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Air Hunger

The Sublime In Nursing Practice

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Abstract:
In sublime moments in practice we may be brought close, incredibly close, to what normally remains at a distance. Or we may momentarily discern what has always been before us and so close to us that it has never before been truly noticed. Two different nursing situations show how meaningful, yet ineffable the sublime in practice can be when it is evoked and how difficult it is to articulate aesthetic dimensions of nursing practices without covering them over with theory and theoretical knowledge. We consider the experience of taken for granted breathing when suddenly severe breathlessness appears. What is it to be present to those in extremis, to be close to the inside workings of human bodies? Using Jean-Luc Nancy's (1993) understanding of the sublime, we consider how the experience of a patient's breath can be existentially revelatory of nursing practice.

Keywords sublime, nursing, nursing practice, phenomenology, Jean Luc Nancy

Introduction

What does it mean to breathe? Breathing is something we do daily, continuously, yet rarely is it brought to our attention. Although we might cough from the force of our inhalation as we run up a hill or, like children, test how long we can hold our breath, feeling our lungs burn, only to gasp when we finally cannot hold our breath any longer, these moments pass quickly as the ebb and flow of our breath returns and once again slips from our notice. Indeed, we cannot stop our breathing for longer than a few minutes, unless it is stopped by something else. And even then, the body's rhythms reappear, now with a forcefulness, desperately trying to pull in the much-needed oxygen.

Breathing, quite simply, is a primal human activity. We must breathe to live. What, then, does it mean? And what does it mean to care for another in their breathing, to someone who cannot breathe? In this essay, we consider the power of the breath as it can appear in the nurse-patient relationship. The accounts presented are drawn from previous hermeneutic phenomenological research according to Max van Manen (1993/2007) on the aesthetic dimension of nursing practice (Cameron, 1998; Goble 2009). Using Jean-Luc Nancy's (1993) understanding of the sublime, we consider how the experience of a patient's breath can be existentially revelatory of nursing practice.

Below an experience of severe breathlessness is presented. Here, as the possibility of death and mortality erupts into this particular world, so too does nursing. We see qualities of nursing expressed in the practices of this nurse as well as the incredible life-force of the person, the *élan vital*, come to the fore. Later in the paper, we see the response of a young nurse when faced with an internal organ during a surgical procedure. Being present to a functioning internal organ draws a response from her that is both unexpected and revealing.

The nurse's specific practices evoked in response to the episode of severe breathlessness, hold sway over theory and theoretical notions often prevalent in the discourses of health professions. The young student nurse, well aware of physiological processes, discovers there is more to anatomy and physiology than objective knowledge alone. The breathless woman reaches new dimensions of living through a mortal episode. Here human science inquiry yields insight into the lifeworld of nursing, a student's response to

a health situation, and a person's experience of lost breath. For the researchers here, as well as the reader, as Vangie Bergum (1989) writes, phenomenological studies may take on the notion of a "research drama" (p. 48) as we stand in the presence of mortality inserting itself into the world.

Air Hunger

Gwen cannot breathe. Her attempts to suck in gasps of air are audible. Her color is poor. A pale circle surrounds her mouth. Her lips are not pink anymore. Her chest heaves and retracts with the effort of breathing. I know as a nurse recently cum researcher that Gwen is perilously close to a respiratory arrest. Her nurse immediately moves to her side, speaks to her while reaching for and replacing her nasal oxygen prongs with a mask and increasing the oxygen flow. Because I am new to this agency I scan the room for the equipment and other elements for dealing with respiratory and cardiac arrests. I look for a suction apparatus in the room; the location of the crash cart and emergency medications. I check how large the vein is that currently has an IV running in it. I look out the window for other staff on the unit. I look back at Gwen and her nurse. I move in close to the other side of the bed.

The nurse bends over to Gwen. She seeks eye contact. She speaks softly but firmly and tells Gwen how to breathe with simple directions. As she speaks she places her hand over Gwen's diaphragm to give emphasis to her words. Her other hand supports Gwen on her back and upper shoulders, gently pushes her forward to a more upright position. She alternately strokes and supports the spine. Her hand goes to Gwen's legs, which reflexively jerk up and down in her anxiousness; flexed knee, extended leg, flexed again to her chest. The nurse strokes and gently guides these limbs to stillness. Gwen allows the nurse to do this and begins to follow the nurse's instructions.

This goes on for a seemingly endless time. The nurse coaches, supports Gwen sitting upright, encourages her to breathe from where her hand is placed. "Breathe down here Gwen, push my hand out, that's it, really good, now another one." I stand across the bed from the nurse. I look for signs of muscle flaccidity and fatigue to indicate a worsening condition. I see

them. The arrest is near yet Gwen's nurse continues. I stand in readiness to invoke the code.

The soothing tones of the nurse's voice, her stroking, and her utter calmness envelops nurse and patient. There are only two in this universe. Yet as, and even before Gwen's breathing slowly returns to slightly approximating normal, I feel a calmness envelop me too. There will not be a respiratory arrest here. Gwen breathes.

I know as clear as the dawn that a less experienced nurse would have called an arrest. Gwen would have been intubated, and would now be on a respirator. I know too that this nurse brought her through with her finely tuned nursing judgment. At coffee break I tell my nurse what I observed during the 'near arrest.' She replies:

"You know if she had progressed to respiratory arrest and I know she was at that point, the fine moment where it could go either way, I would have acted then as per the protocol for respiratory arrests. But to worry about that before it happened would have taken me away from the actual moment. Getting her through it was my foremost thought not treating what might happen. I didn't want her 'tubed' (intubated) with everything else that is going on for her."

Later I ask the nurse, "what were you thinking when I saw you assessing her, what made you hesitate to call the arrest? What made you able to act in this way?" She speaks of theory and of research and breathlessness; no new material here to me. But then she says:

"Gwen has metastases to her lungs, she has fluid on her lungs, her haemoglobin is very low right now, so severe breathlessness is to be expected. Mind you that was more than severe breathlessness I know. But I also knew she had the ability to overcome it and I wanted to give her a chance. She was a ballet dancer you know, she knew about breath control and bodily relaxation techniques all her life."

Later I ask Gwen about this. She tells me:"I knew what she was asking me to do but with little breath and panic, it was too hard and I wondered if maybe this just might finally be it, the dying. Her hand was rubbing my back, I remember that. It's hard to explain. It's just something I felt. She helped me grab

my ballet body, I couldn't have done it by myself, I was past helping myself. Afterwards she taught me a few things too so I can recognize it coming on and control it better. She knows me better than I know myself sometimes."

The Sensible Presentation

How is it that it takes a moment like Gwen's severe breathlessness to remind ourselves that human beings live in a state of fragility? Why is it that we must fight so hard to stay in the present yet the breath takes us there immediately? How is it that rather than attending to the experience happening before our eyes, we in nursing would rather embrace a discourse that valorizes a represented discourse of preplanned concepts and theories to apply (Cameron, 2006). Nancy (1993) writes that aesthetics, when understood as *sensible presentation,* is really the question of presence. He warns that if an experience is covered over by representation, a modality that originates and operates mainly in thought, this is indeed nonsensible.

It is difficult to escape representational modes of thought; they have been prevalent in many practice disciplines over several decades now. When moments in practice come to be, as seen in the anecdote above, momentarily rising up and then fading away, we come up against the question of how to show this event? We can think of many ways that this could be approached through covering over the whole episode with representational constructs. But nursing and the strength of the human being would be lost. Van Manen (2007) helps us understand this further. He writes that understanding what happens in practice is mainly an issue of intelligibility. "Constructionist approaches to practice too easily involve reifying what escapes reification, thematizing what cannot be thematized, and bringing practice within the reach of objectivistic technological thought" (van Manen, 2007, p. 18).

With these thoughts in mind, is it possible to understand what was happening between Gwen and her nurse? It is a strange situation really even to the experienced nurse-researcher witnessing the event. And perhaps most strange is how long it takes the nurse-researcher to get out of the comfortable safety of the standard protocol. We are steeped in the hegemonic safety and risk discourse so prevalent in health care today. Yet we also recognize how this falls short in the face of those in extremis, those suffering.

In this account, what we see is a situated expression of nursing practice that forms in response to severe breathlessness. It is not unexpected given that Gwen is very ill. Indeed, she is dying. Protocol would suggest a highly invasive intervention involving intubation. And yet her nurse very much wants Gwen to be able to have time to continue her movement toward death in as fully a conscious way as possible. Intubation would prevent this and, in the nurse's view, Gwen and her family are not yet ready for the final breath.

At the beginning of the episode we see the nurse's attentiveness to Gwen, standing near, and exuding a calmness that is difficult to achieve if you have ever experienced severe breathlessness. Interlinked bodies, eerie high and low pitched sounds as breathing out becomes as impossible as breathing in, both silent and audible coaching fill the room. Things progress and suddenly deteriorate to no breath. The nurse-researcher sees the limit approaching; from now on things will progress until death unless some action is taken.

The nurse too knows the limit is incredibly near but does not alter the act that has formed and is now fully present in the room. Rationality insists she call a code. But she does not. She waits.

As the nurse-researcher moves beyond her frenetic representational modality, calmness comes over her. She finally sees what is presenting itself in the moment. She turns her full attention to serving as witness to what is happening. It is a moment of the sublime.

According to Jean-Luc Nancy (1993), the sublime is not

> a particular kind of presentation, [such as] the presentation of the infinite. ... It is not a matter of the presentation or nonpresentation of the infinite, placed beside the presentation of the finite and construed in accordance with an analogous model. Rather, it is a matter – and this is something completely different – of the movement of the unlimited, or more exactly of "the unlimitation" (*die Unbegrenztheit*) *that takes place on the border of the limit, and thus on the border of presentation*. (original italics, p. 35)

Nancy (1993) writes that the apprehension of the sublime arises like a figure against a ground. In this way, a nursing practice moment forms; it is not mandated by a prescribed care map to be done in a certain way, but rises up in response to what is at hand. The beauti-

ful, he writes, "reveals itself in extreme fragility" (p. 32). The beautiful appears in the nurse's gesture and is immediately understood by Gwen. The meaning of it "is intermingled with the structure of the world" (Merleau-Ponty (1962, p. 186) that has arrived in the room. But eventually, the limit of the beautiful arrives. It appears with the nearing border between life and death. According to Nancy (1993), if we try to capture this limit, it fades from view. The limit of the beautiful is simply what it is, the nurse's gesture of sustained attentiveness to extreme fragility, the border at which 'safe practice,' according to protocol, is breached.

But where in this is the sublime? We might say that the beautiful gesture becomes sublime at a decisive moment the nurse-researcher recognizes that this 'breach' is in fact exquisite care. It is the liberation of nursing from the bounds of representational forms. Nursing shows itself as a fluid and generous practice. It withdraws from what it is in representation. The sustained nursing gesture moves itself beyond its limits into the sublime; the presentation of the gesture's movement beyond its limits (Nancy, 1993).

And what of Gwen in this final moment of recovering some breath? In daring to approach the limit, the nurse seems to open up the possibility of Gwen's own unlimitation. Gwen comes alongside the nurse in this exquisite movement. Her cancer-riddled body gives way to her beautiful dancer body wherein Gwen breathes.

Breath and the Movement Towards Unlimitation

Breathing is our most fundamental openness to life. In free and effortless breathing, we create our communicative space with no fixed and rigid structures. The lungs are expansive, contractive, full of space as the rhythm of corporeality takes place. The lungs are also a communal space. We breathe in the air that others have breathed out. We often synchronize our breath to that of others; bodies working together in synchronicity.

But too, the breath collects what is going on in the world around us. The lungs are the only internal organ open to the outside world. If one breathes in tension or noxious odors sometimes breathing these out becomes difficult. The air becomes entrapped. If no air can be gathered around one, or air cannot be breathed out, then no atmosphere of living, of possibilities, exist. Life too becomes rigid and fixed.

Breath and breathing can serve as a meditative focus in nursing practice. They can draw us back into the nursing moment that the routine of our work may cause us to forget. As we see in the above anecdote, breath can invite us to attend to the *sensible presentation* of practice. And yet, there is a danger in this appearance: it can be powerful, overwhelming, and all consuming. Andrea tells of an incident that occurred years ago while she was still a student nurse:

> *One morning, I was assigned to the neuro-thoracic theatre. I am told to scrub up for the first surgery of the day, but I am not really certain what will be required of me. I watch as the patient is put under anesthetic, his chest area prepped, and the surgeon makes the first incision. When the primary scrub nurse hands me a basket retractor that is when I discover what my role is to be. With the hands of the surgeon guiding mine, I place the retractor around one of the patient's lungs. All I am to do is gently keep the lung out of the way while the surgery is performed.*
>
> *It is extraordinary. The lung, captured in the basket of the instrument, moves in and out with each breath of the patient, while I am holding the other end. There I am, holding the breath of life in my hands.*
>
> *Without even knowing it, I begin to breathe in time with the lung. Deeply, we breathe in… out… in… out… Until the doctor interrupts, "Don't breathe with him* [the patient]. *You'll pass out." I force myself to look away, now acutely conscious of the unconscious rhythms of my body. I try to focus on the retractor and technicalities of what I am supposed to be doing, but I cannot forget how this moment has taken my own breath away.*

There are moments in practice that can catch us unexpectedly. These moments bring to our awareness the extraordinariness of what we do. While they may happen during extreme circumstances, in crises or instances when we are attending at birth or death, they may also arise in more common everyday moments. They may occur, as it did for Andrea, in the middle of attending a surgery where she is simply doing what she is told: carefully holding an organ aside so that it does not impede the surgeon's actions. In that

moment, she is struck abruptly by the miraculousness and incomprehensibility of that to which she is a witness.

With this recognition, the body that she touches and attends to with nursing hands seems to change. No longer does it appear as a lung to be held aside so that the rest of the body can be operated on (the sick body) or as a body to be treated and cured (the medical body). It may even cease to appear as the body of her patient requiring care and comfort. Instead, she finds herself holding within her hands something alive.

We often assert that we are more than our bodies, implying the importance of the person we are within and beyond that body. But in truth our bodies are much more than the viscera, blood, and bones that we suppose them to be. The body is not a collection of parts joined together through an animating force that some call the soul. It is more than even "[its] glances, [its] gestures, [its] speech" that serves to reveal one person to another (Merleau-Ponty, 2002, p.62). Our bodies have a pre-existence, an incarnation, that we rarely ever fully grasp. But when we do – if only momentarily – we may be amazed, awed, and even shaken by it. It may appear unlike anything we have ever encountered despite our daily encounters with bodies. It may show itself in its incomprehensible aliveness.

This is both the most banal and most miraculous of realizations. We all know that living human beings are alive. And we know that if we are not alive, we are dead, even though we may debate the exact boundary between life and death. We know that we are alive when we go to the store, when we tuck our children into bed at night, and when we talk to colleagues. We know that all of these instances combined are what we commonly call 'living' and make up that which we refer to as 'life.'

And yet, the aliveness that shows itself slowly pulsating with each expansion and contraction of the lung seems very much unlike life as we know it and as we live in and through it. It is not the life we refer to when we ask our friends, "How is life?" Or the life we exuberantly feel surge through us when we have succeeded or that stops us short when we have failed. It is not even the life we know when we see a group of children joyfully and artlessly playing. Rather it is that which makes all these things possible. It is the life that is always present to us, infusing every moment of our existence

and yet nearly always overlooked because of how close it is, how enmeshed it is in us.

Most everyday, we are both the closest to this aliveness and the furthest from it. When whole and hearty, our aliveness is the most given to us and yet often the least attended to aspect of our existence. Paradoxically, it may be only when confronted with a broken body – a body cut open, the interior exposed and partitioned, with face covered, a body so unlike our normal body, so inhuman, so other – that we may break through the everydayness of life to being present to our aliveness, itself. It may be the body that no longer appears as a body that can momentarily disclose the body's sublimity: that it exists. From out of the vital organ, the fact of the body beyond the everyday body is momentarily apprehended.

And yet, what is Andrea encountering? She sees the body and the lung. She apprehends that it is alive. But she may be also grasping that its aliveness is contingent; it is given but not necessitated. To use Nancy's (1993) own phrase, she may be witnessing that which traces "the border of the limit" (p. 35) of the living body. In its movement of unlimitation that simultaneously arises with the lung's appearance, she may be intuiting that it need not have been alive, and that may be what makes its aliveness so remarkable and incomprehensible. What is sublime is "the fact *that* it presents itself and *as* it presents itself…" (Nancy, 1993, p. 37). In this instance, Andrea sees existence.

However, this apprehension of the mystery of being alive is brief. Fleeting and fragile, it can be easily overlooked – it is overlooked by each of us nearly every day. And in those rare instances when it is noticed, we can readily habituate to it. We may wonder if Andrea's wonder would wane if she spent her career in neuro-thoracic surgery? Would those lungs simply become yet another body part to be effectively and efficiently managed? Flusser (2002) writes that: "habit rises like a flood of slime along the scale of values and … it swallows all values" (p. 53). With ongoing exposure, Andrea would not only gain practical competence but may also experience a fading away of her wonder. Such appears the nature and paradox of existence: it is both remarkable yet far too given to be noticed.

Yet, in those rare instances when the sublime does break through, it can be *breath-taking*. The body of Andrea's patient may be a broken body for the moment but it is a living, *breathing* body, pulling in and

expelling out the air of this world, her world, our world. Even in reading her anecdote, this breathing body seems to call to ours. Its aliveness calls for our response. As Andrea stands in the flesh before another's flesh, we too are there. Such a recognition can take our own breath away. The breath of the body may become our breath. We touch it and are simultaneously touched by it; hold it and are held by it. Its existence may become our existence. As we see this body living, somehow we know – recognizing with our own body – the mystery that we share with this body. As if in some bodily balancing, its life draws forth our own. Breath matches breath, partaking of the same air, the same world. Bodily rhythms converge. In its aliveness, our aliveness is poignantly revealed.

We may be so drawn to the body before us that, like Andrea, we may unknowingly begin to mimic its movements. As if lulled into the deepest of sleeps, it may cause us to lose the sense that we are separate. And in that moment, we may no longer be conscientious practitioners. The sublime may interrupt and quietly brush aside that mode of existence, a mode that we could not have maintained even if we wanted. We are briefly nothing but being, feeling, alive. Until we are called back to awareness, called back to what we should be doing and who we should be at that moment: an attending nurse.

The Ineffability of Nursing Practice

In sublime moments in practice, we may be brought close, incredibly close, to what normally remains at a distance. Or, rather, we may momentarily discern what is always been before us and so close to us that it has never before been truly noticed. It is as if the everyday undergoes a process of *sublimation*, wherein it is purified by exposure to an extreme element (sublimation, v. *Online Etymology Dictionary*, 2014), "lifted up" and "delivered" to us in its purest of state.

Such knowledge, however, can come at a cost – sometimes a prohibitively high one. It can interrupt our practical relation to the world and may cause us to momentarily cease to be practitioners. We should not forget that Andrea is a novice nurse and loses her nursing-ness to the breathing lung before her. She must be called back by the more experienced practitioner. This is worrying in the middle of surgery. On the other hand, Gwen's nurse fosters the arrival of the sublime to extend Gwen's life. She also acknowledges that, in an instant, the situation could have shifted and called for a

code and she would go there. Gwen's nurse demonstrates a responsive attentiveness to the happenings in practice that Andrea had not yet developed.

In health care, any given situation can go a myriad of ways. The two vastly different nursing situations presented above show how meaningful, yet ineffable the sublime in practice can be. Moreover, when we try to capture it, it escapes us—as it should. Nursing in its practices is always incomplete; understanding and interpretive judgments are always 'on the way.' Understanding and accepting this prevents us from falling into what Bollnow (1979) describes as "restricting ourselves to those objects in which a certainty of understanding is guaranteed by their very nature, but (rather) by venturing out into the uncertain, trying to grasp what is meant and intended… even if it has not been yet brought to full expression" (p. 25). Only in this way will we begin to understand how practice both conceals and reveals itself.

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