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Towards Studies of Nordic Caring

— A Different Phenomenological Approach¹

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Preface

In nursing research, one should be interested in phenomenological research (JPN NURS RES, 2011a) as well as caring (JPN NURS RES, 2011b). Due to holding an interest in both these areas and participating in a collaborative project called 'Phenomenology of Caring', I have further interest in 'Nordic Caring' as a contact point between phenomenology and caring. Therefore, for two years, I have been engaged in an interdisciplinary collaborative research titled 'A research into theoretical grounds and philosophical backgrounds of Nordic Caring based on field work'. The collaborators on this study are from fields such as philosophy, ethics, thanatology, nursing science, rehabilitation science, social welfare and cultural anthropology.

Our research of binding field work to a philosophical background is not a simple process, and as yet, we cannot gauge the complete results of the study. Nevertheless, I introduce our activity so far as a progress report and provide a different approach to 'phenomenological research' of 'caring'.

Beginning of our Research

I am neither a nursing researcher nor a Nordic studies expert, but I conducted research in phenomenological philosophy (Hamauzu, 2007a). Furthermore, I have been engaged in establishing a platform for dialogue among researchers and between citizens and researchers in medicine, nursing, social welfare, etc., titled 'Anthropology of Caring' (Hamauzu, 2005; 2007c) and 'Clinical Philosophy of Caring' (Hamauzu, 2012a). For the

last three years, owing to scientific grants-in-aid, I have been participating in collaborative research titled 'Foundation and Development of Phenomenology of Caring' and 'Concrete Development and Organization of Phenomenology of Caring' (Hamauzu, 2011). During these activities, I interacted with nursing researchers; however, my interest in Nordic caring emerged due to another encounter, which is explained below.

In 2007, I visited many facilities for elderly people and hospices or palliative care units in Shizuoka Prefecture as part of a collaborative research titled 'Ethics and Laws of Personal Assistance' (based on clinical psychology and human care). Based on this activity, in November 2007, I participated in the 'Study tour of visiting welfare service and feeling every day life in Nordic countries' (Hamauzu, 2008). I visited various facilities for human care in Nordic countries (primarily Sweden and Denmark) with other participants from medicine, nursing and caring and social welfare. These visits and interviews with staff members motivated me to consider the theme of 'Ethics and Laws of Personal Assistance', the issue of 'self-decisions' of the elderly and terminally ill and the paradoxical relationship between 'enrichment of caring' and 'suspension of medicine', among others. This is when I developed an interest in the foundational concepts of caring for the elderly in Nordic countries.

Regarding my phenomenological interests, I belong to the Phenomenological Association of Japan (PAJ), which in 2007 began an international scientific exchange with the following groups: the Nordic (NSP), Korean and Chinese Societies for Phenomenology (Sakakibara, 2007). In 2007, these groups each sent a researcher to conferences in each of their home countries. At the 2007 PAJ conference, Sara Heinämaa, president of the NSP, from Finland's Helsinki University, presented a speech (Heinämaa, 2008). At the 2008 conference, Marcia S. C. Schuback, a Swedish researcher from Sweden's Södertörn University College, made a presentation (Schuback, 2009).

Meanwhile, we began the collaborative research on the 'Phenomenology of Caring'. Schuback's 2008 presentation topic, 'Immensity and A-subjectivity' about the 'possibilities

of encountering the other' overlapped with my ongoing research. She was interested in my development from 'theory of others to theory of caring' . Our conversation at the reception after the conference provided me with information about a Swedish group also interested in 'phenomenology and caring' , and Schuback introduced me to a core member of the group, Karin Dahlberg. In 2009, I had the opportunity to present 'Narrative and Perspective' at the NSP conference in Tampere, Finland (Hamauzu, 2009b), following which I travelled to Växjö, Sweden, to meet Dahlberg.

Karin Dahlberg is the leader of the Växjö research group and Guest Professor at the School of Health and Caring Sciences, Lifeworld Centre for Health, Care and Learning, Linnaeus University. In fact, she contributed to this issue of the periodical. My travel schedule allowed me to participate in an entire three-day event of related programmes in Växjö. The first programme was the inaugural meeting of the European Academy of Caring Science (EACS); the second was an education seminar for doctoral candidates on 'lifeworld-led-care: an existential point of view of well being' ; and the third, a meeting for collaborative research between Bournemouth and Linnaeus Universities, titled 'Lifeworld-led-care and Education' . These programmes indicate a movement of caring science different from that of nursing science in the United States. Phenomenology is central to this movement, and this is extremely interesting for me.

Because the collaborative research 'Phenomenology of Caring' had begun in April 2009, the idea of collaborating with the Nordic researchers was very appealing. However, because the collaborating members on the 'Phenomenology of Caring' research are primarily centred on nursing science and not on Nordic caring (Sakakibara, 2011), it was difficult to incorporate this Nordic collaboration into that research.

Therefore, I interacted not only with researchers interested in nursing science but also with researchers interested in rehabilitation science, caring science, social welfare and so on. In April 2010, the collaborative research 'A research into theoretical grounds and philosophical backgrounds of Nordic Caring based on field work' began. Because

of this serendipitous background, I subtitled this article ‘A different phenomenological approach’ .

The purpose of the research (quoted from the application) was as follows:

‘Many researchers on welfare system on one hand and caring studies on the other have often visited the Nordic countries famous for their well-developed welfare system. Some of these researchers have reported on the concept of “normalization” and the leading values of the Swedish model, such as “freedom, equality, equal opportunities, peace, safety, security and fairness.” Nevertheless, it is insufficient to clarify their theoretical grounds and philosophical backgrounds. To research these welfare systems, not through written literature but by fieldwork, i.e. investigating the operational realization and activation of these ideas, is expected in a super-aged Japan, where a theoretical foundation of welfare and caring is a pressing need’ .

In this collaborative research, we visited various caring facilities (e.g. hospitals, hospices, facilities for the elderly and the handicapped and homes) and interviewed the care staff and clients. In addition, we visited Nordic researchers (of phenomenology and caring sciences) to exchange opinions. In our follow-up meetings, we reported the observations from our visits and conducted detailed discussions with co-researchers.

Development of Our Research

We are in the final year of our collaborative research. During these three years, all members of our project have conducted fieldwork in Nordic countries and reported their findings. Furthermore, based on the members’ reports about Nordic caring within each area of expertise, we held eleven discussions analyzing the results. One more meeting and a symposium have been planned for January and March 2013, respectively, to release the results of our research to the public. The following is a list of our meetings so far:

The first meeting at Osaka University in May 2010:

Shinji Hamazu, ‘Keynote speech—Going towards Nordic caring studies’

The second meeting at Shizuoka University in August 2010:

Taisei Yamamoto, 'Movement of Body and Genesis of Health—from a point of view of using bodily resources'

Nobuhiko Bishu, 'Transition of caring in Japan and the future from Nordic caring'

The third meeting at Kobegakuin University in January 2011:

Ryutaro Maeno, Shinji Hamauzu and Yasuuki Suzuki, 'Report of study in Nordic countries No. 1: United Kingdom, Sweden and Denmark'

Yutaka Nakagawa, 'Report of Study in Nordic Countries No. 2: Music therapy in Norway'

Teruko Takahashi, 'Interest in Nordic caring from nursing field'

Isao Nara, 'A philosophical investigation about caring from the standpoint of physiotherapist'

The fourth meeting at Osaka University in March 2011:

Eijiro Fukui, 'Anthropology, Others and Caring'

Shinji Hamauzu, 'What is Lifeworld?'

The fifth meeting and symposium, 'Nordic education and caring' at Nagoya University of Arts in July 2011:

Naoto Koike, 'The concept of Enlightenment in Grundtvig and Nordic democratic society'

Mitsuru Shimizu, 'Schools for life—from interaction with the Grundtvig movement'

Satoshi Nakazato, 'Nordic education and caring—Reality supporting the field'

The sixth meeting at Osaka University in October 2011:

Junko Stier, 'Nordic caring that a Japanese watched—From experience as a nurse in two countries'

Karin Dahlberg, 'Patient-centered-care as Lifeworld-led-care—From the point of view of Nordic caring'

The seventh meeting at Konan Women's University in December 2011:

Shinji Hamauzu, 'A short Report of Study Travel—Hospice and Palliative Care Unit in United Kingdom and Sweden'

Tsuyoshi Nakamura, 'A Hypothesis about theoretical basis of Caring in Sweden'

Eijiro Fukui, 'Caring and Personhood from the Theory of Donation'

Taisei Yamamoto, 'Psychophysiotherapy in the Mental Health & Basic Body Awareness

Therapy'

The eighth meeting at Seirei Christopher University in March 2012:

Yutaka Nakagawa, 'Development of Music Therapy in Norway and its Philosophical Grounds'

The ninth meeting at Shimane University in June 2012:

Hirobumi Takenouchi, 'To Social Grounds and Philosophical Cornerstones of Nordic Caring—What the "Welfare" in Sweden questions'

Nobuhiko Bishu, 'Sense of Discomfort against Protective and Educational Care'

The tenth meeting and symposium, 'Re-inquiring Welfare—With the Clue of Understanding Human Being Supporting Nordic Caring' at Shizuoka Prefectural Hall of Industry and Economics in December 2012:

Yayoi Saito, 'Caring as a question—Thinking from Elderly Caring in Sweden'

Kanako Korenaga, 'Theory and Praxis of Education of Children with Disabilities—The View of Human Nature Supporting the Education of Children with Disabilities in Sweden'

Teruko Takahashi, 'Nursing and Welfare—Historical Transition and Tasks'

As seen above, the co-researchers each gave a presentation based on their fieldwork considering Nordic caring from their respective fields. As our research developed, we felt the necessity of researching Nordic education, which is bound to Nordic caring. Thus, we invited three researchers from education. By connecting fieldwork research with theoretical investigations and sharing research from each area of expertise, we have amassed discussions and considerations. Because the contents of each presentation can be published in other ways, I first address Junko Stier' s speech, followed by Tomoko Hansson' s (an official guide of Göteborg, a writer and translator who specializes in social welfare) lecture and finally, Karin Dahlberg' s speech to introduce the following three articles.

I first met Junko Stier when I participated in the 'Study tour of visiting welfare service and feeling every day life in Nordic countries' , for which she was the interpreter. She invited us to her home, and I had the opportunity to ask her about Swedish people' s

thoughts on issues such as euthanasia and terminal care (Hamauzu, 2008). We were fortunate to hear from a nurse who has worked in both Japan and Sweden, and who is now an interpreter mainly in tours for medical professionals or caretakers.

The most important points from Junko's stories are as follows: First, in the national movement since the 19th century, solidarity and independence have had inherent linkages. Second, caring is helping someone towards becoming independent; it is also placing importance on self-decision and not interfering extensively. Third, due to medicine and caring focused on patients, the treatment period is short. The average hospital stay is about 6 days in Sweden, whereas it is about 32 days in Japan. The system of caring, both regional medicine and social welfare, is adjusted to enable patients to receive health care at home after leaving the hospital. Fourth, there is a 'social assistant' , and qualification for this position requires vocational education. It is a crossover between nursing and caring. Social assistants play an active role in caring facilities and home caring. In Denmark, they are called social health caregivers.

When we visited hospices and palliative care units in the United Kingdom and Sweden, we attended Tomoko Hansson's lecture about 'Social Welfare in Sweden' . In addition, we visited a group home for people with intellectual disabilities, where we received an explanation about the system of personal assistants for people with disabilities. In February 2012, Hansson's Japanese translation of *Concept and Practice of Caring in Sweden* (Anita Kangas Fyhr and Olga Wilhelmsson, 2012), which is 'a textbook for training staff for nursing and caring in junior high schools' , was published. In the preface, Hansson writes about the concept of 'caring' : 'It means support for clients from surrounding people so that clients can live as comfortably as possible through nursing, caring, treatment and assistance' . Through this book, people can learn about 'life cycle' , 'gerontology' , 'the common soil for nursing and caring' , 'quality of life and health' , 'functional disabilities' , 'rehabilitation and aids' , 'basis for every day hygiene' , 'human engineering and occupational therapy' , 'health control of body' , 'examination and treatment' , 'caring in terminal stage' and 'duties of staff working in facilities for

health care'. This textbook provides an educational programme for training people who support client-centred caring by connecting nursing and caring—it repeats the notion of Nightingale as the founder of modern nursing (Kanai, 1998).

The accounts of Stier and Hansson, who have worked in two fields, and the presentation of Dahlberg, who considers the theory of caring through philosophical texts, seem to correspond to one another. Between fieldwork or practice and theory or philosophy, there is no one-way relationship of influence. Thus, we cannot consider theory or philosophy as a basis for any field or practice, nor that the former is extracted from the latter. However, neither can we think that theory or philosophy is formed independently from any field or practice. There appears to be a corresponding relationship.

The Concept of 'Lifeworld-Led-Care'

Here I introduce the background of Dahlberg's article. As previously mentioned, Dahlberg is a member of EACS, a research network connecting five universities—Bournemouth, Brighton, Uppsala, Borås and Linnaeus. The word *European* in the title indicates the intention to build a 'caring science' on theoretical and methodological bases from European philosophy (but including philosophy, ethics, feminist studies, theology, education, alternative and complementary medicine). These researchers wish to synthesize multi-professional and interdisciplinary cooperative work in health care, thus progressing differently from American nursing science.

The three pillars of EACS are lifeworld-led-care, transcultural care and public health. Dahlberg is the pioneer of the lifeworld-led-care concept. The article she contributes, based on her speech in Japan 2011, has been revised to convey her fundamental ideas to Japanese readers. Since readers can directly refer to its contents, I briefly introduce its background.

First, I clarify Dahlberg's positioning of caring science. In Japan, the relationship

between caring and nursing has been discussed. Beginning with advocates who insist that 'caring is the essence of nursing science' , many discussions have developed about whether caring and nursing are synonymous, whether caring is the kernel of nursing or whether nursing is included within the concept of caring (Hamauzu, 2012c). Nightingale did not distinguish between nursing (nursing care) and caring (welfare care), and thought of 'caring' as encompassing both areas (Kanai, 1998). As previously noted, the idea that 'caring is a common soil of nursing and welfare caring' is widespread in Sweden. Dahlberg' s caring science is considered an academic discipline that serves as a basis for nursing and caring. To build caring beyond 'nursing science', Dahlberg constructed 'caring science' , which not only includes patients but also targets healthy people.

The 'lifeworld' concept is also known in Japan. Edmund Husserl, the founder of phenomenology, initiated lifeworld in his last publication, *Crisis of European Sciences and Transcendental Phenomenology* (Husserl, 1954). This concept has been used among phenomenological researchers, but in the 1990s, it spread to disciplines such as sociology, cultural anthropology, folklore, pedagogy, science of religion, social welfare studies and Manga studies. Recently, however, the origin of 'lifeworld as a forgotten meaning fundament of natural sciences' has been forgotten and it is used freely in various disciplines.

This term did not emerge suddenly in Husserl' s last publication, but was used earlier to indicate the relationship among various influences. In this sense, it has again received considerable attention (Husserl, 2008). In recent research on the relationships between phenomenology and medicine and nursing and caring, researchers emphasize the contrast suggested by Kleinman (1996) and Toombs between 'disease' as objective judgement by biological medicine and 'illness' as subjective experience by patients. The former is a natural scientific explanation, whereas the latter expresses patients' experiences of lifeworld; thus, the original meaning of 'lifeworld' has been retained (Toombs, 2001). However, in recent nursing science, researchers casually employ this term without considering its origin (Miyawaki, 2012).

Dahlberg takes advantage of the concept of lifeworld to approach the cared-for person's world, which may be foreign to the caregiver. The caregiver must extend him- or herself to identify what the cared-for person sees and hears, is interested in and evaluates what characterizes that person's world. Certainly, the cared-for person does not always see or hear the same thing the caring person does. The cared-for person does not always share the caregiver's world. The former's world could comprise time, space, body, relationship with others, values and view of life that are different from the caregiver's world. 'Caring' becomes possible only by approaching the lifeworld of others.

Moreover, by focusing on lifeworld, we could attend to a patient not as a lonely patient forced into self-decision in a hospital but as a living person who lives at home with family or other people, i.e. a being-in-community.

However, not every patient has a family at home; elderly people in Sweden seldom live with the younger generation. Nevertheless, as long as they live at home, they have a history including interactions with those around them, whereas hospitalization often means severing these connections. Providing them with care at home after discharge from the hospital helps them recover their lifeworld. Treating a patient or client not as a being-in-hospital but as a being-in-community, who lives interdependently and is supported at home by people around, is facilitated by the caretakers focusing on their lifeworld. Thus, 'lifeworld-led-care' might be regarded as leading to 'community-based-care' (Takenouchi, 2007).

'Lifeworld-Led-Care' from Perspectives of 'At Home' Care and 'Bioethics'

Although I have contrasted 'at home' and 'in hospital', the phrase 'at home' has different nuances in Japan and Sweden. In the post-World War II era in Japan, over 80 percent of people died at home. Conversely, by 2004, 79.6 percent of people died in hospital. In addition, the percentage of people who die in facilities for the elderly is increasing

(Ministry of Health, Labour and Welfare: MHLW, 2004). However, in Sweden, according to 1996 data (Institute for Health Economics and Policy: LHEP, 2001), about 42 percent of people died in hospital; 20 percent at home; and 31 percent in a 'special house' . A 'special house' should not be considered the same as facilities for the elderly in Japan.

Recently, special nursing homes or group homes for the elderly in Japan have developed a system of unit care, i.e. one unit for nine users, and no facilities remain for large groups of people. Although the Japanese learned unit care from Nordic countries, the Japanese version varies from the Nordic. In a group home in Japan, nine users comprise a group, each with his or her own room, extending to approximately 12 m², and a common a living room, dining room, kitchen, bathroom and three restrooms; the home is designed as a single building. In a group home in Sweden, each of the nine or more residents has his or her own home, including a bedroom, living room, dining room, kitchen, shower and toilet. Furthermore, there is a common dining room and living room; this facility is a group of buildings. In addition, because the residents bring their own furniture, they consider themselves 'at home' . From this background, the 'research about terminal medicine of cared elderly' reports that the rate of death 'at home' is 51 percent including 20 percent 'at home' (in the Japanese sense) and 31 percent in a 'special house' (LHEP, 2002). We must remain aware of the broader Swedish use of the term 'at home' .

Finally, 'lifeworld-led-care' suggests a difference between American and European bioethics. Just like the idea of a 'European Academy of Caring Science' , lifeworld-led-care contrasts the European and American ways of thinking. Specifically, American bioethics has emphasized patients' independence and self-decisions; European bioethics admits these qualities, but positions them within solidarity and community. The European view is based on human beings not only having freedom, independence, self-decision and self-responsibility but also helping each other and having interdependent relationships (Council of German Federal Parliament, 2004). This concept could be understood as undergirding autonomy or independence with solidarity and community (Hamauzu, 2012b).

Since the 1990s, Nordic countries have tried to integrate medicine and caring, i.e. transition from the gravity of care in hospitals and facilities to the comfort of care at home (including the 'special house'). This trend includes medicine, nursing and rehabilitation. Indeed, lifeworld-led-care corresponds to at home and community-based care. As previously mentioned, philosophy or theories and practice have a complex relationship. Lifeworld-led-care is not directly connected with clinical fields, nor is there a one-sided influence. Nevertheless, I reassert that practice and philosophy correspond. Lifeworld-led-care should be a philosophy of caring that corresponds to Nordic caring centred at home.

Nordic Caring from Perspectives of Welfare and Palliative Caring

Dahlberg also emphasizes the interaction of theory and practice. She characterizes the lifeworld approach by its 'open attitude' , considering it the antithesis of 'method' (2008). Her article published in this issue leans towards theory, although it is based on fieldwork. And although her lifeworld-led-care theory is based on fieldwork, we cannot yet confirm whether it drives or supports practice. This article introduces her theory, including its background. At the same time as a point of view from fields that lacks there, I link Dahlberg' s theory to the following articles by Takenouchi and Saito.

Takenouchi (Shizuoka University), who has long been engaged with end-of-life and palliative care (Takenouchi, 2009), returned to Japan in May, after his yearlong stay as a visiting professor at Borås University. During his stay, he visited various fields, interacted with members of those fields, visited many researchers and collected exchanges of opinions and discussions. He emphasizes thinking from the perspective of what influences fields, and arranged a visit to palliative and welfare care facilities in the United Kingdom and Sweden, where we had productive discussions with staff and researchers. It was due to him that we were able to attend Hansson' s lecture and visit a group home for people with intellectual disabilities. This fiscal year, Takenouchi launched

collaborative research titled 'Elucidation of philosophical cornerstones of end-of-life-care in the secularising European society' , wherein he discusses Nordic caring by focusing on welfare care, specifically for people with disabilities.

Saito (Bunri University of Hospitality), who also visited fields of palliative and welfare care in the United Kingdom and Sweden, learned Swedish in Uppsala University and worked as a nurse in a palliative care unit in Japan. Currently, besides constructing a nursing system after the Great East Japan Earthquake and Tsunami in March 2011, she participated in the study trip, learned about Dahlberg' s research and gained many ideas, especially in palliative care. After visiting palliative care units in Sweden and Scotland and comparing their characteristics, she discusses lifeworld-led-care from the perspective of palliative care.

The abovementioned contributions complement Dahlberg' s article and demonstrate original Nordic caring development from perspectives of welfare and palliative care. What Dahlberg calls 'open attitude' as an antithesis against 'method' means reciprocation between top-down and bottom-up. It also means a 'dynamic relationship' between 'Things themselves' and 'method' (Sakakibara, 2009). Nordic caring studies need such reciprocation so the cited articles complement each other.

The common basis of Nordic caring that surfaces from Dahlberg' s lifeworld-led-care, Takenouchi' s welfare care and Saito' s palliative care seems to be 'caring-at-home' . Of course, at home care is not restricted to Nordic countries and is also seen also in other Western countries and Japan. Although various countries practice forms of at home care, it underpins Nordic caring; thus, focusing on it is perhaps the most important lesson from Nordic caring. In the next and last section, I consider the Japanese situation.

Caring 'At Home' in Japan Through Nordic Caring

In Japan, the situation concerning medicine and caring at home has changed over

several years. In 2006, the system of 'clinics supporting home care' was introduced to facilitate the elderly's living at home and in a familiar community while receiving care. Importantly, they can choose to live their final moments at home surrounded by familiar people. This, however, requires a system that makes medical staff available for house calls 24 hours a day, 365 days a year, as per necessity. Without a networking team, a single-doctor clinic cannot implement such care. Such a system also needs the cooperation of visiting nurses, care managers, a centre of supporting regional care and hospitals that could accept patients if necessary.

According to the working paper of the Japan Medical Association Research Institute, 'Current status and issues of clinics supporting home care' (2011), the number of 'clinics supporting home care' has reached 18,052 facilities across Japan, but a bias exists among regions and medical fees. The paper reported that entry into home care remains small, that for clinics supporting home care and clinics not in the system but providing home care, maintaining the motivation to continue is difficult. Furthermore, it reported that 20 percent of clinics cannot ensure cooperative medical facilities and beds to implement the system 24 hours a day.

Considering all of the above, the project 'Home medicine and caring 2011' (MHLW, 2012) has begun, in which the 'promotion of home medicine and care' is declared and the 'regional comprehensive care system' is conceived. This includes 'strengthening cooperation of medicine and caring in areas of everyday life', 'enrichment of caring service', 'promotion of prevention', 'ensuring various services supporting life', 'consolidation of houses for the elderly that are barrier free, enabling them to live there into advanced age'. Further, as 'a promoting project of home medicine and caring', the project declares, 'cultivation of human resources carrying team of home medicine and caring', 'consolidation of basis as implementation sites', 'enrichment of service according to each disease' and the budget for this fiscal year is recorded.

Although this project does not seem inadequate, because of limitations on medical bills

and the economic situation of hospitals, affected by revised medical fees depending on the length of a patient's stay, the elderly must often be discharged. In other words, the elderly living alone are compelled to return home because another accepting hospital cannot be found and because of a shortage of public facilities. This causes great anxiety among patients. Although the system of home medicine and caring is not sufficiently prepared, the governmental limitation on medical bills means that patients who cannot provide for themselves must leave hospitals. Several years ago, many patients hoped to 'die at home', not 'die in hospital', even if it was difficult to accomplish. Patients cannot 'die in hospital' anymore because national policy restricts medical bills. Thus, patients are compelled to 'die at home', but without professional preparation for 'home care'.

But how is it beneficial for Japan to learn from Sweden about advanced home medicine and caring as well as lifeworld-led-care? According to me, Japan's national policy includes many irrelevancies in procedure and deals with immediate issues, in many cases without a fundamental philosophy. Considering Japan's future, a transition to home medicine and caring should be made; this is what the citizens hoped for. The system and current status (fieldwork and practice) do not sufficiently support it, but the current national consciousness, view of life and death and philosophy supporting home care cannot alleviate the situation. However, lifeworld-led-care, which supports medicine, nursing, caring and welfare, could make accessible the cared-for person's world and support their end-of-life-care.

As stated at the beginning of this article, our research on Nordic caring has only reached its third year. We are newcomers among the many researchers interested in the caring and welfare of Nordic countries. However, as mentioned earlier, although many researchers on the welfare system and caring studies have visited Nordic countries, it is not enough to clarify their system's theoretical grounds and philosophical backgrounds. The theoretical foundation of caring in a wider sense, including medicine, nursing, caring and welfare for our super-aged society is urgently needed, and our research is expected to greatly contribute to it.

Conclusion

After the gigantic earthquake in eastern Japan and the catastrophic Fukushima nuclear power plant accident, people have become intensely interested in social security issues and the tax system on the one hand, and in issues of anti-nuclear power and natural energy on the other. This situation could be termed an issue of society and environment sustainability for future generations. Compared to Japan, Sweden has promoted the vision of a 'green welfare state' since 1996. Issues of sustainability of the social and environmental systems are not discrete, but intertwined, with a common basis—the concept of caring not only in human relationships but also in the relationships between human beings and nature.

Incidentally, the Swedish Embassy in Japan regularly publishes a periodical called *Caring* to introduce Sweden to the Japanese people. This highlights the importance Swedish people place on caring, even at the price of a high tax burden. But without understanding the philosophy of care or caring in human activities, Japan cannot understand the Swedish emphasis on caring that it should consider adopting.

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Notes

- 1 This is an English translation of my Japanese article published in: *The Japanese Journal of Nursing Research*, Vol.45, No.05, 2012 Aug–Sep., Special Feature: Nordic Caring for Nursing Research, pp.428-438