible, and is expressed to their personal being in the form of the ‘urge to do’, ‘what to do’ in caring for the patient is a matter of living out the command to be responsible and will be different for each nurse and midwife. However, no matter the outcome, love as moral responsibility will always leave a nurse and midwife feeling there is still more to be done in being responsible.
Appendix 1: Research Invitation

RESEARCH INVITATION

Hello, my name is Les Fitzgerald and I am a nurse and midwife undertaking my PhD.

Invitation
I write in regard to a research project and respectfully ask your participation. I am seeking experienced nurses/midwives to participate in one focus group discussion with about 6 other nurses/midwives for approximately 2-3 hours duration to provide information about the ‘special’ relationships we as nurses/midwives have with some of the people for whom we care.

Purpose
My concern is that this important aspect of our nursing/midwifery practice (nurse/patient relationship) continues to be unacknowledged by our policy makers, funding departments, and Department of Human Services administrators. However, this said, the way we interact in ‘special’ ways with patients/nursing home residents is the very thing our community values as shown in the current nurse recruitment advertisements on TV sponsored by the Victorian Government. People value human caring and the ‘special’ relationships nurses/midwives have with patients/nursing home residents in their charge but nobody is undertaking research into this area of our practice.

What is required of you?
I appreciate that asking you to give 2-3 hours of your time to this project is considerable, but in order to obtain the groups considered opinion and beliefs about the ways in which we interact with the people for whom we care, in this current health care climate, will take time. All you have to be able to do is be willing to share an example of where you believed you showed ‘love’ toward a person for whom you were caring. Please note that we are not talking about romantic love.

All information will be confidential to the research.

When and where?
Feel assured that the conduct of the focus group discussion would be at a time that is convenient with you. The group-focus discussion will be conducted at La Trobe University, Department of Nursing building. Refreshments will be provided.

Contact
Should you be willing to participating in this project or would like more information about the project, could you please make that known to the Unit Manager or simply write your name and a contact telephone number below and give this sheet to the Unit Manager. I will be contacting the Unit Manager in 1 week. Please feel free to ring me at any stage on (03) 54447538.

I agree to be contacted about the study (my name & contact telephone number is)

Name:……………………………….   Ph: ………………………………..
Comment:
……………………………………………………………………………………

Thank you for considering this request.

Regards
Les Fitzgerald (Researcher)
What is the purpose of this research?
This research aims to describe the ‘special’ relationships nurses and midwives develop with some of the people for whom they care. While the mainstream literature on human caring, and Government policy related to the delivery of health care, all fail to acknowledge ‘deep caring’ as a component of nursing and midwifery practice, conversations with nurses and midwives suggest just the opposite. While privately the conversations of nurses and midwives support the existence of ‘special’ relationships with people for whom we care, public acknowledgement of this deep level of human caring and commitment remains unacknowledged, hidden in practice, and to the most part absent from the literature in nursing and midwifery and not acknowledged in Government policy on health.

Invitation:
This research invites you, a clinical nurse and/or midwife, to be part of a focus group conversation with 6-8 other nurses/midwives. The conversation will last approximately 3-6 hours (most likely 3 hours). All participants in the focus group conversation will be nurses and/or midwives.

Where and when:
- Where: The focus group can be organised at a place convenient to you - the suggestion is the Department of Nursing at La Trobe University Bendigo.
- When: September, October and November. An exact date and time will be organised directly with you.

What would be expected of me?
- To be able to identify in your practice of nursing and/or midwifery an example of where you believed you showed a ‘special’ deep level of human caring.
- To be willing to share this example to the rest of the group knowing that it will remain confidential to the group (refer to the confidentiality statement.
on the next page).

- To donate your time by attending one focus group discussion with other nurses/midwives. The focus group will take approximately 3-6 hours (most likely 3 hours).

**How will the focus group meeting operate?**

The focus group will consist of three parts:

Part 1: All participants will be asked to provide a clinical practice example about the phenomena. From all the examples offered the group will choose one to be explored in detail.

Part 2: The group will explore the chosen example in detail.

Part 3: The group will develop an opinion about how the concepts identified in the specific example apply to nursing and midwifery in general.

**Confidentiality:**

I understand that the information I provide will be kept confidential except where I disclose information that suggests unethical or improper behaviour and/or information that suggests another person is at immediate risk of harm. I also understand that the Nurses’ Code of Ethics binds the researcher and other nurses and/or midwives who are present at the focus group and requires they to act on matters of an unprofessional nature. Should I disclose information of this type I understand that the researcher will:

1. In the first instance raise the matter with myself.
2. Suggest possible professional assistance with the matter (such as counselling) and should I agree to such assistance, help with making an appointment.
3. Report the event to the appropriate senior nurse in charge of the clinical situation and/or the Nurses Board of Victoria.

While it is not anticipated that your participation in the focus group discussion should cause you any distress, should this happen for any reason your participation in the focus group will be stopped and with you consent you will be assisted with immediate counselling. Should you become distressed after the focus group discussion has concluded you may contact me directly on (03) 5447538 and I will help you to obtain professional assistance. The people listed below are aware of the research and are available for assistance should it be required.

- Reception Ph: (03) 54447223 (9am - 5pm)
- Counselling Service (La Trobe University, Bendigo)
- Chris Kirwan (Psychologist)
- Liz Griffith (Psychologist)
- Lynda Evans (Social Worker)
The session will be audio taped but only heard by myself. On completion of the research the audiotapes will be destroyed and only a hardcopy with pseudonym names kept. Participation in this research is voluntary. You may withdraw consent and discontinue participation in the research at anytime. If you choose to withdraw you may also request any information gathered from you to not be used.

**Findings:**
On completion of the research you will be invited to attend a seminar outlining the findings of the research.
The findings of the research will be published.

**Contact and answering your questions:**
Should you have any questions or concerns about this research please feel free to contact, in the first instance, myself Les Fitzgerald or the research supervisor Associate Professor Stan van Hooft.

Contact Details:

<table>
<thead>
<tr>
<th>RESEARCHER</th>
<th>SUPERVISOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Les Fitzgerald</td>
<td>Associate Professor Stan vanHooft</td>
</tr>
<tr>
<td>Senior Lecturer</td>
<td>School of Social Inquiry</td>
</tr>
<tr>
<td>School of Health and Environment</td>
<td>Faculty of Arts</td>
</tr>
<tr>
<td>La Trobe University, Bendigo</td>
<td>Deakin University</td>
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<tr>
<td>P.O. Box 199</td>
<td>Burwood Highway</td>
</tr>
<tr>
<td>Bendigo, Victoria 3552</td>
<td>Burwood, Victoria 3125</td>
</tr>
<tr>
<td>Ph: 03 54447538 (9am-Spm)</td>
<td>Ph: 03 92443973 (9am-Spm)</td>
</tr>
<tr>
<td>Ph: 0408123143 (mobile any time)</td>
<td>(Not available July-mid September)</td>
</tr>
</tbody>
</table>

This research has the approval and authorization of the Human Research Ethics Committee, Deakin University HREC No: EC I 97-2001. The research is also supported by the Department of Nursing at La Trobe University, Bendigo.

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125. Tel (03) 9251 7123 (International +61 3 9251 7123).

Thank you for your time.
Appendix 3: How Do I Participate In A Neo-Socratic dialogue?

HOW DO I PARTICIPATE IN A NEO-SOCRATIC DIALGOUE?

Procedures
The Neo-Socratic dialogue normally uses the following procedures:

1. The facilitator sets a well-formulated, general question, or statement, before the discourse commences.

   QUESTION: What is love in nursing?

2. The first step is to collect concrete examples experienced by participants in which the given topic plays a key role.

   An actual example of where love has been used in the practice of your nursing (not romantic love).

3. One example is chosen by the group that will usually be the basis of the analysis and argumentation throughout the dialogue.

4. Crucial statements made by participants are written down on a white board, so that all can have an overview and be clear about the sequence of the discourse.

Accordingly, it is useful to now reflect on the topic before the dialogue begins and to think of any incidents or examples from your nursing practice which illustrates or relate to the question and which you would be willing to offer to the group for discussion.

Criteria for suitable examples

1. The example has been derived from your own experience; ‘hypothetical’ or ‘generalized’ examples (quite often it happens to me that . . . ‘) are not suitable.

2. Examples should not be very complicated ones; simple examples are often the best. Where a sequence of events has been presented, it would be best for the group to concentrate on one aspect or one event.

3. The example has to be relevant for the topic of the dialogue and of interpret to the other participants. Furthermore, all participants must be able to put themselves into the shoes of the person giving the example.
4. The example should deal with an experience that has already come to an end. If the participant is still immersed in the experience it is not suitable. For example, if decisions are still to be taken, there is a risk that group members might be judgmental or offer advice; and if there is still an emotional involvement, the discussion might re-open emotional wounds.

5. The participant giving the example has to be willing to present it fully and provide all the relevant actual information and answer questions so that the other participants are able to understand the example and its relevance to the central question.

5. Positive examples: i.e., examples that affirm the question or statement are preferred.

Rules of participants
There are eight basic rules of participants in the Neo-Socratic dialogue:

1. Each participant’s contribution is based upon what s/he has experienced, not upon what s/he has read or heard.

2. The thinking and questioning is honest. This means that all and only genuine doubts about what has been said should be expressed.

3. It is the responsibility of all participants to express their thoughts as clearly and concisely as possible, so that everyone is able to build on the ideas contributed by others earlier in the dialogue.

4. Participants should not concentrate exclusively on their own thoughts but should make every effort to understand those of other participants. To assist with this, the facilitator may ask one participant to express in his or her own words what another participant has said.

5. Anyone who has lost sight of the question or of the thread of the discussion should seek the help of others to clarify where the group stands.

6. Abstract statements should be grounded in concrete experience or in the example, which is central to the discussion in order to illuminate such statements.

7. Inquiry into relevant questions continues as long as participants either hold conflicting views or have not yet reached clarity.

8. It is important and rewarding to participate in the whole of a dialogue even if there is disagreement. Everyone should endeavor not to leave early or cease participating before consensus is reached.
**Metadialogue**
It is permissible at any time within the dialogue for the facilitator (Les) or for any participant (you) to call ‘timeout’ in order to direct the attention of the group to any problems that may have arisen. It may be that a participant has lost track of the discussion, is unable to understand what others are saying, or feels excluded. Or it may be that one or more participants have become upset with the way the dialogue has developed. Or it may be that the group has lost its way and needs to review the structure or content of the dialogues. Or the group may want to discuss the strategies it is using to seek a consensus of the question.

Whatever the reason, a discussion about the dialogue, or a ‘metadialogue’, can be called for at anytime. If it is thought appropriate, someone from the group other than the facilitator may be asked to chair the metadialogue.

The group should not return to the content dialogue until all the difficulties that led to the calling of a ‘timeout’ have been resolved or until strategies for proceeding with the content dialogue have been formulated.

**Confidentiality**
All the content of the dialogue is bound by the rules of research confidentiality. Notwithstanding this requirement it is worthy of note and your participation in the dialogue binds you to that confidentiality.
Appendix 4: Deakin University Human Research Ethics Committee Approval

Research Services
Office of the Deputy Vice-Chancellor (Research) (Melbourne Campus)

MEMORANDUM

TO: Mr Les Fitzgerald
Social and International Studies
Melbourne

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 4 May 2005

SUBJECT: PROJECT: EC 197-2001 (Please quote this project number in future communication)
WHAT IS LOVE IN NURSING?

This application was for an extension of time for an approved project.

APPROVAL HAS BEEN GIVEN FOR LES FITZGERALD, UNDER THE SUPERVISION OF A/PROF STAN VAN HOOFT, SCHOOL OF SOCIAL AND INTERNATIONAL STUDIES TO CONTINUE THIS PROJECT TO 31 DECEMBER 2005.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the application and approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

Victoria Emery
Secretary, DU-HREC
(03) 9251 7123
Appendix 5: Deakin University Human Research Ethics Committee Consent Form

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE
CONSENT FORM:

I, ............................................ of ..............................................................

Hereby consent to be a subject of a human research study to be undertaken by Les Fitzgerald and I understand that the purpose of the research is to explore the question ‘what is love in nursing?’ I understand also that I will be participating in a ‘Neo-Socratic dialogue’ for about 6 to 8 hours and that this will require me to be forthright and deeply reflective about my professional practice as a nurse.

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the research study, have been explained to me.

2. That I voluntarily and freely give my consent to my participation in such research study.

3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals.

4. Individual results will not be released to any person except at my request and on my authorization.

5. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

Signature: Date:
Glossary

Key words and definitions
For the purposes of this study the following terms will apply.

Patient
The literature and contemporary health care practice use various terms to describe a person who is the receiver of health care, they include, ‘client’, ‘health care consumer’, ‘patient’, ‘resident’, and ‘birthing mother’.

For the purposes of this dissertation the term ‘patient’ will be used to refer to a person living in a nursing home who is commonly called a ‘resident’, a mother recently given birth and referred to as a ‘birthing mother’, a person who is in acute hospital and called a ‘patient’, and a person living in the community and referred to as a ‘client’ or ‘health care consumer’.

Registered Nurse and Registered Midwife
Australia The title Registered Nurse refers to a person who is listed with the Nurse’s Board of Victoria to practice nursing. There are 5 divisions of Registered Nurse, division I includes graduates from accredited university courses, midwives, maternal and child health, psychiatric nurses, and nurse practitioner, division 2 includes graduates from accredited courses in the Victorian Education and Training sector, division 3 is a closed register - psychiatric nurses, division 4 is also a closed register for mental retardation nurses, and division 5 is a closed register for mother craft nurses (Nurses et al., 2001: 8).

A Registered Midwife is a person endorsed on the register of the Nurse’s Board of Victoria to practice midwifery.

A Registered Nurse (Division 2) may also be identified in other countries or in historical terms by the title ‘enrolled nurse’, ‘state enrolled nurse’, or ‘nurse’s aide’.

Singapore: The title Registered Nurse refers to a person who is listed with the Singaporean Nurses Board to practice nursing and Registered Midwife is a person registered to practice midwifery.

Bhutan: The title Registered Nurse refers to a person who is listed with the Bhutan Nurses Registering Authority to practice nursing and Registered Midwife is a person registered to practice midwifery.

In this study all references made that use the title Registered Nurse will relate to a Registered Nurse (Division i), Registered Nurse (Division 2), or Registered Nurse (Division 3).
References


In *Handbook of qualitative research*. Denzin, N. & Lincoln, Y. ed.  


