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Ethos in Time: Nurse Theorist Katie Eriksson as Remembered by Dr. Jessica Hemberg

by Jessica Hemberg, RN, PhD[1] and Mary Morrow, RN, PhD[2]

Abstract: The year 2022 is *Nursing Science Quarterly's* 35th year in publication and we are dialoging with nurse theorists. We hope to uncover influences and origins of their theoretical thinking and hear about their current projects related to nursing science. In this scholarly dialogue column, we dialogue with Dr. Jessica Hemberg, a former nursing student of nurse theorist Dr. Katie Eriksson who was internationally known for her theory of caritative caring. In 1986 Professor Eriksson was invited to create a caring science academic program at Åbo Akademi University in Vaasa, Finland which drew graduate students from all Nordic countries. Eriksson's work highlighted the uniqueness and dignity of the human being and the importance of protecting the vulnerable suffering human being. Dr. Eriksson passed away in 2019, and we are grateful to spend some time with one of her PhD students.

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Ethos in Time: Nurse Theorist Katie Eriksson as Remembered by Dr. Jessica Hemberg

2022 is *Nursing Science Quarterly*'s 35th year in publication, and to celebrate I have had the privledge of dialoging with nurse theorists. The hope was to uncover influences and origins of their theoretical thinking and hear about their current projects related to nursing science. This column is dedicated to Dr. Katie Eriksson (1943-2019) from Finland who is internationally known for her theory of caritative caring. Eriksson had a masters and a licentiate in philosophy, and a education doctorate where she studied the nursing process (Fagerström, 2019). Professor Eriksson served as president of the Helsinki Heath Care Institute (1975-1986) where she developed an academic program for nursing with Helsinki University. In 1986 she was invited to create a caring science academic program at Åbo Akademi University in Vaasa, Finland which drew graduate students from all Nordic countries. She was also a professsor of Medical Faculty at Helsinki University, and honorary doctor at the Nordic School of Public Health in Gottenberg (1998) and at Karstad University (2013). Dr. Jessica Hemberg, a former nursing student of Eriksson and current senior lecturer and associate professor at Åbo Akademi University, graciously agreed to share her knowledge of Eriksson, as well as her own continuing work in nursing science.

Mary Morrow (MM): Hello Dr. Hemberg and thank you so much for taking the time to tell us about Professor Katie Eriksson. How did you meet Dr. Eriksson?

Jessica Hemberg (JH): My first meeting with Professor Katie Eriksson occurred in the late 1990's through her various texts which I read during my studies to become a nurse and a public health nurse. I remember being strongly attracted by her deep, philosophical thoughts about the uniqueness and dignity of the human being and the importance of protecting the vulnerable suffering human being. Never had I read such human science and ethical texts about the human being, health, suffering, ethos, and about caring. I

became very fascinated and increasingly curious about these ontological questions and concepts of suffering and health, especially the idea of ethos and caritas. She wrote deeply about suffering which I had never read before. I was younger then and while some students had difficulty understanding her work, it was really clear to me. I was immediately captured by her text, therefore I continued to read Eriksson.

Caring for the patient according to Eriksson concerns a will to do good, by the means of tending, playing, and learning, and one can mediate faith, hope, and love. Caring is fulfilled in a *caring communion*, which is characterized as caring with warmth, respect, honesty, and tolerance. Ethos is the core of caring and the core mission of caring is to alleviate the human being's suffering in a spirit of faith, hope, and love thereby enhancing dignity. I was attracted to it immediately, maybe because personally I have strong empathetic feelings and feel strongly about unethical treatments.

Eriksson was always very bold, especially when she launched her theories and the idea of the human being as a unit of body, soul, and spirit in 1987. It was not immediately accepted with open arms. Her idea that the patient is a suffering human being also aroused resistance but opened up a whole new way of thinking both in theory and in practice especially as a way for caregivers to truly see the patient. In the Nordic tradition of caring science Eriksson was already a pioneer since earlier in the 1980s she claimed that health was more than soundness in body and mind. In the Nordic countries at that time sickness was seen as opposite of health; however, Eriksson disagreed saying they are not on the same dimension. An important finding in the development of Eriksson's caritative caring theory was that one could experience health despite having a medical diagnosis or illness. This thus confirmed that the human being could be healthy whilst simultaneously suffering from an illness/illnesses. Furthermore, in her theory of caritative

caring, suffering was deeper than just a physical dimension and was on the same dimension as health. Suffering involves the whole human being (body, soul, and spirit), whereas sickness refers to body. Eriksson's division of the concept of suffering into *suffering due to illness*, *life-suffering*, and above all, *suffering caused by care* was also an eye-opener that deepened the understanding of suffering and what it can mean to contribute to more dignified and ethical care.

My first actual meeting with Professor Eriksson took place in the 2000s, when after graduating as a nurse/public health nurse, I immediately started my master's studies in caring sciences at Åbo Akademi University and later as a doctoral student at the Department of Caring Sciences. I was so interested in her theories I wanted to continue my education right away, even though I was working. I had the great honor of having Professor Eriksson as a supervisor for my doctoral thesis, together with the main supervisor Associate Professor Lisbet Nyström.

Professor Eriksson had a warm personality and was very humble. She had the unusual ability to inspire new thinking in her students, while also being a good listener. Even though she was very clear and straightforward with her own ideas, it was lovely that she was open to what I suggested say for a survey. As doctoral students we also had the privilege of listening to her lectures where she would spontaneously draw models on the board. We were so inspired and full of ideas at the end of class. Sometimes both she and Dr Lindström lectured together and discussed and from time to time they had different opinions. It was a once in a moment/historical time to be in that room with these two deep thinkers.

A strong memory that I carry with me is when she personally congratulated me on my completed doctoral thesis. We were in the coffee room, and she took my hands in hers and said that my monograph thesis was a very fine book; but she also said that it might be just like when she herself came out with her new theories, that it will arouse some resistance and cannot be

directly received with open arms. Then she looked at me in the eyes, while still holding my hands in hers, and said: "But in time, when the time is ripe (*mature*), they will understand."

My thesis, *The Source of Life, Love – Health's Primordial Wellspring of Strength* (Hemberg, 2015) was basic research that focused on the ethos of health and the human being's becoming or evolving towards health. The thesis explored and deepened the knowledge of health and becoming in health, among other things, through analysis of Kierkegaard's (1847) work, *The Gifts of Love* and interviews with respondents who have lived through severe personal suffering and found their way back to life and health.

The new understanding from my research, showed that the human beings' source of strength is love, the essence and origin of life. Eriksson (1989) had shown earlier in her theory that human beings' sources were nature, the self, the concrete other, and the abstract other (God or love). My thesis, thus deepened that knowledge and showed that the abstract other (I called it love), was superior to these sources of power, and that love had a deeper dignity than faith and hope. Love carries the strongest power, and faith and hope alone were not enough for becoming in health. My thesis showed that the substance of health is love, which, through the trinity of faith, hope, and love, also makes possible the existence of the source of strength. Love is connected with eternity and is the uniting link between temporality and eternity. The human being's inner longing entails an ontological attraction towards the source of strength. This source of strength is hidden, which provides and maintains its force, like a mystery connected with the darkness of suffering that hides the secret representing the source of strength (life's mystery) but which is revealed in both the darkness of suffering and in the light of joy. A humble fundamental attitude towards life constitutes the basis for a continuous dedication of vitality from this source.

Eriksson (Lindström et al., 2018) had previously created so called axioms, one of which was: "Communion is the foundation of all human life. The human being is fundamentally interrelated to an abstract or a concrete other in community or communion" (p. 145). My thesis deepened the understanding of this axiom as the results of my thesis showed that it was love that formed the basis of the communion, and that it was thus love that formed the basis of all human life and not merely communion. I then reformulated the axiom on my own to say: "Love is the foundation of all human life and of communion. The human being is connected with the abstract other, the first love, which constitutes his/her essence and is the basis of communion with one the concrete other, the self and nature" (Hemberg, 2015, Attachment number 7. 1/2). Communion is a part of human life, of course, but it is not the deepest level. For example, we cannot have a deep relation with the other if love is absent. And then love is the strongest and first source of health. If we do not have love then we do not have the source of self, of nature, or the other. The monograph is written in Swedish, has a summary written in English (Hemberg, 2015, pp 234-245), and the thesis is available online at: https://urn.fi/URN:ISBN:978-951-765-789-1
Later, I published an article on the same topic along with my doctoral thesis supervisors (Hemberg et al., 2017), written in English.

MM: Thank you for sharing how you knew and studied with Dr Eriksson. I did not realize how your doctoral thesis work was connected to hers and that you actually suggested a change to one of her axiom's. Very remarkable! What do you think were Eriksson influences/origins of her theoretical thinking/theory?

JH: The main influences/origins of Professor Katie Eriksson's theory of caritative caring were Søren Kierkegaard, Hans-Georg Gadamer, & Emmanuel Lévinas. Others as well helped shape her theory such as the Greek philosophers Socrates, Plato, and Aristotle, the

Swedish theologian Anders Nygren, Thomas Kuhn, Karl Popper, Susan Langer, Eino Kaila (Finland), and Georg von Wright.

For example, Emmanuel Lévinas (1989) influenced Eriksson regarding the notion of ontological ethics, or that ethics precedes ontology. She was very strict about this in every lecture. This underpinned for example the notion of ethical understanding which means that we cannot fully understand the other since this person represents something totally different and we can learn to get to know the other only by openness, meaning *being open towards the other*. According to Lévinas, openness to the other is characterized by *sensitivity* and *vulnerability.*

Then in regard to caring, it is required of the caregiver that they show a constantly open invitation to the other (to the suffering person/the patient); to come forward in his or her nudity. Lévinas (1989) says that the nudity of the face is a call to action through the honesty directed at me and from the address of the face. The caregivers open invitation demands answers, which means that I can no longer fail to take responsibility. It is about an ethical responsibility being awakened in the caregiver in the encounter with the patient.

Hans-Georg Gadamer (1996) influenced Eriksson to use a hermeneutical approach and hermeneutical thinking in the caritative caring tradition. Gadamer (1996) noted that when we encounter and meet others, we can better understand ourselves. Interpretation is one key to understanding, and understanding is seen as a hermeneutical movement. Humbleness and openness were other keys to Gadamer's thinking that Eriksson used. Gadamer (1996) stated with regards to understanding of the text that hermeneutically trained must be sensitive to the text, and "the important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (pp. 271-272). Inspired by Gadamer, Eriksson argued that by asking questions of a text the reader could grasp a new

understanding. Below is my own interpretation of how Eriksson interpreted the hermeneutical spiral according to Gadamer's thinking:

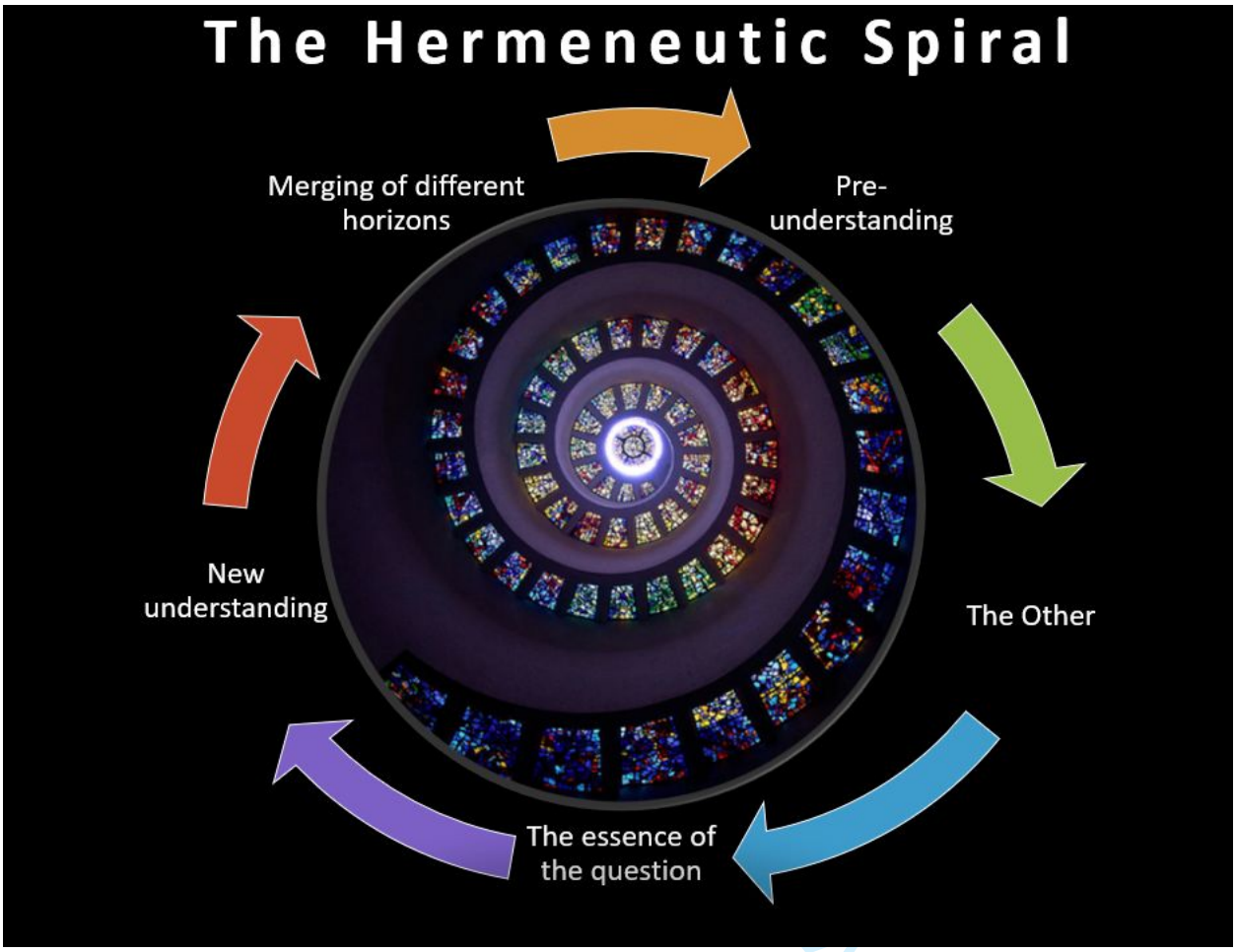

Figure 1. Eriksson's hermeneutical spiral, inspired by Gadamer's thinking (Hemberg's own modified figure from listening to Professor Erikkson's lectures)

MM: Where do you see the future of Dr. Eriksson's theory going?

JH: We have in the caritative caring theory a strong tradition regarding spiritual dimensions and the existential that has formed a special and unique niche of the theory that I feel we need to protect and further develop. The need to care and to always see the human being behind the patient and to protect their vulnerability, thereby protecting and

rebuilding the dignity of the human being, is becoming increasingly important in today's rapidly changing and high-tech society.

First, we need to take further steps to explore the spiritual dimension of her theory, the unity of body, soul & spirit. We must also continue to test and explore the theory of caritative caring's central concepts in different clinical settings and care contexts and implement them in healthcare practices. While the theory is strong due to Eriksson's focus on developing the theory, the concepts, and her basic research, we need to study and implement the theory in the clinical context. Of course, we must further develop this theory by demonstrating that ethics must permeate the professional nursing care, connecting to an inner ethos. Eriksson's caritative caring theory involves a broad-mindedness concerning all that is human, providing an opening for a new way of viewing the world and therefore the theory may also be implemented within other contexts. We must continue to plant seeds of love and ethics as the basis for all caring within different nursing contexts for future generations to come. There is some confusion for those that do not know this theory when we talk about love of the patient. We mean the human humbleness and humility towards a human being. I think it is important to continue to use these strong concepts and words even if misunderstood. Words are important and have such power to even destroy a person and ruin a person's dignity and self-image. If you have the right words or ethically loaded words, and the ethos or love for the other, you can rebuild a person's dignity and self-worth. Words are important in our tradition, so I would like to see this continue. in our tradition. For example, *Only through the inner core of ethos and love within caring bears the potential of enhancing the patient's wellbeing and health.*

The relationships between the concepts need to be further tested within clinical contexts. This entails operationalizing the main concepts to more precise definitions from clinical

contexts, in order to see how the caritative caring theory receives support in the reality of a caring context. While there is lots of basic research on suffering for example, the inner existential dimensions of the concepts of health and suffering together with their mutual connections need to be displayed within different clinical settings. The relationships between the main concepts within the theory also need to be tested within different clinical settings and care contexts.

Another issue I believe that needs to be established within the caritative caring theory is to develop a broader perspective on the unique patient within a life context. Eriksson mentioned that the human being's inner wealth is their culture and their history and that no matter where the human being is in the world, they carry with them their own culture and a historical context. The part that is, so to speak, all around the human being, their life context, belonging to close people, such as family and friends, and other life circumstances needs to be developed and integrated into the theory. We always need to bear in mind that a human being has their own luggage/baggage, and we cannot know what they have been through or carry with them. Therefore, the theory needs to broaden the perspective of the human being, to also include their life circumstances and cultural issues. We need to view and encounter every human being as *a secret writing* (cf. Piltz, 1991), meaning that we cannot take anything for granted and we should be open to what persons express, even though the human being might be familiar to us. Although we *think* we know what they need and desire because we have cared for them previously, they might express something unexpected and new, even to them. This means nurses must also hinder our prejudices and instead be open to new nuances and expressions in the human being or the patient they encounter. By this I mean that humbleness is a key virtue to cherish within caring, because judging someone does not belong in a caring context where you put the human being at

the center of everything and you want to protect and maintain their dignity – similar to the saying "you can never know how a person is doing if you have not walked a mile in his shoes." If you are humble when you meet others, you will learn something about them and yourself.

MM: Since working with Dr Eriksson, what have you worked on related to nursing science?

JH: Since my doctoral thesis I have studied a variety of related nursing science concepts in a variety of contexts. Some years ago, I studied the concept of suffering (within different nursing contexts). The findings of my first study (Hemberg, 2017a) showed that: Suffering is portrayed as a deep darkness. The suffering human being is filled with hopelessness and meaninglessness and feels homeless in life. There is often a hidden inner longing in the midst of suffering that may be uncovered. Embracing the dark corner of the heart, the suffering, provides the keys for initiating a movement towards its alleviation and implications for how to encounter a suffering human being within different caring contexts. I also conducted a study on how to alleviate or find the keys to alleviate suffering (Hemberg, 2017b).

I have since then collaborated with colleagues from Sweden to study the concepts of compassion and dignity in different care settings/contexts, such as home care and palliative care. The results of one study on mediating compassion (Hemberg & Gustin Wiklund, 2019) produced four themes: *Encountering one another as human beings, being in the moment, bearing responsibility for the other,* and *being in a loving communion*. The overall theme was *acting from one's inner ethos, a heart of goodness and love*. We also found that mediating compassion as belonging can be interpreted as the *component* that holds the caring relationship together and

unites the different levels of health as doing, being, and becoming in the ontological health model. Further research should focus on revealing compassion from the perspective of patients.

In a qualitative study I was involved in Gustavsson and Hemberg (2021) explored compassion fatigue as a bruise on the soul. Our findings showed: Compassion stress and overload can lead to compassion fatigue. Compassion fatigue affects the nurse's ability to feel anything, or to be compassionate, and then the caring is no longer experienced in the same way; the nurses experienced it as being deprived of the gift of compassion. Compassion fatigue implicates a crisis with potentially valuable insights. Compassion fatigue can be symbolized as bruises in the soul, hurtful, but with time it can fade away, although it leaves a sense of caution within the nurse, which can affect the suffering patient. Nurses feel a shame when they hurt like this, and need to know what this is, and that nothing is wrong with them, they might just need some time off.

Another colleague and I (Hemberg & Bergdahl, 2019a) have been studying the concepts of ethical sensitivity, perceptiveness, through co-creation in palliative home care. That study showed that through ethical sensitivity and perceptivity, nurses in palliative home care can balance their actions in the moment and change their nursing care actions according to the patient's wishes through co-creation in the nurse-patient encounters. Here the time is crucial, as the time needed is unique to each patient. If nurses fail to be sensitive and perceptive in encounters with dying patients, good palliative home care cannot be achieved. Ethical sensitivity and perceptiveness can also be considered a part of nurses' ethical competence. Patients' dignity can be preserved through ethical sensitivity and perceptiveness, which is fundamental for good palliative care. We noted that co-creation from patients' perspectives should be the focus of future research. Another study we (Hemberg & Bergdahl, 2019b) conducted within the home

care showed that co-creation can be viewed as an essential part of caring and being involved in patients' health and holistic care is a profound endeavor. Currently we have also explored leaders' perceptions on ethical sensitivity and compassion in home care and its association to quality of care and to staff competence. This study is currently under review.

Another recent study (Hemberg, et al., 2020) I have been involved in has been on longing and well-being among frail older adults in home care. The study results uncovered three themes: *Longing for social contacts, longing for nature,* and *longing creativity, aesthetics, and music*. Longing was positively related to well-being when the older adults were able to fulfil their longings. The study provides an understanding of the mechanisms of longing among frail older adults. Longing, here, is an inner resource for setting into motion the transition towards well-being. Further studies could focus on how frail older adults can be supported to combat the negative forms of longing in daily life.

Other colleagues and I have studied loneliness amongst older adults and adolescents and young people from a caring science perspective. Hemberg, et al.'s, (2018) study findings with older adults resulted in one main category and three subcategories. The main category was as follows: *Being homeless in life-loneliness expressed and primarily stemming from existential suffering*. The subcategories were as follows: *Loss of communion with one's partner or other loved ones, loss of meaningful social activities due to isolation,* and *loss of health due to frailty and vulnerability*. This study contributes to an understanding of experiences of suffering from loneliness in older adults receiving home care, with relevance for the healthcare context as well as for what a community or society should focus on when addressing these important issues.

Within the project on loneliness, I have also been involved in looking at the lived experience of loneliness in adolescents and young people (Hemberg, et al., 2021) and their thoughts about

alleviating loneliness (Sundqvist, & Hemberg, 2021). The results from Hemberg, et al.'s (2021) study found two main themes and seven subthemes. Negative experiences of involuntary loneliness were stressful and paralyzing giving rise to physical symptoms, emptiness, anxiety, fear, and invisibility. Other negative experiences resulting from involuntary loneliness were shame, self-blame, and self-contempt, as well as meaninglessness, hopelessness, and exclusion. Positive experiences from self-chosen solitude were freedom, calmness and recovery, creativity, and meaningfulness as well as reflection, recharging, and personal growth.

Another interesting study I (Hemberg, 2019) worked on involved caring ethics within the student healthcare context. This study showed a main theme of *Caring ethics as the foundation for enabling cultural competence*; followed by the subthemes: *Cultural competence as knowledge and acting accordingly with open-mindedness and respect, cultural competence as being willing to understand and learn through a process*, *cultural competence as responsiveness and adaptability*, and *cultural competence as humility and discretion*. Ethics can be considered a core component of cultural competence in student healthcare. In further research, a focus should be placed on cultural competence as perceived from other (for example students') perspectives.

I have recently collaborated with colleagues from Norway associate professor Oscar Tranvåg and professor Dagfinn Nåden (2022) on dignity humiliation as expereinced by wives caring for a home-dwelling husband with dementia. This article was accepted this spring by *Health Care for Women International.*

One of my doctoral students from Norway, *Anita Elvegaard*, is currently working on a very interesting study on suffering and suicide. This study is ontologically rooted within the caritative caring theory and particularly on the suffering theory of Eriksson. Her research

question is: What is it to be near by committing suicide, seen from suffering perspective? I am looking forward to working on that. She will conduct both an integrative review and interviews. Another interesting project I have been part of was looking at existential suffering with regards to cancer survivorship (Ueland, et al., 2021). This was a collaborative project situated in Norway, and we used Eriksson's caritative caring theory (Eriksson, 1989; Lindström et al., 2018) as a framework for this study.

Last year, I conducted an integrative review on ethical leadership with another colleague (Hemberg, & Salmela, 2021). Our findings were: The permeation of integrity can be described as efficient managerial nurse leaders leading relationships and processes by integrating a caring and interactive team spirit and different leadership styles. Such value-based and caring interactions are rooted in the nursing culture, which is the foundation of all activities in an organization. Through an integrated leadership model comprised of leadership and management woven together by integrity, efficient managerial leadership in nursing care can be strengthened. We have also conducted focus group interviews on the same topic with nursing leaders and are currently analyzing the data. We hope to publish these findings this autumn. Lastly, I have another very interesting study in progress on ethical dilemmas in the older adults' care context, but this study is not ready yet but will be finished and published in autumn 2022.

MM: You have been busy! It is interesting to see how you have built your body of work. On another note, this dialogue will be published in our October 2022 issue. The theme of that issue is *Time.* Would Dr. Eriksson have anything to say about the value of time? Would you?

JH: Eriksson developed her theories for over about 50 years and her interest was always directed towards the fundamental questions of caring and a search inward towards the

core and ethos of caring. I think Professor Eriksson would emphasize that there are timeless and eternal questions that deal now and 50 years from now with the human being, with life, health, suffering, and care. Her latest collection of work *Caring Science: The Science of Caring: About the Timeless in Time* published in 2018, even mentions time.

I believe that Professor Eriksson would have emphasized the importance of time more and more in times like we are living in now. I think Eriksson would have particularly emphasized the importance of time in her model of *the nursing care process*, or I believe this should be done. The nursing care process can be related to the passage of time. I believe that whether we give or not give time to a patient affects how the relationship develops and whether one can talk about care at all. Also, time spent in an institution such as a hospital ward can also be seen as a very different time than time spent in your own home. For example, when you enter the hospital room and become a patient, you might immediately *lose* yourself. You might think that you need to change your behavior and become a "patient" especially when you put on the *patient clothes* the hospital requires you to wear. You become more tense and start to behave differently and now you must follow rules (that may be different than our own habitual time to do things during the day) like when to wake up in the morning, when to shower and so on. And we as nurses might easily think we *own* the patients and that we can control them through different routines on a ward. This however silences the patient and is offensive to their dignity which is the opposite of the meaning of caring. Thus, care should be much more time flexible, friendly, and person-centered. Otherwise, we cannot call it care.

Furthermore, experiences of vulnerability and fragility increase during a patient's suffering due to, for example, suffering in relation to one's own self-image and one's own being.

Also, patients in hospitals can be particularly sensitive. When the caregiver offers their time to convey love and compassion to the patient, this can provide relief in the patient's suffering and pave the way for an experience of well-being despite a simultaneously existing suffering. I believe that within caring there can be opportunities that can manifest themselves in blink-of-an-eye-moments, but which can nevertheless mean a time span of strength and new potentials for the human beings' health. Also, even if many argue that time costs money and resources, I also want to remind them that a smile or positivity does not cost anything from the caregivers. But of course, we need sufficient time to create trustful caring relationships where the patients can dare to begin to tell us (nurses) about their troubles and wishes. And thus, a true caring can be formed, in accordance with the patients' own wishes. However, if there is a caring culture reflecting time as stress(ful), the patient does not dare to express their desires or needs for care because the patient feels that the caregiver does not have time and is stressed and thus might try to protect the caregiver from even more tense pressure and stress by silence.

I believe that every caregiver or nurse has a responsibility to brighten up the patient's life with caritas and claritas and then as well as to carry ethos forth to the patient. This is an ethical moment, which creates a caring in the room in the moment (a sort of hidden moment of inner time). This enables the patient to feel secure and a feeling of *at homeness* which can be *health-giving*. Eriksson (2018) also noted that time is a concept that both can enrich the substance of caring sciences and it can form or reshape caring. The presence of a caregiver can provide comfort and relief for the patient when they are allowed to suffer out the suffering in communion with another fellow human being. This can be caring only if the caregiver is able to be truly and genuinely present in the moment, through listening to the suffering human being in the care, by

inviting the patient to this caring encounter, and through the posture reflect the ethos that is timeless.

Another aspect of time is that the patient needs time to be in closeness to the caregiver and other family persons (to get care and security and in order to experience communion), but they also need time to separate from the caregiver and others, to make room to reflect inwards and gather strength. These two needs need to be respected by the caregiver. The patient also needs sufficient time to suffer and to recreate oneself since suffering and illness implies dying from something and eventually evolving into a new entity.

In February 2022 my doctoral student and I (Ahokas & Hemberg, 2022) published a qualitative study on moral distress in elderly care. This study also highlights the isssue of time, since moral distress can arise from a lack of time in a care context. Other findings were: moral distress contributes to a sense of inadequacy but also a sense of responsibility, moral distress arises from an imbalance in values, increased knowledge and open discussion help reduce moral distress and reflection, and increased support and increased resources can reduce moral distress. We will continue on this topic in her research studies this autumn.

Lastly, as I noted earlier in the study of "Ethical Sensitivity and Perceptiveness in Palliative Home Care through Co-creation" (Hemberg & Bergdahl, 2019a) we found that time is crucial, as the time needed is unique to each patient. Time is also an fundamental issue within nursing, in order to enable true caring, nurses need enough time with patients to be able to establish trust in the caring relationship. This is true in all caring contexts.

MM: What advice would you have for future nurse theorists, our readers, nursing faculty and/or nurse service leaders?

JH: This is a broad and challenging question. And I will give a broad and short answer. The most important thing, for both theorists and other persons active in nursing is to always have the human being in the center and always start from this. The fact that ethics precedes ontology means keeping the ethical alive in all circumstances, both in terms of research and in practice. It is about maintaining human dignity and strengthening it; to humbly listen to the human being or patient and strive to understand because theories and nursing should serve the human being and the suffering patient. It is by protecting the human being's dignity and their ethos, caritas, and claritas, that true and good care can be designed and created to be dedicated to the patient.

If you are interested in reading more of my research, you can find more information on researchgate.net: https://www.researchgate.net/profile/Jessica-Hemberg-2 and on my research profile on Åbo Akademi University: https://research.abo.fi/en/persons/jessica-hemberg

MM: Jessica, thank you so much for your time today. I have enjoyed meeting you and hearing about how you came to know Dr Eriksson and how she influenced your work in nursing science.

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Jessica Hemberg, RN, PhD

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