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Seminar Abstracts

Mental health nursing (MHN):

Traditionally the uniqueness of mental nursing arose from the immersion of mental (health) nurses in the everyday life-world of users and carers of mental health services. The professionalization of nursing involved the articulation of knowledge embedded within this life-world, for example, about interpersonal processes and patterns, such as caring, and this was evident in some of the earlier nursing research. Ironically, the professionalization of nursing has reduced the likelihood of 24/7 close proximity between mental health nurse and service users and the solidarity that sometimes arose from this spontaneously. Furthermore, in recent history the intensification of class divisions in the nursing work-force, exemplified by the separation of University and healthcare services has further undermined the extent to which nurses (including academics) can articulate life-world issues. Although nurses in the academy might formally seek to defend this life-world, and its embedded knowledge, from a Habermassian viewpoint, this is will be regrettably subject the drivers of administrative rationalisation and economics [cost reduction and pursuit of profit], and thus frequently colonised by managerial and political economic initiatives both within the healthcare and academic context.

Thus, the key problematics of MHN to me appear to be: Firstly, discursively defending the artisanry of mental health nursing, where it still exists, as accomplished life-world social action, through striving for exquisite sensitivity to lifeworld processes and communicating these process to others. Secondly, acknowledging the validity claims articulated by users and carers about their lived experience of “mental health and illness”, and professional responses to this such as “caring”. Thirdly, developing appropriate social mileux and political institutional structures involving users, carers and mental health nurses to support this kind of life-world reflexivity. Analysing and intervening in the life-world/systems inter-face to potentially inform benign managerial and political economic initiatives that benefit the advancement of artisanry of mental health nursing. Fourthly, addressing through reflexive dialogue the inevitable distortions in even the most well meaning of communications (including this one) about life-world/system interactions.

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Living with clipped wings - patients' experience of losing a leg

This study explores the lived experience of losing a leg as described by the patients themselves post- discharge. Studies have documented that regardless of etiology patients are faced with severe physical as well as psychosocial challenges post-amputation. However, only few studies explore in-depth the patients' perspective on the various challenges following the loss of a leg. The study uses the phenomenological approach of Reflective Lifeworld Research (RLR). Data were collected from 24 in-depth interviews with 12 Danish patients. Data analysis was performed according to the guidelines given in RLR.

The essential meaning of losing a leg is a radical and existential upheaval which restricts patients' life-style and irretrievably alters their lifeworld. Life after the operation is associated with despair, and a painful sense of loss, but also with the hope of regaining personal independence. The consequences of losing a leg gradually materialises as the patients realize how the loss of mobility limits their freedom. Patients experience the professional help as primarily directed towards physical care and rehabilitation. The findings show that the loss of a leg and, subsequently, the restricted mobility carry with them an existential dimension which refers to limitation of action space and loss of freedom experienced as an exclusion from life. Our findings demonstrate a need for complementary care and stress the importance of an increased awareness of the psychosocial and existential consequences of losing a limb.

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Caring for the older hospital patient: layers of vulnerability

Older hospital patients are referred to as a vulnerable patient group, but what does being vulnerable mean and what does it imply for hospital care? The vulnerability of the older patient is often associated solely with physical vulnerability (frailty). This view may be called an outsiders perspective (a perspective of non-patients - scientists, geriatricians, policymakers, etc.). I have conducted a phenomenological study to gain more insight into the perspective of older patients (75+) themselves. The primary discovery from this study is that the older patient feels himself or herself 'an outsider lost in uncertainty'. Being an 'outsider' means not feeling at ease in the setting, not being involved in what happens, and not being recognized as a person for whom illness, decline, and staying in the hospital carry existential meanings. In my study the vulnerability of the older patient appears in various forms, and various manifestations of vulnerability can be identified, such as provoked vulnerability and situational vulnerability. In this presentation I will focus on the different layers of vulnerability and how we can care for the older patient's vulnerability in all its aspects.

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A perspective on the scope of caring science: How the answering the question "what should we be caring about?" contributes to understanding of caring science.

It is accepted that public health is 'everybody's business' because of the breadth of issues that impact on human health and wellbeing. Given this breadth of issues the scope of our caring should encompass the macro, global natural environment. This is because the biosphere provides the life support systems for human beings and the other species that comprise Earth's biodiversity. Public health also encompasses the health and wellbeing of the individuals who make up the population and so the scope of our caring should account for this too. We should be caring about people as human beings and about the impact of the wider determinants of health on their wellbeing. Knowing what we should be caring about contributes to understanding of what caring science includes. The implication from personal engagement and public health points of view is that caring science includes understanding of the importance of the natural environment and biodiversity in relation to human health. It also encompasses understanding of the wider determinants of health and their impact on a person's health and wellbeing.

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Deconstructing medicalisation in Health Care: Renegotiating Patient centeredness

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