

## The centrality of the nurse-patient relationship

### *A Scandinavian perspective*

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The centrality of the nurse-patient relationship: a Scandinavian perspective

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### **Conflict of interest**

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### **What does this paper contribute to the wide global clinical community?**

- Human beings require person-oriented care, which is built upon a strong nurse-patient relationship.
- The ontological base of this premise, together with epistemological reflections ought to inform policy and administrative choices and actions.
- The Fundamentals of Care framework is compatible to the way Scandinavian nurses have been trained to think, both from an ontological and epistemological perspective when building caring relationship.

## ABSTRACT

**Aims.** This paper aims to address aspects of importance in the nurse-patient relationship, as conceptualized within the Scandinavian healthcare context

**Background.** An experiment in Beth Israel hospital uncovered a set of core values (ontology) that were wiped away by stronger forces. Despite this, some of the ideas impacted the development of nursing thought and values in the Scandinavian countries, partly because they connected with deeper social values and also because investment was being put into explicitly identifying and understanding the core elements of nursing (ontology) and how to provide evidence that they were important (epistemology). From that beginning and through the work of key thought leaders Scandinavian nursing is ready to embark on a new phase, which could be helped by the Fundamentals of Care framework.

**Design.** This discursive position paper offers insights from a public healthcare setting, influenced by values such as equal rights to equal care and/or cure. The paper presents two complementing perspectives: an ontological and an epistemological, on establishing caring relationships.

**Conclusion.** There are different pathways to follow in building person-oriented care, however, the nursing approach is both ontologically and epistemologically grounded and based on dialogue.

**Relevance to clinical practice.** Patients meet different nurses, the meeting may be short and, routine actions may be on the agenda. However, nurses must engage with patients experiences' and knowledge, in order to add to patients present and future well-being with their person-oriented care.

**Key words:** ontology, fundamentals of care, epistemology, models of care, nurse-patient relationship, person-oriented care, public health nursing,

## INTRODUCTION

This paper aims to address the ontological and epistemological aspects of the importance of the nurse-patient relationship. It does this by exploring primary nursing as one of the key policy and administrative influencers to have shaped Scandinavian nursing thinking (Marram *et al.* 1979); and then how Scandinavian nursing leaders developed and tested such ideas. The paper concludes with a critique of how the Fundamentals of Care framework (Kitson *et al.* 2010) could be used in Scandinavian countries to reemphasize and reconnect to the core values of nurse-patient relationship.

## BACKGROUND

This paper explores an aspect in the core at the Fundamental of Care framework, and the Scandinavian public healthcare system: establishing a relationship.

“When little things are big things” is the title of a paper by a novice sociologist without previous experience of studying nursing. Her aim was to explore the effect of restructuring frontline employees through a merger of Beth Israel Hospital and New England Deaconess Hospital (Weinberg 2006). The merger’s ill effects on patient care caught the media’s attention. To understand what was lost she first investigated the essential question “What do nurses do?” The answer to this question was “Nurses’ descriptions of their work often emphasized developing relationships with patients, rather than professional activities” (Weinberg 2006, p 31). They spoke of nursing as person-oriented rather than task-oriented. This was puzzling because at the same time Weinberg observed a lack of consistency between how nurses spoke about their practices and the daily therapeutic activities patients depended on. It seemed difficult for nurses to verbalize how the effort from hospital administrators to streamline work and reduce costs made them increasingly dissatisfied.

Beth Israel Hospital had gained a reputation as one of the most professional nursing programs in the world. It earned the reputation of being “Harvard with a Heart” (Weinberg 2006, p 31). The skilled nurses were both nice and highly professional. However, the outcome of their professional actions was not systematically documented. Over the years the Director of Nursing and her team, based on a primary nursing model (Marram *et al.* 1979), built a practice with one nurse being responsible for the patient’s care, as well as the treatment and curing aspects from admission to discharge. The situation changed with budget cuts during 1990s and the merger of two different kinds of hospitals, this suddenly obliged the Beth Israel nurses to advocate for and be aware of how to explain their approach to nursing and its benefits for their patients. Their professional actions moved from a respected hospital into a context where there was a need to defend their high quality nursing care in order to maintain its funding. The main difference the Beth Israel model and other kinds of nursing was partly

explained by a nurse who said that, before the patients knew their nurse by name, the patient and the nurse got well acquainted and each was willing to give a piece of him or herself (Weinberg 2006). After the change, it became a one-way relationship, the nurse offered the patient a task-oriented service and did not have time to take in what concerns the patient needed to share.. The situation in general experienced was that the person-oriented approach initiated by the nurses at Beth Israel had become task-oriented. In this paper, we reflect on ontology as a systematic account of existence, describing the core phenomena that reflect existence, leading into a discussion of the difference between task- or relationship-based nursing. Epistemologically inquiry is drawn on to evaluate how the ontological basis of a former model of American nursing, seen as excellent, may be a way of conceptualizing nursing in Scandinavia that is consistent with its philosophical heritage and social values.

Nurses were unable to present adequate arguments when it came to argue for what was now missing in their practice (Reimers & Miller 2014). Fundamental care such as e.g. serving food and drinks or preventing pressure ulcers, became merely a single task rather than a prioritized element in a coherent plan for nursing of the individual patient.

#### *A Scandinavian perspective*

Meanwhile, in the Scandinavian countries, public funded nursing had a strong ontological influence and there was discussion of the relationship between nurse and patient (Arman *et al.* 2015, Nielsen & Sørensen 2013, Uhrenfeldt & Hall 2007) and on nurses' need for autonomy (Uhrenfeldt & Hall 2015).

Epistemological discussions were mainly reduced to the kind of knowledge nurses needed for a caring practice (Uhrenfeldt 1996). An admiration for the North American nursing care models existed in Scandinavia from the 1970s - 1990s (i.e. Skrumsager 1978) and stimulated Scandinavian nurses to develop nursing philosophies and theories addressing the Scandinavian context (Arman *et al.* 2015).

The epistemological discussion about what kind of knowledge nurses needed in their person-oriented practice evolved in the last decade to address the pro and cons of evidence-based nursing (i.e. Martinsen 2005).

The purpose of caring actions was to positively influence the patient's life world (Scheel *et al.* 2008), to comfort the patient through words, touch and deeds, aiming for a positive relationship with the patient (Martinsen 1990, Delmar 1999, Martinsen 2006) and to address and prevent suffering (Eriksson 1993). However, in the publicly financed healthcare system nursing staff also experienced the burden on the nurse-patient relationships from time pressure (Uhrenfeldt & Hall 2015). In addition, task-oriented and fragmented care was barriers to nurses' professional development resulting in a devaluation of their professional judgement (Mark & Nielsen, 2016). Changes recently made in hospitals have influenced patients' experiences of missing fundamental care such as e.g. help with personal hygiene after surgery (Uhrenfeldt & Høybye 2015) and of professionals viewing patients as objects during operations (Sørensen *et al.* 2014). A publicly financed healthcare system such as in Scandinavia, however, did not seem to solve issues concerning patients' needs for caring and fundamental care (Sørensen *et al.* 2014, Aagaard *et al.* 2017, Voldbjerg *et al.* 2016 a and b).

In 1990, a Danish nurse and leading scholar (the first nursing professor with a doctoral degree) developed and tested a model for change in nursing based on motivational and developmental theories. In her doctoral dissertation, she argued using an epistemological perspective that the patient's perception was of being the object of the situational nursing care. She then illustrated how nursing care with an ontological focus on building relationships between the nurse and the patient could improve the actual planning and delivery of nursing, stimulating further growth and development (Larsen 1990). The concept of nursing presented had four perceptions of human beings as individuals: 1) They are active, responsible and have the possibility of continuous growth. 2) They are influenced by the biological processes that condition human life. 3) They are influenced by the world of phenomena they live in. 4) They are influenced by their current surroundings (Larsen 1990).

These perceptions should lead nurses to initiate a process of change, directed towards a state, which is better or "higher"; the process is individual as is motivation for change (Larsen 1990). Nursing care based on this theoretical frame of reference had the following main elements:

- 1) Admission interview
- 2) Sequential dialogues between patient and nurse
- 3) Planning interventions individually with reference to the patient's activity of daily living
- 4) Using the principles embedded in primary nursing (Larsen 1990).

This nursing care model perspective on the nurse-patient relationship build on mutual respect and a need for nurses and patients to understand each other. Both the patient's and the nurse's viewpoint, knowledge, attitudes and values are influential in laying the foundation for a fruitful relationship, with the patient trusting that the nurse "will do him/her good", have the knowledge and insights to do so, and, it is worth repeating, is built on mutual respect. Nurses' acts must be convincingly caring, and be based on an understanding that each patient is unique, with his or her own perception of the situation.

## **THE DISCONNECT BETWEEN PERSON-ORIENTED AND TASK-ORIENTED CARE**

A recent framework that embraces the person-oriented care approach known from Scandinavia and Beth Israel is the Fundamental of Care (FoC) Framework (Kitson et al 2013; Feo & Kitson 2016). The FoC framework seeks to combine the process of building a relationship between a nurse and patient, as part of the person-oriented care, with the patients' bodily functions/needs and practical activities also being addressed. The aim of the nurses who initiate this person-oriented approach is to help patients to make sense of his/her life as it is now, dictated as it may be by different malfunctions or needs. The FoC combines the processes of building a relationship between the nurse and the patient with the practical actions around meeting patients' physical and psychosocial fundamental care needs.

However, the FoC framework does not explicitly identify its philosophical roots and this may be something needed in the future. Previously, in 1997, Kitson (1997) identified what she regarded as the core of nursing to assist nurses to focus on essential elements, universal topics or guidelines to provide them and their profession with structure, character, visibility and

strength in an ever-changing healthcare system. The advice was for nurses to align their authentic (ontological) and scientific (epistemological) side of caring with the technical basic elements of nursing practice.

“The discernment rest with the perception” is stated by Nussbaum, based on Aristotle’s argument for practical wisdom, in contrast to a system of general rules and other rational arguments applied to situational cases (Nussbaum 1990, p. 66). This kind of moral thinking or clinical wisdom adds specific ethical guidance in life, i.e. to be caring. In building a relationship with someone, discernment replaces judgment and the perceptions by individuals meet through a dialogue or just by wordless sensing/viewing of each other (Uhrenfeldt & Hall 2007). This discernment, maybe part of a clinical assessment and may produce trust or mistrust i.e. in the situation the patient describes, the nurses discernment may lead to a “clinical grasp or forethought” (Benner 2011, p.27) guiding the dialogue or other actions along the way between the nurse and the patient. This is in contrast with task-oriented nursing.

The main problem faced in the FoC framework is to end the invisibility and subsequent devaluing of fundamental care (Feo & Kitson 2016). An explicit valuing, a re-conceptualisation and subsequent action towards the embedding of fundamental care in healthcare education, research, practice and policy is essential (Feo & Kitson 2016) and possible. Therefore, in response to the challenges in nursing, the Fundamentals of Care framework was developed and introduced (Kitson *et al.* 2013, Kitson *et al.* 2014).

The FoC framework incorporates relational, integrative, and contextual dimensions of care (Kitson *et al.* 2014). As such, it consists of three concentric circles with a central focus on the relationship between the patient and the nurse. At the first level, the inner core concerns the establishment of the relationship with the patient and the second level comprises physical, psycho-social and relational dimensions that need integration into nursing care and the patient's dependence or independence of nursing care. The third level and outer circle concerns how the healthcare system or context such as how resources, staffing, leadership and policies can influence the nurse-patient relationship (Kitson *et al.* 2014).

The conceptual FoC framework was developed from contributions of researchers and a narrative review of nursing texts specifically looking at the fundamentals of care (Kitson *et al.* 2013, Kitson *et al.* 2014, and Kitson *et al.* 2010). To develop, strengthen and refine the evidence base of FoC, the conceptual framework is currently being discussed and validated across several countries including Denmark (International Learning Collaborative 2017, Sørensen *et al.* 2017).

In summary, a publicly financed healthcare system has been possible in the Scandinavian countries for decades. However, fundamental nursing care still has flaws from patients' perspective, nurses therefore may need to further their clinical leadership and re-address their caring purpose; to build a person-oriented relationship with each patient and to be able to address both the ontological as well as the epistemological base therein. This paper presents complementary perspectives on fundamental care: an ontological and an epistemological perspective, first the ontological one.

## PERSON-ORIENTED CARE: AN ONTOLOGICAL PERSPECTIVE

The relationship between patient and nurse is the core of FoC, as well as in Scandinavian nursing care due to the North European Lutheran background of “Love thy neighbor” and thus the idea of free and equal right to healthcare (Uhrenfeldt *et al.* 1996). The ontological perspective in this paper is mainly existential with roots in the German- Danish tradition and draws mostly on philosophy from Martin Heidegger (1889-1976) and one of his students Knud Ejler Løgstrup (1905-1981) who has had a major influence on caring theory in Denmark and Norway (Delmar 1999, Martinsen 2006). This section addresses the topic of how to establish a caring relationship from an ontological stance.

### *Language as building relationships*

Caring is a fundamental human power carried by phenomena such as trust, open talk, hope, respect, charity and compassion (Uhrenfeldt 1996, Delmar 1999, Uhrenfeldt 2007). Through this process, the ethical part of caring is an expression of the good from one to the other in the relationship, seen, and heard by people recognizing these phenomena as part of the life-world (Dahlberg *et al.* 2009). It is practical ethics as part of a daily life interaction between people. To care is therefore to converge in openness and trust towards each other's impressions, expressions and diversity. Based on the way a society takes care of those who need help the society can be assessed (Alvsvåg 2010).

At the center of nurses' caring practice is the dialogue with a patient; dialogue in preference to the general term of communication, because dialogue has an inherent relational aspect. The dialogue is between at least two (*Dia*) partners and the aim is to learn from each other

(*Logos*), the learning exists through the human abilities of speaking, thinking, listening, and tolerating mutual quietness and openness in reflections. This dialogue opens an insight that might be the first step in building mutual relationships (Heidegger 1978). A relationship that may add to a person-orientation by focusing on well-being (Todres & Galvin 2010), by moving the dialogical partners, from what seems to be an experienced homelessness being a patient, through a sense of homecoming through the dialogue, and ending with athomeness when the relationship starts to become a fact (Mugerauer 2008). Building a relationship, opens up the possibility of progress for the patients's health when viewed as a homecoming process. Todres and Galvin (2010, p. 2) cite Svenaeus (2000) to propose a view of health as "homelike being-in-the world", "Health is to be understood as a being-at-home that keeps the not-being-at-home in the world from becoming apparent" (Svenaeus, 2000, p. 93).

Another aspect of nurses' caring effort is described as the asymmetric nurse-patient relationship (Martinsen 2006). Professionalism, and as a rule power as well, is on the side of the nurse. The nurse was educated to be able to help and has greater possibilities to use the power the institutional spaces possess based on their structural bodies and to shape them through her power. For this reason, much more is at stake for the patient. His exposure and vulnerability is physically and existentially more urgent. Both the fact that illness may be experienced as a bodily lack of order and the patient's or next-of kin worries and feelings of inadequacy appeal to the nurse to be seen and taken care of. However, the patient has the initiative, when the nurse is struck by the patient's spontaneous demand, the caring act gains both the character of attention and decision in relationship to the taking care of him/her (Martinsen 2006).

Outside the Scandinavian context, the role of relationships has been described as central to moral reasoning and superior as a basis for understanding human choices to any prior linguistic or meta-ethical concept (Gilligan 1982). According to Martinsen, ethical codes and standards as a tool for practical use fail to be relevant to clinical practice in a person-oriented profession (2006). Mutual understanding, negotiating and handling ethical questions arise in nurse- patient relationship where open-mindedness, attentiveness and presence more or less tacitly let the patient express what the nurse can do. The nurse's involvement in difficult ethical situations based as it is on individual experience, character and capacity let the situation inform regarding good and evil or right and wrong (Martinsen 2006). If the nurse observes from an outside perspective, the patient may not be viewed as a person with certain significance but as an object for care and treatment rather than a person with a self-understanding (Sørensen *et al.* 2014, Uhrenfeldt & Høybye 2015). A competent nurse, however, may not be able or ready to stand as a professional who uses their own judgment in these situations but merely one who follows guidelines and rules. Therefore, this may hinder both parties in presenting themselves and engaging in a broader sense as living and perceiving human beings (Benner *et al.* 2009). The nurse may not use her senses to see with a participating, attentive gaze. The risk is that the patient becomes an object without mattering to the one who sees him or her. The courage to live may be reduced and the nurse robbed of the joy of being allowed to help the patient. Each in their own way, the nurse and the patient, may only be present with a part of themselves and robbed of their integrity (Martinsen 2006).

### *Individual nurse's experiences and knowledge*

The situation for developing a relationship between a nurse, a patient and maybe a next-of kin will differ depending on whether the nurse acts with a competent or proficient level or expertise (Benner *et al.* 2009). The nurse at a proficient stage builds relationships with patients aiming for mutual engagement in reasoning-in transitions. The nurse knows that the patient's or next-of kin perspective is the only way to find another qualitatively different approach when needed (Benner *et al.* 2009). Clinical grasp is one of the proficient nurse's ways of understanding the patient's situation, this is a way "to get a sense of who the patient is, the patient's pattern of responses, and the immediate demands and concerns in the situation" (2009, p. 142). When a proficient nurse forms a picture of the whole situation and the patterns and responses within it, it also opens a possibility for the nurse to sense the person, a human being in the role of a patient for the moment and seeing the unexpected in every meaning. Here lies also the possibility for building a genuine relationship; without this relationship the proficient nurse does not develop a full picture of concerns, demands and experiences of his or her own patterns and responses. Proficiency was also a key concern for the Danish scholar Larsen (1987, 1990) and in the next section, we share experiences from working with her model of thinking.

### *Nurses' patient-oriented care at patient admission; inspired by Larsen*

Nurses' patient-oriented care based on Larsen's (1990) theory was initiated with the first two of four main elements:

- 1) Admission interview- a person-centered approach, followed by...
- 2) Sequential dialogues between patient and nurse

In the admission interview a nurse interview the patient in order to picture normal activities in relation to specific health issues and activities of daily living. The interview structure was based on Maslow's motivation hierarchy (1943) and Murray's theory on subjective and objective request for human activities (1938). The interview should be carried out within 24 hours after admission. The sequential dialogues between patient and nurse are continuing dialogues between the patient and the nurse, to ensure information sharing, teaching and individual care. The next section will look at nurses' epistemological approach to reach a person-oriented caring practice.

## **PERSON-ORIENTED CARE: AN EPISTEMOLOGICAL APPROACH**

An epistemological approach to person-oriented care was consciously developed in the Scandinavian countries from the 1970s onward through what has been described as a nursing process or in the Scandinavian terms: *Sygeplejeprocessen* (Skrumsager 1978) or *Vårdprocessen* Eriksson (1979). This nursing process was constructed to improve fundamental care by structure and documentation through a five-step initiative building mutual knowledge about the patient's situation (see BOX 2).

This plan for clinical problem solving in nursing was in use in the Scandinavian nursing schools for educational purposes as well for novice nurses and advanced beginners practice, especially in the 1980s and 1990s. The theoretical framework for caring in the same period came mainly from Kari Martinsen (Norway) and Katie Eriksson (Finland) (Tomey & Alligood 2010), as well as from other influential scholarly work from United States (e.g. Patricia Benner in caring and expertise, Marram *et al.* in Primary Nursing).

*Vårdprocessen*, described the relationship between the nurse and patient and argued for the patient to be autonomous and for the nurse to be part of a caring team, and for them together to build a relationship and a mutual person-oriented situational caring experience (Eriksson 1979). The patient can decide to contact nurses or to act without contact with nurses.

When Larsen (Larsen 1987) drew up her model for collaboration with patients based on their experience of their situation, she believed that this should form the base for informing, guiding or educating them. At the same time a discussion started regarding a demand for healthcare provision to be based on solid evidence whenever possible (World Health Organization 1999). This is however, not an easy task. Melnyk and colleagues in 2000 addressed the unique challenges the nursing profession had experienced in keeping up with evidence due to the load of new information being published every day. At the same time Pedersen (2000), who was engaged in studying the benefit of person-oriented care based on Larsen's theoretical model (Larsen 1990) commented on and contributed to the development of her model. His critique mainly focused on the last two elements of the four presented:

- 3) Planning interventions individually with reference to the patient's activity of daily living
- 4) Using the principles embedded in primary nursing (Larsen 1990),

Pedersen found Larsen to be too general and not to bring forward enough additional guiding factors to be person-oriented in the clinical setting. Patients in the modern healthcare system experience chronic and lifestyle induced illness and need integrated processes to support

recovery (Kitson & Sørensen 2017, Toft & Uhrenfeldt 2015) thus person-oriented care has to have a complexity that meets the demands for an assessment of the patients' situation to be both accurate and precise. Pedersen combined Larsen's model with "Health Promoting Today and a Framework for Planning and Environmental Approach" by Green (2000). The aim of Green's model is Quality of Life (QoL). Healthcare staffs identify the specific health related behaviour that could be linked to the health problems deserving attention. By adding Greens three concepts (predisposing, enabling and reinforcing) the assessment interview could be in the form of a dialogue with the patient about their knowledge, values, attitudes, and experiences (predisposing), of their possibilities for acting on behalf of new knowledge (enabling) or to reinforce the patient due to motivational factors (Pedersen 2000). The risk of low quality and task-orientation instead of person-orientation occurs is if the nurse becomes so efficient that she uses the assessment interview to make one-way communications only, asking for a yes or no, instead of having a dialogue about drafted topics.

Through a dialogue, interventions are agreed, planned, implemented and evaluated. In order to assess and plan nursing care nurses dialogue with patients about their situation. However, nurses must also observe information relevant to nursing care in general e.g. skin integrity, nutritional status, functional status. Based on the dialogue and observation, patients and nurses agree on a tailored care plan. The care plan is implemented by action, dialogue with information sharing and educating the patients and observation, in order to adjust the plan when needed and finally evaluated.

Pedersen's interpretation of Larsen's and Green's models has so far been tested in three doctoral theses in 2010-2017 dealing with issues of fundamentals of care: Hørdam *et al.* 2000- on mobilizing patients, Larsen *et al.* 2015- on patients' self-care when it comes to heart failure, and Trads *et al.* in 2017 on prevention of post-operative obstipation.

In conclusion, Larsen paved the way for an intervention through dialogue with the patient. Green added to this understanding by giving preference to evidence, and Larsen's (1990) four steps starting with an admission interview/ dialogue provided the person-oriented care planning with evidence for fundamentals of care based on nursing relationship and professionalism.

## **PERSPECTIVES FOR THE FUTURE**

We set out to further explore person-oriented care and the ontological and epistemological grounds for establishing a positive nurse-patient relationship that improves patients' well-being. We used the context of publicly financed healthcare that is influenced by values such as equity of treatment and care and equal rights to equal care and/or cure. Our contribution to the FoC framework and the central focus is based on examples from the Scandinavian use of ontology and epistemology to give substance to the caring effort in person-oriented care.

From an ontological perspective, human beings deserve person-oriented care that includes a relationship with the nurses who are responsible for the care. Nurses are aware of evidence that exists and needs to be selected as background for their care; the nurses are the ones to tailor this evidence in a dialogue with the patient for the benefit of the patient's well-being.

From an epistemological perspective, the political aim for the level of care being offered to patients differs across countries and groups of patients, the risk is of a task-oriented care based on evidence only and thereby being too general to offer the individual support needed to increase patients' well-being. This brings forward a question of clinical leadership. Clinical leadership was not part of this paper's aim, however, an increased understanding of the central importance of the communication and demonstration of person-oriented care in nursing care is needed, one of the ways to achieve this is through clinical leadership, but also to be able to answer the question: what do nurses do? The past, present and the future of building the relationship between nurse and patient lies in dialogue and at the same time reaching out to communicate the best evidence possible for the benefit of the patient's well-being and for society's use of resources.

#### *Relevance to clinical practice*

From admission to discharge patients, meet different nurses. If the meeting is brief, there might be only a few routine facts communicated, with reference to the medical diagnosis and treatment. This however, does not constitute the foundation of nursing, and important information on the patient's health and self-care condition might be overlooked. This approach will not improve the patient's well-being in the end. The routine information may be supportive to the healthcare admission, but it takes more for a patient to open up about what is the trouble, what were the experiences that led to the admission, what it takes to come out from here and be "homecoming" (Mugerauer 2008, Todres & Galvin 2010).

The nurses' preparation for comprehensive and specific care plans is important for patients and for the use of healthcare resources. The mutual ability to talk, listen, being quiet and/or think out loud together is the basis upon which relationships are built through dialogue. It takes a person to see another person being "homeless" (Galvin & Todres 2012) and to see what kind of help is needed to be at home in a new world and to begin to understand what needs to be in place to be able to feel "being-at home" in a new situation (Todres & Galvin 2010). The nurse must be professional and a fellow human being that can use their imagination to understand as much as needed in each situation with the patient. Not every nurse can do this; clinical grasp in the situation is the proficient nurse's way of understanding the patient's situation (Benner *et al.* 2011). It is a way to get a sense of who the patient is, for leaders to evaluate if the nursing care is led by too many novice nurses, for the patients to experience a rather generalised response instead of person-oriented care;

The ontological base together with epistemological reflections is relevant to inform policy makers and administrators of the consequences for patients of certain choices made. There is a need for structured dialogues between nurses and patients about their background, preferences, experiences and estimates to combine the individual's experiences with specialist knowledge when planning individualized nursing care aiming for well-being.

## CONCLUSIONS

This paper sets out some of the requirements for a publicly financed healthcare system to enable services to provide high quality. In conclusion, we find that there are different pathways to follow to build person-oriented care, but dialogue must be present.

Fundamentals of Care is compatible to the way Scandinavian nurses were trained to think, in an ontological and epistemological perspective.

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**BOX 1 Model for change in nursing care based on motivational and developmental theories**

- First, each human being is an active and responsible person with the possibility of continuous growth.
- Second, individuals are influenced by the biological processes that condition human life.
- Third, individuals are influenced by the world of phenomena they live in
- Fourth, individuals interacting with their actual surroundings (Larsen 1990).

## **BOX 2 The Nursing Process** (*Sygeplejeprocessen*)

- The first step is data collection, i.e. a practice is being observed and described,
- The second step includes sharing the analysis of data with colleagues and patients.
- The third step a theoretical knowledge transfer.
- The fourth step is evidence utilization
- The fifth step is an action in connection with an assessment of the outcome of the person-oriented care (Skrumsager 1978).