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Using lifeworld philosophy in education to intertwine caring and learning: an illustration of ways of learning how to care

Ulrica Hörberg, Kathleen Galvin, Margaretha Ekebergh and Lise-Lotte Ozolins

ABSTRACT

Our general purpose is to show how a philosophically oriented theoretical foundation, drawn from a lifeworld perspective can serve as a coherent direction for caring practices in education. We argue that both caring and learning share the same ontological foundation and point to this intertwining from a philosophical perspective. We proceed by illustrating shared epistemological ground through some novel educational practices in the professional preparation of carers. Beginning in a phenomenologically oriented philosophical foundation, we will first unfold what this means in the practice of caring, and secondly what it means for education and learning to care in humanly sensitive ways. We then share some ways that may be valuable in supporting learning and health that provides a basis for an existential understanding. We argue that existential understanding may offer a way to bridge the categorisations in contemporary health care that flow from problematic dualisms such as mind and body, illness and well-being, theory and practice, caring and learning. Ways of overcoming such dualistic splits and new existential understandings are needed to pave the way for a care that is up to the task of responding to both human possibilities and vulnerabilities, within the complexity of existence. As such, we argue that caring and learning are to be understood as an intertwined phenomenon of pivotal importance in education of both sensible and sensitive carers. Lifeworld led didactics and reflection, which are seen as the core of learning, constitute an important educational strategy here.

Introduction

Our general purpose is to show how a philosophically oriented theoretical foundation, drawn from a lifeworld perspective (Gadamer, 1960/1995; Heidegger, 1926/1962; Husserl, 1936/1970; 1939/1973; Merleau-Ponty, 1945/2002; 1961/1968) can serve as a coherent direction for caring practices in education. This novel approach is needed because something is wrong in healthcare. There is evidence that unnecessary suffering as a result of healthcare is commonplace (Fridh et al., 2015) and one notable symptom of this, patient complaints, is on the rise (Berglund, Westin, Svanström, & Johansson).
It has become evident that patients experience situations where they often are not ‘seen’ as persons. An extensive body of literature indicates the various ways in which patients’ negative experiences are manifest, e.g. experiences of objectification, abandonment, a sense of imprisonment, alienation, and exile to name a few (Dahlberg & Segesten, 2010; Galvin & Todres, 2013b). Further, there exists at times an excessive focus on signs and symptoms, measurement of physiology and a general reductionist approach which is at the expense of patients’ experience of their everyday situation (Berglund et al., 2012; Carel & Kidd, 2014; Eskilsson, Hörberg, Ekebergh, Lindberg, & Carlsson, 2015; Toombs, 1988).

In this paper, we wish to make a case for the need to attend to this problem in a new alternative way that has at its heart the aim of supporting individuals within health processes as persons, by taking account of both the medical objectified gaze and, simultaneously, an existential approach. In order to take account of both, we need learning environments and learning strategies that can support the essential intertwining of processes within caring and learning contexts and thus support the development of humanly sensitive care (Holst, Ozolins, Brunt, & Hörberg, 2017a, 2017b; Ozolins, Elmqvist, & Hörberg, 2014). A clear foundation of caring and learning, with a lifeworld orientation, has the potential to educate healthcare professionals from a lifeworld perspective providing the sensitised foundation necessary to improve the care of the patients and their complex situations. Practice in care contexts requires certain capacities and a particular kind of attunement to ‘what it is like’ within complex situations of patients. Existing educational practices usefully provide technical and content knowledge, but we argue that something further is needed to resource a human capacity to care: one that meets patients as humans and not just recipients of treatments. A particular kind of experiential learning is necessary, where students are encouraged to try to step into another’s shoes and to reflect on what they find there.

In this paper we first offer a theoretical foundation, discuss its applicability to learning and reflective practices, and secondly give examples from caring and learning contexts with the aim of demonstrating learning strategies with potential to meaningfully support students learning to care for human vulnerability.

Our specific purpose is to point to potential fruitful educational strategies that can overcome dualistic consequences of ‘splits’, for example between mind and body, illness and well-being, theory and practice, caring and learning. We offer and illuminate some ways of helping students develop their existential understandings and the value of a variety of ‘didactic tools’ that have the potential to support this concern.

As a guiding foundation we draw on Husserl’s lifeworld theory and theory of intentionality, Merleau-Ponty’s philosophy concerning how everything is intertwined in existence, as well as Gadamer’s ideas about shared understandings and Gendlin’s work on ‘carrying forward’. Our intention is to show how these philosophical and theoretical sources can constitute tools to develop caring and learning, which have the potential to change a traditional and problematic objectification in care.

A lifeworld foundation

The concept of lifeworld, based on Husserl’s philosophy (1936/1970, 1939/1973), provides a philosophical foundation to grasp individual perspectives within the
seamlessness of everyday living. The lifeworld is not just individual and unique, it is also shaped by and in an ongoing way that is perpetually developing through experience. Consequently the lifeworld can be understood as ‘a world of experiences’. When humans experience various phenomena in the world, these phenomena already have a meaning for them, i.e. the meaning is already there, constituted in the lifeworld. Further, the lifeworld is not a world in itself, it is the individual approach of world and life, a natural attitude which shapes approaches to our daily living and depends on the historical, cultural and social contexts humans are involved in. Individuals perceive things ‘in – the – world’ in different ways (Gadamer, 1960/1995; Heidegger, 1926/1962).

Additionally, Husserl’s lifeworld-theory and the theory of intentionality is further developed by Merleau-Ponty (1945/2002) and clarifies man’s existence in the world as a ‘lived body’ (1945/2002) and the philosophy concerning ‘the flesh of the world’ – the chiasm (Merleau-Ponty, 1961/1968), has both epistemological and ontological significance for what we describe in this present paper as the ‘intertwining of caring and learning’. Such complexity helps us to understand the lived body as an integrated whole, with intertwined aspects of the human existence – ‘the flesh of the world’ where everything is present as visible and invisible. Both existence and matter are affected by the same world in a reversibility, they are from the same ‘flesh’ (Merleau-Ponty, 1961/1968).

Given this theoretical foundation, that provides a more existential view, the human being is seen as a person with innate vulnerability as well as possessing willpower and potential for his/her own agency and personal growth. Therefore, this perspective includes a capacity to strive to fulfil one’s possibilities as well as to live in a world with others, to be in interaction with others and crucially sometimes to depend and rely on others. Such a view is relevant to both caring and to learning, and here both patients’ and learners’ experiences will have unique features as well as more general characteristics that are shared.

**Caring from a lifeworld perspective**

The lifeworld approach places demands on professional carers to strive to recognise the world as the patient does, in terms of both their suffering and their well-being, if we are to provide care that is meaningfully humanly sensitive. This means not only attention to the rich contextual nature of the patients’ everyday lives and their existential situation, but also demands a critical and reflective perspective of medical givens and necessary standardised treatments. In caring practice there is a risk of an unnecessary battle between biological aspects and existential issues in care (Dahlberg & Segesten, 2010; Galvin & Todres, 2013b). However, if the patient is understood from a lifeworld perspective, by its nature an existential view, then there is always ‘both’: both biological aspects and existential issues are intertwined in the patient’s situation and from the patient’s perspective. In this way, the patient is understood in relation to his or her life context. Thus, in caring situations the patient cannot be separated from what life entails in terms of experiences, traditions, culture, close and other relationships, surroundings, environment and so on. The patient is therefore ‘seen’ as a lived body that includes all human aspects of experience, and this means that biological and medical aspects are recognized in the same way as everything else in
the patient’s world. For instance, the patient’s experience of well-being cannot be divided into different conditions or categories of specialisation, namely ‘physical’ (body) and ‘mental’ (mind) well-being, as one example of a detrimental and artificial division that represents a dualistic view. Such dualisms present impediments to any potential to fully support patients’ health processes. Rather, well-being is an experiential and existential condition, expressed as a way of ‘being – in – the – world’. Each person tries to find his/her own balance in existence, and strives to find harmony which is intertwined with his/her whole life situation (Gadamer, 1996). This perspective also includes a notion that scientific, specialised knowledge and lived experiences comprise, in a tangled way, a ‘lifeworld-led care’.

**Lifeworld-led education and learning**

Within learning contexts such a lifeworld perspective also means that the learner’s world of experiences is the starting point for all learning support. Learning is individual and takes its point of departure in the learner’s present and previous experiences as well as expectations or fears, which accompany the learning process (Ekebergh, 2007). This entails that each individual has a specific learning horizon depending on one’s subjective dimension in terms of understanding, values, interests, perspectives, etc.. Consequently, lifeworld-led didactics consider the learners’ lifeworld and are characterized as being open and sensitive to the learner’s view and experiences (Ekebergh, 2009, 2011). Therefore it is of crucial importance to be sensitive to the learner’s horizon of understanding and his/her thoughts, feelings and knowledge regarding health and caring. A lifeworld-led education and lifeworld-led didactics are built on the same ontological and epistemological foundation as lifeworld-led care, constitute a holistic view, with prerequisites for the intertwining of caring and learning in practice (Ekebergh, 2009).

The core strategy within lifeworld-led didactics is reflection; it is the key to learning, which can be understood with the help of the theory of intentionality, linked to the theory of the lifeworld. According to this theory of intentionality, human consciousness is always directed towards something else other than itself, which means that it is directed towards objects, both concrete and abstract. The objects are always experienced as something, which means that we always experience something with a particular meaning. This natural experience implies that a person experiences a specific object with all its characteristics and meanings. However, the experience includes characteristics of the object which are not immediately presented to consciousness, but are present in the way of ‘appresentations’. Consequently, in every single experience there are meanings that are only indirectly experienced. Humans’ consciousness has two directions, on the one hand towards objects, which is the natural attitude, and on the other it can be directed towards itself, which means creating a distance from the natural attitude, and then consciousness becomes aware of itself, which makes self-reflection possible (Husserl, 1900/1970; 1913/1998). Accordingly, the natural attitude is a passive act of consciousness, but self-reflection is an active act, awareness, and has to be effected consciously, by means of creating distance from oneself. This awareness reflection means that the human becomes aware of herself/himself in relation to the phenomenon for consideration. In this aware moment a reflection process starts, which successively ends up in new meanings of the phenomenon. Through this reflective attitude the person develops a deeper or new understanding of phenomena in the world.
We argue that ‘lifeworld-led didactics’, including reflection, support the intertwining of caring and learning, which begins with the patient’s story (Ekebergh, 2011). Carers and students listen and show interest in the patient’s own story about his/her health and illness. Being sensitive towards the person’s experiences and expressions requires an open attitude, and it is a question about coming close to the lifeworld to get the meaning of living with illness and suffering from disease. For example, students and carers can bring the patient’s narrative to a reflective supervision session. A reflection starts in the group-supervision session, which illuminates and penetrates the narratives with the help of caring science concepts, such as suffering, caring and wellbeing (Ekebergh, 2009, 2011). The outcome from this session is aimed at obtaining a deeper understanding of the patient’s situation, how to plan future care and how to support health processes. This supervision is lifeworld-led and also flexible in response to caring science so that the development of understanding of the patient’s world, the caring and the practical knowledge can be influenced by this knowledge base. This can serve as a tool to understand the patient’s world with less emphasis from a third person perspective and new increased emphasis on what the experience might be like from a first person perspective. Accordingly, such lifeworld-led reflective supervision is used as a tool to grasp the patient’s lived experience in deeper meaning, but at the same time this lived experience can be used to grasp scientific knowledge. It is a movement between the theoretical dimensions and the lived dimensions, integrated in the learning process. Currently, to our knowledge, there are few instances of educational strategies in the literature that have taken this integrated step. Most reflective work in health has been focused on the student or professional experience, whereas we are attempting to shift perspective towards reflection as ‘otherness centred’. This is important and necessary because without it we are in danger of perpetuating existing approaches that are less likely to make a difference to the patient or the practitioner/student. We argue that lifeworld-led learning provides students with possibilities to be educated in ways that include the depth and details of the patient’s perspective intertwined with their own learning and therefore has the potential to make a difference for patients. Students will also be better prepared for the challenges in current health care.

**Demonstration of lifeworld theory used in educational practice**

In lifeworld-led education a variation in learning support is required to enable a deeper and expanded understanding of human vulnerability as resource for care. Three approaches to support student nurses’ learning will be demonstrated:

- the first is from the classroom (Hörberg & Ozolins, 2012), using films to support learning
- the second is from clinical settings ‘Development and learning care units’ (Holst, Ozolins, Brunt, & Hörberg, 2017b) and ‘Student led health clinic’ (Ozolins et al., 2014)
- the third concerns a strategy to sensitise students, in an embodied way, to how the patient communicates ‘what it is like’, i.e. embodied interpretation shared as poems (Galvin & Todres, 2011).
Using films to support students learning of caring science and practice

In higher education there is a potential to draw on the philosophy of Merleau-Ponty (Merleau-Ponty, 1945/2002, 1948/1964; Merleau-Ponty, 1961/1968) to understand students’ learning processes and their need of support.

Our perception is not a sum of visual, tactile, and audible givens, as we perceive in a total manner with our whole being. We grasp the unique structure of a thing, a unique way of being, which speaks to all our senses at once. This can be understood as a vast opportunity to embody knowledge. Further, we recognize a certain common structure in each person’s gestures, voice, face, and bearing. Each person is nothing more or less to us than this structure or way of being in the world. What often is described as a man’s body and soul are two aspects of his way of being in the world, and the word and the thought it indicates should not be considered as two externally related terms (Merleau-Ponty, 1945/2002, 1948/1964). Students’ learning is constituted of all these dimensions whereas we argue that film could be important to embody knowledge.

Cinematographic drama is, so to speak, finer-grained than real-life dramas: it takes place in a world that is more exact than the real world. But in the last analysis perception permits us to understand the meaning of the cinema. A movie is not thought; it is perceived. This is why the movies can be so gripping in their presentation of man: they do not give us his thoughts, as novels have done for so long, but his conduct or behavior. They directly present to us that special way of being in the world, of dealing with things and other people, which we can see in the sign language of gesture and gaze and which clearly defines each person we know (Merleau-Ponty, 1948/1964, p. 58).

Film touches upon students’ existence and can be very moving, which can be brought into reflection (Hörberg & Ozolins, 2012). We posit that higher education can benefit from the use of all the students’ senses in learning contexts to bridge the mind and body split as aforementioned.

Earlier research has shown that the use of film can be a valuable strategy to support a student’s learning of caring science (Hörberg & Ozolins, 2012). As a film is not thought; it is perceived, there is a great opportunity to evoke and integrate sense and sensibility, and both are needed to develop good caring. The film could be described as a situated reality and can both be rewound and repeated if needed, in order to reflect on existential aspects and needs. In contrast, in caring within clinical settings the students could ‘repeat’ caring actions but cannot really rewind situations, except in thought. Experiencing the film can enable a shifting focus between the parts and the whole of the situation, without risk of harming another person.

Practically, when using film the aim of doing so has to be explicit. The film per se is not an educational tool but can provide valuable perspectives as a base for supporting learning (Hörberg & Ozolins, 2012; Oh, de Gagné, & Kang, 2013). Students should be encouraged to take, for example, an existential perspective on how the persons in the film could be understood. The caring approach can be illuminated with different kinds of films, together with follow-up seminars, supported by a teacher. The following examples are from nursing education in courses concerning caring science theory where the films Once (2006) and Open hearts (2002) have been used.

Once does not show any healthcare or nursing at all, it is rather about the existential meanings of ordinary life and persons’ special way of being in the world. Open hearts
shows how suffering and well-being could be expressed and understood, in relation to disease and ill health. These two films can serve the understanding of the meaning of life and care, and its possibilities as well as difficulties, i.e. the complexity of human existence.

Initially, and in accordance with Hörberg and Ozolins (2012) the film is presented with aims and scope. After the film has been shown, the students individually are invited to reflect on and write a note on what, how and why they have been touched. This reflection is important as the students need to start in their own lifeworld in learning, to enrich an embodied understanding. The students are then asked to share their experiences in relation to the film to make their lifeworld explicit. Following this, they are invited to reflect together in groups on some caring science concepts, for example vulnerability, existential vitality, rhythm of life (Dahlberg & Segesten, 2010). The teacher offers support to deepen what has become explicit in the discussions and how this could be understood in relation to existential aspects of life and the meaning of health.

There are further possibilities for expanded reflections and learning in the follow-up seminars through creating poems, based on the students’ responses to the film. The students’ experiences are further elaborated through writing the meanings that had emerged earlier on a whiteboard. The teacher clusters these meanings together with the students, and creates a poem to illustrate the meaning of being in the world. According to Merleau-Ponty (1961/1968) we are opened to the world we touch and are touched by at every point of our being and this implicates an existential vulnerability. This could be understood as the students are given possibilities to embody and explicate their understanding and lifeworld, and to stimulate their creativity and make something tangible from their experiences. This can serve their memory and learning and create a sense of coherence as well as giving them a sense that their experiences are important.

The following poems are created by students with support of a teacher. The first example is from the film The hours (2002) based on a novel called Mrs. Dulloway by Woolf (1925). The film elucidates how three generations of women have to deal with suicide in their lives.

**The hours**
Water gives life
Water takes life
I regret nothing
I do not regret life
The time we live is now
We stop living at some moment
What you need is true love
You cannot hide from life by avoiding it
It’s my life, my story, my responsibility
I embrace you. I see you. We need each other
But – Be near me!

The second example is from the film The Diving bell and the butterfly (Schnabel, 2007) and is based on an autobiography by Bauby (1998), editor of Elle magazine, written with the help of an assistant who had to understand his blinking communication in order to
tell his story. Bauby suffers from a stroke and has to live with locked-in syndrome and is tetraplegic and can only move one eye to communicate.

*The Diving bell and the butterfly* – My trapped life after the stroke

I am a butterfly without wings

I’m dumb, but not stupid

I live my life through the eye

My eye is the mirror of the soul

But I’m trapped in my body

I’m empty and without hope

But my mind is full of life.

I have memories of my previous life

Longing to know and recognize my body

I want to be who I was

I want to rise again, with a desire for wings to carry me

These examples illustrate both the power of resonance and new rich insight that has the potential to move or touch students in such a way as to sensitise them to the existential. This can provide an attunement with human vulnerability that can be a resource for the capacity to care by feeding the imaginative capacity for learners so that they can reflect on what it might be like and consider directions for caring practices from there.

‘Development and learning care unit’ and ‘student led health clinic’

Intertwining of caring and learning in clinical settings requires lifeworld-led didactics but also caring and learning environments that confirm these didactics and support development and learning in a fruitful way (Eskilsson et al., 2015). In a research program, in Sweden, there have been developed two kinds of educational units in nursing education, which both are characterized as caring and learning environments; one is labelled ‘Development and learning care units’ (Hörberg & Ozolins, 2012, 2013; Holst et al., 2017a, 2017b) and the other is labelled ‘Student led health clinic’ (Ozolins et al., 2014). They are both grounded in caring science and have an epistemological foundation in lifeworld theory. The main focus in these units is to transform caring science knowledge to become a tool to deepen the understanding for the patient’s situation and how to support health and wellbeing. These units have two aims: one is to support nursing students’ learning process, and the other is to support the development of excellent care from a caring science perspective.

By using lifeworld-led didactic strategies in caring and learning, students and carers can develop adequate knowledge from practice, at the same time as a caring approach is developed. A pre-condition is, however, that the support of the learning process is such that the learner’s lifeworld is taken into consideration in the same way that the patient’s lifeworld is taken into consideration in caring. Learning and caring could be described as parallel processes, but through a lifeworld perspective they could be understood as intertwined. Thus, lifeworld sensitive strategies form the knowledge base for excellent and evident care and health support.
The potential of ‘embodied relational understanding’ – research evidence shared as poems

Building on Todres’ work (1999, 2007), the concept of ‘embodied relational understanding’ has emerged as one example of the kind of knowing that is complex enough to underpin lifeworld-led caring practices (Todres & Galvin, 2008). A concern with the way in which existing extensive qualitative evidence about patient experience can serve knowledge for caring, has led to a consideration of how best to engage learners with qualitative research findings in ways that have the potential to sensitise them to patients’ lifeworlds (Galvin & Todres, 2011). A focus on the use of existing qualitative literature is driven, not because of a desire to exclude other forms of enquiry or other kinds of knowledge, but rather an attempt to refine the contribution that lifeworld oriented research can make for caring practices and specifically learning about caring. In this endeavour, a way in which learners can develop their imaginative capacity, for the purposes of attending to the inner world of the patient, is sought. This specific approach to sensitising learners is situated within an interpretive epistemology (Gadamer, 1975/1977; Gendlin, 2004) that makes way for the evocative power of words which are faithful to experience and which can ‘carry forward’ meanings in ways that are not just individual or unique, nor shared but always ‘in between’. The aim here is to bring patients’ experiences forward palpably, and in a ‘living’ way, so that they can be understood in shared ways ‘between us’. Following Gadamer, such understanding is to understand something unique and personally meaningful and to also understand shared intersubjective horizons within which individual experience takes place.

As such, embodied relational understanding refers to a way of knowing that is contextual, holistic, and attentive to what it is like for instance ‘to be assailed’ by illness or loss, to have to face existential tasks given by specific situations. In other words, it is attentive to the experiential worlds of what it is like for patients to ‘go through something’. This kind of knowledge includes technical evidence, specialised knowing and propositional knowledge, but is integrated with the specific demand of a practical situation (Polkinghorne, 2004). This means a practical ‘know how’ given by the presence of an embodied practitioner in each unique practice situation, as well as a resource given by capacity to imagine the inner world of the patient. When these are integrated, embodied relational understanding is an inclusive resource of three domains of knowledge: technical knowledge, practical knowledge and imaginative ethically sensitive knowledge. Such integrated sensibility may be considered to re-present what Gendlin (1974) referred to as ‘a thick pattern’ of knowing, in which the holistic seamlessness of the lifeworld is a complex enough resource for learning to care. It is complex enough in that it is aesthetically textured, holistic, contextual, and sensitive to unique situations and calls upon an empathic imagination:

… in their engagement, practitioners are ‘a locus of intersection’ of specialised knowledge, historical, personal and professional experience and, in the applied mood, a willingness to look freshly about what this unknown situation needs. Holding on too tightly to knowledge here, needing too much certainty, reduces the range of possible applied resources that are adequate to an actionable epistemology where ‘thick’ knowledge is required (Galvin & Todres, 2011, p. 524).
So how can a capacity for embodied relational understanding be developed in learners? One direction in addition to engaging with film has been to develop a way to transform qualitative research findings in such a way that the words ‘open up’ possibility for a resonant human connection. Embodied interpretation is one way to transform rigorous qualitative research findings into more evocative re-presentations. This approach aims to attend to both the scientific concern of utilising rigorously derived research findings, and in a further step, the communicative concern of re-presenting these findings in more evocative and humanly sensitive ways (Todres, Galvin & Holloway, 2009). Such transformation is aimed towards producing felt knowledge that is up to the task of facilitating embodied relational understanding. It is not possible in the context of the present paper to discuss in detail the epistemological framework (Gadamerian, as summarised earlier) or the detailed steps within this transformative procedure, but we refer readers to Todres and Galvin (2008). For the purposes of this present paper, in summary, in re-representing qualitative findings, the procedure is directed towards finding words that can be faithful to a human experience, with all its holistic, rich detail, texture and complexity. Using four steps influenced by Gendlin’s philosophy (1962, 1981, 1991), research findings are transformed to poetic form. These four steps refer to 1) being present to the other’s story, 2) entry into alive meanings, 3) dwelling and holding so that meaning can form; and 4) finding words that work. The specific procedural process develops Gendlin’s (1991) philosophy of ‘entry into the implicit’, drawing on how aesthetic representation of phenomenological findings requires the body, and a practice that aims to point to ‘more than the words can say’ therefore opening up the possibility for a felt human connection.

What follows is an illustration that makes use of phenomenological research in the experience of stroke, ‘Understanding the meaning of rehabilitation to an aphasic patient through phenomenological analysis – a case study’ (Hjelmblink, Bernsten, Uvhagen, Kunkel, & Holmström, 2007). The aspect that has been the focus of this extract is the experience of aphasia and the lost expression of oneself as a thinking and acting person.

Words cut out
Since the Stroke
left side of head
I am different from them
they melt their words
I have shards to share
cut off thoughts can’t move between, can they?
I live behind a broken screen
I am on the outside of life now.
I hold back to make natural encounters with an alien language more comfortable for them.1

Such embodied interpretations of health and illness experiences can perhaps be productively used to sensitise learners in a way that offers experiential directions for caring practice. This is a step further than mere summative descriptions of the human dimensions of an experience. In order to develop imaginative capacity, it is not best achieved by including more information, but rather by more aesthetic engagement to
make illness phenomena more palpably present. This embodied emphasis, giving primacy to learners’ own bodily awareness has potential to enrich ‘experiential knowing’. Such knowing that is shot through with personal meaning can be deeply felt. Educational methodologies that facilitate such palpability offer a connection to the experience of the patient and can act as a resource for learners in their professional lives. We can imagine how a range of educational approaches can engage students in more embodied and poetic forms of understanding through the use of embodied interpretations. In our view such an educational strategy is one way to orientate learners to the more human existential dimensions of care. Evocation can be through sharing of films and writings which attend to the depths and details of the human experience. The strategies draw on personal and shared understandings and offer a capacity for practice that uses intertwined knowledge for ‘the head’, ‘the heart’, ‘the hand’ (Galvin & Todres, 2013a), and includes a lived space for reflection and learning (Hörberg, Ozolins, & Ekebergh, 2011). We argue that such strategies can develop and support a particular existential attunement and sensitivity, both of which are needed within clinical and learning contexts. We wish to point to a note of caution that we are not attempting to privilege feeling or sensation over thought or cognition, as if either were ‘things in themselves’, but rather we wish to show how an integration of personal knowledge and understanding with specialised professional knowledge can potentially underpin a capacity to meaningfully care.

**Conclusion**

We have developed an original approach of caring and learning through drawing on the philosophical foundation presented in this paper. We argue that, in supporting patients in health processes and student nurses in learning processes, a range of aspects: interrelational, intellectual, emotional and embodied, need to be evoked and reflected upon as a first base for the incorporation of, and the intertwining of, caring and learning (Eskilsson et al., 2015). When intertwined in this way the patients’ health processes will be strongly supported.

We offer these phenomenological oriented strategies to serve as a coherent lifeworld-led educational direction for overcoming the dualistic consequences of ‘splits’ such as between human and world, illness and well-being, caring and technology, learning and caring, youth and old age, life and death, etc. (Dahlberg, Todres, & Galvin, 2009). New ways of overcoming such dualistic understandings are needed to pave the way for care that is up to the task of responding to human possibilities and vulnerabilities, so that the suffering caused by not being in touch with patients ‘as persons’ is mitigated. This approach redefines care and caring to go beyond mere behaviours and tasks. Care is more than just a doing and requires a capacity to be caring. Here, care cannot be authentic care without recourse to a way of being, and capacity to be caring is resourced within the complexity of existence by attunement to existential ways of understanding. Well considered ‘didactic tools’ such as those offered here are urgently needed to support this concern.
Note

1. Extract from Galvin & Todres (2011). See full text embodied interpretation in original source published under Creative Commons License and in Galvin and Todres (2013a).

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Disclosure statement

No potential conflict of interest was reported by the authors.

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Ulrica Hörberg is Associate Professor in Caring Science at the Linnaeus University where she leads the research group Lifeworld led Health, Caring and Learning (HCL). Further, she is in the advisory board of the Centre for health, humanities and medicine at Linnaeus University. Her research explores caring and learning in educational and health care contexts, in addition to forensic psychiatric caring.

Kathleen Galvin is Professor of Nursing Practice at the University of Brighton where her research explores peoples’ experiences of a range of health issues and using phenomenologically oriented philosophy is developing theoretical frameworks for caring practices and contributions to the ethics of care. Before joining the College of Life, Health and Physical Sciences at Brighton University she held positions as Professor of Nursing Practice and Associate Dean at the University of Hull, UK and Deputy Dean, Bournemouth University, UK.

Margaretha Ekebergh has as professor extensive experience in teaching in nurse and specialist nurse education as well as in masters’ programmes and doctoral studies. Her research concerns learning in an educational and caring context, with its primary focus on how reflection impacts the intertwining of healthcare theory with best practice, which includes to study how caring and learning is an intertwined phenomenon. Based on two theoretical perspectives – lifeworld theory and caring science – her overall research purpose is to develop forms of didactics which, from a lifeworld perspective, seek to optimise learning in the healthcare sector with the aim of reaching a deeper understanding for the patient’s needs and situation.

Lise-Lotte Ozolins, Ph.D., works at Linnaeus University, Sweden, as a senior lecturer, and she is a member of the research group Lifeworld led Health, Caring and Learning (HCL). Lise-Lotte has many years of experience teaching caring science at all educational levels, and she has planned and developed the lifeworld led nursing student-run health clinic at Linnaeus University. Her research explores both caring and learning related to health care contexts.

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**Films**


