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Atmosphere in Care Settings

Towards a Broader Understanding of the Phenomenon

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**DISSERTATIONS FROM THE DEPARTMENT OF NURSING,
UMEÅ UNIVERSITY**

ABSTRACT

The overall aim of the study is to understand and describe the phenomenon 'atmosphere in care settings' as experienced by patients, significant others and health care staff. The study consists of four papers, each of which illuminates various aspects of the phenomenon. Data consisted of observations and interviews with patients, significant others and staff (n=126) within a hospice, a geriatric, a medical and an oncology setting, and community care settings for older people. Narrative analysis, grounded theory, and phenomenological hermeneutics were used in a triangular fashion to analyse the data.

The findings illuminate meanings of the phenomenon as emerging from people's personal expectations and how the phenomenon influences their experiences of identity. The findings further delineate the phenomenon 'atmosphere in care settings' as being constituted by two interacting and interwoven dimensions: the physical environment and people's doing and being in the environment. The physical environment is the first dimension, and five aspects were illuminated, namely the physical environment *as a symbol* conveying messages in itself of death and dying, danger and shamefulness, stigma, higher and lower social value and worth; *as containing symbols*, for example wilted flowers and dust balls, conveying messages of caring and uncaring, life and death, the homelike and the institution-like; *as influencing interaction* and experiences of involvement and privacy, welcoming, and the possibilities to create and maintain social contacts in the environment; *as facilitating a shift of focus from oneself to the environment*, being able to escape the world of cancer, and finding light in the midst of darkness, and; *as containing scents and sounds* influencing experiences of at-homeness or alienation. People's doing and being in the environment is the other dimension, and five aspects were illuminated, namely the experience (or absence of experience) *of a welcoming*; *of seeing and being seen*; *of a willingness to serve*; *of a calm pace*; and *of safety*. It was understood that people's doing and being influences experiences of the physical environment and that the physical environment influences experiences of people's doing and being.

The comprehensive understanding illuminated that the phenomenon is not merely subtle qualities of the place for care, but an active part of care. Both the physical environment and peoples doing and being conveys messages of caring and uncaring. The atmosphere of a care setting can at best support experiences of at-homeness in relation to oneself, others and the surrounding world. There have been limited advances in making connections between the environment domain and the client domain in nursing theory. This study can contribute by illuminating how aspects in the client-nurse domain and aspects of the environment domain are interacting and influencing the client domain. This study can also contribute to nursing practice by providing a conceptual basis for intentionally reflecting upon and evaluating health care settings. Florence Nightingale once stated that the art of caring is to provide an environment in which the patient is in the best position for nature to act upon, and Martha Rogers have emphasized that one part in nursing is to pattern the environment into a place where healing conditions are optimal. The findings of this study can contribute to understandings of what this might mean in practice.

Key words: Environment, Atmosphere, Nursing, Symbols, Expectations, At-homeness, Narrative Analysis, Phenomenological Hermeneutics, Grounded Theory.

ORIGINAL PAPERS

This study is based on the following papers which will be referred to in the text by their Roman numerals:

- I Edvardsson, D., Rasmussen, B., Riessman, C.K. (2003). Ward atmospheres of horror and healing: a comparative analysis of narrative. *health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 7(4), 377–396.
- II Edvardsson, D., Sandman, P.O., Rasmussen, B. Sensing an atmosphere of ease – a tentative theory of supportive care settings. *Submitted*.
- III Edvardsson, D., Sandman, P.O., Rasmussen, B. Experiencing symbolic places, others' gazes and breathing spaces – being in the physical environment of an oncology clinic. *Submitted*.
- IV Edvardsson, D., Sandman, P.O., Rasmussen, B. (2003). Meanings of giving touch in the care of older patients: becoming a valuable person and professional. *Journal of Clinical Nursing*, 12, 601–609.

The papers have been printed with the kind permission of the respective journals.

INTRODUCTION

When we are in different care settings we often get a feel for “what’s in the walls” of a particular setting, that is, we experience the atmosphere as influencing us either positively or negatively. I made my own first experiences of atmosphere in care settings when I was a nursing student doing clinical practice in a variety of care settings. Almost instantly on entering a setting I got a strong feeling of the atmosphere in the place, a feeling that largely influenced me in deciding whether this was a place in which I could see myself work or not. In some places the atmosphere was warm and inviting while in others it felt cold and almost hostile, places I wanted to leave as soon as possible. These experiences were so persistent that I can still remember what the atmosphere of each of the different wards felt like. These experiences coincided with the discovery of both my supervisors of the importance of atmosphere in care settings and its influence on people. Their research did not focus explicitly on this phenomenon but rather, the phenomenon was an important finding of their research of caring in general.

In her study on meanings of nursing practice in a hospice, Rasmussen (1999 p. 61) writes,

What was a dim understanding of hospice nursing practice in the beginning, had become a fuller awareness by the end of this study, namely the understanding of the importance of an aesthetic physical environment and the congruence between one’s outer and inner space, and their relation to the meanings of nursing care as a healing environment. Though nursing practice in a hospice includes

interacting nurses, guests and families, it is so much more than that. It is, as described by both the nurses and the guests, an atmosphere – a spirit that includes the view from the windows, closeness to nature, family or colleagues, the color and design of the rooms, the fountain, the lit candle and a spirit of comradeship, hospitality, joy, sorrow, wonderful food and a beautifully set table.

These emerging understandings were the starting point of my doctoral work, whose aim was to understand and describe the phenomenon atmosphere in care settings as experienced by patients, significant others and health care staff.

The term “atmosphere” was chosen rather than “place”, “space” or “environment” because it repeatedly stood out in our data and also, emerged from the literature. For example, Fridell (1998 p. 3) reports that (my translation) “... during every visit to an establishment of health care and nursing I have been affected by the premises and the atmosphere of the environment”. “Atmosphere” is used in this study to include the understanding and descriptions of a tone or mood in care settings or, an expression used previously, of what is contained “within the walls” of that setting. The concepts of atmosphere and climate have been described as interchangeable metaphors describing psychological conditions in a social region, a general image or a feeling-tone of a setting (Hall and Pill 1975; Simpson and Weiner 1989; Ekvall 1990).

The interest in the relationship between environment and humans is not new. Movements such as Rudolf Steiner’s anthroposophy that began in the early 1900s (cf. Jeckert 2003) and the ancient Feng Shui both emphasize the

interrelationship between the environment and human life (cf. Kwok and O'Brien 1991). In contemporary Sweden and elsewhere in the Western world the topic has gained much attention as manifested in numerous television shows and magazines on interior design, gardening, colouring, and home make-overs. Within the field of medicine, Hippocrates believed that the body possesses its own means of recovery and that the main function for medicine is to aid these forces of the body by enhancing therapeutic functions of the environment (Weiss and Lonnquist 2000 pp. 16–17). Likewise for Florence Nightingale, the locus of healing was within the person and the art of nursing was to provide an environment in which patients were in the best position for nature to act upon them (Nightingale 1969 p. 133). This early insight remains of interest today, when the focus is strongly on the medical development in health care. It seems appropriate to consider how we can understand and describe the atmosphere in care settings to further comprehend the environmental influence on patients.

Numerous people have conducted research touching upon the phenomenon atmosphere in care settings, ranging from studies on how enriched environments affect neuronal plasticity in rats, to studies on people's behaviour in different environments. In this vast field of research a surprisingly small number of studies have conceptualized atmosphere in care settings, and therefore it is difficult to extract what research-based understanding we actually have. Much of the existing research has used deductive, hypothesis-testing designs to describe and correlate different environmental variables to health outcomes while research using a qualitative analytical approach to study the phenomenon atmosphere in care settings is rare. Furthermore, the concepts and theories of environmental influence have largely been acquired from disciplines such as environmental

psychology and architecture and it has been suggested that concepts derived from other disciplines cannot automatically be transferred to the domain of nursing (Morse and Field 1996 p. 164). Since quantitative studies tell us little about how to understand phenomena there is a need to apply qualitative approaches to further understand and describe the phenomenon atmosphere in care settings.

BACKGROUND

As a starting point a brief historical exposition of the development of two care facilities in Sweden is given to place this study within the contexts in which it was performed.

The historical development of hospitals and hospices in Sweden

Several of Sweden's large hospitals such as the Huddinge Hospital and Söder Hospital in Stockholm, the Sahlgrenska Hospital in Gothenburg and the Norrlands University Hospital in Umeå were built between 1940 and 1960, a period of large-scale expansion of modern hospital buildings in Sweden. During this time, the development of hospitals was influenced by industrial efficiency, and the key concepts influencing construction were effectiveness, productivity, centralization and rationalization (Birch-Lindgren 1934 pp. 30–33; Fridell 1998 p. 116). The political motives behind constructing these hospitals was to satisfy the increasing demands for health care, and the main ideology influencing construction was a view of patients as objects equal to the sum of their physical parts. The role of health care was to restore parts that were broken (Fridell 1998 pp. 112 and 115). The resulting large block hospitals have been said to represent care factories and these hospitals reflect the development of health care in the

direction of productivity and depersonalization (Dilani 2000). The interior design of hospitals was at the time of construction influenced by demands for hygiene and cost-effectiveness; it had to be possible to keep the hospitals meticulously clean with the least possible effort, and minimum design kept costs down (Birch-Lindgren 1934 p. 211; Fridell 1998 p. 115). From about 1970 onward, the concept of what hospitals should be like changed, influenced by architecture for hotels and housing, and planning of hospitals was inspired by small-scaleness, integration and patient centredness. The view of humans in health care also changed, from seeing patients as malfunctioning physical objects to viewing the person as a whole.

With regard to hospices, Bräcke Diakonigård in Gothenburg and Ersta Hospice in Stockholm opened in the early 1980s, being the first in-patient hospices in Sweden. The word “hospice” literally means a resting place for pilgrims; however, the term “hospice” today is used to refer to a philosophy of care rather than to a specific place (Rasmussen 1999 p. 16). The hospice philosophy includes an acceptance of death as part of life, with patients and their families seen as the unit of care, and an emphasis on palliative rather than curative treatment, involvement rather than detachment, wholeness rather than fragmentation, and quality of life rather than quantity. In the search of the literature I found no study describing the architectural development of hospices, though many hospices around the Western world share some similar features such as a homelike environment, proximity to nature and a soothing colour design (Street 2004 personal communication).

As previously stated, there exists a vast body of literature that touches upon the phenomenon atmosphere in care settings. The following literature review does not claim to be exhaustive. Rather, it summarizes what is

deemed to be the most relevant literature on the topic of atmosphere in care settings to serve as an introduction to this vast field of research, and place the findings of this study within a larger context of knowledge. Some of the literature suggests how the physical environment of a care setting contributes to an overall atmosphere, while other research correlates different environmental variables to various health outcomes, and yet other research provides an understanding of how encounters in care settings may contribute to an atmosphere. The literature will be presented according to the concepts used to study the different aspects of the phenomenon atmosphere in care settings.

Concepts for studying atmosphere in care settings

There are two challenges when attempting to understand the research in this field: the first is the fact that there exists a conceptual jungle describing aspects contributing to the phenomenon atmosphere in care settings and the second is the challenge of understanding how these aspects are described to affect people. Therefore, in the following literature review what may seem like conceptual inconsistency is an attempt to illuminate the existing conceptual heterogeneity. Table 1 provides an introduction to empirical studies, reviews, conceptual discussions and scholarly books that touch upon aspects of the phenomenon atmosphere in care settings. The examples represent a selection of literature chosen to illustrate that different research traditions use different but related concepts in describing the environmental field and should be seen as an introduction to rather than a complete coverage of the literature. The examples are all from the Western world.

Table 1. Examples of concepts related to the phenomenon atmosphere in care settings.

Concept	Field	Examples of authors	Content
Place	Health geography	Kearns and Moon 2002	Conceptual discussion
		Mayerfeld Bell 1997	Conceptual discussion
		Milligan 2003	Conceptual discussion
		Twigg 1999	Interview study
	Public health Environmental psychology Philosophy	Frumkin 2003	Literature review
		Leather et al. 1998; 2003	Experimental studies
		Casey 1998	Textbook
		Malpas 1999	Textbook
Space	Education	Bengtsson 2003	Conference paper
		Hörnqvist 2004	Conference paper
		Diaz Moore 1999	Grounded theory study
		Fridell 1998	Qualitative exploration
	Health geography Philosophy	Conradson 2003	Observational study
		Lefebvre 1991	Textbook
Ward atmosphere	Psychiatry	Devlin 1992	Experimental study
		Eklund and Hansson 1995; 1997	Experimental studies
		Ellsworth et al. 1971	Experimental study
		Moos 1988; 1989	Textbooks
		Moos and Houts 1968	Experimental study
		Moos et al. 1973	Experimental study
Enriched environments	Medicine	Dahlqvist et al. 2003; 2004	Experimental studies
		Nilsson et al. 1999	Experimental study
		Rönnbäck 2004	Experimental study

Table 1. Continued.

Concept	Field	Examples of authors	Content
Enriched environments	Nursing	Ragneskog, Brane et al. 1996 Ragneskog, Kihlgren et al. 1996 Kihlgren et al. 1990 Shertzer and Keck 2001 Wijk and Sivik 1995 Wijk et al. 1999	Experimental study Experimental study Experimental study Experimental study Experimental study Experimental study
Supportive environments/design	Architecture	Dilani 2000; 2001 Verdeber et al. 1987 Verdeber and Reuman 1987	Conceptual discussions Survey study Experimental study
	Environmental psychology	Evans and Mitchell 1998 Ulrich 1981; 1984; 1991; 1992	Conceptual discussion Experimental studies/conceptual discussions
	Public health	Kaplan and Kaplan 2003	Literature review
Caring culture	Nursing	Andershed and Ternestedt 1997; 1998 Gates 1991 Sarvimäki and Sandelin Benkö 1998a; 1998b	Interview studies Ethnographic study Descriptive study and instrument development
Healing environments	Nursing	Bartol 1998 Biley 1993 Kerfoot and Neumann 1992	Conceptual discussion Conceptual discussion Conceptual discussion

Place

Health geographers frequently use the concept of place to describe experiences and influences of place as both a physical and a social construct. Place, then, describes social experiences of a physical world (Mayerfeld Bell 1997). Place is described as a dynamic and fluid agent influencing both actions and experiences. Research has shown that places affect people in many ways, for example by providing spatial orientation, evoking memories, arousing emotions, affecting performance and behaviour and promoting or obstructing social interaction (Frumkin 2003). In a study of the spatial ordering of care, Twigg (1999) showed how place is fluid and socially constructed. For example, home health care disrupts the normal ordering of home insofar as the private place of home gradually transforms into a public place of institution. When the formal care services and medical symbols invade people's homes the boundaries between private and public, home and institution, and autonomy and dependency become diffused (Milligan 2003).

Some studies describe place as influencing and partly constituting personal identity. Malpas (1999 pp. 175–193) drew upon philosophical ideas of identity to argue that people's identity is intimately bound to places in which they live. To be separated from places and possessions is to be separated from parts of oneself (Malpas 1999). It has further been shown that in care settings the place belongs to staff; they are in charge and determine the rules. Being in these places as a patient implies being among unfamiliar objects, and there is a risk of becoming literally and metaphorically stripped of one's history and identity when being forced to subject oneself to unfamiliar and collective regimens and clothing (Twigg 1999; Milligan 2003). This process has been described as depersonalizing in

Goffman's classic account of total institutions (1961 pp. 19–23).

Developing these social constructivist ideas of identity Conradson (2003) describes identity as a “spaced achievement”. He showed that place influences what identities are able to emerge (Conradson 2003). The sense of self, who one is, and feels able to be, is tied to different spatial settings. Furthermore, it has been shown that objects related to medical procedures, for example injection needles and blood pressure gauges, symbolize illness and suffering to patients. These objects have been described as intimately related to a place in which one is alienated from the self and the world, a place in which patients do not recognize themselves and are in considerable pain (Radley and Taylor 2003). The hospital setting has been described as a place where one would not want to be, a place that the participants would want to erase from their memory (Radley and Taylor 2003).

In summary, these studies suggest that place and the symbolic objects it contains have a profound impact on people's sense of self, and of who they are and feel able to be.

Space

Place and space are two related concepts that seem to have been used interchangeably in the literature. Bengtsson (2003) showed that space could be conceptualized and studied in two ways: as geometrical space, that is, a measurable three-dimensional physical entity, and as lived space. Bengtsson described the formation of space in classrooms as often overlooking lived space and taking geometrical space as vantage point, with many classrooms across the world sharing the similar physical set-up that encourages the subordination of students irrespective of the underlying pedagogic ideology

or view of humans. Schools and hospitals built during the mid 1900s have been suggested to share some similarity. Many schools were constructed during a time when pupils were regarded as submissive recipients of knowledge served by the teacher. Education based on the concept of learning as a creative individual responsibility, as is largely offered in schools today, in many cases takes place in spaces neither expressing nor supporting this view (Hörnqvist 2004). In a study of architectural space for caring relationships, it was described that the sparingly designed physical environment of many hospitals expresses the view that patients are objects, something that counteracts the goals of independence and autonomy. However, physical environments containing furniture of good design and beautiful art express to residents that they are independent persons with value – not merely patients (Fridell 1998).

In short, research on space suggests that it has two dimensions that may come into conflict, geographical and lived space. Geographical space can express a non-preferred view of humans, which influences the experience of lived space. Geometrical space in care settings can facilitate feelings, behaviours and interactions that are sometimes contradictory to caring.

Ward atmosphere

The term “ward atmosphere” has been used to describe characteristics of psychiatric settings that exert an influence on treatment outcome for patients. Features such as autonomy, organization, support, aggression and openness of feelings have been described as characteristics of a ward atmosphere that affect the outcome of psychiatric treatment (Friis 1986). It has been suggested that treatment in wards characterized by autonomy and independence and the expression of feelings is associated with patients

residing longer in the community after discharge (Ellsworth et al. 1971; Moos et al. 1973). Furthermore, a ward atmosphere that enhances awareness of personal problems and provides high levels of support has been related to high levels of post-treatment functioning (Eklund and Hansson 1997), and successful treatment outcomes in small-scale psychiatric treatment units have been related to positive assessment of the work environment by staff (Armeliu 2002).

Conclusively, the studies researching ward atmosphere suggest that the treatment of psychiatric patients improves if the staff have a good working environment, and that being cared for in a ward atmosphere characterized as supportive prepares patients for life in the community. Of course, what is considered supportive means different things for different patients, for example patients with and patients without psychoses.

Enriched environments

The concept of enriched environments has been employed in medicine to study functional recovery and neuronal plasticity in the post-stroke brain of rats (Rönnbäck 2004 pp. 16–22). Within this tradition of research, the term “enriched environments” means rat cages containing various stimulating objects that are replaced or moved around frequently, for example boxes, tunnels, running wheels and ladders (Rönnbäck 2004 p. 16). Rats recovering from experimental stroke in enriched environments have been shown to exhibit improved functional recovery (Dahlqvist et al. 2003), increased neuronal plasticity (Dahlqvist et al. 2004) and improved spatial memory (Nilsson et al. 1999).

In nursing, environments enriched with colour and music for example have been described to affect various health outcomes. Music interventions have been shown to positively affect pain experiences and improve comfort among patients after surgery (Byers and Smyth 1997; Shertzer and Keck 2001) as well as creating a calm atmosphere reducing anxiety, irritation and depression, and increasing food intake among persons suffering from dementia (Ragneskog, Brane et al. 1996; Ragneskog, Kihlgren et al. 1996). Wijk and colleagues report that using colour codes and colour cues in the environment enhanced the quality of care for persons suffering from Alzheimer's disease, improved mood and well-being among the elderly, and increased spatial orientation (Wijk and Sivik 1995; Wijk et al. 1999).

It has been shown that training staff in integrity-promoting care, and the creation of a homelike environment positively affected interaction, behaviour and biological factors, and lowered confusion, anxiety and depression in patients suffering from dementia (Bråne et al. 1989; Kihlgren et al. 1990), and that the progression of intellectual deterioration in patients with dementia cared for in a homelike special care unit was slower than in patients cared for in a nursing home (Kihlgren 1992).

In summary, these studies suggest that enriched environments affect behaviour, functional recovery and biomedical processes in rats and improve food intake and spatial orientation, affect interaction, behaviour and biological factors and reduce anxiety, confusion, depression and irritation among patients suffering from dementia.

Supportive environments/design

Studies focusing on aspects of environments in relation to human health are also to be found within the field of architecture/design and environmental psychology, where the terms “supportive environments” and “supportive design” are used. Dilani (2000; 2001) suggests that environments reflect the ideology under which they were constructed, and that hospitals built during the 1940–1960 era often express dehumanizing industrial production. It has been said that supportive environments of care are small-scale, with a familiar and non-institutional atmosphere and harmonious colours as well as access to daylight and nature – aspects that have been shown to reduce stress among patients (Ulrich 1991). Furthermore, environments in which people can make sense of what is going on, in which they feel they are listened to, involved and needed; in which there are places to meet others and which afford a view of nature have been suggested to support health and well-being though empirical support for these suggestions has not been provided (Kaplan and Kaplan 2003).

Perhaps the most well-known researcher in the field of supportive environments is the environmental psychologist Roger Ulrich. Ulrich has shown that environments providing way-finding cues reduce confusion; that being able to exert control over the environment reduces stress, and that positive distractions (features within the environment that attract interest and divert thoughts, for example natural scenery) can ease stress and anxiety for patients (Ulrich 1981; 1992). Ulrich reports that patients assigned to rooms overlooking a natural setting had shorter post-operative stays, received less negative evaluation from nurses, and took fewer narcotic analgesics after gallbladder surgery, than matched patients in rooms facing a brick wall (Ulrich 1984). Views from windows have also been correlated to

reduction of job-related stress for staff (Leather et al. 1998) while windowlessness has been associated with less well-being and poor health status among hospital rehabilitation patients (Verdeber and Reuman 1987). Supportive environments have further been described as being non-institutional and clean, with views of nature, in which needs of privacy are met, and in which one could select one's own activities (Verdeber et al. 1987).

To summarize, research into supportive environments and design describes supportive environments as small-scale, clean and familiar, and as having windows facing natural scenery, and shows how these improve health outcomes such as stress, use of analgesics, and time for recovery as measured in experimental studies. Though many authors suggest how various aspects of environments may influence the experience of being in these environments, in some of the studies such qualitative conclusions emerge from quantitative analyses, or the data from which the authors draw their conclusions remain unknown.

Caring culture

Another concept close to atmosphere in care settings is culture, and it has been suggested that different cultures of care are developed in different settings. For example, acute hospital settings have been described as cultures of cure and “quickness” while hospices and other palliative care settings have been described as cultures of care and “slowness”. It has been shown that in a culture of “quickness” (curative paradigm), significant others described themselves as being involved in the dark, as experiencing neither being seen nor being acknowledged by staff and as having insufficient collaboration. By contrast, in a culture of “slowness” (palliative paradigm) significant others described themselves as being involved in the

light, being well informed and experiencing a trusting relationship between family and staff (Gates 1991; Andershed and Ternestedt 1997; 1998).

Sarvimäki and Sandelin Benkö (1998a; 1998b) defined culture as a set of basic assumptions, rules and meanings that influence ways in which participants interpret, and act in, different situations.

In short, research into different cultures of care suggests that the overall philosophy of care influences experiences of pace and involvement in care settings, and different atmospheres can be created in different cultures.

Healing environments

Another concept of relevance to the phenomenon atmosphere in care settings is healing environments. It has been described that aesthetically pleasing environments can convey a message of warmth, nurture and calmness, and that welcoming supports healing among patients and staff (Kerfoot and Neumann 1992). Environmental features such as visually soothing colours, noise-absorbing floors, windows, artwork and plants have also been suggested to support healing (Biley 1993; Bartol 1998).

Unlike the connotations of the word “healing” to new-ageism in a Swedish nursing context, “healing” is used in a rather unproblematic fashion in the North American nursing context to describe a holistic approach to well-being. It has been used to describe patients’ experiences of being whole, that is, of being involved and able to integrate one’s physical, mental, social, emotional and spiritual needs regardless of whether possibilities of being cured exist or not (Quinn 1989; Criddle 1993; Glaister 2001).

In summary, these articles on healing environments suggest that care settings deliberately designed with colours, plants and windows convey messages of warmth, calmness and welcoming, and that these messages influence experiences of healing.

People's doing and being in creating an atmosphere

Research on caring in general also touches upon the phenomenon atmosphere in care settings. When patients and staff have been asked to describe nursing care they often include experiences of an overall atmosphere. Therefore it is suggested that it is not only the physical environment that contributes to the phenomenon atmosphere in care settings; people's doing and way of being also play an important part in creating an atmosphere. It has been shown that patients at a hospice found experiences of good nursing care inseparable from their experiences of the overall hospice atmosphere (Rasmussen et al. 2000). A consoling atmosphere supports experiences of wholeness, and this atmosphere includes the way nurses touch patients, how they welcome people upon arrival, serve dinner, and bathe patients (Rasmussen et al. 2000). It has also been suggested that the main aspects that contribute to experiences of environments of care are the physical environment, the philosophy guiding the delivery of care and the use of complementary interventions by staff, such as touch (Walker 1994).

The subtle qualities in the way staff approach and touch patients have been reported to strongly influence the patients' experiences of care aspects such as bathing (Twigg 2000 pp. 45–76). In one study staff caring for patients suffering from dementia tried to create an atmosphere not of an institution, but rather, of homelikeness. The staff expressed the belief that human

beings (like plants) need a good, suitable climate in order to thrive and that a homelike setting may promote this (Häggström and Norberg 1996).

Furthermore, general experiences of being seen, welcomed, and connected to others have been shown to facilitate well-being and hope among patients (Halldorsdottir and Hamrin 1997; Fagerström et al. 1999). It has also been shown that the experience of being seen and confirmed as a person, of being embraced in an atmosphere of hospitality and of having the chance to talk openly and freely about emotions and worries is essential for the well-being and recovery of patients (Rieman 1986; Lindholm and Eriksson 1993). For significant others as well, it has been shown that involvement in the care of a loved one was supported by a welcoming and open atmosphere (Weitz 1999; Hertzberg et al. 2001).

In summary, research of caring shows that staff's way of being, and how the staff move around, how they speak to patients (and significant others), how they approach them, touch them, wash them and serve food to them contribute to experiences of atmosphere in care settings. However, no studies have been found with the specific aim to understand and describe the phenomenon atmosphere in care settings.

RATIONALE FOR THE STUDY

Considering all knowledge previously presented, what motivates this study? There already exist a large number of high-quality research studies that tell us much about various aspects important to consider in understandings and descriptions of the overall atmosphere in care settings. From the above review of the literature it seems safe to say that we know that physical environments influence people's sense of self, behaviour and interactions,

and that they also affect biological markers of health and illness. We also know that people's doing and way of being contribute to experiences of atmosphere in care settings, and that this atmosphere is of utmost importance to patients', significant others' and the staff's experiences of caring. However, we do not know – if indeed it is possible to know this – how to comprehensively understand and describe the phenomenon, and perhaps it is naive to try, but that is what this study aims to do.

One reason for attempting to understand and describe the phenomenon atmosphere in care settings is that much of the literature suggests meanings of being in different care environments without showing any empirical support, or without giving further details about how the analyses leading to these conclusions were performed. A number of studies draw qualitative conclusions from quantitative analyses, and these may seem logical to draw but the type of studies enabling such conclusions have rarely been undertaken. The common sense character of this field has been described as making research difficult (Martin 2000). If our knowledge of how the phenomenon is understood and described is unclear, this suggests that we have trouble understanding, teaching, measuring and using it and intervening in it in the practical field of health care. Further knowledge of the phenomenon – albeit tentative – can provide descriptions and understandings useful in health care practice, as well as in health care education and administration, and construction of health care settings.

AIM OF THE STUDY

The overall aim of the study is to understand and describe the phenomenon atmosphere in care settings as experienced by patients, significant others and health care staff. The study is based on four papers with the following specific aims:

- Paper I** To understand the phenomenon ward atmosphere through a detailed case study.
- Paper II** To construct a theoretical understanding of processes contributing to supportive care settings.
- Paper III** To illuminate meanings of being in the physical environment of an oncology clinic as narrated by patients, significant others and staff.
- Paper IV** To illuminate meanings of giving touch in nursing care of older patients.

METHODOLOGICAL FRAMEWORK

Kvale (1996) presents two metaphors to describe different understandings of knowledge. In the first, the “mining” metaphor, knowledge was described as a buried metal and the researcher as a miner who locates and uncovers the metal without influencing its structure. In the second, the “travelling” metaphor, the researcher embarks upon a journey and constructs knowledge in conversations with people encountered (Kvale 1996 p. 3). These metaphors can be understood as describing two different ontological and epistemological traditions within research, where the logical scientific tradition aims to explain a world independent of our experiences of it, and

the phenomenological hermeneutic approach seeks to understand a lived world of meanings constituted by experiencing subjects (Clark 1998; Patton 2002 p. 96). These two positions provide answers to different questions. The present study does not aim to seek explanations and answers to questions of causality but rather, to illuminate understandings and provide descriptions of the phenomenon atmosphere in care settings.

Phenomena in the life world may be compared to objects that can be viewed from several sides, but not from all sides at once (Ricoeur 1976 p. 77). What we come to see depends on the point from which we look at it, and different methods provide various perspectives; in other words, research methods provide us with a range of ways to see the phenomenon under study. In the present study, because of the complexity of the phenomenon, three methods were used in a triangular fashion to shed light on different aspects of the phenomenon: narrative analysis, grounded theory and phenomenological hermeneutics. Different methods, participants and aims can provide descriptions and understandings from diverse perspectives, and together increase our comprehension of a phenomenon such as the one under study here, of atmosphere in care settings.

In paper I, the research question was how meanings of atmosphere were constructed in narrative form, and narrative analysis was considered useful in answering this question. Paper I takes a post-modern view of knowledge as socially constructed, and this paper generated both descriptions and understandings of atmosphere through a micro-analysis of narrative. This method focuses on specificity and particularity, thus illuminating nuances and subtleties rather than generic features of phenomena. Narrative analysis provides knowledge of the telling as well as of the told; by focusing on the

narrating subject it illuminates how persons/groups/organizations come to organize their knowledge in narrative form (Riessman 2002 pp. 695–710).

In paper **II**, the research question was what aspects and processes contribute to experiences of supportive care settings, and grounded theory was chosen to answer this question. Being a method which views the pursuit of knowledge as either mining or construction through travelling, depending upon which tradition one chooses to join (Annells 1996; Kvale 1996; Lomborg and Kirkevold 2003), grounded theory can produce theoretical explanations together with understandings and descriptions. In contrast to narrative analysis, grounded theory can provide a “big picture” of phenomena. Being category-centred and fairly abstract, grounded theory focuses on the general rather than the particular. In paper **II** constructivist grounded theory (Charmaz, 1990) was used to study how experiences of the physical environment together with people’s doing and being can contribute to experiences of supportive care settings.

In papers **III** and **IV** the research questions concerned meanings of lived experiences of being in the physical environment of an oncology clinic (**III**), and meanings of giving touch understood as one way of how people’s doing and being can contribute to atmosphere (**IV**). These papers represent a methodological move towards gaining existential understanding through interpretive description. Phenomenological hermeneutics as developed at Umeå University and the University of Tromsø (Lindseth and Norberg 2004) and practised by authors such as Söderberg et al. (1999) and Rasmussen et al. (2000) was considered suitable for answering research questions of meanings in lived experience.

MATERIALS AND METHODS

The study involved patients, significant others and staff within different health care settings, as shown below.

Table 2. Overview of the papers comprising the study.

Paper	Main content	Settings	Participants	Methods/years of data collection	Methods of analysis
I	Meanings of ward atmosphere	Maternity and surgical ward	One participant narrating from multiple positions (n=1)	Narrative research interview 2001	Narrative analysis
II	Tentative theory of supportive care settings	Geriatrics, internal medicine and hospice	Patients, significant others and staff (n=83)	Narrative research interviews and observations 2001–2003	Grounded theory
III	Meanings of being in the physical environment	Oncology	Patients, significant others and staff (n=29)	Narrative research interviews 2004	Phenomenological hermeneutics
IV	Meanings of giving touch	Settings for care of older people	Staff (n=12)	Narrative research interviews 2001	Phenomenological hermeneutics

Settings

The first paper (I) unfolded from a narrative by one single participant. Her experiences were made at one surgical and one maternity ward, two contexts of which we know nothing further than how they were described by the participant.

The second paper (II) was based on observations and interviews in three different settings, a hospice, a geriatric ward and a ward for acute internal medicine. The hospice is a wooden building located in the countryside of northern Sweden. It opened in 1992, being the first freestanding “purpose-built” hospice in Sweden. The wooden building is shaped like a butterfly and has 16 single guest rooms with a homely design, eight rooms in each wing of the building, each with a kitchenette and a bed settee for significant others. In the centre of the building lies the kitchen, the nurses’ station, the memorial room, a room with a bubble bath, living and dining rooms, an art room, and a winter garden containing plants, flowers and a fountain.

The geriatric ward is located on the third floor of a free-standing, five-floor brick building within the premises of a university hospital in northern Sweden. The building was opened in 1996, and is entirely devoted to geriatric care. The ward contains 24 beds divided into eight single rooms, and eight double bedrooms. The ward is shaped like a cross, having the nurses’ station in the middle and the rooms located off two of the corridors forming the cross shape. The other two corridors contain two living and dining rooms, an activity room, the kitchen and staff rooms.

The ward for acute internal medicine is located on top of a nine-storied building within the same university hospital in northern Sweden. The building was first opened around 1960, and the medical ward consists of one long unfurnished corridor ending with a window overlooking the city. Off this lead three single rooms, three double rooms, one 3-bed room, and two 4-bed rooms. The living and dining room are located outside the ward, and the nurses' station is located approximately in the middle of the corridor.

The third paper (III) was based on interviews with patients, significant others and staff with experiences of being cared for, or caring, at an oncology clinic in a hospital in central Sweden. The clinic is located in a large hospital building on a hill overlooking a bay. The radiotherapy unit, around which most of the interviews revolved, is located below ground level in the large hospital complex. The unit admits patients with head and neck cancer subjected to radiotherapy and had just reopened after a major interior reconstruction in 2003. The unit has one staffed reception desk, a large waiting room located in the middle of the unit designed with colourful furniture, magazines, a coffee-vending machine, a tap for drinking water, and a jigsaw puzzle. It has four chambers for treatment, each with one radiation accelerator, and one large dining area for staff containing a wall of windows overlooking the bay.

The fourth paper (IV) was based on interviews with staff working in different types of settings for care of older people in the county of Västerbotten, Sweden. The different setting included three community-based special care units for residents suffering from dementia, one community-based day-care unit for older people with learning disabilities and three community-based nursing homes.

Sampling and participants

Paper **I** involved one participant, a Swedish woman about 50 years old, and a registered nurse. In paper **I** critical case sampling (Polit and Hungler 1999) was used in selecting a rich story illuminating aspects of the phenomenon under study. Performing such a detailed micro-analysis would be unmanageable with a larger set of data. In paper **II** data were collected from 38 staff members working at the hospice, geriatric ward and ward for acute internal medicine, together with 34 patients and 11 significant others cared for in those settings. In paper **II** sampling was both purposeful and theoretical. Initially, purposeful sampling was used to achieve variation in data concerning physical environments and orientation of care. Subsequently, as the study progressed, sampling was theoretical and was guided by the developing theory (Glaser 1978 p. 37; Coyne 1997).

Paper **III** included interviews with eleven staff members (one administrator, two physicians, a dietician, and seven nurses), two architects responsible for the interior design at the clinic, and nine patients, seven of whom had a significant other present during the interview, receiving care at an oncology clinic at a hospital in central Sweden. Purposeful sampling was used to include participants who had experiences of caring or being cared for at the unit both before and after the restoration of the clinic, which was believed to have sensitized them to being in the physical environment. The architects were included to find out about the underlying choices and thoughts that influenced the design at the unit.

Paper **IV** was based on interviews with twelve health care professionals (two registered nurses, eight enrolled nurses and two occupational therapists), all women (37–59 years of age) with between three and 32 years

of work experience in caring for older people in different types of settings in northern Sweden. They were asked to participate on the basis of being available for interviewing, and also, on the basis of their training and use of touch in their daily work. Sampling therefore was both convenient and purposeful.

Methods of data collection

Narrative research interviews

Papers **I**, **III** and **IV** were based solely, and paper **II** partly, on narrative research interviews. Since it has been suggested that telling stories is one significant way for individuals to express and construct meaning (Mishler 1986 p. 67) the purpose of using narrative interviews was to obtain rich descriptions of meanings of atmosphere in care settings. In paper **I** the participant was asked to describe her experiences of a “good” and/or a “bad” atmosphere in a care setting. In response to this opening question, the participant developed a long narrative, which was subjected to analysis. In paper **II** the interviews were initially broad and open, and as the study progressed interviews became narrower, focusing increasingly on categories of interest (Wimpenny and Gass 2000).

In paper **III** we were three researchers interviewing separately or in pairs or all three together. The interviewees were asked about their experiences of being in the physical environment of the oncology clinic. Where their narratives did not spontaneously include these aspects, the interviewees were asked to elaborate on experiences, for example in relation to architecture, furnishings, cleanliness, art and views from windows. The interviews took place in a secluded room at the oncology clinic, or in the patients’ homes. In paper **IV** the participants were asked to narrate their

experiences of giving touch. To stimulate narration and obtain rich descriptions, the interviews were inspired by the technique of re-enactment (Drew 1993). This meant that the participants were encouraged to remember and re-enact a situation in which they were giving touch to someone, and to elaborate on experiences connected with this situation.

Focus group interviews

In papers **II** and **III** focus group interviews were used in addition to narrative research interviews to achieve breadth (rather than depth) of information. Focus group interviews were used on the basis of the fact that this could stimulate a joint description of the phenomenon as the interviewees could get ideas from others in the group. By using the dynamics of groups, we wanted to provide an opportunity for the participants to consider their own experiences in the context of others' experiences, and possibly be stimulated to further elaborate on these together (Patton 2002 pp. 385–390). Our motivation for using group interviews was similar to that of Rubin and Rubin (1995 pp. 140) who state, “In focus groups, the goal is to let people spark off one another, suggesting dimensions and nuances of the original problem that any one individual might not have thought of.”

Observations

Observational methods were used in paper **II** both to describe and to open up the topics further explored in the interviews. Observations were not limited to include merely visual information. For example, smells and sounds in settings contained possible meanings to further explore in additional interviews and further observations (Savage 2000; Sandelowski 2002). Initially, at all three wards we started observations as complete

participants, partly to let the people there get to know us as observers and, equally important, for us observers to get to know them (Polit and Hungler 1999 p. 367; Patton 2002 pp. 310–314). Observations were initially general and at length, simply because everything was deemed important. Subsequently, as concepts begun to develop, the observations became shorter and more focused. Altogether 192 hours of observations were conducted at the medical ward, the geriatric ward and the hospice between 2001 and 2003. Field notes were taken during the observations, both in writing and recorded on a tape, and these were further elaborated upon after each observational session. The field notes consisted of descriptions of the settings, interactions and behaviours, and thoughts and feelings connected to being an observer. The field notes were kept in a reflective research journal.

Methods of analysis

Narrative analysis

Narrative analysis is the method of choice if researchers want to focus on specific rather than generic aspects of phenomena, and aim to illuminate meanings both in content and in forms of telling (Riessman 1993 p. 2). One form of narrative analysis was used in paper I to identify segments of interview text that took on the form of a narrative, and to analyse how structural and linguistic features, in addition to content of speech, could support interpretations of meanings. While a variety of approaches to narrative analysis exist (Mishler 1995; Riessman 2002 pp. 695–710), narratives are frequently described as being discrete units of discourse with identifiable beginnings and endings. A narrative typically involves the recollection and communication of past events in temporal order, in which narrators evaluate significance of experience. Distinguished by order and sequence, narratives are located temporally and spatially, and narrators often

use certain linguistic devices such as intonation, emphasis, pitch and false starts to give significance to events in the stories (Labov 1972 pp. 359–370; Riessman 1993 pp. 17–18; Hydén 1997). Narrative analysis is said to differ from other qualitative methods in that it does not fragment texts into thematic categories for coding purposes, but preserves the integrity of the narrative and expands the basis for interpretation to include the form of telling (i.e. how experiences are talked about) as being as important as the content (i.e. what is said) (Riessman 2002 pp. 695–710).

Paper I was inspired by a narrative tradition that focuses equal analytic interest on how a narrative is put together as on what is said. Through this type of micro-analysis, interpretation extends beyond the content to which language refers, and opens up language itself (i.e. the form of telling) for study (Riessman 1993 p. 19). The analysis was inspired by poetic transcription as described by Gee (1986; 1991), meaning that we attended to linguistic features in addition to structure in the oral narrative. The interview was transcribed verbatim. By listening closely to the tape-recording and attending to linguistic features, the interview was re-transcribed to exclude false starts and hesitations, and to highlight emphasis, silences and pitch falls/rises. The text was then sorted into a hierarchical structure consisting of idea units (fundamental units of speech marked by a pitch glide that signals the focus of an utterance). These were grouped into lines about one central idea or topic; lines were then formed into stanzas, which are a group of lines about a single topic, and stanzas were paired into scenes, which fell into still larger units, parts, which made up the story as a whole. By analysing changes in pitch, intonation and pauses, together with characters used in the narrative, the relationship between form and meaning could be examined (Gee 1986; 1991; Riessman 2002 pp. 695–710).

Paper **III** used a poetic transcription technique adapted from Gee (1986; 1991) as one part of the analysis process to enhance evocation of meaning for the analysis as well as for presentation of findings. It has been suggested that the power in qualitative research lies in its potential to portray meanings of living and suffering through showing narrative enactments of key moments. By presenting excerpts from interviews, meanings can be witnessed and grasped sensually, unlike explanations (Radley 1999). We found poetic transcription to be a powerful form of evoking meanings in interview segments.

Grounded theory

Grounded theory was used in paper **II** to construct a theoretical understanding of processes contributing to supportive care settings. Grounded theory is described as not merely being a method of analysis, but also, encompassing the whole research process from design to manuscript writing (Glaser and Strauss 1967 p. 43). Using grounded theory, researchers enter empirical fields without having preconceived hypotheses; they follow the “path of discovery” (Charmaz 1990). Grounded theory was first described by Glaser and Strauss (1967) and has since then developed in two directions, one more realist- and the other more constructivist-oriented (Annells 1996; Hall and Callery 2001; Lomborg and Kirkevold 2003). Paper **II** was inspired by constructivist grounded theory (Charmaz 1990).

The constant comparative method of analysis was initiated as soon as data collection started (Glaser and Strauss 1967 p. 102; Charmaz 1990). We compared codes with other codes, and emerging categories with other categories to discover similarities and differences. Initially, coding was substantive, meaning that data were coded line by line using open coding to

generate labels derived from, or close to, the text. Subsequently, as open codes were raised to categories, coding became more selective and the analysis aimed to grasp the breadth and depth of categories, and establish whether these could be integrated in relation to a core category (Glaser 1978 pp. 61–63). Theoretical coding was utilized for the purpose of conceptualizing how the categories could be integrated in a theory. Memos concerning ideas for codes, categories and the developing theory were kept throughout the study. Theoretical memos have elsewhere been described to be the “bedrock of theory generation” (Glaser 1978 p. 83) and in paper **II** consisted of ideas about codes, their relationships and thoughts on the developing theory. Analysis and data collection continued until we sensed a feeling of saturation, meaning that data increasingly involved the same issues (Glaser and Strauss 1967 pp. 61–62; Glaser 1978 pp. 124–126).

Phenomenological hermeneutic analysis

Phenomenological hermeneutic analysis is the method of choice when researchers aim to interpret and understand meanings of phenomena in people’s life worlds (Van Manen 1997). A phenomenological hermeneutic approach inspired by the French philosopher Paul Ricoeur, developed at Umeå University and the University of Tromsø (Lindseth and Norberg 2004) and used by researchers such as Söderberg et al. (1999) and Rasmussen et al. (2000), was used in paper **III** to illuminate meanings of being in the physical environment of an oncology clinic, and in paper **IV** to illuminate meanings of giving touch. Phenomenological hermeneutic interpretation comprises a dialectic process between the whole and parts of the whole in texts, between explanation and understanding, and between the pre-understanding of the interpreter and the sense and reference of the text (Ricoeur 1976; Van Manen 1997).

According to Ricoeur (1976 pp. 87–88), an interpretation of a text should start with the ideas opened up by the text, and follow the movement from what the text says (i.e. its sense) to what it talks about (i.e. its reference). The aim of the analysis is to understand not the speaker's intentions (i.e. the utterer's meaning) but meanings of the phenomenon in the text (i.e. the utterance meaning).

The interpretation moves dialectically through three phases. Firstly, a naive understanding is formulated, based on what emotionally strikes the reader in the text. The naive interpretation is a preliminary interpretation of the whole. This interpretation is not static or linear, but rather, it is dynamic and circular, that is, it is not formulated once and for all but is developed during the course of the structural analyses. Secondly, structural analyses are employed to discard or validate these first guesses at meanings. The structural analyses are directed towards the structure of the text, and towards establishing whether the structure invalidates or validates the preliminary interpretations of the whole. Lastly, a comprehensive understanding is formulated, a more sophisticated mode of understanding emanating from and supported by the first two phases (Ricoeur 1976 p. 74). In formulation of the comprehensive understanding, the meanings in the text have evolved in a critical dialectic between the reader's pre-understanding and parts and the whole of the text, and this understanding is re-contextualized in light of relevant literature to deepen and widen the understanding of the text (cf. Ricoeur 1976; Lindseth and Norberg 2004).

ETHICAL CONSIDERATIONS

People who are dying and/or dependent on care are vulnerable, and subjecting them to research raises ethical considerations. Some researchers claim that dying persons should not be exposed to research (De Raeve 1994) while others assert that it is disrespectful not to give these persons the chance to convey their experiences if they wish to do so (Mount et al. 1995; Rasmussen 1999). We believed that vulnerable persons should be offered the possibility of taking part in research. Throughout the course of this study, data collection was preceded by ethical reflection with help of three ethical principles (cf. Polit and Hungler 1999). The principle of beneficence was utilized to assess how the participants would directly or indirectly benefit from the research versus being harmed by the risk of harm and exploitation it would hold for them. The principle of respect for human dignity came to mean being cautious not to invade private space or cause suffering, and providing full disclosure about the research so that all participants could make voluntary and informed decisions about whether or not to participate. The principle of justice aided in reflecting on the righteousness in asking dying people to participate, and in making sure that the research was not being intrusive. All persons asked to participate in the research were treated with respect. No-one declined participation.

There were two ethical risks associated with this research that deserved special consideration. Firstly, since research was conducted and observations were made in three care settings during a period of almost 2 years, it was unfeasible to provide personal information to all people who might become affected by the research. However, information about the ongoing study was posted at all settings during the time of our presence there, and all persons subjected to focused observations and/or

interviews/conversations were personally informed both orally and in writing, and asked to participate in the study. Secondly, observing patients and significant others in the midst of vulnerable life situations requires caution. We tried to be attentive to patients' right to privacy and careful not to intrude or harm in any way in the process of conducting the observations. Furthermore, in addition to being in a researcher-participant relationship, nurse researchers doing fieldwork may also find themselves in situations calling for their skills as a professional nurse. It was decided that if such situations arose while conducting observations, the researchers would take on the role of a nurse instead of the role as researcher and would, for example, help an enrolled nurse give an older woman a shower at the medical ward.

All material was treated with confidentiality and kept away from others not involved in the research. No single individual can be identified in the final reports. The regional ethics committees approved all studies included in this dissertation.

FINDINGS

The overall aim of the study was to understand and describe the phenomenon atmosphere in care settings as experienced by patients, significant others and health care staff. When we asked people to narrate their experiences of atmosphere in care settings, they could not describe the phenomenon per se. The participants used examples and metaphors, contrasts and similes to convey their experiences; the phenomenon itself seemed too elusive to capture in direct verbal description. The analysis of data has led to an understanding that the phenomenon can be understood and described only indirectly through these examples. The presentation of

findings will delineate the phenomenon atmosphere in care settings as being constituted by two interacting and interwoven dimensions: the physical environment and people's doing and being in the environment. The findings also illuminate meanings of the phenomenon as emerging from patients', significant others' and staffs' personal expectations and how the phenomenon influence their experiences of identity.

Personal expectations

The phenomenon atmosphere in care settings is experienced only in the meeting between a person and an environment, and even though the two dimensions presented below represent shared meanings of the phenomenon, all participants interpreted the atmosphere in light of their own expectations. This was illuminated in papers **I**, **II** and **IV**, where it was found that personal expectations were the lens through which the participants perceived and interpreted their experiences of atmosphere in care settings. The participants narrated experiences of atmosphere when the experiences exceeded – or failed to meet – their expectations. Paper **I** illuminates the devastating effects of experiences that failed to meet the participants expectations. The participant narrated that nothing happened in line with her expectations, and that she was therefore bereaved of the possibility of being who she wanted to be, the mother of an infant daughter. The other part of her narrative illuminated how experiences that exceeded expectations were described as granting her the possibility of being who she wanted to be, a daughter to a dying mother.

Paper **II** showed how having one's expectations exceeded made it possible to sense an atmosphere of ease. These exceeded expectations were very personal, for example, emanating from being overwhelmed by the beauty of the physical environment, or being offered an unexpected cup of coffee. Paper **IV** illuminated that giving touch added something more than the expected to caring for older people suffering from dementia. By giving touch, staff could find meaning in caring by being able to alleviate the suffering of older patients.

The physical environment

The physical environment was found to be one of two dimensions constituting the phenomenon atmosphere in care settings; the other dimension was people's doing and being in the environment. Five aspects of the physical environment were illuminated, namely the physical environment *as a symbol*; and *as containing symbols*; the physical environment *as influencing interaction*; *as facilitating a shift of focus*, and *as containing scents and sounds*.

Paper **III** focused on meanings of being in the physical environment of an oncology clinic. Here the physical environment was illuminated as contributing to experiences of atmosphere in four ways. Firstly, the physical environment was experienced as a symbol with existential and social meanings. Patients experienced symbolic meanings of death and dying, danger, shamefulness and stigma when being in a dark, worn-out physical environment located in the basement of the building. To convey the existential meanings of the physical environment as a symbol patients used metaphors such as 'the tomb', 'the catacombs', 'the underworld' and 'the waiting room of death', when describing the physical environment. For

staff, meanings of having less social value and worth within the organization emanated from the use of up-and-down metaphors of higher and lower value, being relegated to the basement of the building and having management at top.

Secondly, the physical environment contained symbols conveying messages of caring and uncaring, life and death. It was illuminated for example how dust balls in the environment and an empty hook for a painting symbolized uncaring and threw mistrust upon care for patients, and how the presence of wilted flowers symbolized death and dying for both patients, significant others and staff. In addition, paper **II** showed that experiences of recognizing oneself in the environment stemmed from the symbolic meanings of the familiar in objects such as flowers, art, curtains and handcrafted furniture in the environment. However, in the medical setting there needed to be a balance between the home-like and the institution-like stemming from the presence of both medical objects and objects of everyday life.

Thirdly, it was found in paper **III** that the physical environment influenced interaction, and thus could support or obstruct welcoming, involvement, privacy and creating new and maintaining previous social relations. It was illuminated that a reception desk where visitors were met and which they could turn to with questions made the first encounter a welcoming experience. For staff, having a reception meant both an eased workload and more privacy with patients, since there were fewer interruptions in their daily work, with fewer newcomers asking questions. Staff also viewed a reception desk as a caring trait: they were proud to be able to welcome visitors in this way. The waiting room situated in the middle of the unit

meant that staff needed to pass through there to go to the treatment rooms, which supported brief encounters, a gaze, a wave or a hello between staff and patients, experienced by patients and significant others as being involved, being seen and also, seeing what was going on. Staff had not reflected upon how the location of the waiting room was experienced by patients, but narrated that the small waiting room they had had at the unit prior to reconstruction had encouraged talking to and coming close to colleagues and patients. However, some participants experienced that such a small waiting room could bring about an invasion of private space as it exposed them to, and forced them to come too close to, the suffering of fellow patients. They wanted there to be a choice of seating, so they could find a balance between involvement and privacy.

It was also shown in paper **II** how the physical environment could support interaction by facilitating creating new and maintaining previous social relations in the environment, for example by having space to be a visitor or receive visitors, sharing rooms with others and having a personal telephone by the bedside. It was also shown that long corridors were used as places for passage and promoted a brisk pace and a hurried behaviour. Settings with long corridors containing few chairs and tables provided fewer opportunities for social interaction than did settings with more places for lingering and human interaction.

Fourthly, paper **III** illuminated the participants' experiences of being able to shift the focus away from oneself to the environment if the environment contained objects such as an aquarium, a painting, or a view from a window. For patients, the world of cancer could be escaped, if only momentarily, by moving their thinking from the self to these objects, and they experienced

such environments as aiding them in forgetting themselves, their anxiety and sadness. Staff described such environments as giving the possibility of shifting the focus away from one's working situation to the environment, experienced as moments of mere being, giving peace of mind and providing energy.

Papers **I** and **II** showed that scents and sounds were a fifth aspect also contributing to the phenomenon. The familiar scent of coffee and a cake contributed to experiences of recognizing oneself in a geriatric setting. It was also narrated that when the sound of loud alarms, telephones, screaming voices and other noise was absent from the setting an overall calmness was experienced. Such calmness was described in paper **I** as contributing to an atmosphere of at-homeness while chaotic noise contributed to an atmosphere of alienation. In paper **IV**, finding a peaceful and secluded place, listening to soothing music and using aromatic oils were ways in which the physical environment was used by the participants to amplify giving touch.

People's doing and being in the environment

People's doing and being in the environment was the other dimension constituting the phenomenon atmosphere in care settings. Five aspects of this dimension were illuminated, namely the experience (or absence of experience) *of a welcoming; of seeing and being seen; of a willingness to serve; of a calm pace; and of safety.*

It was found in paper **II** that the category welcoming represented a first impression of the setting when arriving there for the first time, or when arriving in new situations within a setting. Being expected, seen, and invited

were properties of welcoming, and indicated that others were aware of and prepared for the person's arrival.

Although being seen was described in paper **II** as a property of welcoming, it was developed in paper **III**. Here it was shown that seeing staff move around and at the same time being seen by staff facilitated experiences of involvement and safety for the participants. However, being forced to come close and witness the suffering of fellow patients was experienced as an invasion of private space. This suggests that there was a shift in the meanings of seeing and being seen, from facilitating experiences of safety and involvement in relation to staff, to representing negative experiences of an invasion of private space in relation to fellow patients. Paper **I** showed that being seen by staff contributed to experiences of at-homeness, and that not being seen by staff contributed to experiences of homelessness. Experiences of being seen emanated from the way staff greeted the participant, had time for her, were present for her, and said hello when meeting her outside of the unit, and were interpreted as supporting her in experiencing at-homeness. By contrast, not being looked at or talked to, and even being openly accused of failure by staff was interpreted as being "on another planet", homeless in a foreign world.

In paper **II** it was found that experiences of doing a little extra and receiving a little extra in relation to others in the environment were properties of a willingness to serve. Doing a little extra was described as people putting in an extra effort to enhance others' experiences of care. Examples of doing a little extra included the enrolled nurse who served a tray with carefully arranged food covered by a silver dome lid to patients unable to dine in the dining room, and the young nurse who dressed in a beautiful old-fashioned

dress to please patients and colleagues. Doing a little extra was also described in connection with persons' doing and the subtle qualities in their way of being when doing: adding a little thoughtfulness and concern to the action, not merely caring for but also, caring about others. Receiving a little extra referred to experiences of being surprised by receiving something extra without having to ask for it, without demands for something given in return, and without being made to feel like being a burden. Having one's expectations exceeded was central to experiencing something as a little extra.

Giving touch, as illuminated in paper **IV**, bears likeness to a willingness to serve, as described in paper **II**. It was shown that thoughtfulness and presence with and concern for patients are central to giving touch. Through giving touch staff did something extra to enhance the experience for the patients as well as for themselves. Paper **I** illuminated how staff's unwillingness to answer questions, and their unwillingness to help the participant initiate breastfeeding, had left her unable to recognize herself in the birth experience.

Paper **II** showed that the pace of staff contained symbolic meanings influencing patients' decisions to call for assistance. A calm pace was experienced to signal availability: to signal that there was time for human encounters, something which encouraged asking of questions and ringing the bed alarm for patients and which facilitated recognizing oneself in the environment. A brisk pace of staff moving around in the setting was experienced to indicate unavailability. Similarly, paper **I** illuminated that a calm pace at the unit aided experiences of at-homeness and, conversely, a hurried pace facilitated experiences of alienation from the self, others and

the surrounding world.

In paper **II** it was described that understanding what happens and being in safe hands are properties of experiencing safety in the environment. Understanding what happens involves being able to understand one's experiences, for example by being involved in the care as a significant other, knowing the course of events as a member of staff, or receiving information in a language one can understand as a patient. Being in safe hands involves experiencing answers and actions to be honest, not receiving conflicting messages or experiencing contradictory actions, trusting that needs and requests are responded to without delay, and seeing staff seemingly confident in what they are doing. Paper **II** also showed that experiencing safety was supported by an underlying philosophy of care that could be experienced through the doing and being of staff. The participants at the hospice related that they knew the course of events and that there was a thread of similarity throughout staff's doing and being. Because of a shared philosophy of care, staff at the hospice likewise felt safe and supported in their work. By contrast, at the geriatric clinic neither patients nor staff knew whether the goal of care was rehabilitation or rest and recreation. Staff at the geriatric and medical wards differed in what they did and said to each other and to patients and significant others, which initiated experiences of uncertainty among patients and significant others, and hopelessness among staff.

Doing and being interacts with the physical environment, and vice versa. Examples of how people's doing and being influence experiences of the physical environment were given in papers **II** and **IV**. Here it was shown how a willingness to serve could change the physical environment through

staff's way of dressing and serving food beautifully, or by decorating the table with a sprig of rowanberries, and how staff used and changed the physical environment to amplify the experience of giving touch. A concrete example of how the physical environment influences experiences of people's doing and being was also given in paper **III**. Here it was illuminated that the location of the waiting room in the middle of the unit meant that staff had to pass through the waiting room when going to the treatment rooms, which created possibilities for patients and significant others of seeing and being seen. In paper **II** it was shown how the architectural design of the medical setting influenced the pace and interaction therein.

Experiences of identity

Together the four papers illuminate the phenomenon atmosphere in care settings as influencing experiences of identity. In paper **I** it was shown how the atmosphere in the two care settings influenced the participant's experiences of identity. In one setting an atmosphere described as healing was interpreted to have supported the interviewee's identity as a daughter to a dying mother while in the other setting an atmosphere described as horrifying was interpreted to have obstructed her emerging identity as a mother. The participant's use of metaphors provided strong cues for how to understand the impact of atmosphere on experiences of identity. In the atmosphere described as healing, the participant experienced going there as coming home, while in the atmosphere described as horrifying, the participant experienced alienation, as exemplified by the metaphor "being on another planet". Paper **I** also showed that the atmosphere in care settings can transcend the actual outcome of each hospitalization (e.g. death and birth), and that experiences of atmosphere can be very persistent. In the

interviewee they were still able to evoke painful memories even though the events that were being narrated had taken place some 20 years previously.

Paper **II** also provided an understanding of atmosphere as influencing people's experiences of identity. An atmosphere of ease made it possible for people to find themselves in familiar and safe surroundings, in which they experienced welcoming, a willingness to serve, and safety, and in which they could recognize themselves and create and maintain social relations. This is to say that an atmosphere of ease represents a place in which people can remain being who they are, instead of being stripped of their contacts and habits within an unfamiliar environment. Paper **III** also touched upon identity. It was illuminated that the physical environment at a symbolic level reflects meanings of worth and worthlessness, shame and stigma to the people in the environment. Paper **IV** showed that through giving touch, staff could identify with themselves as valuable persons and professionals. Giving touch was also described to transform how staff regarded older patients. Instead of seeing a demanding patient suffering from dementia, staff experienced being able to see the person behind the disease, an individual human being like oneself.

COMPREHENSIVE UNDERSTANDING AND DISCUSSION

Together the four papers illuminate the phenomenon atmosphere in care settings as not merely subtle qualities of the place where care is given, but as an active part of the care. The atmosphere conveys messages in itself of caring or uncaring in the physical environment as well as in people's doing and being, and it influences both the interactions and the experiences of patients, significant others and staff.

The atmosphere of care settings can at best support experiences of at-homeness in relation to oneself, others and the surrounding world. That is, it can support patients in continuing to feel like persons even though they may be forced to reside in an institution. It supports them in this by making them feel seen and being addressed by name, as well as by allowing them to keep their own clothes, interests, habits and connections to the outside world and be touched not only in task-related ways. The atmosphere can also support patients in experiencing at-homeness in the setting by balancing familiar objects of everyday life with medical objects, facilitating an understanding of what happens, and expressing caring in both the physical environment and in people's doing and being. Conversely, the atmosphere can contribute to experiences of homelessness, for example in becoming a nameless patient through having to wear collective clothing, being forced to reside in an unfamiliar and uncaring environment in which people are on the run, and speak the foreign language of medicine.

The atmosphere in care settings can also support or obstruct the possibility for significant others of experiencing themselves as welcome to contact, visit, and spend time in the setting, and also, of having the opportunity – if they so wish – to be involved in the care. For staff, the atmosphere can support experiences of at-homeness, for example experiences of being valuable persons and professionals guided by a philosophy of care and being supported by colleagues who are available, knowledgeable, and willing to assist them. Staff can be supported in an atmosphere in which they experience welcoming and can follow their own rhythm and still manage to accomplish all that needs to be done.

At-homeness, and experiences of being at-home, has been described as being interchangeable existential concepts referring to experiences of having a sanctuary of safety and security in which it is possible to recognize oneself and experience wholeness, connectedness and a relatedness to oneself, significant others, significant things, and place. Homelessness is the existential antonym to the concept of at-homeness and includes experiences of being displaced, unsafe, lost, and alienated both from the self and from place, others and things (Marcel 1982; Zingmark et al. 1995; Rasmussen et al. 2000).

The findings of atmosphere as influencing experiences of at-homeness or homelessness are in line with social constructivist literature describing identity as being related to place. Who we are and feel able to be can change from place to place (Malpas 1999 pp. 175–193; Conradson 2003). There is a risk of becoming depersonalized when in institutional environments, which is connected to being among unfamiliar objects, becoming stripped of one's history and identity and being forced to subject oneself to unfamiliar and collective regimens (Goffman 1961 pp. 19–23; Twigg 1999; Milligan 2003). This bears likeness to what existential literature refers to as “becoming homeless” (Marcel 1982; Zingmark et al. 1995; Rasmussen et al. 2000).

Understandings of the atmosphere in care settings as either supporting or obstructing at-homeness seems relevant to health care since many recipients of care have been described as very vulnerable and losing themselves (Rasmussen et al. 2000). Patients who suffer from sudden, chronic or life-threatening illnesses are forced to abandon their homes to reside at an institution. Also, significant others experience a shared life torn apart by

illness, uncertainty and fear about the future. Circumstances previously taken for granted suddenly vanish and the person becomes threatened and vulnerable. Therefore, understanding experiences of atmosphere may assist in supporting patients and significant others in restoring experiences of safety and wholeness.

It has been suggested that one essential part of caring is to create a home for patients (Nelms 1996) and that a homelike physical environment forms experiences of at-homeness for patients suffering from schizophrenia (Pejlert et al. 2000). As suggested in paper II, however, just because a setting is homelike it does not necessarily support experiences of at-homeness. In the medical setting it seems that there needed to be both medical objects and objects of everyday life to achieve a balance between the homelike and the institution-like. When suffering an acute myocardial infarction, a patient would perhaps not experience at-homeness receiving care in an environment looking like anybody's home; also, staff would perhaps not experience at-homeness in providing acute medical care in such a context. The presence of medical symbols such as a white uniform and blood pressure gauges was described as necessary in promoting experiences of safety and security for the participants in that setting. In a hospice setting the same objects would perhaps be attributed other meanings.

The road along which discussions of atmosphere in care settings take place is a narrow and slippery one, however. On one side there is a ditch of personal preference, and on the other side there is a ditch of universal truth, and caution must be taken not to slip into either of them. There seem to be no definite and absolute answers to what a "good" atmosphere is. Whether or not an atmosphere is "good" or "bad", and "supportive" or

“unsupportive”, appears to be related to the overarching philosophy of care and to the individual person’s expectations and needs at a given moment.

Bruner (1990 pp. 47–52) suggests that when people and places are as expected, they are not reflected upon. Simply because it is ordinary, the behaviour or place is taken for granted and there is no need for further explanation. By contrast, when people experience deviation from the ordinary they need to make sense of this exceptional state. Two crucial features of narrative are that they originate from experiences of the exceptional, and functions to render the exceptional comprehensibility. Stories do not develop from experiences that are indifferent to us (Bruner 1990). This is in agreement with the findings of this study, that narratives of atmosphere were developed when the experiences either exceeded or failed to meet the expected, when they deviated from the ordinary in a positive or negative direction.

A physical environment conveying meanings of uncaring, shame and stigma in an oncology setting as described in paper **III** can be seen as a concrete example of when geometrical space and lived space come into conflict (Fridell 1998; Bengtsson 2003; Hörnqvist 2004). The geometrical space conveyed symbolic meanings and views of humans that may counteract the holistic philosophy of care of the oncology setting. It seems that to evaluate atmosphere in care settings, the overall philosophy of care needs to be considered. Does the atmosphere support or obstruct this philosophy? Developing and implementing a philosophy of care is not uncomplicated, but has been shown to be challenging (Lövgren et al. 2001; 2002).

In line with previous suggestions that health care environments convey

different messages of care and the humans in them (Dilani 2000; 2001) this study contributes with empirically derived understandings of how patients, significant others and staff experience symbolic messages of worth and worthlessness, and caring and uncaring in settings. This study further provides support to the assumptions that environments in which people can make sense of what is going on, in which they feel they are listened to, involved and needed, in which there are places for them to meet others but still find privacy, and which offer natural scenery strongly influence experiences of being in these settings (cf. Kaplan and Kaplan 2003; Verdeber et al. 1987). Similar to previous findings on how positive distractions can ease stress and anxiety for both patients and staff (Ulrich 1981; 1992), this study illuminates how such aspects of the environment can aid people in shifting the focus away from themselves to the environment.

The overall pace in settings was shown to be another aspect constituting atmosphere. Similar to previous findings that involvement of significant others can vary between cultures of “slowness” and cultures of “quickness” (Andershed and Ternstedt 1997; 1998), this study showed that the pace of staff contained symbolic meanings indicating availability or unavailability for patients. The pace of staff influenced patients’ decisions of whether or not to call for staff assistance. The study also showed that the physical environment can support or obstruct involvement of significant others simply by offering them a place or not.

Being seen and welcomed has previously been described to facilitate well-being, involvement and hope among patients and significant others (Halldorsdottir and Hamrin 1997; Fagerstrom et al. 1999; Weitz 1999; Hertzberg et al. 2001). This study developed these concepts a little further in

that it started to delineate the category welcoming in which being seen was one property. Willingness to serve also emerged as a quality of people's doing and being constituting the phenomenon atmosphere in care settings. It may seem like a somewhat provocative label, but these were the words used by the participants to describe a feeling of concern and responsibility for others, an affect that has previously been described as essential to caring (Morse et al. 1990). Willingness to serve has a moral quality and could be seen as an example of what Martinsen (1989 pp. 48–52) describes as moral expressions inherent in and emanating from concrete nursing situations, expressions of feelings of concern for and emotional engagement in patients without expecting anything in return.

However, this study raises many questions, perhaps more so than providing answers. The study does not explicate relationships, hierarchies or differences in levels of abstraction between the different aspects constituting the phenomenon atmosphere in care settings, and it was not examined how these aspects might vary between different care settings and between the perspectives of patients, significant others and staff, with the exception of paper III. These questions point towards the complex and interwoven aspects involved in the phenomenon, making further research desirable. For instance, it is not known whether a willingness to serve is related to staffing, organizational forms, or levels of education, or whether it is a personal characteristic, an individual decision to make an extra effort to please others. However, studies from palliative care support the notion that a common philosophy of care support experiences of willingness to serve. Another question worthy of study is what happens with the atmosphere in care settings if the space to provide extras is reduced? The category welcoming and its importance in caring is another issue that would be

intriguing to study. There is a proverb that touches upon the importance of welcoming: there is no second chance to give a good first impression. What impression is formed when patients, significant others, staff and other visitors arrive in a care setting how does this first impression influence experiences of care, and how can it vary?

There also seems to be a need to further understand meanings of symbols and objects in care settings. It would be interesting to study whether and how meanings of objects and symbols in the environment vary between different care settings, and which objects are meaningful for patients residing in different settings. Also, it would be interesting to further understand meanings of objects and places of aesthetic value in care settings for patients and staff. This study also touched upon meanings of smells in the environment, an area in need of further research. Care settings contain a variety of smells that relate to illness, decay, strong antiseptics, and other medications. Do patients, significant others and staff need to become used to these smells to manage staying in these settings? How do smells in the environment influence experiences of care? Further insight into sensate experiences such as those connected to objects, aesthetics and smells may illuminate what living and working in these settings mean.

This study was conducted at a particular point in Swedish health care history, and the findings represent this historical and socio-cultural situatedness.

METHODOLOGICAL CONSIDERATIONS

Locating this study in a constructivist tradition does not imply an “anything-goes” view of research and knowledge. However, taking a constructivist stand implies risks for sliding into inescapable anything-goes relativism. Constructivism views knowledge as constructed through social interaction – and therefore, as the result of social processes (Gergen 1995). Knowledge is “right” or “wrong” in relation to social consensus and in light of the perspective that has been adopted. “Rights” and “wrongs” of this kind are not absolute truths or falsities, but the best to hope for is an awareness of one’s own and others’ perspectives when claims of what is “right” and “wrong” are made (Bruner 1990). This study is based upon observations and people’s narrated experiences of the phenomenon atmosphere in care settings, and therefore cannot claim to make causal connections. On many occasions our participants made causal connections between different aspects constituting the phenomenon, and in this study these aspects can be seen as influencing experiences of the phenomenon – the causality, however, remains to be studied. As Polkinghorne (1988 p. 25) writes, “... the relationship between words does not reflect the external relationship among the things the words signify”.

One critical question in qualitative inquiry concerns the knowledge claims that can be made. Are the findings limited to the participants included in the study, or can the findings be generalized or transferred or are they applicable to other contexts or other people? The results of this study cannot be generalized if one employs a statistical definition of generalizability dependent on sample size and representativity. However, if generalizability is understood as being on a theoretical and conceptual level, the understanding gained from this study may be transferable to people in

contexts beyond those that were studied. Hopefully, the findings can convey understandings and descriptions enabling readers to see their own situation in a new, and expanded, way (cf. Riessman 1993 p. 68).

Another critical question is on what grounds we can believe the findings of a qualitative study. Different methodological traditions have somewhat different arguments for the credibility of qualitative findings. Within grounded theory the criteria of fit, work, relevance and workability have been debated, and the critical question is whether these hold for both realist and constructivist grounded theory (cf. Lomborg and Kirkevold 2003). Using fit as one criterion for credibility in this study, and at the same time acknowledging the constructed nature of reality as *a* reality and not *the* reality entails that the understanding gained and the descriptions presented need to fit data and also, that they need to fit the collective understandings of meanings of things and phenomena.

When it comes to phenomenological hermeneutics, Ricoeur (1976 p. 78) states that it is always possible to argue either for or against an interpretation, and the credibility of an interpretation lies closer to the logic of probability than to the logic of empirical verification. Credibility is argumentative and is established in a discourse. The findings of a study achieve credibility when other researchers come to regard them as sufficiently trustworthy to rely on in their own work (cf. Kvale 1996 p. 245). Credibility in narrative research can also be understood as verisimilitude (i.e. lifelikeness), meaning that the interpretations appear truthful in comparison to one's own lived experiences and in relation to shared meanings in society (Polkinghorne 1988 pp. 175–177; Bruner 1996 p. 91).

To enhance credibility original data and transcription information were presented in all papers and critical steps of the research process were outlined to enable others to evaluate the arguments supporting the interpretations. Also, the methodological procedures were provided for others to examine. Furthermore, it is my belief that credibility was improved by the participation of senior researchers in the whole research process. Their active participation in planning, collecting data, analysis and writing, and their asking of critical questions, proposing conflicting interpretations, and illuminating gaps in the analyses led to refinements of the research.

To achieve variation in contexts, experiences, events and incidents, sampling was based on strategies for obtaining rich and varied information about the phenomenon rather than focusing on people per se (Morse 2000). To this purpose patients, significant others and staff in hospice, oncology, medical, geriatric, and community care settings were interviewed and in some cases observed. To illuminate the phenomenon of atmosphere in care settings from several standpoints and through various perspectives variation was sought in sampling and data collection as well as in the methods of analyses. Still, this study can illuminate only limited parts of the area under exploration. By including the perspectives of patients, significant others and staff, from very different contexts within the same study, one faces a great challenge. It was not easy to keep these perspectives – and contexts – apart during the analyses, and it was even more of a challenge to represent data in such a way as to embrace this variation without the presentation becoming meaningless. These challenges were especially prominent in paper **II**, whose findings represent the beginning of a substantive theory.

In this study three different qualitative methods were used in a triangular fashion to illuminate different aspects of the phenomenon atmosphere in care settings. Narrative analysis was used to illuminate nuances and subtleties, as well as the specificity and particularities of the phenomenon, and the persistence of experiences of atmosphere in care settings over time. Grounded theory was used to shed light on the phenomenon as a process focusing on the general rather than the particular. Finally, phenomenological hermeneutics was used to gain existential understandings of the phenomenon atmosphere in care settings. Using triangulation in relation to data and methods has been described as making it possible for researchers to explore the phenomenon more fully and facilitating a more comprehensive understanding and “thick” description (Maggs-Rapport 2000). In this study, triangulation enhanced the comprehensive understanding and description of atmosphere in care settings but it may have yielded breadth (rather than depth) of knowledge.

It should be noted that the author is aware of the existing debate between grounded theory as described by Glaser (1978) and as described by Strauss and Corbin (1998). Paper II was inspired by constructivist grounded theory (cf. Charmaz 1990). This means believing that theories do not emerge from data without researcher influence. In other words, the researcher is an active agent in the whole process of developing a grounded theory. However, in the coding process analytical techniques as described by Glaser (1978) were used.

One methodological consideration is how to ask interview questions about and observe the phenomenon atmosphere in care settings. Narrative research interviews were used in which understandings and descriptions of the

phenomenon were developed between the interviewer and the interviewee (cf. Mishler 1986 p. 52; Kvale 1996 pp. 42–46). Participants were asked about their experiences of the atmosphere in care settings, and were given a great amount of freedom in narrating.

Observations within nursing research have been suggested to suffer from under-use (Mulhall 2003) and disembodiment (Sandelowski 2002). Several recent nursing research texts argue for “objectivity” from the observing researcher to avoid biasing the data (Polit and Hungler 1999 p. 366; Scanlan et al. 2002; Mishoe 2003). These arguments can consolidate the Cartesian dualism that separates the inquiring mind from the very body in which the mind is located. However, a more embodied approach to observations has emerged within the fields of anthropology and sociology, suggesting that researchers use their own experiences in their fieldwork (cf. Goodall 1989; Conquergood 1991; Fineman 1993; Stoller 1997 pp. xi-xviii; Rasmussen 1999). In this study an embodied approach to observations was increasingly used in which sensate experiences of the researcher together with analytical logic stimulated an embodied insight into what it might feel like to live in, work in and visit care settings. This approach seemed consistent with the theoretical framework within which this study was performed, and provided rich and varied data.

Some of the data in this study were collected by means of focus group interviews. The decision to do so was based on ideas of how to generate rich data, and it was believed that in conducting focus group interviews the participants could stimulate each other to narrate their experiences of atmosphere in care settings. However, one potential weakness would be to subject focus group data to the same analysis as used for individual

interviews, since it has been suggested that one point of using focus group interviews is to make possible an analysis of how meanings are negotiated in groups (cf. Phoenix et al. 2003). Critics could argue that by not subjecting focus group data to analyses of group dynamics, one might lose one of the advantages of using focus group interviews. Nevertheless, using this form of data collection yielded dynamic and rich data seemingly because of the interaction between the participants. These data enriched the analyses and contributed to the overall understanding of the phenomenon atmosphere in care settings.

CONCLUSIONS AND IMPLICATIONS FOR NURSING

The findings illuminate meanings of the phenomenon as emerging from patients', significant others' and staffs' personal expectations and how the phenomenon influence their experiences of identity. The findings further delineate the phenomenon atmosphere in care settings as being constituted by two interacting and interwoven dimensions: the physical environment and people's doing and being in the environment. The physical environment is the first dimension, and five aspects were illuminated, namely the physical environment *as a symbol* conveying messages in itself of death and dying, danger and shamefulness, stigma, higher and lower social value and worth; *as containing symbols*, for example wilted flowers and dust balls, conveying messages of caring and uncaring, life and death, the homelike and the institution-like; *as influencing interaction* and experiences of involvement and privacy, welcoming, and the possibilities to create and maintain social contacts in the environment; *as facilitating a shift of focus from oneself to the environment*, and; *as containing scents and sounds* influencing experiences of at-homeness or alienation. People's doing and being in the environment is the other dimension, and five aspects were

illuminated, namely namely the experience (or absence of experience) *of a welcoming; of seeing and being seen; of a willingness to serve; of a calm pace; and of safety*. It was understood that people's doing and being influence experiences of the physical environment and that the physical environment influenced experiences of people's doing and being.

The comprehensive understanding of the phenomenon illuminated that the phenomenon is not merely subtle qualities of the place where care is provided, but is an active part of care. The atmosphere conveys messages in itself of caring or uncaring in the physical environment as well as in people's doing and being, and it influences both the interaction and experiences of patients, significant others, and staff. The atmosphere of a care setting can at best support experiences of at-homeness in relation to oneself, others and the surrounding world.

The development of nursing theory has been described to evolve in four domains, the client domain, the practice domain, the client - nurse domain, and the environment domain, and there have been limited theoretical advances in making connections between the environment domain and the client domain (Kim 1989). This study can contribute to nursing theory by beginning to illuminate that the client - nurse domain (people's doing and being) and the environment domain (the physical environment) are interwoven and interact, and also that they influence the client domain (experiences of identity).

Martha Rogers' (1970) science of unitary human beings takes an interest in the environment domain. This study was not derived from Rogers' conceptual model, but it seems possible to relate the findings of this study to

some concepts in the Rogerian model. The findings can be seen as illuminating meanings of lived experiences of, if one dares to use Rogers' vocabulary, the integral relationship between the human and environmental energy fields. Where Rogers' described human beings and the environment as irreducible wholes in constant interchange of energy, this study illuminated people's doing and being and the physical environment as interwoven and interacting in constituting the phenomenon 'atmosphere in care settings'. Rogers (1970 pp. 122) further stated that: "Nursing exists to serve people." and this study illuminated the concept willingness to serve as consisting of a feeling of concern for and a responsibility for others; an affect previously described as essential to caring (cf. Morse, Solberg et al. 1990). Furthermore, Rogers conceptual model described therapeutic touch as a purposive patterning of nurse-environmental/patient-environmental energy field process. This study illuminated giving touch as one way of people's doing and being contributing to the phenomenon 'atmosphere in care settings. Thus, it seems as if the findings of this study support Rogers' conceptual model of the interchange between humans and the environment, and might contribute to Rogers' rather abstract vocabulary by providing concrete understandings and descriptions seemingly operational for further research as well as for nursing practice.

Conclusively, this study can contribute to nursing practice by providing a conceptual basis for intentionally reflecting upon and evaluating health care settings. It provides broad principles rather than rules of thumb to be used in practice. This means that nurses and other health care professionals can apply the findings by integrating them with their own professional skills and reflecting upon what these understandings mean in their own setting. For example, are there possibilities to experience welcoming and a willingness to serve in the setting? What expectations do patients' and significant others have upon care? Florence Nightingale (1969 p. 133) once stated that the art of caring is to provide an environment in which the patient is in the best position for nature to act upon, and Rogers' (1970) have emphasized that one part in nursing is to pattern the environment into a place where healing conditions are optimal. The findings of this study can contribute to understandings of what this might mean in practice.

SUMMARY IN SWEDISH - SVENSK SAMMANFATTNING

Redan Hippokrates och Florence Nightingale beskriver att en av vårdens viktigaste funktioner är att skapa en omgivning där människors egna helande och läkande krafter befrämjas (Weiss & Lonnquist, 2000; Nightingale, 1969). Tidigare forskning visar att den fysiska vårdmiljön kan påverka människors upplevelse av hälsa och ohälsa samt att den också influerar självbild, beteende och interaktion. Forskning visar också att när människor beskriver upplevelsen av god eller dålig omvårdnad så beskriver de ofta en upplevelse av vårdatmosfär, det vill säga det är svårt att uppleva god vård i en negativ atmosfär och vice versa. Dock saknas kunskap om hur vi kan förstå och beskriva fenomenet vårdatmosfär. Detta medför att det är svårt att undervisa, mäta, intervenera eller på annat sätt medvetet och målinriktat använda vårdatmosfären i hälso- och sjukvård.

Att sammanfatta kunskapsläget inom detta område är inte enkelt. En mängd forskning inom discipliner som psykologi, arkitektur, hälsogeografi, och sociologi har studerat vad som kan förstås som aspekter av vårdatmosfär. Sammanfattningsvis kan man påstå att många artiklar inom detta forskningsfält antingen diskuterar vad vårdmiljöer betyder för människor utan att redovisa empiriskt stöd för diskussionerna, eller drar slutsatser om vad vårdmiljöer betyder för människor utan att ha genomfört den typ av forskning som möjliggör sådana slutsatser.

Det övergripande syftet för denna avhandling är att förstå och beskriva fenomenet vårdatmosfär som det erfars av patienter, närstående och personal. Avhandlingen består av fyra delarbeten med följande specifika syften:

Delstudie I	Att förstå fenomenet vårdatmosfär genom en detaljerad fallstudie.
Delstudie II	Att skapa en teoretisk förståelse av processer som bidrar till stödjande vårdmiljöer.
Delstudie III	Att belysa innebörden i att vara i den fysiska miljön vid en onkologisk klinik som det berättas av patienter, närstående och personal.
Delstudie IV	Att belysa innebörden i att ge beröring i omvårdnaden av äldre patienter.

I delstudie **I** användes narrativ analys för att tolka en forskningsintervju där en informant med erfarenheter av att både vara patient, anhörig och vårdare berättar om sina erfarenheter av vårdatmosfär. I delstudie **II** användes grounded theory för att utifrån forskningsintervjuer och observationer från ett hospice, en geriatrisk och en akutmedicinsk avdelning skapa en begynnande teori om de processer som bidrar till miljöer som erfars som stödjande. I delstudie **III** användes en fenomenologisk hermeneutisk metod för analys av 17 forskningsintervjuer där patienter, närstående och personal berättar om sina erfarenheter av att vara i den fysiska miljön vid en onkologisk klinik. I delstudie **IV** analyserades med fenomenologisk hermeneutik 12 forskningsintervjuer där personal berättat om sina erfarenheter av att ge beröring i sitt arbete med äldre patienter.

Resultaten visar att hur fenomenet vårdatmosfär erfars är beroende av människors förväntningar, och att vårdatmosfären influerar människors upplevelse av identitet. En övergripande tolkning utifrån de fyra delstudierna är att fenomenet vårdatmosfär kan förstås och beskrivas som bestående av två interagerande och sammanvävda dimensioner: den fysiska miljön och människors varande och görande i miljön.

Fem aspekter av den fysiska miljön som bidrar till erfarenheter av vårdatmosfär belyses nämligen *den fysiska miljön som symbol* som exempelvis genom sin placering och standard uttrycker betydelser av död och döende, fara och skam, stigma samt högre eller lägre socialt värde (III), *den fysiska miljön som innehåller symboler* som exempelvis vissna blommor, dammtussen på golvet, eller den tomma tavelkroken uttrycker betydelser av god och dålig omvårdnad, liv och död, det hemlika och det institutionella (II, III), *den fysiska miljön som influerar interaktion* och erfarenheter av delaktighet och avskildhet, välkomnande, och möjligheterna att skapa och behålla sociala kontakter i miljön (II, III), *den fysiska miljön som befrämjar att flytta fokus från sig själv till miljön* och för en stund slippa tänka på sig själv och sin situation (III) samt *den fysiska miljön som innehåller lukter och ljud* som influerar erfarenheter av hemmastaddhet eller alienation (I, II).

Människors varande och görande är den andra dimensionen som bidrar till erfarenheter av vårdatmosfär, och fem aspekter belyses nämligen *välkomnande*, att vara väntad, sedd och inbjuden (II), *att se och bli sedd*, att se och samtidigt bli sedd av personal, och inte uppleva en invasion av sin privata sfär av andra patienter (I, III), *villighet att tjäna*, att göra det lilla extra och att få det lilla extra (I, II, IV), *ett lugnt tempo*, att se personal vars

tempo signalerar tillgänglighet (**I, II**) samt *att känna sig trygg och säker*, att förstå vad som sker och vara i trygga händer (**II**). En tolkning av resultaten ovan är att den fysiska miljön influerar människors varande och görande samtidigt som människors varande och görande påverkar den fysiska miljön.

I en sammanvägd förståelse kan fenomenet vårdatmosfär förstås som en aktiv del av omvårdnaden och inte endast som subtila kvaliteter hos platsen för omvårdnad. Vårdatmosfären uttrycker i sig själv budskap om god eller mindre god omvårdnad både genom den fysiska miljön och genom människors varande och görande, något som influerar interaktionen mellan patienter, närstående och vårdare och även erfarenheter av att ge och få omvårdnad. Vårdatmosfären kan – som bäst – främja erfarenheter av hemmastaddhet i relation till sig själv, andra och omvärlden.

Utvecklingen av omvårdnadsteori har tidigare sammanfattats i fyra domäner, klientdomänen, praktikdomänen, klient – vårdardomänen, och miljödomänen (Kim 1989). Av dessa har enligt Kim (1989) minst teoriutveckling inom omvårdnad skett inom miljödomänen. Denna avhandling kan bidra till befintlig omvårdnadsteori genom att öka förståelsen och ge beskrivningar av hur aspekter i klient – vårdardomänen (människors varande och görande) tillsammans med aspekter i miljödomänen (den fysiska miljön) interagerar och influerar klientdomänen (upplevelse av identitet). Avhandlingen kan bidra till omvårdnadens praktik genom att ge en begreppslig bas för reflektion och värdering av egen vårdmiljö. Exempelvis, hur välkomnas en ny patient? Har vi en fysisk miljö som befämjar eller motverkar interaktion mellan patienter och vårdare? Kartlägger vi patienters och närståendes förväntningar på omvårdnaden vid

ett ankomstsamtal?

Florence Nightingale skriver att konsten i omvårdnaden är att skapa en omgivning där patientens egna helande och läkande krafter befrämjas, och Martha Rogers uttrycker att en del i omvårdnaden är att forma miljön till en plats med helande betingelser. Förhoppningsvis kan denna avhandling bidra med vissa insikter om vad detta kan betyda i teori och praktik.

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