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The Components of Attentiveness in Oncology Care

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Abstract

This article presents the first findings of a qualitative empirical study of caregivers' attentiveness in hospital oncology care. It takes a care ethical perspective, in which attentiveness is considered an indispensable element of good care. The data are derived from participant observation at the oncology department of a general hospital in the Netherlands. The analysis shows a descriptive exploratory model of attentiveness, which comprises a coherent set of the clusters perception (A), object finding (B), and space for attentiveness (C). The methodological output of this article is an important one: the presented descriptive model of attentiveness promotes further research into the characteristics and functioning of attentiveness in care. It is a fundamental step towards a grounded theory, as it enables a comparison of different cases prior to thematic analyses. The substantive outcomes of the study offer caregivers a tool for understanding and analyzing care practices from the perspective of attentiveness.

Keywords

Attentiveness, Attention, Ethics of Care, Oncology, Grounded Theory, Hospital, Empirical Ethics

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The Components of Attentiveness in Oncology Care

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This article presents the first findings of a qualitative empirical study of caregivers' attentiveness in hospital oncology care. It takes a care ethical perspective, in which attentiveness is considered an indispensable element of good care. The data are derived from participant observation at the oncology department of a general hospital in the Netherlands. The analysis shows a descriptive exploratory model of attentiveness, which comprises a coherent set of the clusters perception (A), object finding (B), and space for attentiveness (C). The methodological output of this article is an important one: the presented descriptive model of attentiveness promotes further research into the characteristics and functioning of attentiveness in care. It is a fundamental step towards a grounded theory, as it enables a comparison of different cases prior to thematic analyses. The substantive outcomes of the study offer caregivers a tool for understanding and analyzing care practices from the perspective of attentiveness. Keywords: Attentiveness, Attention, Ethics of Care, Oncology, Grounded Theory, Hospital, Empirical Ethics

From a care ethical perspective care and attentiveness are internally connected. To promote good care, it is therefore essential to understand more of the hitherto poorly defined and little studied phenomenon of attention as an ethically relevant concept. Different authors have elaborated on the relationship between attentiveness and care (Conradi, 2001; Engster, 2005; Tronto, 2013), of which Tronto's analysis was the most influential. She distinguishes five phases of care, which are conceptually separate, but interconnected in practice. According to her, the first phase is *caring about*, which she links to the ethical element of attentiveness. *Caring about* implies that care is necessary. It means identifying a certain need and establishing that this need should be met. This will often involve assuming the position of another person or group in order to recognize the need. Attentiveness is described by Tronto as the quality of individuals to open up to the needs of others. This view is important, but it is too narrow. We argue in favour of a broader view, in which attentiveness is not only a first instrumental step in care, but also the core element of care and, as such, essential for the following steps as well and even a good in itself (Klaver & Baart, 2011a). Research into the experiences of care receivers suggests that they identify good care with recognition: care receivers value being seen (Van Heijst, 2011; Vosman & Baart, 2011; Wilken, 2010). Attentiveness can make a caregiver see what is at stake for someone and how they might be supported. This means that attentiveness and care are interrelated: without attentiveness good care cannot exist (Conradi, 2001; Tronto, 2013). This applies to oncology care in particular, where patients' diseases are often multi-causal and incurable, and complex and/or chronic or terminal. However, in studies on attentiveness in (oncology) care, attentiveness is in general addressed primitively, by equating it with empathy, concentration or proper treatment. It is regarded a bonus on the side, something that adds friendliness, empathy or humaneness to care that should essentially be technically competent (Klaver & Baart, 2011b). Care ethical studies though, do show that attentiveness, as an indispensable ingredient of attuning to the other relationally, belongs to the

core business of health care (Vosman & Baart, 2011). Despite the crucial importance ascribed to it, however, care ethical literature does not show any empirical studies of attentiveness, which is the starting point for this study.

In order to be sensitive to the broad and complex workings of attentiveness in care, we have let ourselves be nourished by insights on attentiveness from philosophy and phenomenology, psychology, theology, spirituality, and literature and art theories (Klaver & Baart, 2011a). In this intradisciplinary view, in which the focus is care ethical (Klaver, Baart, & Van Elst, 2013), attentiveness can be understood as a social phenomenon that can exist between people. It is located at the intersection of attentiveness as a cognitive ability (Johnson & Proctor, 2004) and attentiveness is expressed as care or love (Conradi, 2001). Attentiveness can make the difference between an instrumental relationship between caregiver and receiver, and a relationship in which good care can be given. In the latter case, this can lead to what might be good for the patient and what the attentiveness should be focused on. In this relational perspective, attentiveness has two essential actors or actor groups: a giver (of attentiveness) and a receiver. Therefore, what is perceived as attentiveness by the caregiver may not always experienced like that by the patient (Tronto, 2013).

This article is based on a grounded theory study undertaken on a hospital oncology ward in the Netherlands. It describes how attentiveness appears in this particular care practice. In this article, we report the findings of this study by presenting a descriptive model of attentiveness. This descriptive model yields profit in two important ways. First, the model is constructed in order to enable constant comparison, which is a prerequisite for the intended grounded theory of attentiveness (Fram, 2013). This is an essential step in a grounded theory which is based on data from participant observation, but scholars do not often transparently elaborate on this intermediate step (Laitinen et al., 2014). Second, as the descriptive model on itself comprises the components of attentiveness, it provides caregivers with opportunities to analyze care situations from the perspective of attentiveness. It enables them to check which components of attentiveness are met in a particular situation and which are left out. The model thereby facilitates judgmental evaluations, without being judgmental itself, and contributes to ethical awareness and moral competence.

Both researchers have a background in social sciences and are skilled qualitative researchers. Besides, the researcher who collected the data has an education and work experience as a caregiver. However, beforehand she was unknown with the particular research setting, and therefore more "outsider" than "insider" (Bonner & Tolhurst, 2003; Corbin Dwyer & Buckle, 2009). The study arose from their affinity with and interest in the ethical aspects of (professional) care. They share the mission to get grip on the often implicit things that make care good care, with the ultimate goal of making healthcare more humane. The first author is a young scholar who was introduced into the care ethical perspective some years ago. The second author, her supervisor, has been working in this field for a long time and has published earlier on the importance and meaning of attentiveness.

Methods

Data Collection

Data were collected through participant observation with incidental conversational interviews. Participant observation was chosen because attentiveness is largely pre-reflexive and embodied. The main question of this study is not what the participants understand by attentiveness or how they voice this explicitly; it rather seeks to understand how attentiveness is acted out all the time and occurs in the experiences of those involved (Charmaz, 2006; Corbin & Strauss, 2015).

The study was performed in a general hospital in the Netherlands and was approved by the Institutional Review Board of the hospital. Participant observation was carried out on three divisions of the oncology department: the nursing ward, the outpatient basis, and the polyclinic. Participants were recruited through 'snowball sampling' (Green & Thorogood 2004). They were doctors and nurses. No distinction was made between differences in education and experience. The position as a researcher was made known to the participants under study. The focus of observation was on interactions in context between caregivers and patients, but the wider activities including meetings, peer consultations, and lunch breaks were also observed in order to gain an insight into the social and organizational structure of care. All handwritten observations were transcribed verbatim immediately. The researcher each time was a (half) day at one department and usually followed one caregiver at a time. This means that the researcher took on a white nurses' or doctors' coat and thereby took on the role of the doctor or nurse. This way, the researcher was not only able to observe what was visible, but also what was heard, felt, tasted, or smelled. Throughout the participant observation, the researcher asked questions to clarify what had been observed.

Data Analysis

The ultimate aim of this study is to formulate a theoretical model that explains how attentiveness works as it evolves from the empirical data. The study takes a grounded theory approach (Glaser & Strauss, 1967) as this method leads to the development of a theory. On the way towards understanding attentiveness in hospital care, theoretical concepts were developed during the research process, and there were no pre-formulated hypotheses. Throughout the analysis, the researchers wrote memos exploring their own perceptions, experiences, and existing knowledge, which were then constantly compared to other data. The researcher perspective is thus interwoven into the analysis. The two authors discussed every step of the analysis of the data in order to achieve peer validation.

The analysis of the data started with an immersion in the data - reading and re-reading the transcriptions, comparable to the heuristic approach according to Moustakas (1990). After this familiarization with the data as a whole, 22 units were selected. For the reason of exploration, this was done through diverse case selection to illuminate the full range of variation (Seawright & Gerring, 2008). The selection was also based on thick description (Ponterotto, 2006), or richness in terms of information (Creswell, 2003).

The first step of the analysis involved initial coding (Charmaz 2006). Essentially, each unit was read in search of the answer to the repeated question "What is this about? What is being referenced here?" We wrote interpretative case descriptions of the data. Then, we switched to focused coding (2006). For every case we answered the question: what is the problem to be solved and what is, or could have been, the significance or meaning of attentiveness here? In this stage, in which the comparison takes place within a small sample of cases, no uncommon or extreme cases were included (Seawright & Gerring, 2008). In order to enable a comparative analysis, the interpretative case descriptions were examined for their common elements. A data matrix was made of the 22 cases containing the tagging of properties into 24 main categories. These categories covered every example in all its specificity, and included:

- What is the reason for the contact?
- How familiar are the caregiver and the patient to each other?
- How does the caregiver perceive the patient?
- What is this image based on?
- What is the caregiver's substantial object of attention?

- Is there any movement or does the object remain the same?
- How does the patient affect this?
- Which context factors play a role?
- What is the result for the patient?

Subsequently, relations between all categories were identified and a model of core concepts that describe attentiveness was made, tested, and refined step-by-step until all categories were adequately linked.

After that, the analysis involved theoretical processes of coding (Charmaz 2006). The common elements, or description categories, were summarized in a descriptive standard model of attentiveness. This can best be described as a process of trial and error. It is likened to "decorating a room; you try it, step back, move a few things, step back again, try a serious reorganization, and so on" (Abbott, 2004, as cited in Saldaña, 2009, p. 215). Analytic insights were tested against new ideas, the initial ordering of problems and concepts was refined, we compared it to other cases, and so on. We searched for categories that grasped the material, and refined or adjusted them until we found the best fit. We then inserted some new cases, apart from the first 22, and tested whether the descriptive model covered these adequately. This, again, was a search for the best fit: can we now describe attentiveness systematically, differentiated and according to a fixed but generally applicable standard? The final model could be standardized, as it allowed cases to be comparable. In this article we present this standard descriptive model of attentiveness. This is an essential step in constructing a grounded theory based on data from participant observation, but scholars do not often transparently elaborate on this intermediate step (Laitinen et al., 2014).

After this, but this falls outside the scope of this article, all cases were eventually described though this standard model. After that, analytical characteristics of being attentive were collected and clustered into patterns in a process of constant comparison. In the pattern-level analysis, respectively 16 types of attentiveness were identified. In any of these provisional types, a characteristic configuration of patterns was found. Those 16 types could be clustered further into 9 encompassing types, from which the main features were described and illustrated. These findings were presented in another article (Klaver & Baart, in press).

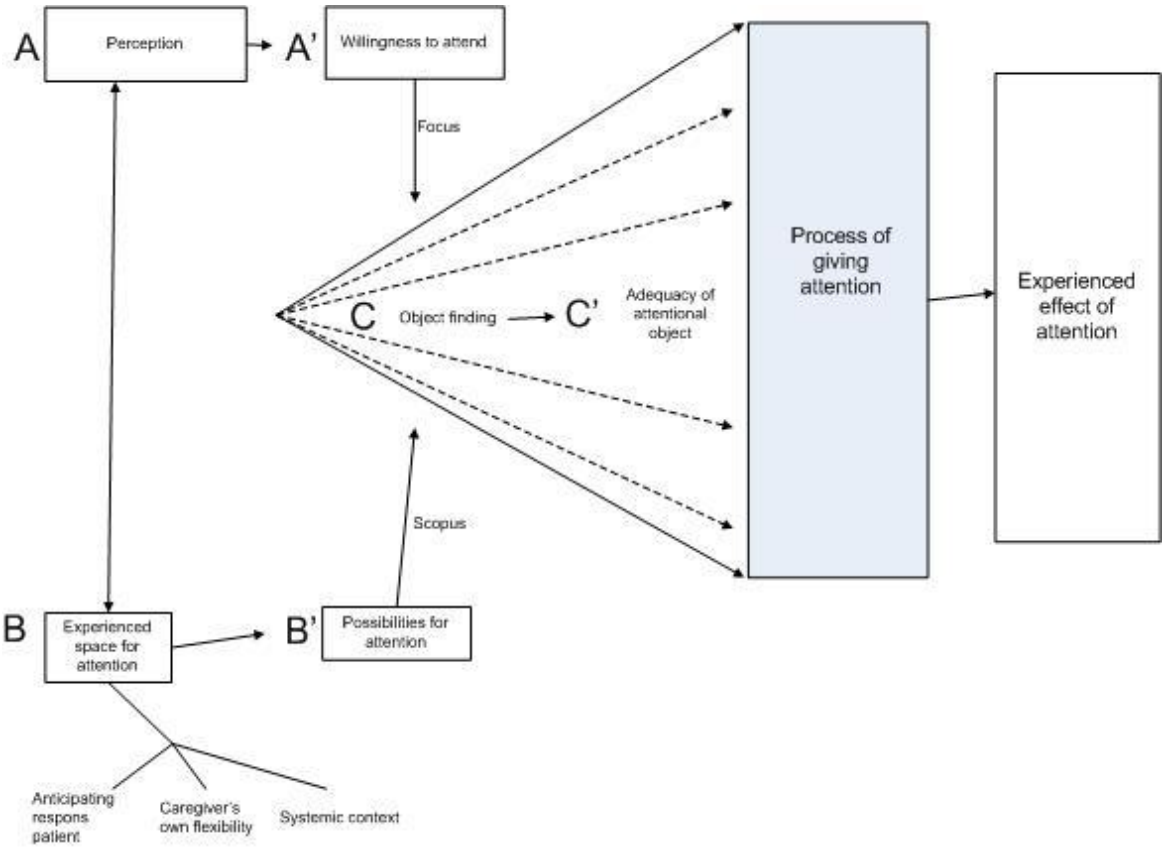
Methodological Discussion

As announced earlier, this article shows a stage in the development of the grounded theory, which we have called a descriptive exploratory model. Why does this study present such a descriptive model, while many other studies using a grounded theory approach, skip this step? This is because the object of this study is *attentiveness*, although we still do not know what attentiveness is exactly. Actually, this is precisely one of the research questions. The data collection took place without the existence of a fixed idea or definition of attentiveness, which is in line with the grounded theory approach. The researcher worked on the basis of sensitizing concepts for what attentiveness might mean (Anfara & Mertz, 2006; Bowen, 2006). The concept is deliberately kept broad and vague. While we assume the collected cases were about attentiveness, in order to allow for the comparison of the separate cases we must now first ensure that there is an agreement on the precise object and on the (working) definition of attention. Therefore, we have developed this model: a standardized descriptive model with which each observed situation that presumably has something to do with attentiveness, can be described based on the same categories. This way the case descriptions become comparable to each other, allowing for similarities and differences to emerge and patterns to be detected.

Results

The analysis of the data shows that attentiveness can be understood as a coherent set of various categories which can be categorized into the following interacting core concepts: perception, experienced space for attentiveness, and object finding. The negotiation of these concepts gives rise to a process of attentiveness, ending in the outcome of attentiveness experienced by the patient. See also Figure 1. In this article, we focus on the components of attentiveness, i.e., the part that is about being attentive.

Figure 1. Coherent Set of Clusters: Descriptive Model of Attentiveness



Perception (A) covers the caregiver's perception of the patient. It contains both perceiving *facts* (i.e., the cognitive processing and interpretation of what someone says, means and thinks, and perceiving *emotions*). This leads to a certain willingness to attend (A'), implying a practical as well as an emotional and a moral willingness.

Experienced space for attentiveness (B) is about the struggle to be able to be attentive. It is firstly about anticipating to the patient, such as wondering how far one can go and what things should the caregiver stay away from. Secondly, it contains finding space in yourself, meaning asking questions like whether you are strong enough to do something. Thirdly, the experienced space depends on the systemic context or the institutional organization of the care containing issues like rules, protocols, professional expectations, collegiality, and so on. These factors culminate in possibilities for attentiveness (B).

The cluster "object finding" (C) is a central figure in the model. It is about finding an answer to the following question (although this often happens preconsciously): "What am I actually looking at?" "Do I understand what is demanded from me?" This finding of the object of attention leads to (a certain degree of) adequacy of the attentional object, adequate from the

patient's perspective (C'). Through, for example, processes of divergence it may occur that an object is determined that is inadequate, because the expectations of the patient and the actual attentiveness of the care provider differ. Now that we have distinguished these components of attentiveness, we can indicate several trajectories that seem to be crucial when it comes to the way patients experience attentiveness.

Perception

Forming a picture of the patient and what is at stake for him or her is done primarily on the basis of what the caregiver perceives. This is strongly influenced by the way patients express themselves. Some patients know exactly what they want and express this explicitly in the form of a clear request.

> Ms. E. has a thick left arm which is encased in a tight stocking. She calls the nurse to say she has such pain in the skin on her chest. Her left breast was amputated and the operation left a scar, the skin is very dry and tight. She feels that it may need some cream be rubbed on, but she cannot do this herself.

Others are very cumbersome in transferring what they would benefit from, or they do not even know that themselves.

> Chris is nearly 80 and his file says he functions at the level of a 3-year-old. Plaintive moans come from his room: Chris cries. The nurse enters his room, sees his teddy bear lying on the ground, picks it up and gives it to him. Then she says "Now it's good eh!" I think, yes? (Chris still cries). Then she asks: "Is that good? Are you ok?" But there is no response, Chris continues to cry. The nurse shrugs, looks at me questioningly, and then leaves the room.

Apparently, caregivers cannot always immediately see what is going on. There is more than just the direct perception. Since forms of interpretation are also part of the perception, we must not forget that the caregiver may draw from other sources when imaging what is at stake for a patient, such as his memory, expectations or beliefs.

> The nurse inspects the scar. The skin is tight and there are some small flakes on it. It looks like it could really use some cream. I give the bottle to the nurse and she rubs the skin. She does this without gloves. She asks if it hurts, but Mrs. E. says she has a high pain threshold. Ms. E. has a friendly face with wide cheekbones. Her head was bald but now, some thin soft hair is growing there again. She has trendy fifties style glasses. Her pajamas look expensive. She looks well cared for, despite being ill: blue eye shadow, pink lipstick. Her eyebrows have fallen out due to the chemo, but she has signed lines with a brown pencil. Sometimes she looks at me and gives me a friendly smile. I do not feel uncomfortable. I do not get the feeling that Mrs. E. finds it annoying that I am watching them. The nurse rubs with care, and gently massages it until all white cream has disappeared. I realize this rubbing is not just rubbing, but it is done with an eye for possible shame and pain. This is based on previous experiences with patients who had undergone a mastectomy, but also on their own experiences of being a woman, of needing care, of undressing in front of others, and so on.

The image of the patient may vary from a multifaceted picture to a simple sketch. In certain cases, the image does not reach beyond the medical image, making it impossible to bring about an attentiveness that includes the person. This is often very logical and understandable, for example when an emergency situation forces a caregiver to concentrate on fighting physical danger. More often though, the picture is expanded with details of different natures: the image may include personal characteristics of the patient, details about their emotions, about what their life is about, and so on. The occurring image is not static: it may narrow or widen depending on purpose and context. This is reflected in the way patients are discussed in doctors meetings:

> Mr. H. (64) is operated by the urologist. He has abscesses in the surgical area. He has a recto fistula and he pees pus. The urologist does not want to come by on this oncology ward, says the physician assistant.
>
> Physician1: "We are really just doing post-operative care for the surgeon which is nasty..."
>
> Physician2: "I suddenly remember that I had his brother as a patient a few years ago. His brother had the same disease..." [He gives his colleague a questioning look]
>
> Physician1: "Could be..."
>
> Physician2: "His brother passed away here in the hospital that time, or no, no, he just got home, I believe. So that family is now going through exactly the same misery as then..."

It also matters to what extent the image is specific to this patient. In some cases, it seems that the caregiver's image of the patient is mainly based on his general knowledge about people, or patients, or cancer patients, more specifically. Sometimes, the attentiveness is influenced by the caregiver's personal opinion on the patient, finding them sympathetic, for example.

> On a deeper level of explanation and understanding we see a specialist who does her very best. This is noticed by the way she approaches the patient and her partner, how she acts, what she does first and what later, attention to detail, and so on. Presumably, her commitment is also so great because she likes this couple. Not only do they share the same sense of humor and type of appearance (e.g., haircut, clothing, diction, or hobbies) but the doctor and the couple also are fully fledged partners. They have even worked in healthcare. There is a large degree of reciprocity: the patients are attentive and helpful to the specialist and the other way around.

Evidently, the caregiver's imaging of the patient influences the occurring attentiveness, as it leads to a certain willingness to attend. However, it is not only about this image and willingness; attentiveness also depends on other circumstances. The influence of these circumstances is discussed in the next section.

Experienced Space for Attentiveness

The research data show that the space for attentiveness experienced by the caregiver is constrained by at least three sources: the patient, the caregiver himself and the systemic context. These forms of space definition will now be discussed.

Firstly, it is not always true that patients benefit from caregivers attending to what is at stake for them. In many cases, the attention had better focus on a just part of what matters, rather than to all of it, and sometimes even better on something else. The simplest example is when a medically acute situation occurs: whatever the patient may go through at that moment (e.g., agony), the caregiver should only focus on fighting the disease or any other physical danger. Other things that might possibly be better to ignore are, for instance, a patient's personal issues that they don't want to be addressed by the caregiver.

The second factor defining the space for attentiveness is the flexibility of the caregiver himself. Sometimes attentiveness requires caregivers to cross their own boundaries. It takes courage to really face someone who feels miserable, and not to close your eyes, or stop feeling. A caregiver may start feeling insecure because he thinks that an appropriate response is expected of him, while he has no experience with such major issues.

> Mrs. R. must unexpectedly undergo a rectal examination. She is quite overwhelmed, as she likes to keep control. When the investigation is finished, (the doctor says he has found nothing strange) Mrs. R. says "I'll tell you one thing: giving birth is easier than this!" "Really?? Was it that bad?", the doctor cries out surprised. "Terrible", Mrs. R. replies. The doctor leaves the room. He is in shock: Mrs. R. has told him this now and he hadn't noticed it. He looks startled.

It also occurs that they don't want to be confronted with the misery of a patient, because it reminds them too much of sad things that they experienced themselves. Furthermore, it is frequently required to oppose a colleague or a superior in the interest of the patient, while the caregiver doesn't actually have the courage to do this.

> Along with the nurse I walk over to Mr. B. He has suddenly broken his arm this morning and has many questions about how to move, what to pay attention to, whether he should stay in bed, etc. The nurse stresses that this could have happened at any time, because he is so fragile, it can hardly be avoided (later she tells me: there is probably another tumor in his arm). Then the physician-assistant enters the room; she has seen the X-ray. The arm is broken indeed, and now the surgeon must decide what the best option is. The doctor says that she had already called the surgeon, but she was told that it is "not desirable" for an assistant to do so. She must now wait until she can discuss it with the oncologist, so that he can discuss with surgery. Meanwhile, Mr. B. and his family are in uncertainty.

Emotions may also be impeded when a caregiver dislikes a patient. Being attentive for caregivers often means discovering their personal limits.

The systemic context also affects the experience of space for attention. Caregivers are not "free" to focus their attention on whatever occurs. Attention is always given from a certain position and in a certain context. A doctor and a nurse have similar points of attention, but they may also look at very different things in the same situation. The appearance of attentiveness in health care is related to the structural context in which the care is given. The profession of the

caregiver, the organization of the department, and various protocols and rules expect certain things of caregivers.

Object Finding

The interaction between perception and experienced space for attentiveness defines the space in which the attention can be focused. The caregiver has an idea of what is at stake for the patient and he feels a certain space to attend to this. This finding of the object of attention leads to a certain degree of adequacy of the attentional object from the perspective of the patient. Through processes of divergence it may happen that an object is determined that is inadequate from the perspective of the patient, because the expectations of the patient and the actual attention of the care provider differ. This difference arise when a caregiver focuses on the medical image while denying the lived experience of the patient.

> Mrs. J. is a patient who feels ill but "objectively, she is doing fine", the doctors say. She lies in bed. On her lips are dark crusts. SO1 gives her a hand. He begins by summarizing the situation: all results are good, catheter was taken out yesterday.
> Pt: "I am short of breath, doctor."
> SO1: "Yes, the body has had a lot to suffer!"
> Pt: "The pain doesn't get less."
> SO1: "Yes ... yes ... but your body needs time to recover, you know, it takes up to six weeks before you're all over it."
> Pt: "No, two weeks, right ??"
> SO1: "Six." [pause] "So, how are you doing further?"
> Pt: "Well, if the results are good it will be good, but it is still hard, doctor."
> SO1: "You will feel better soon."
> Pt: "Okay, doctor"
> SO1: "Okay. Yes. Then we'll try it this way. Yes. Good. Goodbye, Mrs. Jansen!"
> [He shakes her hand. The assistant does as well. Mrs. Jansen jumps at feeling his cold hand. They all laugh.]

It may also consist of the difference between the focus on a device versus a living person, or on a small aspect versus the bigger picture. This seems to suggest that the patient's experience is only positive when there is convergence regarding the attentional object, or, in other words, when the caregiver's attention is focused on the same object as the patient's. But this is not always true. In some cases, a caregiver focusing on a different object can be more beneficial to a patient.

> This patient has a cervical carcinoma and chemotherapy is given in combination with radiotherapy. The oncologist visits her at the policlinic where she undergoes the chemotherapy. She tells him her whole *underside* is scorched by the radiation treatment; her whole is open and damaged. Soon they will also start internal radiotherapy, which will make it even worse. She uses a cream from the drugstore and has lots of pain urinating. The doctor prescribes an anesthetic cream. He also says "drinking a lot, that's the only thing that helps!", but that is a huge mistake because the woman should instead drink as little as possible because of comorbid heart failure. The woman also indicates having an infection in her armpit. The doctor looks at it: it is a large reddish brown spot

> with a gauze pad completely drenched in pus. When he touches it the lady cries out in pain. The oncologist will ask someone from surgery to look at it: "You should not let me do this, I can't", he tells her.

The finding of an object is not a static, single event but rather an ongoing, dynamic process. Once the space for attentiveness has been identified and settled, signs occurring outside this area are usually not perceived. However, within the predefined space, new signs can occur that may be noticed and focused on. Caregivers often seem to look slightly next to their original focus and sometimes we will find them focusing on a completely different object after a while. As described earlier, these objects are no fixed things, but interpretations thereof. Arvidson (2006) makes a distinction between attentional capture and contextual capture. In attentional capture, a theme, such as hearing your name aloud, causes you to turn around to attend to this new theme. In contextual capture, one context is replaced by another that sees, for example, the patient as a full person. Or, in a lesser attentional transformation, the context is elucidated in a way that brings out, for example, the humanity of the patient. In the case of elucidation, what is unclear gets clarified, what is also relevant but obscured becomes more apparent as contextual. For example, that healing a person involves a person and not just a mechanical thing to fix. The process of object finding can be understood as a learning process, characterized by motion, dynamics and flexibility.

Discussion

In this article we aimed to explore how attentiveness appears in hospital care. This is the first empirical study departing from a care ethical perspective and using a broad, intradisciplinary conceptualization of attentiveness. Our analysis identified a coherent set of various aspects which can be categorized into the following interacting clusters: (A) perception, (B) experienced space for attentiveness, and (C) object finding.

Perception is understood as the process of forming a picture of the patient and what is at stake for him or her and we have shown the variations when it comes to these images. Many phenomenological studies have shown that perception is related to attentiveness (Arvidson, 2013; Steinbock, 2004; Waldenfels, 2010). The issue of interpretation and understanding is often described when it comes to the diagnostic work of doctors and nurses (Evans, 2012; Malterud, 2001). The current study adds to these insights that similar mechanisms play a role when it comes to attentiveness wider than the clinical gaze or the intention to diagnose. Specifically, the findings show that a caregiver's personal expectations, beliefs, and opinions on the patient influence the attentiveness that will be experienced by the patient. This is in line with findings in spiritual care, where the "personal factor" is decisive for the quality of care (Leeuwen, Tiesinga, Post, & Jochemsen, 2006). This finding is important especially given that many forms of medical and care education try to leave out of consideration the personal influence of the specific caregiver as much as possible, because it is considered to be an inhibition of good care, rather than a constitutive condition of it, (Crehan, 2002; Evans & McNaughton, 2010; May & Alnst, 2006). Besides, the majority of criteria on quality of care are not about *good* care, but about *accountable* care (Epstein et al., 2014; McClellan et al., 2010), which inherently displaces the personality of the specific caregiver to the background. This study underlines the importance of integrating the person of the caregiver into thinking about quality of care, as the findings show that the attentiveness of caregivers is influenced by their own personal emotions, beliefs and opinions. This also confirms that, for a thorough understanding of attentiveness in care practices, it is not sufficient to turn to the neuropsychological models of attention (Petersen & Posner, 2012; Posner, 2012). These models were not developed on the basis of research into care practices anyway, and they are

often used to assess an individual's ability to perform an attentional shift and, as such, may be relevant. However, although a caregiver's attentiveness to patients to a certain degree may be dependent on this ability, it fails to grasp the actual working of attentiveness in care. This is because a caregiver may score very high on attention in this model and still be completely inattentive to a particular patient. The neuropsychological models of attention don't take the moral aspects of attention into account either. In the broad understanding of attention that is used in our study, attention has morally relevant moments such as responding to a tacit appeal or not, recognizing an unarticulated desire or not. As attentiveness is the core of care and all care is morally loaded, attentiveness has a share in that moral venture. Arvidson (2006) uses the work of Buber when explaining what happens when attention becomes focused on some*one* rather than some*thing*. He calls this "moral attention," by which he means that another person has some special relevance to the subject. This does not only mean that it has a practical or emotional relevance, in the sense that someone, for example, uses someone else, or appreciates or pities them; in moral attention, the relevance between the theme, or object, of the attention and the context must be such that the other (i.e., the patient) becomes the object within the context of the ongoing attentive life of the subject (i.e., the caregiver). This is what we mean when we say that another person matters to you: You are directly relevant to me. This "compassion" - literally "standing together" - is a special principle of relevance for attention (Arvidson, 2006).

The results also show that caregivers often find they must cross their personal boundaries in order to give good care. This also comes to the fore in research on emotional labour (Larson & Yao, 2005). The systemic context is another factor constraining caregivers' attentiveness. The profession of the caregiver, the organization of the department, and various protocols and rules expect certain things are expected from caregivers and that they are not "free" to be attentive to whatever occurs. The constant negotiation between what seems ethically good and the space there is to act accordingly, is consistent with the literature on moral distress (Gallagher, 2010; Gutierrez, 2005), which occurs when caregivers cannot do what they think is right.

Furthermore, the methodological output of this article is important. The presented descriptive model of attentiveness enables further research into the characteristics and functioning of attentiveness in care. It is a fundamental step towards a grounded theory as it enables comparison of different cases, which precedes thematic analyses. In addition, the article contributes to the describability of attentiveness in terms that are relevant for the ethics of care. This study provides an insight into caregivers' attentiveness in hospital oncology care.

Nonetheless, there is a limitation that needs to be discussed. Although qualitative methods score high on internal validity and in general accurately document the phenomenon studied (Pope, Van Royen, & Baker, 2002; Starks & Brown Trinidad, 2007), there is one important limitation, which refers to generalizability. The data collection was limited to one oncology department that is located in a general hospital in the Netherlands. Oncology is a specific department, at which caregivers generally seem to be more attentive to patients' experiences than e.g., at orthopedic departments. We suggest that certain patterns are tenable to other departments and other countries, but that some other mechanisms would change. This, however, is an issue for future research.

The current study has first and foremost relevance for oncology care practice, as the disclosure of attentiveness and its components provides caregivers with opportunities to understand and analyze care practices from the perspective of attentiveness. This enables them to check which components of attentiveness are met in a particular situation and which are left out. The model thereby facilitates judgmental evaluations - without being judgmental itself - and thereby contributes to their ethical awareness and moral competence (Jormsri, Kunaviktikul, Ketefian, & Chaowalit, 2005; Reynolds, 2008; Tronto, 1993; Winston, 2012). It

may also help oncology caregivers to express empathy and to build rapport within the tight time constraints of a hospital.

The findings presented in this study underline the importance of looking at attentiveness when it comes to the evaluation of quality of care. There is a lack of indicators and criteria that enable a sharp picture of the caring side of health provision (Council for Public Health and Healthcare, 2006; Lepnurm, Dobson, Voigts, Lissel, & Stamler, 2012; Watson, 2009). Such indicators often remain hidden in contemporary approaches to quality of care, but nevertheless, they seem to be highly relevant from the perspective of patients. Gaining an insight into the components of attentiveness may reduce this problem.

The exploratory, descriptive model that emerged from the initial data matrix has proved successful. We recommend the use of this model to study attentiveness in care because it ensures the relevant information from the data material is revealed. The model enables the comparison of different practical cases about attentiveness. More research on this topic is necessary in which both the amount of data examples should be expanded and further analytic steps should be taken to uncover the various aspects and trajectories within the components of attentiveness, in order to develop a grounded theory. The current study provides the building blocks for such a follow-up. Additionally, attentiveness in this conceptualization has important ethical implications. In this article, a first descriptive analysis of the data material is presented which touches on these moral aspects of attentiveness. In order to fully understand the ethical sides of attentiveness this should be followed up by a thorough (care-)ethical analysis.

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