International Journal of Nursing
June 2024, Volume 11, pp. 15-31
ISSN: 2374-2321 (Print), 2374-233X (Online)

Published by The Brooklyn Research and Publishing Institute
DOI: 10.15640/ijaah.v11p2
URL: https://doi.org/10.15640/ijaah.v11p2

# Empirical Phenomenological Study on Caring in Nursing. The Prerequisites for an Ethics of Care

**Maria Caterina Salvini[1*], Luigina Mortari[2]**

**Abstract**

To act well at the nursing level it is essential to act well at the caring level. Good nursing care practice cannot be separated from well-done nursing practice. This reference to the good in referring to the appropriateness of care in general, and nursing in particular, is the object subjected to clarification in the research. Caring is a multidimensional activity, in which thought, feeling and competent action are mutually integrated. This multidimensionality is essential for good caring to be practiced. From the narratives of the care practice collected, ethically significant actions emerge, which explain how this good is expressed in the concrete action of the nurse towards the patient, through an intentionality in acting in relation to the history of the individual patient. The research is methodologically structured on two dimensions: the phenomenological and the empirical one. The results obtained lay the foundations for the search for an ethics of care.

**Keywords:** Caring, Nursing, Empirical Phenomenology, Qualitative Research, Narrative Medicine, Bioethics

## 1. Introduction

The starting question of the research is: what does good nursing caring consist of? This question, however, is broken down into four other sub-questions: What is the essence of care? What are the specifics of nursing care? What are the behavioral indicators of care? What are the appropriate research methods to investigate the topic of care? The research team is made up of two academic researchers – one with experience in qualitative research, one with experience in quantitative nursing research – and six nurses.

The phenomenological method involved questioning the thoughts of healthcare professionals, trying to understand their experience through the narration of their experiences. Reports have emerged in which the words are full of reality and researchers have had the delicate task of reconstructing the meaning and conceptualization of nursing caring.

This research aims to investigate care in the nursing field from a phenomenological point of view, and in what sense we can talk about good care and, therefore, good nursing practice. Underlying every care practice is the dynamic between healthcare worker and patient, from which emerges the asymmetry deriving from the patient's condition of fragility, which is therefore at the center, and the caregiver's assumption of responsibility.

Phenomenological work is fundamental to outline the essence of this dynamic condition between caregiver and patient. But a theoretical analysis of the postures that can be had in front of the sick person is also fundamental. Both of these investigations must be enclosed in a further epistemological framework since the research work continually requires clarification of its methodological demands. In relation to the patient, we will therefore analyze both a description of his ontological condition and the posture that the patient himself and the operator who has to deal with this situation experience in front of it.

[1]Scholar at University of Verona, member of CERC (Caring Education Research Center), Email: caterina.salvini@gmail.com ORCID: 0009-0003-1848-4306.
[2]Full professor in Epistemology of qualitative research at University of Verona, Email: luigina.mortari@univr.it ORCID: 0000-0001-7181-6072.

## 2. Phenomenology of the Patient's Experience

The core of the patient's experience is that of the illness, of the relationship with his weakening body and of the pain, which is never just physical. In outlining such a complex phenomenology of the patient's experience it is important to start from the Steinian concept according to which body and soul are one. Not only does the body contain the soul of the person, but the person feels and lives every part of his body thanks to the soul. This phenomenological conception of the body - which is also found in Husserl and Merleau-Ponty - is accentuated when faced with the experience of illness, in which it becomes clear how the wounds of the body have repercussions on the soul, marking it. In this sense, we cannot speak of the patient as a mere object of clinical practice, but as a subject who deeply and subjectively experiences his illness.

Illness is a condition of fragility and vulnerability in which the human being is dramatically faced with his finitude, that of an entity that is placed in being but alone is not capable of independently preserving and maintaining this state uncorrupted. Stein writes: "my being […] is an inconsistent being; I am not of myself, of myself I am nothing, in every moment I find myself faced with nothingness and I must receive being as a gift moment by moment again" (34, p 92). However, despite not being masters of our being, even in the moment of suffering, we find ourselves forced to be. Levinas uses an even stronger verb: "in suffering we find ourselves forced to be" (20, p. 244). When we are healthy, we feel the vital force that gives meaning to the steps of our actions. When, however, the body becomes ill, the pain penetrates through the flesh to the soul, making our being fear having ontological inconsistency. This anguish of thought that grips body and soul make us experience a radical passivity reveals "the impossibility of retreating from being" (20, p. 244). In the passivity of the disease, the patient is faced with the dilemma of whether to let a posture of distressing passivity prevail, or whether to let a posture of patience and acceptance win. Although this second posture may prevail in the patient, the analysis of experiential experiences highlights how a loss of even minimal sovereignty over being causes a sense of impotence to be felt in which the patient feels reduced to an object.

For these reasons, investigating the basis of good caring which translates into the basis of good nursing is essential to help the patient deal with the disease in the best possible way, avoiding being trapped in the passivizing anguish of unheeded pain and not treated. The body-soul dichotomy arises from the idea contained in Plato's Phaedo in which he describes the soul as freed from the material weight of the body, which is seen as a prison. Plato explains that it is when the soul frees itself from the chains of the body that it can seek "that which is pure, eternal, immortal and invariable" (31, Phaedo, 79d). This Platonic dualism gave rise to the reductionist conceptions of medical care that have permeated Western culture. With Edith Stein the conception of body and soul as a unicum is recovered, in which they must never be conceived separately, but as an animated body and as a corporeal soul. In this theoretical approach we can recover a concept of person understood not as an immaterial substance that feels nothing, but rather as a soul in the body, or as an animated body. Matter and spirit are inseparable, and this inseparability is what makes the human being a body that "breathes its essence in a spiritual way" (20, p. 386).

In this sense, the pain of the body is pain of the soul and for these reasons good treatment cannot separate the physical component from the spiritual component of the patient. Just as the pain of the soul manifests its signs on the body, so the pain that pervades the flesh overflows into the soul. This dynamic explains the fact that the patient should not be objectified in his exclusively bodily or exclusively mental component. It is therefore necessary to carry out well-done care work that takes into consideration this intrinsic human vulnerability, trying to heal the wounds of suffering that continually cross the border between body and soul.

*a) Care as an Ontological Premise*

Care understood in a generally ontological sense, not already reduced to the nursing scope of application, is that practice that repairs the wounds of being and facilitates the conditions for the flourishing of being. According to Collière, care is the first art of living: "from childhood to death, participate in the mystery of the life that is sought, of the life that blossoms, of the life that fails, of the life that resumes, of the life that enters the darkness" (1996, p. 11). This conception of care as a practice that cultivates the possibilities of existence is already found in Heidegger when he explains that care is what illuminates in its essence that entity which is the human being, and which therefore turns out to be an essential ontological trait, that is, primary, of being (1976, p. 420). The work of care is incessant due to our condition of vulnerability: "human life is uncertain, incomplete" (Murdoch 1970, p. 87).

The cure requires continuous ontological work, but it never manages to exhaust its project because it is always something that must be realized or repaired in being there. The term cure can be understood under different meanings. The first recalls the Greek term mérimna which means pain, trouble, anxiety; and is used in

the Gospels to describe the concern to safeguard the possibilities of continuing to exist. We find it in the parable of the birds, when Jesus invites us not to worry about life and to look at how the birds of the sky and the lilies of the field are cared for by God (Matthew, 6, 25), or how an excess of concern for life or attachment to riches leads to suffocation of the logos (Matthew, 13, 22). The sense of impotence of human life leads to taking care of life, to taking on the commitment to create a life that is fully human and worth living. In the second meaning, care recalls the Greek term epimeléia, which literally means concern and attention, and is understood as an openness to transcendence which takes over from the awareness of the intrinsic limit of being there. In fact, it is not enough for human beings to pursue the objective of mere subsistence, but they feel the need to find horizons of meaning that realize their own being. In the first meaning, the term care recalls the work of preserving living, while in the second meaning it recalls the broader attempt to make being flourish.

There is a final type of care, understood as that which helps the being in moments of maximum vulnerability and vulnerability when the body becomes ill. And here we refer to treatment as therapy. Heidegger also indicated two extreme possibilities of the cure. The first, with a negative meaning, in the sense of replacing the other in one's care work. In this sense the other finds himself dominated and this collides with the human need to feel free. Opposite to this substitution of the other, there is care as a support without substituting the other. This is authentic care that nourishes but makes responsible.In the healthcare sector, authentic care is that in which the nurse is not only concerned with carrying out the practices of the established therapeutic path, but enters into a relationship with the patient, listens to him and guides him, helping him to manage the situation with maximum autonomy and hope. new life condition in which he found himself. Then there are such serious living conditions in which no care is given other than that in which one assumes responsibility for others. In chronic disabling illnesses, serious disabilities, or in certain temporary conditions of serious illness, the caregiver is required to take on the complete burden of the other person.

When these situations of inevitable dependence occur, care must not lead to the denial of the other's being, expropriating it with excessive concern, but always balancing what is supportive with that which allows the other to express himself. In these extreme conditions, as can occur in intensive care or palliative care hospices, it is very difficult for the operator to find this point of balance and decisions are taken with great difficulty also because the other is not always able to give back confirmatory feedback. We reach the extreme point where it is the operator who decides for the patient. An example of this drama is the condition in which one finds oneself in difficult discernment in discriminating the boundary between care and therapeutic fury. For both the patient and the healthcare worker these are the kind of circumstances in which the disproportionality is felt between the desire to be and act and the risk of not being or not acting sufficiently. These are the situations in which loneliness is felt the most.From the experience of solitude which makes evident the inability to exist as singular existences, the plural dimension of care emerges. As Levinas says, “we never exist in the singular” (1993, p. 19).

However intensely we may work to take care of our lives, doing so in solitude will never be exhaustive of the measure of care our lives need. In this sense, the dimension of the disease only makes more evident an ontological condition that precedes the disease itself. We are made up of an intrinsic need for relationships with others. In illness, this experience is lived with a hint of anguish and desperation since feeling the loss of one's independence is correlated to the loss of one's being. It is in that dark point of the ontological condition of necessary dependence that the essentiality of the relational dimension of our existence arises. When we feel that our independence is lacking and we find ourselves depending on others, knowing that we can count on someone who takes care of us, in the respectful form of concern and attention, then our being finds breath again.

Caring for others is achieved in different possible degrees. The most discreet is thoughtfulness, the most intense is dedication or devotion. Devotion is a term that recalls a certain sacredness, in fact a devotee is he/she who is intensely consecrated to something or someone. This form of consecration to the other derives from the perception of the sacredness of the other from me since it is recognized as having a primacy of inviolable value to be preserved and safeguarded. From this ontological awareness comes an attentive and receptive posture towards listening to others.

*b) Ethics and Intentionality of Care*

But where does the theoretical posture of listening to the irreducible value of the other and the consequent form of care such as concern or devotion come from? To answer this question we must consider ourselves on the ethical level of intentionality. According to what values, therefore, is a human being led to act well, and therefore with care, towards others? The basic assumption that establishes this possibility of good and care for others can be found in further ontological evidence highlighted by Aristotle in the Nicomachean Ethics: "everything tends towards the good". If the human being, like any other being, is intrinsically driven towards good, then the sphere of his intentionality - made up of thought and action - is driven by the intrinsic search for

good. For Aristotle this good coincides with eudaimonia, which corresponds to "living in a good dimension of the spirit", or to living by experiencing good, in which living well coincides with doing good (Et. Nic., book 1, 4, 1097b 22). If care is a primary ontological dimension and the primary intentionality of being is the search for the good, then the intention that guides a good action of care can only be the search for what is good for living. And since our existence is intrinsically based on our constitutive relationality, then seeking the good coincides with seeking what is good with the other.

In this relational conception of care as a practical tension towards the good, any possible reference to the egoism-altruism dichotomy disappears because the care of others coincides with the care of oneself, and vice versa, in a continuous exchange that enriches both dimensions. Virginia Held writes: "in caring relationships people act at the same time for themselves and for the other. Their way of being there is neither selfish nor altruistic [...], well-being in a care relationship implies the joint becoming of the well-being of all the subjects involved" (2006, p.12).

However, if we deviate from the intentional outline outlined, it is possible that degeneration of the treatment may occur. The criticism of the concept of care present in society lies in these risks of intentionality. "Our society does not encourage the flourishing of the ability to care but weakens it in various ways" (Manning 1992, p.50). This devaluation of the misinterpreted concept of care has long characterized the various social contexts: that of training, that of work, and indeed that of the action of nursing staff. Only since the 1970s has care become a real object of study by philosophy, psychology, pedagogy and nursing. For a long time, the practice of care was confined to the female universe alone, emptying it of its essential value.

In the healthcare sector, this devaluation has for a long time meant that only technical clinical skills were valued, but not caring skills in which the patient is considered not only as a biological organism that requires therapies that intervene on the body, but as a person with his own experience of suffering that involves him at the height of his life. "The same technically competent action "done with care or without care can have significantly different consequences" (Benner & Wrubel 1989, p. 4). Benner and Wrubel are the thinkers who first highlighted the essential difference between the two English terms disease and illness. In the first case reference is made to the condition of disruption of the organism's balance; in the second case, however, we refer to the personal experience that the patient has of his psycho-physical conditions, also incorporating the entire process of reworking the meaning of the disease.

Unfortunately, even today we often find ourselves faced with a healthcare organization with impersonal characteristics, in which the emphasis is placed more on the efficient management of pathologies and economic resources, and little space remains for attention to the patient's care needs. We are concerned with treating the patient, without actually taking care of him. In English we perceive the difference between the verb to care and the verb to cure. More attention is paid to the investments of resources in technical innovations, increasingly neglecting the need to improve the quality of nursing caring practices which are fundamental for the success of specialist interventions. Instead, it is essential to accompany the use of new therapeutic techniques with good nursing support since the complexity of new therapeutic procedures can often cause a sense of disorientation and anguish in the patient. However, if these practices are accompanied and guided by a healthcare professional who also has good relational care skills, that sense of self-objectification that often makes patients uncomfortable is reduced.

This awareness introduces the delicate and controversial topic of nursing training, so that it is aimed at training healthcare workers not only on a technical level, but also transmitting a "way of being humanly engaged in practice" (Benner 1994, p. XV). In fact, if we start from the assumption that the purpose of inferential caring is the recovery of the patient's overall well-being, it is clear that it cannot be limited to the possession of mere technical skills in the management of therapies. It is interesting to recover what classical antiquity taught about education. In the Apology of Socrates, Plato argues through dialogue how the problem of education is mainly to find educators who possess what human beings are asked to learn, that is, a "certain knowledge of the virtues of living humanly and politically" (Apology of Socrates, 20b). The "virtue of human living" cannot be overlooked when carrying out professional training in the healthcare sector. This type of wisdom that Socrates speaks of consists in the ability to know how to treat other human beings, precisely because we are intrinsically relational beings, that is, in need of care in our relationships with others. In every type of training and working context, knowing how to treat other human beings is the key virtue of our existence, even more so this is not negligible in the healthcare sector.

The ontological introjection of the concept of caring into the concept of nursing, as defined by Leininger (1984), is thus postulated. Peta Bowden writes about nursing caring: "caring expresses ethically significant ways in

which we care for others, transforming interpersonal relationality into something that goes beyond ontological necessity or brute survival" (1997, p.1). Following Leininger's contribution, attention on this topic has certainly improved. From the analysis of the literature it emerged that the current debate on the topic of caring in nursing has been polarized on two very different perspectives. On the one hand, caring is interpreted in a spiritual way; on the other hand we ask ourselves whether caring can become a science. In the first perspective we use terms such as "charitas (agapé), magic, spiritual, love" (Watson 2005) which evoke new age cultural environments, rather than scientific rigor. In the second research perspective, however, a scientistic culture emerges in which caring is assimilated as a real science. However, it is difficult to accept this perspective as the term science refers to a practice whose results can be objectively controlled through systematic or algorithmic investigation procedures. Just as caring cannot be reduced in a simplistic way to the sphere of feelings, so also the studies that report field research often suffer from a poor theoretical clarification of the empirical research, as if the only criterion of validity of research could be the use of quantitative-spiritual epistemic tools.

**3. Phenomenological Eidetic Research Plan – the Qualities of Caring**

The first heuristic action for a complete theory of nursing caring consists in identifying the essential qualities of the phenomenon investigated. The theoretical analysis of this phenomenon must develop in a circular exchange with empirical research, as care expresses itself as a practice. On the basis of this assumption, the two levels of research are outlined: the theoretical level (deskwork), which dissects the conceptual essence of the treatment; and the empirical research plan (fieldwork), which is structured in the form of qualitative research that gives voice to practitioners, to those who act daily with care practices. In this way, a descriptive theory of caring is hoped for as an outcome of the research. The research question is: what does good nursing caring consist of? From this question other essential questions then emerged: What is the essence of care? What are the specifics of nursing care? What are the behavioral indicators of care? What are the appropriate research methods to investigate the topic of care?

In fact, it often happens that the original research question undergoes changes and transforms over time, based on the reflections that emerge from empirical research. The questions listed above were in fact born from a question debated in the literature and which we had summarized in the question: is it possible to measure caring? since in our culture we tend to recognize value only in what can be calculated, and it is assumed that only what can be quantified can then be monetized. To answer this question, research into the essence of the phenomenon under consideration is necessary.

The search for this essence was placed both on the level of eidetic analysis (Husserl 2002), which involves the search for the essential qualities of the phenomenon, and on the field research of the manifestation of this phenomenon. We can therefore speak of the essence of the concrete: the two dimensions of research, eidetic and empirical, are in fact complementary. Without empirical research, the phenomenon investigated would be sterilized in abstract discourses. Without the support of theoretical research, however, the phenomenon investigated would flatten out in its multiple dimensions, not allowing the data collected to speak and opening up new interpretative scenarios. We will therefore attempt to bring eidetic research into dialogue with empirical research. The epistemological background assumed is of a pragmatist nature as it gives dignity to the investigation of phenomena that are essential in the world of life and gives dignity to practical experiential needs. The question has thus gradually transformed, becoming: What does the eidetic essence of a good caring practice in nursing consist of?

First of all, we attempted to define what the concrete essence of care consists of. In phenomenology, every object of thought has an essence, and it consists in the fullness of the specificities that constitute it (20, pp. 108-109). There are many ways in which a cure can be implemented, and each of them differs according to the subject who implements it, the context in which it happens, the temporal determination, the feeling that accompanies the action of the cure. However, the essence of care is unique and occurs every time you act with care. Particular phenomena highlight particular properties of the cure that depend on its way of happening.

These properties do not fall within the general essence but contribute to defining a particular essence. In fact, everything has its essence as an individuum: this is why we speak of the essence of the concrete, since it is distinguished from the eidetic essence which is the general essence of a series of phenomena. In fact, care is expressed in multiple ways depending on the context, which can be educational, family, healthcare or purely relational.Since we investigate a concrete essence of care, it is necessary to bracket the Husserlian thesis according to which the eidetic essence is grasped through an intuitive act (Husserl 2002, p. 47). Instead, it is necessary to hypothesize that the cognitive act investigating the concrete essence of the treatment requires the clarification of investigative points that focus on the general essence of the treatment:

- *What kind of phenomenon is it?* Caring is a practice, not a mere feeling. It is not an idea, but something you do in relation to others.
- *In which space does it occur?* Caring takes place within a relationship between a person who takes responsibility for the care and a person who receives the care.
- *What is it activated by?* What sets a caring action in motion is the interest in the other and the concern for their condition, according to various orders of gradualness and intensity.
- *What is its object?* We take care when we take care of something essential for the other and which the other is not able to provide alone; otherwise it is a service.
- *What is the intention that drives it?* Caring aims to provide well-being for others. In this way the treatment acquires an ethical status. If, with Aristotle, every act that deals with the good is understood as ethical, every act that procures well-being, then it can be asserted that care work - insofar as it is oriented towards procuring the benefit - also takes on a status ethical. However, when we try to define how this good is expressed, the ethical dimension reveals all its problematic nature. In fact, "good is indefinable" (Murdoch 1970, p. 42): every possible definition risks being reductive or too vague.

After having outlined the main features of the general essence of care, that is, that something that is valid in every care situation, it is necessary to define the particular essence of nursing care. Care is a practice aimed at providing benefit to another; therefore, the principle of benevolence is the substantial substrate of the ethical essence of care. In this concern for the well-being of the other lies the essential assumption of responsibility towards the being of the other, which can be implemented in different relational ways: respect/reverence, concern/attention.

Nursing care aims to restore good health, promoting the well-being of those who are in a state of suffering in body and/or soul. Since care is a practice, it is necessary to identify the ways of being there that qualify a good care action. This theoretical research into the concrete essence of care is done through a phenomenological analysis that investigates in which ways of being with the other a practice that attests respect and concern occurs. In some of these ways a passive-receptive posture is required, in others a more attentive-responsive posture. Therefore, the ways of being of care can be informed by a posture of receptivity, in which one makes room within one's own mind for the being of the other; or from a posture of responsiveness, in which concrete actions are implemented in favor of the other.

### 3.1. Paying Attention

Receptivity is expressed primarily in attention. In paying attention to the other we are moved by interest in something and that something is brought into our full presence. The attention that cares lies in the recognition of the value of the other. Attention "is a tension, an effort and, obviously, a source, perhaps the most considerable of effort" (Zambrano 2008, p. 51): giving oneself with full concentration to the other requires in fact a putting aside of the really me. Levinas analyzes in depth the attention that the other's face arouses: "I pay attention to the other precisely because his face speaks to me" (Levinas 1985, p. 71). That a face speaks to us means that it shows us its pain, its expectations, its fears and its hopes. But to really understand what that face shows and intends to communicate, attention must be sensitive and receptive. This type of attention, in which we try to understand how the other manifests himself, cannot be intellectualistic: it must be participatory, which requires the full involvement of the mind and heart. Iris Murdoch defines this way of understanding attention as "a just and loving gaze directed at a specific individual reality" (1970, p. 37). If attention is understood in this way, it becomes the characteristic of a moral agent. To act morally, a clear, continuous, intense, sensitive and attentive vision is needed which makes a clear, concentrated and loving look at things possible. In this sense, paying attention is a moral posture of the mind and heart. Even more so, attention reveals its ethical quality when faced with the reality ofsuffering. At all times we are asked to keep our minds attentive to things in order to deliberate well. Sensitive attention to others is thus an essential condition of the ethics of care.

### 3.2. Feeling Responsible

Being there with care requires feeling responsible for the other. It is by feeling being vibrate in the other that we feel called to responsibility (Levinas 1983). Responsibility is a term that comes from the Latin verb respondere, which refers to the willingness to respond to the call of another. In Levinas' thought, the face of the other calls us to an irrefutable responsibility. This ethics of care based on responsibility takes on even more value when expressed in the context of healthcare in which the face of the other expresses all of his vulnerability and fragility due to the disease. Levinas notes a paradox in this assumption of responsibility: "I find myself obliged

without this obligation having originated in me" (Levinas 1983, p. 17). Consciousness and the decision to act responsibly follow deliberation. In paying real, sensitive attention to the other, the other touches me, questions me and questions me, ordering me to respond (Levinas 1985, p. 73). Being responsible therefore means being ready to respond to others. Sometimes this call can turn out to be an immense request for self-esteem, and may seem realistic in the abstract, but not very sustainable in ordinariness. Levinas' concepts are a fruitful ground for reflection, but they must also be remodulated and contextualized. Levinas' concept of responsibility, if taken in its entirety, risks legitimizing a sacrificial conception of care. In fact, he speaks of "sacrifice without reservations, or of "designated hostage sacrifice" (1983, p. 20). Expressing the sense of responsibility in these strong and bellicose tones does not corroborate the motivation to act intentionally according to conscience that all practical ethical action requires.

### 3.3. Understanding the Other

The intention to understand the experience of the other is essential for acting with care. Returning to Heidegger, understanding constitutes a fundamental existential phenomenon (1976, p. 182 and p. 403). Understanding the other requires knowledge of the other's condition. But it is not easy to acquire certain knowledge of the other, of his conditions and of his way of interpreting his existence: not only because the human heart is an enigma, but also sometimes the other does not feel free to reveal himself. And even if we seem to have, after numerous and tiring attempts, understood the other, we need to undo this belief again because it would erroneously lead us to think that understanding the other could be a closed path. Human beings, however, always remain obscure to each other (Murdoch 1970, p. 33). To understand the other, it is important to consider Levinas' invitation to think of the other's face as a trace of the infinite, which is an enigmatic splendor (1983, p. 17). For this reason, it is essential to cultivate a certain degree of humility, which is expressed in the tendency to always take what we can conceive less seriously.

### 3.4. Feel the Other Empathically

In order to understand the other, we need the ability to feel the other's feelings, i.e. empathy. This ability requires knowing how to understand the quality of emotions such as pain in the moment of suffering, also knowing how to show silent closeness. In the difficult clarification of the concept of empathy, we are often led to confuse empathy with compassion. In Murdoch's conception of empathy we refer to feeling the feeling of another which helps to grasp the quality of reality, which is why he speaks of "realism of compassion" (29, p. 67). Compassion, on the other hand, is that condition of co-feeling, resulting from an ethical evaluation of the condition of the other. Being capable of empathy and compassion is not a form of irrational sentimentalism: it is instead a form of thinking with the heart (20, p. 452). Thinking with the heart means thinking by letting yourself be touched by the being of the other: it is a thought that feels the feeling of the other, and in this particular cognitive capacity, understanding is made possible. Understanding therefore means turning to another with an intensively receptive attention, in which even the smallest details of things say a lot.

### 3.5. Act Delicately

In the asymmetric care relationship, the members find themselves in a situation of dependence on each other. In fact, Eva Kittay (16, p. 30) defines care work as dependency work. In care work, an action occurs that involves dependence on someone, and this observation allows us to underline the ethical problematic nature of caring since those who find themselves dependent see their state of vulnerability accentuated. A good act of caring for the sick person requires a certain type of respect for both his body and his spiritual life. A suffering body requires to be treated delicately. Delicacy certainly cannot spare the pain of certain therapies, but it can help you better face the most difficult moments. Delicacy is necessary in practical gestures as well as in words. Feeling treated with delicacy and respect allows the patient not to feel treated as an object, and this intentional posture, on a therapeutic level, translates into greater support to find the vital strength to face difficult disease conditions.

### 3.6. Having Steadfastness

Since care work is configured as dependency work, it also places the caregiver in a condition of vulnerability. Whoever occupies the dominant position in the care relationship may risk abusing her power. Similarly, those receiving care can engage in behaviors that abuse the caregiver's availability. In the condition of illness, the person is difficult to control and balance their actions in receiving treatment. Therefore, it is the caregiver who must take a firm stand, interrupting or modulating situations that lead to unnecessary waste of energy. Knowing how to position yourself firmly requires continuous work on yourself that analyzes your actions, dissecting unnecessary feelings of guilt and always keeping in mind the need to bestow your care in the right measure.

### 3.7. Being Indignant at the Neglect

Situations of indifference, negligence and carelessness may occur in care contexts. In this case, acting with care means developing contrastive actions towards these contexts. In the face of evil, it is appropriate to act both individually and politically in order to change things, which is why the ethics of care is also configured as a civil commitment. It is right to practice a form of disobedience to evil: this can take the form of certain actions of daily personal courage, but it is not reasonable to focus only on the singular dimension to reduce this type of suffering. There is a need to act also on the plural level of the organizations and rules that govern healthcare work to reduce to the root any form of neglect or cruelty, to prevent those gestures of courage out of the ordinary of the individual from becoming routine, thus leading way to consume the individual's vital energy, which requires a different type of use.

### 3.8. Cultivate Reflective Thoughtfulness

Care is driven by the tension towards the good, but it has always been difficult for human reason to define what it consists of. In Plato's Republic, Socrates states that the idea of the good constitutes the highest knowledge because it is the idea that serves as a measure for every other (31, The Republic, 505 a). To discern in each context what acting with care as a tension towards the good consists of it is necessary to develop the thought to question what the good is. It is necessary to constantly question ourselves about the quality of one's own good behavior in relation to each specific situation.

To act well, the nurse is asked to continuously examine our intentions and the situation, taking into consideration the needs that the patient expresses. This consists in activating reflective and experimental thinking, which examines each time the outcomes that follow a certain intervention. The need arises to continually interpret the situation of the other. Noddings speaks of "the urgency of continued reflection" (44, p. 21). However, this reflection on the suffering of patients should not only be conducted alone, but also together with other individuals who share the same commitment. It is therefore important to support the moments in which nurses, during breaks, share their experiential experience. It would be optimal if these moments are not limited only to sharing but are supported so that they also transform into places of co-construction of an agreement on how to act with care in the given context.

## 4. The Ethical Dimension of Care

The intrinsic ethical value of care consists in its tension towards the practice of actions that lead to good. For Aristotle, ethics manifests itself in virtuous action. Virtue is, in this conception, the disposition to act well and which as such causes pleasure. What allows us to act well is the virtue of finding the right measure in the things we do. Excess and defect destroy the value of a thing, while averageness makes it possible (1, II, 6, 1106 b 11-12). Good caring occurs when the operator acts according to the virtue of moderation, that is, he manages to find the right balance between the opposites in which the action would tend to oscillate. Some examples of opposites in which the search for a middle ground is required are between sharing and keeping a distance, between the obligation of honesty in speaking and in certain cases holding back the conversation when one feels that a certain degree of truth would too much harm to the patient, between indulgence in ways so as not to appear imposing and harshness in calling the other to make decisions. In all these experiential contrasts, acting with care means knowing how to find loving firmness in treating others.

Being exposed to suffering for a long time risks making even healthcare workers fragile. You should be able to count on a supportive environment that is a source of new vital energy. Sometimes it is also essential to know how to carve out spaces of solitude, in which to cultivate dialogue with oneself. Taking care of yourself means deepening the life of your mind, practicing exercises that nourish your inner life force, working on the emotional dimension to nourish positive feelings. "A nurse grows in her ability to express care and her being there expands when self-care is valued and practiced alongside care for others" (7, p. 32). Caring relationship work needs to be nourished by personal care work.

Therefore, it is important to promote a space for professional updating that not only involves the acquisition of new technical-scientific skills, but also that is conceived as a place in which to share the difficult experience of one's work and seek environmental strategies or solutions that facilitate the 'exercise of good care work. It is important to nurture a true culture of care that also involves the organizational framework of healthcare management, often animated exclusively by market logic. Often, in fact, patients' needs come into conflict with managerial economic interests, reaching the point that "profit-making" (3, p. 126) takes priority over the level of caring offered. A good health policy is one that is committed to dismantling the ideological, material, managerial and training obstacles to the exercise of good caring.

**5. Methodology of Empirical Phenomenological Research**

To grasp the essence of nursing caring it is not sufficient to examine the ways of being of care from a mere theoretical perspective. To access the empirical data, understand it and interpret it, it is appropriate to seek the basis of a phenomenological analysis of the concrete essences, analyzing the phenomenon of care as it happens, or collecting the narratives of the actions that are qualified by nurses as good caring practice. What does it mean to reach the essence of the concrete? The research intends to elaborate the narratives of those experiences in which nurses are able to report positive and negative experiences of caring.

Narration is the basis of this heuristic process as it allows access to the nursing experience in the lived experience of nurses. All the power of narration is manifested in bringing to light the experiences of nurses in their difficult daily task of in turn coming into contact with the otherness of their patients, seeing them not reduced to objects to which they can bestow technical skills, but people who in their uniqueness they must face the challenge of the disease. Charon writes about this fertile use of narrative in the healthcare sector which allows us to clarify and facilitate the relationship between the doctor and the patient: "we stay in the presence of this freight of meaning, not only filled with gratitude that we can, now, see it but also filled with satisfaction that we have helped its meaning to be appreciated. Knowing something about the body grants us the license to near another. It grants us admission to a proximity to the self of the other and, by reflection, of ourselves" (6, p. XII).

In this way, the participating nurses are given the floor to put us in direct contact with their world of conscience, or rather with their experiences of what can be defined as good caring and what cannot. From a methodological point of view we are based on the assumptions of "naturalistic inquiry" (10) which sees research as a process of continuous re-elaboration, and which is structured in progress. In the field of qualitative research, the methodological vision is shared according to which, to access the experiential experience and the network of meaning of a certain context, it is essential to give the investigation a phenomenological-hermeneutic slant. The epistemological principle of qualitative research foresees that, to understand the experience, it is necessary to take as its object the world of meanings in which a person acts, taking as its object of investigation the meanings that people attribute to their experience, trying to reach an understanding as faithful as possible to the participants' point of view (24, p. 6).

Qualitative research is sometimes accused of lacking systematicity as it is not possible to fully predict a research design delimited a priori before going into the field, analytically specifying the sequence of heuristic actions, instead leaving room for a possible revision of the research design. This emergency vision of the research design is positively evaluated by naturalistic inquiry since reshaping the research based on what happens in the field is not seen as a limit, but rather as a strong point of relevance and ever closer proximity to the data. This way of proceeding does not use mathematically formalized tools, such as algorithms or statistical processing, but procedures close to those in use in everyday life contexts, i.e. observations, interviews and stories. At a methodological level, we therefore opted for an emergent epistemology with the application of grounded phenomenology (27, 28). The traits of the emergent epistemology of naturalistic inquiry (22, p. 187) are:

- *Natural setting*: the collection of data regarding the lived experience must be carried out in the participants' living environment, where the researcher can acquire direct knowledge of their life world and have access to information that makes a correct interpretation of the material possible. The material taken as given consists of everyday narrative productions.
- *Significant Participants*: you must have a significant sample of participants for them to qualify as significant informants.
- *Evolutionary emergency design*: no research design defined in advance can be able to account for the complexity that emerges in the field, since the experience cannot in fact be compressed into a predefined interpretative system.
- *Inductive elaboration of theories*: it is necessary to inductively elaborate theories with local value, defined as "working theories" (22, p. 38) since they give a detailed account of the context investigated.

In the post-modern epistemological panorama, methodologies have taken on a neo-pragmatist orientation, linked to Foucault's critical philosophy, in which there is a tendency to consider the method as a set of regulatory criteria which can lead one to think that the research process is based on rationality. as mere adaptation or submission to these criteria (33, p. 47). In this type of research (45) we instead try to outline a rigorous methodological structure, subjected to a metacognitive commitment of constant, but not rationalizing, revision, so that it adapts to the complexity of human experience. This methodological dynamic is suggested by the etymological analysis of the term method itself. The term, from the Greek, is composed of: méta, which means

next or after, and from odós which means path. It is no coincidence that the metaphor of the journey is the one that best lends itself to describing the research work, understood as a thought activity that follows walking, that is, that accompanies each step of the journey, and that can take definitive shape only after the journey has ended. The method cannot be a priori but is shaped during the research experience. Conceiving the method in these terms requires an attitude of continuous metacognition and reflection and an exercise of epistemic virtues. The epistemic virtues that must be exercised in this type of research are respect for others, humility in proceeding and loyalty in treating data without force within a procedure. Conceiving the method in emergency terms recalls the pragmatist vision of William James (41, p. 45) who saw the method as a rigorous way of proceeding, but open to identifying ways in which one can keep oneself as anchored as possible to the concrete profile of the facts manifest themselves.

Starting from the research question, we attempt to investigate the caring experiences of the participants, therefore taking the world of people's meanings as the object of investigation. The method that is most appropriate for this type of object, of experiences of consciousness, is the phenomenological-hermeneutic one. Starting from Greek philosophy up to that of the phenomenological tradition, the scientific method consists in the investigation of the phenomena. With this term Aristotle distanced himself from the tradition inaugurated by Parmenides which was based on the dichotomy between being and appearing and which considered phenomena insufficient manifestations for knowing the reality of things. Phenomenology has also recovered the phenomenon as an object of investigation, recomposing the dualism between being and appearing, and considering it fully as a manifestation of being. Various currents have evolved that have interpreted the Aristotelian conception of phenomenon. Marta Nussbaum considers the phenomenon as what we think about things, or tà legómena (30, p. 456).

Taking this perspective, this research asks nurses to talk about their experience in order to be able to interpret the phenomenon of care work. However, the use of the phenomenological method in the empirical field has often proved to be hasty, as reported by an analysis of the relevant literature. Husserl's original idea was in fact to search for the essence of phenomena on the purely eidetic level, not on the empirical one. Too often the empirical sciences have unduly transferred the eidetic Husserlian method directly to the empirical level. To give validity to the chosen method it is necessary to verify whether the concept of essence can be used not only in the eidetic context, but also in the empirical context.

For Husserl, essence is an invariant, that is, the "necessary universal form without which something like this thing, as an example of its species, would be unthinkable" (15, pp. 314-315). In this case the cognitive act that can grasp these essences is intuition. Intuition is a cognitive posture that cannot, however, be applied to empirical research. The empirical sciences, in fact, do not study the essence of a thing in general, but a phenomenon or a series of phenomena, or a finite series of events in their concrete implementation. The empirical sciences are interested in the multifaceted becoming of details of facts, therefore in the secondary and contingent determinations of phenomena. For this reason, empirical sciences seek the concrete essence of phenomena. However, the search for the eidetic essence - as it has been searched for in the ways of being of care - is a necessary condition to identify the object of empirical research, which however will no longer be interested in the ideal concept of care, but in the phenomenality concreteness of its implementation.

The eidetic essence is therefore the set of universal and necessary qualities of a phenomenon; the concrete essence must therefore be able to express the essential qualities of the changing and changing things of experience through the analysis and interpretation of concrete experiential phenomena. The essence of the concrete is the set of current qualities that the phenomenon presents, and, in this research, it is identified with the experiential ways in which caring by nursing staff is experienced and practiced. In the empirical investigation, the same phenomenon - the way of experiencing nursing caring - is analyzed in its plurality of variations, or in the multiple ways in which it can manifest itself and be practiced. In the changing nature of the phenomenon, a series of phenomenal manifestations are analyzed, i.e. a series of caring practices, to then go on to interpret the set of different qualities that characterize nursing practice in the sense of caring. For Husserl the multiple "differences" of the eidetic essence are "irrelevant" (15, p. 315), as he is only interested in the invariant data. In the empirical sciences, however, precisely those differences, which describe the phenomenon in its mutability, are extremely examined as indicators that say something more about reality.

Reaching an essence of the concrete therefore means building concepts of broad value, but which do not lose the multiplicity of the initial clues. To find the concrete essences of caring, we must first consider the characteristics of caring that occur most frequently, which therefore constitute the extended data. It is then necessary to consider the partial data that characterize subsets of phenomena; and finally the particular data that are contained in the stories. In this process of hierarchization of the concrete essence of the caring phenomenon,

the analysis is not conducted in an eidetic way as for pure essences, but through subsequent cognitive and metacognitive acts of the researcher who rearranges the narrative material collected in the field. The phenomenon of caring is investigated mainly through stories, but direct observation is also used, i.e. the observation of nurses in carrying out their care work: or through indirect observation, i.e. examining video recordings of their activity), or through observation, that is, examining the experiential narratives of nurses. The type of questions asked directly to nurses is not an eidetic question such as what the essence of caring is but is an experiential question that asks them to recount experiences. In this research, we were asked to tell a case of good caring, i.e. an experience that brought benefits to the patient, and a case of bad caring, i.e. an experience in which good patient care was not achieved.

The analysis method was built on the basis of subsequent heuristic actions:

- *Preliminary action*: each text is reported in a file and the results of the experiences described are reported in a table next to the text.
- *Holistic reading*: the stories are read several times to try to reach an overall vision.
- *Identify the quality of each textual unit and translate it into labels*: each significant part is described by a label that identifies its specific quality.
- *Reflective self-investigation*: annotation in the researcher's diary of the problems that the researcher encounters in the difficult work of coding the narratives. It is a work of phenomenological meta-analysis in which the researcher also analyzes his own mental experiences in relation to the analysis of experiential experiences. This is why this diary is called a diary of the life of the mind.
- *Apply the principle of epochè when reviewing the material*: it is essential to avoid pre-constructed perspectives.
- *Apply the principle of fidelity*: the data obtained between individual researchers is compared to verify the degree of descriptive adequacy of the labels.
- *Apply the principle of fidelity*: the analysis of the thesis starts again by putting it to the test of the coding system drawn up.
- *Group labels into categories*: each group of similar labels constitutes a category. This is the first level of abstraction in the inductive process of theory.
- *Grouping the categories into macro categories*: the categories produced are examined and grouped into higher order categories. In this way a cluster ordering of the conceptual material develops.
- *Identify the essence of the concrete*: calculate how many times each label is present in the collected material. In this way it will be possible to highlight the most common and the most unique qualities. This step is used to evaluate the extension of a concept; to understand how important it is considered by practitioners. This creates an orderly map of the qualities that characterize caring, according to the nurses' perspective.

In the preliminary phase, to prepare the six nurses involved in the research work, they were asked to develop two stories: one on the experience of good caring, one on the experience of bad caring. The first provisional form of codification of concrete essences was drawn up on the basis of this preliminary material from the researchers. Subsequently, a phase of literature study followed, both theoretical and empirical. This phase was thought of as secondary so as not to influence the analysis that would inform the first categories with the literature.

In the subsequent phases, however, the researchers will carry out the phenomenological analysis, moving from empirical stories to the recovery of literature in a cadenced manner. In this intermittence between the empirical and theoretical moment of the researcher, the application of the principle of epoché of the material that is processed from time to time, noting the doubts, questions and uncertainties of proceeding in the diary of the life of the mind, is fundamental. In an entry from the diary of the life of the mind, one of the researchers states: "there is no object, not only theoretical but also - and perhaps even more - empirical which, invested with a process of knowledge, is not emotionally felt from the subject […]. As I read, I continually have to stop due to the overabundance of data, an overabundance not of quantity, but of quality."

Example of how the analysis of the narratives was proceeded:

- Significant parts of the text: "she wanted to get out of bed, she was very edematous, highly asthenic, getting out of bed was a challenge but she wanted at all costs not to lose at least this little autonomy. And I decided to comply with her request".
- Brief description: the nurse welcomes the patient's need to maintain as much autonomy as possible and, despite her doubts, she acts to satisfy her desire.
- Descriptive label in progress: she supports the patient's choices.
- Definitive descriptive label: she accommodates the patient's needs.

Group comparison in this work of coding action paradigms is essential to bring out a critical gaze capable of seeing any interpretative distortions and inventing appropriate ways of coding. It is difficult for researchers to develop identical labels alone; therefore it is necessary to meet several times in a group. A total of 240 stories were collected and the researchers proceeded in pairs to establish the initial labels and then proceeded with group meetings.

## 6. Results

This way of developing taxonomies has always been used in the natural sciences: it is difficult to apply it to the world of meanings because the material has undefined boundaries, and it is the researcher who must identify the boundaries that allow the setting of significant narrative units. Therefore, the researcher must implement two postures at the same time: on the one hand he must remain carefully immersed in the reality that he analyses, on the other he must continuously implement metacognitive surveillance. As Levinas says, the other is always an "overflowing presence" (2004, p. 201) with respect to the theories preyed upon. A careful phenomenological analysis is one that allows it to happen and is able to grasp the manifestation of this overflow of being of the other. If you don't have the care to return repeatedly to the data, you risk forcing reality into false constructions. From the nurses' stories emerges all the heaviness of care work and the difficult, sometimes painful, experience of illness.

The narrative material was categorized into a coding system divided into three parts: care for others, which consists of direct actions on the patient; contextual care, which consists of the actions that nurses perform on the relational or physical context; and the invisible of care, which describes those invisible reflective actions that structure the immaterial background of care.

### 6.1. Caring for Others

We mean the search for conditions that make the other feel good, welcoming and satisfying their needs. "I have always tried to respond to the needs they have, even small ones. In my opinion it is essential to think that even the little things are important to them. There is one patient who needs to sleep with the pillow turned in a particular way, the other has to put it behind his back and since he was not self-sufficient, we had to arrange the pillow ourselves in the evening. I remember the first time he explained it to me I had to stand in the room for quite a while, trying and trying again because I didn't get it right.

To understand the real needs of the other you have to stop and listen and try again and again until you see that he is better, and he told me that he was finally able to sleep that way, and he thanked me" (O96). Often the most direct way to promote patient well-being is to relieve pain. "I position him comfortably, I cover him with the underwear and when I touch him, I feel his cold skin, so I look for a blanket and put it on him" (G75). Inattention often turns out to be a serious form of neglect, therefore it is necessary to carefully observe the patient and concentrate on him. "No one had stopped for a moment to think that perhaps that pain was not a simple stomach ache, but certainly everyone, including the doctor, allowed ourselves to be distracted by too many things to do, we did not investigate the situation in detail, perhaps we did not we didn't even stop too long to talk to the patient, perhaps listening more carefully could have directed us towards the real problem; instead, he died of cardiac arrest" (M34).

In the nursing work of nurses, the search for a relationship with the patient is fundamental. For a treatment action to be effective, it is important that the caregiver considers the patient not only as the substrate of his mechanical actions, but as a person with whom he can come into contact. "So it was on that night that I finally managed to get in touch with Daniele, he offered him some chamomile as a remedy for his insomnia and some time for a chat in the silence of the night" (M211). "Carla is in bed, her face is relaxed, her breathing is agonizing… I approach her, for the first time I sit on her bed, I touch her face and say: 'have a good trip'. At that

precise moment I see a tear fall, I think it was her way of saying goodbye" (O88). When the nurse seeks a verbal relationship with the patient, taking an interest in his experience, he stops feeling like an anonymous user: seeking dialogue is a sensitive act of care. "I remember a young lady, 43 years old, terminally ill, who came in urgently for thrombocytopenia. One morning I found her in tears. I sat on her bed, I put down the drip I had in my hand, and I invited her to say her thoughts out loud... she started to tell me her story" (O106). It is not only the words spoken, but also the tone of the speech, that tone that communicates respect and attention, that make dialogic relationships fruitful. "During the night shift my colleague introduces me to the patient I will have to take care of: Anita is severely obese with a significant history of alcoholism.

The colleague tells me that she is an unbearable patient, that she continues to call and complain for no reason, hindering the care of other patients, she warns me not to pay too much attention to her. Shortly after Anita starts tapping the oximeter on the edge of the bed and calling, I worry about responding to her requests and putting her in a comfortable position but she continues with her worries, I'm getting angry but then I think that I'm influenced by my colleague's judgments and I decide to control myself and ask her sweetly who she would have liked to have near at this moment, she looks at me and starts to cry..." (ΓΙ200).

To establish a relationship in which the patient feels listened to and understood, it is necessary to dedicate time to be with him. "After doing personal hygiene, I accompanied the patient to bed because she was tired, and I stayed with her until her daughter who had gone to have breakfast returned" (O90). There are times when a patient needs a word to help him regain the vital strength that is weakening during illness. "I told her: 'look ma'am, you have a husband here with you who loves you, who loves you. We're getting up now." I took her hands, I squeezed them tightly, I hugged her, I sat close to her on the bed... then I took her out of that bed which had become a kind of cage, I sat her down and I said: 'now we wash together'. Finally, I combed her hair" (O113). It is essential to also worry about the patient's emotional dimension.

If the patient feels respect and concern, he returns to the caregiver that trust which also increases the therapeutic potential. "I observe that the patient lowers his eyes and asks if he will feel pain during the positioning of the PEG and if he will still be able to go home. The doctor replies that it will be performed under sedation and that the feeding tube can also be managed at home. I notice that the patient is disoriented and looking at us is looking for further information, so I intervene by telling him that I would come back later to talk about it in more depth" (C150).

### 6.2. Care of the Context

It is important to act on the context, both physical and relational, to facilitate the conditions of care. "We decide to call the son of a patient hospitalized in intensive care because he is getting worse. I make him sit down, I help him put on his coat and shoes and I inform him that he has been called per his father's specific wishes; he is worried and anxious, and he asks me to accompany him to his father's bed. I ask him if he wants to call the chaplain and if he wants to accompany his father in the most difficult moment: death... he looks me straight in the eyes and tells me: 'Betty, I trust you', and so I accompany him" (Γ145).

### 6.3. The Invisible of Care

To practice good caring actions, it is essential to think about what you do and reflect on your experience. "I realize that when I work I am certainly always and everywhere open to managing patients' problems but one of my limitations or perhaps my inexperience to be unblocked is that of being too focused on myself and my way of being while interacting with others and by doing so I often don't enrich myself with the resources that others can give me and the support that the voids and fears of a relationship with a patient like Lorenzo sometimes present" (M186). Reflexivity is a fundamental posture for learning to manage one's emotions in the face of the patient's attitude. "I entered the room and found the patient shouting threateningly at a student, with her cane in her hand! In a split second I had to think about how to behave, and I thought about what to do. In the end, even though I was angry inside and a little scared, I managed to appear calm" (O99).

The categorical labels, with the related subcategories coded on the basis of all narratives collected, are:

- *Care for others*: pay attention, dedicate time, understand the other, try to establish a relationship with the patient, satisfy the patient's needs, worry about the emotional dimension, have respect for the other.
- *Care of the context*: acting on the context (organizational, family and team) to make it easier for the care action.
- *The invisible of care*: thinking, reflecting on experience, dealing with one's emotional experience.

## 7. Limitations

To analyze the topic of caring in this research we proceeded with the use of the grounded empirical phenomenological method (28). There are numerous criticisms of the empirical application of the phenomenological method, despite the fact that it presents itself as effectively responsive to the need to analyze complex phenomena such as those linked to the healthcare context. The question of applying the phenomenological method to empirical sciences, such as nursing, is a long-debated issue. "The hardest thing to do is to promote this 'phenomenological philosophical hermeneutics of naturalism' in congruence with a rigorous phenomenologically founded qualitative research." (26, p. 163). In this type of studies, which seek the essence of a complex health phenomenon such as caring in nursing, one cannot stop at the quantitative aspects that can be detected in a purely empirical way since this would consist in a distortion of the phenomenological method.

"Experimental 'evidence based' empiricism is vital to health care sciences. But empiricism is necessarily restricted to what Husserl calls the real (sensory-perceptual). By itself, it excludes the unreal (more than sensory meanings) that are also of vital interest to healthcare practitioners" (26, p. 164). That is, according to Morley, it excludes the world of meanings of the life of the mind which are essential to be sought in their essence, as a correct phenomenological application would require. In order to understand the world of meanings that accompanies this type of phenomenon, it is essential to regain access to the level of experiences through the search for essences, which however in this context will be empirical essences, caring being a phenomenon of praxis, as explained by Mortari (28). In the application of the phenomenological method on the empirical level it is essential not to neglect eidetic research, since otherwise it would be difficult to get to the heart of the phenomena, based only on empirical data collection. Caring is in fact one of those phenomena that requires analyzing the level of intentionality of its actor-nurses, and not just the cataloging observation of their practical actions. The specification of the concrete term linked to this type of analysis is important as we are no longer on a purely eidetic level, like that of Husserl, but in the search for the essence of a concrete phenomenon: nursing care.

In this type of research, a correct application of the epochè cannot be overlooked. "The epoché is the especially crucial first step in doing phenomenology. It is the reflective position that allows us to come to see our unconsciously taken for granted assumption of the world as res extensa – as just things. The epoché allows us to wake up to the streaming life of consciousness that permeates and sustains all experience. While a complete or perfect epoché is as impossible as it is a perfectly controlled experiment, it is this practice of the epoché that opens the door to grasping the world as a given-ness to experience" (26, pp. 164-165). In the empirical phenomenological method used here (28, 2022), the emphasis is placed not only on the epoché, which also has this indispensable value in analyzing the narratives of experiences: just think of the use of the diary of the life of the researcher's mind.

There is one final criticism that is often leveled at those who attempt to apply this methodology to the empirical sciences: that concerning the way in which the narrative material is collected. In criticizing the application method of Giorgi's descriptive phenomenological method, Morley writes: "beginner interviewers ask distracting and leading questions that result in intellectualizing. Phenomenological psychologists avoid asking leading and intellectualizing questions, yes. But so do most trained interviewers – of any persuasion. And, yes, for this reason, the emphasis has been on unstructured interviews. But the term 'unstructured' here is a misnomer. The very raison d'etre of the 'so called' unstructured interview is to avoid the mistake made by designers of questionnaires which pre-frame the categorical structures of the phenomena before the interviewee even speaks. Phenomenological interviewers prefer, as much as reasonable, to take a 'discovery' approach to interviewing" (26, p. 165).

A good empirical phenomenology interview should be conducted both by avoiding overly articulated descriptions and overly intellectualized descriptions. In this research we operated correctly from this point of view since semi-structured interviews were proposed, with open and not rigidly cataloging questions, but - at the same time - the nurses were asked to strictly stick to their significant personal experiences, in order to avoid pre-packaged intellectualisms.

## 8. Discussion

There is agreement in the literature in considering caring as an essential and essential factor in nursing practice; however, it remains a debated concept in nursing research because it is difficult to grasp its meaning and extension in an extensive and complete way. In investigations on caring, quantitative research methodologies alternate with qualitative research.

In quantitative studies, through a comparative procedure, similarities and different perceptions of caring are compared between nurses, patients, students and teachers, taking into consideration the different healthcare contexts and the different pathologies of the patients. As part of the quantitative procedures, valid caring measurement scales have been developed. To name a few: the Caring Assessment Evaluation Q-sort (CARE-Q), the Caring Behaviors Inventory (CBI), the Caring Behaviors Assessment (CBA), etc. (2,40). This type of survey detects the patient's perception of caring or the nurses' opinions on how patients perceive caring. In this way, caring is measured according to the needs linked to the costs of healthcare management, but the effects on patient well-being are not demonstrated. The results are unable to account for the caring behaviors that nurses perceive as most relevant: the evaluations usually receive a high average value on the Likert scale (from 1 to 5), and this does not help to discriminate the various facets of the caring phenomenon. Self-report measures, on the other hand, are of low reliability since the questionnaires contain a list of pre-selected caring behaviors which can lead to a distorted perception of the phenomenon being assessed. The results of quantitative studies tend to show the dimensions of caring carried out more frequently; in comparative studies they compare the choices made a priori between the subjects involved. In this process of synthesis we risk losing the nuances that characterize the phenomenon by focusing on overly general descriptions. A frequent result of quantitative studies is respect for others understood as an essential dimension of caring, but the characteristics of this type of respect are not captured. Exploring this result would imply understanding with which actions the nurse actually acts with respect, and how these actions allow the patient to express his emotions about the illness, therefore feeling authentically welcomed into her needs and listened to with attention. The research presented here aims to enrich the investigation into caring by anchoring itself on the experiences narrated by nurses to grasp the most subtle nuances of caring actions.

Qualitative studies are usually used to understand the meaning of caring, the behaviors and practices of caring or non-caring, the barriers that hinder caring behaviors with possible strategies to overcome them, and the caring actions that make a difference to the patient. In this context, various methodologies are used: the phenomenological method (9; 32; 11; 38), Grounded Theory (12; 35; 36; 37) and qualitative analyzes of content (25). In qualitative studies, narratives of caring episodes, semi-structured interviews and non-participatory observation of relationships between nurses and patients are used. This type of studies is increasing and is making an important contribution in describing caring actions, identifying their antecedents, descriptive characteristics and consequences for both the patient and the nurse. Sometimes, however, these studies present methodological problems, such as the low number of subjects involved, and the partial or absent description of their characteristics. Often the method of data collection or the comparison with the literature, the phases of data collection and how the saturation point was reached, the posture of the researcher and the practice of epochè as a check on one's pre-understandings are not clarified.

In this qualitative research (45), which aims to examine the behaviors and actions that nurses associate with a caring practice, the literature was also examined, both on quantitative and qualitative studies. Articles published in Italian, English and German since 1979, the date of the publication of Jean Watson's book on nursing caring: The Philosophy and Science of Caring, were included, as it represents the first important systematization of the topic. Combined keywords related to the topic were then used (care, caring, caring behaviors, caring actions, nursing, nurse), querying various databases: MEDLINE, CINAHL, EMBASE. In a first phase the two researchers selected 574 references, by carrying out a screening on the abstracts they then selected 152 relevant titles. From reading these 152, 46 articles were then selected, of which 31 were found to be actually relevant for the review, as they investigated the perception of caring of patients, students, family members and colleagues. The caring behaviors described by the quantitative studies found pertained to the following research areas: communication with the patient, nurses' facilitating attitudes, professional skills and knowledge. From the qualitative studies, other thematic areas were grouped together: deep and close relationship between the nurse and the patient, the nurse's ability to manage care, guarantee comfort, create a supportive environment, caring attitudes. In these qualitative studies, the debate often emerges whether caring is a natural/innate attitude, or whether it can also be taught or developed with experience.

## 9. Conclusions

The themes that associate caring practices with nursing in this research were found to be related to those that emerged from the literature review of both quantitative and qualitative studies. The caring indicators that are most discussed in the literature were confirmed. They are: ensuring presence, listening by giving attention to the patient to understand his story and allowing him to express his emotions, cultivating relationships with the patient through physical gestures and dialogue, being capable of empathy , being respectful of the dignity and intimacy of others, recognizing in gestures of physical care of the body an intimate encounter with the person, offering emotional support that cultivates trust, involving family members by offering them understanding and emotional

support, acting on the context by involving other colleagues and professionals to adapt the care to the specific situation of the patient.

The qualitative analysis of the stories told, compared to quantitative analysis, allows us to better evaluate the nuances of these care practices. In the study presented here, however, the recurring themes present more expressive shades of the same phenomenon of care in other qualitative studies. Reassurance, for example, is described in this study as the result of a complex process, characterized by an intentionality in taking charge of the individual patient which often goes beyond the usual ways of care, also taking the form of unforeseen actions which go beyond the routine activity. Even the theme of listening does not emerge as a dimension that concerns all relationships with patients in general but reveals itself as an interest in the history of a specific person, as attention to his feelings, to his verbal or physical manifestations and to his painful silences.Both in the literature and in this study, the clinical expertise of nurses, their knowledge and professional skills are the sine qua non of caring. However, from the stories examined in this research it emerges that it was not the technical skills, although indispensable, that allowed the occurrence of a significant caring story. Regarding the debate which asks whether there is a correspondence between nursing and caring, this research proposes the idea that nursing coincides with caring, but with different levels of intensity, ranging from competent care of therapeutic needs up to taking care - intentionally caring - about the history of the individual patient.

Furthermore, the entire value of the reflective dimension of nursing practice emerges from the analysis of the stories. In the stories told by nurses it is possible to follow the steps that emerge in the self-awareness mechanisms that focus on focusing on certain thoughts about the patient's condition, up to devising extremely personalized care actions. This level of intentionality of nurses, with its practical outcomes of personalized caring, does not emerge from other studies. In particular, it is not detectable in quantitative studies that use scales to measure nurses' behaviors. The value of this study lies in the possibility of expression given to the nurses: they were able to tell their thoughts, rethink their decisions already made, question themselves and self-evaluate their actions with critical reflections, listen to their emotions, explaining how they managed them. These invisible dimensions of care belong to the silent experience of nurses, but they inform caring in its broadest and deepest meaning.

The results of this research (45) lay the foundations of an ethical theory of care which has its origins in Aristotelian wisdom, recovering its full relevance. The authentic care that a nurse can provide occurs when he does not limit himself only to applying his technical skills, but when he dedicates himself to the patient in the singularity of his history, frequently asking himself about his needs and accompanying him and helping him to manage the disease condition with the maximum autonomy and, when this is not possible, taking on the responsibility of the other. The narratives collected highlight how caring is practiced well when nurses put relational virtues into practice, mainly empathy, respect, responsibility, courage and the epistemic virtue of reflexivity. What allows us to act on this ethical line is the intrinsic necessity of the good that Aristotle had already begun to discover.

**Acknowledgements**

We would like to express our sincere gratitude to Enrico Calini, Julie Rosario, and Evan Knight for their support to this work.

**Declarations**

Conflicts of interest/Competing interests: the authors have no competing interests to declare that are relevant to the content of this article.

Informed Consent Statement: Informed Consent was obtained from all subjects involved in the studies presented as examples of application of the EPM in the healthcare field.

Funding: not applicable.

**References**

1. Aristotele (1993), *Etica nicomachea*, Rusconi, Milano.
2.Beck C. T. (1995), *Perceptions of nurse's caring by mother experiencing postpartum depression* in Journal of Obstetric, Gynecologic and Neonatal Nursing, 24: 819-25.
3. Bowden P. (1997), *Caring*, Routledge Bow, C/97, London and New York.
4. Brenner P. (1994), *Introduction. Interpretive phenomenology*:13-27, Sage, Thousand Oaks, CA.
5. Brenner P. E., Wrubel J. (1989), *The primacy of caring: Stress and coping in health and illness*, Addison-Wesley Pub. Co., Menlo Park, California.

6. Charon R. 2006. *Narrative Medicine. Honoring stories of illness*. New York: Oxford university press.
7. Chow J., Grant Kalischuck R. (2008), *Selfcare for caring practice: Student nurses' perspectives*. International Journal for Human Caring, 12 (3): 31-37.
8. Collière M.F. (1996), *Soigner…le primier art de la vie*, InterEditions, Paris.
9. Colaizzi P. (1978), *Psychological research as the phenomenologist views it*. In Valle R. S., King M. (Eds), *Psychological Phenomenological Alternatives for Psychology*, Oxford University Press, New York.
10.Erlandson D. A., Skipper B. L., Allen S. D., Harris E. L. (1993), *Doing Naturalistic Inquiry: A Guide to Methods*, Sage Publications, Newbury Park, CA.
11. Giorgi A. (1985), *Phenomenology and psychological research*, Duquesne University Press, Pittsburgh, PA.
12. Glaser B., Strauss A. (1967), *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine Publishing Company, Chicago.
13. Heidegger M. (1976), *Essere e tempo*, Longanesi, Milano (*Sein und Zeit*, Niemeyer, Tübingen, 1927).
14. Held V. (2006), *The ethics of care*, Oxford University Press, Oxford.
15. Husserl E. (1995), *Esperienza e giudizio*, Bompiani, Milano (*Erfahrung und Urteil*, Klaassen Verlag, Hamburg, 1948).
16. Kittay E. (1999), *Love's labor. Essays on Women, Equality, and Dependency*, Routledge, New York and London.
17.Lévinas E. (1983), *Altrimenti che essere*, Jaca Book, Milano (*De l'existence à l'existant*, Fontaine, Paris, 1947).
18.Lévinas E. (1985), *Umanesimo dell'altro uomo*. Il Melangolo, Genova (*Humanisme de l'autre homme*, Fata Morgana, Montpellier, 1972).
19. Lévinas E. (1993), *Il tempo e l'altro*, Il Melangolo, Genova (*Les Temps et l'Autre*, Fata Morgana, Montpellier, 1979).
20. Lévinas E.(2004), *Totalità e infinito*, Jaca Book, Milano (*Totalitè et infini*, Martinus Niyhoff's Boekhandel, Vitgeversmaatschappiy, 1971).
21. Leininger M. M. (1984), *Care: The essence of nursing and health*, Charles B. Slack, Thorofare, NJ.
22. Lincoln Y. S., Guba E. G. (1985), *Naturalist Inquiry*, Sage, Newbury Park.
23. Manning R. (1992), *Just caring*. Browning Cole E., Coultrap-McQuin (Eds.). Explorations in feminist ethics. Theory and practice: 45-54. Indiana University Press, Bloomington and Indianapolis.
24. Merriam S. B. (2001), *Qualitative research and case study applications in education*, Jossey-Bass, San Francisco, CA.
25. Morse J. (1995), *Exploring the theoretical basis of nursing using advanced techniques of concept analysis*, Advances in Nursing Science, 17: 31-46.
26. Morley J. (2019), *Phenomenology in nursing studies: New perspectives – Commentary*. International Journal of Nursing Studies 93: 163-167.
27. Mortari L., (2007), *Cultura della ricerca e pedagogia*, Carocci, Roma.
28. Mortari L. (2022), *Fenomenologia empirica*. Genova: Il Melangolo.
29. MurdochI. (1970), *The sovereignty of good*, Routledge, London.
30. Nussbaum M. (1996), *La fragilità del bene. Fortuna ed etica nella tragedia e nella filosofia greca*, Il Mulino, Bologna (*The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, 1986).
31. Platone (2000), *Platone: tutti gli scritti*, Bompiani, Milano.
32. Ricoeur P. (1976), *Interpretation Theory: Discourse and the Surplus of Meaning*, Texas Christian University Press, Fort Worth, TX.
33. Rorty R. (1994), *Scritti filosofici*. Volume 1, Laterza, Bari (*Essays on Heidegger and Others Philosophical Papers*. Vol. I, Cambridge University Press, Cambridge, 1991).
34. Stein E. (1999), *Essere finito ed essere eterno*, Città nuova, Roma (*Endliches und ewiges sein. Versuch eines Aufstiegs zum Sinn des Seins*, Archivum Carmelitanum Edith Stein, Geleen, NL, 1962).
35.Strauss A. (1987), *Qualitative Analysis for Social Scientists*. Cambridge University Press, New York.
36.Strauss A., Corbin J. (1990), *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage Publications, Newbury Park.
37. Strauss A., Corbin J.(1994), *Grounded theory methodology: an overview*, in Denzin N., Lincoln Y., (Eds.), Handbook of Qualitative Research. Sage Publications, London.
38. Van Manen M. (1990), *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. State University of New York Press, Albany, NY.
39. Watson J. (2005), *Caring science as sacred science*, F. A. Davis, Philadelphia, PA.
40. Watson J. (2008), *Assessing and Measuring Caring in Nursing and Health Sciences*, Springer, New York.
41. William J. (1994), *Pragmatismo*, Il Saggiatore, Milano (*Pragmatism*, Longmans – Green, NY, 1907).
42. Zambrano M. (2008), *Per l'amore e per la libertà*, Marietti, Genova-Milano (Filosofia y Educatión. Manuscritos, Fundación Maria Zambrano, Màlaga, 2007).
43. Mortari L., Saiani L. (2013), *Gesti e pensieri di cura,*McGraw-Hill Education, Milano.
44. Nodding, N. (2002), *Starting at home,* University of California Press, Berkeley & Los Angeles, Los Angeles.
45. Mortari, L., Saiani, L. (2014)*Gestures and thoughts of caring*, McGraw-Hill Education, Milano.