A HEIDEGGERIAN PHENOMENOLOGICAL STUDY OF NURSES' EXPERIENCE OF PRESENCE

by

Dianne Welch, RN., B. Applied Science (Nursing)

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TABLE OF CONTENTS

Declaration

I certify that this thesis entitled "A Heideggerian Phenomenological Study of Nurses' Experience of Presence", submitted for the degree of Master of Health Science is the result of my own research, except where otherwise acknowledged. This thesis has not previously been submitted, either in whole or in part, for any other academic award.

Signed: ....[redacted].....

Date: .....14/12/01.....

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Abstract

Nursing brings together two persons' worlds, one being that of the nurse and the other of the patient. Their worlds embody past experiences, expectations, limitations and potential. Nurse theorists have described this bringing together as an intersecting intersubjectivity or presence. This Heideggerian phenomenological study enabled the researcher to explore six registered nurses' meaning of presence as experienced within their clinical practice. These registered nurses were all clinicians with extensive experience in a variety of clinical settings. A hermeneutical analysis of their experiences revealed that presence is a powerful intersecting of nurses' and patients' subjective worlds. Presence, according to these nurses, was an enriching experience within nursing practice that provided them with immense professional satisfaction. It was from the spiritual connectedness of care that their need to care for and be with patients in meaningful interactions was fulfilled. Despite the difficulties these participants encountered, their commitment to care and need to find meaning in their practice motivated them to transcend these encumbrances and connect with patients in deep meaningful ways. This study recommends strategies be implemented within nursing to acknowledge these experiences, and for nurses to create times and space to share these subjective experiences.

Chapter 1

Introduction

Caring, as the human mode of being, is caring from the heart; caring from the core of one's being; caring as a response to one's connectedness ... Being infused with the reality of interconnectedness, the caring relationship touches the depths of the spiritual encounter. *(Roach, 1997, p.16)*

1.1 Background of the Study

Nursing is a profession whose central focus is caring. Caring and the development of caring relationships within nursing practice requires the nurse to interact and accept patients as unique human beings with individual needs and desires. Roach (1992) discusses caring as essential to human development and that caring is expressed in human behaviour as having the ability to demonstrate affection, compassion and concern for other human beings. These behaviours, as described by Roach, are reflective of humanistic nursing practice where caring is focused upon being with and

doing with another person, to provide an environment of mutual empowerment and involvement.

Benner and Wrubel's (1989) research into caring relationships highlights that caring within nursing, is linked to the nurses' "ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the base of much of nursing as a caring practice" (p.13). For these researchers, presence is a shared experience between nurse and patient which infers that to experience presence within a nurse-patient interaction, the nurse is available to understand and be with that patient.

For this researcher, clinical nursing practice was and still is about caring, being with the patient, expressing genuine concern and getting to know the patient's interests within a caring relationship. The nurse's way of being with patients fosters trust within the relationship and acknowledges concern for their well being. The nurse's care and presence supports the patient during moments of anxiety, suffering, joy and sometimes death (Bishop and Scudder, 1996). The patient, as a result of the positive attitudes within the interaction is transformed. That is, their anxiety or fears are lessened and they sense that the nurse really cares about their well being. Consequently, the nurse's mode of caring for the patient continues to focus upon maintaining a caring physical and emotional environment where the patient

feels valued and is willing share their inner feelings and concerns with the nurse. It is the patient who is the focus and recipient of caring behaviours, not the nurse.

It was shortly after leaving clinical practice that I began to reflect upon the meaning of nursing care and presence within care interactions. Research in caring highlights the positive impact upon patients of nurses care interventions and caring presence (Mayeroff, 1971; Leininger, 1984; Watson, 1985; Benner and Wrubel, 1989; Gilje, 1992; Roach, 1992; Wilkes and Wallis, 1993; Gaut and Boykin, 1994; Webb, 1996; Roach, 1997). The purpose of caring according to Chipman (1991) is threefold, that is, caring involves "attention to or concern for the patient; responsibility for or providing for the patient; and regard, fondness, or attachment to the patient" (p.171). Furthermore, care is a human undertaking by nurses, which influences patients' satisfaction with health services. Thus, as consumers of health services patients not only value care but need care and will "devise strategies to get what they need or [they] succumb to what they [see] as injustices to their humanity" (Chipman, 1991, p.172).

Whilst preparing a unit of study for students in an undergraduate baccalaureate degree of nursing, my thoughts were again focused upon caring and nursing presence. Although this unit of study related to the philosophy of

care and nurses' being with and caring for patients, my interest concentrated on the need of nurses to care for patients. That is, what is the relationship between nurses as providers of health services and their need to care for patients? In addition, if patients devise strategies to meet their needs as identified by Chipman (1991), do nurses similarly devise strategies to meet their own needs to care for patients? Furthermore, what does being with and caring for patients mean to registered nurses, to their nursing practice? It was from these early questions and reflections that the basis for this study was formed.

Further reading on caring within nursing practice brought to light the phenomenon of presence within nursing interactions. As Paterson and Zderad (1988) suggest, presence or making contact with patients, is not an inanimate object that can be grasped but rather the meeting of the inner being and the embodied mind, body and spirit of two people. Presence can only be experienced, it is not a psychomotor skill of the nurse that can be assessed as being competent. Rather it requires qualities of nurses to move beyond competence in practice, to not view nursing as routine technological skills but to acknowledge and to meet the need within them to care for and be with patients. From these early readings, this researcher questioned how could this phenomenon of presence be acknowledged and recognised within the sphere

of contemporary health care systems, which accredits and prioritises the quantitative attributes of technological procedures rather than quality human relationships between nurses and patients.

Within current health care systems other contextual issues such as nurse - patient ratios, reducing resources and demands from patients' family members (Karl, 1992) place enormous stress upon registered nurses and the subsequent care given to patients. Therefore, the opportunity for nurses to experience presence or to be with patients in meaningful ways fluctuates as many of these issues often simultaneously demand or detract nurses' attention from the immediate care interaction. In addition to these stressors, nurses must be focused upon the humanness of the nurse-patient interaction for presence to be experienced. Focusing within the interaction require high personal energy levels. This high energy has been discussed in the literature as emotionally draining to the nurse, yet concurrently the experience of presence is professionally rewarding (Osterman and Schwartz-Barcott, 1996). The phenomenon of presence described in this context seems to be a dichotomy, one that is exhausting and rewarding at the same time.

This researcher therefore conjectured, what is the meaning of presence for registered nurses working within a current health care system that is ever changing and placing multiple contemporaneous demands upon registered

nurses? Furthermore, as registered nurses are human beings with a human desire and need to care for and be with patients in meaningful relationships, how do they go about fulfilling this need?

1.2 Aims and Objectives of this Study

Presence is discussed throughout literature as valuable to nurse-patient interactions. In the main, the patients' perspective of the experience of presence has been the focus of previous research. What has not been extensively explored is the nurses' perspectives of the experience of presence. Bäck-Pettersson, Jensen and Segesten (1998) highlight that the experience of presence fosters excellence in nursing. However, Bäck-Pettersson, Jensen and Segesten's study focuses upon how nurses' actions will benefit the patient rather than the nurses' perspectives of the experience of presence. Only Mohnkern (1992) has identified that nurses do feel professionally rewarded and affirmed by the experience of presence.

This research project seeks to explore the meaning of the experience of presence from registered nurses' perspectives. Therefore, this research aims to gain understanding of presence by exploring and articulating registered nurses' experiences of presence. Exploration of the meaning of presence from registered nurses' perspectives will encourage a professional awareness

and recognition of the experience of presence within contemporary nursing practice. Furthermore, this study aims to illuminate the professional significance of this experience to nurses and the profession. In addition, this study aims to shed light on how registered nurses, caring for large numbers of patients with a high acuity within complex health care systems, experience presence. Lastly, this study aims to reveal from registered nurses' perspectives, the consequences or benefits to them as registered nurses from the experience of presence.

This study seeks to explore from registered nurses' perspective:

1) the meaning of presence within nurse-patient relationships;

2) an understanding of how registered nurses foster presence interactions within clinical nursing practice: and

3) the influence these interactions have had upon the registered nurses' practice.

1.3 Overview of Thesis

Chapter two of this thesis discusses the literature reviewed for this study. The chapter explores the complex nature of the term presence and the difficulties

in defining this phenomenon. The literature review highlights the connection between humanistic nursing values and the application of these values to promote presence interactions and the subsequent benefits to the patient of a presence encounter. The literature review concludes by highlighting the devaluation of presence within nursing practice and the dilemmas of nurse practitioners that experience presence.

Chapter three outlines the philosophical framework that underpins and guides this phenomenological study. The work of Martin Heidegger is discussed in relation to existential philosophy and the main tenet of Heidegger's philosophy of Being and *Dasein.* The chapter continues with a discussion of Heideggerian hermeneutic phenomenology and the hermeneutic circle, which was used during the process of data analysis of this study.

Chapter four details the methodological approaches employed during this study. The chapter provides a brief description of the participants and the process of inviting participation. The ethical considerations addressed throughout data collection and analysis are discussed especially in relation to the interview techniques and the research setting. The chapter also describes the application of the data analysis technique of Diekelmann, Allen and Tanner (1989) to provide a clear audit trail of data analysis and interpretation.

Chapter five presents the relational themes revealed following analysis of the data. These themes highlight the participants' common experiences of presence and the meaning of presence within their practice. These themes are: intimacy of experiences; humanness of interactions; listening with all body senses; and emotional tensions. Each theme is presented with excerpts from participants' narratives to highlight the meaning and interpretations attached to their experiences.

Chapter six presents the constitutive pattern of presence described as: commitment to care and the spiritual connectedness of care. A constitutive pattern highlights the relationship between the relational themes and captures the participants' interpretation of the ways in which the experiences of presence influenced their nursing practice. The participants' style of practice that enabled them to foster environments of care to meet their own and patients' human needs and desires is also illuminated.

Chapter seven discusses the findings of the study in relation to the literature review, the philosophical underpinnings of the study and the participants' own experiences. The participants' commitment to care, their concern and inner strength to practice within a humanistic framework to experience the spiritual connectedness of care is discussed. Furthermore, the chapter argues that the 'between' of nursing practice as proposed by Paterson and Zderad

(1988) is not a one way energy flow, but rather an intertwinement of nurse and patient's inner Being and a pouring out of their streams of humanness. The chapter highlights that as a result of these surges of humanness experienced during a presence encounter, the participants were changed.

This thesis concludes with Chapter eight which highlights the major themes of the study. The chapter discusses the implications of this study in relation to clinical practice, nursing education and further research. The chapter recommends strategies based upon the findings of this study to assist students and registered nurses to share their experiences of presence and more importantly, to reduce the negative impact these experiences have had upon registered nurses. An overall summation of the study is included to enhance the understanding, and meaning of the phenomenon of presence to the nursing profession. The following chapter, Chapter 2, reviews the literature pertinent to this study.

Chapter 2

Literature Review

Introduction

In this chapter, the literature pertaining to the descriptions and experiences of presence within nursing practice is reviewed. Although the word presence has in the past been associated with the existence of a higher being, such as "the spiritual presence of a supreme being" (Osterman and Schwartz-Barcott, 1996, p.24) or within a theological sense when referring to God's presence, this chapter focuses on the literature concerned with the phenomenon of presence within nursing practice.

Firstly, the chapter explores the varying definitions of presence. These definitions and descriptions highlight the complexity of the phenomenon. Secondly, humanistic nursing practice and presence is explored, in particular highlighting the way in which humanistic nursing practice facilitates nurses' ability to experience presence encounters. Thirdly, this chapter examines the benefits of presence within nurse-patient relationships.

Lastly the phenomenon of presence is reviewed in relation to and within the context of the current health care environment.

2.1 Definitions of Presence

Presence is a complex phenomenon to define. Many scholars, researchers and writers use the term "intersubjectivity" to describe the experience of presence (Cody, 1995; Gilje, 1992; Munhall, 1993; Paterson and Zderad, 1988). Definitions of the phenomenon include descriptions of differing levels of presence experienced by nurses, such as the mere physical presence of being there, to the psychological or spiritual experience of a nurse being with another.

Intersubjectivity according to Paterson and Zderad (1988) is known as presence or "the between" (p.22) of nursing practice. The "between" or presence is the stream that runs through nursing interventions "in which and through which nursing can occur" (p.22) and conveys the nutrients of healing and growth.

Similarly, Munhall (1993) discusses nursing practice as bringing together two perspectives of a situation, that of the nurse and patient, requiring intersubjectivity. That is, "the verbal and non verbal interplay between the

organised world of one person and the organised world of another" (p.126), or more simply, the intertwinement of two peoples' worlds. Further, Cody (1995) refers to intersubjectivity as a shared understanding of meaning between the conscious minds of human beings. This shared understanding develops through direct relationship with a person or indirectly by time, distance and language. Cody states it is intersubjectivity "which makes meaning possible" (p.52). Within this context "the between" (Paterson and Zderad, 1988, p.22) or presence of the nurse – patient relationship is intertwined bringing together the meanings and understandings of both peoples' subjective worlds.

Gilje (1992) identifies seven definitions of the phenomenon of presence. Presence as being or the essence, is equated to "the very personal, individual, unique attribute, quality or spirit which makes one human" (p.55). This description of presence supports that of Buber's (1987) and Heidegger's (1962) interpretation of presence as being the core of a person, the essence, which "can be experienced by being in relationship to and with others" (Heidegger, 1962, p.55). Heidegger further describes presence as to enjoin or to be accessible and explains that "being can be experienced by sharing one's presence" (p.55). Further definitions proposed by Gilje (1992) include "presence as being here *and* not elsewhere", "presence as

being there *and* being with", "presence as feeling or believing" and "presence as caring" (pp.55-59).

Based on these previous definitions, Gilje (1992) proposes a theoretical definition of the phenomenon presence for nursing as "an intersubjective and intrasubjective energy exchange with a person, place, object, thought, feeling, or belief that transforms sensory stimuli, imagination, memory, or intuition into a perceived meaningful experience" (p.61). Further, when applied to nursing it implies embodiment of mind, body and spirit, and a conscious ability of the nurse to reflect and value presence within nursing practice as essential to understanding human experiences. Parse's (1994) 'Human Becoming Theory' describes presence as "a powerful interhuman connection experienced at all realms of the universe. It is being with the rhythms of the sounds and silences, the visions and blindness of the whole-in-motion" (p.18). This concept of 'whole-in-motion' and being in rhythm reflects the embodiment of mind, body and spirit as discussed by Gilje (1992).

As presence is an abstract phenomenon to grasp, Gilje (1992) highlights that it is sometimes more easily understood if the opposite is examined, in this instant the absence of presence. Gilje (1992) illuminates several interpretations of this concept as, absent in the physical sense and also in the

psychological, emotional and spiritual realms, that is an absence of relationship or soul. To further simplify these interpretations, Gilje describes two opposing nursing interactions. The first involved a nurse who experienced presence with a patient. In this incidence, the nurse was conscious of her/his own "thoughts, feelings and actions ... The patient sensed the nurse's compassion and felt understood" (p.57). Another nurse is described as only being physically present with a patient, that is having an absence of presence. Although this particular nurse competently checked the patient's intravenous equipment, the nurse failed to acknowledge the patient either verbally or with eye contact. In this interaction, there was no connection between the nurse and the patient in either the physical, emotional or spiritual realms of the patient's world of experience. Gilje (1992) states that the nurse "was not conscious of the patient's needs or desires" (p.57) nor their own, thereby there was an absence of presence.

Recent research by Osterman and Schwartz-Barcott (1996) identifies four varying levels of presence or being there within nursing practice. These are titled "presence", "partial presence", "full presence" and "transcendent presence" and are "based upon the quality of being there, the focus of the nurse's energy, and the nature of the nurse-patient interaction; and ... possible outcomes of each type" (p.23) of experience. For these researchers

the lowest level is simply titled presence which reflects the mere physical presence of a human being who is "self absorbed" (p.25) in their own thoughts and actions. However this lowest level of presence is not the same as Paterson and Zderad's (1988) or Gilje's (1992) definitions of presence who suggest presence is a spiritual connection and more than simply a physical presence. Rather, this lowest level of presence, as described by Osterman and Schwartz-Barcott (1996), is similar to Gilje's (1992) example of absence of presence, where a nurse within this presence context has no awareness of patient needs and may inadvertently place patients at risk.

Partial presence, as discussed by Osterman and Schwartz-Barcott (1996), is the combination of physical presence of a nurse who is focused upon the task at hand together with a degree of awareness of the patient's responses. This may equate to a nurse who is physically present, competently performing a wound dressing and being aware of the patient's responses, yet does not connect psychologically with the patient.

Ostermann and Schwartz-Barcott (1996) suggest their description of full presence is similar to presence as described by Paterson and Zderad (1988). Full presence according to Ostermann and Schwartz-Barcott (1996) is a way of being with patients that encompasses the physical actions and

psychological expressions of the nurse. In this context, the nurse is physically present, utilising positive body language, touch and eye contact to focus and meet the needs of the patient. As well, this nurse psychologically connects with the patient by way of therapeutic communication skills such as attentive listening and responding. Bishop and Scudder (1996) equate full presence to Zaner's (1981) description of vivid presence. Vivid presence, according to Zaner (1981) occurs within a reciprocal relationship where both persons have an awareness of the other and are tuning into the others presence, thereby creating a shared experience rather than two separate experiences.

Lastly, transcendent presence "is broader in scope, more abstract, and elusive. The energy exchange here is transforming and more spiritual in quality and moves beyond the interactional to the transpersonal" (Ostermann and Schwartz-Barcott, 1996, p.26). These researchers describe this level of presence as being felt by not only the nurse and patient within the interaction, but also other nurses and patients not engaged in the interaction. Feelings of peace, comfort and harmony pervade the environment as a result of transcendent presence. From a nursing perspective, transcendent presence is being connected and sensing a oneness with the patient. Zaner (1981) describes this relationship as co-presence,

which requires nurse and patient to have knowledge of each other and to share within the relationship with a degree of intimacy. Within this intimate relationship the nurse and patient "make music together" (p.236), whereas Bishop and Scudder (1996) describe this presence as a "caring presence" (p.41), which permeates the whole health care atmosphere fostering positive attitudes, mutual concern and trust.

From these varying definitions of presence, presence can be referred to as an interhuman connection of the nurse and patient existing in harmony with each other, sensing the experiences, the feelings of each other from which both may grow. It is through presence, or intersubjectivity, that the nurse connects with and gains understanding and mutual meaning of the patient's subjective experience.

2.2 Humanistic Nursing Practice and Presence

The definitions of presence presented in section 2.1 describe presence as an existential phenomenological phenomenon, that is, as a subjective experience. Therefore to facilitate the experience of presence, nursing practice needs to be grounded within a framework such as humanistic nursing theory which acknowledges and supports the subjectiveness of care and values the humanness within care practices.

Paterson and Zderad (1988) and Pearson (1991) identify humanistic nursing practice as having its foundations in existential and phenomenological philosophies. These philosophies focus upon the uniqueness of individuals and the value of being human. Paterson and Zderad (1988) describe humanistic nursing practice as a "mode of thought or action in which human interest, values and dignity are taken to be of primary importance" (p.174). Furthermore, humanistic nursing practice emphasises the importance of understanding individuals' experiences, the meaning of experiences and, as unique individuals, each person has the ability to choose based upon these understandings and meanings of experiences.

La Monica (1985), McKee, (1991) and Watson (1985) outline that humanistic nursing practice takes into account all that is known about a patient such as their experiences, feelings, desires and thoughts. Furthermore, a nurse who delivers care based upon humanistic nursing values acknowledges the uniqueness and unpredictability of the person being cared for and values the patient's own perception of their life experiences. By accepting the uniqueness of individuals, nurses gain an appreciation "of different ideas, tastes and divergent views of life, death, and the world in general" (Watson, 1985, p.11). Therefore care based upon

this appreciation will be meaningful, purposeful and focused upon the shared experience.

Humanism according to Roach (1992) is that of "a mutual quest for truth" (p.114) and when caring is focused upon this quest the result will be "common themes and purposes, ... concern for human dignity of the human, [and] improvement in the human condition" (p.115). Mutuality can be equated to the sharing of experiences, a harmonious lived experience of both people working together with an openness, a oneness in the shared situation.

Paterson and Zderad (1988), McKee (1991), Roach (1992) and Hall and Allan (1994) emphasise the importance of the concept of wholeness within humanistic nursing relationships. Wholeness within this relationship acknowledges that both nurse and patient perspectives of health are of value and are shared between the two with honesty and openness. Similarly, Bishop and Scudder (1990) refer to the personal sense of nursing as the relationship between nurse and patient. In this face to face relationship, the nurse values the patient in an open personal manner. This also relates to Buber's (1987) description of "I-Thou" relationships in regard to how human beings experience their world from within, and another human being must meet that individual as a "Thou", as a whole, not an object or an "It". Nurses who adopt "I-Thou" relationships within nursing practice would

interact within the relationship as a whole person and respect the patient as a person with worth.

McKee (1991) further argues that a humanistic nurse would not be solely focused upon tasks and solving problems but rather aims to explore the situation and be with the patient to reach a deeper understanding, acceptance and an awareness of the patient's individual needs. McKee suggests that a humanistic nurse would record carefully what is known together with the responses of the individual being nursed, and equally as important, the observations and responses of the nurse - as participant in the experience. Therefore, the humanistic nurse records what happens between the patient and the nurse rather than simply what skills were performed. From this perspective McKee proposes that humanistic nursing care requires the nurse to connect with or experience presence within a nursing encounter. This connection between nurse and patient enables the nurse to gain valuable insight into the patient's subjective experience of health, ultimately guiding care interventions. Interactions that are underpinned by humanistic nursing values or as Roach (1992) suggested by seeking a "mutual quest" (p.114), openly acknowledge the value of each individual within the interaction and allows for each to experience the subjective feelings of the interaction.

To experience the subjectiveness of the interaction, that is to experience presence, nurses need to acknowledge and value themselves as unique individuals equally contributing to the humanness of the experience. This requires nurses to draw upon the attributes of self-awareness, a self in-touchness of all human senses, to have an openness and availability to experience the intersubjective transaction, that is presence within nursing encounters (Paterson and Zderad, 1988). Paterson and Zderad, (1988) further suggest that self-awareness requires an authenticity with one's self that is more than an intellectual awareness, "[A]uditory, olfactory, oral, visual, tactile, kinesthetic, and visceral responses are involved and each can convey unique meaning to man's consciousness" (p.4). This awareness according to Paterson and Zderad offers opportunity for expanded meaning because the nurse is open to the whole experience thereby becoming more in accord with the potential humanness of the interaction. The relationship is focused upon mutuality of common thoughts, purpose and responses to human caring.

Munhall (1993) extends the descriptions by Paterson and Zderad (1988) and McKee (1991), of humanistic nursing attributes and the experience of presence. Munhall (1993) describes nurses who experience presence, have a certain openness, readiness or availability that is reflected in the living out

of nursing actions and being with others as a whole. Munhall refers to openness as "unknowingness" (p.125) and suggests that it is essential for nurses to acknowledge they do not know patients' subjective worlds. Further, within each person's subjective world are the organised thoughts, feelings, illusions and distortions, which may be experienced within the shared perceptual field of the two worlds intersecting. According to Munhall, it is not until the nurse clearly focuses upon the 'in-between' and remains in the unknowingness, that caring, understanding, empathy or misunderstandings can be realised and acknowledged.

Doona, Haggery and Chase (1997) elaborate on these earlier theories suggesting that for nurses to experience presence with patients, the nurse must firstly make a commitment to care. Commitment relates to a willingness and openness to enter another person's world with a commitment to give to that other person. Being present in this manner according to Doona, Haggery and Chase requires the nurse to interact with meaning and offer the gift of care.

Benner and Wrubel's (1989) research into caring refers many times to the relationship between caring and the nurse's ability to presence oneself or make contact with patients. Nurses, who are able to experience presence with patients, gain an in-depth understanding of "the meaning of the illness for the person" (p. 9). According to Benner and Wrubel, nurses who base their

practice upon humanistic nursing values, facilitate the experience of presence by being attentive to the situation, having a deep knowledge of the disease and by the effective use of humour. Simons' (1987) research discusses presence as being more than the mere physical presence of a nurse and that, it "reflects a being 'in tune' with each other, an awareness of unique personhood. Specific actions such as eye contact, body language and tone of voice..." (cited by Benner and Wrubel, 1989 p.13) were observed as making contact with patients. The nurses' chosen responses were apparently stimulated from their understanding of how the patient was experiencing their subjective world. Benner and Wrubel's research supports this notion that nurses who have the ability to be with others as a whole or to presence with all human senses, experience the intersubjective transaction and gain understanding of patients' subjective worlds.

In summary nursing care that focuses upon humanistic nursing values and the mutuality of the relationship, will facilitate an intersubjective transaction, a presence experience between nurse and patient. This mutual encounter allows for both persons' own perspectives of the lived experience to be understood within a shared experience. Accordingly, a nurse who reflects humanistic values will foster an environment of sensitive interactions, openly

demonstrating acceptance of the other as a unique human being who is valued within the interaction.

2.3 The Value of Presence in Caring Situations

Humanistic nursing practice is a process where the nurse is continuously responding to meet the needs of the patient, including the subjective dimensions of care. Embedded in humanistic nursing theory is the concept of care or having concern for another which supports the worth and value of a human being. Much has been documented regarding the positive influence of nurses' 'caring for', 'caring about' and, 'attention to or concern for' another person and the subsequent healing of that person (Leininger, 1984; Benner and Wrubel, 1989; Paterson and Zderad 1988; Diekelmann, 1992; Roach, 1992; Cohen, Hausner and Johnson, 1994). It is through a nursing presence or the between of interpersonal caring relationships that meaning of the experience is gained and healing promoted.

The research of Benner and Wrubel (1989), Benner (1994), and Hall and Allan (1994) into caring and humanistic nursing practice describe nursing practice, within this theory, as focusing on reciprocity of care. Caring within this context occurs "within the client's world" (Hall and Allan, 1994, p.110) which is unknown to the nurse, unlike the known professional world

of nursing. Benner and Wrubel (1989) reveal that nurses who interact within the patient's realm of experience are recipients of the gift of understanding. This understanding moves "back the walls of isolation and suffering created by the disease" (p.11). Nurses who connect with patients in their subjective world, that is, experience presence, centre care that is strongly focused on "improving clients ability to live ... to focus their lives in meaningful and useful directions" (Hall and Allan, 1994, p.111).

Roach (1992), Bishop and Scudder (1996) and Morrison (1997) further consider nurses' presence within nurse-patient interactions. These researchers concur that nurses who experience presence within everyday clinical practice are able to support patients in their experience of illness. The humanistic values of hope, compassion, concern for the well-being of the other and relating to the other as a person, are experienced by patients "as a caring presence" (Bishop and Scudder, 1996, p.38) and beneficial to their healing. According to Roach (1992) nurses who focus on the person, that is, who accept the person as a unique human being and establish a caring presence, have the capacity to heal "a multitude of wounds" (p.15).

Gardner (1992), Mohnkern (1992) and Rogers (1996) highlight findings within their research that support the positive outcomes of patients when presence is experienced. Positive outcomes for patients include a lower

heart rate, alleviation of distress, diminished feelings of powerlessness and of isolation associated with being hospitalised. These positive outcomes are not exclusive to patients, as nurses too experience the therapeutic benefits of presence.

Mohnkern (1992) reports that nurses who experience presence understand and learn much about their patients. Paterson and Zderad (1988) state that the experience of presence enables the nurse to appreciate "how this particular man [sic], with this particular history, experiences being labeled with this general diagnosis and being admitted, discharged, and living out his [sic] life with his [sic] condition as he [sic] views it in-his [sic] world" (p.5). Mohnkern (1992) further suggests that nurses are professionally gratified and affirmed by the experience of presence. Bäck-Pettersson, Jensen and Segesten (1998) also concur that for nurses, the experience of presence fosters "professional growth and excellence in nursing" (p.16).

The value of the experience of presence within nursing practice has been highlighted in this section. Both nurse and patient are nourished following the experience of presence. The physiological status of the patient responds positively, whilst simultaneously the subjectiveness of the experience is sensed by the patient, such as feelings of worth, value and compassion from the nurse. These feelings experienced by the patients are reciprocated.

Nurses also sense the subjectiveness of the experience; they too feel valued, enlivened and appreciated. It would seem that this reciprocal relationship acts like a shuttle, exchanging the subjective experiences of nurse and patient back and forth. The interchange illuminates a deep sense of mutual understanding and feelings of self worth for both.

2.4 Presence within Contemporary Nursing Practice

Nurses early in their professional careers are educated about the importance of developing a caring relationship with patients. It is from these relationships with patients, that nurses come to understand the subjective world of patients. Locsin (1995) identified that establishing caring relationships, which facilitate the connectedness of nurse and patient in meaningful ways, is the basis of nursing care. However, Darbyshire (1993), Locsin (1995), Bernardo (1998), Jackson and Borbasi (2000), and Barnard (2000) highlight, current health care settings focus strongly on technocratic values rather than humanistic values. Care has become standardised to facilitate high patient throughput and cost reduction within the services provided. This depersonalisation of care within the health sector is in direct conflict with the humanistic values of nursing practice.

Locsin (1995) argued that within contemporary health care settings, nursing practice more than ever involves the scientific aspects of care, the documenting of procedures and the monitoring of complex technologies. Telford (1992) suggests that the value of accomplishing tasks and procedures is deeply embedded within nursing culture and the health care environment. Hall and Allan (1994), Smith and Agard (1997), Tschudin (1997) and Barnum (1998) further suggest that although these values are essential, nurses are continually enculturated to focus upon delivering care objectively for the purpose of containing costs, reducing excessive waste of resources and to facilitate high patient throughput.

Bernardo (1998) highlights that the health care environment has become more technologic, nurses are caring for increased number of patients with a high acuity of illness, in an efficient and cost-effective manner. According to Victorian State Government statistics, approximately 220,000 more patients were treated in 1998 - 1999 in the public hospital sector than in 1992-1993 (Department of Health Services, 2000). These increased numbers together with the patient acuity and reduced length of inpatient hospital stays, may stifle the humanism of nurse-patient encounters thereby influencing the opportunities for nurses to connect with patients in meaningful relationships.

Clarke and Wheeler (1992) and Cohen, Hausner and Johnson (1994) propose the health care environment discourages nurses developing meaningful relationships with patients due to the time required and the cost containment issues related to the unquantifiable nature of caring relationships. Cohen, Hausner and Johnson (1994) reveal that nurses are frustrated and dissatisfied with the lack of time available to get to know patients. Nurses from that study yearned to sit and listen when their patients wanted to talk, however, lack of resources in particular, staff shortages, prevented them from spending time and developing a meaningful nurse-patient relationship. Other factors such as shorter length of hospital stays for patients, workload issues of inadequate nurse-patient ratios, skill mix among staff, such as the high proportions of recent graduates or inexperienced staff, plus an inability for continuity of patient care were identified as inhibiting nurses' ability to experience presence encounters with patients.

Darbyshire (1993), Hall and Allan (1994), and Tschudin (1997) identify the difficulties of nurses practicing nonhierarchical relationships within current health models. These researchers queried "how much of self can a nurse invest in a specific encounter with a client, given the fragmentation of nurses' time and energy" (Hall and Allan, 1994, p.114).

Tschudin (1997) questions why nurses continue to work within these restrictive and unrewarding forces of health care systems. According to Tschudin, nurses are required to focus upon cost reduction, ensuring high patient throughput and lengthy documentation necessary for patient funding. Tschudin further notes the physical and emotional impact on nurses of experiencing presence within the constraints of current health care systems. These include but were not limited to medical conditions, feelings of guilt, anger, shame, impotence, humiliation, detachment, depersonalization and material costs of absenteeism and sickness.

Ostermann and Schwartz-Barcott (1996) argue that care which is highly focused upon technology, high patient acuity and throughput, rather than the meaning of the patient's subjective experience may lead nurses to unknowingly neglecting to acknowledge the patient as a person. This insensitiveness augments the lack of recognition and understanding of the value of presence within nursing practice.

More recently, Barnum (1998) encapsulates the previous researchers findings and comments that within the current health care environment it is very difficult for nurses to experience presence encounters with patients. This is mainly due to reduced staffing levels and increased patient acuity within hospitals. To cope with these stresses, Barnum suggests that nurses may

develop strategies that focus upon distancing themselves from the patient, the nurse - patient relationship reflecting an objective "I-It" (Buber, 1987) rather than the subjective "I-Thou" (Buber, 1987). That is, nurses would choose to tend to the technology and tasks rather than demonstrating openness and availability to the patient.

Highlighted throughout this section are the difficulties that registered nurses encounter in current health care systems where priorities are not aligned with the humanness and the subjective nature of nurse-patient interactions. This may create many conflicts for those nurses, who fundamentally want to care for patients.

Conclusion

Presence has been described in many varying terms, each exploring differing levels at which presence may be experienced within a nurse-patient relationship. These include presence as simply being a function or, being recognised as a "thou" (Buber, 1987), as an equal not an object within the interaction. The literature outlines that nurses who do not respond to nursing situations with genuine intersubjectivity that is, relating to another as a 'presence' or 'thou', are unable to co-experience the patient's world. Conversely, nurses' who do presence oneself with all human senses

experience the intersubjective transaction and gain understanding of how the patient is experiencing their subjective world.

Research supports the importance of the phenomenon of presence to nursing. The literature highlights that this experience requires the nurse to dwell in the patient's subjective world, to share in the experience. This experience allows the nurse to connect with and gain understanding of the patient's experiences. This connection with the patient has a strong healing benefit for the patient, however, this experience requires time and energy on behalf of the nurse. The literature also alluded to difficulties of experiencing presence within current health care environments that focus upon objectivity and procedures.

From the literature reviewed, it is identified that registered nurses' perspectives of the experience of presence has not been fully explored. Gaining understanding of the experience of presence from registered nurses' perspectives will firstly illuminate commonalties of meaning of presence and secondly, how nurses facilitate the experience despite the difficulties within current health care systems. The following chapter will discuss the philosophical framework that will guide and underpin this research study.

Chapter 3

Philosophical Framework

Introduction

This study intends to uncover the interpreted meanings, insights and understanding of registered nurses' experiences of presence within contemporary health care settings. The philosophical framework that underpins this research to explicate these experiences is Heideggerian hermeneutic phenomenology. This chapter firstly outlines the philosophy of Martin Heidegger, was a philosopher. Heidegger's philosophy, in particular a discussion of *Dasein* as an interpretation of Being and Being-in-the-world, is described along with an explanation of Heideggerian hermeneutic phenomenology. An important concept of this phenomenology is the hermeneutic circle, from which all interpretations are based. Throughout the chapter this concept and the philosophy of Heidegger is discussed in relationship to forming the framework for this study.

3.1 Philosophy of Heidegger

The philosophical thoughts presented in this chapter have been drawn from many notable philosophers and researchers. However, the primary focus of this chapter is that of Heidegger's philosophical writings as it was his thoughts that formed the basis for this research study.

Martin Heidegger (1889 - 1976), a German philosopher, was a former pupil of another German philosopher, Edmund Husserl (1859 – 1938). Husserl's interest was in the epistemological questions of knowing and the detached description of the lived experience. This detachment, Husserl called bracketing, from which description of experience can be exposed without being polluted by the observer's or researcher's prior understanding of the phenomenon (Walters, 1994). Unlike his teacher, Heidegger focused on the ontological existential perspective of the meaning of human existence, rather than knowing. Heidegger (1962) posed the ontological question of "the meaning of Being" (p.1) or simply what does it mean to be a person? This ontological question made known his rejection of the Cartesian tradition of mind – body split (Walters, 1994), that is, humans viewed as objects, rather than a person whose actions and understandings form a comprehensive self. These early philosophical thoughts of Heidegger were the beginning of existential phenomenology.

According to Macquarrie (1973), Heidegger is one of three great existentialists, the others being Kierkegaard (1813-1855) and Sartre (1905-1980). Although existential philosophers focus on many different doctrines, three common themes consistently occur in most existentialist thinkers, these being "freedom, decision, and responsibility" (Macquarrie, 1973, p.3). Existential philosophy proposes that individuals are free to choose and that it is through this freedom that human beings are able to attach meaning to life experiences and be responsible for their life situations. Existential philosophy further proposes that human beings are unable to set aside prejudgments or presuppositions. Meaning emanates from being connected to the world and the emotional aspects of living (Macquarrie, 1973; Heidegger, 1962). For Heidegger (1962), a person comes to the experience already with background understanding on which interpretations and meanings are based.

Background understanding enables individuals to interact in the world in meaningful ways assigned through the concept of embodiment. Embodiment acknowledges the uniqueness of how people experience their own bodies, encompassing the lived body and the unconscious unity of mind and body (Benner and Wrubel, 1989; Boughton, 1997; Lawler, 1997; Madjar, 1997). According to Heidegger, human beings are active participants within experiences and find purpose and meaning within the world. For nursing,

Heidegger's concept of embodiment acknowledges the interconnectedness of nurse - patient relationships that enables nurses to dwell in the experience of the patient and sense feelings, pain and suffering.

Heidegger (1962) further argues that, because of embodiment, individuals can not bracket their background meanings or expectations as proposed by Husserl's philosophy. Many nursing practices are embodied within the everyday skills, knowledge and meaning of nursing practice. Nurses are unable to bracket their understanding and interpretations of these everyday nursing experiences, as it is from these experiences within everyday practice that they grasp purpose and meaning. It is from these interpreted meanings that care is contextualised and lived out by their actions in the world of nursing (Benner and Wrubel, 1989; and Lawler, 1997).

Heidegger (1962) refers to human existence as *Dasein*, which is an expression of Being. Dreyfus (1992) explains, "*Dasein* in colloquial German can mean 'everyday human existence', and so Heidegger uses the term to refer to human being" (p.13) in an ontological sense. For Heidegger (1962) the entities of the human world must be considered from an ontological perspective for the meaning and interconnectedness to be grasped. From this perspective human existence, *Dasein,* and the everyday actions of human beings is described by Heidegger (1962) as Being-in-the-world. Being-in-

the-world for *Dasein* is never separate to or merely alongside the world, as *Dasein* is 'in' the world. In this context, alongside infers that human existence could never value or touch anything with emotional meaning, that is, in the ontological sense. Therefore, 'in' according to Heidegger (1962) is 'to reside' or 'to dwell in' or 'to look after something' (p.80), to care. Care is the unifying entity of *Dasein* that lies before and in every attitude and situation of *Dasein*. Care is primordial of all human action and is central to Being-in-the-world.

The ontological concept of 'Being-in-the-world' expresses the different degrees of awareness and the interconnectedness of the world. Being-in-the-world includes firstly, an awareness of the 'present-at-hand' entities within the physical world such as houses, trees, mountains and people. Secondly, when the world of a nurse or the world of a mechanic is referred to, many multiple objects that are connected to the meaning of the 'world of' can be brought to conscious thought. Dreyfus (1992) discusses this as Heidegger's ontological-categorical sense of "the essential characteristics of the entities that make up the set" (p.89). The world thirdly, is where people are said to live or dwell and has a pre-ontological meaning, "a constellation of equipment, practices...[such as] the child's world, the world of fashion or the business world" (Dreyfus, 1992, p.89).

Further to Dreyfus' interpretation, is that human beings have pre-ontological understanding of Being-in-the-world, in which many of the practices, concerns and equipment go without noticing. Heidegger's last concept of Being-in-the-world is as 'a priori', that is human beings "already live in an understanding of Being" (1962, p.23). Leonard (1989) explains 'a priori' understanding of the world as acquired by humans via language, culture and in history. Leonard (1989) states:

> *Language creates the possibility for particular ways of feeling and of relating that make sense within a culture...The world is constitutive in that the self is raised up in the world and shaped by it in a process that is not the causal interaction of self and world as objects, but rather the nonreflective taking up of the meanings, linguistic skills, cultural practices, and family traditions by which we become persons and can have things show up for us (p.43).*

Taylor (1994) summarizes the concept of 'a priori' by explaining that human beings are always coming out of history, that is their past experiences and understanding of being-in-the-world. Further, human beings make decisions in the present, here and now of their life from which meaning, purpose and an anticipation of the future is perceived from their past experiences, culture and traditions. Within everyday nursing practice, nurses actively interact with patients and bring to relationships all that they are and have experienced as human beings and as nurses. Nurses interact from their 'a priori'. The world-of-nursing does come with its own meaningful practices, language and

culture, an 'a priori' that relates to particular ways of caring for, and responding to patient interactions. Nurses base decisions upon their past experiences, culture and interpreted meanings from Being-in-the-world nursing.

Macquarrie (1973) highlights Heidegger's concept of Being's relationship with Being-in-the-world, that is the relationship of human beings and their complex world as "where everything seems to affect everything else. What articulates this world and gives significance to each single item within it is human concern" (p.61). It is through concern that 'things' of the world matter. For Heidegger, things of the world matter because *Dasein* or our 'Being-attuned' is what, in-the-world makes a difference.

Further exploration of Being-attuned reveals that the phrase Being-there is a state-of-mind and indicates in ontological terms "our mood, our Being-attuned" (Heidegger, 1962, p.172). Dreyfus (1992) uses the word "affectedness" in place of state-of-mind to highlight Heidegger's point of "our being already affected by things" (p.168). According to Dreyfus interpretation, things of the world matter to human existence because people are concerned and care for the world in which they dwell. Thus, nurses as human beings, care for and about entities within-the-world, including the patients they care for within-the-world of nursing. Nurses do have a concern

for patients, they are significant within the world of nursing. This concern motivates nurses to care for patients in meaningful, interconnected relationships, to experience presence.

Heidegger (1962) refers to concern as solicitude which is expressed as Being-in-the-world as Being-with. "This 'with' is something of the character of Dasein ... the world is always the one that I share with Others. The world of Dasein is a *with-world.* Being-in is *being-with* Others" (p.155). Heidegger describes two types of solicitude as one that leaps in and takes over for the Other and secondly, the type of solicitude that leaps ahead of the Other, not to take away care but to give it back. Both are necessary in the everyday Being-with-one-another as both pertain to concern (Benner and Wrubel, 1989, p.49).

Leonard (1989) and Dreyfus (1992) support this notion of human beings gaining significance and value from entities with-in-the-world as a direct result of care and concern. Leonard (1989) restates Heidegger's point that finding significance is a result of *Dasein,* that is, *Dasein* is always finding

> *itself primarily and constantly in things, because, tending them, distressed by them, it always in some way or other rests in things. Each of us is what he [sic] pursues and cares for. In everyday terms we understand ourselves and our existence by way of the activities we pursue and the things we take care of (p.46).*

It can therefore be concluded from the writings of Heidegger and others presented here, that human beings gain significance and value from things within their world because an essential characteristic of *Dasein* is care. Human existence in the everyday Being-in-the-world, which Heidegger (1962) discusses as "dealings in the world and with entities within-the-world" (p.95) or of going about our business, exhibit characteristics of concern and care with those entities in-the-world.

Nurses reside in-the-world of nursing, always interpreting, interacting and gaining significance from their everyday-nursing world brought about by their desire to look after, care for and concern for patients. This concept of care and solicitude enables this researcher to explore the meaning and significance of presence as expressed via the participants' 'a priori' of their experiences of meaningful relationships with patients. That is, the participants' understanding of Being in-the-world of nursing, of what in the world of nursing has significance and is of concern for them will be unveiled via the language and stories expressed of their experiences of presence. Similarly, this researcher's 'a priori' of Being in-the-world of nursing will also facilitate the researcher to illuminate the skills, language and culture of nursing that is associated with the experience of presence.

3.2 Heideggerian Hermeneutic Phenomenology

Heideggerian hermeneutic phenomenology is a research method based on the philosophy of Heidegger, who totally transformed Husserl's (1859–1938) definition of phenomenology. Husserl describes a phenomenon from the perspective of a person experiencing that phenomenon. Within his description, personal experiences are utilised to understand the phenomenon and, as evidence of the phenomenon. These descriptions do not include any judgments or prior understanding from the investigator. However for Heidegger, phenomenology includes those aspects of human experience that could be shared but perhaps be never totally articulated, therefore suggesting "no indubitable evidence shows itself" (Dreyfus, 1992, p.30). That is, phenomenology attempts to uncover from the perspective of the individual experiencing the phenomenon, the meaning of human experience and how they interpret those experiences (Walters, 1994). Heidegger (1962) further proposed that phenomenology takes into account the subjective emotional human experience thereby allowing for interconnections that perhaps were previously hidden, to be illuminated.

Heidegger (1962) states that "phenomenological description as a method lies in interpretation" (p.61) because all human beings have prior knowledge and understanding, that is, come to the phenomenon with history and background

understanding which cannot be detached. For Heidegger "phenomenology posits that human beings both constitute and are constituted by their interpretations, with background meanings handed down in language and cultural practices" (Lionberger, 1986, p.171). According to Heidegger, this prior knowledge or pre-understanding will influence the interpretation of the phenomenon.

Heidegger's philosophical stance heavily influenced his definition of phenomenology. In particular, hermeneutics, which is the art of interpretation, originally focused upon written historical texts. Heidegger subsequently extended this concept to apply to "the interpretation of the human being, through the understanding of Being implicit in *Dasein*" (Taylor, 1994, p.45). Heideggerian phenomenology is a philosophical framework that "seeks to make visible the nature and meanings" (Rather, 1992, p.48) of the everydayness of *Dasein*, that is, of human existence. Individuals' interpretation of experiences is strongly influenced by Heidegger's concept of 'a priori', that is, human beings are self-interpreting and experiences cannot be bracketed or put aside. Therefore, an important component of Heideggerian phenomenology is the concept of the hermeneutic circle.

Heidegger (1962) distinguished three interrelated modes of interpretation that he called "fore-having", "fore-sight" and "fore-conception" (p. 191). These

three modes are known as the hermeneutic circle or the "fore-structure". The hermeneutic circle is the framework from which all interpretation is accomplished in seeking to increase understanding of the phenomenon. Plager (1994, p.72) presented Heidegger's fore-structure as:

1. A *fore-having:* we come to a situation with a practical familiarity, that is, with background practices from our world that make an interpretation possible.

2. A *fore-sight:* because of our background we have a point of view from which we make an interpretation.

3. A *fore-conception:* because of our background we have some expectations of what we might anticipate in an interpretation.

Heideggerian hermeneutic phenomenology was chosen for this study because it allowed this researcher and the participants of the study to engage in a personalised, interactive process that acknowledged each person's fore structure. In accordance with Heideggerian hermeneutic phenomenology, this researcher was also an active participant, within the hermeneutic circle. That

is, the researcher came to the study with her pre-understanding of nursing language, culture and experiences of nursing. During the process of analysis, the researcher was within the hermeneutic circle, transferring the participants' interpreted meanings of their everyday clinical experiences within-the-world of nursing to the reality of the researcher. Hence, the hermeneutic circle enabled this researcher to interpret meanings of their clinical experiences "in a careful and detailed manner" (Packer, 1985, p.1082), thereby shedding light on the value and significance of presence within clinical practice.

Conclusion

This chapter has outlined the philosophy of Martin Heidegger who is accredited with the beginnings of existential phenomenology. This philosophy proposes the ontological question of the meaning of Being, that is the meaning of human existence. Being and Being in-the-world, rather than being alongside without meaning or emotion is an expression of Daesin, was discussed. Further Daesin with-in the everyday world, has concern and cares for the entities with-in the world. This is because for Daesin things in the world and of the world matter and have significance. Finally, a description of Heideggerian hermeneutic phenomenology was described. This phenomenology acknowledges that human beings or Daesin, are always interpreting and finding significance from experiences based upon the key

concept known as 'a priori'. This concept explored that individuals can not disregard or bracket previous experiences. Therefore, interpretation, practices and decisions are founded upon background understanding and familiarity with the situation or experience. Interpretation from this perspective is known as the hermeneutic circle or forestructure.

The chapter outlined that Heideggerian philosophy and the hermeneutic circle will provide the framework for this study, as it acknowledges that nurses reside in-the-world of nursing, interpreting, interacting and gaining significance from their everyday nursing. This is brought about by their desire to look after, care for and concern for patients. Furthermore, nurses are unable to bracket previous experiences as it is from their 'a priori' that meaning and purpose to their practice is embodied. In the following chapter the methods and processes used during this Heideggerian hermeneutic phenomenology study will be detailed.

Chapter 4

Methodology

Introduction

This chapter details the methods utilised in this Heideggerian phenomenological study, that set out to explore registered nurses' lived experience of presence within nursing practice. The rationale for choosing the qualitative research design method of phenomenology will be presented. Snowballing technique, the method used to identify, approach and invite participation is described. Information pertaining to participants of this study, is provided. The interview techniques utilised for the individual interviews are explained including an overview of the interview settings. The interpretative hermeneutic data analysis process of Diekelmann, Allen and Tanner (1989) utilised in this study is presented. The ethical considerations addressed, in particular informed consent and confidentiality are described. Finally the concept of trustworthiness that ensured rigor of this qualitative study is discussed.

4.1 Research Design

This Heideggerian phenomenological study focuses on the human experience of presence within nursing practice. This study aims to explicate the meaning of presence from registered nurses' perspectives, together with an understanding of how they are enriched from these experiences. Furthermore, this study aims to identify strategies that the participants utilise to facilitate the experience of presence within contemporary health care systems.

It is appropriate for this study to utilise a qualitative phenomenological design, as this approach will illuminate understanding from registered nurses' perspectives of their everyday activities and meaning of presence within nursing practice. To enable the meanings and experience of the phenomenon of presence to be revealed, the research design consisted of interviewing registered nurses. Utilising an in-depth unstructured interview data collection method enabled the registered nurses to describe their interpreted meanings and understandings of their experiences of presence. In addition, the personal interaction during the interviews allowed this researcher to interpret meaning from the language, words and gestures disclosed by the registered nurses during the interview.

4.2 Selection of Participants

The snowball sampling technique was used to recruit participants of this study. This technique according to Minichiello, Aroni, Timewell and Alexander (1995, p.161) requires participants being asked by the researcher if they knew of any colleagues who fit the criteria for inclusion and would be interested in participating in the study. The criteria for inclusion were that each participant must be a Registered Nurse (Division 1)[1], currently engaged in clinical nursing practice and have experienced presence or felt that they had connected with and sensed a oneness with a patient(s) in their practice.

Initial expressions of interest were received from two (2) registered nurses who were then asked to put the researcher in touch with other potential participants. Keeping true to snowballing technique, the researcher continued to contact interested participants until saturation of data had been reached. Saturation occurs when no additional data could be added to the categories that are being developed (Minichiello, et. al., 1995). Initially the

[1] (1) A person is qualified to be registered in division 1 of the register if that person--
(a) has successfully completed a course of study accredited by the Board; or
(b) in the opinion of the Board, has a qualification that is substantially equivalent or is based on similar competencies to an accredited
course; or
(c) has a qualification that is recognised in another State or Territory of the Commonwealth for the purposes of undertaking work of a
similar nature to that which a person, who holds a qualification to which paragraph (a) or (b) applies, is qualified to undertake.

researcher had anticipated eight (8) participants as being necessary, however following six (6) interviews saturation of data was achieved.

Following the initial introduction, all prospective participants were recontacted via the telephone to establish rapport and to ascertain if they had experienced presence. Once rapport had been established and the researcher had an appreciation for their experiences, confirmation of their willingness to participate was obtained. The interview time, date and location agreeable to both researcher and participant was then arranged.

4.3 Participants

The participants were Anglo-Celtic females aged between mid thirties to fifty years, with varying professional backgrounds and diverse nursing experiences. The participants were initially given pseudonyms names of Helen, Louise, Jocelyn, Katherine, Judy and Christine, who at the time of interview, were employed either part or full time in clinical nursing practice. Each participant had over twenty years of clinical nursing experience. To ensure the participants' identity remained anonymous, the background information of each has been aggregated. At the request of the participants, the pseudonyms names were not used during the writing up of this study.

Each of the participants is a unique individual possessing qualities and experiences that provide this study with a rich data source. The participants' experiences reflect similarities such as all are registered nurses with many years of clinical experience. Their clinical experiences included areas such as acute care, geriatric nursing, palliative care, midwifery, home nursing care, operating suite and psychiatric nursing including drug and alcohol rehabilitation. The post registration educational qualifications and professional background of the participants were varied. One participant has a degree in philosophy. Two participants have experience as nurse academics within tertiary education. Three of the participants are experienced clinical educators, one manages her own nursing business similar to district nursing services. Also three of the participants have experience within the home nursing care services. One participant is also employed part time with a large international airline company as a nurse consultant.

4.4 Ethical Considerations

Throughout the conduct of this study, consideration was given to the welfare of the participants. The principles outlined by The Australian Nursing Council Inc. (1994) Code of Ethics for Nurses in Australia, National Health and Medical Research Council (1995) and the Code of Conduct for Research

Victoria University of Technology guided this researcher in safeguarding the participants and research data. Two major ethical issues of informed consent and confidentiality will be discussed.

As previously mentioned, the participants engaged in an initial telephone conversation with the researcher during which time the purpose of the study was explained. The researcher also outlined to the participants that during the interview, an audiotape would record their stories so that their experiences, as expressed at time of the interview, could be transcribed verbatim by the researcher. At the time of interview, further explanation of the study was given to each participant to ensure understanding of the nature and processes being utilised. At this time, participants were given a plain language statement to read prior to gaining informed consent (Appendix A). This gave the participants an opportunity to clarify any further issues relating to this study.

Participation was purely on a voluntary basis and interviews did not proceed until verbal informed consent was gained and the consent form signed. A blank written consent form is attached (Appendix B). Further, the participants were informed of their right to withdraw from the study at any time without prejudice. The participants were assured their identity would remain confidential throughout the study and in any subsequent dissemination

of the findings. All data collected was coded to ensure confidentiality of participants. In order to achieve confidentiality, the following principles were adopted throughout the study.

1) No discussion regarding any of the participants would take place with any other person.

2) The interviews were conducted at a time and place suitable to the participants.

3) Following the initial transcription of interviews, the participants were no longer identified by a pseudonym. The participants were now identified by number and all data were coded so that no other person would know their identity.

4) Data were grouped and presented anonymously.

5) Any names of persons or places disclosed during the interviews were edited out and would not be divulged in any dissemination of the study findings. Where changes were made to the data to ensure confidentiality, care was taken not to distort the meaning conveyed by the participants.

6) No other person other than the researcher and the researcher's supervisor had access to the audiotapes and unedited original transcripts.

7) All data collected including audiotapes, original unedited transcripts and edited transcriptions were stored under lock and key during the study.

8) Data stored on the computer hard drive during the research process was password protected and accessible only to the researcher.

9) On behalf of the University, the School of Nursing, following submission and completion of the research thesis will store for a minimum of five (5) years, all data including the audiotapes and the original transcripts (edited and unedited).

Other ethical issues considered throughout the conduct of this study were that of promoting an open and honest environment where the participants felt at ease to intimately describe their experiences of presence. As the interviews were of a conversational style, both researcher and participants actively contributed to the research environment. The relationship between the researcher and participants was reciprocal that is the researcher openly and honestly disclosed to the participants her professional background and interests as did the participants share their background with her. This process of sharing assisted the participants in knowing the researcher as a person and conversely the role the participants would take within this study.

4.5 Data Collection

The success of achieving the aim of this study depended upon the extent to which the participants reflected upon and shared their experiences of presence within nursing practice and the subsequent accurate data recording. The data for this study was a combination of the participants' own stories and of the researchers' notes. The stories were audiotaped at the time of interview and transcribed verbatim by the researcher immediately following the interview.

4.5.1 Interviews

All participants nominated a convenient time and date for the interview to be conducted. They also chose that the interview setting be in their own homes. Being interviewed within their own home reduced the degree of disruption to the participants and more importantly, provided a known safe environment where they felt at ease to express their experiences of presence.

Prior to each interview, the researcher checked the working order of the tape recorder to avoid any delays and distractions at the time of the interview. The tape recorder was placed in an unobtrusive position, usually to the side and between the researcher and participant. This placement of the tape recorder assisted to decrease any level of discomfort or embarrassment the participants

may have about a tape recording device. The recording of the interview commenced as soon as the researcher and participants were comfortably seated and the everyday conversation of sharing background information had begun. This technique was used to assist the participants in becoming relaxed and accustomed to the tape recorder, prior to the open-ended research question being introduced in the interview setting. When the researcher observed visible signs of the participant being relaxed and ready to commence the interview, the open-ended question related to this study was introduced.

All participants engaged in a single, one to one and half-hour unstructured in-depth interview. An unstructured in-depth interview provided an ambience conducive to conversational interaction between participant and researcher. Although the length of the interview may be argued to be non-conducive to a relaxed environment, some of the initial interview time was spent in open conversation.

According to Minichiello, Aroni, Timewell and Alexander (1995, p.73) in-depth interviewing is a technique which enables the researcher to gain understanding of meaningful human interaction via the participants' point of view. The goal of in-depth interviewing is to have the participants reconstruct their experiences of the phenomenon under study, in doing so, they attach their own interpretations and meanings to the experiences. This method of

in-depth interviewing is important within phenomenological studies where meaning and understanding of the participants' experiences is being sought, as it is via the participants' language that the essence and meaning of their experiences is elicited.

As mentioned, the interview was a conversational interaction, referred to as an unstructured interview. The purpose of an unstructured interview is to seek understanding of the participants' experiences as expressed in their own words without being directed by a script of questions (Minichiello et. al, 1995, p.65). Although this interview implies there is no planned sequence of questions, the researcher does maintain focus to the interview by the style of questioning throughout the interview. This researcher was at all times, throughout the interviews, conscious of keeping the participants focused on their experiences of presence. When the conversation strayed from this focus, the researcher would use reflective conversation to draw the participant back to a previous point raised to reconnect them to the study.

At the beginning of the interview, this researcher expressed her interest in caring, in making contact with patients or the experience of presence and, what the meaning of this experience is for the participants. The researcher then followed with an open-ended question of *"Can you describe to me what making contact or experiencing presence within nursing practice means to*

you?". The aim of this question was to assist participants with the unfolding of their experience of presence within nursing practice. Occasionally a second open-ended question such as *"Can you tell me about your experiences of presence or making contact with patients within your nursing practice?"* was used to elicit further information of the participant's stories.

The participants' stories were the basis of further probing into their experiences of presence. Probing into their stories enabled this researcher to clarify understanding of the meanings attached by the participants and to elicit rich descriptions of their experiences. Various methods of probing were used to assist participants in exploring more deeply their stories and to clarify the researcher's interpretation at the time of interview. Probes, known as nudging probes and reflective probes (Minichiello et. al, 1995, p.91) were used to maintain focus, gain clarity and further insight into the meaning of presence for these participants. Nudging probes used by this researcher included *"can you tell me more?", "Hmm" "What are your thoughts about presence in the acute situation?"* or *"How does that make you feel?"*. Whereas the reflective probes included statements such as *"So you wrote something down?" and "So you saw that it wasn't only a benefit to you but also to the patients?"* Lastly, occasionally throughout the interviews the researcher gained clarification of understanding by asking the devil's advocate question.

According to Schatzman and Strauss (1973, cited in Minichiello et al, 1995, p.90) this method is more directive and aggressive and primarily used to provoke the participant to provide more information to test the validity of the researcher's interpretation. This method of probing was only used when rapport, interpersonal familiarity and comfort had been developed between the researcher and participant. One such question strongly posed was *"How do you know?"*

Probing of the participants' experiences provided an opportunity for them to further explore and make connections within their own experiences. This method of interviewing is consistent with phenomenological research enabling the researcher to gather a wealth of rich and meaningful data.

4.5.2 Field Notes

The notes generated by the researcher during and following each interview provided valuable data for analysis. These notes recorded the participants' facial expressions and other body language such as, body posture and hand gestures made by the participants during the interview. Following each interview the researcher also noted any of her thoughts and ideas about the stories expressed by the participants.

4.6 Data Analysis

Data analysis was guided by the hermeneutic interpretative analysis process developed by Diekelmann, Allen and Tanner (1989) who explicated the work of Heidegger's hermeneutic circle. Heidegger's (1962) concept of fore-structure (the hermeneutic circle), which was discussed in the previous chapter, enabled this researcher to begin interpretation of the participants' stories as they were being unfolded during the interviews. The researcher, already in the hermeneutic circle, came to this study with background understanding of being-in-the-world of nursing and caring for patients.

Engaged in the circle of interpretation, the researcher was constantly moving back and forth in a dynamic state of interpretation during the interviews. That is, from listening attentively to the participants' stories unfolding, to the emotion being expressed and then to the emphasis placed on a word, a sentence or particular encounter. As the researcher interpreted parts of the story and then collectively with the whole experience of the participant, new understandings emerged of the meaning of presence within nurse-patient interactions. Similarly, the participants within their own forestructure, described parts of particular interactions with patients against the whole of the relationship. This style of engagement assisted the researcher in understanding the significance of the interaction and shed further light onto

the meaning of these experiences for the participants. The hermeneutic circle of interpretation continued throughout all processes of data collection, interviews, transcribing and analysis stages, until the completion of the final written report.

Diekelmann et. al. (1989) developed a seven stage analysis process whereby the text analogues of the collected data are examined for meanings that arise "either implicitly or explicitly in the texts" (p.11). This process as applied to this study, is described in detail on the following pages. The purpose of the multiple stage analysis is "to expose unsubstantiated meanings and inaccurate interpretations not supported by the text" (p.12) and to lay open meanings arising implicitly or explicitly. Later Diekelmann (1992) extended this argument by stating that the multiple interpretations throughout the whole analysis process, "serve as bias control ... Since shared practices and common meanings are described, it is assumed they will be recognisable to the reader who shares the same culture" (p.74). The multiple stages of analysis supported the hermeneutic circle of interpretation as the researcher moved back and forth throughout the analysis process, further meanings and interpretations were illuminated.

The hermeneutic method of analysis as described by Diekelmann et al. (1989), was devised for a team approach to research. Within this study, only

one researcher was involved, therefore minor modification to the stages of analysis was necessary. The following details outline the modified hermeneutic interpretative analysis process used by the researcher for this study. A multifunctional computer software analysis package, Q.S.R. Non-numerical, Unstructured Data, Indexing, Searching and Theorizing (NUD·IST), was used as a tool to support and manage the analysis process.

Stage 1. Following transcription of the interviews, the first stage of analysis was to examine the individual text analogues (Diekelmann et al., 1989) also known as transcripts of the interviews. Whilst reading the text of each interview and listening to the audiotape, the researcher was again immersed in the participants' stories. Hearing the stories again extended the researcher's overall understanding of each participant's experiences. Minor editing of the text analogues was made at this particular point, which included typographical errors and the removal of all identifying information. Notations made by the researcher at the time of interview were also added to the texts at the appropriate points, these included any hand gestures, facial expressions or body language demonstrated by the participants. Also added to the texts were any emphases that the participants' placed on words, sentences or particular interactions with patients.

Stage 2. Using NUD·IST, each individual text was then summarized into interpretative sections. The researcher identified sections as natural breaks within the conversations or when the focus changed. At times, the participants' stories were very long, therefore when this occurred the researcher divided the story into manageable sections usually when the participant paused briefly. When it was necessary to divide the stories into these sections, the researcher was careful not to distort the meanings expressed by the participants. At this point meaningful statements and or, excerpts from the texts were used to support the researcher's interpretations. Whilst writing the interpretative summaries in the memo section of NUD·IST, the researcher identified any categories or themes within the individual texts that were interpreted as significant, such as repeated words, skills, actions or emphasis of meaning. These were then labelled as nodes within NUD·IST and the supporting text transferred to each node. An example of a node is attached. (Appendix C).

Stage 3. This stage required the researcher to compare the identified categories/themes within each individual text for similarities or differences. That is, each participant's text was again individually re-read whilst the researcher checked the interpretations written in the summaries against the participant's own stories. According to Diekelmann (1992), "if

unsubstantiated meanings are revealed and inaccurate interpretations are not supported by textual reference, the team [researcher] returns to the text" (p. 74). Therefore, where any differences were noted, the researcher returned to the original transcript and the interview tape. This process of comparing the researcher's interpretation with the raw data, enabled the researcher to listen to the tone of voice and meaning being attached to the story by the participant, therefore, clarification of any discrepancies was identified. When necessary, NUD·IST was used to assist in the deleting or combining identified categories to accurately represent the interpretations carried out.

At the completion of stage 3, the researcher identified from the six (6) individual text analogues, twenty-three (23) categories which are represented as nodes within the NUD·IST program (Appendix D).

Stage 4. The texts generated in the previous stages of analysis were now re-read as a whole rather than as individual texts. The purpose of this stage is to identify the relational themes. A relational theme cuts across all texts, highlighting the similarities or contradictions of meaning within the participants' experiences (Diekelmann et al., 1989). Following extensive re-reading and interpretation of the texts, four (4) relational themes were identified. These were: intimacy of the experiences; humanness of the

interactions; listening with all body senses and; emotional tensions. These will be discussed in detail in the following chapter.

Stage 5. The researcher began to compare and interpret the relational themes to uncover the constitutive patterns existing within the relational themes. The constitutive pattern expresses the relationship of all the themes previously identified. The constitutive pattern of Presence: commitment to care and the spiritual connectedness of care was illuminated. This will be discussed in detail in Chapter 6.

Stage 6. The purpose of this stage is validation of the interpretations. The researcher's supervisor viewed drafts of the themes and constitutive pattern. All responses and suggestions received were integrated into the final draft. The individual texts and audiotapes were also revisited many times enabling this researcher to become further immersed in the hermeneutic circle, gain in-depth understanding of each of the participants' experiences and further validated the interpretations.

Stage 7. Following validation of the interpreted data, the final analysis occurred. Excerpts from the participants' own words that reflected the strong meaningful transactions were included in the final written report.

4.7 Trustworthiness

Much has been written regarding the methods to achieve rigor and validity within qualitative research. The terms rigor and validity are traditionally linked to quantitative studies and generally refer to the ability of the research findings to accurately represent the study. This representation allows for replication in future studies. However, qualitative research interests lie not in controlled replication of studies but rather "emphasizes the meaningfulness of the research" (Sandelowski, 1986, p.29) and in gaining understanding of human experiences.

Guba and Lincoln (1989) refer to rigor in qualitative research as trustworthiness, which is evidenced by the faithful descriptions presented by the researcher. These descriptions when read by others can recognise the experience as meaningful and applicable to their own experience. Further, trustworthiness according Streubert and Carpenter (1995) refers to the ability of the researcher to accurately represent the participants' experiences as expressed. Accurate descriptions include the strategies employed to demonstrate the trustworthiness of the study (Holloway and Wheeler, 1996). Burns and Grove (1995) suggest that trustworthiness within qualitative research "is [also] associated with openness, scrupulous adherence to a philosophical perspective, [and] thoroughness in collecting data" (p.397). To

establish trustworthiness within this study Guba and Lincoln's (1989) criteria of auditability, fittingness, and credibility were applied throughout the study.

4.7.1 Trustworthiness: Auditability of Study

Auditability of a study enables any other person to logically follow the progression of events and is primarily demonstrated "if the reader is able to audit the events, influences and actions of the researcher" (Koch, 1996, p.24). Auditability is also known as a "decision trail" (Sandelowski, 1986, p.32). The decision trail of this researcher has been documented and describes the methods and processes used in this study, including her interest in the phenomenon, the aims of the study, invitation to participate and the decisions that encompassed the choice of method and analysis process. The descriptions of the themes and the constitutive pattern include exemplars from the participants' stories. These are provided to facilitate the audit trail and illustrate that the descriptions and interpretations fit the raw data.

4.7.2 Trustworthiness: Establishing Credibility of Study

The credibility of a study equates to the faithful representation or descriptions of the participants' experiences as reflected within the data. Following transcribing of interviews each participant reviewed their own transcribed interviews. This provided the participants with the opportunity to delete or

modify any of the stories recorded. The participants did not modify any of their stories, however two transcripts required minor editing of deleting a patient's name from one text and the other deleting a clinical agency's name. One participant queried a word contained within a sentence as she felt it did not fit into her own usual conversational style. Following a revisit to the audiotape the participant agreed with the sentence structure.

Minichiello et al. (1995) clearly links credibility to in-depth interviewing and the methods to be used by researchers to establish trustworthiness of data. Minichiello et al. explains that trustworthiness is achieved by ensuring "a close fit between data and what people actually say and do" (p.176). Understanding the participants' point of view and seeking clarification of their perception ensures trustworthiness of data. During the interviews, this researcher constantly utilised various methods of probing and cross checking as previously discussed to assist with accurate interpretation and truthfulness during data collection and analysis.

4.7.3 Trustworthiness: Fittingness of Study

Sandelowski (1986) extends Lincoln and Guba's (1985) writings on fittingness of study explaining that if findings can 'fit' into situations outside the study and have significance or meaning to others not connected to the

particular study then "the criterion of fittingness" (Sandelowski, 1986, p. 32) has been meet. Fittingness also refers to the appropriateness of methods used for data collection, sample size and that the descriptions "fit the data from which they were derived" (Sandelowski, 1986, p.32).

The participants of this study are a representation of nurses employed within clinical practice. The findings and stories presented represent "a slice from the life world" (Sandelowski, 1986, p.32) of the participants. This slice has meaning and significance to others, thus reflecting the fittingness of this study. There is evidence to support that the findings of this study do have meaning and significance that can fit or be transferred outside of this study. Presentation of preliminary findings at two seminars indicates that the findings were meaningful and pertinent to nurses employed from a variety of practice areas.

The research design fitted the phenomenological perspective, which is grounded in human experience and the understanding of those experiences. Therefore the method of data collection, in-depth unstructured interviews carried out within the participants' own environment and the researcher's field notes allowed the participants to reveal their experiences and understanding of the phenomenon.

Conclusion

This chapter has described the methods used within this phenomenological study. A description of the participants' professional background and the technique utilised to identify and invite participation in this study was outlined. An overview of the methods utilised for data collection and the ethical considerations applied prior and throughout this study were identified. Further, a detailed account of the hermeneutic analysis process of Diekelmann, Allen and Tanner (1989) explained the multiple stages of analysis used to obtain an accurate description and interpretation of the participants' experiences and meaning of presence. Finally the issues of credibility, fittingness and auditability were discussed and the methods undertaken by this researcher to establish the trustworthiness of this study. In the following two chapters the findings of this study will be presented. These chapters include the relational themes and constitutive pattern that emerged from the interpretations of the participants' experiences of presence within nursing practice.

Chapter 5

Relational Themes

Introduction

Following analysis, four (4) relational themes and one constitutive pattern emerged from the data that described the registered nurses' experiences of presence within their nursing practice. As explained in section 4.6 of Chapter 4, relational themes cut across all text analogues expressing the similar or different meanings of the participants' experiences. Thus in this chapter, the relational themes embedded in the text analogues are revealed. The four (4) relational themes are: Intimacy of experiences; Humanness of the interactions; Listening with all body senses and Emotional tensions.

This chapter will present the relational themes together with the categories that comprise each relational theme. Each category of the individual themes is discussed in detail describing the relationship to the relational theme. The constitutive pattern of Presence: Commitment to Care and the Spiritual Connectedness of Care will be discussed in Chapter 6.

In order to provide clarity between citations, all quotes from the participants appear in italics. During the interviews the participants had many long reflective pauses, these are identified with a em dash (long dash) within the quotes (Peters, 1995) rather than the conventional method of square brackets [long pause]. Pseudonyms have been used when referring to patients, families or other registered nurses to ensure confidentiality.

5.1 Intimacy of Experiences

The first relational theme of intimacy of experiences pervaded the beginning of each interview. This relational theme was uncovered during reflection of the researcher's field notes recorded during and immediately following the interviews. These notes reflected upon the participants' initial response to being invited to share their experiences of presence with the researcher. The responses included the categories of verbal and paraverbal language conveyed at the beginning of each interview. In particular, the researcher's notes reflected the participants' strong non-verbal body language.

As this researcher invited the participants to share their experiences of "making contact" or "being with" a patient, their initial response was almost like a key turning to unlock a door to secret places yet unexplored. Unbeknown to this

researcher at the time, the hidden stories about to be expressed by the participants were powerful and intimate, held close to their heart with lasting meaning.

During the interview when asked to share their experiences, five (5) of the participants' primary response was to lean forward, rest their arms across their chest and gently pat their upper chest wall. One other participant sat on her chair in the 'foetal position'. Whilst waiting for the verbal response, the researcher reflected upon their body language and wondered whether it was a protective mechanism of 'is it safe to express these thoughts and experiences?' or 'was the body language reflecting the deep emotional intimacy of these long lasting interactions with patients?'

Before responding to the interview question, the participants sat for some minutes quietly reflecting upon their experiences. Whilst reflecting and seemingly searching for the conscious words to express these everyday embodied professional experiences, each participant began to gently rock back and forth, occasionally patting their chest.

When they began to speak this researcher then understood from the intonation of their voices that the body language was not a protective mechanism but rather their experiences were intimate interactions, never before articulated or acknowledged as meaningful nursing experiences. Each participant spoke

slowly, with warmth and compassion about "being with" a patient on numerous occasions. Throughout the interview, recalling their experiences of presence many times resulted in tears being shed. These intimate experiences reflected the uniqueness of each setting, situation, person involved and their own interpreted meanings.

As the interviews continued, the participants gently uncoiled as they expressed their feelings and reflective thoughts of these intimate nurse–patient experiences. Why these experiences had remained hidden from self, profession and colleagues slowly unfolded throughout the interviews as the participants spoke of their experiences of presence with patients. Furthermore, this relational theme reflects the trust that developed during the interviews that enabled the participants to feel safe to reveal their experiences of these intimate relationships. The participants sensed that they were valued as a person and a professional nurse who had experienced meaningful relationships with patients. The trust and respect that developed between the participants and researcher were important attributes to them. These attributes together with others that were unveiled during the interviews, were the foundations of these participants' clinical practice, that is, these qualities influenced their style or way of practicing and interacting with patients.

5.2 Humanness of Interactions

The second relational theme uncovered is humanness of interactions. This theme reflects the humanistic quality of nurse-patient interactions and the essential attributes of the nurse that are necessary to facilitate the experience of presence. The categories identified within this relational theme were developing trust; valuing the patient as a person; willingness to believe in patients; and equals within the interaction. These categories describe the attributes and conditions necessary in creating an environment to express the humanness of interactions and for presence to be experienced. Without these attributes and conditions, subsequent connections with patients would not have been experienced.

5.2.1 Developing Trust

Developing trust within the interactions was pivotal to the humanness of interactions. Without a deep level of trust the participants would not have been able to dwell in the patients' subjective world nor facilitate healing and growth of the patient. The level of trust between the participants and patients was closely linked to the participants' genuine openness and interest in their patients' life experiences. One participant described the level of trust as a

totality, commenting that patients are "*trusting you with who they are and what they are...total faith, total trust that I'll always do the right thing*".

This trusting relationship enabled many patients to readily share with the participants their inner most feelings, hopes, dreams, thoughts and fears. The participants sensed that patients felt safe to disclose their feelings and experiences. This resulted in the participants gaining understanding and, for a short period of time, to share in the patients' subjective worlds. Reflecting upon trust within relationships, three participants expressed these thoughts:

> *People share things about themselves that may not be related to their health care — They feel that they know you enough in such a time, that they can share things, with you, about their life (Participant # 4).*

> *People feel that you do understand. And it's honest. That you are being honest — They talk more. They share more, and then they trust you more (Participant # 3).*

> *Trust, I mean for someone to trust you about more than their little toe or something — that's pretty precious. They're entrusting you with something precious (Participant #1).*

The trusting relationship reflected like a mirror, the patients shared openly with the participants and the participants willingly shared their own personal thoughts, feelings and experiences with the patient. One participant commented that:

> *If they [patients] trust you enough, feel that the things they've got to say, their observations — share their insights about life, they trust you enough to tell you, then, they're feeling something about you which is awfully nice too. So therefore it's a lot easier then to give that back (Participant # 4).*

Reciprocal sharing within the humanness of interactions was important to the establishment and maintenance of trust within these relationships. One participant commented that without sharing something of oneself, the nurse would perhaps be focused on only the tasks. This participant reflected upon the importance of the subjective nature of interactions from which humanness flows within the relationship. She stated that:

> *In nursing we can put on a uniform and basically you don't need to have a personality at all. But, in this one to one encounter, I find that something of me, of my person is required (Participant # 1).*

The trust that developed from within these humanistic interactions enabled the participants' and patients' thoughts, fears and emotions to be revealed. The following story highlights one interaction experienced by a participant that encapsulates the significance of developing trust and the reciprocal openness and sharing that occurred within the participant-patient relationship. She retold this story:

> *There is one fellow who talked to me about a near death experience that he had, that he hadn't really spoken to anyone else about. He didn't want to talk to the family about it, because he said that would only worry them. But, I thought and I said to him, that "I felt that it might be something that's very comforting for them" ... I felt that it was lovely that he chose me — I was a safe person too...I thought it was rather special...It was a good experience that he had, he said it was very peaceful and he said he wasn't frightened anymore — I said the family needed to know that (Participant # 4).*

This story reflects the trust the patient had in the participant. The patient sensed the participant's trust and willingness to listen. Trust was reciprocated in these relationships, the participants also sensed they too could trust patients and share with them their own personal life experiences.

Another participant's words expressed the trust and reciprocal openness that had developed with a 97-year-old resident of a nursing home. The openness and trust of the relationship enabled both the participant and resident to gain significant meaning from their interactions and for a short period of time, share in the subjective world of the other. The participant had shared with the resident personal aspects of her life such as her daily swimming routine to ease her back pain and also the never ending pranks of her three dogs. The resident gained much meaning from these interactions and would often

inquire when the participant would be on duty next. This participant recalled these thoughts of this relationship:

> *She [the patient asks] "When are you on next?" "Couple of days time." "OK, have nice days off." Then she says "How's the swimming, how's the dogs." She has taken a real interest in me...There's a bond, a relationship, a connection there...When she's dying that is going to be very comforting thing for her, to have me about, she trusts me (Participant # 1).*

The participant revealed her inner feelings, her daily difficulties of living with chronic back pain to a patient whom she trusted. Exposing her feelings and experiences with this patient brought humanness and meaning into this nurse-patient relationship.

For the participants these trusting relationships reflected like a mirror. These mirror relationships acknowledged the humanness of both participant and patient who had valuable life experiences. The interactions were powerful, where each were accepted as human beings, trusting each other and sharing openly their inner feelings.

5.2.2 Valuing the Patient as a Person

Valuing the patient as a person was interpreted as not only fundamental to the humanness of interactions in nursing practice but also to connect with patients. Nursing care for these participants focused not just on completing

tasks, but on the value of human interaction, of the patient as a person. The valuing of the patient as a person acknowledged human to human interaction, respecting each other's past experiences, knowledge and skills as valuable to the interaction. The participants expressed valuing the patient as a person in many ways. The following quotes are examples of three of the participants' words that reflect valuing the individual and the life experiences of the patient as a person.

> *Valuing of what they've got to say — Valuing them as a person. Getting their opinion about things that are happening to them. — I'm bothering enough to ask how they're feeling — I guess acknowledging them and how things have been for them (Participant # 4).*
>
> *Valuing of the humanness — value the fact that I'm human but I'm valuing the humanness of that other person — Human contact with human (Participant # 1).*
>
> *Still giving the patient a sense of choice. They haven't lost their identity by coming into hospital. They are still there as a person. They're valued enough as a person to be given that choice (Participant # 5).*

Valuing the patient as a person for these participants was fundamental to the humanness of interactions. Without valuing the other as a person, the participants would have engaged in interactions from an objective, task orientated focus, rather than being person centered. Therefore, to share or dwell in the subjective world of patients, these participants consistently endeavoured to acknowledge and value the humanness of interactions. That is, both the patient and the participant were valuable to the experience, each

bringing with them their own life experiences. Further to developing trust and valuing the patient as a person, the participants highlighted the importance of believing in patients.

5.2.3 Willingness to Believe

Willingness to believe patients contributed to the humanness of the interaction, it went hand in hand with the valuing of the patient as a person with life experiences and the trust developed within the relationship. One participant commented with a strong conviction that to believe in patients was crucial when caring for them and stated that:

> *A willingness to believe what's happening for them — Believing what they say and respecting them — It doesn't matter what they are saying, thinking or feeling — That's what you start with — I can't get anywhere in a presencing situation without that raw data (Participant # 1).*

For these participants, willingness to believe in the patient was an essential attribute of acknowledging and demonstrating the humanness of interactions. Willingness to believe in patients was closely linked to valuing the patient as a person with valuable life experiences. To understand a patient as a person, the participants required a willingness of self to believe in the patient.

5.2.4 Equals Within the Interaction

Finally, humanness of interactions required these participants to demonstrate an ability to accept patients as equals within the interaction. Acceptance as equals was closely entwined with the participants' willingness to believe in patients' experiences, the valuing of the patient as a person and developing trust.

These participants were not intimidated by the concept of equals within interactions. Rather, being equals within these relationships enabled the participants to empower patients to participate in their own care. The patients' input into care was vitally important to the humanness of the interaction, to enrich the experience of presence. Therefore, the participants were conscious of always striving for equality within nurse-patient interactions. Regardless of whether it was neutralizing the perceived power associated with a professional uniform or consciously positioning themselves to offer reciprocation, the participants remained focused and committed to equality and the collegiality within the interaction. Two participants reflected upon the importance of equality within relationships, in particular within the home nursing setting. The first participant said:

> *It is a more equal relationship and when people try to put all the responsibility onto me, I try to share and change that perception. So that they see me not as someone that can come in and take over, but, I'm there to help. And we'll work at this together (Participant # 3).*

The other participant spoke of not wearing a uniform and recalled a home nursing situation where the patient said:

> *[The patient said] "You haven't got a uniform?" I said, "No, this is sort of near enough isn't?" So it took her by surprise. I think that was equalizing. I'm the same as you, not, I'm the nurse and you're the patient and we're different — There is some sort of sameness (Participant # 1).*

The same participant continued reflecting upon this home visit. This particular lady required minimal assistance with showering and dressing. Unbeknown to the participant, it was this lady's first anniversary of her husband's death. Upon arriving, the participant sensed this lady wanted to talk, she recalled:

> *I remember positioning myself at least at the same level as she — but close enough — I was there if she needed me — In a sense I was making myself available to her...I couldn't believe when she said about the death [of] her husband. So I just asked a couple of questions and away she went. She just talked, and talked, and talked, and talked — But I felt that at the end of that hour and a half she was in a much better place than what she was at the beginning, and more able to cope with being by herself (Participant # 1).*

Equality within the relationships supported an atmosphere of trust whereby the patients responded to the participants' willingness to believe in their subjective experiences. Their experiences were not a threat to the relationship

but rather a valuable contribution. Equality prevented barriers of power and "I-It" interactions developing, thereby these participants were able to connect with patients within their subjective worlds.

Throughout the interviews, all the participants consistently authenticated the humanness of the interactions. When reflecting upon their experiences, most times each referred to the patient as 'this person or these people' and sometimes by the patient's first name rather than the professional terms of patient or client. To these participants referring to an individual as a patient only seemed to disempower and reinforce the inequalities within nurse - patient interactions.

One participant reflected upon nurse-patient interactions where there was an apparent lack of acknowledgment of patients as equals within the interaction. She sadly conveyed a story of a lady she had been caring for in a nursing home. This lady *"always had a strong spirit"* which this participant had admired. Yet this lady's spirit was slowly being eroded because of the perceived positions of power and control nurses had over her. One evening when given the opportunity to make a decision about her care, this lady responded with *" I don't do what I want anymore, I do what others want"* Recalling this story caused this participant a degree of distress, she continued for some time to reflect upon nurses' inability to acknowledge patients as

human beings with valuable experiences and capable of making decisions. Thereby reducing the opportunities to experience presence or connect with patients in meaningful ways.

By acknowledging patients as unique individuals, these participants affirmed and expressed equality and the humanness of nurse – patient interactions. To share in the subjective world of patients, the participants had remained focused upon the humanness of interactions. This incorporated a deep level of trust, valuing the patient as a person, demonstrating a willingness to believe in patients and maintaining equality within the relationship. Humanness within interactions was essential to gain understanding of patients' life experiences and to connect with their subjective world. Connecting with patients required humanness of interactions together with an ability to listen with all body senses.

5.3 Listening with all Body Senses

To facilitate the experience of presence, these participants needed to listen with all body senses when interacting with patients. However, the participants believed that to listen with all body senses they also needed to have self-awareness and a self in touchness with who they were as a person. For the participants, listening with all body senses emerged from their

understanding of self and the refining of therapeutic communication skills. The therapeutic skills, which included body language that reflected sincerity, openness, honesty, and compassion, enabled the participants to enhance and communicate the humanness of interactions. These skills conveyed to the patients the participants availability and their willingness to believe.

The participants utilised therapeutic communication skills to facilitate the development of the participant-patient relationship and the opportunity to experience presence. The skills included *"listening", "not standing", "being on the same physical level", "putting your hand on their arm", "touching", "eye contact",* to *"show compassion"* and being *"genuine and sincere in what I say and do".* Other therapeutic skills such as conveying acceptance, unconditional regard for patients and the use of silence, were demonstrated in the participants willingness to believe in patients, their commitment in developing trust and having equality within relationships.

The therapeutic communication skills of the participants had been highly developed and refined. According to the participants, during their years of clinical practice the art of developing and refining therapeutic communication skills had remained an equal priority to that of carrying out psychomotor nursing skills such as dressings or administration of medications. This refinement of therapeutic communication skills lead to these participants'

ability to listen with all body senses or "to tune in" to the needs of patients and their family needs. Listening with all body senses provided the participants with opportunities to gain insight into patients' values, their perspective of illness, health behaviours, together with the patients' desires and understanding of the outcomes to their health state. The following are three participants' thoughts of listening with all body senses:

> *Sometimes it wasn't in the saying it was just in listening ...It doesn't even sometimes have to be in words (Participant # 3).*

Another participant commented that:

> *Just being there, not saying anything. Just listening. There is nothing being said. But there is other listening going on, to what their body is doing, what the family is doing. Just stand there and listen — that in a sense can trigger off that sort of situation. Being prepared to listen not only gives me the right, but it gives me the opportunity to enter into their world at a appropriate level (Participant # 1).*

Listening with all body senses for a third participant was recalled as:

> *Listening to what you [the patient] had to say, I think that is important too. I think that is part of presence too — it's mentally being there as well — Physical presence, mental presence. To a certain extent an emotional sort of presence. Someone who is willing to listen and try and understand what you [the patient] are talking about — Just as important as clinical skills (Participant # 6).*

However, the participants identified that to "*tune in*" to patients' needs required firstly that they have a willingness to give of themselves, have a self awareness of their own abilities, weaknesses and strengths. That is, to

listen with all body senses to themselves, to tune in to and know themselves as a person.

According to the participants, without knowing oneself and having a willingness to give, then tuning in to or listening with all body senses to the subjectiveness of interactions was not possible. On such example was given by a participant who commented that nurses needed to be "*a giving person, you know, tuned in intellectually and ... in a giving way*". For the participants, listening with all body senses to themselves was fundamental to their ability to listen with all body senses to patients. This participant clearly expressed the importance of knowing oneself. She said:

> *They [nurses] really need to tune in to what they are prepared to give of themselves. I suppose they need to be fairly comfortable with their own thoughts before they go about trying to give to other people [patients] (Participant # 2).*

One participant who was at the time a clinical facilitator recalled a particular student's interactions with patients and the student's ability to give of herself. Although this student performed all the psychomotor skills with competence, she lacked the willingness to give anything of herself and therefore was not able to listen with all body senses during patient interactions. The participant recalled:

> *She is not getting in there ... putting anything of herself out to the patients. So there is no interaction happening there at all ... If I was the patient I certainly wouldn't feel that I was getting any sense of caring ... She's making the beds and doing the functional things, but there is just not that element (Participant # 4).*

The participants spoke of their ability, which had developed over many years, to listen with all body senses and thereby facilitate environments to experience presence. The combination of both professional and personal maturity, the ability to reflect upon life experiences, having role models and a degree of instinct, were all regarded as influencing the participants' ability to listen with all body senses. One participant was insightful about her ability to listen with all body senses and commented that:

> *It didn't happen over night. It has happened with maturity...I learn a lot through reflection ...I don't think I've always had the sensitivity that I have now (Participant # 6).*

All the participants commented that role models in their early formative years of nursing had strongly influenced them in their attitudes and caring practices. One participant who had initially revealed that listening with all body senses was an instinct, when probed about role models in her nursing career, thoughtfully answered:

> *I think given time and given tolerance of those around you, you could learn...I suppose the best way to learn is to watch and listen from someone else ...experienced staff (Participant # 2).*

Further, in order to tune in to patients and listen with all body senses, these participants needed to abandon temporarily their own personal problems so that they could focus completely on patient care. One participant recalled that:

> *[tuning in] has to do with leaving your stuff or concerns that might be taking energy away from them [patients] behind. So in a sense you are there for them, and there is energy available for them (Participant # 1).*

Another participant believed that personal experiences had strongly influenced her ability to tune in and listen with all body senses. She commented that:

> *I know when things have been a bit torrid here at home, how it effects you at work. And how perhaps your mind is not fully on your job (Participant # 2).*

Even though at times tuning in to patients and listening with all body senses was difficult because of external factors, these participants remained committed to connecting with patients in meaningful ways. Listening with all body senses was interpreted as enabling these participants to gain sufficient understanding of the patient's subjective world, thereby facilitating opportunities to experience presence within nursing practice.

5.4 Emotional Tensions

The participants experienced a medley of emotions as a result of connecting with patients and experiencing presence in their nursing practice. These emotions included the professional satisfaction gained from the experience, exhaustion following such intense experiences and conversely frustration from lack of recognition and support from colleagues. Consequently, the participants' experienced significant emotional tensions.

5.4.1 Professional Satisfaction

Professional satisfaction was a positive emotion experienced by the participants. All the participants expressed that being there for patients and experiencing presence gave them much professional satisfaction. The patients' openness and genuine interest in the participants as human beings was, to use a participant's words, "*...something very precious...*" that provided these participants with meaning and significance to their nursing practice. Another participant simply said that the experience of presence was an "*...enriching part of nursing for me, otherwise it would be functional...*", only performing tasks in a detached manner.

Presence experiences were a source of much professional pride for the participants. Connecting with patients and gaining understanding of patients' experiences enabled the participants to provide nursing care that encompassed all dimensions such as, assisting patients and families in coping with life changes, illness, recovery and death. For these participants, professional satisfaction arose from connecting with patients, thereby providing nursing care that was functional or skill based, yet they simultaneously focused upon the individual needs of the patient.

Furthermore, the participants believed that patients experienced an enhanced recovery because of the humanness displayed within their interactions with patients. This recovery also attributed to the participants' increased level of professional satisfaction and feelings of self worth. Many times the participants expressed thoughts that encompassed the objective and subjective dimensions of nursing care. For these participants to go beyond the functional and technological aspects of care and embrace the humanness of the interaction was significant to their nursing practice. One participant's comments reflect the significance and value of embracing the subjective dimensions of care whilst providing the psychomotor or functional aspects of care. She said:

> *People recover better. People cope a lot better than just someone going in to just give them a shower and go out again (Participant # 3).*

For these participants, the patients' recovery and optimal healing was enhanced by the experience of presence, to share in the patients' subjective worlds. However, the positive emotions experienced from the sharing within the subjective world were reciprocal. The participants' experienced an heightened sense of professional satisfaction and self worth. One participant commented that:

> *I think it's very satisfying even if you only have a couple of minutes to spend with someone. To be able to leave them more comfortable, not only physically comfortable, but mentally comfortable than before you went in (Participant # 2).*

Another participant acknowledged her sense of professional pride gained from the experience of presence. She said:

> *There is a deep level of job satisfaction ...I get job satisfaction from doing a good job ...There is a deep sense of job satisfaction (Participant # 1).*

These participants experienced many positive emotions themselves as an outcome of experiencing the patients' subjective world, from connecting with patients. Words such as *'healing balm'*, *'emotions effect your healing'*, *'feeling of warmth'*, *'healing benefit'* and *'positive influence'* were often used to describe the feelings sensed by participants during and after experiencing presence.

One participant talked about the busyness of the wards and how this busyness many times resulted in nurses feeling burnt out. This feeling of burn out, according to the participant, was attributed to the lack of support from colleagues and performing only the psychomotor skills, that is from focusing on the objective dimensions of care. However, for these participants focusing equally on the subjectiveness of care to facilitate the experience of presence regenerated and inspired them. Connecting with patients and experiencing presence was for this participant described as:

> *Moments of healing ...I've found it always to be a positive thing. In a sense it heals me when I'm out there being beaten around the head by somebody professionally. It's sort of like an oil. It's a soothing healing balm for me because it's been such a positive warm thing (Participant # 1).*

Another participant described the positive emotional experience of presence to self as:

> *A two way feeling. You just seem to get a warm feeling, an emotional experience...You are truly yourself as a person. It's just a feeling of warmth, compassion. You develop a closeness, a bond — I mean it's like if someone shows warmth to you, it's easier to give back, or like love I suppose. And the same must apply with my patients (Participant # 3).*

For the participants, focusing upon the humanness of the interaction provided them with enriched nursing experiences and an abundance of professional satisfaction. The genuine concern and care received by the patient was returned to the participants. This expression of openly acknowledging the

humanness of the participant from the patients was a well of soothing healing oil that affirmed their self worth and gave meaning to their professional nursing practice.

5.4.2 Exhaustion

Exhaustion emerged as a consequence of the participants' commitment to care. Commitment to care and the experience of presence required high levels of emotional energy to remain focused upon that moment in time. Being focused meant that the participants were consciously detaching themselves from their personal life and other professional demands within clinical practice. One participant commented that if she was *"tied up with what I have to do next or what I've done...or what's going on with me personally or professionally, then I can't be there for them [patients]"* as these factors distracted her from the moment in time. That is, from being focused on the subjectiveness of the experience and the opportunity to connect with patients.

This focused energy was itself an emotional tension within the participants. For instance, although they gained much meaning and professional satisfaction from being there for patients, the energy required was at times considered wearisome. One participant described these experiences as *"really*

the most draining nursing I have ever done". The 'draining' effects to other participants were described as:

> *There is a cost. There's those benefits but there's the cost there as well ...I'm quite drained ...There's not much energy left for much else after that encounter — But it's very satisfying (Participant # 1).*

Another participant said:

> *I just feel exhausted, that emotional drain. A mental tired that made you physically tired (Participant # 3).*

The participants experienced a medley of emotions that emerged in physical and mental exhaustion and emotional anguish. The participants endured the exhaustion for a period of time because of their commitment to connecting with patients, and desire to gain meaning and understanding from their everyday clinical practice. Unfortunately, eventually the exhaustion led to feelings of frustration.

5.4.3 Frustration

Frustration emerged as a negative emotional tension. It was revealed in a myriad of forms, which included feelings of sadness, guilt, disheartenment and anger. The participants' feelings of frustration arose from the lack of resources within the health environment. Lack of resources identified was

time, funding and lack of recognition and support by colleagues of such an important aspect of nursing care.

To establish a situation for presence to be experienced, according to the participants, time with patients was needed. However, often throughout the interviews the participants referred to insufficient time to spend with patients in a one to one meaningful interaction. The health care budget is calculated upon measurable activities, such as time required to provide particular technical care to patients. However, the time calculated does not incorporate the subjective dimension of care that often requires extra time to be spent with patients. Therefore, according to the participants, regardless of the significance of these interactions for both patients and nurses, these interactions were considered a non-essential nursing practice by fellow colleagues and health management.

This lack of recognition and appreciation of the significance of these interactions, lead to frustration in the participants. Frequently the participants stated similar thoughts such as:

> *People won't pay if they can't see it. How do you quantify it? A lot of people say in institutions," oh how can you justify taking that long?" (Participant # 3).*
>
> *There isn't the funding or the recognition [to spend time with patients] (Participant # 6).*

> *Professionally and also from the Government, the Commonwealth funding point of view, this sort of nursing is not funded (Participant # 1).*

The participants were continually frustrated by colleagues and hospital management's lack of understanding of the importance of these one to one interactions. Only one participant spoke of any form of recognition by colleagues. The Director of Nursing at the nursing home where she was employed noticed that the stress levels of staff and residents were lower when this participant was on duty. However, this acknowledgment also saddened the participant and she questioned during the interview:

> *Why could one person have such a dramatic effect on the place?" "Why can't other people do it as well?" So it's a sadness that not more people are able to, or want to or do this —, being there for the patients (Participant # 1).*

Frustration also surfaced as disheartenment. The participants' disheartenment was linked to their own personal longing to share the significance of these experiences with other professional nurses. However, the constant lack of recognition from peers created a sadness of heart and a reluctance to share their experiences. Therefore, the positive feelings experienced remained hidden within the participants until they shared these experiences with this researcher.

During the interviews, all the participants acknowledged that they had not shared these experiences with colleagues. The participants' sensed that fellow colleagues were focused on the tasks, or, that lack of time did not provide opportunities for them to share these experiences with each other. One participant referred to taped handovers and how these have reduced registered nurses opportunities to share experiences with colleagues. She commented that:

> *What I found difficult was trying to cope ... and not have anyone or time to unload. That's what I think hospitals and places lack. You know we now have taped handovers, to save time with the change over time. You can't put 'things' onto a tape. It has to be communicated if we are going to make a difference. There has to be time and nurturing (Participant # 3).*

Consequently, the participants had kept their stories hidden within them or wrote about their experiences in a diary. One participant revealed this untold story that had occurred some twenty years earlier, she was disheartened and frustrated by the lack of opportunity to share her experiences and feelings with fellow colleagues. She said with meaningful emotion and tears in her eyes:

> *I can remember looking after a guy in the resus unit. I must have been in my second or third year. I can still see him there with his trachy and on the respirator. We really nursed him back to health. Anyway one night he had a cardiac arrest and he died. I'll never forget that. I can see, I can still remember that. When they spoke it must have been last year, the anniversary of the Westgate Bridge collapsing so many years ago. I thought I can remember George. You know he was one of the labourers on the bridge. I mean, that was all those years ago and I know that we had this bond. He was relying on us for his life (Participant # 2).*

This participant and the other participants continued to emotionally share their untold stories throughout the interviews. They shared not only the stories but also their feelings about the relationships and the experience of presence. The participants became weary from their constant struggle to overcome feelings of sadness and disheartenment. Sadness arose from the lack of recognition from colleagues and disheartenment from the inability to share their feelings with others. These feelings were not congruent with their desire to develop meaningful relationships and to enter the patients' subjective worlds.

These emotional tensions experienced by the participants challenged their values and beliefs of nursing and nursing practice. The participants reflected upon their practice and acknowledged that they did have a strong desire to establish meaningful relationships with patients. Without these relationships, the participants were left with a sense of professional loss and betrayal to

their patients. The participants then began to further question their clinical nursing practice. Did their patient care take longer? Were these relationships and the experience of presence beneficial to them and the patient? Was it really a healing moment?

For these participants, professional satisfaction arose from providing humanistic nursing care. This remained their priority. Furthermore, it was from their reflections and self-questioning, that significant insight into their nursing practice was gained. They began to reconceptualise and make choices about their nursing practice. The participants identified that spending 'time' to establish meaningful relationships with patients and family in a palliative care context was viewed by other professionals as appropriate and necessary. One participant expressed her frustration with this belief from colleagues. She said:

> *To avoid conflict I would rarely do it, other than a legitimate situation like somebody is dying. That is OK somehow. Spending time with people is good palliative care, or good death and dying care (Participant # 1).*

Sadly, a patient's pending death provided the participants with an opportunity to legitimately spend that perceived extra time with patients to establish meaningful relationships and to perhaps make connections within the subjective world of the patient.

Every participant spoke of numerous meaningful interactions where they had chosen to be there for a dying patient and the family. The following is one story of a participant who had developed a meaningful relationship with the patient and his son. The participant chose to spend extra quiet time with the son following his father's death. The participant gained professional satisfaction from being with the patient whilst he was dying and then with the son following his father's death. She said:

> *It was enough for him that he knew that I had been there, and then he could just be with me for a little while — together. That's a lot of giving from a nurse's point of view. But you have got to understand that's what that relative needed ... He could be with that someone for a little while and almost transpose that feeling ... It's only a few more minutes of quiet time and you've given something lasting to that relative (Participant # 2).*

Just as the participant above made a choice to be open with and spend extra time with a relative, other participants made choices "*to presence outside of work*". This meant returning to their place of employment out of work hours or staying following the completion of a shift. These decisions or choices emanated from the participants' belief in the importance of humanness within interactions and their desire to provide equality in care to all people not just to those deemed legitimate by others.

However, in choosing when to spend time with patients for presence to be experienced, some of the participants' subsequently experienced a

paradoxical guilt. The guilt reflected the emotional turmoil, firstly the feeling of professional satisfaction gained from connecting with patients. As one participant said, *"I nearly feel guilty that it feels so good. I'm getting paid to enjoy them [patients]"* and then conversely the guilt felt when the participants chose not to make connections with patients in certain situations. The same participant commented further about choosing based upon the external factors of available resources and the tension experienced by that choice. She said:

> *I can choose that in this sort of situation I need to be there for that person. On my own, privately, quiet, not stressed and be available to them. So I can plan that and choose to be there in order to bring about some sort of nursing intervention for their healing... And if I'm doing this, if I'm presencing with somebody or being there for them, someone else isn't getting cared for (Participant # 1).*

The participants' frustration focused them to reflect upon their practice, in particular, what was important in their nursing practice. Identified was a pervasive inner desire to move beyond the objective aspects of care to provide humanistic nursing care, and to establish meaningful relationships with patients. The participants then made choices about how they would fulfill their need to connect with and experience the subjective world of patients. These choices made as a protective strategy, to be there or not with patients, enabled the participants' time to rejuvenate their energy and reflect upon their nursing practice. Within their reflections further meaning and significance of nursing practice was illuminated.

Conclusion

In this chapter the relational themes of intimacy of experiences, humanness of interactions, listening with all body senses and emotional tensions interpreted during data analysis have been discussed in detail. Much of the data in this chapter was based upon the participants' interpreted meanings of their experiences of presence or being with patients in clinical nursing practice. The interactions embody a deep intimate relationship reflecting the humanness of nurse and patient. Openness between participants and patients facilitated the establishment of meaningful relationships and the connectedness of nurse and patient. The participants focused upon a willingness to believe in the patient, valuing the patient as a person and accepting the humanness of the other. The patient in turn reflected these qualities like a mirror, responding with openness, honesty and trust. However these mirror relationships caused emotional turmoil for the participants. Emotional conflict emanated from varying factors that challenged the participants' professional satisfaction and meaning within their nursing practice.

Within the relational themes the participants' words were used to elicit the essence of the categories comprising the relational themes. The relational themes are intertwined, illustrating the complexity of attributes, skills and

emotions experienced by the participants. The following chapter will present the constitutive pattern of presence. The constitutive pattern reflects the essence of presence in nursing for these participants.

Chapter 6

Constitutive Pattern

Introduction

In this chapter the constitutive pattern that emerged during analysis of data will be presented. As previously identified in section 4.6 Chapter 4, a constitutive pattern is the highest level of hermeneutic analysis and is referred to as a concern or situation that engages self, giving meaning and characteristic modes of action and understanding of being-in-the-world (Rittman, Northsea, Hausauer, Green, and Swanson, 1993). The constitutive pattern of Presence: Commitment to Care and the Spiritual Connectedness of Care was identified as expressing the essence of presence within nursing practice for the participants of this study. These participants' own experiences of presence and their interpretations of the meaning of presence enabled them to bring to being modes of action or style to their clinical practice, to create options of care. This constitutive pattern embraced the participants' commitment to humanistic nursing practice and shed light on how those beliefs influenced their commitment to care in creating

environments that facilitated presence and ultimately the spiritual connectedness of nurse and patient.

6.1 Presence: Commitment to Care and the Spiritual Connectedness of Care

The constitutive pattern of Presence: Commitment to Care and the Spiritual Connectedness of Care illuminated the essence of presence as experienced by the participants. As human beings themselves, they were searching for meaning in their day to day nursing practice. Their commitment to care emanated from their inner need to care for and connect with patients. Thus, the participants developed a style of care that was meaningful, sensitive to the humanness of the moment and would facilitate the spiritual connectedness of care. This spiritual connectedness of care was the ultimate fulfillment for the participants and it became their personal philosophy within nursing practice. The participants' style of care was an outward expression of their professional philosophical beliefs and values.

For the participants, being able to practice within a humanistic nursing framework and to experience the spiritual connectedness of care, was the essence of nursing. Within their stories, nursing experiences focused upon *"working together ...human beings sharing together"*, always *"being genuine*

and sincere" and *"to tune into people[s]"* needs. By practising these values of humanism, the participants fulfilled their need to care for patients and to find meaning in their everyday nursing practice. Meaning arose from their commitment to care in all aspects of everyday nursing activities, as it was from these meaningful interactions that opportunities to connect with patients and gain a deep understanding of their physical condition and psychosocial history were encountered. However paramount to this, it was from the participants' experiences of this spiritual connectedness of care that professional satisfaction and heightened self-worth were elicited.

Thus their style of practice reflected that everyday nursing practice was not simply functional or getting the job done. Whilst their everyday nursing practice focused upon psychomotor skills they were simultaneously sensitive to the subjectiveness of the nurse-patient encounter. Being sensitive to the subjectiveness of the encounter enable them to gain an understanding of patients as unique human beings. One participant encapsulated this sensitivity of sharing in the spiritual connectedness of care. She said:

> *An experience, a lived experience for what is happening to them [patients] now. Not 'is the IV rate correct?', 'Is the right IV up?', or 'The nasogastric feed tube in the right place?' Yes, that is all important. But, what does it feel like for that person to have a nasogastric tube in their nose. Bloody revolting! They live with that 24 hours a day, and we think 'Oh yeah, whack the feed up no problems' (Participant # 1).*

The participants' faithful willingness to engage with and believe in patients, enabled them to *"comfort a patient where others [staff] step[ped] back"*. This ability to comfort both psychologically and physically, where others could not or were not willing, evolved from their desire to meet the care needs of patients and to fulfill their own professional satisfaction. For the participants, even the perceived simplest skill such as ensuring that *"the patient is comfortable, their nurse call bell is in reach, they're warm, their pillows are right and that their environment is safe"* elicited much gratification on a professional level. Three participants revealed these thoughts about this style of care. They said:

> *[This] is what nursing is all about...That's where it's roots are (Participant # 1).*
>
> *Isn't that what nursing is about, looking at individual needs (Participant # 3).*
>
> *That's where I think nursing should be at. There's a great need for people to really care (Participant # 6).*

This style of care was the foundation and essence of nursing practice for the participants. Regardless of the technological advancements of machinery, associated psychomotor skills, advanced nursing knowledge and the reducing time allocated for patient care, they remained committed to this style of care. They cared for patients equally regardless of the circumstances, that is, it did not *"matter if someone's unconscious or on a monitor ...or if they've [patients] got tubes coming out of them"*, what was important was providing

care that related to the humanness of the situation. That is, care was congruent with the participants' values, beliefs, and commitment to care. Therefore, their commitment and desire to connect with patients enabled them to move beyond, to transcend the technology and other constraints within the health sector, to create environments that supported the humanness of nurse–patient interactions.

The participants' philosophical beliefs and values enabled them to create environments that psychologically transcended the objectiveness of functional or technological care. Transcending this environment required the participants to give of themselves, to create environments of meaning, significance and equalness. They skillfully demonstrated care that reflected a supportive and positive emotional atmosphere for all patients, families and peers. The environment reflected an ambience of warmth and trust whereby patients and participants acknowledged the humanness of the interaction and felt safe to share their feelings, thoughts, anger and pain. Other attributes that reflected their commitment and style of care included their honesty and openness with patients, "*telling it as it is, what it is all about*", being sincere, listening with all body senses "*you know, really listening, not just pretend to listen*" and spending time with patients. All these characteristics were an outward reflection of their belief that "*so much more is achieved in that short*

period of time" when humanistic care transcends the objective technological environment.

Furthermore, these participants' commitment to care was a significant influence upon decisions regarding their style of care practices for all patients. As previously discussed in Chapter 5, the participants became frustrated with constraints of the health care environment. Their frustration and disheartenment lead them to reflect upon their practice, their values and ideology of nursing. As a consequence of their reflective thoughts, the participants made deliberate choices about their practice. These included choices to return to their place of employment out of hours to visit patients or, chose to work on night duty and in some circumstances, elected to work in aged care or home based nursing. These decisions were brought into existence from their inner need to experience the spiritual connectedness of care from which the participants were fulfilled, enriched and rewarded professionally. The meaning and significance of their nursing practice whirled within them giving strength and comfort. This participant's words describe her feelings related to her decision to move from an acute care area into home based nursing. She stated:

> *I think back [about acute] hospitals. People standing around beds. People getting caught up with machines and tubing and the pressures of phones and expectations. I never felt overly comfortable in that, because of those pressures. I didn't feel I could give what I felt was the priority. And sometimes that is spending time with someone. May not even be the fault of the nurse in the acute situation. It's just different. Different priorities, I wouldn't go back into that area (Participant # 3).*

For these participants, their choices reflected their commitment to care and their inner desire to experience the spiritual connectedness of care with patients. This was the ultimate fulfillment of nursing for them. The bringing together of the nurse's and patient's subjective worlds enhanced their self-respect and self-love as a nurse. As one participant commented, connecting with patients and experiencing presence is:

> *So much part of our nurses' role. Part of our healing role that for me, to not to do it, I'm not really being a proper nurse. I'm not really living to my full nurse potential. I'm not being the healing mechanism that I could be (Participant # 1).*

These participants gained significant fulfillment from sharing within the patient's subjective world, to be able to " *travel along together for a short period of time*" towards the focused mutual goal of healing. Moving towards healing and maintaining human dignity, altruism and equality in their care embraced their commitment to care and remained their priority. These participants believed that for patients to gain optimal healing and adaptation to life, then travelling for a short period with the patient, was crucial. If caring for patients and sharing in their life experience was not possible then

the participants' professional life was left soulless, without meaning and as one participant clearly stated:

> *I do not want to be nursing or in a job where I cannot be there for that person. I do not want to be in some sort of destructive, disempowering, disrespectful [interaction]. I want that humanness (Participant # 1).*

For these participants, the experience of presence revealed powerful reflections of nurse–patient encounters that illuminated the connectedness and warmth shared within these unique experiences. The connection is not purely a physical bringing together of nurse and patient. These experiences were a spiritual connection of nurse's and patient's inner beings. During the spiritual connectedness of care both nurse and patient travel and share together, working harmoniously for healing and growth. Feelings of warmth and tenderness were mutually shared and for this short period, the subjective worlds of nurse and patient are entwined. The participants acknowledged that these experiences were special lasting moments that stirred the inner self and energized them to continue offering their gift of care. This participant's words encapsulate the inner feelings and the emotions experienced in the spiritual connectedness of care. She said:

> *There's a closeness. There's a warmth. There's an openness, understanding. There's clarity. There is no fear. So it's safe. There's respect, equalness. There's a connection. Something moves between two people — so there's a connection but there's movement, things are moving between. Like a sharing, the warmth — respect — There is a sort of mutual crossing over of these things — It's hard to define — It's a buzzy, fuzzy thing (Participant # 1).*

Within the spiritual connectedness of care these participants experienced an emotional exchange of *"warmth, compassion"* in an environment that enabled them to be truly themselves as a person and to be a recipient of care. It was from the reciprocation of their care and interacting with patients at this level that substantial professional satisfaction was achieved. These feelings of inner warmth and tenderness gently and quietly inspired the participants' to continue to search for meaning and significance within the seemingly ordinary, everyday clinical practice. These experiences gave the participants' purpose and meaning to their professional life and validated their sense of self worth. Furthermore, the experiences of the spiritual connectedness of care remained with the participants in their professional and personal life, they *"felt enriched...life was different in some way, in a more positive way"*, they were self fulfilled within their practice.

Conclusion

This chapter discussed in detail the constitutive pattern that emerged at the higher level of hermeneutical analysis of the interpreted data. From the interpretations described, it is evident that the experiences of presence for these participants influenced their way of being a nurse. Commitment to care highlighted their nursing beliefs and the influences these had upon their seemingly ordinary everyday nursing practice. The participants created environments of care as an outward expression of their values and beliefs regarding humanistic nursing care and concern for patients.

The spiritual connectedness of care reaffirmed their moral sense to experience presence, and supported them in finding meaning and significance in all aspects of their nursing practice. Further, the spiritual connectedness of care was the ultimate fulfillment for these participants' professional life. These experiences gave purpose to their everyday-clinical practice. Each of the characteristics discussed within the constitutive pattern are interrelated and reflect the philosophy of care and the contextual inferences of experiencing presence. In the next chapter, Chapter 7, the findings of this research will be discussed in relation to the reviewed literature.

Chapter 7

Discussion

Introduction

In this chapter, the findings of the study are discussed in relation to the literature reviewed. Firstly the varying definitions of presence and the terms used within the literature is discussed in relation to the participants' experiences and understanding of the presence. Secondly, the findings of the participants care, concern and strength are described. The concepts of care and concern demonstrated by the participants are explained from an existential phenomenological and humanistic perspective. In addition, the participants' strength was crucial to maintain their commitment to and style to care in clinical environments that are not always supportive of humanistic aspects of care is highlighted. Lastly, the chapter illuminates the meaning of the experience of presence from the participants' perspective.

7.1 Experiencing Presence

Within the literature many descriptions of the phenomenon of presence are revealed (Marcel, 1951; Heidegger, 1962; Zaner, 1981; Buber 1987; Paterson

and Zderad, 1988; Benner and Wrubel, 1989; Gardner, 1992; Gilje, 1992; Mohnkern, 1992, Roach, 1992; Munhall, 1993; Parse, 1994; Cody, 1995; Bishop and Scudder, 1996; Osterman and Schwartz-Barcott, 1996; Rogers, 1996; Morrison, 1997; Bäck-Pettersson, Jensen and Segesten, 1998; Barnum, 1998). These authors highlighted the complexity of presence and the different levels at which presence may be experienced. The definitions outlined that the experience of presence brings together two human beings, one being a nurse and the other a patient. Furthermore, many terms have been used to define and describe the different levels of the experience of presence.

The participants in this study also referred to the phenomenon of presence in many different terms, such as *'making contact'*, *'being with'*, *'magic moments'* and *'healing moment'*, to illustrate their experience of presence within nursing practice. From their descriptions, it appears that their experiences of presence began at the second deepest level that is described as 'presence', 'being here', 'full presence' or 'vivid presence' (Zaner 1981; Paterson and Zderad, 1988; Gilje, 1992; Osterman and Schwartz-Barcott, 1996). As highlighted by these authors, understanding of the patient in this instance is achieved by connecting with the patient within the therapeutic relationship. The participants referred to this level as *"making contact"* or

"being with the patient". Within this encounter, the participants' mode or style of care was founded upon therapeutic use of self. This style of care and interaction enabled them to be open and empathic with the patient, to develop trust within the relationship and thereby encourage the reciprocal flow of energy between them and patient.

Describing the deepest level or experience of presence has been referred to as 'co-presence' (Zaner 1981), a 'caring presence' (Bishop and Scudder, 1996) or transcendent presence (Osterman and Schwartz-Barcott, 1996). For the participants, this deepest level was acknowledged as *"special moments"* or *"healing moment"*. This was when the spiritual dimension of self and the other came together. The spiritual warmth that flowed during these moments in time created feelings of attunement and peace within the participants, they sensed a oneness with the patient. This spiritual connection between participant and patient permeated the clinical emotional environments with feelings of comfort, calmness and tranquility. Zaner (1981) describes this style of connection as 'making music' with the patient and creating an environment of 'harmony' that is sensed by all.

More importantly for the participants, these experiences lingered within them, providing them with feelings of self-fulfillment, accomplishment and self worth. The findings of this study support the analysis of Zaner (1981),

Bishop and Scudder (1996), and Osterman and Schwartz-Barcott (1996) that this deepest level at which presence can be experienced, is the optimal experience of being with or connecting with a patient. However, the literature does not discuss whether the nurse actively engages and focuses care interventions to move from one level of presence to a higher level, such as from 'full presence' to 'transcendent presence' (Osterman and Schwartz-Barcott, 1996). Yet, the findings of this study suggest that the participants' commitment to care was a stimulus to endeavor to connect with and experience the spiritual connectedness of care with patients. Regardless of the level of presence experienced with patients, the participants wanted to move on towards the deepest level of experiencing presence, to a "*healing moment*".

7.2 Care, Concern and Strength

The participants of this study had begun their professional nursing career with a personal commitment to genuinely care and nurture patients. For them, understanding of patients' needs and meeting those needs was a priority and essential for positive human development and healing. As the participants' knowledge and experience developed, their initial personal perception of nursing and caring developed into an intimate professional commitment to

care. This desire to come to know their patients' subjective worlds was embedded in their commitment to care.

The participants' way of Being as a nurse and thus their style of care in clinical practice that focused on openness, understanding of individuals' perspectives, growth, choice and freedom support the view of care from a existential phenomenological perspective. The participants continually encouraged and empowered their patients to make choices about their care and treatment. This style of care supports Heidegger's (1962) concept of solicitude, that is, the participants genuinely cared and had concern for their patients. It was this style of care that facilitated the participants' opportunities to make meaningful connections with patients and subsequently share within the subjective worlds of patients attaining mutual understanding of the meanings of their patients' experiences. Therefore, the participants knew when it was appropriate 'to leap in and take over' or, 'to leap ahead' (Heidegger, 1962) for a short period of time to gain back control for the patient.

Other characteristics of care that the participants valued were similar to those identified by Roach (1992), such as compassion, commitment, competence, confidence and conscience. Furthermore, the participants' commitment to care and genuine concern for patients, enabled them to focus their care

interventions equally upon the psychomotor skills and technical care required, whilst simultaneously to be sensitive and responsive to the unique subjectiveness of the interaction. The participants understanding of the significance of humanness within interactions facilitated meaningful relationships and the spiritual connectedness with patients. This understanding of the participants support Paterson and Zderad (1988) notion that humanistic nurses' respond to an individuals' request for assistance with purpose, focusing on all aspects of care.

In addition to humanistic aspects of care, the participants' came with 'a priori' as asserted by Heidegger (1962), that is they came to all nursing interactions with their understanding of the world of nursing including nursing language, culture and practices. It was from their past experiences that they gained understanding, attached meaning to experiences and were motivated to focus on being involved with the patient.

Furthermore, their understanding and interpretation of Being-in-the-world of nursing, similar to what Heidegger (1962) proposes as 'fore-structure' empowered the participants to participate within nurse – patient relationships with an expectation to connect with patients in meaningful ways. This included faithfully searching for significance and meaning in the everydayness of Being in the world, including the world of nursing. For the

participants, *Dasein* (Heidegger, 1962) was constantly in the world of nursing, and it was from their searching that they were able to experience the emotional meanings of nursing and thereby share in the patient's pain, suffering, happiness and death.

The participants recognized that by dwelling in the world of nursing, where Being-with and Being-there for patients does matter and, does have a positive impact upon the experience of illness or recovery. Further, Being-in-the-world of nursing as a nurse for these participants meant focusing on a style of care that demonstrated their concern and genuine interest in the patient as person. This style of care reflected an artful attitude of caring and knowing the patient. The word 'art' has many meanings, two of which are relevant to this study. They are: art as the expression of what is beautiful or appealing and art as a skill; that is a method of doing something, particularly if it is difficult (Belbridge, Bernard, Blair, Butler, Peters and Yallop, 1998). The participants focused upon expressing their Being as a nurse and understanding of humanistic nursing care in an artful attitude and style of care. Their style of care was aesthetic and harmonious to the humanness of the interaction and encouraged opportunities to experience the spiritual connectedness of care.

The experience of presence as described in the literature, in the main, discusses the philosophical aspects of practising humanistic nursing care,

including how nurses should respond within nursing interactions. The findings of this study indicate that for the participants to experience presence and to practise humanistic care within contemporary health settings often required an inner strength. The participants demonstrated strength in their willingness to enter deep trusting and meaningful relationships, which were often emotionally exhausting and physically draining. Inner strength was also required to maintain openness within the interaction and to share their inner feelings and thoughts with patients. The participants exhibited strength in their ability to endure the clinical environment. That is, an environment that provided them with little support or acknowledgment of the significance of the spiritual connectedness of care and the experience of presence. Within this non-supportive environment, inner strength was needed to persevere their commitment to care, to maintain their genuine concern for patients and subsequently their style of care.

Research by Darbyshire (1993), Cohen, Hausner and Johnson (1994), Hall and Allan (1994) and, Tschudin (1997) suggest that technological advancement and the complexity of patient care within contemporary health systems inhibit the experience of presence. These researchers suggest that factors of the health care environment such as workloads, time management and insufficient resources significantly impact upon nurses' ability and

perhaps desire to connect with patients and experience presence within their nursing practice. The findings of this study do support these researchers' exposition. For the participants, the *'healing balm'* of the spiritual experience of presence was tarnished by similar factors identified by Darbyshire (1993), Cohen, Hausner and Johnson (1994), Hall and Allan (1994) and, Tschudin (1997). These factors together with colleagues' lack of support or interest in this phenomenon also impacted upon the participants' opportunities to develop meaningful relationships with patients. However, the participants' courage to remain committed to care and connect with patients within a shared world was their stimulus to transcend the technological, objective attitudes and negative forces of the health care system. Connecting with patients within the spiritual connectedness of care is what mattered to the participants as professional nurses. The participants' commitment to care and genuine concern for patients, reflected their sense of 'destiny, [of having] a meaning, and an overall purpose in life' (Keegan and Dossey, 1996, p. 29). That is, the participants' purpose within their professional life was to engage in deep meaningful relationships with patients, to move together with them to release the inner stream of humanness.

7.3 Streams of Interconnectedness and Change

The experience of presence for the participants in this study reflected a swirling stream interconnectedness of warmth, respect and mutual understanding within them and the patients. Paterson and Zderad (1988) refer to presence as the stream that flows between nurse and patient during care interventions. For Paterson and Zderad, this stream carries with it the entire essential nutrients for healthy existence, growth and healing. This analogy of presence by Paterson and Zderad infers that this stream like any other stream, is a one way energy flow. The findings of this study suggest that the stream that flows during a presence experience is not flowing one way, it is more like a swirling pool, mixing together the nurse's and patient's subjective worlds.

From the participants' perspective, this swirling intertwining stream of connectedness focused upon the wholeness of body-mind-spirit that is embodiment of self and the patient. Embodiment promoted awareness of self, openness, clarity of existence, sharing of insights and an escalation of humanness that enhanced feelings of wellness. The participants were empowered and rejuvenated by the experience of presence, their wounds of tiredness and feelings of rejection from colleagues were washed away following *'a healing moment'* with patients. The stream within the spiritual connectedness of care was intertwined, surging together participant and

patient's inner being. The stream was not flowing as a one-way current as implied by Paterson and Zedrad (1988).

Paterson and Zedrad (1988) further propose that the experience of presence changes the nurse but how the nurse is changed is unclear. Keegan and Dossey (1998) suggest that the change is the inner healing of the nurse, an inner silence that allows for a greater understanding of one's own wisdom. The findings of this study support that of Keegan and Dossesy (1998), that is, the participants were changed. Experiencing the spiritual connectedness of care restored, revitalised and transformed these participants. The inner sensations of warmth, compassion, self worth abided within them. It was these lingering feelings that made their professional lives meaningful, purposeful and Being's source of wholeness. The experience of the spiritual connectedness of care changed the participants forever.

Based on interpretations of the findings of this study, this researcher proposes that the experience of presence enriched and empowered the participants' Being, giving meaning to their everydayness of Being-in-the-world of nursing. The participants' spirit of humanness lay quietly within them, waiting to be aroused and released. As the participants' searched for meaning and interacted with patients, their spirit of humanness was awakened according to the responses and the trust that was formed throughout the

interaction. Whilst remaining firmly embedded within the participants' own existence, Being, the spirit of humanness slowly emerged from the participants' inner self, swirling and searching for mutual meaning, purpose and sharing of the experience with patients. As the interaction developed and the spirit found mutual responses, the swirling stream of humanness began to connect with the patient's stream of humanness. It was as both streams of humanness swirled and connected, that the energies of humanness focused together to transcend and empower both human Beings. For the participants' it was from within the experience of presence, Being found hope, faith in self and others, and an interconnectedness with in the world.

Conclusion

This chapter has discussed the findings of this study in relation to the literature review and the philosophical underpinning's of the study. The literature review highlighted the importance of presence within nursing practice and the differing levels at which presence may be experienced. However, presence, and more importantly the significance of the spiritual connectedness of care on registered nurses' sense of professional fulfillment is not identified in detail within the available literature. The chapter highlighted that the participants of this study, gained significant professional satisfaction and fulfillment from their experiences of presence. For them the

experience of presence was a nourishing well of humanness, warmth and compassion that sustained them within nursing practice. The chapter further discussed that literature has identified that the opportunities for presence to be experienced may be inhibited or restricted by contemporary health care systems. Nonetheless, the participants of this study transcended these obstacles. Their style of care continually reflected humanness of care, to facilitate the spiritual connectedness of care, thereby fulfilling their need to care for patients. Furthermore, it was from the connectedness of care that these participants were changed and their professional self worth and self-respect as a nurse were enhanced. The following chapter will discuss the implications of this study and conclude this thesis.

Chapter 8

Implications and Conclusion

This Heideggerian phenomenological study was in response to this researcher's reflective thoughts and questions regarding the meaning of presence from registered nurses' perspectives. The questions initially arose from the researcher's own clinical experience, then evolved further when developing a unit of study within tertiary nursing education. This study provided the opportunity for six (6) registered nurses to reveal their innermost feelings and experiences of the phenomenon of presence from their clinical practice. The findings of this study illuminated a deep understanding of the meaning and significance of presence for these participants. For them, the experience of presence is a powerful energy source that heals and rejuvenates the inner self. Furthermore, these meaningful encounters have a significant influence upon the professional growth, feelings of self worth and career satisfaction of the participants.

The implications arising as a result of this study suggest that nurses' initial motivation to care for and nurture patients in times of need does not alter with years of experience. Nurses remain within the profession because they gain

significant satisfaction from providing a style of care that supports the humanistic aspects of the interconnectedness of care. Therefore, nursing education and clinical practice needs to be congruent. Both domains must acknowledge and encourage students and registered nurses to focus equally upon the humanness of interactions, whilst simultaneously developing the psychomotor and technical skills of nursing practice. Congruency between these domains will support nurses' desire to gain understanding and meaning from practice, thereby increasing their motivation to remain in clinical nursing practice.

In addition, this study has identified from the participants' stories that there is a significant need for the experience of presence to be shared amongst colleagues of nursing. The participants experienced feelings of isolation, frustration and guilt, however these feelings could have been reduced by having the opportunity to share in a supportive environment with fellow colleagues, their experiences of presence. Nursing strategies in education and clinical practice must be developed and implemented to acknowledge the significance of the experience of presence to nurses, that is their commitment to care and desire to connect with patients' within the spiritual connectedness of care.

Prior to a more detailed discussion of the implications of this study the limitations will be described.

8.1 Limitations of Study

As the phenomenon of presence can only be experienced and not observed, a limitation of this study is, gaining understanding of the experience of presence and its meaning is reliant upon nurses' themselves having experienced presence and, in having a willingness to share these intimate, personal experiences. Another limitation of this study is that the participants all had over twenty years of clinical experience, and may be considered expert practitioners. This raises the question, would another study that included recently graduated nurses provide a different perspective on professional satisfaction and the meaning of presence within their clinical practice. Furthermore, all the participants of this study were all females of Angelo-Celtic origin. A sample that included males and participants from differing cultural backgrounds may provide insight into different meanings of the experience of presence from registered nurses perspectives.

8.2 Nursing Education

Nursing education needs to find ways to incorporate and emphasize to nursing students the knowledge and skills that are consistent with their humanistic passion to care for and concern for patients, together with the requirements to

gain scientific knowledge and competence in the technical aspects of patient care. Nursing education needs to acknowledge within the learning environment that the humanistic aspects of care such as developing trust, respecting patients as individuals and having a willingness to believe in patients as people is valuable to the nurse-patient interaction and perhaps more importantly, to their own professional satisfaction and growth.

The bringing together of the scientific and humanistic aspects of care requires nursing education to have a commitment to further develop nursing students' communication skills beyond the foundational introductory level. Students usually learn the value and significance of developing a therapeutic relationship with patients early in their education program. It is essential that this significance be supported throughout the curriculum to enable students to develop a deep sensitivity to the humanness of interactions and that their commitment to care is acknowledged from an ontological perspective. That is, all nursing interactions have subjective meaning that will enhance and enrich nurses' experiences of being with and having concern for patients. Sensitivity and an openness to the humanness of interactions may be facilitated by encouraging students to have a self awareness of their own culturally derived life experiences. That is, students' need to have an understanding of who and what they will bring to nurse-patient interactions.

In addition, teaching students to observe patient's body language, gestures, intonations in relationship to their own feelings and expressions during nurse-patient interactions will further acknowledge the importance of the subjectiveness of interactions.

Furthermore, those who teach within education programs need to advocate the humanness of interactions, be role models to students in their own language and attitude to respecting patients and students as people. The simple use of positive phrases such as "this patient is living with epilepsy" rather than "this patient is an epileptic" demonstrates to students the valuing of patients as people. Communication and teaching styles that incorporate this style of humanness will provide students with role models to base their practice.

Encouraging students to reflect upon their own experiences within the clinical environment will bring to the surface students' understanding and interpreted meaning of their experiences, together with the significance these experiences have on their professional growth. Students need to be encouraged during their reflections, to explore their subjective responses, their feelings and thoughts during nurse-patient encounters, thereby enabling the nursing students to acknowledge and articulate the ontological perspective of the subjective experiences of nursing practice. Whether within the classroom or

clinical briefing sessions, reflecting on and articulating these experiences will provide opportunities for nursing students' feelings of self worth and satisfaction within the profession to be affirmed.

The bringing together of these skills and knowledge will educate nursing students as whole persons who have not been restricted to learning facts, objectives and techniques (Canales, 1994). Therefore, nursing students will have the scientific knowledge and skills together with an understanding of the ontological perspective of care to facilitate the development of meaningful relationships with patients, and be open to being touched by patients' lived experiences of illness.

8.3 Clinical Practice

Within contemporary nursing practice caring is mooted as the central concept of patient care. However, the findings of this study indicate that the participants were unable or reluctant to share with fellow colleagues the humanistic dimensions of care, in particular their experiences of presence. The participants attributed the lack of sharing to insufficient time and or opportunities to be with other nurses to reflect upon and share the significance of these experiences. Registered nurses should endeavor to find time and opportunities to reflect critically upon their care practices and to share the subjective experiences embedded within their practice.

Within current health care systems, nurses need to reconceptualise the time allocated for and the content of patient handover between shifts. During this overlap time, handover focuses largely upon the psychomotor skills and patient treatments. This objective information is recorded within patient histories, yet nurses persistently repeat this recorded written information. However, this time could be utilised to enable nurses to reflect upon and share with colleagues the ontological perspectives of care, in particular their experiences of presence and developing deep meaningful relationships with patients. Alternatively or additionally, nurses could specifically reserve time on a weekly or monthly basis to meet to debrief, discuss and further reflect upon the humanistic aspects of their care practices. Reflecting and sharing of feelings and interpreted meanings of patient interactions will affirm the significance of nurses' commitment to care and their desire to gain meaning and purpose to nursing practice.

Supporting nurses' commitment to care from a humanistic perspective would require reevaluating time allocated to all patient care. Staffing levels within the clinical area would need to consider the time necessary for nurses to develop deep meaningful relationships with patients. That is, allowing nurses' time to develop a deep level of trust and understanding of their patients' subjective experience of illness.

Nurses who share, whether during handover times, during reserved meeting times or by publishing, their experiences of connecting with patients within the clinical environment will openly acknowledge the worth and value of being with patients in meaningful relationships. Furthermore, the sharing of these experiences would enhance nurses' feelings of accomplishment, self worth as a nurse as they would no longer sense isolation from colleagues' lack of understanding of the significance of the experience of presence to their practice. In addition, sharing would assert within contemporary health care settings, that nursing is a lived experience that encompasses subjective, intuitive and humanistic dimensions.

8.4 Further Research

This study affirmed that the experience of presence is a spring of professional satisfaction that conveys purpose and meaning to nursing practice. Connecting with patients in meaningful ways was a significant influence upon the participants of this study way of Being as a nurse and a motive for remaining in nursing. Prolonged life expectancy and the number of people surviving with chronic illness is increasing. The participants of this study identified that spending time with patients within meaningful encounters was legitimate when a patient was dying. The time spent with these patients was viewed by fellow colleagues as essential to quality care of the dying patient.

This finding suggests research to explore the meaning of practice with registered nurses' working in the palliative care area may be helpful. Research in this area may illuminate understanding of a relationship in their chosen area of practice and their ability to practice a style of care that supports their commitment to care and desire to connect with patients in the spiritual connectedness of care.

Further research with students and registered nurses' of their commitment to care and the meaning this has upon their professional satisfaction and style of care practices can only benefit the quality of patient care and the professions understanding of key characteristics that sustain, rejuvenate and expand the professional gratification of nurses.

Conclusion

This study brought to light the essence of the meaning of presence from registered nurses' perspective and understanding of how their style of care facilitated the experience of presence. For the participants, connecting with and sharing within patients' subjective worlds was an essential quality of nursing practice. The experiences of the spiritual connectedness of care were a swirling energy exchange between nurse and patient of warmth, compassion and acceptance. The reciprocation of the stream of humanness was what gave meaning and purpose to the participants' professional life, it was the essence

of their existence as a professional nurse. These experiences fulfilled their need and desire to care for and be with patients. Furthermore, the lingering feelings and nourishment that remained within them following an experience of presence enhanced their sense of achievement and self worth as professional nurses.

This study identified that within the context of current health care systems, many factors influenced the participants' opportunities to experience presence within practice. The participants' acknowledged that the increase in technology involved with patient care, is not a barrier but rather a hindrance which nurses can transcend thereby enabling them to connect with patients in meaningful relationships, within the spiritual connectedness of care. Other factors that influenced opportunities for the participants to experience presence was the continual lack of recognition, from within the profession and other health professionals, of the significance and meaning of the spiritual connectedness of care. This discouraged and disheartened the participants leaving them with feelings of indifference and without purpose and meaning to their practice.

However, the meaning and significance of the spiritual connectedness of care was strongly embedded in their Being as a nurse. This influenced their style of care, which demonstrated a commitment to care from an existential

philosophical perspective. That is, caring from a humanistic perspective remained their priority in practice, regardless of any distracting or disrupting factors. It was from their style of care that fulfillment of their own inner desire to care for patients and acknowledge the humanness of the moment was achieved. For these participants, their nursing care was faithfully and purposefully directed towards respecting the human to human interaction between nurse and patient.

This study identified that the participants required an inner strength to practice their style of care and to transcend the barriers within health care. The participants' strength sustained their style and commitment to care, as connecting with patients within the spiritual connectedness of care is what mattered to them as professional nurses. These experiences gave them purpose and meaning to their nursing practice, for the participants this is what *'nursing is all about'*.

Emerging further from this study is a deeper understanding of the meaning of the experience of presence, that is the spiritual connectedness of care. Nurses' Being of existence is enriched and their feelings of self worth as professionals are heightened as a result of this experience. Nursing is a lived experience where the feelings, thoughts and experiences of the persons involved are crucial to patient care and nurses professional satisfaction.

Therefore, nurses must openly acknowledge care that reflects both competent, skilful use of technology and equally as important, the artful skills of caring such as compassion, availability, giving of self and openness.

Without opportunities to practice nursing care that facilitates this style of care, nurses will continue to feel disillusioned and dissatisfied with their professional life. Accordingly, the implications of this study focus upon registered nurses acknowledging, fostering and sharing the subjective dimension of caring from their own perspective. That is, nurses must have a genuine care and concern for their colleagues, foster feelings of self worth and value within the profession and share their experiences including the subjective dimensions of care, with one another.

This researcher proposes that the nursing profession whether in clinical practice, education or health administration must acknowledge, retain and maintain meaning and purpose to their practice, as without this, nursing practice will be further eroded, objectified and technologically focused. In other words, if nurses are unable to meet their inner need to nourish their centre of existence, then Being will be without purpose, lost to a technological environment. Their heartless practice may leave them with no alternative but to abandon their profession and find purpose and meaning in another career.

It is highlighted here again that all interactions have the potential to experience the spiritual connectedness of care and release the stream of humanness that lies quietly within each Being. However, without the opportunities for nurses to openly share and explore these experiences less understanding of the concept of presence will be known. Nurses professional self worth and self-concept will continue to be challenged and perhaps lead to a further decline in the retention of professional nurses within clinical practice.

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~~Victoria University of Technology~~

PO Box 14428
Melbourne City
MC 8001 Australia

Telephone:
(03) 9365 2830
Facsimile:
(03) 9365 2832

St Albans Campus
School of Nursing
McKechnie Street
St Albans

VICTORIA UNIVERSITY OF TECHNOLOGY

Appendix A

Plain Language Statement

As a graduate student at Victoria University of Technology (Master of Health Science), I am carrying out research into Registered Nurses' experience of *presence*, within nursing practice. Presence, for the purpose of this study is defined as the inner spiritual, psychological and emotional intunement of a nurse within a nursing situation enabling the nurse to understand the patient's realm of experience. Through this research I aim to provide a written description of the meaning of *presence* in the everyday nursing practice as experienced by Registered Nurses', to uncover commonalties in meaning, experience, and practice and to discover exemplar cases that embody the meaning of *presence* within nursing practice which would facilitate nurses' understanding of, and the meaning of *presence* in nursing practice.

Participants of this study would be requested to undertake two interviews with myself. The interviews would take the form of a discussion about the participants' experience of *presence* within a nursing situation. Each interview is expected to last no longer than an hour and would be conducted at a time and place suitable to both participant and myself. All interviews will be audio-taped and transcribed verbatim. A subsequent interview will also be requested to give participants an opportunity to include further information or delete information prior to data analysis.

All data collected will be treated in the strictest confidence, being numbered so that no other person will know the identity of the participants. Only the researcher will have access to the audio tapes and following completion of the project all audio tapes and unedited transcriptions will be kept for a period of five (5) years under lock and key, then destroyed.

Participants may decide to withdraw from the study at any time without prejudice.

The outcome of this study will be presented as my thesis for the award of Master of Health Science higher degree. Findings from this study may also be included in papers for presentation in referred health related journals, and at appropriate nursing or allied health conferences. No participant will be identified in any presentation of the study.

If you have any questions regarding this study please don't hesitate to contact me or the Principal Investigator.

Di Welch
Co-Investigator
11 Whistlewood Close
Doncaster East 3109
Ph. (03) 9894 5003

Jenny Cheung
Principal Investigator
Department of Nursing
Faculty of Human Development
Victoria University of Technology

Victoria University of Technology

PO Box 14428
Melbourne City
MC 8001 Australia

Telephone:
(03) 9365 2111
Facsimile:
(03) 9366 4852

St Albans Campus
McKechnie Street
St Albans

VICTORIA UNIVERSITY OF TECHNOLOGY

Appendix B

Consent Form for Participants

CERTIFICATION BY PARTICIPANT

I,
of

certify that I have the legal ability to give valid consent and that I am voluntarily giving my consent to participate in the study entitled:

A Heideggerian Phenomenological Study of Nurses' Experience of Presence

being conducted at Victoria University of Technology by:
Dr Jenny Cheung, Department of Nursing, Principal Investigator
Ms Di Welch, Co-Investigator

I certify that the objectives of the study, together with any risks to me associated with the procedures listed hereunder to be carried out in the study, have been fully explained to me by:

Ms Di Welch, Co-Investigator
and that I freely consent to participation involving the following procedures.

Procedures:

1. My involvement is voluntary, and entails being interviewed on two or more than two occasions.
2. I have been informed that the confidentiality of the information I provide will be safeguarded, according to research Code of Conduct principles.
3. I agree that data collected for the purpose of this project may be published, provided my name is not linked to the information.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardize me in any way.
I have been informed that the confidentiality of the information I provide will be safeguarded.

Signed: ..... **Date:** .....

Witness other than the experimenter:

..... **Date:** .....

Any queries or complaints about your participation in this project may be directed to the Co-Investigator, Di Welch, 11 Whistlewood Close, Doncaster East, 3109 (telephone no: 03 9894 5003), or the Principal Investigator, Dr. Jenny Cheung, Department of Nursing, Victoria University of Technology.

Appendix C

Example of Node - Trust with supporting text

```
Q.S.R. NUD.IST Power version, revision 3.0.4 GUI.
Licensee: Di Welch

PROJECT: THESIS, User Di, 2:31 pm, May 20, 1998.

************************************************************************
(5 1)                                    trust
*** Definition:
Rapport with patients, being genuine, honest,sharing and open.
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT: IV1
+++ Retrieval for this document: 8 units out of 1182, = 0.68%
++ Text units 1145-1152:
1145  T:But there's the trust, that's what I haven't
(5)             (5 1)
1146  said.  Trust, I mean for someone to trust you
(5)             (5 1)
1148  about...  more than just their little toe or
(5)             (5 1)
1149  something, I mean that's a pretty precious,
(5)             (5 1)
1150  yeah there's something, a precious um ......
(5)             (5 1)
1151  yeah, like they are entrusting you with
(5)             (5 1)
1152  something precious, (5)
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT: IV3
+++ Retrieval for this document: 31 units out of 974, = 3.2%
++ Text units 542-549:
542   so we're doing assessments and providing the
(5 1)           (18)
546   care so that you are given the opportunity to build up a
(5 1)           (18)
547   trusting relationship and develop that sense of knowing.
(5 1)           (18)
++ Text units 778-794:

791   so I mean
(5 1)           (5 5)
792   it's sort of..... being able to talk, for people to be able to share
(5 1)           (5 5)
793   those things, (mm, mm) you know and to be able to talk
(5 1)           (5 5)
794   honestly... (5 1)           (5 5)
++++++++++++++++++++++++++++++++++++++++
+++ ON-LINE DOCUMENT: IV4
+++ Retrieval for this document: 26 units out of 813, = 3.2%
++ Text units 47-51:
47    I think it's when .... people share things
(2)             (5 1)
48    about themselves that  may not be related to their health care
(2)             (5 1)
49    particularly, but when they feel that they know you enough in
```

Appendix D – Index Node Tree

Parent node and child nodes created during stage 3 of analysis