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### ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

#### **Trust leading to hope - the signification of meaningful encounters in Swedish healthcare. The narratives of patients, relatives and healthcare staff**

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#### **Abstract**

*Background:* The fact that patients and relatives experience poor healthcare encounters is evident in the number of complaints to patients' advisory committees, and from studies and statistics. Looking at 'the other side of the coin', research into good caring encounters experienced as meaningful encounters in healthcare is scarce.

*Aim:* To illuminate the signification of meaningful encounters in healthcare. 124 narratives from patients, relatives and healthcare staff regarding experiences of meaningful encounters in Swedish healthcare were analysed using a phenomenological hermeneutic research method.

*Conclusions:* The results indicate that a meaningful encounter means gratefulness, is founded on trust, cooperation and courage, and results in self-trust through wellbeing, increased understanding and life-changing insights. The encounters have given insight into, and increased understanding of, the patient's own life, the families' lives, and/or healthcare professionals' lives. With this, and awareness of the importance and power of meaningful encounters, healthcare staff might use a meaningful encounter as a powerful instrument in caring.

*Implications for practice:*

- For patients and relatives, trust derived from meaningful encounters in healthcare leads to self-trust
- Caring within healthcare consisting of meaningful encounters, 'the other side of the coin' gives important knowledge that could facilitate improvements in healthcare staff's encounters with patients and relatives, and also enrichment in their own professional development
- Increased understanding and awareness of the power of meaningful encounters can be discussed in terms of patient safety

**Keywords:** Meaningful encounters, caring, patients, relatives, healthcare staff, narratives, phenomenological hermeneutics

#### **Introduction**

What constitute good caring encounters in healthcare is a discussion with different meanings depending on whose voice is given precedence. Healthcare staff interacting in a pleasant manner with patients or patients' relatives requires communication and understanding that extend beyond the knowledge often used in everyday healthcare situations (Söderberg et al., 2011). However, caring encounters (Laitinen et al., 2011) between caregiver and patient, or interaction with relatives (Shattel et al., 2008), appear as important in terms of good care or high quality of care (Papps, 1994; Green et

al., 2008; Jonasson et al., 2010). In empirical research, there is a notable imbalance in the expectations, opinions and attitudes of healthcare staff and patients concerning the purpose and meaning of caring encounters (Shattel, 2004; Snellman et al., 2012). In many western countries, as in Sweden, patients have the legal right to participate in their own care, which should be individually adapted based on their wishes and abilities. According to the Swedish National Board of Health and Welfare (2012), good healthcare (including caring) should, among other things, be characterised by professional and individualised treatment. A good relationship based on a caring, respectful encounter can be seen as a prerequisite for good and professional care, and can have a significant impact on the outcome of patients' care and treatment (Croona, 2003; Alexanderson et al., 2005).

The requirement for respectful treatment is regulated by the Swedish Health and Medical Services Act (SFS 1982:763). If good healthcare is to be achieved in this sense, there must be time, resources and opportunity for patients and healthcare staff to create relationships where staff meet patients and/or relatives in encounters that might be regarded as meaningful. The concept of 'meaningful' is understood as something that makes a difference and has significant importance. However, interesting questions are: what is the signification of meaningful encounters in healthcare? Can healthcare staff knowingly make encounters meaningful for patients and relatives? Since an encounter needs at least two participants, and healthcare encounters commonly have three participants – patients, relatives and healthcare staff – this study includes the voices of patients, relatives and healthcare staff (registered nurses, physicians, nurse assistants, nurse aids, physiotherapists and social workers). The theoretical perspective in this study is caring science (see, for example, Mayeroff, 1971; Watson, 1987; Eriksson, 1995; Roach, 2002).

In today's Swedish healthcare, there appears to be an imbalance between what patients expect of healthcare staff and the care and treatment they are given (Attre, 2001; Schmidt, 2003; Williams and Irurita, 2004; Larsson et al., 2007). Within health and social care, there is often a desire to increase efficiency, reduce costs and to provide healthcare in a rational manner, all of which may conflict with requirements related to the Swedish Health and Medical Services Act (SFS 1982:763). Healthcare capacity may be insufficient to meet patients' needs and expectations of good healthcare. Could this failure to comply with healthcare requirements be mitigated by increasing healthcare staff's knowledge and understanding regarding the signification of meaningful encounters? This gap between patients' needs and what they receive is shown by the number of complaints made to the patients advisory committee relating to healthcare staff's encounters with patients and relatives. There are studies (Shattel et al., 2005; Laitinen et al. 2011; Berman, 2012; Wessel et al., 2012) and statistics showing that patients and relatives are experiencing poor caring encounters (Swedish National Board of Health and Welfare, 2012).

Looking at the other side of the coin, there is a scarcity of empirical studies regarding experiences of good caring encounters – meaningful encounters in healthcare. However, one study of this subject, conducted by Snellman et al. (2012), found both similarities and notable differences in patients' and caregivers' definitions of a meaningful care encounter. The similarities were that both caregivers and patients felt that attributes such as calmness, courage and warmth were important personal qualities in healthcare staff. When these qualities were applied to caring, patients felt that their needs were being taken seriously. The differences between patients' and caregivers' opinions lay mainly in the list of caregivers' personal qualities valued by patients. Caregivers stated that physical contact and being able to use humour to communicate with patients were important but these were not mentioned by patients.

The present study takes its point of departure from the narratives of patients, healthcare staff and relatives. This provides the opportunity to paint a broader picture of the interpretation of meaningful encounters in healthcare. The aim of this study is to illuminate this using narratives from Swedish healthcare.

## Design

This study employed a qualitative, inductive, descriptive approach, while a qualitative, phenomenological-hermeneutic method, inspired by Ricoeur (1976; 1981) and developed by Lindseth and Norberg (2004), was used for the text analysis. The aim of the method is to interpret – illuminate and understand – the meaning of a phenomenon as it appears in front of the text (Ricoeur, 1981). The scientific openness of Gadamer (1989), as well as Ricoeur's (1976) distancing, questioning and critical approach, influences the interpretive process in this study. According to Ricoeur (1976), a lived experience remains personal but its meaning can be transmitted by interpreting narratives. The aim of the interpretation is to reveal the meaning of a text – to interpret the world that is opened by a text. The meaning is not created by our interpretation; it already exists in the world, but interpreting text we can learn more about phenomena in the world.

The data consisted of narratives written by patients, relatives and healthcare staff, all based on their personal experiences of meaningful encounters in healthcare. The narrators were instructed to write down their experiences of a meaningful encounter; what a meaningful encounter was, or was not, was decided by the narrator. The narratives varied in scope from a single page to 12 pages: some were short yet still described how the meaningful encounter occurred, what it contained and the experienced meaning; others were very long and provided detailed descriptions. The narrators represent inpatients and outpatients, childhood experiences and the stories of adults and older people. The group of relatives includes husbands, wives, partners, siblings, parents, adult children and close friends. Healthcare professions represented included registered nurses, physicians, nurse assistants, nurse aids, physiotherapists, midwives and social workers.

The data was collected by the journalist Catherina Ronsten. In 2003, a Swedish national advertising campaign asked for narratives of meaningful encounters in Swedish healthcare from patients, relatives and healthcare staff. The campaign resulted in 338 narratives, some of which were made into a book, *Meaningful encounters – people as prescription* (Ronsten, 2004; Ronsten, 2010). Early in 2011, one of the authors (CG) met Ronsten and was offered the narratives for research.

A group of researchers was gathered (CG, LK and IS) and Ronsten was assigned the task of collecting informed consent from the narrators. Of the 338 narratives from 2003, 97 were verbal and these narrators were asked to transcribe their stories. Sixty-three narrators had changed email address and could not be contacted. This resulted in 275 letters requesting informed consent to use the narratives from the 2003 campaign. Ronsten received 128 signed informed consents and the relevant narratives were numerically coded and delivered to the researchers (see Table 1). The reasons for non-participation were: informed consent was not received because of unknown address, time constraints when transcribing a verbal narrative or the narrator was dead.

Participant	Persons	Sex	Sum of narratives
Relatives	n=19	4 men/15 women	20
Patients	n=43	7 men/36 women	63
Healthcare staff	n=65	7 men/58 women	98
<b>Total</b>	<b>n=127</b>	<b>18 men/110 women</b>	<b>181</b>

The inclusion criterion for narratives selected for the present study was that the narratives contained a story of meaningful encounters between a patient or relative and healthcare staff. Some of the narrators contributed more than one narrative (see Table 2).

<b>Table 2: Results of inclusion process</b>			
<b>Participant</b>	<b>Persons</b>	<b>Sex</b>	<b>Sum of narratives</b>
Relatives	n=18	4 men/14 women	18
Patients	n=33	6 men/27 women	42
Healthcare staff	n=47	6 men/41 women	64
<b>Total</b>	<b>n=98</b>	<b>16 men/82 women</b>	<b>124</b>

### **Ethical considerations**

The research was carried out in accordance with the Declaration of Helsinki (2008) in respecting participants' informed consent. Consequently, all included narrators gave their written informed consent and were informed about guaranteed anonymity to the researchers; the only one informed of the narrators' identities was Catherina Ronsten.

### **Data analysis**

The process of interpreting the narratives was guided by phenomenological hermeneutic analysis, focusing on the phenomena of meaningful encounters, and included three phases: naïve reading, structural analysis and comprehensive understanding (Lindseth and Norberg, 2004). Initially, the three groups of narratives, from patients, relatives, and healthcare staff, were analysed separately. Each narrative was read several times to grasp its meaning as a whole – to give a naïve understanding. A structural analysis, also analysed separately within the three groups of respondents, was performed and maintained in a process related to the naïve understanding in order to illuminate the different parts of the text. Initially, the text was split into 'meaning units', defined as a piece of any length that expressed a signification of a meaningful encounter. After this, the meaning units were condensed and reflected on in relation to similarities, variations and differences, and placed in a scheme in order to create sub-themes. Sub-themes were then grouped into themes based on reflection and abstraction (Lindseth and Norberg, 2004). After this first phase of the analysis, the sub-themes and themes from the three groups were merged together. During the process of structural analysis, consideration and revisions of the naïve understanding were carried out. The narratives were then read again as a whole, and related to naïve understandings and findings from the structural analysis. They were then reflected on in discussions with all three authors, resulting in interpretations of possible signification of meaningful encounters experienced by patients, relatives and healthcare staff. The text was interpreted as a whole with the aim of increasing understanding, and a comprehensive understanding was formulated. This was accomplished based on the authors' critical reflections and relevant literature, and resulted in interpretations of possible significance regarding meaningful encounters in healthcare.

**Figure 1: Sub-themes and themes from the structural analysis**

Sub-themes	Themes
<ul style="list-style-type: none"> <li>• Hope for life, myself, my capacity and/or my family</li> <li>• Professionals' confidence</li> </ul>	Trust leading to hope
<ul style="list-style-type: none"> <li>• Genuine solicitude from healthcare staff</li> <li>• Doing good and kindness</li> <li>• Receiving support</li> <li>• Confirmation and respected dignity</li> </ul>	Wellbeing in healthcare encounters
<ul style="list-style-type: none"> <li>• Participation</li> <li>• Involved relatives in the care</li> </ul>	Cooperation in the care
<ul style="list-style-type: none"> <li>• Courageous healthcare staff</li> <li>• 'Walking the extra mile'</li> </ul>	Courageous encounters
<ul style="list-style-type: none"> <li>• Life-changing insights</li> <li>• Professional understanding/development</li> </ul>	Increased understanding

## Results

### *Naïve understanding*

A naïve understanding linked to the structural analysis was formulated as follows: a meaningful encounter means gratefulness. It is founded on trust, cooperation, and courage, and results in self-trust through wellbeing, increased understanding and life-changing insights. A meaningful encounter means change and re-consideration; it concerns gratitude to the person or persons who participated and the lesson learned in the situation. The gratefulness is related to the dimensions of recovered trust leading to self-confidence through wellbeing, facilitated by experiences of cooperation and other courageous actions. A meaningful encounter is one that has given insight and increased understanding in the patient's life, the families' lives and/or the healthcare staff's professional lives.

### *Structural analysis of the narratives of meaningful encounters in Swedish healthcare*

When leaving the naïve understanding and proceeding to the structural analysis, it appeared that meaningful encounters as narrated by patients, relatives, and healthcare staff had meanings in common. These appeared in the following themes:

- Trust and self-trust
- Wellbeing in healthcare
- Cooperation in the care
- Courageous healthcare staff
- Increased understanding and insights in life

### *Trust leading to self-trust*

This theme concerns narratives of hope turning into trust, resulting in self-trust. The sub-themes 'building' the theme are: Hope for life, myself, my capacity, and/or my family's and professionals' confidence. A distinctive feature of meaningful encounters in care-giving involves healthcare staff's calmness and confidence when encountering a patient or a relative in an often-chaotic situation. However, genuine interest in the patient or relatives combined with patience, trust, and giving the patient or relatives hope is also evident in a meaningful encounter. Meaningful encounters mean that healthcare staff enable the power to rethink and the return of hope.

*'During my stay in hospital she took care of me, her tranquility and confidence made a strong impression on me; at the same time I was humble and grateful for being alive, she gave me hope to return to a normal life.'* (Patient 200)

The calmness and confidence of healthcare staff when exercising their professions also have an important meaning for experiences of security and hope.

*'I got all the support that I needed to cope with the situation we found ourselves in. They have helped me to grow as a person and realise what kind of power there is within me.'* (Patient 179)

The theme of trust leading to self-trust and self-confidence mainly concerns patients' and relatives' narratives; however, a few stories concern healthcare staff's experiences of gaining confidence in their professional activities, which is confirmed in patients' and relatives' responses. Indeed, they are recognised as healthcare staff but are experienced as fellow human beings who were present and provided genuine solicitude to the relatives and the patient. The narrative of hope and confidence leads to insights in trust and self-power and, sometimes, life-changing insights.

### **Wellbeing in healthcare encounters**

Wellbeing in healthcare means experiencing being taken care of but also includes the dimension of doing good for someone in need. The sub-themes structuring the theme are: genuine solicitude, doing good and kindness, support, confirmation and respected dignity. The theme describes wellbeing in terms of healthcare staff acknowledging the patient's suffering and being someone who listens, has the courage to stay and understands. It also has the characteristic of genuine solicitude; someone who really cares for the patient, someone who protects the patient and/or relatives through their genuine interest and consideration – for example a nurse supporting and respecting a patient by confronting them:

*'The fifth time I was a psychiatric inpatient, I thought I had been chosen to preach the word of God to all around me. A nurse asked me if I had a favourite passage in the Bible. I mentioned one. The next day, she had read it and confronted me with the fact that I did not practice what I preached; this made a big impression on me.'* (Patient 210)

Meaningful encounters, as narrated by patients, are significant to wellbeing through healthcare staff's genuine solicitude and genuine engagement with the patient. This is often experienced in situations characterised by crisis.

*'Amidst all the chaos, there was a person there for us, holding our hands, being fearless in our grief and daring to support us 100%. The social worker guided us through our acute grief, pain, and alienation.'* (Patient 209)

In stressful situations, engagement results in feelings of being cared for and wellbeing. Relatives' narratives of meaningful encounters tell of the significance of healthcare staff's solicitude, kindness, support, and caring for the relative (not only the patient) with support, engagement, attention and respect for dignity.

*'Without all the support and encouragement the physicians and nurses gave me – I felt that they were always by my side – I would never have managed to stay in the most difficult situation of my life without their support... Their support in letting me be with my husband (with their support), around the clock, gave me peace of mind. I can bear to look at myself in the mirror for the rest of my life. Because I stayed with him, and I did my best to give him confidence and support while he was dying...'* (Relative 8)

The theme of wellbeing in healthcare is also dominant in patients' narratives, and the sub-theme of doing good and kindness contains narratives from healthcare staff, describing the dimension of wellbeing present in the act of doing good for someone in need.



### **Cooperation in care**

The sub-themes that give the theme structure are: involving relatives in the care and participation. One element of meaningful encounters was founded on healthcare staff's invitations to relatives to be involved and participate, leading to cooperation. For the relatives, meaningful encounters in healthcare mean healthcare staff giving hope by confirming the relatives' suffering in a difficult situation.

*'There was both happiness and grieving... We knew our newborn son was dying but at the same time the paediatrician, A, was anxious to involve us and respect us as the parents we were... and should have been, be it just for a very short time.'* (Relative 83)

The dimension of participation appears in healthcare staff's invitations to relatives to participate in decision making and the care of the patient.

*'In the third week of the palliative care of our father, the physician called for us, he informed us about the situation, how things usually are. Furthermore, the treatment was now pain relief. He said we were welcome to stay with our father, and that they would serve us food. He also advised us to be careful, because the sense of hearing is the last sense to give up, so be careful what you talk about in the room, keep on talking and socialising as usual, it will give your father peace and quiet.'* (Relative 205)

Concerning patients' participation, meaningful encounters concern cooperation and the fact that the patient is someone to be included when planning for the future.

*'The healthcare staff drew up a care plan with me, relatives and friends were also involved, they helped me to build a social network.'* (Patient 189)

### **Courageous healthcare staff**

The sub-themes building the theme are: courageous healthcare staff and staff who 'walk the extra mile'. The meaning of courageous is having the courage of one's convictions and acting accordingly, especially when facing criticism. This concerns staff who dare to be untraditional and who, in certain situations, listen to their hearts instead of following regulations. It also concerns gratefulness for the courage shown by healthcare staff who are brave enough to stay and give support in a chaotic situation. For the patients, meaningful encounters mean they are given hope through support and kindness.

*'There was a woman on my ward, every morning she prayed to God for forgiveness for all her sins and sinful dreams and I got so tired of all these sins. One morning I couldn't stand it anymore: "Please, dear R, there is no point asking God for forgiveness. He cannot hear you because he's on vacation!"*  
*"What?"*  
*"He is on vacation; he went fishing in outer space and will be gone for a few months, during that time you can do anything you wish."*  
*R looked at me and started laughing and said that was really funny.'* (Staff member 147)

Healthcare staff 'walking the extra mile' is about patients' gratitude when someone has the courage to go beyond what is normal or expected.

*'I needed physiotherapy at the weekend, my physiotherapist tried to change shifts or arrange for someone else to come to me. When she arrived, I asked if she had managed to change shifts – she hadn't; she came in her spare time to help me, and I was moved to tears.'* (Patient 32)

Another way this is experienced is as giving extra time to someone in need:

*‘There was a woman who was a patient about to undergo an abortion because of bad morning sickness. I had time to sit with the woman to inform her about the surgery. But eventually we talked about life, her life, her relationship with her husband, demands and their three-year-old son and feelings of feebleness. The day after, she discharged herself without going through with the abortion. I met her four years later and she said that had it not been for me, because I actually listened to her, there would not have been a son.’ (Staff member 225)*

Accepting that someone is ‘walking the extra mile for me’ is narrated with gratefulness. But gratefulness is also felt by the person that walks the extra mile for someone and experiences the result of doing so.

### ***Increased understanding and Insights in life***

The sub-themes building the theme are: professional insight and professional understanding/development. The dominant meaning is healthcare staff learning, gaining better insight and improved understanding in their caring and their profession. Importantly, it also involves gratefulness to the patients and relatives who made their insights possible.

*‘“You don’t get to decide how much it hurts!” That small, obstinate statement from a little five-year old boy was one of the most important lessons I have learned.’ (Staff member 163)*

Meaningful encounters for healthcare staff emerge in a different dimension. For staff, the encounters mean learning and better understanding of their profession and their professional role. This comes from reflecting on admirable and brave patients, and feelings of courage in allowing oneself to be emotionally touched and engaged. It is apparent in learning from unexpected situations, and in healthcare staff’s courage to be personal and sometimes behave in a way that might be deemed ‘unprofessional’. It also includes the satisfaction of doing something good for a person who is suffering and the confirmation in seeing a positive result.

### **Reflections**

Gratefulness appears to be central when trying to understand the signification of a meaningful encounter. Taking a step back and looking at the respondent categories individually, the following understanding becomes apparent. For patients, a meaningful encounter means something ‘for me and my life’; this is based on narratives describing: hope; support; kindness; ‘walking the extra mile’; confirmation; gratefulness; someone listening; understanding; daring to stay; being present for me; providing safety; trust; solicitude; and caring for me with genuine care. The meaningful encounter could be the beginning of a new understanding with trust in the future, self-trust and hope for a better situation. For relatives, meaningful encounters appear to mean ‘for us, my coping’, based on narratives concerning: support; hope; confirmation; power to re-think; the return of hope; courageous healthcare staff; staff who dared to stay; support; and someone being present for me. Similarly to the patients, there is also a meaning of trust, not only for themselves but for their situation as the relatives of someone in need. For healthcare staff, meaningful encounters are directed towards learning, ‘for my understanding, my professional life’. This is based on narratives that describe: learning; understanding; admiration for brave patients; being touched; and unexpected situations and behaviours. Furthermore, healthcare staff describe meaning in doing good for a person who is suffering and the confirmation of doing ‘that little bit extra’ – something that is not a routine task or an activity regulated by routines, rules or legislation.

Since the authors are caring science researchers, the following discussion has its foundation in caring science theories. Considering meaningful encounters as caring (as a healthcare professional), they can, in other words, be described as: helping the person being cared for to achieve or realise his or her innate or natural potential for a fulfilled or meaningful life. As a person taking care of another, the



person becomes what he or she is meant or intended to be (Marcum, 2011). However, the growth and fulfillment associated with care or caring is not unilateral; rather, healthcare staff who exercise caring also grow and are self-actualised through their caring for another. Although caring appears asymmetrical, it is reciprocal in that the person who is caring benefits from the care given to the other, especially in terms of finding meaning or fulfillment for their life: to take care of others and to be taken care of by others. Importantly, Mayeroff (1971) highlights that taking care of another is a process that unfolds over time as, through their caring/cared-for lives, both persons bring into being what was originally, possibly rudimentarily, present. As a human behaviour, caring is developmental in that the relationship between two persons matures as both realise their potential and fulfill their lives (Marcum, 2011). The caregiver experiences the satisfaction of meeting the needs of the cared-for person and, in turn, feels needed by that person – Mayeroff's reciprocal dimension of caring. This reciprocal connection not only establishes the caring relationship but also enhances it by expanding the potential of a caring person to reach out to others in need of care.

The meaning of hope leading to self-trust may derive from the experience of not being heard. The realisation of the damage this can cause may possibly have been experienced by many of us. For healthcare staff, meaningful encounters were experienced significantly as learning. Much of the time, if we are sensitive and open-minded, the encounters teach us more than we may ever be able to acknowledge or believe (Tschudin, 2003). The results of the naïve understanding and structural analysis point to the conclusion that meaningful encounters, in the present study, are founded on an ethic of caring. Noddings (1984) describes this as ethics from caring, embedded in receptivity, relatedness, and responsiveness; thus, the relationships between people in healthcare encounters are so significant that a whole approach to ethical reasoning can be based on them. An ethic of care does not, in the first instance, consider the principles (doing right, or doing the right thing); it first considers the needs of the person to be heard, accepted, and responded to (Tschudin, 2003). In the analysis of narratives from patients and relatives, it became clear that the need for care is paramount; when healthcare staff respond 'correctly', it increases the opportunities for a meaningful encounter. Similarly, when considering healthcare staff's narratives, the need 'to care' is supreme. Noddings (1984) has explored this, saying the 'one caring' is also receiving. This leads to that almost indefinable factor that many healthcare professionals know/describe as 'job satisfaction', which is reached when real caring happens.

Mayeroff (1971) highlights some 'major aspects/ingredients' necessary for caring, regardless of the profession within the healthcare area: knowledge; patience; honesty; trust; humility; presence; alternating rhythms; and courage. These correspond well with the results of the present study. The concept of alternating rhythms, in particular, needs some explanation. It means the movement between past experience and the present situation, between narrow and wide frameworks, and between attention to detail and attention to the whole. We learn from the past and act now; we are active in one moment and passive in another. This is interpreted as a way of reflection, a process by which the meaningfulness or not of an encounter might be decided (Gustafsson and Fagerberg, 2004; Gustafsson et al., 2007).

From a caring science perspective, the results can also be discussed in relation to Roach's (2002) aspects of caring, the five Cs, similar to Mayeroff's (1971) eight aspects. Roach conceptualises certain qualities and specific characteristics of caring, all of which start with the letter C: compassion; competence; confidence; conscience; and commitment. These Cs can all be found in the narratives as important dimensions for the experience of a meaningful encounter. Van Hooft (2003) says the concept of caring is especially clear in the nursing profession. Caring is not just a matter of doing the job of looking after the sick effectively, it is also a matter of having a compassionate and benevolent attitude towards care recipients.

### **Critical considerations**

One considerable weakness of the study is that the narratives that constitute the data could be considered quite old (nine years have passed since the data was collected). However, we do not consider this a big problem since the narratives concern situations that could still occur today. Similarly, the age of the stories is not given any importance as the non-age-dependent meaning of the phenomenon is in focus. Another weakness is that the narrators were predominantly female (16 men and 82 women); this is, of course, a limitation of the study when referring to patients as groups including both sexes. Further research with a gender perspective could help demonstrate any differences.

This study was undertaken in the context of Swedish healthcare. The intention was to gain a better understanding of the signification of meaningful encounters. The interpretation process was an ongoing dialectical movement between the whole and parts of the text, between nearness and distance to the text with the purpose of validating what the text is talking about. This was accomplished by all the authors being involved in each part of the analysis. Ricoeur (1981) argues that there is always more than one way of understanding a text, but this does not mean that all interpretations are equal. The results of these analyses should be judged taking into account the authors' pre-understandings. All of the authors have experience of Swedish healthcare from all three perspectives (as patients, relatives, and healthcare staff) and all are experienced registered nurses and educators, with knowledge of and interest in caring and healthcare. To these authors, the results represent the most useful and credible understanding of the significance of meaningful encounters.

There has been an emphasis on describing the interpretation procedure in a way that provides potential for the reader to follow the interpretation from raw material to comprehensive understanding. Therefore, transferring the findings to other contexts presupposes a recontextualisation of the results to the actual context (Lindseth and Norberg, 2004). The results may be credible if the reader recognises descriptions or interpretations as comparable to their own (Sandelowski, 1994; Lindseth and Norberg, 2004). In this way, the results can be transferred to other comparable situations.

### **Conclusion**

Knowledge and understanding of the power of a meaningful encounter is important. A meaningful encounter can be the first impression for patients or relatives. A profound understanding of the power of the first impression is that the initial encounter may have consequences for the forthcoming caring process. A common expression in Sweden is: '...it takes ten good encounters to repair a bad first encounter'. This is important in the context of healthcare, which is built on a foundation of trust. If a bad encounter occurs, encounters with patients or the relatives might have bad consequences. One question to ask is, can we afford this; do we have time to offer 'ten good encounters' to repair a bad one, to rebuild trust? This can also be discussed in terms of patient safety. A lack of trust could mean that patients do not follow the recommendations or prescriptions of healthcare staff. We would also like to state that it is the right of patients and relatives to be met in a pleasant manner with respect by competent staff and treated with dignity in encounters with healthcare staff.

Through deeper knowledge and understanding of the power in meaningful encounters, healthcare staff can improve their professional actions and behaviour in an effort to make them meaningful to the person being cared for. Importantly, it appears that it is impossible to *make* healthcare encounters meaningful because it is clear that the experience of an encounter as meaningful or not is multifaceted. An encounter that has all the 'ingredients' of being meaningful might not be so for the recipient because he or she might not be in the mood, may be insensitive or simply not have the need. Therefore, it is impossible to give instructions as to how to make encounters meaningful. Nonetheless, it is always the foremost responsibility of healthcare staff to provide the best conditions to care recipients to enable them to experience meaningful encounters. Healthcare staff should also be open-minded and sensitive to aggregating meaningful encounters that give them reason to reflect on their practice and learning. They are also responsible for developing their professional healthcare work with the

intention to increase patients' and relatives' self-trust and self-confidence. By enlightening meaningful encounters we can increase our knowledge of their power and this knowledge give us the potential to improve healthcare. Our experience is that good healthcare is sparsely discussed. If we look at our narratives we can see so many examples but these are seldom highlighted; the focus is more commonly on poor healthcare.

Being aware of the signification of meaningful encounters based on the patients' and relatives' experiences is important and helps healthcare staff to individualise care. Similar knowledge directed towards one's own learning might motivate professionals to reflect on their own and others' learning – professional development. This, considered from different aspects, can be important knowledge when helping and supporting patients and relatives with what they most need support with.

We also think that healthcare staff need to develop their ability to create a good caring encounter while in professional training. One suggestion is that during healthcare training, students can use the knowledge of the signification of a meaningful encounter when learning. For example, through educational drama, students can practice using personal qualities such as calmness, empathy, courage, and warmth (Snellman et al., 2012) in a caring situation so that patients feel that they are being supported, taken seriously, and can meet the caregiver in a mutually trusting way. Similarly, if the caring encounter is experienced as a meaningful encounter, it will also give trust, leading to hope.

## References

- Alexanderson K., Brommels M., Ekenvall L., Karlsryd E., Löfgren A. and Sundberg, L. (2005) *Problems in Health Care in the Handling of Patients' Sick Leave*. Stockholm: Section for Personal Injury Prevention, Department of Clinical Neuroscience, Karolinska Institutet.
- Attre, M. (2001) Patients' and relatives' experiences and perspectives of good and not so bad quality care. *Journal of Advanced Nursing*. Vol. 33. No. 4. pp 456-466.
- Berman, A. (2012) Living life in my own way - and dying that way as well. *Health Affairs*. Vol. 31. No. 4. pp 871-874.
- Croona, G. (2003) *Ethics and Challenge. About Learning of the Attitude of Professional Training*. Doctoral thesis, Växjö University, Växjö, Sweden.
- World Medical Association (2008) *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*. Retrieved from: [www.wma.net/en/30publications/10policies/b3/17c.pdf](http://www.wma.net/en/30publications/10policies/b3/17c.pdf) (Last accessed 28th January 2013).
- Eriksson, K. (1995) Understanding the world of the patient, the suffering human being. The new clinical paradigm, from nursing to caring. *Advanced Practice Nursing Quarterly*. Vol. 3. No. 1. pp 8-13.
- Gadamer, H.-G. (1989) *Truth and Method*. Second revised edition. Weinsheimer, J. and Marshall, D., trans. New York: Crossroad.
- Green, C., Polen, M., Janoff, S., Wisdom, J., Vuckovic, N., Perrin, N., Paulson, R. and Oaken, S. (2008) Understanding how clinician-patient relationships and relational continuity of care affect recovery from serious mental illness: STARS study result. *Psychiatric Rehabilitation Journal*. Vol. 32. No. 1. pp 9-22.
- Gustafsson, C., Asp, M. and Fagerberg, I. (2007) Reflective practice in nursing care: embedded assumptions in qualitative studies. *International Journal of Nursing Practice*. Vol. 13. No. 3. pp 151-160.
- Gustafsson, C. and Fagerberg, I. (2004) Reflection, the way to professional development? *Journal of Clinical Nursing*. Vol. 13. No. 3. pp 271-280.
- Jonasson, L., Liss, P. E., Westerlind, B. and Berterö, C. (2010) Ethical values in caring encounters on a geriatric ward from the next of kin's perspective: an interview study. *International Journal of Nursing Practice*. Vol. 16. No. 1. pp 20-26.
- Laitinen, H., Kaunonen, M. and Åstedt-Kurki, P. (2011) When time matters: the reality of patient care in acute care settings. *International Journal of Nursing Practice*. Vol. 17. No. 4. pp 388-395.
- Larsson, I., Sahlsten, M., Segesten, K. and Plos, K. (2007) Patients' perceptions of barriers for participation in nursing care. *Scandinavian Journal of Caring Science*. Vol. 3. No. 25. pp 313-320.

- Lindseth, A. and Norberg, A. (2004) A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*. Vol. 18. No. 2. pp 145-153.
- Marcum, J. A. (2011) Care and competence in medical practice: Francis Peabody confronts Jason Posner. *Medicine, Health Care and Philosophy*. Vol. 14. No. 2. pp 143-153.
- Mayeroff, M. (1971) *On Caring*. New York: Harper Collins Publisher.
- Noddings, N. (1984) *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.
- Papps, E. (1994) How do we assess 'good nursing care'? *International Journal of Quality in Health Care*. Vol. 6. No. 1. pp 59-60.
- Ricoeur, P. (1976) *Interpretation Theory. Discourse and the Surplus of Meaning*. Fort Worth: Christian University Press.
- Ricoeur, P. (1981) *Hermeneutics and the Human Sciences*. New York: Cambridge University Press.
- Roach, S. (2002) *Caring, the Human Mode of Being: A Blueprint for the Health Professions*. Second Revised Edition. Ottawa, Ontario: CHA Press.
- Ronsten, C. (2004) *Betydelsefulla Möten inom Vården (Meaningful Encounters in Healthcare)*. Göthenborg: Förlagshuset Gothia.
- Ronsten, C. (2010) *Människor som Recept, Berättelser av Patienter, Anhöriga och Vårdpersonal som Delar Med Sig av Glädje och Sorg inom Vården. (People on Prescription, Stories of Patients, Relatives and Health Professionals Who Share Their Joys and Sorrows in Healthcare)*. Eskilstuna: Betydelsefulla Möten and Förlag.
- Sandelowski, M. (1994) Focus on qualitative methods. The use of quotes in qualitative research. *Research in Nursing and Health*. Vol. 17. No. 6. pp 479-482.
- Schmidt, L. A. (2003) Patients' perceptions of nursing care in the hospital setting. *Journal of Advanced Nursing*. Vol. 44. No. 4. pp 393-399.
- SFS 1982:763. *Hälso- och Sjukvårdslagen. (Swedish Health and Medical Act)*. Stockholm: Sveriges Riksdag, Rikstrycket
- Shattel, M. (2004) Nurse patient interaction: a review of the literature. *Journal of Clinical Nursing*. Vol. 13. No. 6. pp 714-722.
- Shattel, M., Hogan, B., and Thomas, S. (2005) 'It's the people that make the environment good or bad': the patient's experience of the acute care hospital environment. *AACN Clinical Issues: Advanced Practice in Acute & Critical Care*. Vol. 16. No. 2. pp 159-169.
- Snellman, I., Gustafsson, C. and Gustafsson, L. (2012) Patients' and caregivers' attributes in a meaningful care encounter: similarities and notable differences. *International Research Scholarly Network ISNR Nursing*. Vol. 2012. Article ID 320145.
- Söderberg, S., Olsson, M. and Skär, L. (2011) A hidden kind of suffering: female patients' complaints to patient's advisory committee. *Scandinavian Journal of Caring Sciences*. Vol. 26. No. 1. pp 144-150.
- Swedish National Board of Health and Welfare (2012) *Tillståndet och Utvecklingen inom Hälso- och Sjukvård och Socialtjänst, Lägesrapport 2012. (The Condition and Development Within Health and Welfare and Social Work, Progress Report 2012)*. Stockholm. Retrieved from: [www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18585/2012-2-2.pdf](http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/18585/2012-2-2.pdf). (Last accessed 28th January 2013).
- Tschudin, V. (2003) *Ethics in Nursing, the Caring Relationship*. London: Butterworth-Heinemann.
- van Hooff, S. (2003) Caring and ethics in nursing. In Tschudin, V. (Ed.) (2003) *Approaches to Ethics, Nursing Beyond Boundaries*. London: Butterworth-Heinemann. pp 1-12.
- Watson, J. (1987) *Nursing: The Philosophy and Science of Caring*. Boulder: Colorado University Press.
- Wessel, M., Lynøe, N., Juth, N. and Helgesson, G. (2012) The tip of an iceberg? A cross-sectional study of the general public's experiences of reporting healthcare complaints in Stockholm, Sweden. *BMJ Open*. 2:e000489. pp 1-7.
- Williams, A. and Irurita, V. F. (2004) Therapeutic and non-therapeutic interpersonal interactions: the patient's perspective. *Journal of Clinical Nursing*. Vol. 13. No. 7. pp 806-815.

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