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Intensive Care Unit Nursing: An Interpretable and Hermeneutic Practice

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Abstract

Intensive care unit nursing is an interpretive practice. Hermeneutics, as an interpretive philosophy, is an ideal approach to make meaning of the ambiguities that exist in this intensive practice setting. This paper uses the underpinnings from Gadamer's philosophical hermeneutics to explore the idea that ICU nursing is an interpretive practice.

Keywords

Hans-Georg Gadamer, philosophical hermeneutics, intensive care unit nursing

Nursing is one of the Fine Arts: I had almost said, the finest of Fine Arts.
Florence Nightingale (1820-1910)

The art of intensive care unit (ICU) nursing refers to a professional discipline that skillfully gathers knowledge, interprets particulars, and then intervenes accordingly (Benner, Hooper-Kyriakidis, & Stannard, 1999; Carper, 1978). The adult ICU attends to the acutely ill who require focused monitoring. Since the birth of the first ICU in the 1950s, the technological advances and unique patient population make nursing work in this setting distinct (Hay & Oken, 1972; Strauss, 1968). The craft of ICU nursing lies with confronting the unpredictable human realities of suffering, loss, healing, and the possibility of bearing witness to the unexplainable (Benner et al., 1999). The ongoing interpretation of each sound, smell, sight, and touch is intrinsic to the care that ICU nurses provide to patients and their families.

As an ICU registered nurse and current doctoral student, I plan to conduct a research study that

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attends to the following question: *How might we understand the meanings of work-related critical incident stress for RNs working with adults in the ICU setting?* Hans-Georg Gadamer's (1900-2002) philosophical hermeneutics will be used to guide the exploration of this research question. Hermeneutics, the art of understanding, is an interpretive and practical philosophy (Moules, McCaffrey, Field, & Laing, 2015) that recognizes all human experiences, such as those encountered by nurses in the ICU, are rich and complex (Holroyd, 2007; Kinesella, 2006). In hermeneutics "art is a concept, or rather an experience of truth" (Grondin, 2003, p. 31). In this paper, I use underpinnings from Gadamer's philosophical hermeneutics to explore the idea that ICU nursing is an interpretative practice. Therefore, hermeneutics, as an interpretive philosophy, is an ideal approach to make meaning of ambiguities that exist in this intensive practice setting. As I write this paper, I recognize that understanding is related to interpretation (Gadamer, 1960/2013).

ICU nursing is an interpretive practice. I have spent a significant amount of time considering this claim. To explore this idea I returned to the tradition of ICU nursing by re-reading several of my old journal entries that had been written 10 years ago. As an ICU nurse, I would frequently take time to reflect and write about experiences that were mysteries, difficult to discern, and often morally distressing. Mysteries can be understood; they reveal the incompleteness of meaning and that there is always more to be understood (Davey, 2006). As I vividly read and recalled the details within each journal entry, I paused at various points that offered insight and perspective. One of the insights that became blatantly obvious was that numerous examples spoke to my interpretive way of being in clinical practice, particularly during situations that were ambiguous and difficult to discern. Hermeneutics, like ICU nursing, attempts to grasp and bring to light that which is fragmented and hidden (Geanellos, 1998). A context is required to elaborate on the idea that hermeneutics is consistently at play within ICU nursing and thus, I will share a personal experience from one of my journal entries. "All experiences, in the hermeneutic sense, are learning experiences. Our experiences serve to revise the way in which we understand our past and anticipate our future" (Holroyd, 2007, p. 9).

My Journal Entry: Interpretation at Play

> *September 24, 2006. I received day shift report from Jane (pseudonym) who took care of "Jack" (pseudonym) and his family. Jack, 56-years of age, was admitted to the ICU after having fallen from his tractor as a result of a sudden and unexplained cardiac arrest. Upon admission to the ICU, Jack was diagnosed with an anoxic head injury, several fractured ribs, bilateral pneumothoraxes, and an abdominal injury that required surgical intervention. Jack had the abdominal surgery approximately six hours prior to my arrival and he remained intubated and mechanically ventilated. Immediately after I received report I began my methodical and typical routine that involved: reviewing the alarm settings, zeroing the arterial and central venous pressure lines, examining the patency, drip rate, and calculations for each intravenous drip, conducting a thorough head-to-toe assessment, and attending to family. Jack's initial vital signs were within a targeted range and the rest of his assessment was unremarkable given the nature of his injuries. Immediately after my initial assessment, I left Jack's bedside for 5 minutes to prepare his 2100 medications. Upon my return, I heard the monitor alarms and noted a 5 mm Hg drop in his systolic blood pressure (BP) that was now 80/56, and his heart rate increased*

to 110 beats per minute (bpm) from 90 bpm. I immediately looked at his urine output, skin color, and adjusted his arterial catheter to ensure patency and accuracy of the BP. Each of these objective assessment findings remained unremarkable. My initial concern was the possibility of internal abdominal bleeding, however, I could not rule out the possibilities of an undetected brain hemorrhage or a second cardiac event.

Despite the lack of evidence to support these possibilities, I suddenly became like a detective investigating a mystery and eager to uncover the truth. I began to increase the frequency of Jack's head-to-toe assessments to every 30 minutes rather than every 4 hours as initially ordered by the ICU physician. My "gut instinct" told me "something" unusual was going on with Jack's physical status. Within 10 minutes, I heard the monitor alarms for a second time and again noticed Jacks systolic BP dropped by another 5 mm Hg (75/34 mm Hg) and his heart rate increased to 125 bpm. This time my assessment findings revealed: his abdomen was more distended, the urine output dropped to 10 mls/hour, and I was convinced that there was active bleeding in his abdominal cavity. I made the decision to collect blood from his arterial line so I could review his complete blood count, specifically his hemoglobin and hematocrit level. Once the blood work results had returned from the lab, I informed the ICU physician of the information. The physician ordered additional diagnostics that confirmed my initial suspicion, Jack was experiencing an acute internal abdominal hemorrhage. Within 30 minutes, Jack returned to the operating room to have a general surgeon repair his abdominal bleeding.

Interpretation as a Daily Practice for ICU Nurses

"Hermeneutics begins with the premise that the world is interpretable" (Moules, 2002, p. 4), and thus the day-to-day often taken for granted practices of ICU nursing are also interpretable. The word hermeneutics means to interpret (Oxford Canadian Dictionary, 2006) and is derived from the Greek god Hermes, a mischievous and cunning character who delivered messages of the gods to mortals (Moules et al., 2015). His messages were often playful and obtuse, "enticing interpretation" (Moules et al., 2015, p. 2). The etymological source of the word "interpret" originated in the late 14th century and refers to the action of explaining the meaning of something (etymonline, 2016). The act of interpretation takes place through engagement and participation, by being in the world (Davey, 2006). Heidegger (1889-1976) used the term *Dasein* or "being there" to emphasize that, by being in the world, one is always interpreting (Annells, 1996; Grondin, 2003). As an ICU nurse by "being" engaged in the world of critical care, I was unknowingly making meaning of each patient care experience.

There was a dialectical approach evident in my interpretation of Jack's situation. I consistently moved between the parts and whole of the experience to make meaning of his rapidly changing status. The dynamic and iterative process parallels the hermeneutic circle, a metaphor for conceptualizing understanding (Debesay, Naden, & Slettebo, 2008; Moules et al., 2015). The hermeneutic circle refers to the ontological structure for understanding (Grondin, 2003; Walsh, 1996). "The circle, then, is not formal in nature. It is neither subjective nor objective, but describes understanding as the interplay of the movement that takes place in language" (Gadamer, 1960/2013, p. 305). For example, the changes in Jack's vital signs were not interpreted as simple numerical data, rather were explored through a historical and contextual

lens. According to Gadamer (1960/2013), "understanding is, essentially, a historically-effected event" (p. 310). This lens was evident in my use of past trends and attention to the existing overall clinical picture, to make meaning of Jack's assessment findings. The changes in Jack's blood pressure and heart rate were understood relative to the color of his skin, the amount of urine output, and his central venous pressure. Making meaning of Jack's changing status is an example of hermeneutic understanding. Hermeneutic understanding complements scientific and diagnostic reasoning to make meaning, recognizing that science does not dominate the understanding and is only one component of the larger picture. *Combined with* "scientific and technical knowledge there exists another body of knowledge that is not the result of proof and demonstration but is laid down by tradition, received wisdom, and practical experience" (Davies, 2006, p. 40). Hermeneutic understanding takes place by examining whole and parts, attending to history and context, in order to make sense of particulars and intervene based on the implications of that meaning (Moules, McCaffrey, Morck, & Jardine, 2011). By re-reading my past journal entries, I have come to realize that hermeneutic understanding has always been inherent in my nursing practice.

Interpretation as a Ritual for ICU Nurses

Hermeneutics seeks to question what is typically taken for granted (Moules et al., 2015). I have often thought about the routine day-to-day practices as an ICU nurse that I considered habitual and conducted unthinkingly. For example, the beginning of each patient care experience consisted of a thorough and methodical assessment. My routine would begin with an evaluation of the patient's physical and psychological status, as well as a review of the monitor alarms and the technological devices that were used for treatment, such as the ventilator. By re-visiting my experience with Jack, I began to wonder, is there meaning behind the rituals that we often take for granted? Max van Manen (2002) wrote about the importance of considering the meaning behind the ritualized experiences. "And yet, in each ritual there may exist traces of meaning that belong to the original phenomenon that gave rise to the experience" (van Manen, 2002, p. 9). In an algorithmic manner, I completed my initial assessment of Jack; this routine component of my clinical practice was significant. It offered me more than just a baseline assessment; it revealed what was familiar, foreign, common, and strange. My ritualized experience created a space for me to enter and remain in the hermeneutic circle for ongoing interpretation of the particulars. It was this ritual that presented me with clues to Jack's emerging mystery (the acute abdominal hemorrhage) as well as the questions and dialogue that accompanied. The dichotomy of familiarity and strangeness is at play in hermeneutic work (Gadamer, 1960/2013). The understanding that emerges through each ritualized experience within the practice of ICU nursing is interpretive and thus hermeneutic.

Interpretation in the Form of Practical Wisdom

Patricia Benner (1999) used the term "clinical forethought" to describe a nurse's judgment and wisdom that are typically unexplainable, yet are pervasive in the logic of clinical practice (p. 64). While caring for Jack, I recalled experiencing a "gut instinct" that was inarticulate; it was an intuitive sense that functioned like an alarm bell alerting me to *"something."* I was unable to discern that "*something,"* but recognized there was value in attending to this instinct. Knowing "how to distinguish… lies the true art" (Gadamer, 1996, p. 19). Intuition or "this experienced

based wisdom, refers to a knowing without necessarily having specific rationale" (Benner et al., 1999, p. 64). Nurses in the ICU use clinical wisdom to interpret salient particulars and respond to possibilities in a timely manner (Benner et al., 1999). Engaging in clinical forethought requires judgment and an anticipation of potential clinical events using intuitive thinking (Benner et al., 1999). I anticipated further diagnostics would be ordered by the physician thus, I collected blood from Jack's arterial line to obtain a complete blood count. The results from the blood work provided me with another piece to the mysterious puzzle, enhancing my insight into Jack's deteriorating status. I believe clinical judgment is inherently interpretive (e.g., hermeneutic), as it integrates various types of knowledge for new understandings to emerge. Clinical judgment requires knowledge which is "abstract, generalizable, and applicable in many situations," including intuition derived from practice and experience as one grasps clinical situations (Tanner, 2006, p. 205).

Hermeneutics is what Aristotle referred to as practical wisdom (*phronesis)* that is translated as practical knowledge and moral knowledge (Grondin, 2003; Moules et al., 2015). The term *phronesis* was used by Aristotle to distinguish between contextualized and objective knowledge (Moules et al., 2015). This is "a form of knowledge arising from experience that undergirds hermeneutic phenomenology" (Moules et al., 2015, p. 24). Practical knowledge demands judgment (Moules et al., 2015) where "the knower is not standing over against a situation that he merely observes; he is directly confronted with what he sees" (Gadamer, 1960/2013, p. 324). The work of phronesis penetrates through ICU nursing and hermeneutic philosophy, it is a form of knowledge that emphasizes, "experiential understanding of life as it is lived in everyday practices" (Moules, Field, McCaffrey, & Laing, 2014, p. 6).

Conclusion

The art of ICU nursing is inherent in a discipline that engages in the event of interpretation, a process of ongoing discovery. Making meaning involves "attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing" (Carper, 1978, p. 13). The day-to-day work of nurses is "deeply interpretive" and "hermeneutic in character" (Moules et al., 2011, p. 2). Like hermeneutic understanding, nurses use various modes of knowledge to make meaning. Re-reading my journals has offered me insight into the present and a glance at the future. When our past and present collide, we are invited to pause and take note. As an ICU nurse, I am always knowingly or unknowingly interpreting using historical, existing traditions, and context to guide clinical possibilities. The practice of hermeneutics "ventures into the contextual world" encouraging us to to know differently (Moules et al., 2015, p. 3). ICU nursing is a "deeply interpretive discipline wherein the work of something like hermeneutics is already at work" (Moules et al., 2011, p. 2). Re-visiting my past has revealed to me what was once concealed, that I am always already understanding, that my ICU nursing practice has been "already deeply hermeneutic" (Moules et al., 2011, p. 2).

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