

Article

A Critical Hermeneutic Analysis of Presence in Nursing Practice

Alicia L. Bright

Department of Nursing, School of Health and Natural Sciences, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94920, USA; E-Mail: alicia.bright@dominican.edu; Tel.: +1-415-272-0644

Academic Editors: Sara Horton-Deutsch and Pamela Ironside

Received: 22 September 2015 / Accepted: 15 November 2015 / Published: 9 December 2015

Abstract: Nursing presence, although it involves action at times, is a humanitarian quality of relating to a patient that is known to have powerful and positive implications for both nurse and patient. However, this phenomenon has not been well understood. Three theories, drawn from the work of Paul Ricoeur and Hans-Georg Gadamer, served as the boundaries for both data collection and analysis. The theories were narrative identity, play and solicitude. This study follows a critical hermeneutic approach to field research and data analysis. Literature regarding nursing presence is reviewed and discussed, and in-depth conversations with eleven participants are recorded. Examining the phenomenon of nursing presence through the hermeneutic lenses of narrative identity, play and solicitude has elucidated the role of ethical orientation, creativity and connection with the human experience through exploration of self and other. This more nuanced and complex understanding adds depth to the conversation and offers new possibilities to the effort to encourage and support presence in nursing practice.

Keywords: presence; nursing; care; hermeneutic; play; solicitude; narrative; identity; art of nursing; ethics

1. Introduction

Anita, a woman in her 80s, was hospitalized for three months following a myocardial infarction. For much of that time, she was intubated, in the intensive care unit, and unable to respond to those who provided her care. She was, however, acutely aware of them and was later 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 a healthier state. 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?

Nursing presence is described as an aspect of the art of nursing. This could be called *phronesis* [1], or moral and practical wisdom. The caring presence of a human being has a profound effect on the healing process [2,3]. Technical expertise is certainly important, but expertise does not guarantee the appropriate application of that knowledge to the individual patient. This study engaged a critical hermeneutic approach to explore the phenomenon of nursing presence.

2. Significance

The state of being present with someone in need characterizes the practice of professional nursing. 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 [4]. It is often linked with other concepts, such as caring, or with behaviors, such as listening and touch. Researchers agree that nursing presence is desirable in nursing practice because it benefits both the patient and the nurse [3,5–8]. Most significantly for the patient, presence has been identified as the foundation of nursing judgment [6,9]. In addition, it humanizes health care for both patient and nurse and prevents burnout in the nurse [6,8,10]. 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 the issue of presence within the context of nursing education, and administrators should encourage presence in nursing practice.

3. Background

Presence in the context of health care has been referred to in Western literature dating back to the Bible. It is referred to in passages found in Deborah's care of Rebekah in the Old Testament, in Homer's *Odyssey*, in writings by the Knights and Ladies of Malta, and within nursing orders during the Crusades [3,6].

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 [11,12]. The concept of care, *Sorge*, as he interpreted it from Aristotle, is central to his understanding of the human being. Heidegger ([13], p. 275) states, "The being of *Dasein* is care". Ricoeur 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 ([1], p. 314)?" His answer affirms this relationship. Presence in this sense refers to the engagement that a person feels with the world and in particular refers to the people with whom one interacts.

Incidental references to what would now be understood as presence are in nursing literature written as early as Florence Nightingale's work. However, 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 Madeleine Clémence Vaillot [3,5,6]. Vaillot studied the philosophy of Gabriel Marcel and Martin Heidegger and applied it to nursing theory [3,5,6]. Vaillot 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” ([14], p. 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 describes as the therapeutic use of self. Smith ([6], p. 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”. The idea of commitment implies a choice to engage, to care. The act of supporting someone in the healing process is essentially an ethical and moral act that involves, among other things, being present with the patient.

For modern nurse theorists, presence is an integral part of being a nurse. Watson [15] described the transpersonal caring moment as an ontological, transpersonal experience in her model of caritas nursing. Benner [16] describes presence as a quality demonstrated by expert nurses.

The concept of caring has often been used either interchangeably or in combination with the concept of presence, as in “caring presence” [5,7]. This is true within the nursing literature, as well as within the work of Heidegger and Ricoeur. Covington [7] 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. Covington [7] 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 nursepatient relationship that makes it safe for sharing with one another” ([7], p. 312). Covington [7] concludes that presence and caring are used interchangeably, but that they are separate concepts that have many of the same qualities.

Fingeld-Connet [5] continues Covington’s efforts to clarify the relationship between the concepts of *presence* and *caring*. Fingeld-Connet [5] 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 [7], Fingeld-Connet [5] 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 [5] and Covington [7] is that of the relationships between time, caring and presence. Covington [7] reports that caring was found not to be bound by time, but that presence occurs “in the moment” ([7], p. 312). Fingeld-Connet [5] 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.

3.1. Working Definition of Nursing Presence

One challenge to the promotion of nursing presence has been the difficulty of adequately defining or describing the concept. Doona *et al.* [3] describe presence as an inter-subjective and interpersonal experience that “changes the nurse as well as the patient”. Fingeld-Connet [4] defines presence as 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. To engage in such an experience is to make a moral decision and choose a course of action.

A review and synthesis of the literature reveals the following description which is employed for this study: Presence, although it involves action at times [4,17] is a humanistic quality of relating [6] that is ethically generated [18] and has real-world implications for both patient and nurse [17]. This description held up under scrutiny during the course of the investigation.

3.2. Controversies

Within current literature on nursing presence, two main controversies exist. First, the issue of patient safety has been addressed as a concern. Osterman and Schwartz-Barcott [19] consider 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 [5] 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. Additionally, Covington ([7], p. 312) states that healing presence “makes it safe for sharing with one another”, and includes benefit to the patient as an outcome of an instance of this.

Since sensitivity to oneself as well as the patient is a hallmark of presence, presence enhances safety for the patient and does not pose danger.

The primary source of controversy in the discourse about nursing presence resides in whether presence is a technique or a quality. Most researchers describe presence as humanistic, interpersonal phenomena [3,4,6,7]. 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. Quantitative approaches to nursing presence have been proposed with the goal of more specifically measuring the effect of presence on patient outcomes. For instance, can presence be prescribed and used like a medication?

Easter [20] 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 [19] posit that there are four levels of presence in nursing practice, ranging from physical presence, through partial presence, full presence and finally transcendent presence.

Most recent articles, with the exception of McMahan and Christopher [9] have abandoned the effort to distinguish types or levels of nursing presence. Doona *et al.* [17] state that, contrary to the claim of Osterman and Schwartz-Barcott [19] 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 [6] and Fingeld-Connet [5] concur. I will revisit the significant issue of whether presence is a technique or a quality in the discussion following presentation of the data.

4. Research Protocol

This study involved a critical hermeneutic approach to the exploration of the questions posed earlier about nursing presence. 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 ([21], p. 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.”

Critical hermeneutics offers a way to explore presence in nursing practice in terms of its moral and practical significance for the participants. It also involves a creative aspect whereby those most intimately involved in the issue make recommendations for action toward a better future. Flaming [22], Hikari [23], Charelambous [24], Charelambous *et al.* [25], and Thompson [26] make the case for the role of critical hermeneutic research in nursing research and practice.

Charelambous *et al.* ([25], p. 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 the theory of interpretation avoids the Cartesian subject/object split and therefore makes it useful for the researcher seeking to explicate intersubjective knowledge [25]. Since nursing presence is by nature intersubjective, this approach is an appropriate way to elucidate the phenomena.

For this research project, I followed the protocol for field-based participatory hermeneutic inquiry as described by Herda ([21], p. 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 [21]. 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 conversation partners are deliberately chosen to include people who are familiar with the subject at hand, yet provide differing perspectives on it. 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.

IRB approval was obtained for this study. Eleven nurses agreed to participate as conversation partners. All were experienced nurses with a minimum of three years in practice and some as many as thirty-five years. All were familiar with the idea of “being present with the patient”. They had a wide variety of clinical experiences. One was male and one was originally educated in Guyana. Of the female participants, two identified as women of color.

The research questions were:

- (1) What is the experience of a nurse when one is present with a patient?
- (2) How is this capacity developed?

Questions used to guide the research conversations included:

- (1) What is your experience with being present with a patient?
- (2) How did you learn to be present with a patient?
- (3) What does being present require from you?
- (4) What does being present with a patient feel like?

5. Research Findings

After a literature review and a pilot study, I chose three theoretical categories to guide the inquiry. I reevaluated the appropriateness of these categories during the course of the study and could have changed them if warranted, but I found them to be appropriate, and therefore they remained constant throughout the study. The categories are narrative identity, play and solicitude.

5.1. Narrative Identity

Identity is explored, interpreted, and understood through the narratives that we accept about ourselves and that we share with others. Through language people think about and share who they were, who they are, and who they imagine that they will become. Ricoeur [1] describes the process of change as mediated through dialectic between *idem* and *ipse*: between the person that is and the person that is becoming. This dialectic is known as narrative identity [1].

Three themes emerged from the data in this category. The first was The Identity of the Nurse, or how the nurse understands her or himself to be. The second, A Learned Practice, involves memories of how the ability to be present has changed over time, including engaging in practices that improve that capacity within the nurse. The third, Seeking to Know the Patient, describes a desire on the part of the nurse to connect with the patient in a way that is authentic and that then involves both people in the co-creation of a narrative that describes the situation.

5.1.1. 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, as well as a sense of the ethical nature of the interaction. 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 [1] would call this their *idem*, a part of who they are that remains constant. When I asked Ann Rose 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". Karen 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.

5.1.2. A Learned Practice

Although my conversation partners may possess an inherent tendency to connect deeply with other human beings, that 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 ([1], p. 121) describes this process as follows: “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*.” More succinctly, he states, “Habit gives a history to character ([1], p. 121) .” My conversation partners often described themselves as having an inherent desire to connect with and help people which guided them to learn more skillful ways to do this in practice.

Gayle describes the ability to be present as “a willingness” on the part of the practitioner. Marlene 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 1980s 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. 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. “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, the intention and commitment remain constant.

Marilee, who has taught nursing for many 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. 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.

5.1.3. Seeking to Know the Patient

A nurse, with a preconfigured understanding of self, enters into a relationship with a patient. 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 the future. During the interaction, both patient and nurse are changed.

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. He also indicates the felt sense of the interaction: "when it does happen it's pretty clear that it's happening." Other conversation partners also describe this felt sense of presence.

Ricoeur ([1], p. 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." Nurses configure information to create a narrative that informs them about who they are, who their patients are, and that guides their actions. The narrative of a nurse about her or himself in relation to being present with a patient includes an appreciation of others and acknowledges a desire to connect, along with an ethical sense of duty. 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.

5.2. Play

Play is a dynamic that draws people into the moment. There is a focus on the here and now. One puts aside distractions to participate fully in the creation of an experience that changes the participants. Gadamer [27] describes play as the interaction between a person and The Text. Charelambous ([24], p. 1283) states that the patient can be understood as a text. She describes the nursing assessment as an interpretation of the patient as text. Presence involves this aspect of engagement, which Gadamer [27] describes as play.

Play is a dynamic interaction intrinsic to the creative process as well as to social life. Several of my conversation partners describe presence as a creative process. The presence of the one individual is combined with the presence of the other. This creates an opening and the interplay that occurs changes the consciousness of the people who so engage.

Three themes emerged from this category: Preparing the Gound, Giving In, and 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.

5.2.1. Preparing the Ground

Gadamer [27] proposes that preparation is required for play to occur. 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. "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" ([27] p. 107).

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." 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.

Ann Rose gives a vivid description of what it feels like to enter the patient’s space.

“There was an elder in the bed and I’m runnin’! I got these meds to give! And I met her energy field and it stopped me. Because she was in this quiet place and I met her energy and just quieted down. Before I could do anything with those meds, I needed to be right there with her. It was a feeling.”

As she entered the patient’s environment, Ann Rose noticed the change in her own environment and acknowledged that she was entering a different space. She shifted right away into a more receptive approach. She engaged with the patient, letting go of her hurried agenda, and gave in to the need of that particular patient in that moment.

5.2.2. Giving In

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” ([27], p. 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 ([27], p. 103) proposes that “The players are not the subjects of play; instead play merely reaches presentation (*Darstellung*) through the players.” Illustrating this principal beautifully, Ms. Indra Thadani, MSN, RN 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.”

Gadamer ([27], p. 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.” Players must not be passive, but must be serious about their engagement in the moment. 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.

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.” 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’.” Full participation in the moment holds risks as well as rewards. Gayle said, “You never know what’s going to happen.” Ann Rose points out, “It’s a risk. We take that leap into the unknown.”

5.2.3. Timelessness

Gadamer [27] 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. He describes a different sense of temporality experienced by one who is engaged in play. “This contemporaneity and presentness of aesthetic being is generally called its timelessness” ([27], p. 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 five 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 necessary to accomplish and it doesn’t take long. All of this happens in a nanosecond and it’s a felt sense.”

Gadamer ([27], p. 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.” The sense of momentum one feels when “in the game” is an aspect of what Gadamer ([27], p. 105) describes as the primacy of play over the consciousness of the player.

In the case of nursing presence, there is fullness in the moment when the nurse commits to engaging with the patient in a focused way that creates a creative potential in the moment. This is the creative process that the nurse engages in when interacting with the patient to create and 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. 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.

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” ([27], p. 103). She tells of a transpersonal state 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.

Gadamer ([27], p. 22) states, “It is worth looking more closely at the fundamental givenness 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.” He also points out that “Play arises from an excess over and above what is strictly necessary and purposive” ([27], p. 125). This givenness 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.

5.3. *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” ([1], p. 190). Solicitude can be viewed as the heart of what Ricoeur ([1], p. 172) calls the ethical intention, which he defines 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 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 [1] 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 claims “solicitude is not something added on to self esteem from outside but that it

unfolds the dialogic dimension of self-esteem” ([1], p. 180). Furthermore, he asserts, “self-esteem and solicitude cannot be experienced or reflected upon one without the other” ([1], p. 180).

Within the category, Solicitude, three themes emerged. The first, The Self, addresses my conversation partners’ deepening sense of connection with themselves as unique, irreplaceable, and vulnerable humans. 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 present can be very challenging but it also offers personal and professional renewal.

5.3.1. The Self

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 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 ([1], p. 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. It was at the heart of each narrative and created a felt sense of sense of right action in each interaction. 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” ([1], p. 193).

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.

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.”

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. ([1], p. 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 ([1], p. 194) words, "Becoming in this way fundamentally equivalent are the esteem of the other as a oneself and the esteem of oneself as another."

5.3.2. The Other

When a professional nurse enters into an interaction with the patient, the nature of the relationship is that the patient 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. Ricoeur ([1], p. 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."

Sharing the pain of suffering with the one who suffers requires resilience and the willingness to engage as a human being. 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 [1] proposes that the ability to respond to a suffering person 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 ([1], p. 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.

This authentic reciprocity may be viewed as the gift within the moment when suffering is shared.

5.3.3. The Gift

The instances when the nurses I spoke with connected in presence with a patient were uniformly described as deeply gratifying. 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.”

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!” 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.”

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.” Ricoeur ([1], p. 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.” 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.”

5.4. 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. 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 of overwhelm which shifted into a sense of solicitude:

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 left was a tremendous desire just to simply be there with another human being who is suffering.

Gayle realized that the usual approaches to pain management would not help in this case. The pain medication that the patient had available 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 non-pharmacological approaches to pain management 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 and co-creating an experience with the patient.

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. I literally held his (in Jin Shin Jyutsu terms, his thumb, his one)...I grabbed his thumbs 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 that involved establishing resonance with him. 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 worked with the 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 the breath in a way that was happened for him. At same time I was using some therapeutic touch to help restore flow.

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 min 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.

6. Discussion

Examining the phenomenon of nursing presence through the hermeneutic lenses of narrative identity, play and solicitude has elucidated the role of ethical orientation, creativity and connection with the human experience through exploration of self and other. This more nuanced and complex understanding confirms some of what has previously been said about the phenomenon and adds depth and new possibilities to the conversation about how we encourage and support presence in nursing practice.

For instance, Vaillot's [14] claim that commitment is required, affirmed by Fingeld-Connet [4], is validated by these findings. Furthermore, it is a commitment that unfolds over time in such a way that it reinforces itself. The narrative identity of the nurse who practices presence includes a commitment that stems from a moral aesthetic (a felt sense of what is beautiful and what is ugly) that favors solicitude. The self-understanding, including this felt sense, is reinforced over time through engagement in practice. It is also reinforced by engagement in self-care and reflective practices that deepen the nurse's understanding of what it means to be human and what it means to heal.

This study also confirms Covington's [7] claim that presence occurs in the moment. The theory of play addresses the issue of temporality, as well as explaining the role of creativity in the interaction. Commitment is then demonstrated again in the moment of engagement (play) with the patient as the nurse releases distractions and focuses on the interaction with the individual right there in the moment.

However, when considering the debate about whether presence is a quality or a technique, the vignette used to illustrate the three theoretical lenses in practice demonstrates that it is a much more complex phenomena. While Gayle came to the interaction with a great variety of skills and techniques, as well as great depth of knowledge, the essential nature of the interaction had to do with compassion, ethical comportment and the courage and confidence to engage in a creative moment with the patient. Moreover, it occurred because there was time and space for it to occur. Gayle was invited in by other nurses and was free to make the commitment to be with the patient for as long as it took to make him comfortable. This meant she also had confidence that she was safe enough in that environment to engage in an unorthodox way of working with the patient, as well as confidence in herself to engage in the co-creative process with the patient. Knowledge, skills and techniques empower the nurse and create options for creativity in the moment of interaction with the patient in the same way that brushes, paint and canvas empower the artist.

Nurse researchers and nurse leaders should resist the temptation to reduce the dynamic process of nursing presence to a set of variables that can be quantified and implemented mechanistically. To do so

is to deny the creative, ethical and unique circumstances wherein these instances arise. Efforts to measure presence directly or to use it as a tool to accomplish particular outcomes, while historically useful as a thought exercise, would most likely result in the prescription of a mechanistic process; yet more boxes to check on an unending list of drop down menus for the Electronic Medical Record. To attempt to regulate presence directly is to disinvite it.

Instead, knowing that the ability to be present is fostered by certain capacities within the nurse, as well as certain environments, we can work to cultivate those capacities in nurses and in the patient-care environment. Knowing that self-knowledge and confidence are important, we support nurses in self-reflection and self-care. Knowing that to engage (play) in an instance of presence takes focus, we encourage the nurse to engage in practices that build ability to focus, such as meditation. Knowing that it also takes the capacity and courage to be creative, we understand that the arts have an important role in the ongoing education of a nurse. The humanities, as well, help to inform nurses on what it is to be human, to suffer and to heal.

Finally, knowing that the root of presence is solicitude we understand that this quality of ethical comportment cannot be commanded or regulated but can be recognized, shared, encouraged and celebrated. Nurses and particularly nurse-leaders can acknowledge the capacity in each nurse to act in this way and can role model it for them during interactions. We take seriously the needs of the nurse as well as the needs of the patient, and respond with compassion. Perhaps we can find ways to provide an environment with a little bit of “an excess over and above what is strictly necessary and purposive”, as Gadamer ([27], p. 125) put it.

7. Recommendations for Further Research

As was pointed out earlier, measuring presence directly is futile at best, but other factors that contribute, such as self-care opportunities, workload, ethical reflection and so forth could be identified and measured. The data could be compared with nurse and patient perceptions of presence.

A natural area for future research is the experience of patients in terms of nursing presence. Studies that compare the experience of the patient in relationship with the nurse who is present would be relevant. As customer satisfaction begins playing a bigger role in the health care industry, we may find support for nursing presence growing, despite the highly competitive economics of health care systems. The Watson Caritas score offers a way to measure caring as perceived by a patient [28]. Perhaps this would be the best way to measure nursing presence indirectly but in a way that allows for quantitative improvement to be demonstrated.

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. 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. It is a disciplined way to explore the lived experience of people within organizations and to glean wisdom from the people who are most directly involved in the work at hand. With its emphasis on moving from text to action, this is a powerful approach to organizational development in a way that engages those most affected by the change.

8. Conclusions

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 cooperation, cannot discern the subtle nuances in a patient's condition that signal despair, and cannot choose the right moment to hold the hand of a person in need, share the grief of that moment and affirm the humanity and resilience of that person.

It is well established that nursing presence is an important part of nursing practice. When examined through the theories of narrative identity, play, and solicitude, it becomes apparent that nursing presence results from a moral and practical capacity. A nurse with enough connection and understanding of self who has the ability to release distractions and focus on the unique moment with the patient and who has an ethical orientation toward connecting in a helpful and compassionate way with another human being has the capacity to be present with a patient in unique circumstances and in a way that nurtures the patient and fulfills the nurse. These capacities can and should be fostered in nursing education as well as in practice settings and continuing education.

Conflicts of Interest

The author declares no conflict of interest.

References

1. Ricoeur, Paul. *Oneself as Another*. Chicago and London: University of Chicago Press, 1992.
2. Watson, Jean. *Nursing: The Philosophy and Science of Caring*. Boulder: University Press of Colorado, 2008.
3. Doona, Mary E., Lois A. Haggerty, and Susan K. Chase. "Nursing Presence: An Existential Exploration of the Concept." *Research and Theory for Nursing Practice* 11 (1997): 3–16.
4. Fingeld-Connett, Deborah. "Meta-Synthesis of Presence in Nursing." *Journal of Advanced Nursing* 55 (2006): 708–14.
5. Fingeld-Connett, Deborah. "Qualitative Comparison and Synthesis of Nursing Presence and Caring." *International Journal of Nursing Terminologies and Classifications* 19 (2008): 111–19.
6. Smith, Thomas D. "The Concept of Nursing Presence: State of the Science." *Scholarly Inquiry for Nursing Practice: An International Journal* 15 (2001): 299–321.
7. Covington, Holly. "Caring Presence Delineation of a Concept for Holistic Nursing." *Journal of Holistic Nursing* 21 (2003): 301–17.
8. Welch, Di, and Sally Wellard. "The Phenomenon of Presence within Contemporary Nursing Practice: A Literature Review." *The Australian Journal of Holistic Nursing* 12 (2005): 4–10.
9. McMahan, Michelle A., and Kimberly A. Christopher. "Toward a Mid-Range Theory of Nursing Presence." *Nursing Forum* 46 (2011): 71–82.
10. Godkin, Jennie, Lynn Godkin, and Phyllis Austin. "Nursing Presence, Patient Satisfaction, and the Bottom Line." *Journal of Hospital Marketing & Public Relations* 14 (2002): 15–33.

11. Marcam, James. *Humanizing Modern Medicine; An Introductory Philosophy of Medicine*. Dordrecht: Springer, 2008, vol. 99.
12. Heidegger, Martin. *Four Seminars*. Bloomington: Indiana University Press, 2003.
13. Heidegger, Martin, Joan Stambaugh, and Dennis J. Schmidt. *Being and Time*. Albany: SUNY Press, 1962.
14. Vaillot, Madeleine Clémence. *Commitment to Nursing: A Philosophic Investigation*. New York: Lippincott, 1962.
15. Watson, Jean. *Postmodern Nursing and Beyond*. London: Churchill Livingstone, 1999.
16. Benner, Patricia E. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Reading: Addison-Wesley Publishing Company, Nursing Division, 1984.
17. Doona, Mary Ellen, Susan K. Chase, and Lois A. Haggerty. “Nursing Presence as Real as a Milky Way Bar.” *Journal of Holistic Nursing* 17 (1999): 54–70.
18. Råholm, Maj-Britt, and Lisbet Lindholm. “Being in the World of the Suffering Patient: A Challenge to Nursing Ethics.” *Nursing Ethics* 6 (1999): 528–39.
19. Osterman, Paulette, and Donna Schwartz-Barcott. “Presence: Four Ways of Being There.” *Nursing Forum* 31 (1996): 23–30.
20. Easter, Anna. “Construct Analysis of Four Modes of Being Present.” *Journal of Holistic Nursing* 18 (2000): 362–77.
21. Herda, Ellen A. *Research Conversations and Narrative: A Critical Hermeneutic Orientation in Participatory Inquiry*. London: Praeger, 1999.
22. Flaming, Don. “Nursing Theories as Nursing Ontologies.” *Nursing Philosophy* 5 (2004): 224–29.
23. Hiraki, Akemi. “Tradition, Rationality, and Power in Introductory Nursing Textbooks: A Critical Hermeneutics Study.” *ANS. Advances in Nursing Science* 14 (1992): 1–12.
24. Charalambous, Andreas. “Interpreting Patients as a Means of Clinical Practice: Introducing Nursing Hermeneutics.” *International Journal of Nursing Studies* 47 (2010): 1283–91.
25. Charalambous, Andreas, (I)Rena Papadopoulos, and Alan Beadsmoore. “Ricoeur’s Hermeneutic Phenomenology: An Implication for Nursing Research.” *Scandinavian Journal of Caring Sciences* 22 (2008): 637–42.
26. Thompson, Janice L. “Hermeneutic Inquiry.” In *Advancing Nursing Theory Through Research*. Edited by Linda E Moody. Thousand Oaks: Sage Publications, 1990, vol. 2, pp. 223–80.
27. Gadamer, Hans-Georg, and Robert Bernasconi. *The Relevance of the Beautiful and Other Essays*. Cambridge: Cambridge University Press, 1986.
28. Watson Caring Science Institute. “Watson Caritas Patient Score—Watson Caring Science Institute.” 2015. Available online: <http://watsoncaringscience.org/watson-caritas-patient-score/> (accessed on 15 July 2015).