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What is This?
Implications of Holding Ideas of Evidence-Based Practice in Nursing

Gail J. Mitchell, RN; PhD

Abstract
The author of this paper examines emerging implications of holding ideas about evidence and evidence-based practice. Evidence has a very specific role in the delivery of safe clinical care, but it is creating a serious problematic for the practice of nursing. It is proposed that evidence-based practice be re-situated or reconstructed as a collective and organizational responsibility and not the responsibility of individual nurses in practice; nurses re-focus on articulating a more ethical foundation for praxis, one that emerges from nursing philosophy and one that is co-constituted with persons/families/groups; and nurse leaders and educators establish teaching-learning and practice environments that enable a peer-to-peer process of critical review and curious inquiry of available evidence in the contexts of shared work.

Keywords
Evidence, implications, nursing practice

Evidence plays an important role in the delivery of modern healthcare, especially care involving clinical procedures, drug protocols, and even public and social messaging aimed at promoting population health. When persons are offered, or subjected to, healthcare interventions, the procedures and protocols need to be as safe as possible. And, when we know as a society that smoking is harmful, that drunk drivers are dangerous, and that violence against women is wrong, we have an obligation as concerned citizens to support public health messaging based on evidence and shared mores. There is no question that evidence has a place in these instances, and in life in general. However, there is a compelling problematic with the current movement of evidence-based practice (EBP) within nursing and further discussion is warranted in order to examine “the implications of holding certain ideas” (Thorne & Hayes, 1997, p. xii). The emergence of disturbing implications affiliated with ideas of EBP has helped to define the problematic addressed in this paper.

I chose the word problematic in keeping with the definition in the Oxford Companion to Philosophy (Honderich, 1995) that states a problematic is perplexing and questionable. There are persisting perturbations about the evidence-based movement and I must admit that sometimes I feel like Alice (in Wonderland) struggling to make sense of the evidence-based underworld and its claims to practice. Other authors (see for example, Baumann, 2010; French, 2002; Kemmis, 2007b; Kitson, 2002; Rolfe & Gardner, 2005; Smith & McCarthy, 2010) are also perturbed about the placement of evidence in contemporary arenas of nursing practice and education. In order to portray some of the perplexing messages of EBP, I compiled a list with a sampling of some of the more salient and repeating perspectives on evidence from the literature. These are:

- “Nurses increasingly have been encouraged to get involved in research and adopt an evidence-based practice (EBP). EBP is broadly defined as the use of the best clinical evidence in making care decisions . . . there is general agreement that findings from rigorous studies constitute the best type of evidence for guiding nurses’ decisions and actions” (Loiselle, Profetto-McGrath, Polit, & Beck, 2011, p. 3).
- “Nursing practice that is relational and responsive to the uniqueness of people/families must be informed by multiple knowledges including experiential, contextual, spiritual, theoretical, biomedical, ethical, and ideological knowledge” (Doane & Varcoe, 2006, p. 7).
- “Most RCTs focus on clinical questions and management of ideas. Many of the major determinants of health or illness, such as absolute or relative poverty, social class, literacy, transportation, or other infrastructure, are not amenable to medical interventions. RCTs can only answer questions for which quantitative results are applicable . . . ”

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things that really count, cannot be counted” (Jadad & Enkin, 2007, p. 9).
- “The term theory-based is rarely heard now because the era of evidence-based practice has replaced it . . . Research is now regarded as central to the determination of what constitutes best practice” (Pringle, 2006, p. 272).
- “Theoretical thinking is essential to all professional undertakings” (Meleis, 2005, p. 8).
- “A component of thinking nursing is an interdependence of skills, knowledge, attitudes, values, and professional identity that allows complex thinking to occur” (Thorne & Hayes, 1997, p. 126).
- “Nurses need to consistently use a nursing framework that fully respects the dignity and worth of each individual patient, and have an open mind that can synthesize knowledge from diverse sources to guide practice” (Baumann, 2010, p. 226).
- “Five inextricably connected components of gerontological nursing are theory, evidence base, caring values, relational care, and later life conditions” (Tolson, Booth, & Schofield, 2011, p. 238).
- “The evidence-based view makes practice almost unrecognizable from the perspectives of professional practitioners whose intentions, values, and commitments are crucial in the conduct of their work . . . The technicist view threatens to empty practice of its moral dimension. This is a price professional practitioners should not be prepared to pay for the ‘certainties’ allegedly given by the particularly restricted range of ‘evidence’ that ‘counts’ in the evidence based approach” (Kemmis, 2007b, p. 25).
- “All professional nurses, from the new graduate to the seasoned veteran, should have the ability to apply research findings to practice . . . Particularly staff nurses who are at the bedside caring for patients on a daily basis, must have the tools to critically analyze research in order to make EBP decisions” (Boswell & Cannon, 2007, pp. 88-89).
- “The concepts of a gold standard of research and a hierarchy of evidence are inappropriate for the discipline of nursing, and . . . the RCT provides only a limited source of evidence on which to base nursing practice. We believe that the practice of nursing is fundamentally different from the practice of medicine and requires a fundamentally different view not only of evidence, but of what it means” (Rolfe & Gardener, 2005, p. 300).

Clearly present in the messages are at least three distinct streams of thinking—one view that locates evidence as the central guide for nursing practice, a second that situates evidence within a bounded zone of specific clinical relevance—a zone that exists within a larger foundation of philosophical and theoretical knowledge, and a third that situates evidence as a sociopolitical tool that provides little actual direction for nursing practice. Waters, Rychetnik, Crisp, and Barratt (2009) identified similar diverging views on evidence in their inquiry with nursing and midwifery leaders in Australia.

This paper has two main sections. In the first I detail some perplexing aspects and questions affiliated with evidence-based ideas. Following exploration of three implications of ideas affiliated with EBP, I propose the following: (a) evidence-based practice (EBP) be re-situated or reconstructed as a collective and organizational responsibility and not the responsibility of individual nurses in practice; (b) nurses re-focus on articulating a more ethical foundation for praxis, one that emerges from nursing philosophy and one that is co-constituted with persons/families/groups; and (c) nurse leaders and educators establish teaching-learning and practice environments that enable a peer-to-peer process of critical review (considering social determinants of health, social justice, and politics) and curious inquiry of available evidence in the contexts of shared work, patient/family situations, and organizational resources.

Exploring the Problematic of Holding Evidence-Based Ideas

Emerging Implications for Nursing Education

One emerging implication of the EBP ideology is that some nurses educated over the past decade have been indoctrinated with the mantra that research evidence is knowledge and individual nurses require evidence to be competent professionals. This is not surprising since accrediting bodies in several countries require integration of EBP in baccalaureate level education (Smith & McCarthy, 2010; Waters et al., 2009). Student nurses engage with ideas that evidence is needed for decision-making about how to be, and how to do, as a nurse in practice. An unsettling story recently shared by a nurse practicing on a medical unit in a Canadian teaching hospital sheds light on one of the emerging implications of embracing the EBP ideology. The discussion involved a man who was suffering following a series of strokes that left him with bilateral paralysis, aphasia, and intense loss and grievings for an absent family and career. The nurse described a sense of concern that she did not know the evidence about how to be with him, about how to be a nurse with someone suffering. When asked what she would do, she said, “well I might form a personal relationship with him, but that is discouraged now that we are evidence-based.” She left me wondering if her reluctance and uncertainty might signal emerging implications for nurses indoctrinated with the idea that evidence guides how nurses think and act in practice.

I am concerned that graduating nurses feel ill-prepared for engaging persons unless they have evidence or a best practice guideline (BPG) to tell them how to be a nurse. This concern has been validated in recent discussions with other
nurses who describe uncertainty about how to approach and be in relation with persons and families. One mid-career nurse described a hesitancy and reluctance when thinking about a home visit with an elderly woman diagnosed with depression because the nurse did not know what evidence to use to intervene. If these examples ring true for other educators and nurses, then we need to seriously re-visit the implications of embracing the idea that nursing practice is primarily informed by evidence. I am in agreement with Kemmis (2007b) who proposed that nurses should not settle for such a narrow view of practice and the evidence-based movement may pose a serious threat that humankind cannot afford. For Kemmis (2007a), practice exists among densely woven patterns of cultural-discursive, material-economic, and social-political pre-conditions that form practice architectures for supporting or restricting individual and group practices. In other words, the practice of nursing coexists with layers of complexity and meaning that go far beyond the simplistic and perhaps idealistic portrayals of EBP.

Idealistic Portrayals of Evidence

Idealistic portrayals of existing evidence link with a second perturbing implication affiliated with the EBP movement. There is a widespread belief that evidence actually exists to guide nursing practice. Perhaps evidence about clinical issues such as spread of infection, drug errors, effects of immobility—to name several—is thought of as evidence for nursing practice, but as already articulated by Cody (2006) there is an important distinction between evidence-based clinical care—that informs various professional groups—and values-based nursing care/practice. A review of published papers and systematic reviews on the Cochrane Library website consistently demonstrates that questions linked with nursing practice issues are just not addressed or are addressed but evidence is frequently reported to be inconclusive. Even when I turned to a fairly simple question linked with helping cancer patients experiencing debilitating fatigue, the evidence indicated that only exercise out of a dozen or more possible recommendations met the criteria required for action in practice (Mitchell, Beck, Hood, Moore, & Tanner, 2007). This could be why so many examples in the literature promoting EBP use examples from drug trials or generic clinical care to make points about the effectiveness of EBP.

For instance, Melnyk and Fineout-Overholt (2005) offer an example of a clinical question in the following way. “In teenagers (the patient population), how effective is Depo-Provera (the intervention) versus oral contraceptives (the comparison intervention) in the prevention of pregnancy (the outcome)” (p. 9). This question is a general clinical question within the scope of medical or shared clinical practice for physicians/pharmacists/nurse practitioners with the legal mandate to prescribe birth control interventions. And, certainly, if nurses working with teens are asked a question about effective birth control, they could pursue the answer, but the evidence of effective birth control is not a guide for nursing practice that is relational—that requires a human with human process that evolves through relationships. A question relating to nursing practice in a similar situation might be: what are the central concerns for teenagers using birth control? When I went to the Cochrane Library, there were no reviews that examined concerns of teenagers taking birth control. After 30 minutes of browsing I was able to locate two connected reviews—one on the effectiveness of home visits with teens with reported drug and alcohol abuse, and another that evaluated the effectiveness of interactive computer programs to enhance sexual health. Both reviews proposed that home visits and computer interactions may be helpful but more study was needed to justify that either has benefit. I searched other sources relating to the topic of teen concerns about birth control but found no evidence.

To digress for a moment, I did locate an impressive virtual library of qualitative research and participant video experiences for many different situations at the following site: http://www.healthtalkonlineline.org/. The site has a sister site where I found a full menu of stories and qualitative research on issues important to young people, their sexual activities, body image, and other health-related issues (see: http://www.youthhealthtalk.org/Sexual_Health_of_Young_People/). These sites are dedicated to explicating personal experiences of health/illness for professionals and the public. The stories enhance understanding and provide context for thinking about personal health and nursing practice in light of disciplinary knowledge.

To the point of evidence-based healthcare and the illusive nature of evidence-based nursing practice, I must point out the degree of the perplexing drift in the literature that substitutes generic clinical healthcare for nursing practice. Again, Melnyk and Fineout-Overholt (2005) appeal to skeptics of EBP to consider real life scenarios for undeniable proof that evidence changes practice. They stated, “Many primary care providers continue to prescribe antidepressants as the sole treatment for adolescents when systematic reviews of their effectiveness have indicated that medication alone is not beneficial in treating mild to moderate teenage depression” (p. 18). Similarly, Rycroft and colleagues (2004), offered an example about the uptake of low molecular heparin post-operatively to illustrate how evidence is more powerful if aligned with clinical experiences. I wonder how these examples link with nursing practice. Or, are the clinical and pharmacological examples provided merely to offer clarity about how evidence based on causal relationships can guide decision-making in generic healthcare situations? Interestingly, Melnyk and Fineout-Overholt included a chapter on how patient concerns and choices influence EBP, but an example provided involved a surgeon’s decision about whether to conduct spinal surgery on a 93-year old woman. The elderly woman wanted to have the surgery because she believed she might dance again, but the evidence did not
support her as a good candidate for success. The hospital found a surgeon willing to do the surgery and the woman recovered nicely. The example demonstrated patient-centred healthcare, perhaps, and how surgical risk needs to be considered within the context of the individual. But how does the example link with the practice of nursing?

Which begs the question: Is nursing becoming an evidence-controlled activity? And, does the generic healthcare perspective of EBP contribute to the persistent presence of modernist controls and techniques that compress human experiences (of nurses and persons/families) in order to maximize efficiency and control? Do different health professions embody unique domains of knowledge and skill, or have we already moved to a generic inter-professional matrix where boundaries and domains of knowledge are no longer useful in the current model of healthcare service? Taylor’s control of the pig iron workers through time and motion studies comes to mind here (Doll, 2008). His work inspired development of managerial science, a science focused on efficiency, effectiveness, compliance, and measurement. Are these modernist values affiliated with the beliefs and actions of EBP?

Rycroft-Malone (2006) considered the political implications of the EBP movement and pondered the managerial control of all practitioners through the delegated research protocol. Equally well articulated is Clegg’s (2005) critical realist view that EBP is a technical tool of the government that undermines professional wisdom and the living of values in practice. She purported that, “Evidence-based practice serves an ideological function that is disguised through the rhetoric of independence and the idea that policy is disinterested and objectively informed” (p. 419). Similarly, Winch, Creedy, and Chaboyer (2002) considered EBP from Foucault’s concept of governmentality and proposed that evidence is a government technique directed at control and manipulation. The authors suggested that nurses will benefit from a critical analysis of evidence-based issues linked with power, knowledge, and practice. It is interesting that a Cochrane review by Thomas and others (2009) supported the substitution of professionals with the use of evidence-based guidelines to reduce cost and decrease variability in practice. The issue of cost-benefit analysis based on evidence is raising questions of control over professional practice and the issue has recently entered the public media.

For instance, an article in the Wall Street Journal addressed how some physicians are voicing concerns about the recent decision in America to stop testing for prostate cancer because the outcomes do not justify the costs (http://online.wsj.com/article/SB10001424052970203388804576617310963936364.html). And consider the following report about healthcare in Greece: “This Saturday, one of Greece’s most respected newspapers, To Vima, reported that the nation’s largest government health insurance provider would no longer pay for special footwear for diabetes patients. Amputation is cheaper, says the Benefits Division of the state insurance provider” (see: http://dailycaller.com/2010/10/11/greek-health-system-opts-for-amputation-as-money-saver/#ixzz1bFtBeNq). It is noteworthy that more than a decade ago Colyer and Kamath (1999) suggested that patient choice and autonomy would decrease as EBP advances. Are these decisions by government bodies and insurance agencies reflective of the emerging implications of embracing the ideology of EBP? One wonders how evidence will support nursing care, or any care for that matter, for persons with incurable diseases, such as advanced cancer or dementia since the outcomes will surely not justify the costs. If recent decisions to withhold or deny healthcare offer insight into the implications of embracing ideas of evidence as a foundation for practice, will nurses continue to embrace evidence as the privileged informant for practice? Can the evidence-based ideology prepare nurses for the ethical challenges emerging in practices rationing healthcare? Even if definitions of evidence are extended to include values, expertise, and experiences, will it serve to help or hinder nursing practice?

Expanding Definitions of Evidence—Extending the Problematic

In the beginning, evidence-based medicine defined a hierarchy of evidence that held the randomized control trial (RCT) as the gold standard, since then the RCT has been trumped by the systematic review (Clegg, 2005). RCTs work well with drug trials and in labs where controls are possible, not so well in real life situations. The narrow definition of evidence may have contributed to the trend to develop broader definitions of evidence for nursing practice. However, extending the inclusion criteria of relevant evidence may add to the problematic of EBP. If qualitative research findings, patient values and preferences, and clinical experiences/expertise can also count as evidence, how can there be any clarity or confidence regarding health decision-making. Meanings, values, experiences, narratives, and theoretical interpretations provide different ways of coming to know—ways that are not like evidence. Viewing truth in the moment (Parse, 2008) or truth as emergent reality (Eriksson, 2010) as instances of unfolding evidence for nursing science, provides some appeal, but truths and realities taken into the frame of evidence will not enlighten the pre-destined attitude of objectivity, judgment, value, and worth. Evidence is already intertwined within a discourse that includes habits of interpretation (Davis & Sumara, 2006).

The idea of a pre-destined attitude or frame of reference is captured in Bolt’s (2011) analysis of Heidegger’s insights about science. She stated, “objectification and mastery go hand in hand. Through its ability to reduce everything to an object, science-as-research enframes us: it sets a limit on what and how we think and how we interact with the world” (p. 149). Enframing for Heidegger is a process of destined that limits other views and possibilities. Enframing for nurses and other health professionals may restrict responsive
practices that are open to emerging events and relationships. Perhaps we will miss seeing the forest for the trees, miss seeing persons for the evidence, miss seeing ourselves as human beings engaged with other human beings.

Although broader definitions of evidence may have been intended to avoid missing things, everything seen as evidence is subject to its destining frame. Therefore, the more specific and rigorous we can keep the definition of evidence, the more likely we can truly examine its usefulness for care. If we can separate nursing practice from evidence-based clinical care we may be able to bring additional sources of nursing knowledge into view—especially philosophical and theoretical views that offer a qualitatively different approach—different enframing and destining. Further sources for coming to know such as the imagination and art may better enable nurses to relate with persons in life and health-enhancing ways. Bolt (2011) reminded us that art is what connects us with ethics, relationships, and truth—not science. Perhaps we need a counter movement called humanities-based nursing. The arts and humanities provoke a deeper looking and connecting that does not enframe what we can know to past discoveries. Evidence, on the other hand, requires a looking behind for solid footing that leads to a third problematic of EBP.

Knowledge Discovered and Knowledge Invented

A third perplexing implication of embracing EBP is that decision-making tends to exclude thoughts and actions that are aligned with creativity and innovation, emergence and imagination, responsiveness and relation. Many post-modern thinkers in philosophy and education, especially those informed by complexity science, contend that the modernist reliance on evidence and knowledge based solely on what can be discovered from the past has outlived its usefulness (Davis & Sumara, 2006; Doll, 1993, 2008; Westley, Zimmerman, & Patton, 2006). Perhaps the relevance of evidence for nursing is already past—it may have helped us define who we are not.

Regrettably, the ideas of emergent discovery, responsive/reflexive practice, and innovation in the interpersonal relations of practice are lacking in many texts and papers on evidence-based nursing practice. How can nurses be in relation with other persons experiencing complex realities of health and illness if they cannot imagine and picture their approaches and dialogues based on what might be? Is the purpose of knowledge not to enable us to know how to be in the future within the unique situations we know exist? Recall the stories from nurses described earlier in this section—they were not able to imagine nursing practice in the absence of evidence. Baumann (2010) suggested that “it is understandable that clinicians would like to have a solid ground upon which to guide their clinical decision-making, but the reality is that no such ground exists” (p. 227). There are many uncertainties for professional nurses that exist at multiple levels as noted by Kemmis (2007b).

Kemmis (2007b) provided a provocative analysis of the individualistic and the extra-individual (organizational) features and dimensions of professional practice, but few authors in nursing have tackled the reality that mutual relationships among nurses and persons they work with require an openness, a willingness to participate with the interplay of messages and actions, a responsiveness to the particular person and family. Relational nursing with unique human beings requires a foundation of knowledge and skill informed by philosophy, values, theory, experience, and imagination. EBP does not embrace the reality that human beings create and invent ways of living when challenged by life happenings and when engaged in relationships with others. Nor does it take advantage of the reality that most learning and growth happen in relationship with others through dialogue and curious inquiry involving imagination (Doll, 2008). Learning, growth, dialogue, and curious inquiry conjure a different set of implications from those affiliated with evidence.

In summary, the first section of this paper has been considering some of the implications of aligning with EBP ideas. Proposed implications for the nursing community include the following.

- EBP as an ideology and foundation for nursing practice may be contributing to nurses’ feelings of discomfort and uncertainty about the relational foundations of practice.
- EBP as a requirement of educational and practice organizations forces a limiting and potentially harmful framework for nursing practice.
- EBP as a frame for professional practice excludes other ways of knowing through destining—whether explicit or not, knowledge is also theoretical, values-based, and aligned with particular philosophical and personal assumptions.
- EBP encourages a generic view of healthcare practice where boundaries and contributions among different kinds of services become blurred and unrecognizable in the shadow of the research protocol.
- Evidence is a sociopolitical tool as much as a clinical tool and recent government bodies and insurance agencies are forecasting serious and far-reaching implications for human health and healthcare.

These implications invite nurses to reconsider and re-situate evidence and its relationship with nursing practice.

Re-Situating Evidence in Nursing Practice and Education

In the second half of this paper, three ideas for additional consideration by nursing colleagues are proposed. The ideas are not necessarily new but may extend thinking of others...
who have clearly articulated the complex realities of relational practices (see for instance, Kemmis, 2007b; Smith & McCarthy, 2010). The three ideas are that:

1. EBP be re-situated or reconstructed as a collective and organizational responsibility and not the responsibility of individual nurses in practice.
2. Nurses—especially nurse educators and leaders—re-focus on articulating a more ethical foundation for praxis, one that emerges from nursing philosophy and one that is co-constituted with persons/families.
3. Nurse leaders and educators establish teaching-learning and practice environments that enable a peer-to-peer process of critical review (considering social determinants of health, social justice, and politics) and curious inquiry of available evidence in the contexts of shared work, patient/family situations, and organizational resources.

Each of these ideas requires some additional consideration about the implications they may engender.

**Re-Situating EBP to the Collective and Organizational**

The amount of literature suggesting that individual nurses are responsible for EBP is growing and may be contributing to a generation of nurses who are expressing uncertainty and unknowing when facing the complex and ambiguous realities that constitute relational practices with human beings. It is not responsible, and may indeed be harmful, to continue the rhetoric that knowledge equals evidence and evidence guides practice. Even in the realm of care, individual nurses should not be expected to identify clinical problems, on their own, conduct literature reviews, place gathered evidence in a hierarchy of credibility, and change practice on their own. Reflecting on more than 30 years of practice experience, I cannot think of one situation where such individual activity is possible or even desirable. Even nurses practicing at the graduate level, who may have the time to conduct and evaluate evidence, need to discuss changing a clinical protocol with peers and leaders, as well as patients and families involved in the situation. I have imagined many occasions and have asked colleagues and nurses in practice to describe situations when a review of evidence would lead one nurse to change practice in a clinical situation. In each situation described, peers, clinical leaders, policies, politics, economics, traditions, and persons/families need to be consulted and considered. And even then there is a mix of ambiguity that requires responsiveness, relationality, and emergence in the moment.

Frustration with assumptions that the absence of evidence application in nursing is, at least in part, the fault of individual nurses who do not have the knowledge or the skill to conduct research reviews for purposes of guiding practice has been ardently expressed (Mitchell, 1997, 1999). These claims continue and now extend to the educators who teach nurses (Stichler, Fields, Kim, & Brown, 2011). These authors stated that many faculty “do not have the knowledge, attitudes, or competencies in EBP to include the content in their coursework or student assignments” (p. 93). Further, the authors reported that doctorally-prepared nurses have the most negative attitudes toward EBP. Should we not then question the assumption that faculty should be teaching EBP or that nurses should be using evidence in practice. Perhaps evidence, beyond informing clinical protocols/procedures, is just not meaningful for nursing practice.

Estabrooks and colleagues (2005), in their study of sources of practice knowledge among nurses, addressed the issue of regarding evidence over other forms of knowing. These authors report that nurses draw on multiple sources of knowledge and that a primary source is the knowledge that emerges in their interactions with each other and persons and families. Gerrish and Clayton (2004) reported similar findings from the United Kingdom. This means that nurses’ lived realities of practice are more consistent with views of knowledge informed by complexity science. Complexity science views knowledge as potential, as the co-created ability to know how to go forward amid ambiguity and complexity through relationships and dialogue with others (Davis & Sumara, 2006). If nurses know how to be with others by being with others, their practices can be seen as emergent and self-organizing. Emergent nursing practice shows the give and take, the questions and answers, the silence and speaking of contemplative relating in ways that attend to the issues and concerns of persons and families. Emergent knowledge that unfolds in relationship cannot be contained in prescriptive protocols that typify EBP.

The process of consultation for developing evidence-based protocols takes time, sometimes months to generate and evaluate sufficient evidence to inform a collective of recommended changes in practice. But even then, the change or guideline generated needs to be considered within the larger context/reality of the practice situation. In Ontario, Canada, the Registered Nurses Association of Ontario (RNAO) has conducted extensive reviews and consultations over years to compile best practice guidelines for nurses and organizations. And nursing societies representing several specialized groups in America are also developing evidence-based guidelines (see for example, Mallory, 2010). This level of engaged scholarship is where EBP belongs, as well as in hospitals and other healthcare settings where clinical protocols and policies guide interventions. Healthcare organizations bear responsibility to create collectives of professionals who spend their paid time at work reviewing and developing evidence-based procedures, protocols, policies. It is reckless and unacceptable to place this burden on individual nurses, especially at the baccalaureate level, and the time seems right to stop the talk of evidence as the guide to practice for individual nurses.
Re-Focusing on the Discipline and Purpose of Nursing

Instead of broadening the meanings and kinds of acceptable evidence, it is proposed here that nurses align with the narrow definition of evidence, with its hierarchy of credibility for informing generic clinical decision-making. Evidence belongs with collective clinical decision-making, and we need to re-situate nursing practice in the disciplinary knowledge of wholeness, consciousness, caring, pattern, transformation, transcendence, relationship, and meaning—the concepts emerging from intersections of unitary nursing theories (Cowling, Smith, & Watson, 2008). The purpose of nursing is to care for human beings experiencing changes in life that influence their health and well-being. Nursing is a relational practice involving a relational inquiry that evokes responsiveness (Doane & Varcoe, 2006). Nurses happen to assist with clinical care and protocols in certain settings. Clinical protocols and interventions make appearances in practice, but they are not foundational components of nursing practice. Philosophy and theory are essential and the defining foundations of nursing practice—essential because our purpose is to care for human beings in situations that are emerging, ambiguous, complex, and dynamic.

Smith and McCarthy’s (2010) impassioned exposé of how some nursing associations and educational institutions in the United States are limiting the role of nurses to the clinical and evidence-based scope—is a trend also happening in other countries (Rycroft-Malone, 2004; Waters et al., 2009). Limiting nursing practice to an evidence base dehumanizes nurses and our service to society. Ultimately, the technical and the evidence-based protocols will be automated or, as is happening today, will increasingly become the responsibility of persons and family members themselves. If nurses are not in practice/service to attend to humanness, to lived experiences of health and illness, to contribute to ethical care and quality of life through relationships that are helpful and supportive, then nursing need not be considered a profession or a discipline for it will meet the purposes and standards of neither.

Kanes’ (2010) thoughtful consideration of professionalism provides different ideas about professional practice—ideas that may generate different implications than those emerging with the ideas of evidence. He suggested that professionals know how to translate and interpret generalized, abstract knowledge and make it meaningful in specific contexts. Professionals practice holism by interpreting detail in light of a broader context and they are responsive to emerging changes, ideas, constraints, and meanings. For Kanes, professionals bring an ethical enrichment that involves “interpreting knowledge helpfully, engaging with knowledge openly, acknowledging uncertainty about knowledge frankly, and sharing knowledge appropriately—against an overriding value of caring for patients” (p. 197). How might these ideas inform nursing practice and education?

Enabling Teaching-Learning and Practice Environments

Nursing leaders and educators are called to continue the dialogue about the realities of enabling teaching-learning and practice environments that restore the philosophical and relational foundations of nursing. We have an obligation to address the question of what implications are emerging within the culture and ideology of EBP. Individual nurses are responsible for using the knowledge of the discipline to know how to be with persons in situations that are unfolding within occasions of changing health patterns. Leaders and educators are responsible for enabling environments that generate knowledge and understanding of our humanness. This knowledge and understanding emerges from philosophy and theory. Nursing relationships are “based on partnership, presence, and shared meaning” (Smith & McCarthy, 2010, p. 46) not evidence.

Evidence-based practice is an organizational, collective, and interdisciplinary affair that has a place in clinical decision-making. If EBP is not kept firmly situated in its place, it also has the potential to harm as is already happening in the abyss of cost-benefit and measurable outcomes. Evidence is most certainly a political tool that is manifesting power of persons concerned with efficiency and control—power that can compress and even remove voice and presence from nursing practice and human care.

Kemmis (2007b) addressed the issue of evidence and politics as do Rycroft-Malone (2006) and Colyer and Kamath (1999). It is important for nurses to ask provocative questions about the use of evidence to sustain the status quo for instance, or to extend colonization of dominant ideologies and agendas. World leaders and politicians do not practice evidence-based policy-making unless it meets their desired ends. For instance, the evidence indicates that poverty is a social determinant of health that adds significant personal and societal burden—in the areas of health inequities, chronic disease, and healthcare resources (Raphael, 2006). Nurses have moral courage and we can help by questioning assumptions and by exploring who is benefiting from decisions based on power and agenda? I hope we can continue to examine the implications of EBP and reject it as a foundational concept for nursing and humanity.

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References


**IN MEMORY**

**MARTHA E. ROGERS, RN; ScD; FAAN**

_A Founder of the Society of Rogerian Scholars_

The Society of Rogerian Scholars has established a Martha E. Rogers Scholars Fund as a perpetual memorial. The fund enables the Society to sponsor activities such as visiting professorships that foster its mission to advance the Science of Unitary Human Beings created by Dr. Rogers. Speakers and consultants are also available through the Society.

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What is This?
Evidence: To See or Not to See

Katie Eriksson, RN; PhD

Abstract

“To see or not to see” is an allusion to the classical Shakespearean quotation “to be or not to be, that is the question.” Evidence as a concept pertains to truth, reality, and being in the world; it involves seeing, realizing, making visible, and clothing thoughts into words. A new interpretation of the concept of evidence in caring science is presented in this column, based on the etymology of the concept and Gadamer’s hermeneutical philosophy. Ontological or absolute evidence is based on being and the true reality that extends beyond the immediate reality. The truth, or the substance, lies concealed within the true reality. Evidence includes envisioning, seeing, knowing, attesting, and revising.

Keywords

evidence, evidence-based practice, ontological evidence, truth

“‘To be, or not to be,’ I there’s the point,
To Die, to sleepe, is that all? I all:
No, to sleepe, to dreame, I mary there it goes.”
—Shakespeare (1980, p. 147)

The classic phrase, “to be or not to be,” originates from Shakespeare’s Hamlet, a play written around the turn of the 17th century. Hamlet is an account of the human’s being in the world, how we view the world, and our courage to face it. The key question is, “Is it better to live or to die?” where Hamlet ponders whether it is nobler to suffer and endure or to face an unknown destiny in death. The depiction of Hamlet might just as well have been written in the year of 2010, since it mirrors what we all have to face: the struggle of being. To have the courage to see and face the true and real reality is the prerequisite for living a life that is worth living. To see and realize the real and to unveil the truth constitutes the original meaning of the concepts, evidence and evident.

The ontological basis in the exploration of this concept consists of molding the view of reality, the real object on which caring science and all theory development is founded. Caring is something natural and original and has been around for as long as humankind. The leading idea of caring, that has subsisted over times, has its origin in the thought of love and charity, caritas; the mission of caring consists of serving life and health and alleviating suffering (Eriksson, 1990).

A vision of this original core of caring forms the basis of ontological evidence. Several years ago I had the pleasure of expressing my vision on 2050 in Nursing Science Quarterly. There, I wrote: “Having a vision involves having the capacity to see and perceive, to sense something of that which can lead to the discovery of the truth, the beautiful, and the good, that is, the eternal or everlasting in caring” (Eriksson, 2007, p. 201).

At the end of the 1970s, a form of paradigmatic shift took place within the development of nursing knowledge: nursing and caring science toward a human science way of thinking, and a caring science and nursing that were not guided by the classical paradigm of medicine. This became evident in the international discussion around the theory development, which resulted in an attempt to locate the innermost structure and core of caring, along with the formation of new concepts. Despite the fact that the theoretical concepts from a linguistic point of view at times appear quite dissimilar, an underlying common message and a common core provide a convincing force to theory and bestow it with relevance. Martha Rogers and Rosemarie Rizzo Parse were two of the forerunners for this development.

I was fortunate enough to commence my research career during the latter part of the 1970s, and the first step involved the development of a model of the caring process, where the core comprises the patient–carer relationship. This development was followed by the exploration of the concepts of health, caring, the caritas idea, and the concept of suffering (Eriksson, 1990, 1991, 2002, 2006). The core of caring can be summarized as an ethos of love and charity, a message of daring to believe in the possibilities of love. The substantive of the theory of caritative caring has been summarized in a number of axioms and fundamental theses formed around the following fundamental constructs: human beings as the entity consisting of body, soul, and spirit, health; and

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suffering, as well as caring communion where human beings’ dignity comprises fundamental worth. This has even involved the necessity of developing an autonomous caring science as an academic discipline complete with a research program (Eriksson, 2002; Lindström, Lindholm, & Zetterlund, 2006). The Department of Caring Science at Åbo Akademi University in Vaasa, Finland was founded in 1987, and it is at this institution that the theory of caritative caring has developed and where I and others have created a caring science tradi-
tion based on the human sciences and Gadamer’s (1999) her-
meneutical philosophy.

The development toward a human science way of thinking within caring science and nursing science brought about the need for a wider and deeper perception of the concept of evidence. In the beginning of the 1990s we commenced with a research project: The Trojan Horse, with the purpose of developing evidence-based caring cul-
tures in practice. The Trojan Horse was used as a metaphor with a view to illustrate how original caring cultures can be rediscovered and form the basis for a caritative caring (Eriksson & Nordman, 2004). The concept of evidence has been developed further and resulted in a theory of evidence for caring science. This, in turn, forms the basis for a her-
meneutic epistemology for caring science with an explicit ontology and ethos (Eriksson, 2009).

The Concepts of Evidence and Evident
The concept of evidence concerns reality and truth. Evidence as a concept and phenomenon has been a part of the scientific discussion for centuries and was originally developed in law. Schjøth (1933), a Norwegian philosopher, emphasized in the early 1900s that evidence does not mean creating a more or less good concept of experience, but it is a means to bring about knowledge of reality. The reality is shaped by concepts, and through a detailed determination of concepts, new aspects of reality can open up. Through studies of the etymology of the concepts, that is, their history, origin, and evolution, their true and real essence can be clarified. A ling-
guistic analysis of a concept cannot be directly translated into another language, but by going to the origin, the etymol-
ogy, we often find similarities in different languages. Evi-
dence and evident (Eriksson, in press), in the Swedish language as in English, are derived from Latin.

The concept, evidence, is derived from the Latin evidentis and eviden’tia and means quite generally a basic feature of the truth. Evidentis consists of è (ex), out of, and vidère, meaning “see” and “realize”, which is related to know. Ety-
mologically, the concept know is derived from to see, experi-
ence and feel. The Sanskrit word veda means I know. The Sanskrit word vedayati means allow to know, announce, inform (Hellequist, 1993). Wessén (1961) distinguished between eviden“t” and eviden“s” in that eviden“t” means obvious, natural, authentic, while eviden’s’ means apparent certainty. Additional nuances of the concept include, among others, the following: in evidence plainly visible; to be seen, law as legal evidence. Linguistically significant terms of interest include video, which refers to that which I see and intuition (Latin, intueri), which refers to realizing, signify-
ning, viewing, and observing and which has a reference to vision (Eriksson, 2009; Wessén, 1961).

The origin of the concept of evidence is clear in law, and the expressions of King’s and Queen’s evidence, which occur primarily in the English literature. King’s and Queen’s evidence is defined as testimony, witnesses’ statements under oath, and something which makes evident—with direct or indirect strong probability (Webster’s Third New Interna-
tional Dictionary of the English Language, 1961). King’s and Queen’s evidence can be seen as an illustration of evidence based on the power of a specific person in an organiza-
tion or the evaluation of research results (Eriksson & Nordman, 2004).

Through an examination of the etymology and semantics of the concept of evidence, four essential dimensions emerge: to see and realize, to know, to attest, and to revise. These dimensions are the basis for a caring science ontological definition of the concept of evidence. Based on the linguistic importance of evidence-evident, it can be seen that these words, in their original meaning, have a completely different significance than today’s empirically highlighted concepts of evidence (Martinsen, 2009).

Truth and Reality
Evidence implies that truth assigns itself in reality and is to be found in its natural or naked form, in that which repres-
ents the true or absolute reality. Already in the year 180 AD Irenaeus of Lyons (born about 130 AD in Smyrna) shaped the Regula Veritatis—the rule of truth, as a synonym for Regula Fidei, the rule of faith. There is no rule for the truth but truth itself is the obvious truth. Regula Veritatis always refers to the original, for that which stands solid from the beginning and which is as an immutable truth (Hågglund, 2003). In order to highlight the absolute reality, the true image of one’s own view of reality needs to be clarified; in other words, what can be found in the caring reality, which entities are to be found there, and what is their essence? Reality signifies to work, to operate, to be active; when it is clad in words and made visible, a force is released that is car-
ing (Eriksson, 2009).

The theory of evidence for truth can be deduced from the etymology of the concept and includes the thought that what is true emerges in the experience of evidence. Heidegger (1993) replaced the evidence-theory with a theory of truth as aletheia (from the Greek), that is, the truth as something naked, something not hidden, not covered, not secret, which is revealing—an ontological truth. Heidegger stated that
through being, the issue lies open before us, and when human beings in their constructive understanding face being, they have reached the reality as it is. Gadamer (1999) related the truth to something that emerges from a background in that it illuminates a specific situation; this is supported by the semantics of the concept of evidence, which is related to light.

Peirce (1932) argued that the very origin of the concept of reality shows that it basically contains the notion of community, without fixed borders and with the ability to be a definite growth of knowledge. The foundation consists of common core values, an ethos. Peirce connected truth with the consensus theory of truth (from the Latin, consensus, consistency, unity); that is, that which is true constitutes that which an infinite number of people would reach if they for all eternity tested a given claim. A claim is therefore true if it, in a useful and productive way, can be part of such an infinite scientific practice.

Reality is constantly changing, and an ontological experience of evidence can only come forth in the here and now. Schjøth (1933) spoke of acknowledging reality, saying that a first ordinary condition or term that seems quite obvious is that there exists a reality that is more extensive than that which is immediately given—than direct experiences in the present. Much of the real and true reality is hidden from human beings and the world of phenomena, since material objects, methods, and theories form a Maya’s veil that blinds us. Maya (Māyā) originated from Sanskrit and means a supernatural power, an illusion. Within Hinduism, Maya denotes the ignorance that is like a veil hiding the higher and true reality and at the same time hiding the supreme God’s ability to create and the result of creativity, that is, the material reality (Nationalencyklopedin, 1995). Maya’s veil can be compared with Gadamer’s (1999) thoughts on accident forming ad hoc, not defined characteristics of being and the contextual phenomena that can obscure the innermost essence. The interpretation of accident may, however, lead to the essence. This requires the ability to see and realize the concrete situation, the here and now, which can take place through a hermeneutic observation where there is also always an interpretation involved (Bergbom, 2007). Through the creative moment which, according to Gadamer (1997), is an event and an experience, you are drawn into a course of events of truth, an experience of evidence.

**Ontological Evidence—The True, the Beautiful, the Good, and the Eternal**

Ontological evidence implies that the true reality may emerge and become visible in all its beauty and goodness. That which is evident, according to Gadamer (1997), is always something that has been said and which then needs to be made visible and valid. Nothing is evident until it is spoken and dressed in words. According to Gadamer, it is likewise clear that the evident is always something surprising that widens the field observed. It is like when you finally understand something. Gadamer called attention to the hermeneutic experience, believing that it allows for a genuine experience to take place, that is, an experience of evidence. Gadamer connected this with the beauty that is evident. Beauty’s attraction to human beings reveals aletheia, a truth; the beauty emerges not only in that which is sensual-visible, but also in such a way that the visual does not exist until it is visible—profiled as one unit out of diversity. The beauty is, by itself, really the most brilliant. Gadamer insisted that the internal structures are not a retrospective design pattern, but are innovative linguistic forms of expression, the text, the concepts, and the words in which they take shape and are known. The structures exist directly identifiable or hidden; the clarification or detection of them remains the task at hand (Gadamer, 1997).

**Ontological evidence** signifies that the core of caring and the primary substance become visible in thought, words, attitude, and action, and thus profoundly influence the caring culture. Ontological evidence is that which is meaning-bearing and lasting and is dependent on how well the substance is anchored in the tradition of caring science (Eriksson & Nordman, 2004). The ontological evidence is ultimately bound to what we perceive as the ethos of truth, in other words, the basic values that we espouse and with which we feel at home. Being a carrier of an ethos means having openness to the unknown and the courage to push the limits. Truth itself, the manifest reality, is indicative of the regime of truth that shapes the reality of caring. Evidence implies that the order of beauty and goodness prevails.

**A Theory of Evidence for Caring Science**

A pattern of thought that forms a theory of evidence emerges from the central dimensions of the concept of evidence (Figure 1). This theory has its basis in the caring reality from which the substance emerges. The theory of evidence covers a course of events including the following phases: the vision, the seeing, the insight, the knowing, the attestation, and the revision (Eriksson & Nordman, 2004). The relationship among these concepts depicts the inner movement, the phases of evidence, and the forms the structures of a theory. By the aid of this relationship, a clear picture is attained of how evident judgments are formed.

The vision provides direction for the movement. The concept of vision includes having foresight and has a connection to evidence through the Latin words vidēre, to see, and vidimus, we have seen (Hellequist, 1993) and has been given the following definitions: a thought, a concept, or an object formed by the imagination; a manifestation to the senses of something immaterial; the act or power of imagination; the act or power of seeing. The seeing and the knowing are connected with the light that is seen. Bergman (2003) brought
the etymological interpretations of the words together and provided support for the reasoning conveyed in this column. Know is etymologically linked to the Latin, video, I see, and Bergman posed the question: “What more do we need in order to realize that see and know belong together? [italics in original]” (p. 176). The vision thus provides a picture or an idea about the substance of caring, which guides the movement toward a deeper seeing and knowing, toward ontological evidence.

Attestation signifies guaranteeing validity through the derivation from evidence. To attest refers to a witness, as in the Old Swedish word, vitne, meaning evidence, argumentation, testimony and testimonial, more concretely, a person who attests testifies to witan, to know; that is, a witness is a person who knows something—corresponding to the Greek eidos, a person who has seen (Hellquist, 1993). By attestation an evaluation is made of whether something is true, or an estimation of the truth. In the attestation, the copy, the picture (Gadamer, 1997) attained as a result of research, is compared with the original, the ontological picture, and in the revision a change of reality against the original takes place. In accordance to an aesthetic way of thinking, the picture is also assessed on whether it corresponds to the good and the beautiful.

To attest means to express that which has been seen. Through attesting an assurance is made about something as being fully in accordance with the truth about real conditions. By attesting to a document, for instance, one indicates that the copy is in agreement with the original. To bear witness is to provide a statement about something that is the truth. A witness is a person who is used as a source of knowledge and who brings forth evidence and testifies to something; that is to say, one announces what one knows in a matter (Nationalencyklopedin, 1995).

Through revision, that is, revising, examining, working up, and changing, the aim is to bring the reality closer to the ideals and the ideals closer to reality. The concept revise is not addressed in Hellquist (1993); however, it is described in connection to the concept revider. Revider is from the Latin, revidere, to meet or see again, from re- and videre, which through the reference to see also has a reference to evidence (Hellquist, 1993).

A distinction can be made between an inner and an outer revision. An outer revision concerns developing a structure and organization, while an inner revision occurs by means of new understanding and granting the truth. Revision also signifies working with one’s own understanding and prejudices in order to, with a keen eye, see reality for what it truly is.

A new reality emerges as a result of the process of formulating evidence, and something of what is true emerges, and thus, an ontological clarity has been reached. Knowing appears as different patterns of knowledge and gradually an underlying ontological theory steps forward (Eriksson, 2009). The process of evidence is to be understood as a hermeneutical movement among understanding, interpretation, whole-part, and the unique and the particular. The moment of application is, according to Gadamer (1999), ever present. Through seeing and insight into different realities a picture emerges of the caring reality and a concrete situation is shaped. The real, the true is made visible through arguments in the form of proof and testimony. The movement may be viewed as a process of research where an ever-present risk arises of reality being obscured behind the veil of Maya. Obscuring the real object of research might lead toward an examination of the accident, thus running the risk of providing wrongful evidence. In spite of this fact, contextual evidence can still be shown, yet denoting more evidence of the accident that constitutes the real being. It is obvious that in order to reach ontological evidence, this presupposes a development of methods in a hermeneutical frame of mind.

**Evident or Not Evident—To Be or Not to Be**

One of the eternal truths, which needs to be repeated time and time again and to be handed down to the coming generations of nurses is the old head-heart-hand model (Dock & Stewart, 1925), based on the assertion that nursing is simultaneously an art and a science. The model summarizes the linguistic meaning of evidence and Gadamer’s thought on evidence as the truthlike, the beautiful, and the good. It is through refinement and ethos that human beings can take up an approach and act in a way that allows the true, the beautiful, and the good to come forward as thought, the address of the heart, and the deed of the hand. Knowledge becomes refinement when it is connected with an ethos, which means that human beings are able to widen their horizon. Research and scientific knowledge provide evidence and a limited and fragmented knowledge about reality, but these are not in themselves prerequisites enough to reach the depth of the world of caring and nursing. A will to really understand is
needed, as well as an absolute presence in the concrete situation. Whether knowledge will prove of use for patients is a question of individual nurses’ being in the world and having the insight that the patients’ situation is also their concern. In order for the true, the beautiful, and the good to be shown as an active part of caring, nurses are needed who have uncovered Maya’s veil and who have keen thought and a keen eye, and who, with a warm heart and loving words, allow the hand to form the caring deeds that carry the light of beauty. I want to leave the last word to Shakespeare (1980):

My words fly up, my thoughts remain below. Words without thoughts never to heaven go. . . .-the rest is silence. (pp. 87-144)

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the authorship and/or publication of this article.

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Aim. This paper aims to explore the existential aspects of living with addiction.

Background. This study arises from data from a previous research project carried out by the author and takes as its point of departure the patient’s perspective. Addiction is described as being related to traumatic experience and to loss of control, shame, guilt and low self-esteem, but also to spirituality. This causes profound suffering and drugs are used as a means of handling this suffering.

Design. Hermeneutic inquiry was used to explore peoples experiences of living with addiction.

Method. The first study was based on interviews with people with rich, personal experience of addiction. This study constitutes a secondary analysis of the same data and was conducted using a hermeneutic approach.

Results. On an existential level the experiences of living with addiction can be understood as a striving to meet and resolve challenges associated with spirituality caused by a person’s suffering and, paradoxically, also by his/her efforts to relieve that suffering through the use of drugs. These challenges are presented as themes focusing on the conflict that must be met; meaning – meaninglessness, connectedness – loneliness, life – death, freedom – adjustment, responsibility – guilt, control – chaos.

Conclusion. Living with addiction appears as being in the midst of a struggle with existential challenges. Furthermore, the use of drugs is paradoxical as it momentarily relieves suffering but at the same time increases it.

Relevance to clinical practice. Addressing the challenges will facilitate nurses interaction with addicted persons. When facing challenges, including the motivational aspects, instead of focusing on problems, health can be promoted and suffering relieved.

Key words: addiction, hermeneutics, narratives, nursing, secondary analysis, spirituality

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Introduction

Within caring and nursing science, health is considered not only as the absence of illness, but also as a sense of well-being and wholeness. Thus health could be perceived as ‘an individually defined phenomenon’ (Watson 1985, p 219) making any operational definitions of the concept impossible. However, efforts have been made to describe health, for example by Eriksson (Eriksson et al. 1995, Lindström et al. 2006) who in her ontological health model relates wholeness to a multidimensional view of the person as body, soul and spirit and a person’s perception of unity within as well as in relation to the world (Eriksson 2006). This perspective of health involves considering not only the patient’s symptoms, problems and suffering related to illness, but also the person’s very existence. To alleviate suffering the nurse should consider the patient’s experiences in life and be able to assist him in finding constructive ways of dealing with these experiences.

Background

Earlier research relevant to this study has focused on the addicted person’s reasons for taking drugs as well as on the process of recovery. Traumatic experiences may cause such profound suffering that a person will seek to handle the...
situation by means of drugs (Davis 1997, Nehls & Sallman 2005). Perceiving oneself as inferior to others and alienated from self and others, as well as being afraid of revealing oneself as vulnerable, are also described as motives for using drugs (Boyd & Mackey 2000a, Wiklund et al. 2006). Research also reveals that the use of drugs changes perceptions of self (Gray 2005) and aims to provide a means to escape psychological pain (Boyd & Mackey 2000b, Zakrzewski & Hector 2004). However, drugs contribute to further suffering, such as loss of control but also feelings of shame and guilt associated with low self-esteem (Merrit 1997, Ehrmin 2001, Edwards 2002, Lillibridge et al. 2002, Brown 2006), feelings of addictive behaviour and experiences of failure. Furthermore, feelings of being inferior to others might be manifested in a process of subjectification (Curtis & Harrison 2001), where individuals internalise social power relations and thus look at themselves through the eyes of others. These feelings contribute to suffering and as long as they are not resolved they will become a barrier to healing. Feelings of shame and guilt appear to be related to the human conscience as the person struggles with what is and what ought to be (Stolte 1999). Thus addicted people are ambivalent, knowing the trouble the abuse causes, but also the relief it provides (Smith 1998). The turning-point is also an important phenomenon, a place of no return where a shift in behaviour and/or view of self is necessary (Koski-Jannes 1998, Kearney & O'Sullivan 2003). Several researchers also relate addiction to the spiritual aspects of being (DuPont & McGovern 1992, Bowden 1998, Finfgeld 2002, Wright 2003).

The study

The study constitutes a secondary analysis of narrative data. Secondary analysis is an appropriate method for supporting existing theories as well as generating new knowledge and expanding understanding of a particular phenomenon (Thorne 1993, 1998, Szabo & Strang 1997, Corti & Thompson 2004).

Pre-understanding and aim of the study

My pre-understanding derives from an earlier study (Wiklund et al. 2006), based on the same data, but analysed using a different method to answer different research questions. The former study described the struggle of suffering in addiction as a struggle between shame and dignity and also as a struggle with life. I consider that these findings represent my pre-understanding and can be taken as the point of departure for this research.

It is likely that struggling with life will raise existential questions. As the earlier study did not focus on this area closely enough further analysis is motivated to highlight the topic. This paper thus aims at exploring the existential aspects of living with addiction.

Data

The approach used to secondary analysis is described by Thorne (1993) as ‘analytic expansion’, which is the researcher’s use of own data. Data consists of written material from qualitative research interviews (Kvale 1992) with informants who had rich experience of drug abuse. The informants were four women and five men aged between 35–46 years. The interviews focused on informants’ life-histories (Hagemaster 1992) and started with an open question: ‘Could you tell me about who you are and what experiences you consider important for you becoming this person?’ Subsequent questions aimed at exploring and expanding the informants’ narratives. The interviews were transcribed verbatim and the text used as data in a hermeneutic process.

Data analysis

The text analysis was guided by a hermeneutic approach based on Gadamer’s (1989) philosophy of understanding, developed by Ödman (1988, 1992) and further refined by Söderlund (1998) and Söderlund and Eriksson (2006). Within this tradition questions of meaning are central and linked to a person’s reciprocal interplay with the situation, which makes inquiry focus on ontological aspects (Annells 1996). The process started with a thorough reading of the material to grasp the whole. Generative words and phrases were then marked in the text to grasp their meaning in relation to the aim of the study. Interpretation then followed conducted in three phases, as shown in Table 1.

The first phase was a ‘rational interpretation’ (Ödman 1997), often described as ‘good-reason-essay’, aiming to understand the person’s motive for acting. The idea behind this level of interpretation is that human beings act for reasons that make sense to them. The question posed to the text in this phase was: ‘What is the person trying to accomplish through the use of drugs?’

The next phase involved ‘structural interpretation’. In this phase the research object is studied more closely with focus on specific situations, events and actions. The purpose is to study the contextual structure of which the research object is a part, by recognising how different aspects are related to the informant’s situation and the surrounding context. This explanatory step makes it possible to understand the different
parts in relation to the gestalt of which they are part (Söderlund & Eriksson 2006). The question that seeks an answer is ‘What circumstances influence the addicted person’s perceptions of being?’

The next phase is ‘existential interpretation’ and at this level interpretation focuses on the existential world as the world of the text (Söderlund & Eriksson 2006). The understanding is related to the experiences and living conditions for human beings and develops when the researcher is able to appropriate, or to ‘make one’s own what was initially alien’ (Ricoeur 1995, p. 185), the meaning of the text. Thus, in this step, interpretations are de-contextualised from people’s perceptions, focusing the text as a carrier of meaning. The findings are described in terms of existential themes that arise when re-reading the text in the light of the former levels of interpretation. The term ‘existential themes’ thus describes results of analysis and is a consequence of the hermeneutic approach referring to the level of interpretation.

These themes, however, should not be understood exclusively as separate entities. To obtain a hermeneutic understanding they, as parts, should be understood in the light of each other and thus also in the light of the whole (Gadamer 1989). Thus, as one theme is given prominence the others are simultaneously more or less explicit in the background (Dahlberg 2006).

**Ethical considerations**

I strongly agree with Sandelowski et al. (1997) when she argues that we have to be more wary of asking vulnerable individuals to participate in yet more studies if our aim is to obtain data that already exists. The aim of the original study, which was approved by a local research committee, was to explore patients’ experiences of suffering with addiction and of alleviation from suffering. Thus the material is used in a similar way to that which the informants and the committee first agreed. Furthermore, the informants have given their informed consent to re-use of data.

**Findings**

The presentation of findings follows the phases of interpretation described above. However, focus will be on the existential level of interpretation.

**Rational interpretation**

This phase of the study focused on understanding individuals’ motives for using drugs. The main motive was to escape suffering, but the researcher was able to recognise two sub-themes. The first was linked to the more direct capacity of drugs to relieve anxiety and unbearable feelings, the second related to the effect the drug had on the person’s perception of him/herself as a person:

I had an identity when I was on drugs. I could set the boundaries and make my voice heard. But when I was sober, I felt incredibly small and afraid. Then I did things to get people to like me, to see me, things I really didn’t want to do just to be seen by others. So when I quit taking drugs, I had a tremendous identity crisis, ‘Who am I?’ Because when taking drugs I was somebody. But without them, I was nothing, I didn’t exist.

The use of drugs is used as a means to gain an identity with which one feels secure and confident.

The environment does not acknowledge the real person, neither does the person acknowledge himself/herself.

Life and death (feeling socially and psychologically alive). Connectedness and loneliness (cut off from inner self and from others).

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<tr>
<th><strong>Rational interpretation</strong></th>
<th><strong>Structural interpretation</strong></th>
<th><strong>Existential themes</strong></th>
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**Table 1** The interpretation process

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This first interpretation places focus on the person’s ‘good reason’. The use of drugs makes sense to the abuser as it helps him/her to handle feelings of shame and inadequacy.
Structural interpretation

Taking analysis further, focus expands from the individual as a part to the context as a whole. To what extent is the use of drugs a matter of interaction with one’s environment and not just a means to handle inner experiences? The informants describe how the environment either ignores or exploits them when they are not high; ‘I was nobody, what I wanted didn’t count’ (Margareta), ‘I used to lie, be dishonest and pinch things to buy friendship’ (Per) and at the same time they fail to confirm their own value. They also narrate experiences that promote their perception of themselves as a person that needs to take drugs to become a person able to please others:

And then, having these therapy sessions with her, she says: ‘It’s impossible to talk with you, you are so childish, so naive. You will never grow up’. She was saying this all the time; it was how she saw me… Then I took myself a relapse and came back high [—]. And she started ‘Oh my God, you are so nice. You have really grown up. You’re so polite and well-mannered. (Hans)

The interpretation at this level reveals that the informants are acting together with others in a system that in different ways reinforces their experiences of alienation from the common world. Because other people do not acknowledge them as individuals when they are not high and then show them appreciation when on drugs, it is hard to quit. Or, as the informant said: ‘It’s not quitting that’s difficult, it is living without drugs’. To be able to function in the world without the perceived strength and/or relief from suffering that drugs offer appears impossible, as the person feels unable to handle life on his/her own.

Existential interpretation

The main emphasis in the findings is laid on interpretation of the existential world. The earlier phases of interpretation provide the basis for this, but the focus now has shifted from the individual and the contextual level to a level of common understanding of this aspect of humans being in the world. In this phase of interpretation existential themes were found in the text, themes that appeared as a struggle or a movement between different aspects of being.

Meaning – meaninglessness

Human beings by their nature create meanings to understand the world. Our search for meaning is a question of not only how we understand the world and ourselves, but also of what it is that gives our life a particular direction. It is about having a belief in something and about experiencing oneself as whole and connected to life. It is not only about knowing things, but also about being aware of what we know and what implication this knowledge of the world has for us:

I never got the chance to learn the most important thing – the most important corner-stone in life, to be able to love myself. I sought out and lived in destructive relationships, relationships that constantly confirmed how bad I was. Today I can see that I let that happen, because I believed that I was useless. (Maria)

Earlier experiences help us create maps that will help us to seek guidance in life. If those early experiences are of being unloveable and worthless they will colour one’s view of the world. The inner picture of oneself as worthless and shameful is a frame of reference that helps the sufferer to create a pattern of meaning in the sense of making life understandable by organising experiences accordingly. Everything that happens in life can be explained as a consequence of being such a bad person.

As a person creates a meaning of him/herself as worthless, the meaning of life might be that it is meaningless. Thus, when understanding life from this perspective, life itself appears to be without meaning. Being worthless makes all desires and wishes worthless too, one’s longings do not matter anymore.

Connectedness – loneliness

When considering meaning one is also presented with the theme of loneliness and connectedness. Ascribing a meaning to life of not being worthy of being in communion with others will bring to light feelings of loneliness. At the same time, as shown in the earlier phases of interpretation, the person is striving to be part of a community with other people and drugs might serve as means of making this possible. Loneliness develops in relationship with others – we will experience loneliness when we feel that we are not accepted by others and unable to share feelings and thoughts with them, either because there are no other people present or because we are afraid that they will not understand our feelings and, instead of listening, neglect us or even blame us:

It was just that feeling, of not belonging together with others. I set myself aside in a way. And that feeling became even stronger when I started to take drugs. Then I became less myself, but in a way I felt confident with this new person, who never had to think about how to behave to fit in. But at the same time I was afraid that people should see who I really was, that they would turn their back on me. (David)

Not recognising one’s own feelings makes people become strangers not only to others, who never get the chance to know the real person hiding behind the façade of addiction, but also to themselves. Feelings of being rejected lock people into loneliness. Being alone with oneself, unable to meet the
inner person, makes people start wondering and this might lead to questions not only about being lonely, but also about life itself.

**Life – death**

Experiencing life as more or less meaningless and oneself as lonely will also raise questions about life and death. Thus, being in the midst of suffering might also about questioning one’s own right to be alive:

As a teenager I thought that nobody loved me, nobody even liked me and that there was no place for me here, instead I… I didn’t think that I would ever live to become grown-up […] and then when I was grown-up I tried to jump from the balcony. (Lars)

Another aspect relating to this is more symbolic – when feeling neglected as a person the struggle involved in suffering is also a struggle to stay alive or die as a person. Drugs provide the means to become someone whilst paradoxically, preventing one from being oneself:

When I quit taking drugs, I had a tremendous identity crisis. ‘Who am I?’ Because when taking drugs I was somebody. But without them, I was nothing, I didn’t exist. (Maria)

The use of drugs thus aims at creating a feeling of being alive, of existing – at least on a shallow level. Drugs make you become someone, even if it is not yourself.

**Freedom – adjustment**

Another theme is linked to our need for freedom and our longing to feel free and experience happiness. However, paradoxically, it is not possible to experience freedom when lonely. Freedom and the happiness associated with it, is closely linked to relationships, not to an individualistic self. When feeling alone, one starts to adjust to others to fit in, thereby losing a profound sense of freedom. Instead it is a pseudo-freedom linked to actions, not to being:

I had to adjust to them. And there were always lots of demands that I had to fulfill to get any kind of freedom, or as I experienced it, anything that I could decide on my own. (Eva)

However, if people do not feel free in relationships with other people and feel that they have to adjust and hide behind a facade, they will try to escape from the boundaries created by the situation by using drugs. Eva continues:

I really do remember getting drunk for the first time. It was a feeling of freedom I had never imagined before, almost divine. It was like a new world opening up for me. I felt just so great, like ‘Life is now! Now!’ Finally I had found something that could give me strength, make me feel that I’m just as good as everyone else, maybe even better.

As drugs will activate parts of the brain that are associated with pleasure and happiness they will have only a temporary effect, creating a craving for drugs because they seem to fulfill the need for freedom and happiness. But because it is a faked experience in an inner world, lacking a connection to the person’s outer reality, it will not last, but rather enforce feelings of guilt and shame.

**Responsibility – guilt**

When re-connected to themselves and starting to feel alive and ascribing new meaning people also experience responsibility and guilt. Guilt as well as responsibility is linked to the sense that one is connected to others and that one is free to take responsibility for one’s own actions. Being connected to others means that one has to take responsibility for one’s own actions, being not only able to face up to things oneself, but also to see that those actions will have consequences for others:

I’ve done so many bad things, been a real pain in the ass for them. For my parents, for her, for everybody […] there wasn’t anybody as hopeless as me. And it was possible to help me, to make me change and get out of that situation, then it must be possible for everybody else too. And if I can be an example for them, that is what I want to be. (Erik)

Thus, getting out of the lonely world of addiction people will often suffer from feelings of guilt, as they will have probably caused other people trouble as a result of their addiction. This often results in an urge to help others, thereby paying back and trying to make things right, but it will also help people to restore their own sense of value and dignity.

**Control – chaos**

When lacking freedom and personal space, being unsure of who one is and of one’s place in relation to others, feelings not only of meaningless arise, but also of chaos. As has been shown the addicted person is constantly struggling to create meaning in a world where inner and outer experience do not match. Informants’ descriptions of life can be interpreted as a struggle in a chaotic world, striving to get some sense of control. Seeing oneself as a bad person one acts accordingly, trying to get one’s inner and outer world to match and thereby experience order:

I felt so bad, in my own world, in my own circle. […] Because I was so fixated on my own affairs, thinking that all I had was a great problem. […] I could not put on the brake. It was like a treadmill and at the same time I wanted out. But everything just went on and on. (Erik)

The informants thus are busy handling different aspects of their lives, trying to keep some kind of control. Strategies
aimed at regaining control, i.e. taking drugs are perceived as possible ways out of loneliness, meaninglessness, guilt and other aspects of suffering, will in the end increase experiences of chaos, because instead they contribute to a person’s feeling of being cut off from life and being forced to adjust.

Towards a new horizon of meaning

As result of analysis, experiences of living with addiction are interpreted as struggling with different challenges. These challenges arise from the existential themes identified by analysis and people living with addiction are constantly struggling to resolve the conflicts raised in them. Drugs are aimed as a means to resolve the challenges but, whilst giving temporarily relief, they simultaneously increase the perceived tension related to the challenges. When the tension is clearly felt by the person involved it can be described as a turning-point that provides a pivotal moment towards a new direction in life and towards recovery.

When these challenges are raised in the lives of addicted people the spiritual dimension is involved. The author chooses to use the concept spiritual instead of existential further on to (i) be in line with the view of humans as body, soul and spirit in accordance with Eriksson’s health theory that underpins the study (Eriksson et al. 1995, Eriksson 2006), (ii) distinguish between findings (spirituality) and method (analysis of existential themes) and (iii) be consistent with the most common terminology within caring science (Westman et al. 2006). Spirituality is in this paper understood as a meaning creating driving force (Speck 2005) including three elements: self, others and ‘God’ and the relationship between them (Dyson et al. 1997). Living with addiction could thus be described not only as an illness or a behaviour causing bodily harm, or as a consequence of psychological distress or shortcomings, but also as a spiritual concern.

Discussion

The concepts ‘existential’ and ‘spiritual’ are debated in nursing literature (sf. Westman et al. 2006) where some researchers use existential as a wider concept or prefer it to avoid religious associations. This wider description of ‘existential’ refers to humans thoughts on how to understand the world, the meaning of life and how one should live it and is thus in line with the hermeneutic approach chosen in accordance with the aim of the study. Other researchers describe the human search for meaning as the existential aspect of spirituality (Fry 2000, Emblen & Pesut 2001, Fawcett & Noble 2004). In this study ‘spiritual’ is used to describe findings while ‘existential’ refers to methodological concerns. Thus, humans understanding of the world is an existential matter (Gadamer 1989) and some aspects of understanding of our existence are related to spiritual issues. The author does not claim that challenges described are exclusively spiritual as it is not possible to divide the human being into parts; body, soul and spirit are in real life indivisible but focusing on one aspect facilitates the understanding of a complex reality. Thus the challenges should be understood as associated with spirituality and the discussion focuses on the connection between the challenges and spirituality.

Meeting the challenges is closely related to the view of spirituality as a driving force within the person (Speck 2005). When coming to terms with the challenges persons also perceive growth, as they have to make changes in life. Each of the challenges described also has links to spirituality. The challenge related to meaning – meaninglessness is easily understood within the framework of spirituality, as meaning is often described as central in spirituality (Fry 2000, Sivonen 2000). The question of meaning is also a question of one’s own being in relation to others and with the world of which God might be perceived to be a part. It is argued that the other themes too are to be considered as describing spiritual aspects of being. The other challenges are in one way or another related to how the person creates meaning in life and the challenges described as connectedness – loneliness, freedom – adjustment and responsibility – guilt are explicitly related to one’s relationship with other persons (sf. Dyson et al. 1997). However, these challenges also speak about the person’s relationship with self as they are about being connected with – or cut off from – oneself, experiencing oneself as genuinely free and taking responsibility for one’s actions. Life – death is related to spirituality as it is about experiencing oneself as being alive as a person, while control – chaos are related to the other challenges, as striving for control aims not only at acting responsible but at regaining a sense of being alive and connected with others, feeling free and experiencing meaning in life.

As presented in the background, patients’ experiences of shame and guilt are already well known (Merrit 1997, Smith 1998, Boyd & Mackey 2000a, Ehrmin 2001, Edwards 2002, Zakrzewski & Hector 2004, Nehls & Sallman 2005, Brown 2006), as is the importance of people’s experiences of self (Finfgeld 1998, 1999, 2000, 2002) and the taking into account of the spiritual dimension (DuPont & McGovern 1992, Bowden 1998, Wright 2003). Questions related to meaning have also been described (Fredriksen & Lindström 2002) as have those related to belonging and freedom (Gray 2004). So what is new in this research?
Relevance to clinical practice

I claim that the description of challenges is new in the sense that themes are described and synthesised to a new whole, not as separate parts. By letting each theme momentarily take its place in the forefront and exploring it in the light of others gives birth to a somewhat new understanding. Re-contextualising themes as challenges for patients to meet presents a new understanding of living with addiction. Furthermore, exploring these challenges, can contribute to the understanding of what is happening when the patient reaches the turning-point described earlier as central to recovery (Koski-Jannes 1998, Lillibridge et al. 2002, Kearney & O’Sullivan 2003, Zakrzewski & Hector 2004). In Paper 2 another step will be taken, to explore the kind of caring needs linked to the challenges and reflect on how nurses can assist the patient in meeting them.

Methodological aspects

Hermeneutic understanding is concerned with questions of how we understand and experience existence (Ödman 1988, Gadamer 1989). Thus it is a question not solely concerned with research methodology. In a wider sense hermeneutic philosophy is also about humans being in the world and in this study about living with addiction. Focusing on existential aspects of living with addiction is thus a consequence not only of a methodological choice made to describe an informant’s experience, but also of a view of humans being in the world, while linking the two to spirituality through analysis.

Narratives are characterised by relevance rather than authenticity (Cöster 1981). Thus the value of a narrative is not dependent on the circumstances surrounding its creation, or whether it is true or not, but on its relevance in relation to understanding the world of human beings. In this light it is possible to argue for re-use of data as plausible in narrative-based research as long as there has not been substantial change in human conditions in the area to be studied.

Could a meta-synthesis (Finfgeld 2003, Zimmer 2006, Bondas & Hall 2007) have led to the same findings or would empiric data have been necessary? A meta-synthesis might have contributed to a similar result, but probably it would have been more difficult to find the inherent pattern linking different themes to each other. New empiric data would, probably have given findings close to these as the interviews already focused on the participants’ experiences of life using the hermeneutic approach.

Another aspect of this secondary analysis is to ask to what extent the findings are misleading and only reflect my pre-understandings. This is an obvious risk, but as other research questions were posed to the text and a different method for analysing data was used this risk has been minimised. Throughout the process I have striven to be open to what is presented by the text and the fact that new aspects have arisen, such as freedom and loneliness and believe this justifies this approach. However, it is obvious that there are similarities between the findings in this study and the earlier one, especially in relation to informants’ experiences being described as a struggle. Nevertheless, this is not necessarily a flaw, rather it can be related to the fact that aspects of struggling are central to suffering (Lindström et al. 2006).

Generalisation in qualitative studies is not about making statements that make it possible to draw conclusions from the sample applicable to a larger population, but about giving a basis for the nurse’s reflection and decision-making in clinical situations with individual patients. Thus it is more a question of the credibility and fittingness (Sandelskow 1986) which is obtained when the findings fit situations outside the research situation and readers’ perception of them as being meaningful and applicable in relation to their own experiences.

Conclusions

In this study living with addiction appears in two forms. On the one hand, the use of drugs helps the person to deal with life; on the other abuse, in the long term, does not relieve feelings of chaos, loneliness, guilt and shame and being cut off from life. At a profound level it is a struggle between life and death where people have to meet spiritual challenges. Spirituality as a driving force (Speck 2005) should be considered with care. It is not enough to focus on the negative side of the challenges and deal with them as problems. To promote growth it appears important to consider values linked to the positive side and help patients to achieve them, as this will give them strength to deal with the negative aspects in new ways, instead of using drugs. In this study, aspects of this dimension have been highlighted, by describing existential themes reflecting spiritual challenges that individuals have to meet. A later paper develops caring needs from those challenges and reflects on how nurses can assist patients in meeting them.

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Patient perspectives

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Contributions

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The hidden and forgotten evidence

Evidence is concerned with reality and truth and pertains to general nursing science as well as practical caring. Surprisingly little attention has been paid to the question of evidence in our journals of nursing science, a fact which can be seen as paradoxical in view of the increased diversity of empirical studies. Is it really the case that the identity of nursing science is rather feeble and that we are hiding behind a seemingly obvious concept of evidence rooted in natural science? Multiplicity of knowledge can either be a rich resource or a “Maya’s veil” covering up reality and reducing caring to techniques and procedures. Absolute evidence presupposes that the ontological questions have been elucidated and given verbal expression. The ontological questions which concern human life are eternal and difficult to capture. It is the ontological evidence and the fundamental questions of caring that we, Kari Martinsen and Katie Eriksson, have made the subject of our dialogues since the beginning of the 1980s.

We are both grappling with these questions, from a shared background in humanist sciences but rooted in different traditions. We maintain that working with the ontological questions yields evident insights, an absolute form of evidence which needs to be constantly re-created, using rediscovered and creative words and concepts that others can receive, find resonance in, transform, and share again and again, in new forms of expression. This implies that what is evident, has to be dressed in words, in Eriksson’s expression, or that dynamic word shaping is important, in Martinsen’s expression. Not everything can be expressed in the same way, and when one aims to express the fundamental presuppositions of human existence, then a narrative style in the form of that-statements and a more essayist type of writing are required and unavoidable. These that-statements have to do with life’s fundamental conditions not chosen or created by human beings. Included under such phenomena would be that life is vulnerable, that we are frail and fallible beings, that we are dependent on each other and at each other’s mercy in matters of responsibility and power, that we are always sensing and always trying to make sense of what is touching us through sensing, that suffering is an integral part of life, that life is finite and death assured, but also that life is sustained by phenomena such as hope, mercy and charity. These fundamental aspects of existence are subsumed under the ontological questions where ethos and the ethical questions are integrated. All of this presupposes a concept of evidence rooted in the human sciences, as discussed in our book Å se og å imme (“To see and to realize”) (1), where we present a more holistic/comprehensive concept of evidence. Evidence as a concept of nursing science unifies what is human and what is nature-given.

Katie Eriksson approaches the question of evidence from an etymological, conceptual, and linguistic perspective anchored in Gadamer’s philosophical hermeneutics and his views on evidence. Evidence as a concept pertains to truth, reality, and being in the world; it involves seeing, realizing, making visible, and clothing thoughts into words. The etymology of concept and Gadamer’s hermeneutical philosophy provides a deeper understanding of the concept of evidence. Ontological or absolute evidence is based on being and the true reality that extends beyond the immediate reality.

Evidence as a concept and phenomenon has been part of the scientific discussion for centuries and was originally developed in law. Schjøth (1933), a Norwegian philosopher, emphasized in the early 1900s that evidence does not mean creating a more or less good concept of experience, but it is a means to bring about knowledge of reality. The concept of evidence is derived from the Latin evidentis and evidentia and means quite generally a basic feature of the truth. Evidentis consists of e (ex), out of, and videre, meaning “see” and “realize”, which is related to know. Etymologically, the concept of know is derived from to see, experience and feel. The Sanskrit word veda means I know. The Sanskrit word vedayati means allow to know, announce, inform. These dimensions are the basis of a caring science ontological definition of the concept of evidence. Based on the linguistic importance of evidence-evident, it can be seen that these words, in their original meaning, have a completely different signification than today’s empirically highlighted concepts of evidence.

Ontological evidence implies that the true reality may emerge and become visible in all its beauty and goodness. That which is evident, according to Gadamer, is always something that has been said and which then needs to be made visible and valid. Nothing is evident until it is spoken and dressed in words. According to Gadamer, it is likewise clear that the evident is always something surprising that widens the field observed. It is like when you finally understand something.

Kari Martinsen enters the discussion of evidence from the point of view of phenomenological philosophy. The task is to work with what is present in everyday experience but overlooked. Phenomenological philosophy will remind our everyday understanding about something in its own presuppositions which it has difficulty making explicit: the existence of life’s fundamental conditions as expressed through that-statements. These represent phenomena, which are by their very nature universal and typical in appearing before us in singular situations. We cannot lock
their meanings into tight definitions, nor do we have exhaustive knowledge about them. We cannot know more about them than we ourselves have experienced or others have shared with us of their experience. We can discover something about them on the basis of a singular situation which is always sensitively tuned, filled with impressions, and which a person is seeking to express. All life is tuned. We recognize tuned sensations which emerge from holding in our hands something of the life of a vulnerable person. We have in our own lives experienced what the compassion of others can mean. In our sensing we are always tuned by impressions carrying significant meanings, impressions which we are touched by and which move us. Phenomenology deals with releasing and expressing some of the meaning inherent in the impression which moves us (life’s fundamental conditions expressed through that-statements). It is to uncover and be able to describe the tuned sensations within the phenomena that reveal their universality in the singular situation.

“The articulation of impressions” is my designation of this phenomenological philosophy which takes as its pivot the thinking of K.E. Logstrup, the Danish philosopher.

In the articulation of impressions two aspects are essential: The first concerns what the individual person receives, the meanings carried by the impression itself. This is what is being received, e.g. from the patient. In the interpreting release of the impression one needs to be aware of the resistance which the impression in itself offers against our intervention. It is a critical resistance or challenge to the understanding subject exerted by the phenomenon which makes an impression on us. It evokes a cautious gentleness not to violate or infringe on the untouchable zone of the other. The second aspect essential to the articulation of impressions is what the individual person contributes. Here we find three inseparable considerations: That we are open and perceptive to what makes an impression on us, that we actively discipline ourselves to stay with the impression and let it sensitively tune us, allowing some meanings to emerge from what has made an impression on us, and that we make room for reminiscences in the interpretation of our impression. In reminiscing, we will in the here and now be reminded of something which brings us toward something else. Reminiscence refers us to a creative aspect of articulating our impressions in a sensitively tuned space for thought.

The articulation of impressions involves the art of actively shaping words, which aims to find expressions allowing the tuned sensitivities of the impression to resonate through. Phenomenology is concerned with interpreting the sensitively tuned impressions. It invites a variety of expressions in narrative form. Phenomenology can thus not be said to be an expression of “sameness,” for which it has been criticized. It is rather the opposite, setting distinctions and contrasts in order to describe the same phenomenon in the greatest possible range of nuances and variations. This enables us to recognize vulnerability as a phenomenon as described in a variety of situations.

Summary

It is necessary to discuss and reflect upon evidence as a concept of human and caring science. We maintain the ethical obligation of constantly repeating the basic sustaining expressions of care to open up for alternative insight into true reality. In the sensitively tuned space for thought in phenomenological philosophy, and in Gadamer’s philosophical hermeneutics, there must be room for reflection, wondering and imagination, and furthermore for expressions that assume and reflect a connection between the concrete aspects of the situation and the phenomena one strives to express (life’s fundamental conditions in the form of that-statements). There is thus no avoiding the dynamic shaping of expressions which may uncover and display the ontological aspects of human existence as evident, as well as articulate them, translate them into words and deeds which can reach the suffering person.

Absolute evidence exists only here and now in a concrete situation where the universal meets the particular and is unified in a receptivity of truth, where theory and its practical application are joined in a harmonious unity: the fundamental, sustaining idea of caring, and a great variety of knowledge forms is developed for the good of mankind.

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