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Presence in Nursing Practice: A Critical Hermeneutic Analysis

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PRESENCE IN NURSING PRACTICE:
A CRITICAL HERMENEUTIC ANALYSIS

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Dissertation Abstract

Presence in Nursing Practice; A critical hermeneutic analysis

Research Topic

Presence, although it involves action at times, is a humanitarian quality of relating that is ethically generated and has real-world implications for both patient and nurse. It is an interpersonal process characterized by sensitivity, holism, intimacy, vulnerability, and adaptation to unique circumstances that results in enhanced mental wellbeing for nurses and patients, and improved physical wellbeing for patients. Knowing and *being with* are foundational to being present.

Theory and Protocol

This research is grounded in critical hermeneutics and follows an interpretive approach to field research and data analysis (Herda 1999). This orientation places the researcher and participants in a collaborative relationship that exemplifies the power of conversation and the importance of language to unveil new understandings about our world.

Research Categories

Three critical hermeneutic concepts, drawn from the work of Paul Ricoeur and Hans-Georg Gadamer, provided the categories for this research. The concepts were narrative identity, play, and solicitude. These categories served as the boundaries for both data collection and analysis: Narrative identity informs the nurse about herself, the patient, and provides context for the development of possibilities. Play describes the nature of the interaction between nurse and patient. Solicitude describes the ethical foundation of the relationship that the nurse has with the patient and also with her or himself.

Findings

Being present with a patient requires the ability to be open to possibilities in the moment, along with a strong ethical commitment. The ability of a nurse to be present with a patient requires self-knowledge, knowledge of the process of healing, and the ability to fully engage in the shared experience with the patient. The ability to be present with a patient can be fostered through self-care practices, meditation, other healing practices, and the provision of an environment that is conducive to nursing presence

This dissertation, written under the direction of the candidates dissertation committee and approved by the members of the committee has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

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Dedication

This dissertation is dedicated to all those who are willing to slow down, dig deeper, and ask the larger questions.

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CHAPTER ONE: STATEMENT OF THE ISSUE

Introduction

A woman recently hospitalized for three months, following a myocardial infarction, recounted how she had been "practically in a coma" and unable to respond to her caregivers. She was, however, acutely aware of them and able to describe the difference between feeling cared for and respected and feeling as though she was being "treated like a piece of meat." She said that the nurses and a respiratory therapist who treated her with love and respect stood out in her mind. She could feel that they cared for her and believed in her and in her capacity to recover from her illness. Their presence, she said, drew her back into health.

What was the difference between the nurses who provided her with what she felt was real means for recovery and those who were simply performing technically correct actions? What is the nature of the interaction that takes place when the nurse enters the room and touches the patient's world? Technical expertise is certainly important, but expertise does not guarantee the application of that knowledge to the individual patient. What does it take for the nurse who walks through that door to be cognizant of the unique circumstances that exist within and around that interaction, and to bring to bear the best possible judgment? There is an important debate in the nursing literature (McMahon & Christopher 2011; Zyblock 2010) about how to understand, describe, and encourage the quality of presence that was so needed and so appreciated by the woman telling the story.

The state of being present with someone in need characterizes the practice of professional nursing. The caring presence of a human being has a profound effect on the healing process (Watson 1999:181). Presence is a complex concept that has not been well

delineated in the nursing literature but which, despite the lack of clarity, is a central concept for several nursing frameworks (Fingeld-Connet 2006:708). It is often linked with other concepts, such as caring, or with behaviors, such as listening and touch, which may obscure the understanding of the concept.

The purpose of this inquiry is to explore the lived experience of presence through critical hermeneutic fieldwork. Previous researchers have approached the issue by way of phenomenological or quantitative methods (McMahon & Christopher 2011; Fingeld-Connett 2000; Easter 2000; Osterman et al. 1996). Some of these researchers have described behaviors associated with presence. Others (Doona et al. 1997, Covington 2003) explore the lived experience of patients or nurses who experience presence within the nurse-patient relationship. Much of this work is reviewed in Chapter Two. Traditional qualitative and quantitative approaches to research view language as a tool with which information is communicated. The critical hermeneutic approach views language as "a medium through which we interpret and begin to change ourselves and our condition" (Herda 1999:22).

Presence is described as an inter-subjective and interpersonal experience that "changes the nurse as well as the patient" (Doona et al. 1997:6). To engage in such an experience is to make a moral decision and choose a course of action. Presence, although it involves action at times (Fingeld-Connet 2006, Doona et al. 1999), is a humanistic quality of relating (Smith 2001) that is ethically generated (Raholm 1999) and has real-world implications for both patient and nurse (Doona et al., 1999). Critical hermeneutics offers a way to explore presence in nursing practice in terms of its moral and practical significance for the participants and has not yet been done.

The research categories listed below provide the boundaries for this inquiry:

1. Narrative identity - Identity is explored, interpreted, and understood through the narratives that we share.

2. Solicitude - The exploration of the relationship between oneself and the unique, irreplaceable other, including issues of power and advocacy.

3. Play - A dynamic which draws people into the moment. There is a focus on the here and now. One puts aside distractions to participate fully.

These categories guided my conversations with professional nurses wherein we discussed their experiences with presence in their nursing practice.

Statement of the Issue

There is an art to healing (Dossey et al. 2005; Watson 1999). This could be called *phronesis* (Ricoeur 1992), or moral and practical wisdom. The act of supporting someone in the healing process is essentially an ethical and moral act (Markam 2008:115) that involves, among other things, being present with the patient. What it means to be present with a patient is not well understood, though, and seems to involve more than physical presence or technical skill. While many people would be able to identify an experience of presence it is difficult to describe.

The concept of presence is referred to in the Old Testament, and appears historically in religious writing such as that of Christian mystics (Smith 2001). Presence has appeared in nursing literature since the 1960's, but there are many aspects of it that have not been well addressed. It is often associated with healing or with an interpersonal connection that eases suffering and even lends meaning to it. While medicine, focused on finding cures, has made many advances in recent decades, people continue to suffer and to face illness, loss, and death. Nursing practice addresses the needs of the whole person across the lifespan, promoting health and wellbeing regardless of the situation and

attending to physical, emotional, educational, and spiritual needs. This means that nursing care is every bit as relevant when a person is facing imminent death as it is during the birthing process and at any other point. There may be nothing to do in a situation except to be present with the patient. The quality of that presence may make all the difference in the world to that patient. While knowledge, skills, actions and resources are important, nursing presence seems to refer to something that includes all these, but adds another dimension. It is a qualitative way of being and it changes the interaction in a significant way but does not lend itself to measurement.

While some fieldwork has been done on this topic (Osterman & Schwartz-Barcott 1996; Raholm & Lindholm 1999; Doona et al. 1999), it has primarily been done from an epistemological perspective. Positive outcomes associated with presence have been identified as having situational factors, but the topic has not been explored in an interpretive manner with an ontological grounding.

Background of the Issue

As early as 1856 instances of what might now be described as "presence" were documented when one of the nurses accompanying Florence Nightingale during the Crimean War wrote in her journal of being a witness to the suffering of her patients. Stories about what can qualify as presence have been published as case studies or narratives (Smith 2001:304).

Several prominent nurse theorists have incorporated the concept of presence into their work. Madeline Leninger (1981) lists presence as a term that is understood or valued differently across cultures. Patricia Benner (1984) counts presence as one of her eight competencies for nurses in their helping role. According to Smith (2001:311),

Rosemary Parse states that the goal of nursing care "is to move the patient toward a way of being in which he 'becomes', or co- creates (with nurse and family) rhythmical patterns of relating in open process with the universe." Most recently, Watson (1999) described the transpersonal caring moment as an ontological, transpersonal experience in her model of caritas nursing.

During the 1990's, several articles were published that described different degrees of presence and confused the boundaries of the concept. Gardener (1992) describes behaviors associated with presence, emphasizing that presence becomes manifest through understanding the patient. The literature increasingly seeks ways to document objectively this deeply inter-subjective experience (Smith 2001:312).

More recently, nurse researchers have worked to clarify the concept and call for field-work to ground the concept in the realities of practice (Fredrickson 1999; Smith 2001; Tavernier 2006). Positive patient outcomes related to experiences of presence have been documented. In light of the current emphasis on measurable outcomes, positive patient outcomes are seen as indicators that presence is a desirable capacity in nursing practice. The critical hermeneutic tradition offers a way to explore the ontological aspects of presence as well as the meaning of this capacity for relationship in nursing practice.

The understanding of presence also has important implications for nursing education. The goal of nursing education is to prepare students to practice in a safe, caring, and technically competent manner. Students are taught the knowledge, skills, attitudes and ethical principles that are felt to be essential to nursing practice. While these are relevant to the process of working with patients, technical information does not of itself prepare nurses to be present with people in painful situations. It may be possible to

explicitly prepare nursing students in a way that supports the development of their capacity to be present with patients. If so, this is an important insight for nurse educators.

Significance of the Issue

The experience of presence is positively associated with quality of care by the patient and family as well as increased job satisfaction by the nurse (Fingeld-Connet 2006:712). In particular, there are many times when cure is not possible and suffering cannot be relieved by technical interventions. During these times, as well as many others, the presence of a caring individual who has the capacity to be with the one who is suffering may make a significant difference for the one afflicted. A better understanding of the nature of presence, what conditions are conducive to it, and how to foster the ability of the nurse to be present with patients, would support the development of capacity for presence within nursing education. In addition, there is a great deal of pressure on the health care system, including nursing, to adapt to a faster paced environment, including spending even less time with patients and using telemedicine and other long distance approaches to communicating with patients and delivering nursing care (Fingeld-Connett 2006:713). This will potentially compromise the ability of the nurse to be present for a patient unless a better understanding of the significance of presence is developed and understood.

Summary

While presence is a familiar phenomenon with known positive associations, it is not well understood, and not well fostered. The concept has been in nursing literature for almost sixty years; however, it has not been explored through critical hermeneutic fieldwork. This inquiry explores the lived experience of presence with an eye toward the

nature and circumstances of it, as well as the cultivation of the ability to be present.

CHAPTER TWO: REVIEW OF LITERATURE

Introduction

This Chapter reviews literature relevant to the topic of presence in nursing. The first section discusses anthropological theory as it pertains to the exploration of health care and discourse within nursing practice. The second section reviews nursing literature on presence in nursing practice. The third section presents literature on the role of interpretive research in the expansion of nursing knowledge and in particular on the significance of critical hermeneutic theory for this area.

Anthropological Theory

The field of anthropology has changed significantly over time and has moved from an approach that valued objectivity to one that emphasizes what Geertz (1973) first described as "thick description" and interpretation (Bhasin 2007:2; Geertz 1973:268). The work of three anthropologists is briefly discussed to demonstrate this reorientation.

Claude Levi-Strauss (1908-2009) and wrote about the structural character of social phenomena (Levi-Strauss 1963). He discusses spatial, temporal, numerical, and other correlates of social structures. He explores the structure of kinship patterns and the role of ecology and economics in culture. His writing primarily focuses on relationships between phenomena rather than the phenomena themselves. For example, he explored the role of reciprocity between groups in the maintenance of social stability. He also described the structure and logic of myths.

Within a global context, he moved the academic conversation about racial differences away from one that assumed superiority of Western man over others by writing that the structure of "the savage mind" is not different from that of "the civilized

mind". Levi-Strauss rejected the idea that cultures naturally evolved in one direction from less complex to more complex. He documented that some South American cultures had indeed moved away from more complex social structures to less complex ones.

Most significantly, Levi-Strauss wrote about how change occurs in culture and how interactions with historical events and with other cultures shape change in a culture. He noticed that informants are not always objective about their own cultures, and that most people are not generally conscious of the rules of grammar or of social life until they are required to be. They are constrained in their understanding of their own situations by their language and culture (Levi-Strauss 1966). In the current state of migration, people from different backgrounds meet, exchange ideas and influence each other.

This is apparent in health care, as well as in other areas (Bhasin 2007). Concepts of health, illness and the healing process vary throughout different cultures (Levi-Strauss 1966; Bhasin 2007; Geertz 1973). As healers from various belief systems compare perspectives and observe the results of their efforts, they come to appreciate that there are a great variety of ways to approach health and healing, and their wisdom as healers may be deepened.

Clifford Geertz (1926 – 2006) first explored anthropology as an interpretive practice and described "thick description" as the appropriate task of the anthropologist. Geertz (1973:35) asserts that culture is foundational to the essence of human nature; "men unmodified by the customs of a particular place do not exist, have never existed, and most important, could not in the very nature of the case exist." Furthermore, he states, "A cultureless human being would probably turn out to be not an intrinsically

talented though unfulfilled ape, but a wholly mindless and consequently unworkable monstrosity" (Geertz 1973:68).

Geertz' thick description of Balinese culture calls into question the objectivity valued in Western medical research. He describes the phenomena of trance within the Balinese culture. This striking description portrays wildly unusual behavior that results in physical feats that would seem impossible under other circumstances. Geertz (1973:36) also describes the sense of wellbeing experienced by those who participate in this social and personal event:

> Consider Balinese trance. The Balinese fall into extreme dissociated states in which they perform all sorts of spectacular activities- biting off the heads of living chickens, stabbing themselves with daggers, throwing themselves wildly about, speaking with tongues, performing miraculous feats of equilibrium, mimicking sexual intercourse, eating feces and so on-rather more easily and much more suddenly than most of us fall asleep. Trance states are a crucial part of every ceremony. In some, fifty or sixty people might fall, one after the other ("like a string of firecrackers going off" as one observer puts it), emerging anywhere from five minutes to several hours later, totally unaware of what they have been doing and convinced, despite the amnesia, that they have had the most extraordinary and deeply satisfying experience that one can have. What does one learn about human nature from this sort of thing and from the thousand similarly peculiar things anthropologists discover, investigate and describe?

Geertz' description of Balinese trance is illustrative of differing norms and expectations across cultures which indicate effects on the functional physiology of human beings. This suggests, as does Veena Bhasin's (2007) work, that the relationship between the healer and the patient, along with the rituals and circumstances that accompany the relationship, can contribute significantly to the process of healing and the concomitant sense of wellbeing.

The field of medical anthropology explores how people from different cultures define health and illness, choose who to turn to for help, and what those to whom they turn do to support them in their efforts toward health (Bhasin 2007:3). Bhasin is an Indian Medical Anthropologist who does fieldwork in the Himalayas with the Ladakh people and with other people groups in Rajasthan. She has explored the relationship between religion and health, between the environment and health, and between social change and health. Bhasin explores in depth the implications of situations that she refers to as "medical pluralism" (Bhasin 2007:5-9), in which patients receive care from contrasting medical paradigms such as Western Medicine and Traditional Tibetan Medicine. She has observed that traditional medicine is particularly useful in dealing with problems that are not perceived by Western practitioners, such as demonic possession (Bhasin 2007:13). She also notes that religion plays a role in mental health, especially in terms of adjusting to change.

Bhasin (2007) described the role of community-based healers in contrast to Western style specialists and examined the difference in relationships between different healers and patients and how those relationships affect care. In her view, medical and ecological anthropology are inter-related (Bhasin 2007:3). Bhasin places the delivery of care firmly in the domain of culture. Investigation of nursing phenomena through an anthropological approach is appropriate and offers insight that complements other forms of research being done in this area.

Nursing Literature

This part of the literature review examines the history of the concept of presence in nursing practice, discusses what is known about the interpersonal, intrapersonal and

environmental influences that support the practice of presence, and discusses possible approaches to fostering the capacity of nurses to be present.

Background

Researchers agree that nursing presence is desirable in nursing practice because it benefits both the patient and the nurse (Doona et al., 1997; Fingeld-Connet 2008; Covington 2003; Welsh & Wellard 2005). Most significantly for the patient, presence has been identified as the foundation of nursing judgment (Doona et al. 1997; McMahon & Christopher 2011). These researchers claim that if nurses are to exercise good judgment, they must be fully present in the unique circumstances in which the judgment must be brought to bear. It follows that nurse educators should address presence within the context of nursing education, and administrators should encourage presence in nursing practice. There are many obstacles to being present with patients within nursing practice (Welsh & Wellard 2005; Godkin et al. 2002; Smith 2001). Within nursing education, the need to cultivate presence is clear, but the way to do so is not.

History of presence in nursing

Presence is described in the Old and New Testaments and is invariably associated with divinity (Smith 2001). In the Old Testament, presence is understood as a manifestation of divinity. For example:

> God, create in my a clean heart, renew me with a resolute spirit
> do not thrust me away from your presence,
> do not take away from me your spirit of holiness
> (Ps.51:10-11 New Jerusalem edition)

In this instance, there is a close connection between the presence of God as something from which one could be separated, and the spirit of holiness that one carries within.

In the New Testament, divinity manifests itself most notably through the person of Jesus in relation to stories of miraculous healing. Of this healing work, Jesus said, "It is the Father living in me that is doing this work" (John 14:10). This connection between the concept of presence and the act of healing provides a precedent for the practice of presence by nurses.

Historical references to presence in the context of health care have been identified from the Knights and Ladies of Malta, nursing orders during the Crusades, Homer's Odyssey, and Deborah's care of Rebekah in the Old Testament (Doona et al. 1997; Smith 2001). During the Middle Ages, hermits who practiced mysticism sought communion with the divine. Smith (2001) reports that the mystic known as Teresa de Avila distinguished visions from presence, which she associated with the presence of God, stating that presence leaves results. These results included leaving the soul light, moving it to tenderness, and experiencing an increase in love.

The concept was taken up and explored by existential and phenomenological philosophers, often in the context of care. Martin Heidegger used the term *Dasein* to refer to the human experience of being-in-the-world (Heidegger 1973). The concept of care, which he referred to as *Sorge*, is central to his understanding of the human being. Ricoeur (1992:314) explores the juxtaposition and interconnectedness of self and other and the nature of the relationship between them. Basing his question on Heidegger's concept of care, Ricoeur asks, "Must one make *presence* the fundamental nexus between being oneself and being in the world?" His answer affirms this relationship. Presence in this sense refers to the engagement that a person feels with the world around them and in particular refers to the people with whom one interacts.

Incidental references to nursing presence are in nursing literature written as early as Florence Nightingale's work. Mrs. Croke was a nurse who accompanied Nightingale to the Crimean War to care for wounded soldiers. She wrote in her diary about her experience of being present with a young soldier whom she cared for as he was suffering from wounds (Smith 2001). This description included a description of the feelings and concerns she had for this young man by whose situation she was deeply moved.

The concept of presence in nursing practice was first introduced into nursing literature in 1962, along with existential philosophy and phenomenology, through the writings of Sister Madeline Clemence Vaillot (Doona et al. 1997; Smith 2001; Fingeld-Connet 2008). Vaillot studied the philosophy of Gabriel Marcel and Martin Heidegger and applied it to nursing theory (Doona et al. 1997; Smith 2001). Vaillot (1966) describes instances when nurses are "immersed in the situation [becoming] part of it, having thrown their lot in with the work and with the patient" (Vaillot 1966:505). While she does not often use the word presence, Vaillot describes commitment as a characteristic of the professional nurse. She advocates combining this quality with what Peplau, an earlier theorist, described as therapeutic use of self. Smith (2001:307), however, differentiates between the practice of therapeutic use of self and the quality of commitment pointing out "while therapeutic use of self is a technique that can be learned, commitment is not a technique, nor can it be learned" (Smith 2001:307). Smith states that Ferlic (1968:30) quotes Marcel's definition of presence, "one who is capable of being with me with the whole of himself when I am in need." Ferlic goes on to state that presence, pertaining to nursing care, "implies closeness, perception, awareness, and involvement – not refusal to see or really be with the patient" (Ferlic1968:30).

During the 1980's and 1990's, presence was explored as a classifiable and potentially measurable phenomenon. The work of Osterman and Schwartz-Barcott (1996) and Easter (2000) are exercises in this direction. Their work continues to influence the literature. For instance, in a recently proposed mid-range theory of nursing presence, McMahon and Christopher (2011) view presence as action that can be administered in the same measured way as a medication (McMahon & Christopher 2011). This viewpoint stands in contrast with less recent writing, such as that of Doona et al. (1997), Fingeld-Connet (2006), Covington (2003), and Smith (2001) who understand presence as a humanistic process and emphasize that presence is a "way of being", rather than a series of actions (Doona et al.,1997; Fingeld-Connet, 2006; Covington, 2003; Smith, 2001). Doona et al. (1997:11) criticizes the effort to classify types or levels of presence as a weakening of the concept and object to the proposition that presence is a tool to be used strategically. Doona and colleagues value the humanistic and philosophical aspects of presence and object to the utilitarian and dehumanizing view of a nurse's self as a tool to be used.

There is still some debate about what is meant by presence. There is also debate about how to teach or foster it in students. However, it is widely accepted as necessary and beneficial for patients and nurses alike, thus efforts to understand and foster this quality in practice are ongoing.

Definitions and Descriptions

Various definitions and descriptions have been offered for presence. Doona et al. (1997:11) present a concept analysis in which they define nursing presence as "an intense and inter-subjective reality that changes the participants and has permanence." By way of

offering a contrast to the experience of nursing presence, they describe a case in which a patient died as a result of a lack of nursing presence.

Doona et al.(1999) present an analysis that demonstrates there is more to the phenomenon of nursing presence than information processing. Six aspects of nursing presence were identified: uniqueness, connecting with the patient's experience, going beyond the scientific data, knowing what will work, knowing when to act, and being with the patient. Unknowing, or being open to the experience of the moment, was identified as part of the process. Nursing presence is understood as a creative moment, with the nurse participating, not as an objective observer, but as a partner with the patient (Doona et al. 1999).

Fingeld-Connet (2006) finds that presence is foundational to nursing practice. It is an interpersonal process characterized by sensitivity, holism, intimacy, vulnerability, and adaptation to unique circumstances that results in enhanced mental wellbeing for nurses and patients, and improved physical wellbeing for patients. Attributes, antecedents, and consequences of presence are identified for both the nurse and the patient (Fingeld-Connet 2006).

Most recently, McMahon and Christopher (2011) propose a mid-range theory of nursing presence and address organizational and educational issues pertaining to presence. They describe presence as a relational skill. They express concern that nursing's relational work is at risk due to economic and time restraints, nursing shortages, increasing use of technology, agency expectations, and accreditation mandates (McMahon & Christopher 2011). In contrast with the findings of other researchers (Doona et al.1997; Fingeld-Connet 2006; Covington 2003; Smith, 2001) that presence is

a humanistic, interpersonal phenomenon, McMahon and Christopher (2011) propose a utilitarian approach to nursing presence, stating that presence can and should be used by the nurse to intervene in the patient's situation, and can be administered and regulated in a manner similar to medications. They stress intentionality, describing what they call a "nurse pause", where the nurse pauses to reflect on the appropriate physical, psychological, or therapeutic level of presence needed and then provide the appropriate dose. They use the word "dose" while discouraging the idea of levels of presence.

Presence and Caring

The concept of caring has often been used either interchangeably or in combination with the concept of presence, as in "caring presence"(Covington 2003; Fingeld-Connet 2008). This is true within the nursing literature, as well as within the work of Heidegger and Ricoeur. Covington (2003) describes four aspects of presence, and views presence as an independent characteristic of nursing practice. She describes presence as a model of interaction involving essential patterns and themes that lead to healing outcomes. Knowing and being with the patient are foundational to the process.

When presence is placed within the context of caring, the phenomenon is viewed somewhat differently. Covington (2003) suggests that the term "caring presence" merges the concepts into a construct that clarifies this elusive human experience. She defines caring presence as "an interpersonal, inter-subjective human experience of connection within the nurse – patient relationship that makes it safe for sharing with one another (Covington 2003:312)." Covington (2003) concludes that presence and caring are used interchangeably, but that they are separate concepts that have many of the same qualities.

Fingeld-Connet (2008) continues Covington's efforts to clarify the relationship between the concepts of presence and caring. Fingeld-Connet (2008) presents side-by-side concept analyses of both caring and presence. She finds that they share antecedents, attributes, and have outcomes in common. She states that the two concepts are essentially the same and may be used interchangeably. In contrast to Covington (2003), Fingeld-Connet (2008) recommends that they not be used together because the combination of terms does not add clarity to the conversation.

Another point of differentiation between Fingeld-Connet (2008) and Covington (2003) is that of the relationships between time, caring and presence. Covington (2003) reports that caring was found not to be bound by time, but that presence occurs "in the moment" (Covington 2003:312). Fingeld-Connet (2008) does not find a difference in temporal relationship, and does not specifically mention temporality at all except to note adequate time as conducive to the ability of a nurse to be present with a patient.

Controversies

The primary source of controversy in the discourse about nursing presence resides in whether presence is a technique or a quality. Easter (2000:374) concludes, "Using presence is not a skill that is currently taught in nursing education. It is a trait that takes many years to develop." If presence is a technique, then it follows that it can be taught; yet prominent theorists (Easter 2000; Fingeld-Connet 2008; Doona et al., 1999) state that it cannot be taught but that nurses develop the ability to be present as they mature. The controversy about whether it is possible to teach presence or if it is a trait that develops over time is ongoing.

Osterman and Schwartz-Barcott (1996) raise the important question of whether the experience of presence can have negative consequences. They propose a possibility for overwhelming the patient by the energy of the nurse, or the loss of boundaries. However, Fingeld-Connet (2008) responds to this concern, stating that this may be attributable to the nurse not being sensitive to the patient (not present enough with the patient) or not present to her/himself within the context of the relationship, causing a loss of healthy boundaries.

Most researchers describe presence as humanistic, interpersonal phenomena (Doona et al. 1997; Fingeld-Connet 2006; Covington 2003; Smith 2001). This lends itself to description, but is difficult to quantify. There have, however, been efforts to classify and measure nursing presence in terms of quantity or levels. Easter (2000) attempts to distinguish between ways of being present and describes four modes of presence. She views presence as a transactional clinical art that is used by the nurse and is associated with attributes, behaviors, patient outcomes, and consequences for the nurse as well as the patient. Osterman and Schwartz-Barcott (1996) posit that there are four levels of presence in nursing practice, ranging from physical presence, through partial presence, full presence and finally transcendent presence.

The effort to define and differentiate levels of presence may be a useful exercise, but may lack practical applicability. Most recent articles, with the exception of McMahon and Christopher (2011), have abandoned the effort to distinguish types or levels of nursing presence. Doona et al. (1999), state that, contrary to the claim of Osterman and Schwartz-Barcott (1996), nursing presence is an all-or-none phenomena; and that this is

not something that can be measured, but is known by the participants. Smith (2001) and Fingeld-Connet (2008) concur.

Challenges to Enacting Presence in Practice

Most of the research on nursing presence is focused on the nature of the phenomenon and the characteristics of nurses who provide it. Some researchers, though, are looking at the environmental challenges nurses face and how that influences their ability to be present for patients. It has been said that the modern health care system, with its emphasis on productivity and high patient throughput, poses challenges to the ability of the nurse to be present with any given patient (Welsh & Wellard 2005; Smith 2001; Godkin et al. 2002).

Welsh and Wellard (2005) report that nurses are increasingly pressured to focus on cost cutting, to support high patient throughput, and to document extensively to justify funding. The pressure on nurses to engage in supporting the system, rather than the patient, reduces nursing presence and results in negative consequences for the nurses such as medical conditions, guilt, shame, anger, impotence, depersonalization, and humiliation. Welsh and Wellard (2005) find that the costs of absenteeism and illness are not factored into the system level accounting.

Godkin et al. (2002) propose that nursing presence can be institutionally nourished and can positively contribute to institutional development, patient satisfaction, and increased profitability. They argue that patients are not able to readily discern whether nurses delivered technically proficient care, but can easily identify those nurses who exhibited caring behaviors, and that caring was a desirable quality from the point of view of the patient. The argument connects nursing presence with patient satisfaction,

and patient satisfaction with the financial success of the organization. Godkin et al. (2002) is published in a marketing journal and seeks to justify the financial cost of nursing presence. Godkin et al. (2002) make an effort to operationalize presence within an institutional context by using a "Nursing Presence Grid" (Doona et al. 1999) that describes the six dimensions of nursing presence. They claim that use of this grid would allow an organization to mark progress toward support for nursing presence in a measurable way.

Nursing practice is being changed by the increased use of technology and by telecommunications, in addition to financial pressures. Sandelowski (2002) explores the somatic character of nursing and points out that, heretofore, nursing presence has been characterized by physical presence. She suggests that this is now changing due to technological advances that provide sophisticated interfaces between nurses and patients at a distance. Nurses now interact with patients with whom they may never share physical proximity. While Sandelowski (2002) urges nurses to embrace technology in the interest of improving care for patients, she urges them to understand how technology changes relationships between nurses and patients, between nurses and doctors, and to ask, "What sort of presence is this?" (Sandelowski 2002:66).

Implications for nursing education

Nurse educators do not agree on how to prepare nurses to be present with and for patients despite the fact that the literature describes presence as desirable. Presence is described as both a way of being and also a set of behaviors. Researchers claim it is something that only a mature, highly skilled and committed nurse can engage in, yet

nurse educators are called upon to include it in undergraduate curriculum (Doona et al. 1999; Fingeld-Connet 2008; McMahon & Christopher 2011).

McMahon and Christopher (2011) and Godkin et al. (2002) describe the behaviors associated with presence and seek to promote and measure those behaviors so that they can be dispensed as one would dispense a drug. Four characteristics of nurses that use presence are described: professional maturity, moral maturity, relational skill maturity, and personal maturity (McMahon & Christopher 2011). The discussion of moral maturity related to presence is unique to McMahon and Christopher (2011). Raholm and Lindholm (1999) explore caritas ethics, the human relationship with suffering and the role of the nurse in the alleviation of suffering. They discuss nursing as an ethical practice, but do not address the idea of moral development of the nurse. Ironically, McMahon and Christopher (2011), while seeking to promote the teaching of nursing presence skills in a baccalaureate nursing program, also posit that only the mature nurse can enact presence in clinical situations.

On the other hand, Doona, Haggerty & Chase (1997 and 1999), Smith (2001), Fingeld-Connet (2006 and 2008), Raholm and Lindholm (1999) and particularly Bruce and Davies (2005) all point to a level of awareness on the part of the nurse that includes not only the patient's situation, but also the nurse's situation, as well as the environment in which the interaction takes place. A combination of skills and awareness of self, as well as awareness of the patient and the situation gives rise to the quality of nursing judgment reported by Doona, Haggerty and Chase (1999).

To prepare student nurses to practice presence, McMahon and Christopher (2011), support what they call "reflective activities", but these sorts of activities are

supposed to help the student deconstruct the complex process by which a nurse determines the dose of presence to be administered. There is no discussion of the internal experience of the nurse, either in terms of self-awareness or of ethical orientation.

There is a growing body of research on how the practice of mindfulness meditation influences patients and health care practitioners. Mindfulness meditation trains the mind and cultivates the ability of the individual to attend to the inner and outer experiences of the moment and the surroundings, including other people. Mindfulness meditation cultivates embodied awareness, and develops sensitivity to self and others (Bruce & Davies 2005). Bruce and Davies (2005) discuss the practice of mindfulness meditation in the context of hospice caregivers who practice mindfull end-of-life care. Mindfulness meditation also helps to cultivate an attitude of "un-knowing" (Bruce & Davies 2005) which has been identified as an antecedent to presence (Doona et al. 1999). It may offer nurse educators insight into the cultivation of the ability of nursing students to be present with patients.

Every description of nursing presence in each of the articles mentioned above involve an interaction with a conscious patient in which the patient is actively engaged. The emphasis on conscious participation on the part of the patient creates a question about whether a nurse can have presence with an unconscious patient. This is important because nursing judgment is particularly critical because presence is considered to be the basis of nursing judgment. This is even more relevant in the case of an unconscious or nonresponsive patient because these patients are in a particularly vulnerable state. Doona et al. (1999) emphasize the mutuality of the presence experience, but then conclude that, "Presence can only be known from within, in the tension of the moment because presence

proceeds from the source of the self immersed in and involved in its circumstances (Doona et al. 1997:7)." Nursing presence should be explored in the context of patients who are unable to consciously participate.

Nurse educators must ask themselves how nursing schools can provide an environment that fosters in their students the ability to be present. Mindfulness meditation, which developed from traditional Buddhist meditation, offers a technique whereby nurses cultivate awareness of and openness to a situation and the patient (Praissman 2008, Paulin et al. 2008, Baer 2003). More research is needed on this process and on other techniques to cultivate this ability.

The Interpretive Approach to Nursing Research

Flaming (2004), Hikari (1992), Charelambous (2010), Charelambous et al. (2008), and Thompson (1991) make the case for the role of critical hermeneutic research in nursing research and practice. Although nursing science requires a significant amount of technical knowledge and expertise, it is at heart a humanitarian service and a social science. The description of a human being often used within nursing literature is that of a biopsychosocial being. This paradigm emphasizes that humans are more than a biologically functioning unit, but include complex psychological processes and exist within a social context. Nursing practice defines the scope of nursing as focused on the individual, the family, the community or the population in question. While research has focused on the biological and psychological aspects of patients, the social interactions between nurses and patients and between individual patients and the network within which they reside have received less attention. There is a great need for deeply considered inquiry into the social issues in nursing practice.

While the epistemological approach informs us about the natural world that exists, an interpretive approach to nursing has the capacity to open new possibilities for nursing. As Herda (1999:19) offers, "The question of which state of affairs should be produced is not to be resolved scientifically. No ought can be derived from an is and no value can be derived from a fact." While strategies for achieving outcomes can be investigated scientifically, the process of choosing appropriate outcomes is guided by values and by the interpretation of the situation by those involved.

Herda (1999:22) proposes that, "The difference between a positivist approach and an interpretivist approach, most simply stated, is in how language is viewed- language as a tool representing the world or language as a medium through which we interpret and begin to change ourselves and our condition." Heidegger (1947:1) refers to language as "the house of being." Language mediates our understanding of both the personal life world and the shared world. Nursing can be viewed as a communicative practice (Hikari 1989:111). Ultimately, the experience of health is a deeply personal one that is experienced ontologically and interpreted in its significance within the lifeworld of the individual and of those close to him. As health care systems continue to adapt to the changing social environment, new possibilities must be carefully considered. The interpretive approach offers an opportunity to describe, refigure, and explore new approaches to the challenges in nursing practice.

Skott (2001) promotes an anthropological perspective on narrative with an understanding of the critical nature of language within nursing research and patient care. She contends that the tasks of nursing include examination of the links between the socially established explanatory model of biomedicine, the mediating institutions within

which health care takes place, and the individual's embodied experience of illness and nursing care.

Charelambous et al. (2008:637) states that hermeneutics "is recognized as an approach to health research which focuses on meaning and understanding in context." The authors review the work of Paul Ricoeur and discuss how it relates to nursing practice and nursing research. In particular, they describe hermeneutics as appropriate for the holistic nursing community because theory of interpretation avoids the Cartesian subject/object split and therefore makes it useful for the researcher seeking to explicate intersubjective knowledge (Charelambous et al. 2008:637).

Summary

A nurse goes through a personal process in order to be present with and for a patient. This is inter-subjective and interpersonal but is also is partially independent of the patient. Qualities of nurses with great presence include personal and professional maturity, self-knowledge, and professional competence, ethical orientation and inter- and intrapersonal competence. Nurses must release distractions and give themselves over to being in the world of their patients for the duration of their interactions. This ability results from an ethical position and may be fostered by reflective or meditative practices.

While concept analyses indicate a humanistic foundation for nursing presence, much of the focus of clinical research on presence has been on observation of behaviors. This may be attributable to the current emphasis on a utilitarian approach to health care (Smith 2001; Doona et al. 1999; Welsh & Wellard 2005). Efforts to classify types of presence have taken diverse directions. Each instance of presence is unique and may

involve different modes (Easter 2000), ways (Osterman & Schwartz-Barcott 1996) or aspects (Covington 2003).

The ability of a nurse to be present can be supported by the culture of the organization in which she works (Welsh & Wellard 2005; Godkin et al. 2002). An ethically oriented environment that values the humanistic aspects of health care will consider the importance of nursing presence when devising staffing patterns and care processes (Welsh & Wellard 2005). Supporting the ability of nurses to be present with patients creates an environment that is conducive to the safety and the healing process of patients, as well as providing a humanizing influence for patient and nurse alike (Doona et al.1997; Doona et al.1999; Fingeld-Connet 2006; Welsh & Wellard 2005; Smith 2001; Godkin et al. 2002).

Nurses go through intrapersonal and ethical processes to have presence with and for the patient that are partially inter-subjective with and partially independent of the patient. These processes are unique to each circumstance and cannot be reduced to a series of steps that can be memorized by students. However, it is possible that the capacity to be present with a patient can be cultivated through reflective practices and an ethical orientation.

If nursing presence is to be promoted at the undergraduate level, it must be done in a way that is more than a set of behaviors to be memorized, mimicked, and measured. The skills and knowledge that contribute to the ability of a nurse to be present are antecedents for presence, but so are self-knowledge and the willingness to "internalize another's struggles" (Fingeld-Connet 2006:708). To be a presence for a patient, a nurse must be a presence to herself or himself (Doona et al. 1997). While presence itself

consists of a unique experience each time and may not be teachable, the capacity of a nurse to have presence may be cultivated through techniques that can be taught. Nurse educators can cultivate the ability of nurses to have nursing presence in nursing schools, and health care organizations can do so in institutions.

Anthropological research has developed from earlier functional and structural approaches, such as that of Levi-Strauss, to thick description and interpretation, as demonstrated by Geertz (1973). The anthropological exploration of medicine, healing and culturally informed approaches to health care is well established, as demonstrated by Bhasin (2007). Anthropology is an appropriate discipline from which to explore nursing practice.

The concept of presence in nursing is widely acknowledged and has been described as desirable and intrinsic to nursing theory. However, it is not well researched nor even clearly defined. Fieldwork needs to be conducted to describe this interpersonal phenomena and its significance in nursing practice. In addition, a better understanding of this would support the development of capacity for presence in nurses.

Several authors have affirmed the appropriateness of the hermeneutic tradition of inquiry for nursing research. In particular, the ontological, ethical and interpersonal nature of the phenomena lends itself particularly well to exploration through critical hermeneutics and through participatory research. In Part Three, I describe the research process including theoretical framework, research protocol, and process of data analysis.

CHAPTER THREE: RESEARCH PROCESS

Introduction

In this section, I discuss the theoretical framework for this research. The theory behind each research category is described and discussed as to its relevance to the topic, then the research protocol is discussed and the process of data collection and analysis is described in detail. This research used a critical hermeneutic orientation to explore the experience of presence in nursing practice. I used three categories to guide my inquiry. The categories are narrative identity, play, and solicitude.

Theoretical Framework

This section discusses the concepts that comprise the theoretical framework. These concepts are narrative identity, solicitude, and play. These three concepts served as the categories that provided directives for the research data collection and analysis.

Narrative Identity

Ricoeur (1992) describes two aspects of identity; that of personal identity and that of narrative identity. He posits that there is a temporal aspect to identity because there are aspects of a person that change over time and there are aspects that remain consistent. Personal identity refers to two aspects of a person. The first aspect is the enduring part of a person, called *idem,* which remains consistent over time. The second aspect, called *ipse*, changes over time (Ricoeur 1992). Heidegger (1962) argues that consciousness of self resides within language. Ricoeur (1992) describes the process of change as mediated through a dialectic between idem and ipse; between the person that is and the person that is becoming. This dialectic is known as narrative identity (Ricoeur 1992).

Narrative identity can be explored and discovered through conversations between people and in particular through the stories that people tell about themselves and their shared world. Through language people share who they were, who they are, and who they imagine that they will become. Ricoeur (1984) describes this as a three-fold process which that involves the implotment of a narrative in relationship to time. Ricoeur (1984:54) states that "We are following therefore the destiny of a prefigured time that becomes a refigured time through the mediation of a configured time," and calls this process memesis.

Memesis has three aspects. The first, $memesis_1$, refers to the person's historiocity, what they understand about their past. The second, $memesis_2$, refers to the current situation. $Memesis_3$ refers to the future. When a person is undergoing this process, the order of these stages is $memesis_1$, then $memesis_3$, and then $memesis_2$. $Memesis_1$ informs one about who one is, $memesis_3$ indicates what one imagines one's future to be and $memesis_2$ refers to the thoughts and actions taken in the current time in support of the desired future. First a person understands his circumstances, next he/she imagines what the future may hold, then acts in a way that he believes will bring about the desired future.

Play

Play is a dynamic that draws people into the moment. Play is focused on the here and now. One who plays puts aside distractions to participate fully. Play is a dynamic interaction intrinsic to social life. Hans-Georg Gadamer explored the concept of play specifically in his classic work, "Truth and Method" (1975) and also "The Relevance of the Beautiful and Other Essays" (1986). In his later work he states, "It is worth looking

more closely at the fundamental giveness of play and its structures to reveal the element of free play as free impulse and not simply negatively as freedom from a particular ends" (Gadamer 1986:22). This impression of play as free impulse is reminiscent of the impression of solicitude as benevolent spontaneity.

Play occurs when one suspends a larger agenda, just for a short series of moments, and engages in an interaction, a back and forth, with a certain amount of openness, of willingness to participate in a non-purposive activity that may result in a change in one's state of being. Gadamer (1986:125) states, "Play arises from an excess over and above what is strictly necessary and purposive." Furthermore, Gadamer (1986:24) asserts that play is an activity that "is intended as something, even if it is not something conceptual, useful, or purposive, but only the pure autonomous regulation of movement". The sense of momentum one feels when "in the game" is an aspect of what Gadamer (1986:105) describes as the primacy of play over the consciousness of the player.

A quieter example of play, and one that has great significance in hermeneutics, is that of an individual who enters into the presence of The Text. The Text may be a piece of literature that one reads and with which one mentally and/or emotionally engages, or it may be a work of art. It may be a conversation, an epiphany elicited by a quiet moment with nature, or a moment of truth between a nurse and a patient. The presence of the individual is combined with the presence of the object "other" (art, text, etc…). This creates an opening and the play that occurs changes the consciousness of the person who so engages. Charelambous (2010:1283) states that the patient can be understood as a text. She describes the nursing assessment as an interpretation of the patient as text. I propose

that is possible that presence involves this level of engagement, which Gadamer (1986) describes as play.

Play draws people into the moment. The focus is on the here and now. When we are fully present in the moment, we are more aware of the situation in which we reside. Our ability to act creatively and proactively is directly influenced by our level of awareness of our situation. When we are distracted and not really paying attention, we are less likely to be aware of our options. When we are fully present, there is room for play in the moment. When we are focused, we are aware of the opportunities, and we have more ability to be creative. This has strong implications for nursing practice both in terms of relief of suffering and in terms of patient safety.

Solicitude

Solicitude is the ethical relationship between oneself and the unique, irreplaceable other, and includes issues of power and advocacy. Ricoeur understands solicitude as "a benevolent spontaneity, which is intimately related to self esteem within the framework of the 'good' life" (Ricoeur 1992:190). Solicitude can be viewed as the heart of what Ricoeur (1992:172) calls the ethical aim, which he defines as *"aiming at the good life, with and for others, in just institutions* (italics in original)." Ricoeur grants solicitude a more fundamental status than obedience to duty. Obedience to duty is an expression of the normative behavior of a moral person. Ricoeur describes the ethical aim as superseding moral behavior. While physical presence might be considered a moral duty, the quality of presence being discussed in this paper is similar to Ricoeur's (1992) description of the Aristotelian idea of the ethical aim. Ethical aim goes beyond behavior

and pertains to intentions. It includes the ontological understanding of the one who is present.

Ricoeur (1992:193) posits "Solicitude adds the dimension of value, whereby each person is *irreplaceable* in our affection and our esteem." This complements the nursing ethic that calls for the nurse to value each individual as unique and to respect the endless variety of circumstances within which we find people. Fingeld-Connet (2006:708) states "Presence is an interpersonal process that is characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances." She further states that nursing practice must be based on "moral principals of commitment and respect for individual differences (Fingeld-Connet 2006:708)." The intimate nature of nursing care mandates a strong ethical component within nursing education and nursing practice. This quality of solicitude holds relevance for the practice of nursing as it pertains to presence with patients.

Summary of Theoretical Framework

The three categories just described, narrative identity, solicitude and play, serve as guidelines for this inquiry. These categories illuminate explore the phenomenon of presence through three different lenses. Narrative explores who it is that is present. Play inquires into how it is that one is present. Solicitude illuminates something about the nature of the relationship between the nurse and the patient with whom the nurse is present.

Research Protocol

For this research project, I followed the protocol for field-based participatory hermeneutic inquiry as described by Herda (1999:2) who states, "The work of

interpretive participatory research is a text created by the researcher and the research participants that opens the possibility of movement from text to action." The protocol involves an orientation on the part of the researcher toward language as a medium and a willingness to engage authentically in conversation that potentially changes one's view of the world. This protocol allows people who are familiar with the topic at hand to come together in conversation that challenges them to reevaluate their presumptions and prejudices and to discover new ways of viewing the world (Herda 1999). The process leads to a deeper understanding of the topic and has the capacity for building community with the potential for action. It also offers an opportunity for the participants to discover meaning within the social context of the topic, and to explore moral and ethical issues.

Field-based participatory inquiry involves recording conversations between the researcher and knowledgeable individuals who can contribute to an increased understanding of the topic. The conversations are transcribed to create a text and can be commented on and clarified by the participants. Data analysis relies heavily on viewing the conversations in light of critical hermeneutic theory. The result is a text that discloses new understandings of the topic and opens new opportunities for meaningful action.

Research Categories and Questions

In participatory field-work, research categories are chosen to provide direction and boundaries for the area of inquiry and structure for the interpretation of data. Categories are often not discreet (Herda 1999:103) and may change as the researcher learns more about the topic and discovers information that indicates another category would serve better. The following questions under each category serve as conversation guides. They may or may not be answered specifically:

1. Narrative identity – Identity is interpreted and understood through narrative.

Questions:

a. What is your experience with presence?
b. How did you learn to be present with a patient?
c. What supports you in being present?
d. How might you support others in developing the capacity to be present?

2. Play- A dynamic which draws people into the moment. There is a focus on the here and now. One puts aside distractions to participate fully.

Questions:

a. In what circumstances do you experience presence?
b. What does being present with a patient feel like?
c. What does being present require from you?

3. Solicitude- The exploration of the relationship between oneself and the unique, irreplaceable other, including issues of power and advocacy.

Questions:

a. What is the nature of the relationship between you and a person with whom you are present?
b. Is there a difference between being present with a patient in professional circumstances and being present with someone else in a non-professional setting?

Pilot Study

Introduction

The following are excerpts from a pilot project that was done in the Fall semester of 2010. The complete pilot project is found in Appendix A.

The purpose of this study is to explore the attitudes, assumptions and understandings held by nurses through the language used to describe the images of the human body, health and healing by nurses. One of the things that have changed in recent years is our understanding of the role of the mind in health and healing. The number of "mind body" practitioners is growing and the science behind it is being established. For

instance, research on Guided Imagery has been accumulating for over forty years. The "placebo effect" is a well- established phenomenon. Also, many of the disorders that plague modern society are considered to be stress related, and much of that stress is mediated by mental images and emotional responses.

The Significance of Language in Health Care

Nursing can be viewed as a communicative practice (Hikari 1989:111). The language we use to discuss health and healing with our patients and clients contributes to their understanding of their own lifeworld through their own ontological processes. To examine and make explicit the language and symbols that we use in those conversations offers nurses the opportunity to reflect on their own ontological processes and therefore to better understand their own assumptions. Most of the interactions that nurses have with patients or clients are informal conversations; interactions that are casually phrased and reveal our assumptions and our images of what it is to be human, to be sick, and what it takes to become well. The assumptions made by healers are revealed in the images they use to describe what they do. This paper is an effort to discern those assumptions and images and to make them explicit.

Background of Conversation Partner

My conversation partner was Dr. Christina Campbell, RN, PhD. Christina has 34 years of experience in the health care field as educator/consultant, researcher, clinician, psychologist and nurse. Christina has practiced as a nurse in pediatrics, medicine and psychiatry since 1968. She received her Masters degree in Community Mental Health in 1977, and her doctorate in Educational Psychology Counseling from the University of San Francisco in 1984. She has been a Clinical Specialist in Psychiatric Mental Health

Nursing since 1982 and is a licensed mental health counselor. Christina is currently in private practice in Sausalito, California, and teaches psychiatric nursing at Dominican University of California.

Data Presentation

The following is an excerpt of the data presentation and analysis from my pilot project. The entire work for this part is found in appendix IV.

The questions that guided the conversation were the following:

1. Tell me about the human body.
2. What does it take for a person to heal?
3. How are you, the healer, involved in the process of healing?

Along with these three questions, we also explored other questions that came up during the conversation.

Working with her clients, Christina creates narratives that implot the patient's story along with her own understandings about the cause of illness to make sense of what she sees in the patient's situation. Attachment theory describes development of relationships between people, starting with a primary caregiver during early infancy and early childhood. According to this theory, the primary relationship is vital for the ability of a person to develop healthy relationships as the person matures. In this case, Christina interprets her patient's situations in terms of attachment theory, which is a scientifically accepted theory through which she interprets the situations of her patients.

> In the new attachment theory, a mother's ability to pick up on the child's emotions and needs, nonverbally, and to meet those emotional and physical needs is related to normal brain development. And so, the assumption I take from that is, we need that human contact, someone to connect with our deepest emotions and connect with that human being. As a way to have the integrity of our nervous system stay in balance. So large amount of, or people who isolate have a tendency to have more

> depression and anxiety. And then what I find is that withholding emotions creates enormous strain on the immune system which is a type of isolation. And so sometimes people learn to not reach out and they become strong and invulnerable and that sense of strength and invulnerability manifests in a posture that is like, um- Reich talked about this- it's like, girdled. It's tight so that you can't breathe.

She makes predictions of what may happen with her patient based on her interpretation of the patient's story in light of the theory she espouses about the connection between emotional strain and an impaired immune system.

> And, uh, I had seen a lot of people- when I interviewed cancer patients they thought they were strong as iron. They would not express their emotions or their vulnerability. And recently I hear a physician say that that holding and being strong triggers the sympathetic nervous system. So what you have is constant triggering of the sympathetic nervous system so people are in adrenaline rushes without stress or fear being a real factor. And so consequently eventually that wears the immune system out and that's what I think predisposed people to illness.

Christina clearly values science and expresses that in our conversation. For instance, she expresses feeling validated in her practice by scientific studies that measure some of the dynamics that she has been working with for years.

> I feel that the new neuroscience having to do with attachment really gives me validity in terms of the science behind the importance of trying to understand people's emotions to, um you know make an environment that is safe for them to express those emotions again, and my first task at hand is to create a safe environment.

Christina and I both know about and value an ontological approach to health and healing, but continue to struggle when it comes to incorporating it into our role as healers. The following quote illustrates this struggle:

> Alicia: So maybe as healers part of what we do is a reality check for people?
>
> Christina: Yes. Clarify reality. But more than reality, the consequences to that reality. To health. If you do this long- term, this is likely the outcome. This is a risk to your health. You know. What are your options?

An attempt to shift to an ontological paradigm yields mixed results. On the one hand the role of the nurse shifts from that of giving instructions to educating people. On the other hand, it is not clear what the criteria for judging health decisions would be. Traditional health education approaches these criteria based on changes in behavior geared toward decreasing risk factors for disease.

Analysis

The quality that Christina calls being an alternative healer is part of her enduring sense of self, or what Ricoeur (1992) calls idem. Over the years, the way she works with patients has changed. This change happens through the process of memesis. Early in her practice she was working with children in a pediatric ward, now she has a private practice with adults. Her way of practicing has changed (ipse), but she still feels that the mind and feelings are as important as the body.

Narrative figures prominently in the way in which Christina works with patients. When she works with a patient, she gains an understanding of who he understands himself to be. The patient's past ($memesis_1$) is explored through narrative. Christina then interprets that understanding in light of her own knowledge of theory and talks with the patient. Some of what she does is to share her understandings with the patient in such a way that the patient can change his narrative of the past to one that affords him more possibilities in his current life.

Through conversation and narrative, the patient's understanding of who he is changes, informed by interaction with Christina. She then works with her patient to imagine different possible futures (memesis$_3$).

Metaphor appears several times in the conversation. Christina employs them both casually and formally. The Armored body, the Machine, being "stuck in mud" all communicate a sense of stress that can then be addressed also using metaphor.

Implications

What Christina's work with people reveals is that people can reorient themselves toward a healing process by use of language that opens them to possibilities. The interpretive approach allows for the human need for meaning, as well as the integration of ethical issues into the research process. As we learn to engage with our patients in the healing process, rather than "doing to" them, we open up new realms of meaning, of understanding and of human potential. When we do this within our institutions, we reform them in a profound and much needed way.

Reflections of the Researcher

My conversation with Christina Campbell provided me with an opportunity to explore the meaning of communication with patients. The words we use, and perhaps more importantly, the way we listen to our patients and interpret the information we get from them have profound implications for the people we serve. As I explored the text of the conversation, I became aware of my own habitual positivist attitude. It became clear to me about halfway through the data analysis that my pilot project was headed in the wrong direction. My focus was unclear because I kept falling back into a positivist

paradigm. I was still in the habit of viewing language as a tool to be used for healing, rather than understanding language as a medium in which individuals who are present together explore, grow and share their understanding of events and their significance. Heidegger explains language as the world that we inhabit. It was necessary for me to rethink my direction and examine my habits and assumptions more closely. The purpose of interpretive research is to explore issues and develop deeper understandings of them. The focus is on *phronesis*, not on *techne*. My experience of the pilot project was that of expanding my understanding of what is possible with an ontological orientation.

As I worked, through my choice of words, to develop an interpretive way of relating to the conversation and the subject matter, I realized how much of a challenge it is for me, and began to see the implications of such a shift. They are profound and highly beneficial to practice and, I believe, have profound implications for research within nursing and health care. I am encouraged to continue in this research tradition. As a result of this rethinking, I chose to narrow my focus to the discussion of presence and to change my research categories to reflect what I feel is more relevant for this particular focus.

Pilot Summary

Narrative, imagination and the understanding of identity all play a role in the healing process. As nurses, we often work with these issues in an unconscious fashion and it behooves us to examine our metaphors and our assumptions and to reevaluate and revise them. A deep inquiry into language through which we interpret and communicate the world we share would inform our individual practice and would nurture a reformation of our understanding of health and healing, which is desperately needed in our health care system.

Background of the Researcher

I have been practicing as a Registered Nurse since 1987. Before that, I was a Nursing Assistant and a Licensed Practical Nurse. Earlier in my career, I focused on the technical aspects of nursing, including the pathophysiology of the patient and skills pertaining to the treatment of health problems. Working in an intensive care unit gave me the opportunity to closely watch the physiology of my patients and to observe the effects of treatment. I began to notice the change in a patient's condition that could be brought about by the presence of a family member or a caring nurse. This presence went beyond technical skills. I saw patients that would cling to life waiting for a certain family member to come before they could pass peacefully into death. This phenomenon has been observed anecdotally by hospice nurses and formally in research articles.

In addition, I observed that certain nurses were able to really connect with patients and make a real difference in their condition because of that connection. This went way beyond technically proficient execution of nursing skills, although that seemed to also be important.

As my practice matured, I became involved in a small company that did research on the biochemical causes of aging. This was, in a way, the extreme technical solution for so many health problems. At the same time, I was led to explore complementary and alternative therapies. My Masters degree is in Integrative Health Practices and I am an Advanced Practice Holistic Nurse- Board Certified, 2007. In addition, I have studied martial arts, meditation, and yoga. This intensified my curiosity about the healing process and the nature of the relationship between the healer and the patient.

Proposal Summary

Presence in nursing practice is a topic that has great relevance for practice and yet is not adequately explored in the literature. I propose to explore this topic in the critical hermeneutic tradition, through a research protocol for participatory fieldwork as described by Herda (1999). I will use the research categories narrative identity, solicitude and play to define the limits of my research. My pilot project provided an opportunity to explore the difference between positivist research and interpretive research, and my direction since then has changed. An interpretive inquiry into the phenomenon of presence in nursing practice will expand our understanding of this phenomena and contribute to nursing knowledge.

Data Collection

Potential conversation partners were contacted through my existing social and professional networks. I sent a letter of invitation to potential conversation partners that explained the general purpose of the conversations as well as a little about the nature of participatory hermeneutic research (see Appendix A). I secured the permission of each conversation partner to record, transcribe and analyze the conversations. The conversations took place at a time and place that was convenient for the conversation partners. Conversations were recorded by audio and then transcribed. A follow up letter was sent to the conversation partners along with the transcribed record of the conversation (see Appendix B). Conversation partners were given an opportunity to reflect on what was said during the conversation, and to change or correct anything that they felt would better reflect their thoughts (See Appendix C). Two of them did so. Others acknowledged that they were satisfied with the transcript. There was one follow-

up conversation with Gayle Swift. In addition to the conversations, I kept a research journal with personal observations and thoughts about the data being collected. Herda (1999:98) describes this journal as "the life-source of the data collection process for in it goes the hopes, fears, questions, ideas, humor, observations, and comments of the researcher." This journal provided a structure in which to reflect on the conversations and will enrich the data analysis process.

Data Analysis

The creation of a transcribed text from the conversations is a step in the process of distanciation. This allows the researcher to step back from the data and reflect on it, then analyze it through hermeneutic theory. Ricoeur (1982:53) notes that the "text must be unfolded, no longer towards its author but towards its imminent sense and towards the world which it opens up and discloses." Herda (1999:98-99) explains that data analysis happens in the following stages:

- The conversation is fixed by transcription, preferably by the researcher rather than by a machine or another person, thereby allowing reflection.
- As the researcher reflects on the material, themes are identified and placed within the research categories. If necessary, categories are adjusted to more accurately reflect the data.
- Themes are substantiated with quotes from the conversations.
- Themes are examined in light of the theoretical framework of hermeneutics. Outside documents and research journals are considered.
- The researcher remains open to the possibility of continued dialog with conversation partners to gain clarity on the data.
- A context for a written discussion is developed.
- Themes and sub themes are developed, grouped and discussed in light of theory and the problem at hand.
- The researcher seeks out new insight offered by the research and discovers new direction for the issue or problem being investigated.
- Aspects of the research that warrant more study are identified.

Entry to Research Site

As a professional nurse, I have many contacts within the nursing community. Some of these are nurses I know personally or professionally and who were interested in discussing the issue of presence in nursing practice. I have also been a member of the Holistic Nurses Association for ten years. Several of my research conversations took place at the 2012 AHNA conference in Snowbird, Utah.

Research Participants

The following is a list of participants. Each is an adult who has been licensed as a nurse, except for a patient (Anonymous). This was a woman with whom I had been somewhat acquainted with for two years who urgently requested that I include her story when she heard what I was researching. Each nurse is familiar with patient care and has considered the issue of presence in their practice. The conversations began during the Spring of 2012 and were completed in mid-June 2012. Some conversations took place in the home, some in the hospital setting and some at the 2012 conference of the American Holistic Nurses Association. On the following page is a chart listing conversation participants.

List of conversation Partners

Participant	Title	Age Range	Background
Dr. Marlene Bacon	PhD, RN	60-70	Staff Nurse, Administrator, Faculty
Sister Cynthia Cammack	OP, MSN, RN	40-50	Staff Nurse, Case Manager
Ms. Sharon Cassidy	MSN, RN	55-65	Staff Nurse, OR, Call Center
Ms. Ann Rose Dichov	MSN, RN	45-55	Staff Nurse
Ms. Karen Fink	CMT, RN	35-45	Staff Nurse, Healing Services Provider
Ms. Marilee Ford	MSN, RN	50-60	Staff Nurse, Faculty, Cancer Survivor
Mr. Baruch Golden	MSN, RN	45-55	Staff Nurse, Hospice
Ms. Mintie Indar-Maraj	MSN, RN, EdD (c)	45-55	Staff Nurse, Doctoral Candidate
Anonymous	Teacher, Patient	70-80	Approached me and told me her story when she heard what I was studying.
Ms. Gayle Swift	MSN, RN	55-65	Staff Nurse, Clinical Nurse Educator,
Indra Thelani	MSN, RN	50-60	Nursing Instructor
Ms. Judy Ullibarry	BSN, RN	50-60	Staff Nurse, Psychiatric Outreach

Summary

A pilot study was conducted in the fall of 2011. Through conversation with Christina Campbell, I explored the significance of language in nursing practice. The words we use, and perhaps more importantly, the way we listen to our patients and interpret the information we get from them have profound implications for the people we serve. I struggled with the focus of the project because I kept falling back into a positivist paradigm. I was still in the habit of viewing language as a tool to be used for healing, rather than understanding language as a medium in which individuals who are present together explore, grow and share their understanding of events and their significance. It was necessary for me to rethink my direction and examine my habits and assumptions

more closely. A summary of that study is included in Appendix B. I also kept a journal with my reflections and thoughts about the conversations and the concepts involved. These thoughts were included in the process of analysis.

Data were collected during the winter, spring and summer of 2012 through conversations with experienced nurses in several settings, including hospitals, homes, and professional conference settings. The conversations were guided by questions pertaining to narrative identity, play, and solicitude, but were free-flowing and provided the participants with an opportunity to think about and explore their experience with and thoughts about presence in nursing practice.

The conversations were transcribed and the transcriptions were sent to the participants for review and comment. Follow-up conversations were held with several of the participants. Themes were developed and grouped and are presented in the next Chapter.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

Introduction

In Chapter Four, I present data from the research conversations and analyze them for their significance in understanding nursing presence. Data are organized into the categories of narrative identity, play and solicitude. Data are analyzed in light of critical hermeneutic theory for themes that emerge from within each category of the data. Several themes emerged within each category and are explored and discussed.

Narrative Identity

Three themes emerged within the category of Narrative Identity. The first, Identity of the Nurse, describes my conversation partners understanding of self in the context of how they are with patients. This theme illustrated a very personal connection with the healing process as well as a desire to connect with patients. The second, A Learned Practice, describes how my conversation partners had sought ways to deepen their ability to be present with patients. It also reviews what practices have been helpful to them. The third, Narrative Informs Action, describes how the interaction between nurse and patient influences action on the part of the nurse, and sometimes on the part of the patient.

Ricoeur describes the act of configuration as a creation of meaningful totalities out of scattered events. He proposes, "The subject becomes, to borrow a Proustian formula, both reader and writer of his own life. Selfhood is a cloth woven of stories told" (Ricoeur 1985:246). Nurses configure information to create a narrative that informs who they are, who their patients are, and guides their actions. The concept of narrative identity is demonstrated through narratives about who the nurse is and what she/he understands

nursing to be. It is further demonstrated by co-creating a narrative with a patient. This co-created narrative provides a foundation for wise action on the part of the nurse. It can also result in an expanded awareness of opportunities on the part of the patient. In this section, I explore the role of narrative in the nurse's understanding of her/himself and of the patient.

Identity of the Nurse

My conversation partners shared with me their stories about who they are and how they came to be able to be present with patients. While they each described ways that they had learned to be present, they also acknowledged an inherent desire or ability to do so. Many of my conversation partners stated that the desire to connect with their patients was an inherent part of who they understand themselves to be. They often described stories from childhood that involved connecting easily with other people. Ricoeur (1992) would call this their idem, or a part of who they are that remains constant. When I asked Ann Rose Dichov MSN, RN how she learned to be present with a patient, she replied, "I didn't. It was there. And I think that's where part of it comes as a gift." Ms. Karen Fink CMT, RN also described being a child to whom other children looked for comfort and how it always seemed natural to her to be available to provide comfort to them. Although most of the participants indicated that the desire to connect in this way was intrinsic to who they are, they also listed many ways in which they learned to be present with patients and also how they learned to value this part of their practice.

A Learned Practice

Although my conversation partners may possess an inherent tendency to connect deeply with other human beings, which Ricoeur might refer to as idem, they also describe

their ability to do so as having been enhanced by learning and by practicing (which Ricoeur calls ipse). Ricoeur (1992:121) describes this process; “It is this sedimentation which confers upon character the sort of permanence in time that I am interpreting here as the overlapping of ipse by idem”, or more succinctly, “Habit gives a history to character”.

Ms. Mintie Indar-Maraj, MSN, RN, EdD(c) feels that she learned caring presence through the example provided to her through her grandmother when she was a child. ”I learned how to care through my grandmother. My grandmother was a very caring person. I learned forgiveness from her. I learned to be open minded.” Mr. Baruch Golden, MSN, RN describes presence as an awareness of self and other and feels that it can be cultivated. His way of cultivating presence is through mindfulness practice, which he has practiced for many years and now teaches. About mindfulness meditation he says, “Once you start doing it, it’s a way of training yourself to be present.” Ms. Sharon Cassidy, MSN, RN describes her personal practice that augments her ability to be present for patients as, “It’s taking care of yourself.” She cites meditation, Tai Chi and yoga as practices in which she engages that support her ability to disconnect from the distractions of the chaotic hospital environment, and that support her ability to connect in the moment of presence with the patient.

Ms. Gayle Swift, MSN, RN also feels that the ability to be present as “definitely a practice that requires practice.” She also calls it, “a willingness” on the part of the practitioner. She reports that it is not difficult to teach presence, but it is difficult to learn because presence is an experiential practice. “It’s a felt experience rather than a head experience.” She feels that this approach to teaching and learning stands in contrast to the

dominant culture of nursing education which she believes is linear and materialistically dominated.

Dr. Marlene Bacon, PhD, RN tells of her introduction to presence and how she has come to understand the role of presence in nursing practice. She has been a nurse since the early 1980's and recalls that presence was not a word that was used then, but the way of being with a patient that she now describes as presence was fundamentally integrated into her nursing education. Ricoeur (1992:124) posits that narrative identity occupies the milieu created by the dynamic polarity "between two models of permanence in time- the perseverance of character and the constancy of the self in promising." For Marlene, the practices she learned as a student and her current practice are consistent with each other, although the language used to describe the interaction with the patient has changed. She recalls: "I came from a nursing program that emphasized the traditional nursing arts: holding hands, being with patients, sitting and talking to them, giving backrubs. The touching more than the task was probably one of the best emphasis in the program that I went to." These activities were valued but the relationship with the patient that determined the quality of these interactions was never articulated. "Nobody ever said 'This is what it's like to be with a patient'. They just taught me that that was part of good patient care." As a practicing nurse, and more recently as an administrator and nursing faculty, Marlene's description of what she does has changed, but the intention and commitment remain constant.

Ms. Marilee Ford, MSN, RN who has taught nursing for years, also observes that there is constancy between what she sees as a character trait and what she sees as a learned practice. She describes her ability to be present as a combination of trait and

learned skill. “I don't know how I learned it, I just have always known it from when I was a student nurse from the beginning, but I didn’t have names for it then.” She told me that she has had transformative experiences where she connected with people that were ill, dying or dead and that these influenced her tremendously.

> *Alicia: It doesn’t sound like it’s a set of actions, it sounds like it’s a state of being.*
>
> Marilee: It is absolutely. But you can prepare yourself for it.
>
> *Alicia: How do you do that?*
>
> Marilee: I choose to believe that you can learn to do it by learning how to center and ground yourself but that’s the first thing you have to do, you have to have a practice that grounds you in yourself. So there has to be a certain amount of self-awareness and self-comfort. I think you probably can learn by experiencing it. Experiencing it from someone else, from a mentor, or just having it happen.

Marilee believes that one can prepare oneself for opportunities to be present with a patient through developing a good relationship with oneself. This is consistent with the description by Marilee and others, that a nurse’s character may predispose her/him toward the ability to be present with a patient, and that to honor that part of her/himself, the nurse should engage in practices that further his or her ability to do so.

Yet sometimes instances of presence occur unintentionally or serendipitously. Marilee reminds us: “A lot of times you don’t intend for that to happen but all of sudden you connect and you’re there. So yeah, maybe you intended that, maybe it just happened because you were able to connect as a human being.” She feels that this is an important subject for nurse educators to explore with students.

> In that sense you can teach it because you can teach beginning nurses, you can insist that they take better care of themselves, and give them permission to do that and if they can do that, number one,

> they'll stay in the profession longer because they won't get burned out, and number two they'll learn about being present to themselves so then they can understand about what it means to be present for somebody else. So in that sense maybe you can teach them. I don't think there's a methodology about it but there's kind of a general approach that creates the environment where it can happen.

In response to a question about how she would go about fostering this ability in nursing students, Indra Thelani proposes that role modeling is the most effective way. "Well, role modeling is number one. They see you do it and you'll be able to change a person's emotional state, getting back to that example of touching a person." She described a situation in which she, with students, entered the room of a man whose hand had been amputated. He was very angry and hurt and taking it out on the nurses. She had a brief interaction with him and then put her hand on his shoulder and said, "I'm really sorry that this happened to you." The patient started sobbing, releasing some of the emotional burden caused by the loss of his hand and all that this meant to him. Her students were very impressed with how quickly the patient had moved from being angry and hurtful to being honest and vulnerable with his grief. She tells her students that it is important for them to be open to this sort of vulnerability on the part of the patients because, she says, "The ability to release is just as important as giving them the IV antibiotic and helps them have their energy not be blocked with grief and sadness."

Indra describes what she feels is important preparation for being present with patients in the way described above. She describes her process of becoming a better listener and "listening not just with my ears but also with my heart." A personal history of trauma led her to engage in self-healing practices that she feels directly contribute to her ability to be present for patients. She described how, through therapy and groups she was able to retrieve parts of herself that were, in a sense, lost during traumatic events and

how this process resulted in her evolution toward being a more resilient person who could be present with other people experiencing or recovering from trauma. She states: “I'm much better, I think, at what I do because I’ve done the self-work.” Indra believes that attention to her own healing process supports her ability to support others in their healing processes.

Ricoeur (1983:68) states that $memesis_3$ is joined to $memesis_2$ through the configurational act and that we “ought not to hesitate in comparing the configurational act with the work of the productive imagination.” The act of imagining a possible future, $memesis_3$, is linked to actions one takes in present time to bring about the imagined future. Working with a mentor or with someone who engages the nurse in the healing process, can provide the imagination with new possibilities for the future.

Sister Cynthia Cammack, OP, MSN, RN cites the very personal process of pain and healing that she feels has contributed to her ability to be available and present for patients. “I think for me it’s that sense of brokenness that I’ve had in my life that has allowed me to come to the point of knowing and that sense of being OK with and surviving within and with that sense of brokenness.” As well as the personal healing process, Cyndie states that she was able to observe role-modeling from other people who supported her in her healing process. “It allowed me to experience some of that as other people were present to me, helping me get through some of those pieces.”

Gayle also credits the healing process as generative of the ability to be present with others and to facilitate their healing processes. She indicates that the people who have a sense of being called to be really present with patients are people who are wounded. She elaborated by saying that in indigenous traditions a person who became a

shaman was one who had been injured in some way. “They had some malady, some injury, some bad event happen to them that they worked their way out of, so they knew how to move someone from a disharmony to harmony.” She senses that, “There’s something about woundedness that’s essential to recognize that somebody is suffering. So the true healers are the ones who understand suffering because they themselves have suffered and have found a way through that suffering to the other side.” She feels this is essential to the development of a deep ability to be present with and respond to someone who is suffering. During our conversation, however, it seemed to me that sometimes that same woundedness also prevents us from being present. Gayle responded, “If we have not done our work.” The work she refers to is the work of healing that Indra and Cyndie have also referred to. When asked what she feels is the most important way to foster the ability to be present, Gayle said, “Teaching people about their interiority. What am I thinking, feeling?”

Cyndie points out that while skills and techniques can be learned and demonstrated, the creativity with which they are employed cannot. She describes the relationship between interpersonal skills and presence in terms of art.

> You can ‘teach’ somebody how to be present. It’s kind of like you can teach somebody how to do art. Yes, we can go through the fundamentals, we can teach them how to paint, we can’t teach them how to make art. We can teach them how to use a camera, we can teach you how to take pictures, that doesn’t mean we can teach you how to do art.

The nurse who is born with a talent for connecting with others can learn interpersonal skills that make her more effective, but the technical skills require a talent or perhaps a passion on the part of the nurse in order to achieve the interconnected moment of presence.

Narrative can also influence the way the nurse approaches her day. In the first example, Mintie described a "mindset", that could be understood as the narrative through which the nurse understands the constrictions on what she can do:

> *Alicia: What do you see as impediments to being able to be present with somebody?*
>
> Mintie*:* Distractions and carrying the mindset that I'm too busy for this, I've got too much to do. In terms of hospital nursing and bedside nursing that's what happens.
>
> *Alicia: Time pressures?*
>
> Mintie: Time pressures. Procedure pressures, and it's the mindset. That's the common excuse I hear from bedside nurses for why they can't care about people is because they're too busy and I just listen to it and I don't even bother to argue with them because it's really a mindset.

Mindset, in this case, can be understood as the narrative the nurse has told herself about $memesis_3$, about what is possible. On the other hand, Marilee describes a situation where a nurse chooses to reinterpret (in $memesis_2$) her circumstances to allow for more openness to her patients; a different interpretation of $memesis_3$ than in the previous example. She describes the way a nurse that she works with approaches a day that she knows in the beginning will be very challenging. Instead of going into the mindset, as Minty described, of not having enough time to do a good job, this nurse says:

> I make a conscious decision that OK, I know this day is going to be hell but what I'm going to do is I'm just going to behave as though it's not hell. I am going to take it step by step and I'm going to carry along at my same pace and I'm going to get things done and it's all going to work out and if I have to stay overtime then that's what I have to do. I am not going to allow the situation to govern my choice to be present for my patients.

Marlene is also concerned about the conditions in which nurses practice. As a hospital administrator she had the opportunity to influence the expectations of nurses who worked on her unit. Herda (1999:26) states "Human beings are linked to others in a social system that is constantly in the process of being created through language acts." Through conversations and describing what she felt was important to patients, Marlene was able to encourage the nurses that she supervised to really engage with patients. She describes the predisposition toward being present with patients as a talent that she could recognize in new nurses. She then describes the importance of an education that emphasizes, "the values of being with a patient, the traditional art of nursing, that connectivity, that receptivity, that ability to really love someone enough to give them good nursing care is valued, is promoted, and then continues on after they graduate." She then describes the importance of the practice setting where those values are upheld as highly contributory to the ability of the nurse to flourish. She said,

> It's kind of like putting a plant into fertile soil. You have someone who has basic talent, you have someone who is educated into the values of nurses, socialized into becoming a nurse with presence, with true caring and then you plant that wonderful new graduate into some fertile soil where they themselves are nurtured still into the caring aspects of nursing, and then they grow and then they nurture others.

She emphasizes the importance of the support of wise administrators who have a clear vision of what the value of presence is.

Nurses whose personal understanding of self includes the talent or passion to have presence with a patient find this innate ability enhanced by experiences and by practice. These include exposure to suffering in themselves and in others and especially include the process of healing that they go through to recover from personal trauma. Their sense

of self is enhanced in this area by practices that they engage in because they know that these practices are important for their own health as well as for the health of the patients they serve.

Seeking to know the patient

A nurse, with a preconfigured understanding of self, enters into a relationship with a patient. Their interaction usually, but not always, includes conversation. Through the course of the relationship, the nurse seeks to discover who the patient is. The nurse then co-creates a narrative with the patient. This narrative usually comes in the form of conversation and other forms of assessment. Nurse and patient then interpret the interaction configure memesis$_3$. During the interaction, both patient and nurse are changed.

Kearney (2002) speaks of the power of stories:

> When someone asks who you are, you tell your story. That is, you recount your past memories and future anticipations. You interpret where you are coming from and where you are going to. And so doing you give a sense of yourself as a narrative identity that perdures and coheres over a lifetime (Kearney 2002: 152).

People willingly share their stories with nurses, and together, nurses and patients create new stories. The nurse who seeks authentic presence with a patient engages in a deep inquiry into who the patient is. It may or may not take much time. Gayle Swift sums it up: “I don’t see really how we can provide care without understanding who this human being is that’s in front of me.” Ann Rose cites listening and acknowledging as fundamental to the process; “The act of listening…letting the other person knowing they’ve been heard.”

Marlene describes what it looks and feels like when a nurse is present with a patient. “What a difference it means to sit down in a chair, to look someone in the eye, to smile at them, and to listen to them. People can tell when you’re listening to them.” She implies that there is a felt sense of connection. She also describes observable behaviors. The emphasis on listening, rather than talking, invites the patient to contribute his or her narrative to the conversation and helps the nurse learn what the patient is experiencing.

Baruch points out the complexities of this process and remarks on the fact that although a nurse may have a sense of what the other person is thinking or feeling, the nurse cannot have real certainty about it. He describes his sense of the process that occurs during an interaction with a patient.

> There’s a couple things going on. There’s what’s going on with me and if I'm present with myself and what’s happening, and then there’s my ability to be aware and present with what’s happening with me outside the other person, and then there’s the process of what’s happening with me and what’s happening with the other person and how we’re interacting or relating with each other.

Note that Baruch stresses the importance of a nurse being present to self as well as the patient. Despite the complexity and uncertainty involved in the details of an interaction, Baruch states that, although presence does not happen often, “when it does happen it’s pretty clear that it’s happening.”

This sense of connection that goes beyond externally observable behaviors was reported by most conversation partners. Cyndie understands presence as recognition; “It’s kind of a knowing of that it’s there.” Marilee describes a nonverbal process of listening:

> When I'm listening to somebody I'm listening to their body language, I'm looking at their eyes, I'm looking at the way that they’re sitting, I'm looking at the energy that they’re emanating.

Note Marilee’s use of the word, “energy,” in the verbal context of a perception.

Several conversation partners referred to "energy". While this is not a concept commonly referred to in the nursing literature, there was a common sense of what the word meant to those who used it in our conversations. Bhasin's (2007) work validates the role of culture in the relationship between patient and healer- in this case the nurse. Different cultures have different ways of conceptualizing this relationship, and each nurse I spoke with described it in a slightly different way. Indra shared a playful image of what it took to be present. One of her students described her as "tuned in." She said, "So that got me thinking… Do I have these little antennas up that I pick up on people's energies and then try to respond accordingly?" The image of a nurse with antennae who is able to receive radio waves emanating from the patient may be a useful metaphor for being aware of nonverbal subtleties. On the other hand, several conversation participants used the term *energy* to describe the interaction with patients. On developing an awareness of who the patient is at the moment of interaction, Cyndie states: "It's almost like a change in energy field, that sense of a blending, …a meeting of energies." Ann Rose also used the term "energy" when she described encountering the presence of the patient and the information she received from that sense of energy about what action she needed to take right away in order to connect with the patient:

> There was an elder, in the hospital bed and I'm running! And I had the meds to give her and I met her energy field and it stopped me. Because she was in this quiet place and I met her energy and it just quieted down. And before I could do anything about those meds, I needed to be right there with her. And it was a feeling.

Listening to patients provides patients with an opportunity to reconfigure their own personal narratives in ways that allow them to better come to terms with their circumstances. Cyndie models receptivity on the part of the nurse when she acts as a

sounding board for families caring for loved ones undergoing palliative care. She described a situation in which a daughter sorted through all the possible explanations for her father's illness that had been offered as possibilities by the physician involved. Her father had been having vague health problems but nothing explained by medical diagnostics. Through conversation, the daughter was able to identify the recent death of her mother, as the root cause of her father's malaise. This reconfiguration of the situation allowed the daughter to change her focus from potential medical problems to the human need her father had for support from his family in his grieving process. Through conversation, Cyndie supported the daughter's reconfiguration of events. This opened new healing possibilities for her family.

Presence does not require verbal interaction on the part of the patient. When my conversation partners were asked whether they felt a nurse could be present with a patient who was unconscious, not one of hesitated at all in replying confidently in the affirmative. Instead, each of them offered a story about the same sort of attentive engagement that they had with conscious patients. They had a similar sense of connection with an unconscious patient. This was at least as pronounced in the case of dying patients.

Marilee describes an experience she had with a patient who was going through a very conscious dying process:

> First of all I walked into the room and I was hit by this bright feeling of light, not that there was light, but it was a feeling of light. At some point when I was sitting by his bedside there was like this communion that happened, which approximates kind of the feeling that happens when you really connect with someone that's conscious. But it was obviously a spiritual connection because he wasn't able to respond verbally. In that moment I knew what the omnipresence of God meant, because that's where he (the patient)

> was. He was in that space and I was fortunate enough to be able to connect into that space in that moment. It was no longer than a moment as far as I know, but it was a transcendent experience.

Mintie describes how she can tell that an unconscious, ventilated patient has felt her presence. "They may not buck the vent that often, the alarms may not be triggered as often… I can tell because I'm *there*. Not every nurse is there. It's subtle. Subtle and very different."

Levi-Strauss (1966) pointed out that expectations are created or limited by culture. As Geertz (1973) illustrated with his work on Balinese trance, culture influences expectations. Expectations then seem to influence physiology. Bhasin (2007) makes the case that the relationship between the healer and the patient, along with the rituals and circumstances that accompany the relationship, can contribute significantly to the process of healing and the concomitant sense of wellbeing. Clearly, the narrative created by the nurse about her/himself is important. The narrative that she/he can then co-create with the patient, in the context of the nurse-patient relationship, can have a profound influence on the wellbeing of both the patient and the nurse.

Narrative Informs Action

Herda (1999) discusses the creative and interrelated nature of memesis, and describes how critique leads to new possibilities.

> All three stages of memesis are creative acts and are interrelated. Although action is present in all three stages, it is most important in memesis$_2$ … There is a new possibility for living our lives and carrying out our policies when we critique our taken-for-granted world (Herda 1999:79).

Baruch understands that part of being present with a patient involves drawing the patient's attention into the present moment that Ricoeur (1983) refers to as memesis$_2$. This affords patients an opportunity to review what they know about themselves and their

situations (memesis$_1$) and to develop new understandings and new possibilities for their future (memesis$_3$).

> Baruch: That's one thing I do talk with people about because people become so attached to what is happening and I always am reframing this is what's happening right now; we don't know what's going to happen in the next moment. … later may be different.
>
> *Alicia: So bringing the attention back to what's happening right now and stop the thinking about the future, planning and worrying.*
>
> Baruch: Yes. Usually it's a matter of trying to work with people to bring them into the present moment because there are so many fears about the future and they get so caught up in that, just like we all do.

Ricoeur (1983:64) describes memesis$_2$ as "the kingdom of the *as if*." Memesis$_2$ is the moment in which we act to bring about what we have envisioned for memesis$_3$. Marlene narrates a story that invokes all the feelings of an inexperienced nurse touched by the situation of the human being in her care. She was a new nurse, working night shift, and was assigned to care for a young man who had been in a motorcycle crash and had severe trauma, including head trauma. As Marlene cared for the patient, she reflected on his life and his current condition. It occurred to her that, "this morning he had gotten up and brushed his teeth and ate breakfast and he had no idea that this might be his last day on earth." Marlene had a strong sense of how young and beautiful he was and what a tragedy his death would be for him and for his family and also of the uncertainty of life. She felt a sense of helplessness and of not knowing quite what to do for him. She reached out. "I just picked up his hand while I was standing next to his bedside, and I just kind of touched his hand and all of a sudden I thought, "Oh, he's cold." And I thought, "I wonder why he's cold?" Drawn into the moment, this simple observation led Marlene to get a warm blanket to spread over him. She proceeded to wash the blood away and

perform basic nursing care tasks as a way of connecting to him. She also started talking to him about his situation. Again, it was a simple monolog on her part that was focused on the patient. Marlene said, "It was keeping me awake but it was also connecting me to this man who was unconscious and shutting down." She continued, through the night, to care for this young man, who was not expected to live, as though he would indeed recover and go on with his life.

This narrative invokes all the feelings of helplessness and shared humanity that will be more deeply explored in the section on solicitude. In terms of how narrative shapes action which in turn shapes narrative, she continues the story to tell of how this patient survived and later told her how much he had appreciated the warm blankets that he knew she had brought him. Even though there was no way she could have known that he would recover and remember the warm blankets, she engaged in the interaction with him *as if* he would. Her actions in that moment fostered the recovery of the patient because she could see and share possibilities for his future, $memesis_3$.

Ricoeur (1992; 170) states; "We have made narration serve as a natural transition between description and prescription." Through narrative, the nurse and patient configure events into a meaningful story that guides the acts of caring on the part of the nurse and may provide the patient with an opportunity to reconfigure his or her own understanding of the significance of events in his or her life.

Play

Three themes emerged from the category, Play. The categories were Preparing the ground, Giving In, Creating With. The first, Preparing the Ground, illustrates Gadamer's claim that play occurs in a space and time set aside for it. The second, Giving In,

describes the experience of my conversation partners as they immerse themselves in the moment with the patient, allowing the interaction between themselves and the patient to take primacy. The third, Creating With, describes the creative process that emerges as the nurse and patient interact as unique individuals to form a connection and share an experience.

Several of my conversation partners describe presence as the art of nursing. Some liken presence with a patient to the creative process. Charelambous (2010) proposes that a nurse approaches a patient as one would approach a text. Gadamer's work discusses the approach to the text, often in terms of art as a text, and presents play as the to-and-fro interchange that happens between a person and the text. This dynamic interaction results in a change in the person who interacts with the text. "The work of art has its true being in the fact that it becomes experience that changes the person who experiences it" (Gadamer 1986:103). Nurses typically think about what they do that changes the situation of the patient. It requires a different way of thinking about being with a patient to acknowledge the change that interaction with the patient brings about in the nurse.

Gadamer (1986) asserts that there is a sense of timelessness associated with the experience of play, and also that preparation is required in order to fully engage. Boundaries exist around the interaction that set it off from usual activities. One example of these kinds of boundaries are the experience of sacred time contrasted with the profane. A more concrete example is the boundaries of a field on which a game is played such as soccer or baseball.

Preparing the ground

Gadamer (1986) proposes that preparation is required for play to occur.

> Setting off the playing field- just like setting off sacred precincts, as Huizinga rightly points out- sets off the sphere of play as a closed world, one without transition and mediation to the world of aims" (Gadamer 1986:107).

What does this setting off of the playing field look like in nursing presence? Each of my conversation partners had a clear idea or sense of what this required. Baruch states, "It is a quality that is brought in intentionally." Karen describes actually preparing the space in which she will be present with the patient in her role as a massage therapist working with Healing Services. She turns down the lights and puts on music. This, she says, not only creates a special space and time for the patient, but signals other nurses that she is working with the patient and they should be mindful of coming into that environment. For Marilee, it is about the environment in which a relationship develops. "It's about creating the environments so that that (presence) can occur, and then it's up to the other person to figure out what their place is in it and where they're going to go with it." She then discusses the unfolding of the relationship within the boundaries created:

> I think to be present means that you're able to be in that moment. You're with the person and you're not thinking about what's going on someplace else or you're not thinking about the traffic, you're not thinking about what you're going to do next, it's kind of like the '60s book, "Be Here Now." You are here right now and all that you have is focused. When you're truly in that place of being present there's a transcendence that at least I become aware of where you're not out of your body but you're on a different playing field.

Sharon describes what she does to prepare for entering into a space with a patient. She says,

> Maybe I've taken some time passing the threshold of the door of the patient to kind of let things go that are in my mind, monkey talk that's going on. I'm taking a deep breath and being open to an individual who is in a compromised state, being my patient or my

> client, and being open to all the possibilities of what is going to happen in that encounter.

Sharon describes a process of being open and kind of vulnerable to the opportunity and being able to respond in a heartfelt way to whatever is particular to that unique situation. She says, "The exciting thing about it is it's always different, you never know what the outcome is and it's an effort to make that happen."

Marlene describes her sense of what the nurse does as, "You're opening. Yes. And that ability to be open, verbally, non-verbally, creates that basic trust and rapport that I think is at the basis of caring." Cyndie describes it as, "Being able to suspend all the other things that are going on to be present to that person and that moment, or that family and that moment." Ann Rose says simply, "It requires stopping." Gayle cites the attitude required to enter presence as "Being willing to let go, let go of our positionality and letting go of 'I have the answers'."

Not all patient circumstances are conducive to being present. One of the descriptions of play is that of a sense of looseness and a freedom from restriction. "Play arises from an excess over and above what is strictly necessary and purposive" (Gadamer1986:125). In circumstances where the nurse is rushed or uncomfortable, she/he may not fully engage in the moment, and this is true for patients as well.

Indra feels that a certain level of security or trust in the nurse is required for patients to be comfortable engaging in the moment of presence with the nurse:

> When people feel safe they are more likely to open up and I think that that's essential in the healing process, whether it be an amputation or a heart attack or diabetes. I think that for we as nurses that's an important role, is to give that to our patients, that ability to express how they're feeling and to bring the presence of fullness to them.

Emotional safety is important for the patient to feel comfortable opening, the same can be said for the nurse. Karen reports an instance where she felt that she could not be present with a co-worker because she did not feel safe. “I could not be present when I was being attacked. So I think that’s when I hit my wall, is when I’m being attacked.” Anger and fear clearly present an obstacle for her ability to be present in a given situation.

Timelessness

Gadamer (1986) describes a different sense of temporality experienced by one who is engaged in play. “This contemporanaeity and presentness of aesthetic being is generally called its timelessness” (Gadamer 1986:119). Each of my conversation partners cited a sense of timelessness, of a telescoping of time in interactions that they qualify as an instance of presence with a patient. They reported that awareness of time is superseded by the details of the moment. Their agenda for the patient or for themselves is suspended in favor of taking in all that is available in present time and space

Baruch talked about a sense of time shifting during periods of presence. He feels as though during those times he and the patient are not so bound by time. He reports a feeling of things slowing down a lot. Gayle’s description is more like a telescoping of time. She describes, “those moments where minutes feel like hours. Where you feel like you’ve been there for an extended period of time and you walk out and it’s been 5 minutes.” She also feels that having an open heart is a prerequisite for this experience. “If my heart is open then it’s easier to be in timeless awareness in that moment, knowing

there's the exact amount of time necessarily to accomplish and it doesn't take long. All of this happens in a nanosecond and it's a felt sense."

Gadamer (1986:119) describes the richness of the moment; "The suprahistorical, 'sacred' time, in which the 'present' is not the fleeting moment but the fullness of time, is described from the point of view of 'existential' temporality, characterized by its being solemn, leisurely, innocent, or whatever." In the case of nursing presence, there is fullness in the creative potential of the moment, as explored in the section on narrative identity. This is the creative process that the nurse engages in when interacting with the patient to interpret the moment. Marilee describes it as very similar to creating a work of art:

> It's kind of like being in that space when you're training in art, is that when you really get in the flow you're in a transcendent moment and time slips away, it doesn't matter what's going on anywhere else – you are just there with that person right then.

Even though this sense of presence can take very little time, for the nurse who is hurried, a sense of restriction on time can be an impediment to being present with a patient. Mintie reflects on the cultural differences in terms of attitude towards time that she found between practicing in Guyana and practicing in New York. She gives an example of working in a New York hospital on a unit where the nurses must clock in and clock out at precise times and are expected to work without pay if they are not able to complete their work during their shift, regardless of the workload. Medications must also be given strictly on time or punitive action is taken. She feels that this emphasis on the clock detracts from the ability of the nurse to prioritize being present with the patient. She contrasts this with her experience in Guyana, where she practiced as a young nurse.

> Maybe somebody dies and you can spend time with them without worrying about the medication you have to give or whatever else you have to do. Somebody else will pick it up for you. Here (in New York) it's very different, depending on where you practice. You may want to be present with those patients, but you may have ten others who are waiting for you to be present with them, too.

A nurse who is under so much pressure to accomplish the agenda set for her by the needs of patients and the institution will be less inclined to set those agenda aside and less likely to give in to the to-and-fro interaction required to fully engage in presence with a patent.

As an administrator, Marlene understood the importance of supporting nurses in their relationship to patients by setting expectation, but more specifically by providing adequate staffing to account for the small amount of extra time that allowed for a feeling of "giveness", as Gadamer (1986) calls it. This giveness, or lessening of pressure is very valuable to the nurse who is trying to focus on the wellbeing of the patient rather than the accomplishment of too many tasks. Marlene describes what she did as an administrator that supported the nurses whom she supervised.

> I built that into the acuities. The expectation for nursing care was that there would be backrubs on the floor, there would be time for them to sit down in a chair by them and look at them with eye contact. In actuality it really only added up to a very few minutes per day but the perception of the patients, the perception of the doctors, the perceptions of the nurses was that they were giving real nursing care.

Entering an open state of mind, characterized by the principal of play, requires a decision or at least an awareness of the possibility of openness. It is easier for the nurse to enter this state of mind when she/he is not overwhelmed by time pressures or by emotional or interpersonal factors. The nurse learns to manage powerful emotional states through self-healing practices, and through grounding and centering. These reduce distractions and make her/him more available to the patient, because the nurse's internal

environment has been managed. The external environment can also serve as an impediment to presence through distraction.

Giving in

Gadamer (1986:122) claims that there is an essential difference between someone who "gives himself entirely to the play of art and someone who merely gapes at something out of curiosity." He describes play as "a process that takes place 'in between,'"(1986:122) and creates its own momentum. The sense of momentum one feels when "in the game" is an aspect of what Gadamer (1986:105) describes as the primacy of play over the consciousness of the player. Each player brings her/himself to the field, however the primary focus and is that which their interaction creates. Gadamer 1986:109 reports, "We have seen that play does not have its being in the player's consciousness or attitude, but on the contrary, play draws him into its dominion and fills him with his spirit". Each conversation partner described that sense of absorption in the experience of the moment with the patient.

Gayle described a sense of entering into a sacred time where her experience is fundamentally transpersonal. Her description confirms Gadamer's view that "Play fulfills its purpose only when the player loses himself in play" (Gadamer 1986:103). She asks, "Am I the doer or no, am I just a conduit for light action?" She tells of a transpersonal state that holds that holds no limitations and acknowledges the spiritual, and indeed the mystical nature of the interaction. "I'm not the doer; it's more as though I'm holding the lamp like Florence Nightingale. Isn't it interesting that we use the lamp… It's not me being the doer but rather me being the one present to another human being's process." In this view, the nurse bears light that shines on the instance of togetherness in which the

nurse and patient find themselves. The focus is on the patient's situation rather than the individuals.

Although interaction is primary, the players must not be passive, but must be serious about their engagement in the moment. Gadamer (1986:121) states, "Being present does not simply mean being there along with something else at the same time. To be present means to participate. If someone was present at something, he knows all about how it really was. It is only in a derived sense that presence at something means also a kind of subjective act, that of paying attention to something." As Marilee put it, "You're giving *into* the process rather than giving over." The players must take the play seriously and actively offer what each brings to the field. Gadamer (1986:22) claims "It is worth looking more closely at the fundamental giveness of play and its structures to reveal the element of free play as free impulse and not simply negatively as freedom from a particular ends." This giveness arises from the availability of the nurse to be fully in the moment and also from a generosity of spirit, or a sense of solicitude. This will be discussed further in the next section.

Judy reports the sense of effort that it takes to really engage with a patient: "You never know what the outcome is and it's an effort to make that happen." Gayle reminded me, "It's a practice. It's most definitely a practice. It's a practice but it's a practice of being willing to let go, let go of our positionality and letting go of 'I have the answers'."

Again, it does not always happen that nurse and patient can engage in this level of interaction. Baruch describes it as a rare occurrence. He attributes this kind of barrier to presence that is attributable to the agenda of the person providing the care.

> Presence between two people… I don't think it happens very often because the provider is usually so preoccupied with what is going on with them that they're really not that present.

Sometimes the lack of engagement is attributable to the nurse being preoccupied and sometimes the nurse has expectations made stale by experience and is seemingly blind to the circumstances. Baruch cautions, "There's a way where you can be even more shut down if you know exactly what you're doing; if you know less than what you're doing then you might be more open to that serendipitous thing that happens." Either way, the unwillingness to give over to the co-creation of an experience may be understood as a barrier to being present.

Another barrier might emanate from a family situation. Cyndie describes a situation with a family in which she felt that they were unwilling to engage in her offer of presence. She states, "They were present in the room physically, but they were not of a mind to have anything but what they wanted heard and said and done." She attributes it to the agenda that they were not willing to reconsider or let go of.

Presence requires the nurse to actively participate in a fluid moment with the patient. This interaction will result in an outcome that she/he does not impose upon the patient but is created along with the patient.

Creating With

Gadamer (1986:103) proposes that "The players are not the subjects of play; instead play merely reaches presentation (Darstelung) through the players." Illustrating this principal beautifully, Indra uses the metaphor of music to convey this sense of creating with the patient. She terms it, "In concert with another person but also in concert with yourself."

Marilee sees a direct connection between the process of creating art and the process of being present with a patient and describes art classes as a possible avenue for teaching students about presence:

> "Actually being able to get into a creative space, I think, has a lot… that maybe it is a way that you can teach about presence. If you can translate that into what it means to be present, the creative process itself creates presence. It's all the same thing, it's all about getting into the flow of relationship in one way or another."

Karen understands it as, "Being present and creating, co-creating those relationships." She describes this dynamic in more detail as, "being present in the room but also being present to the physical, the emotional, the spiritual between the patient and myself." She emphasizes the collaborative nature of the interaction and describes a relationship without hierarchy and with a high degree of sensitivity to the patient on the part of the nurse. "It's listening to the verbal, looking at the physical, listening to intuition about things that they don't say and being able to pick up on that So it's definitely a collaboration, you're here, I'm here, if we're both present then things can happen."

The potential of the moment where nurse and patient connect is profound. It holds potential but also risk. Gayle said, "We're literally standing in that place where anything can happen. It really takes us to the heart of the mystical experience." Cyndie feels, "You never know what's going to happen." Ann Rose points out, "It's a risk. We take that leap into that unknown."

Being present with the patient in the moment means letting go and giving over to the interaction, entering into a place where anything can happen can carry great risk. However, Gadamer (1986:125) suggests that this letting go offers great promise, as well as risk, stating, "What rends him from himself at the same time gives him back the whole

of his being." In the next section I will examine nursing presence through the lens of solicitude, a study that offers confirmation of Gadamer's promise.

Solicitude

Within the category, Solicitude, three categories emerged. The first, The Self, addresses my conversation partner's deepening sense of connection with themselves as unique, irreplaceable, and vulnerable human. The second theme, The Other, described how through deepening the sense of connection with themselves, often through self-healing or meditative activities, they found themselves more available to connect with others. The third theme, The Gift, illuminates the gratitude and sense of grace experienced by my conversation partners when they felt that they had been able to share an experience of presence with a patient. Being really present can present a challenge, but it also offers personal and professional renewal.

Ricoeur (1992:180) defines the ethical perspective as "aiming at the good life, with and for others, in just institutions." He names the second component of the ethical aim, "with and for others" solicitude. Ricoeur claims "solicitude is not something added on to self esteem from outside but that it unfolds the dialogic dimension of self-esteem, which has up to now been passed over in silence" (Ricoeur 1992:180). Furthermore, he asserts, "self-esteem and solicitude cannot be experienced or reflected upon one without the other" (Ricoeur 1992:180).

Modern nursing practice occurs in a system heavily influenced by protocols, standards of practice and endless lists of tasks to be accomplished. Several conversation partners have stated that they have found themselves under great pressure to meet unreasonable workload demands and feel that their ability to be present with patients is

sometimes compromised by the need to adhere to performance standards. Ricoeur addresses this in the following passage:

> Our wager is that it is possible to dig down under the level of obligation and discover an ethical sense not so completely buried under norms that it cannot be invoked when the norms themselves are silent, in the case of undecidable matters of conscience. This is why it is so important to us to give solicitude a more fundamental status than obedience to duty (Ricoeur 1992; 190).

For each of the nurses I spoke with, presence with another human being in the form of their patient was something that felt good and right to them. While being emotionally available to someone who is suffering can be uncomfortable, they felt that they had, through life experience and self-care, built reserves that allowed them to be more available for the patient. They expressed discomfort with nursing care that did not include that level of respect and connection. Ricoeur explains this sense of discomfort in the following words:

> For it is indeed feelings that are revealed in the self by the other's suffering, as well as by the moral injunction coming from the other, feelings spontaneously directed toward others. This intimate union between the ethical aim of solicitude and the affective flesh of feeling seems to me to justify the choice of the term 'solicitude' (Ricoeur 1992:193).

In this section I present and discuss data that explores the relationship of the nurse to her/himself, to the patient and the gift that is created by this interaction.

The Self

Each nurse I spoke with told of the importance of tending to ones own needs and exploring ones humanity in order to grow the capacity to serve the needs of the patient. Karen describes it quite simply, saying, "It may not have been something that I experienced from other people and learned from. I think to myself 'what would I want, how would I want that situation to be' and I think it just kind of naturally occurs."

Indra described the importance of self-care in terms of providing safety for patients. Acknowledging that unhealed trauma on the part of the nurse offers risk to the patient, she stated, "I think it's essential if you want to be present for people that you find how to heal yourself so that you don't take trauma to the relationship, any relationships."

Ann Rose proposes that the principles of Holistic Nursing serve the nurse and patient well because of the attention to self-care emphasized by holistic practice guidelines. She reports:

> I find all the inner work I've done has served me very well. When we are aware of who we are and how we are go about the way as holistic nurses, when we understand that bringing medication to a patient is not just about bringing somebody some pills that it's more than that. From the holistic worldview, presence is an automatic. It is the way we are as holistic nurses.

While some might think that a nurse should set her/himself aside in order to be present for the patient, Karen proposes that this is impossible and even if it were possible it would detract from what the nurse brings to the situation. She tells of a student who claimed to completely leave herself outside the patient environment and not bring any personal feelings in. Karen responded, "Of course you're bringing yourself into there!" To the student, she said, "So you think your care is good?" She said, "Yes." Karen said, "But aren't you denying them something when you don't bring yourself in?" She didn't get it. Because you bring yourself in as 'I'm a mother, I'm a sister, I'm a brother.'" Karen emphasized to the student that her own experience as a human being informs her practice in caring for other human beings.

Cyndie described that she learned the sense of what it takes to be present through learning to be present for herself in her own self-healing experiences:

> I think it comes to me with that sense of being in the moment, that same kind of an idea that you get with a lot of self-healing and other types of different therapies and things, that whole idea of being present for the moment or present to what it is that you're doing.

The self-healing activities of these nurses are central to their discussions of what it takes to be present for another. Cyndie attributes her sense of resilience to her own painful experiences; and the process of healing that followed. Referring to the "brokenness" discussed as part of her narrative identity, Cyndie described how, having gone through the healing process herself, and having been supported in this process, she is better prepared to support others. She implies that there is always a risk to the healing process and that the nurse takes a risk to travel that road with the patient.

Indra offers her conviction that healing herself from trauma she had sustained has contributed directly to her ability to be present:

> I personally have sustained quite a bit of trauma and I had to leave my body. Over years through therapy and groups I retrieved parts of myself and so when I hear questions about the evolution and my own ability to connect and be present with patients and students has evolved. I'm much better, I think, at what I do because I've done the self-work.

Mintie cites the structure offered her in formal education as crucial to her own path of self-healing, which she feels is foundational to the ability to be present. Although her early experience in Guyana taught her to be present with patients, her work in New York did not support her in this. She describes the process whereby she became more empowered to care for herself and to honor her own needs in her graduate education, as well as other life experience. "I've learned to be present through my own personal experience and through my own education, my own journey." I asked her what kind of education supported her in this and she that her graduate work had supported her by

providing structured activities. She describes being required to take a self-care class where for the entire semester she had to write in a journal every day. She had to spend fifteen minutes every day for herself and could choose her activity. She reports regaining a sense of connectedness, improving her sense of wellbeing and losing ten pounds of excess weight. She emphasizes the importance of coming back to self-care practices, "Because I get very lost. You know the pace and the things you do and the energy fields you come into contact with, you can get very disconnected if you're not being aware of it until suddenly you realize you have a neck pain or a foot pain or something and you've lost your connection." She has embraced more self-care in order to maintain that sense of connectedness and wellbeing.

In response to my question about what would impede a nurse's ability to connect in this way with another, Sharon answered;

> Not being familiar with taking time for yourself and being in the moment with your own life. So that's why my focus has been more in nurturing the nurse, to give her moments of intention and presence.

Marilee makes a direct connection between this familiarity with who a nurse is as a human being and the ability to connect with another human being:

> Maybe the ability to be present is being willing to connect into being fully who you are as human being. Because presence isn't a professional relationship, it's a human relationship.

The Other

The focus of ethics is on the relationship between the individual and the larger world. Ricoeur proposes that the presence of the other provides context in which an action can be considered good.

> I am speaking here of goodness: it is, in fact, noteworthy that in many languages goodness is at one and the same time the ethical quality of the aims of action and the orientation of the person toward others, as

> though an action could not be held good unless it were done on behalf of others, out of regard for others. It is this notion of regard that must now attract our attention (Ricoeur 1992:189).

Esteem for oneself and esteem for the other are intimately connected through the understanding that we are each selves. Although each of us is understood to be unique and irreplaceable, we do have in common that quality of being unique and this is a way to create an understanding. In Ricoeur's (1992:194) words, "Becoming in this way fundamentally equivalent are the esteem of the *other as a oneself* and the esteem of *oneself as another*."

When a professional nurse enters into an interaction with the patient, the nature of the relationship is that the patent is somehow in need. In Ricoeur's terms it could be said that the patient is one who suffers and the nurse acts and responds to suffering because of a sense of solicitude. As Cyndie put it, "They (patients) need to know that somebody is paying attention to what they're feeling, paying attention to what they're saying, hearing what they're not saying, and just being present with them." Mintie stated concisely, "You are there with them at that time because they need someone to be present." Mintie's description of the connection between care and presence, of being at the bedside and doing things for the patient at the bedside justify Ricoeur describing presence as the connection between self and being in the world.

As Baruch pointed out earlier, one cannot know with any certainty what another person is thinking or feeling. Ann Rose expressed this sense when asked about the connection, "The mystery! We are all unique with our own experiences so there will always be that part that is the unknown, that is maybe even unknown to us as we explore our own sense."

Mintie describes what it is like to care for a patient:

> Caring is what I do on a day-to-day basis. I do that for you. I care for you. Maybe I give you a massage, or a shower, maybe I just sit and listen to you, whatever you have to say. And sitting and listening, actively listening to you and being there, my presence there focusing only on you is what presence is to me.

She implies that listening and focusing are parts of being present. She also lists the tasks associated with nursing care. While being present with a patient includes these essential tasks, the tasks can be done without presence. Cyndie reports;

> It's really easy sometimes to get caught in the tasks and the mechanicalness of doing what we need to do and forgetting that that's Mrs. Jones, that's not the woman with cancer. We're not thinking of you as your diagnosis.

Marlene, a long-time hospital administrator and nurse manager, told me how she judged whether a nurse was really present with a patient.

> Well their body language speaks volumes, it's like 'I'm in a hurry. I don't have time for you. I'm getting out of this room as quickly as I can to go on to the next person.' Well, that's certainly not going to generate receptivity to a patient, they're going to feel as though that nurse is way too busy to be bothered or simply doesn't care. That's the worst that they can think. So definitely, it's receptivity. It's the approachability that a patient feels toward a nurse that then creates rapport that then creates that feeling of connectivity that a nurse may have with a patient. That is the core of what you want to get to with nursing care. We want to make patients feel valued. We want to let them know by what we do how we care for them and one of the ways that we show them that we care is by listening to them, touching them, showing them respect by sitting with them and looking them in the eye instead of talking to them with our back to them.

Karen describes the attitude with which she feels one should approach a patient, "You're acknowledging him as a person and not just as a patient." She elaborates on the way a patient told her how it felt when Karen was with her:

> One of my clients just said, "It's like I'm the most important person. I feel like you don't have anybody else to see all day long, I'm your only person, even though I know that's not true."

Baruch describes a moment of connection and what that felt like:

> There was this stillness between the two of us and I remember her looking at me and I'm speaking directly to her, and answering this question.

In terms of what is going on when the nurse enters the presence of this patient, this "other", Baruch focuses on the different parts of the interaction.

> There's a couple things going on. There's what's going on with me and if I'm present with myself and what's happening, and then there's my ability to be aware and present with what's happening with me outside the other person, and then there's the process of what's happening with me and what's happening with the other person and how we're interacting or relating with each other. So to be present, and it doesn't happen that often, it is being available to the person in a way that the person is able to be in that moment. So that doesn't necessarily happen all the time, but when it does happen it's pretty clear that it's happening.

When asked how one would go about preparing a student for this kind of encounter, Baruch replies;

> Teaching them to have some kind of awareness of themselves and having some kind of an awareness of the other and to be doing both at the same time.

However, maintaining an awareness of suffering that may also trigger one's own pain can be a daunting prospect.

Cyndie describes the process of being present with a suffering other as a challenge;

> Can I stand in their situation with them and I think that kind of becomes part of… can I stand in their illness, can I stand in their brokenness, can I stand in that spot with them because it's a scary spot to be in.

To meet the challenge, one must have a sense of one's own strength, one's resilience.

Ann Rose offered her approach to the challenge of being with a suffering person:

> I have learned, especially through self-care and through TM (transcendental meditation), to let that just wash and to just stay with the patient within that immediate environment, just stay with the patient.

Gayle offered an example of the feelings of helplessness that a nurse can go through when confronted with suffering, and the process by which she was able to stay with the patient, physically and emotionally to act in a way that relieved his suffering simply by being present with him. She reports, "I felt my smallness, I felt my humility, I felt my desire and compassion to really help this human being. I felt all of that and when I reached him all that went away and all that was present and all that was left was a tremendous desire just to simply be there with another human being who is suffering." Gayle's compassion and desire to help overcame her sense of helplessness and smallness, and she was able to manage her own feelings and reach out to the patient to deeply connect with him. She describes the state of being from which healing emerges. "The state is learning how to move out of suffering and into care, into compassion." This vignette is presented during the summary of this Chapter because it offers an eloquent example of how narrative, solicitude and play all interact in a patient encounter.

Ricoeur (1992:190) posits that suffering is at the other end of the spectrum from solicitude and also that "Sharing the pain of suffering is not symmetrically opposite to sharing pleasure." In order to share the pain of suffering with the one who suffers requires resilience and the willingness to engage as a human being, Marilee wonders:

> Maybe the ability to be present is being willing to connect into being fully who you are as human being. Because presence isn't a professional relationship, it's a human relationship.

This is not easy, but within the situation is a gift. Ricoeur (1992:191) states, "A self reminded of the vulnerability of the condition of mortality can receive from the friend's

weakness more than he or she can give in return by drawing from his or her own reserves of strength." As nurses, we share the condition of mortality with our patients. Sharing moments of profound connection in this way reveals strength as well as pain.

The Gift

The instances when the nurses I spoke with connected in presence with a patient were deeply gratifying. Cyndie said, "It's a heart thing, it's not even heart. It's soul, it's spirit, it's someplace even deeper than heart." She went on to describe a sense of mutual recognition, "I think some people look at it as that spiritualness, that sense of spirit and the spirit in me and the spirit in you/me." Indra, using the metaphor of music, described presence as being "In concert with another person but also in concert with yourself." Marilee described it as, "You're really getting what the other person is saying, they're really getting where you are, there's a sense of true connection." Marilee's description illuminates an image of the imperfection of life giving way, through that human connection to a certain level of clarity and place of mutual understanding. She described it as:

> Kind of being in the muck together so to speak. Being in the muck to the point where you find that place of human mutuality, that connection, that place of oh yeah, we're in this together and we have come to a place that we can both understand.

Ricoeur (1992) proposes that the ability to respond to a suffering patient in this way is fundamental to living an ethical life. The dissymmetry in the relationship, the vulnerability of the patient relative to the situation of the nurse, creates an opportunity for the nurse, in turn, to make her/himself vulnerable to the patient and to act with compassion to connect on a human level. That, in turn, affirms the shared human

connectivity of both the nurse and the patient. About this shared humanity, Ricoeur (1992:191) says:

> In true sympathy, the self, whose power of acting is at the start greater than that of its other, finds itself affected by all that the suffering other offers to it in return. For from the suffering other there comes a giving that is no longer drawn from the power of acting and existing but precisely from weakness itself. This is perhaps the supreme test of solicitude, when unequal power finds compensation in an authentic reciprocity in exchange, which, in the hour of agony, finds refuge in the shared whisper of voices or the feeble embrace of clasped hands

Solicitude is the natural response of a person who seeks to live what Ricoeur (1992) refers to as the Aristotelian concept of the good life. It is the natural response of the nurses I spoke with. Each one spoke of the reward inherent in being available, truly present with and for their patients. Ricoeur (1992:190) describes the status of solicitude as "that of benevolent spontaneity, intimately related to self-esteem within the framework of the aim of the good life." Because the impulse toward just and compassionate action stems from spontaneity, rather than obligation, "receiving is on an equal footing with the summons to responsibility"(Ricoeur 1992:190). The patient is not made less by receiving care, but instead the nurse and patient both honor their humanity through need and response to need. Ricoeur (1992; 190) describes the equality inherent in the interaction that exists despite the superficial appearance of asymmetrical giving: "This equality, to be sure, is not that of friendship, in which giving and receiving are hypothetically balanced. Instead, it compensates for the initial dissymmetry resulting from the primacy of the other in the situation of instruction, through the reverse movement of recognition." Indra affirms that there is a gift for the giver within the instance of presence. She reports, "When you are able to show that you care about somebody through your nonverbal

communication, through your written communication, and verbal communication it can really heal something within yourself." This healing is, to Indra, the gift.

A nurse who shares a moment of presence with a patient may experience revitalization. As Marilee put it, "That's what nurses describe when they describe a caring moment. Is they come away from it feeling like, yes, this is why I did nursing!" When nurses can connect with patients in this way, it reflects well on the organization as well, through comments on patient satisfaction surveys. Marlene told me:

> Nurses who really practice with presence, that relationship is strengthened and the patient satisfaction surveys reflect that. Nurses who are more task-oriented, who don't spend the time, who are not present with their patients, who just rush in and rush out, they don't have nearly the patient satisfaction that nurses who are more present have.

Judy describes the sense of personal reward and affirmation she receives. As she put it, "It gives us worth to what we're doing. It's like, OK, I'm not crazy for trying to do this in this totally insane system."

There is a gift in the moment when the nurse is present for the patient that is shared by both parties. Gayle reminded me of the iconic image that is associated with nursing-- that of Florence Nightingale holding a lamp at night in a dark army hospital. Being present with a patient is in many ways like holding a lamp that provides light and comfort to the both patient and to the nurse. Gayle echoes what Marilee and Indra expressed, "If you can go into that state you heal too."

Ann Rose expresses this sense in a particularly holistic way. When I had my conversation with her, she had just finished a workshop in which she created a mandala that she felt expresses her feelings better than she could have done in words (See Appendix D). The mandala portrays a spiral with a rhythmic pattern and writing that

repeats through the pattern and says, “Thank you for this moment!” again and again. A picture of the mandala is on the next page. Perhaps, though, Marlene summed up presence in the most concise and poetic way. She said simply, “Being present is love, it’s love in action.”

Love in Action

The following vignette illustrates the practice of narrative identity, play, and solicitude within an instance of nursing presence. Through the orientation of solicitude, the nurse engages in an open interaction with the patient (play) that is rooted in present time (memesis$_2$). The narrative that is constructed guides the action that results in acts of caring, both technical and interpersonal. Gayle’s story about the patient in crisis with whom she engaged illustrates all three concepts, narrative, play and solicitude, in one vignette. The first part begins with the narrative she has constructed with information she gained from other nurses and also from what she observed herself:

> I was called to see a patient who just had had open heart surgery the day before and this was around 10 o’clock in the morning and they had just extubated him and he was in grievous pain. He was moaning and writhing on the bed and just so uncomfortable and they’d really maxed out every med they could give him to help him be comfortable.

The next section is a description of what solicitude feels like and how the suffering of others can trigger our own suffering. I have added italics for emphasis. Gayle had been called by the nurses on the unit to help this patient because the other nurses felt that they could not. When Gayle entered the situation, she had the following experience:

> So, I had the egoic moment of ‘Oh my God, what am I supposed to do?’ *I felt my smallness, I felt my humility, I felt my desire and compassion to really help this human being. I felt all of that and when I reached him all that went away and all that was present and all that was left was a tremendous desire just to simply be there with*

> *another human being who is suffering.* And just thinking about it I can feel state come over me.

The pain medication had not worked and she could not have given more because it would have resulted in respiratory suppression and significantly endanger the patient. She began to inventory the skills that she had learned and found them insufficient to the situation:

> He was hard of hearing so I couldn't use imagery, he couldn't take a deep breath because it hurt so I couldn't use essential oil, and he was moaning!

So she let go of the agenda, entered into an open space (play) where unforeseen possibilities could emerge and she began to seriously engage with the patient. She let go of the need to know right away what to do and entered into a state of receptivity. She was open to simply being with the question.

> So I thought 'Well, this is interesting." And so there was yet again another story of 'What do I do? What do I do? What do I do?' And it moves into *you simply are, you simply be, and what starts to unfold*.

Gayle's understanding of herself, her narrative identity, includes her life experience and all the skills she has accumulated and can be brought to bear in service of the patient:

> So in that moment *it's very helpful to have a lot of tools in your kit, the more tools in your kit the more you can let go* and I think that's part of the process, too, is learning a full cornucopia of things that you can do to support, and here, again, is the key, particular in the acute-care setting – the task is to move somebody out of the fight-or-flight, because this man was so stimulated, so over-stimulated from fear and pain and that there is no medication short of literally knocking someone out that's going to help at that point.

Gayle created a narrative that she began to share with the patient:

> So it was the power of presence that started to shift it for him and I literally held his, in *gin shin Jyutsu* terms, his thumb, his one, and I grabbed his thumb and *I got as close to his face as I could and I said "I am not leaving you until you are comfortable."*

She then engaged in an energetic interaction with the patient. It was nonverbal for the most part, but resulted in the establishment of a deep rapport that stabilized him.

> So, I wanted him to know my commitment to him, that I was going to support him to find comfort. So, basically what I started to do is breathe, so I work with his breath. There's something called entrainment, vibrational entrainment, he is in chaos, I'm not in chaos. So, I've got to match his rhythm and then have his rhythm start to come closer aligned to my rhythm which is more harmonious and less chaotic. So I started with his chaotic kind of moaning, at the same time working with his breath in a way that was happened for him. At same time I was using some therapeutic touch to help restore flow essentially.

This unconventional engagement with the patient did not conform to the norms of practice to which nurses are held. In this way, it is clear that solicitude had taken primacy over norms. The difference that this made in the clinical course of the patient is clear:

> So in 15 minutes he was asleep. The next day I came to see him and he was just bright faced, had been up walking and it had completely turned his journey around.

Here was an instance of nursing presence, as understood through the lenses of narrative, play and solicitude, which had a significant impact on the course of a patient's recovery following heart surgery.

Summary of Chapter Four

Chapter Four presents data gathered in research conversations about presence that described narrative identity, play and solicitude as they appear in nursing practice. The committed and compassionate nurse with a strong connection to self, $memesis_1$, explores possible futures, $memesis_3$, with a patient. My conversation partners learned to do this through mentoring and by going through the healing process themselves. They entered into the moment with the patient, $memesis_2$, and work to create the possible future. Through language, my conversation partners interpret the stories of who they are, who

their patients are, and find both meaning and direction for activities that pertain to care. They engaged in an open interaction with patients that focused on the moment to the exclusion of other demands. The interactions had a sense of lightness, yet also a sense of purpose and engagement. The conversation partners cited a sense of suspended time. All of these descriptions fit with Gadamer's description of play. Finally, solicitude is demonstrated in the narratives shared by conversation partners. Their work springs from an ethical aesthetic that cannot tolerate the sense of discomfort that an unanswered need for care presents them.

The Chapter concludes with a vignette that illustrates all three of these concepts in action within the context an instance of nursing presence in the case of a patient recovering from heart surgery that was experiencing intractable pain and anxiety.

CHAPTER FIVE: SUMMMARY, FINDINGS AND IMPLICATIONS

Introduction

In Chapter One I presented a vignette about a woman, hospitalized and very ill, who noticed distinct differences between her caregivers although she was not able to respond to them at the time. Then I posed the following questions: What was the difference between the nurses who provided her with what she felt were real means for recovery and those who were simply performing technically correct actions? What is the nature of the interaction that takes place when the nurse enters the room and touches the patient's world? Technical expertise is certainly important, but expertise does not guarantee the application of that knowledge to an individual patient. What does it take for the nurse who walks through that door to be cognizant of the unique circumstances that exist within and around that interaction, and to bring to bear the best possible judgment? Chapter Five addresses these questions and provides a summary of the research that includes the issue at hand, the literature review, the conversation partners and the theoretical framework. Implications for nursing education and nursing practice will be discussed, as well as possibilities for future research. Chapter Five is finalized with my personal reflection on this exploration.

Summary of the Research

Presence in nursing practice has been a significant concept and foundational for many theories of nursing practice. Presence has been in the nursing literature since the nineteenth century, and has been explored to a limited degree in recent years. Research studies agree that presence is desirable. Consensus about what presence is, whether it is possible to teach it, and how to encourage nurses to demonstrate it has not been achieved.

Although some researchers have sought to reduce presence to behaviors and measure it, these efforts have not been satisfactory and researchers have been seeking different ways to study presence in nursing.

Interpretive theory has been shown to be relevant to nursing practice. Scientific inquiry, though valuable for understanding how to achieve outcomes, is insufficient for the process of discovering meaning and creating new possibilities. Critical hermeneutic research involves processes of description, reconfiguration and prescription and can provide insight about many issues in nursing practice that are not well addressed. In particular, critical hermeneutic research explores meaning and may lead to the creation of new possibilities for clinical nursing care through new understanding of the relationships between nurses and patients.

This research explored the phenomena of presence in nursing practice with eleven research conversation partners and analyzed the data using the concepts of narrative identity, play, and solicitude. The conversation partners were experienced professional nurses. Experience levels ranged from five years to over thirty years and included a very wide range of areas of practice including acute and intensive care, hospice and home care, psychiatric care, case management, administration and nursing education. These nurses are passionate about their nursing practice and were eager to share with me their thoughts and feelings about that which they feel is at the heart of nursing practice. The analysis of these conversations resulted in a new understanding of presence in nursing practice.

Research Findings

Nursing presence is a concept already woven into the narrative about what nurses are and what they do. Nurses have scientific and technical expertise, but are also skilled communicators and moral actors. Technology cannot replace the need of human beings for trusting, caring relationships with the people around them. It is the art of communication and the aesthetic sense of right action in response to a vulnerable human being that makes the difference between technically proficient care and the kind of care that gave the patient in Chapter One what she felt provided her with real means for recovery. The data analysis supported the following findings.

Awareness. Being present with a patient calls forth an awareness of the interaction that includes moment-to-moment changes as well as the context of a situation. It requires that the nurse maintain an awareness of self as well as an awareness of the patient, and is more than a set of observable behaviors. This can be cultivated by practices that have been developed specifically to increase awareness of the moment, such as mindfulness meditation. Eastern philosophy teaches cultivation of awareness and mindfulness meditation derives from traditional Buddhist practices. There is currently a body of literature addressing the practice of mindfulness in health care and education, and the data in this research supports the integration of these practices into nursing education and nursing practice (Praissman 2008, Paulin et al. 2008, Baer 2003).

Self-healing and healing others. The nurses I spoke with were informed of possibilities for healing that are unexpected and profound ($memesis_3$) by their training as well as their own experiences of suffering and healing ($memesis_1$). Their ipse included an ethical orientation toward a humanitarian response. They engaged with patients in an

open, explorative manner that involved the patient in the creation of a new narrative ($memesis_2$). My conversation partners cited self-care and self-healing practices, such as meditation, massage or counseling as generative of the capacity to be present with a patient. Having done this self-healing work, they are better able to manage the overwhelming feelings that arise and can distract one from being present with the other when one witnesses human suffering. This helps them stay present and to choose action that is consistent with their sense of solicitude for the suffering other.

A Moral aesthetic. To engage in presence with a suffering person satisfies a moral aesthetic that is deeply ingrained in the nurse's sense of self. Because of who the nurse is a human being, she/he has a desire to engage in interaction with the patient at a level that goes beyond technical expertise and addresses the issue of human suffering. This desire springs not only from a sense of duty but also from a sense of shared humanity and an ethical aim. From this aesthetic sense of right and wrong, the nurse moves spontaneously toward praxis, or ethical action.

Identity evolves and is reiterative. The nurses sense of solicitude informed their idem, which in turn informs the narrative she/he holds about her/his past ($memesis_1$). It also informs the nurse about what how she/he should interact with the patient ($memesis_3$). It is the nurse's ability to engage in play ($memesis_2$) that involves the patient in the process of imagining the future, reconfiguring $memesis_3$, and choosing actions that move in the desired direction ($memesis_2$).

Implications for Practice

The data and analysis suggest the following recommendations pertaining to nursing practice. Nurses can be encouraged to engage in self-care activities that

acknowledge and help to heal the pain that they themselves are in, and also to practice techniques, such as mindfulness meditation, that calm and focus the mind. This will not only help them develop the capacity, insights and attitudes that support patients, but also to develop more situational awareness of the situations that may endanger patients. Through these practices nurses can, as Indra put it, move from woundedness to healing or as Gayle put it, from chaos to order. By reflecting on one's own experience as well as that of the patient, a nurse gains a sense of resilience and is less likely to be overwhelmed by the pain that the patient experiences. This has implications for patient safety as well as the healing process, and clearly constitutes an important area for professional development.

Nurse leaders and nurse administrators have an opportunity to encourage the practice of presence with patients by describing it, praising it, and providing practical support whenever possible. Nurses who are distracted by their own pain, by workload pressures and by a bureaucracy more concerned with protocols, logistics and financial concerns than with serving the needs of individual people are not as likely to be available in the moment to vulnerable patients. Although the business model has created great challenges for nurses it has also generated a desire to measure customer satisfaction. This is, ironically, supportive of nursing presence because, as several of my conversation partners stated, patients may not be able to judge whether a procedure was done properly, but they are quick to notice whether their nurse cared about them as people. Since reimbursement rates will soon be determined to some degree by patient satisfaction levels, administrators now also have an economic interest in encouraging nurses to engage in this quality of care with patients.

The art of nursing is still important and can be cultivated. Modern health care is dominated by an emphasis on technology, which has advanced rapidly over the past seventy years. Nurses, as expert technicians and scientists, have been at the forefront of application of that technology and have served as the interface between the technology and the people it is designed to serve. And yet, the best technology available cannot connect with a frightened person to gain their trust and soothe their fears before surgery, cannot discern the subtle nuances in a patients condition that signal despair, and cannot choose the right moment to hold the hand of a person who has just lost a limb, share the grief of that moment and affirm the humanity and resilience of that person. This is the art of nursing, and it is every bit as important as the skills and technologies nurses use to save lives. This humanitarian mission is at the heart of nursing practice. Nurses should embrace it and value it. To do otherwise is to remain voiceless.

Recommendations for Nursing Education

Researchers have called upon nurse educators to teach nursing presence in schools of nursing. I found that presence can not be taught as a separate skill set that is measurable but that the ability to be present with a patient is something that can be fostered in the process of educating a nurse. While there is no clear recipe for presence, my conversation partners also cited activities that supported their ability to be present with patients. These activities included reflective, meditative, or other self-healing practices. In light of this opportunity, the following recommendations are offered.

Faculty can offer students the experience of being valued as unique human beings by engaging them in reflective dialog about issues of significance in their lives. This

experience supports a students sense of self and encourages her/him to value her/himself while demonstrating care for the other.

Self-care practices could be structured into the curriculum. Mindfulness meditation could be included in the curriculum, and students can be offered counseling services and other opportunities to address their own needs for healing. Students given the opportunity to heal their own pain will be better able to be present to the pain of others. They are also informed on a personal and intuitive level about the healing process. It is appropriate to include self-healing, meditative, and reflective activities in the curriculum that foster each student's sense of connectedness with self. Faculty who participate will demonstrate to students the value of these practices. Mindfulness meditation is a practice that encourages the student to be open to their internal and external environments. It has a body of research around it that has achieved a level of acceptance in the medical community and could be considered a fundamental skill.

Ethical education for nurses should include personal reflection and the cultivation of a strong sense of their own ethical orientation. It is important for these courses to be focused on clinical practice. Students should be supported to grow their understanding of what it means to be an ethical actor and taught to be articulate about the choices they make. This could help them to respond more clearly to the sense of solicitude that they have and to be better able to advocate for their patients. As nursing students grow to esteem themselves more, so shall they better be able to esteem others.

Nurse educators could encourage students to explore their feelings and thoughts about the situations they encounter in the clinical area as well as within their personal lives. This would cultivate reflexivity in students. Ricoeur proposes that people learn

about themselves through reflexivity, and thus become more understanding of other selves.

Many of my conversation partners felt that the ability to be present was a trait that they had always possessed. Nursing students typically come to nursing with a desire to help people, although some may come because of the availability of jobs in that area. It seems to me, as a nursing instructor, that many of those without at least some talent in terms of connecting with people either choose not to come into nursing, or choose not to continue once they get a sense of what is required. Therefore, the majority of nursing students come into the field with the potential to be present for patients and it behooves us, as educators, to cultivate their ability to do so.

Areas for Further Research

Nursing research primarily has focused on how to best achieve patient outcomes. While this may be appropriate when the known outcome is clearly identifiable, this is not always the case. The connection between nurse and patient lies at the heart of nursing care, which is a humanitarian intent to ease the suffering of fellow human beings. This connection is unique to each circumstance, and two situations are quite alike, therefore the stories of these relationships, which include rich detail, are an important part of nursing knowledge. It is ironic that this area has been de-emphasized in the modern era of health care in the United States. Research is needed to better understand the nurse-patient dynamic and to learn how to foster it in nursing practice, starting with nursing education. With its focus on description and prescription, critical hermeneutic inquiry offers significant possibilities to the process of change in the United States health care system.

A natural area for future research is the experience of patients in terms of nursing presence. What is their experience and how could nurses be more helpful? One area ripe for exploration is the experience of nursing students in terms of their own need for healing during the educational process and their relationships with faculty. Since nursing is a moral and ethical practice, the relationships between nurses themselves would be of interest. In particular, the relationships between nurse managers and staff nurses would be an area of inquiry that could create new possibilities for the profession.

Finally, it may be that the fostering of self-care practices may also foster assertiveness and leadership in nurses. This possibility and others should be explored. The stories of how nurse leaders developed may lend insight into how to foster this capacity in nursing students, as well.

Personal Reflection

The process of reviewing the literature, choosing conversation partners and engaging in the exploration of this issue was life affirming for me. I, like my conversation partners, have been inspired in my practice when I have had the opportunity to be present with people who are experiencing life altering situations. Presence is a gift and not an easy one to bear. I have been strengthened in my ability to be present by healing projects undertaken in my personal life.

Five years ago, I completed a Masters Degree in Nursing. The focus of the program was on Integrative Health Practices. For my thesis, I traveled to Mexico to examine the decision-making process of patients who chose alternative medicine approaches and left the US to go to clinics in Mexico. Many of the treatments offered at those clinics had not been approved by the U.S. Food and Drug Administration. People

who chose to circumvent these regulations intrigued me. My father, who died of cancer in 2004, was one of these people.

Each of the patients I conversed with there had a story to tell about how the treatment they had chosen was supposed to work, and every one of them had finalized their decision because of a connection they felt with the people offering the treatment. While the facilities were not up to the standards one would expect in an American hospital, the patients all spoke very highly of the care they received and most of them expressed dismay and great pain over the lack of caring presence that they received from American nurses and physicians.

Changing my focus from complementary and alternative medicine to nursing presence has felt like a natural development. Nurses have always used whatever technology is available to care for people. We have always been astute observers, in the scientific tradition, of what works and what does not work. We must not get distracted by the technologies themselves or by the requirements of the business model that has corrupted our practice. We must be much less attached to the technologies we use than the cause that we serve, which is to respond with compassion and act to relieve the suffering of the other. Furthermore, we should embrace what it is that we do and not think it somehow less than the natural sciences or business practices, both of which heavily influence the health care industry. This art of nursing is the strength of nursing and when we embrace it, we find our voice. To repeat what Marlene said, nursing is love in action, and there is nothing as powerful as love.

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APPENDICES

Appendix A: Letter of Invitation and Research Questions

Date:

Participant's Name
Participant's Address

Dear (Name of Participant),

I am a doctoral student at the University of San Francisco in the Organization and Leadership Program. I am conducting my dissertation research on the experience of presence within nursing practice.

My research is grounded in interpretive theory and has a participatory orientation. In place of formal interviews or surveys, I engage participants in conversations using guiding questions directed toward their experiences with presence. Upon your approval, the conversations are audio and/or video recorded and then transcribed. You may request the recording device be turned off at any time during the conversation. I will send you a copy of the transcript for your review. At that time, you may add, delete or change any of the transcribed text. Upon receipt of your approval, I will analyze the data. Please note that participation in this research, including all data collected, the names of individuals, and any affiliations is not confidential. Before participating in the research you will be required to sign a consent form.

I am particularly interested in discussing your understanding of what it is to be present and what that means in the context of patient care. Since presence has been associated with positive outcomes for the patient as well as the nurse, I would like to explore what can be done to foster the ability of a nurse to be present with a patient. The following questions may be used to guide the conversation:

1. What is your experience with presence?
2. In what circumstances do you experience presence?
3. What supports you in being present?
4. Do you feel your overall ability to be present with people has changed over the years? If so, how has it changed?
5. What is the nature of the relationship between you and a person with whom you are present?

If you are willing to participate in this research, or if you have questions about this study, please feel free to contact me. I can be reached via email at ihpnurse@gmail.com or by telephone at (415) 272-0644.

Thank you for considering this request.

Sincerely,

Alicia Bright
Research Doctoral Student
University of San Francisco
School of Education
Organization and Leadership Program
alicia.bright@dominican.edu
(415) 272-0644

Appendix B: Research Participant Confirmation Letter

Date

Participant's Name
Address

Dear (Participant's Name)

Thank you for agreeing to speak with me about the research I am conducting for my doctoral dissertation. I look forward to hearing your insights about the phenomena of presence in nursing practice.

This letter confirms our meeting on ***Day, Month ##*** at ***Time***. As discussed, we will meet at ***PLACE***. Please contact me if you would like to arrange a different time or meeting place.

With your approval, I will be recording our conversation (audio and/or video), transcribing it into a written text, and providing you with a copy of the transcripts for your review. After you have reviewed and reflected upon the transcript, you may add, delete, or change portions of the transcript as you deem appropriate. The conversations are an important element in my research. Please take notice that all of the data for this research project including your name are not confidential. Additionally, I may use your name in my dissertation and subsequent publications.

I appreciate your contribution to this research and look forward to speaking with you.

Best regards,

Alicia Bright
Research Doctoral Student
University of San Francisco
School of Education
Organization and Leadership Program
Alicia.bright@dominican.edu
(415) 272-0644

Appendix C: Sample Thank You Letter

Date
Participants Name
Participants Address

Dear Dr./Ms.,

Thank you for meeting with me on _____. Your insights and experience have been invaluable to my dissertation research and I appreciate your willingness to participate in this project.

I have enclosed a copy of our transcribed conversation for your review. Please take a moment to read through the transcript and make any additions, changes or deletions to clarify any points as you see fit. I will contact you in two weeks to see if you have any questions and to discuss any changes you might have made.

After this is complete, I will use the edited version of our conversation to analyze along with other conversations and sources of data.

Thank you, again, for your participation. I have enjoyed our conversation and I hope that this process has provided you with new understandings about your experience as well.

Kind Regards,

Alicia Bright
Researcher, Doctoral Student
University of San Francisco
Organization and Leadership, School of Education
ihpnurse@gmail.com / 415-272-0644

Appendix D: Mandala by Ann Rose Dichov