Towards understanding the unpresentable in nursing: some nursing philosophical considerations

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Abstract

While nursing practice embodies certain observable and sometimes habitual actions, much inheres in these actions that is not immediately discernible. Taking on Lyotard's exegesis of the unpresentable, I undertake an analysis of the unpresentable as it occurs in nursing practices. The unpresentable is a place of alterity often excluded from dominant discourses. Yet this very alterity is what practising nurses face day after day. Drawing from two nursing situations, one from a hermeneutic phenomenological study and the other from the literature, I elucidate the unpresentable from a nursing point of view. Evoking Lyotard as well as selected philosophers from the continental philosophical tradition, I also question whether nursing in its present discourse is capable of responding to the unpresentable in nursing situations. Through the philosophical stance of presentation and representation, I delineate the urgent need to bring the otherness of the unpresentable into our nursing discourse. Nurses in practice confront a wide array of human differences and diversities and come to the realization that no framework alone can ever really have primacy over the multiform presentations of human suffering that so strikingly evoke alterity.

Keywords: unpresentable, nursing practices, nursing theory, presentation, representation, philosophy.

How is the world given to us? At first, not in representation, from a distance, but in the experience of presence. (Dufrenne, 1987; p. 125)

Rethinking Mind and Body in Nursing was the theme at our Philosophy in the Nurse’s World Conference held in Banff in 2001. This theme evoked rich discussions as we endeavoured to understand the place of
the body in nursing and yet somehow the body kept eluding us. What eventually did come to our midst were elements that took us to the edges of life, i.e. suffering, ethical conundrums, and death itself. Throughout the conference, we were constantly faced with the tension between incommensurate forms of knowledge as the theme of the conference itself suggests. Intriguing to all of us was that this tension led us towards something quite unnameable.

At the end of the conference, we knew that we needed to turn our attention toward politics, ethics, toward those things that might be called ineffable, things not quite contained or recognized in the language of theoretical discourse as they are often difficult to put into words, phrases. Yet the ineffable is always rooted in an experience, an entity that manifests itself in life. Dienske (1985) writes that the ineffable is connected with the ‘atmosphere or world usually at the background of our existence’ (p. 6). Dienske also says that the ineffable is that which cannot be objectified; rather it must be shown. It is a wonder that the flesh itself raised these philosophical themes and claimed our attention to address these ineffable things. Yet are these themes of ethics and politics emanating from the flesh presentable, held within our discourse?

Our thoughts and discussions emanating from the body at the 2001 conference took me to initiate a dialogue at the 2003 conference Philosophy, Ethics, and Politics about those things in nursing that are not easily presentable. Evoking Lyotard’s (1984) writing from the Postmodern Condition where he speaks about ‘the unpresentable’, I began to address the notion of Lyotard’s philosophical thought of the unpresentable from a nursing point of view.1

The unpresentable to Lyotard (1984) are those things that are not easily presented or actually sometimes even present within the discourse. Often the unpresentable is an excluded or an ineffable thing, something difficult to bring to words. Lyotard writes that the unpresentable is often (1) excluded from the dominant discourse where the existing rules of representation fall short of categories into which to place the unpresentable ending thus in its dismissal (Lyotard, 1984); (2) incommensurable with the totalizing thinking of the dominant theories in the discourse where it is therefore subsumed (misrepresented) by something else (Lyotard, 1984, 1988); (3) a horrific unthinkable thing such as the holocaust that defies existing categorizations or its reduction to a single genre or line of thought within the discourse (Lyotard, 1988; Silverman, 2002).

In what follows, rather than developing a full analysis of Lyotard’s philosophical position, I take on Lyotard’s thoughts above as a way to begin to elucidate from a nursing perspective the unpresentable as it shows itself in the practices of nursing. Lyotard’s thought concerning the unpresentable helps us make way to understand elements of nursing held within its very practices. Indeed in this writing, I anchor my discussion in nursing episodes that show the unpresentable while at the same time I search for presentations of nursing that stay close to the realities of the practising nurse. My intent here is not so much to enjoy new presentations of nursing as it is to move closer to nursing as it reveals itself in the unpresentability of practice. In nursing we urgently need to import a stronger sense of the ‘unpresentable in presentation itself’ (Lyotard, 1988; p. 81) into our thinking and acting if we as a professional discipline are to remain attuned to the health of the world’s peoples.

The urgency to speak the unpresentable

What is the impetus for us to speak of the unpresentable other than emanating from the philosophical conferences above? Recent world events previously unthinkable have brought before us a number of events that to many of us would have been and are still unthinkable, not to say a powerful showing of the unpresentable. Day after day, as Stephen Lewis (2005), the United Nations Special Envoy for HIV/
AIDS in Africa poignantly remarks, millions of people in the world constantly live through unimaginable human suffering. Poverty, war, environmental destruction, corporate agendas, striking global inequalities in the distribution of the world resources, racial tensions as well as countless others occasion undue suffering where human displacement, famine, infectious diseases, and absence of proper (or even basic) healthcare services are the daily bread of the majority of the world.

We have had these very situations before our eyes innumerable times. Speaking of Rwanda, Romeo Dallaire (2004) brings us back to the unimaginable extent of human destruction that can happen so quickly while we keep on going almost unawares. The devastating effects of the Tsunami in South-east Asia (December 2004) remind us of our global interdependency. The recent bombings of the London underground (July 2005) also make us rethink the taken-for-granted stability of our political systems and question the priorities of the North in view of the current world situation. We cannot remain oblivious to these events in our discourse or synthesize them into an emancipatory ending. A new form of discourse must emerge here as the unpresentable keeps bursting forth in the midst of our life; a text that awakens a new form of solidarity between the local and the global community or between the presentable and the unpresentable so to speak. Or perhaps between us and the Other as Levinas (1947/1987), Dussel (1996), and other philosophers call out to us.

In nursing, healthcare restructuring including the extensive downsizing of nurses, the administrative practice of part-time positions (Aiken et al., 2002), redefining the way nursing is delivered and shifts in how complex nursing interventions are undertaken have had an eroding effect on the practices of nursing and nurses themselves (Cameron, 1995). Enforced work management models upon nursing practices, tied to prescribed caremaps or care pathways and documentation systems that often delineate a limited scope of patient outcomes (Campbell, 1988a) driven by economic systems, are already in place in many nursing institutions. Systems such as these slowly eradicate articulated nursing ways of knowing and acting inherent to nursing practices. As members of a profession with a large body of knowledge, we must preserve our practice from being overtaken by systems that while imposing their outside criteria dismiss our professional judgement to determine the need for nursing care (Campbell, 1988a,b). How can our theoretical discourse be activated to speak for practising nurses and patients in a way that advocates to administrative systems for strong professionally determined mandates of care? In projecting ahead to the future, nurses continue to question how nursing as a profession will survive these onslaughts at a time when the world projects a serious shortage of nurses on the near horizon (Canadian Nurses Association, 2003).

Thinking about these striking and somewhat unfathomable realities that we face today both in the world and in nursing together with my work elucidating nursing practices has made me ponder not only how the unpresentable shows itself in nursing but also if nursing in its present discourse is capable of responding to these situations. How do we bring to our presence these mostly unspeakable unpresentable things, these acts that defy any representations or any comforting means to be applied to them? Nurses often face unthinkable things in their practices. In reality, much of our nursing work lies in the realm of the unpresentable as we currently see nurses and other health professionals attending to the people affected by the events above as well as responding to the daily demands of their clinical practice.

When we turn to our traditional modes of representation in nursing, i.e. nursing theories, we find great difficulties in bringing the unpresentable into the discourse as the unpresentable is not directly accessible and resists representation. Take for example the bath in nursing practices. If we turn to nursing theories and models, we realize that little if nothing is said in the conceptual representation of the bath about the complexity or the elements of this nursing act (Cameron, 1998, 2004). What does the theoretical representation say about what it is like to stand before a naked human being? Here we realize how the existing rules of nursing discourse have systematically misconstrued this act of nursing that is so ele-
mental in nursing practice as an act of hygiene alone. In their unique understanding and integration of knowledge with the situatedness of practice, nurses develop a particular way of approaching the irreducibility of concrete human situations.

It is difficult to evoke these unpresentable realities through language as they evade linguistic representation. We need to grope for words that take us back to the space where we can bear witness to the fullness of the human condition. In nursing, we need in our discourse to return to the space where ‘the subject is still one with the object, our flesh still symbiosis with the flesh of things’ (Dufrenne, 1987; p. 125). In speaking the unpresentable, there needs to be an entwining of our words with the flesh that takes us to originary ground where the presentable and the unpresentable are one. The diminishing or absence of the unpresentable to meet existing theoretical parameters is a concern for a profession that exists so close to life itself.

**Evoking the unpresentable in nursing**

In this section, I present excerpts from my research study ‘Understanding Nursing and its Practices’ (Cameron, 1998). This study was a hermeneutic phenomenological inquiry where I investigated how to show the complexities that inhere in each act of nursing. In particular, I addressed the questions, ‘What are the qualities of nursing as revealed in the practices of nursing?’ and ‘To what extent do the varying representations of nursing that exist in the discourse of nursing still resonate with the practices of nursing?’ The first question led me to look at the bath and other nursing practices as integral nursing acts and the second to examine how the theoretical discourse of nursing expresses an ongoing tension between presentational and representational forms in nursing. In an attempt to understand how nursing comes to be in its practices and following the tradition of interpretive inquiry (Burch, 1991; Bergum, 1997; van Manen, 1997), I gathered nursing experiences through extensive participant observation and hermeneutic conversations (Smith, 1994) with nurses, patients, and families. I then assembled these findings in a form of writing I refer to as direct description (Cameron, 1998) where I seek to restore to the practices of nursing its own tempo and temporality (Bourdieu, 1977), a (re)presentation of practice, as it were. Below I present two nursing situations one from the study mentioned above and the other from literature, through which I seek to illustrate the notion of bearing witness to the unpresentable in nursing. Following each of these, I offer a discussion of how the unpresentable is always already present in nursing practices.

**Take I: Mr Phillips**

In the middle of the night, at exactly 0300 h, the time of night where ghosts are real and concrete thoughts too easily slip from our grasp, Mr Phillips, an esteemed author, begins to sing. The night nurse hears him singing (at the top of his lungs) and she walks to his room.

**At report the next morning**

*Night Nurse:* Mr. Phillips had a psychotic episode tonight, he hasn’t had this before has he? I couldn’t see it written in the chart?

*Head Nurse:* No he hasn’t, what happened?

*Night Nurse:* Well I heard this singing and banging at about 3 AM. It was coming from Mr. Phillips’s room so I went in to see him. He was really agitated, talking about the sky falling down and he was singing to keep the sky up. He said he felt a piece hit his head. He wouldn’t stay in bed and he was pulling at his IV site. He said the IV pump was his bass and he couldn’t find his bow to play it.
I calmed him down. At this point I didn’t challenge him. I mean that the pump was his bass fiddle; that was where he was. I checked his vital signs. His blood pressure was up, temperature normal. I asked him about pain but he wouldn’t answer. He didn’t seem in pain, just confused. I settled him, told him I’d be back in 3 minutes and went to check the chart. I told him I would stand in the anteroom where he could see me.

I checked out his fluid status, his medications and possible interactions, his blood work. His blood work profile has not changed. He is still severely neutropenic. He has not been getting anything for pain. His temperature has been normal. Electrolytes are OK. Bacteriology reports were negative. There was no documentation that he had ever been like this before. Apparently Dr B has his old charts so I couldn’t check them. I got an order for Haldol but when it started working he fought even more.

It was very hard to see him like this. Basically I just had to stay with him most of the night. I left only to do the things that were essential for the others and Mary took on a lot of my work. He could not be left alone for long. I thought of calling his wife but wasn’t certain if that was a good idea in his state as she too has seemed so distant from this exacerbation. His blood work is back this morning and the values are the same as yesterday, not much of a change in the profile at all.

His wife was visiting when I started my round but she left about 8 PM. I called the resident but he was reluctant to order anything in case it was a drug reaction, so basically we just sat in the room all night, sat on his bed, trying to reorient him but mostly keeping him safe.

He was really odd. He is sleeping right now, he fell asleep about 1/2 hour ago and he is really out. I think he exhausted himself. But even as he sleeps he fights, he is having huge myoclonic jerks. Gosh that guy is strong, he has worn me out keeping his arms away from his IV site, his pump, trying to keep him safe. He was not combative or anything, just determined. I didn’t need security. I could most of the time talk him out of things, or keep him talking about something bizarre that he had brought up, or singing with him. He was gentle about this outburst, but it is really disconcerting. Well we made it through anyway, I hope when he wakes up he is in himself again.

Staff Nurse: I have been off a few days but does his wife still visit him in her silk suits and read the newspaper? Not that there is anything wrong with that, but I don’t think she has engaged much yet in this reoccurrence. He might be reacting to that, I think he’s been really alone through this.

Day Nurse: Well she asked for some clean sheets and towels for him yesterday before I left at 7 PM, so I showed her where to get all of that and to feel free to help herself and to call us for help if they needed it. When we were in there making the bed she left the room. He was very quiet.

Head Nurse: It could be the human gamma globulin. Some people do get an episode like this, when did he last have it?

Night Nurse: Two days ago and he is due for more today.

Head Nurse: I think we will hold it until we can discuss this with the doctor. I’ll go in and talk to him this morning too. I think we just need to keep him talking. I’m sorry to see him like this, he is such a dignified man. He told me he just published a new book.

Night Nurse: All I can say is watch him closely. He is somewhere, I’m not certain where but it is important for him to be there right now. He is just plain scared. He needs to work out that this may be his last exacerbation I think and the nature of this kind of episode gives him permission to do so. His sky really is falling down. He needs to connect with us too and not just the doctors. Apparently his doctor told him he has had his last remission. Last night I think he really saw what is stretching out in front of him and he is very very frightened. Just watch him. I don’t have a good feeling about him, he could go any way today. We need to get his wife on board.

(Re)presenting this to you

Surrounded by continuous conversation, a text of nursing weaves itself together as one shift of nurses prepares to leave, the new shift prepares to nurse, and one exhausted patient finally sleeps. In this emerging text, Mr Phillips and his singing has erupted into the nursing world and much is needed to understand. There is concentration in this conversation; exceptional nursing work as one nurse tells and others hear and integrate these knowledge pieces; all individual pieces yet to be woven into the text of understanding. Together, the nurses build a true intertextuality where the text does not just represent one’s own subjectivity, one’s own interpretations, but an intertextuality that works hard to leave nothing out.
Roland Barthes (1977) writes that the text is a tissue, a woven fabric, and I would suggest a living tissue having come from trees, linen, cotton, and a human hand. He also writes that the weave of the garment is woven from threads already written and already read, that intertextuality is a given of text and each text is in relation to many other texts. In Mr Phillips’ situation, there are many concealed texts that are not immediately discernible. At first sight we could say that this is a man with an episode of delirium. Yet this is the first layer to understand the text of this situation, an initial albeit necessary approximation only. If we stayed with this layer alone, we would be unable to understand the interwovenness of the many texts present here (and yet unpresent). Mr Phillips’ nurse is able through her present engagement to see the hidden texts that lie behind this delirium.

Tonight Mr Phillips has realized the nearness of his mortality and a piece of his sky has indeed fallen. His mortality, something we in our everyday lives are able to hold at a distance from ourselves, has hit his head and become a very concrete possibility. In fact, the uttermost possibility of his existence (Heidegger, 1927/1962). The unpresentableness of life has abruptly entered Mr Phillips’ room as his delirious state takes over his immediate existence. It is, in fact, an eruption of the unpresentable into our very midst. And especially so as this now delirious body is such a contradiction in this esteemed author’s life. It is indeed an existential contradiction (against speaking, Skeat, 1958) as this moment speaks against the very text of his ownmost existence.

Always this eruption of being brings with it a need for the nurse to be directly with it; to directly apprehend it, to engage existentially with it, before the conceptual or diagnostic layer can be threaded through. We hear her thinking forward of the episode, her interpretations, her clinical judgements, her having a nursing dialogue to extend and clarify her understanding. In truth we see a nursing hermeneut in full action, one who is able to quickly read and understand the many texts present here and translate them into nursing Mr Phillips. One way to look at this episode of delirium would be to see it as a metabolic disorder or a psychological emergency alone, but that is the presentable part, one element of this episode; the pathological approximation. Dussel (1996) writes that pathology is the only way alterity can enter our discourse in the modern age. In Mr Phillips’ situation, to stay with delirium is to stay with the lens of pathology. There is a hidden, an unpresentable text here that pathology forgets. It is the very otherness of this situation that introduces an element that remains foreign when we stay with this layer alone.

When in this situation a theoretical layer is applied alone as a univocal account, these deeper, hidden texts fall away and the unpresentable cannot enter the discourse as it does enter Mr Phillips’ room. It remains other, foreign, out of place, unrecognizable. The unpresentable part is being-with, staying-with the delirium and understanding its presence as it works itself through his body, his life. Much later before he died, Mr Phillips told me that this single event in his illness trajectory turned him and his wife toward his approaching death. Through the nurse’s actions in this situation, Mr Phillips knew he could trust to be cared for until the end. In his own words, he saw ‘what stretched out before him and felt the nearness of death for the very first time’.

If we evoke Levinas (1947/1987) here, we might say that the night nurse sees Mr Phillips’ coming death. This coming death, invisible to him as ‘pure otherness’, which he is unable to see as yet, is taken on by the nurse sitting on his bed; she sees death before him. This nurse has ‘become an accomplice of the death to which the other who cannot see it, is exposed’ (p. 83). In this complicity, the nurse is able ‘to accompany the other in his mortal solitude’ (p. 83). In her actions, there is an existential recognition of the otherness of this delirious episode while also the awareness that without looking at serious illness and death in the face one cannot presume what another goes through.

Tonight Mr Phillips’ night nurse’s place of nursing has been disrupted and these interruptions are what much of nursing is about; something happens to our patients and we go there. Nurses often have to engage with the unpresentable in their practices. To be present to the unpresentable is what makes nursing a profession of the primary. To be a profession of the primary is to directly apprehend originary being, that which is coming to unconcealment with our patients and families and ourselves as we nurse. The unpre-
sentable in nursing practices evokes a tension between presentation and representation and we as a discipline with a practice profession must remain attentive to it in our discourse. The tension we are faced with is how to present it without falling into representational modes alone. I examine this tension in the next section.

The tension between presentation and representation in nursing

Gadamer (1981) laments that today theory has become synonymous with science and its applied methods. He evokes the ancient notion of theoria as ‘the highest manner of being human’ (Gadamer, 1989; p. 454). Theoria in ancient times did not have the ideal of objectification that is present in modern science. In ‘The Enigma of Health’, Gadamer (1996) pursues this line of thought as he questions whether it is possible to go back to bodily experience after the objectification that results from modern science. He asks, ‘Can science be connected once again with our own lived experience or must the experience of one’s own individuality be lost irrevocably in the context of modern data banks and new technology?’ (p. 72).

Gadamer’s questions take us back to Mr Phillips’ nurse who does not only turn toward her objective body of knowledge, but rather blends her nursing and clinical knowledge of delirium with the contextual nuances of Mr Phillips’ situation. Here we see not only how the nurses access their knowledge system but also how they apply it in a concrete nursing situation. Mr Phillip’s nurse does not relate to her knowledge system alone in isolation from the situation. Neither does the nurse carte blanche apply universal principles of nursing, or preset categories of thought devoid of context, ignoring the other nuances of the situation. Rather how she relates to her knowledge system is evoked through her relation and knowledge of Mr Phillips and his particular situation. She considers what is happening from an englobing perspective so to speak which in turn enables her to act in a minute particular way.

To understand how a particular situated and timely nursing act happens, how the nurse recognizes and incorporates the unpresentable into her thinking and acting is integral to comprehending nursing as it comes to presence in the world of practice. So in this section, I put forward the question, ‘does our discourse have the capacity to address the unpresentable in nursing?’ Or as Lyotard (1988) writes ‘is it happening?’ (p. 70). Are these unpresentable, often ineffable elements that inhere in our practice, being held within our theoretical discourse? Is the unpresentable coming forward ‘in presentation itself’ (Lyotard, 1984; p. 81) in nursing or is it hiding in representational form?

According to Skeat (1958), etymologically the word present comes from the Latin word præsens meaning near to or in front of being. Present is to stand before the nearness of being. To present nursing would be to show it as it stands before us, to break open the ‘being’ of nursing so to speak. On the other hand, represent comes from the word representor which in old French means to exhibit the image of; to act the part of; to bring before one again. To represent nursing then is to place something in front of nursing at a distance from the aliveness of it; to not be directly involved in it, to be at a bodily and cognitive distance from it. Always at the heart of representation is a reductive and discriminating element; a representation self-selects the knowledge it will depict. Thus the represented world loses the power to insert itself back into the world because it selects in advance the concept that stands for the being of nursing. It presents ‘the object by its outside, or its envelope’ (Merleau-Ponty, 1964; p. 172).

My intent here is not to artificially polarize nursing in two poles as presentation (nearness to the unpresentable) and representation (self-selecting something to stand before the nearness of being) and thus add another conceptual layer here. Rather I want to question how within this constant tension between presentation and representation in nursing we can still hold a nearness to the unpresentable. It is here where I think we need to turn once again toward the place where the unpresentable is always already present, the place where nursing happens. In this place nurses constantly experience the tension between presentation and representation as they move back and forth between the rawness of their patients’ situations and the daily institutional workings that they face.
Going back to the bath, when in our theorizing we represent this act of nursing as a mere technical procedure to achieve a specific outcome, i.e. to remove a hygiene self-care deficit, we fail to recognize the nurse’s clinical judgement that goes with these sometimes deceptively simple acts. In doing this, we open the door for the management system to pass this integral act of nursing to less skilled workers thus reducing it to an almost incidental act bereft of its ownmost nursing properties. In aligning itself with modern science pursuits, our theorizing ‘lends itself to the unitary and totalizing practice of the system’s managers’ (Lyotard, 1988; p. 12) to the detriment of our professional practice. As a practice discipline we must be cautious when our theoretical frameworks are difficult to translate into the practices of nursing as they obscure or reduce the unpresentable to a mere incident.

Through nursing acts nurses are able to bring about a relation and as they do this, they bring nursing into the world in a specific way for this situation that can never be caught, represented, universalized. While nursing acts in general have a basic structure that assists the nurse in the safe performance of the act, i.e. monitoring oxygen saturation levels during the turning and positioning of the critically ill patient, much of nursing lies in the realm of the not-yet. The basic structure of the nursing act cannot speak to the not-yet that nurses face as they perform the bath with a particular individual. This is the problem with the theoretical representation: it illustrates the work of the nurse, but it does not present its component parts, its whole, how it is constituted moment by moment in response to a particular situation. In fact, theoretical representations remove the nurse’s judgement from the nursing act. They turn nursing practices into mechanistic operations with predetermined ends judged for their use not their intrinsic worth.

Lyotard (1988) writes that our ethical problem and indeed our ethical demand is to bear witness to the unpresentable as it exists in the world. This ethical demand he writes is always upon us. Returning to Gadamer (1996) above, there is a need for watchful vigilance in our theoretical discourse to protect our ethical commitment to the practising of our profession. As our understanding of the global health situation grows, as we also increase our understanding of how our discourse affects the developing world, we come to realize that our nursing discourse needs to be re-examined, rethought in its ethical congruency with our practising and teaching nurses as well as the global community of nurses. We must also be conscious of our ethical responsibilities to countries that import and apply nursing theories developed in a wealthy and specific cultural environment. We can no longer let hegemonic forms lead our discourse. If we continue to do so, we jeopardize our professional mandate to be responsive to and responsible for the world’s health.

**Apprehending the tension**

The tension that we are faced with when addressing presentation and representation in nursing is: can nursing ever become presentable alone? The difficulty in bringing presentation into a text is that the unpresentable resists showing itself in presentation. It tends to stay outside the discourse, in the margins. I think here of bell hooks’ (1990) spaces of resistance that flourish in the margins. Is it not in these spaces where we are able to sustain life? People enduring continuing political hardships often go to the margins to recover themselves, retrieve their breath. Mr Phillips’ nurse also endures his trial as she brings him through it. In enduring the unpresentable, nurses are able to hold the very nakedness of life, life at its edges, breath. Is the unpresentable not also another space of resistance that claims immense ethical attentiveness and respect?

In discussing marginalizing practices in health care, Hall (2004) turns to practising nurses, those out there in the world engaging in health situations both dire and ordinary. She writes that theories and models have taken practising nurses to the margins of our discourse. One might also wonder if along with this marginalizing, what we are also seeing today is nurses retreating to the margins as the theoretical text in their discipline (and the managerial one) no longer resonates with their daily practices. Nurses, as we see in Mr Phillips’ situation, weave a complex text that includes many elements that remain otherwise concealed.
While it is important to recognize the scholarly work of theoretical endeavours in nursing, it is also necessary to revisit this work and its resonance with nursing practices. Sartre (1940/2004) in his philosophical exegesis of the image writes that a photograph gives us one glimpse of something and no other context or interrelations or changes over time can be added to it. It is a static event. When we are confronted with the image generated through theorizing, we come to experience the dissonance, bodily, and cognitive, with the daily lived practice of the nurse. In the context of pedagogy, van Manen (1997) asks ‘what is the significance of theorizing and research and scholarly thought if they absolutely fail to connect with the bodily practices of everyday life?’ (p. 148). And in the context of nursing we might ask, what is the significance of theorizing if this endeavour leads us to cover the unpresentable with conceptual layers that in turn obscure the nurse’s work?

With the title I have chosen for this section, I would like to bring our attention to the conjunction and. The and here holds our tension as, I evoke Dufrenne’s (1987) thinking here, it may ‘designate a relation of opposition as in being and non-being. But it can also mean a relation of priority as in cause and effect, or even a relation of complementarity as in form and content’ (p. 69). The and helps us here not to exclude any of these possible meanings from our text (including the text of the theory) and also to be mindful of the tension that this interwovenness generates in our midst and that practising nurses and the nurses of the world always embody.

Take II: the English Patient

I would like once more to go to a nursing situation and try to speak about the unpresentable in a wartime context. In wartime situations we experience horrific events that hold the unpresentable. These world events are even more present today and yet so hidden that we personally dismiss them, hold them at a distance to ourselves as we move about in our lives. Like in our discourse, we tend to cover up the unpresentable, to make it invisible in our daily lives. Yet nursing always goes there.

Consider the bath in ‘The English Patient’ by Michael Ondaatje (1992). This story is situated in the aftermath of the Allied invasion of Italy where the Allied forces push the Nazi army northward. The medical and nursing personnel follow close behind the Allied forces to treat and tend to the wounded on the combat lines. Seriously injured soldiers and civilians and a few nurses are evacuated from temporary field medical stations to Italian hospitals recently liberated from the Nazi Regime and others follow the push North. A young Canadian nurse chooses to stay behind in a nearby Italian villa with a severely burned patient who cannot withstand the move to the hospital, some distance from the field station.

Every four days she washes his black body, beginning at the destroyed feet. She wets a washcloth and holding it above his ankles squeezes the water onto him, looking up as he murmurs, seeing his smile. Above the shins the burns are worst. Beyond purple. Bone.

She has nursed him for months and she knows the body well, the penis sleeping like a sea horse, the thin tight hips. Hipbones of Christ, she thinks. He is her despairing saint.

He lies flat on his back, no pillow, looking up at the foliage painted onto the ceiling, its canopy of branches, and above that, blue sky.

She pours calamine in stripes across his chest where he is less burned, where she can touch him. She loves the hollow below the lowest rib, its cliff of skin. Reaching his shoulders she blows cool air onto his neck, and he mutters.

What? She asks, coming out of her concentration.

He turns his dark face with its grey eyes towards her. She puts her hand into her pocket. She unskins the plum with her teeth, withdraws the stone and passes the flesh of the fruit into his mouth.

He whispers again, dragging the listening heart of the young nurse beside him to wherever his mind is, into that well of memory he kept plunging into during those months before he died. (Ondaatje, 1992; pp. 3–4)

Michael Ondaatje brings a small piece of experienced life to the fore; he brings it into being, so to speak. For our purposes, he presents it for us and to us. And Hannah, the nurse, not only presents nursing for us, but through the act of bathing, elements of nursing itself. Here the nurse is present, committed, absorbed. This is not a routine task to be done, but a
complex act full of judgement and skill. It is this nurse’s enacting a fundamental nursing act in a certain way that pulls at us. She gives the English Patient his dignity, his living.

Hannah deals with extreme embodiment. Bodily care, normal maintenance, and those bodies in extremis are ever present entities in nursing practice. The story does not mention the smells, the odours that would emanate from the English Patient’s body, or the sight of burns, the black scar, the hard crust that harbours necrotic tissue, the psychological horror of seeing the overt disfigurement. Somehow these aspects of the English Patient’s body and bath are just taken for granted as part of the ordinary wartime scene. Rather, Ondaatje concentrates on the nurse’s actions and on the English Patient’s body; her absorption in what she is doing, her attention to the body as is, how she knows that there is at least one part of his body that resembles normality; ‘the hollow beneath the lowest rib, its cliff of normal skin’. There is an immediacy to this act of nursing. The English Patient’s body has become as familiar as her own.

When he mutters, she understands, he is hungry. When it is a chilly night and the English Patient is shivering, she lies beside him to share her body heat with him. Hannah, the nurse, stands alone here. She does not have technology, supplies, resources to employ in her care. She has only herself, her nursing skill, a bit of cloth, a bit of morphine. Yet she weaves a text of nursing that is elemental and profound. A harmony forms, a mutuality, despite the disfigured body.

What is it that motivates this young nurse? This is a war that has pushed the boundaries of humanness and overturned all there is to know about being human. To be human will never be the same after this war. Incomprehensible actions have been done to human beings in concentration camps. Never again will the term ‘murderer’ have the same connotation again; there is no known form in the history of the world yet to absolve humankind of the nature of these atrocious acts (Arendt, 1994). Yet despite her background, her recent personal traumas, here is a tiny island of human caring; a skilled, devoted nurse with a listening heart, a patient with desperate needs, and what happens between them. There is something unforgettable and irreplaceable in this nursing bath.

Ondaatje also opens another door for us to ponder. Hanna herself has had to deal with her own unpresentable in her life; the recent death of her fiancé, her fellow nurse the victim of a land mine, and the tragic death of her father, a labour activist, back home. Nursing in its very acts through encountering the stranger/unpresentable in the other almost always makes us confront the stranger/unpresentable in ourselves. Indeed, Kristeva (1991) writes that what we most have to fear is not the alterity of the foreigner but the otherness in ourselves. Hannah gives us here just a little glimpse of something else inherent in nursing that eludes representation. Even though the nurse endures the unpresentable in herself, she is still able to nurse the unpresentable in others.

When this part of the book was read on Canadian Broadcasting Corporation Radio in Canada, there was the sound of water in the background. You could hear the nurse agitating the water, wringing out the cloth in the basin. Also in the book and portrayed in the movie, after a few hours of sleeping Hannah tip-toes into the English Patient’s room. She does what countless numbers of nurses have done before her and will do again; the timeless act of entering a patient’s room. You enter the room and you notice, you listen for what is different; their voice, their breathing, the smell, the sense of presence, all elements that remain invisible to the reader and need to be woven into the evolving text. Hannah walks slowly up to the English Patient and puts her nose right up to his to see if he is breathing. The English Patient opens his eyes and whispers, ‘I’m here, I’m always here. This little bit of breath I have, it never leaves me.’

It is these seemingly invisible elements that show how much inheres in a single nursing act. A person standing in the doorway watching Mr Phillip’s nurse sitting on his bed or watching Hannah feeding the English Patient, might not be able to see the full text of the situation, to understand the full structure that underlies these actions of nursing. Yet nursing acts do have a structure that continuously evolves. Gadamer (1998) writes in ‘The Beginning of Philosophy’ taking his text from Dilthey that structure denotes a con-
connectedness among parts, an interplay among effects, in which no one part is thought of as having priority. This evolving interplay of both unpresentable and presentable elements is very much what constitutes the structure of nursing practices.

As we see here, the bath in human experience and the bath in nursing practice is sometimes much less about getting clean than it is about something else. For some, the bath is a symbol of grace, of benediction, of cleansing in a bodily and spiritual sense. It is an absolution of sorts. There is a sense of this with the English Patient, the nurse’s care and relation assists him to work forward through his memories, his hauntings, his life written on his body. The nurse’s presence and engagement also enables this individual to face his own death. At a time when Hanna’s patient is ‘no longer able to be able’ (Levinas, 1947/1987; p. 74), she, as his nurse, is able to re-enable him to go there.

### Turning towards the unpresentable in nursing

The unpresentable is always present in the work of the nurse. We cannot forget the nuances of war, of conflict, that somehow nurses absorb and still nurse. Hannah embodies both the horror and the tension that comes from the many dubious sides of war. Nurses like Mr Phillips’ nurse, Hannah and many nurses in the world always face this tension in their extreme proximity to the edges of human existence. Nurses in practice confront a wide array of human differences and diversities and come to the realization that no framework alone can ever really have primacy over the multiform presentations of human suffering and of practice itself. This is the humbling insight that the skilled nurse and the skilled clinician develop as they are relentlessly exposed to the vulnerability of life.

Throughout this text, we mark the tension between representational forms and the unpresentability of life, yet we also know that language limitations often prevent us from addressing this tension. Whereas in modernity, we are mostly apt to resolve, reconcile, or reduce difference, we must learn how to turn our attention towards alterity without transforming it into sameness. We must search for ways to address the otherness of the unpresentable in nursing and courageously bring alterity into our midst.

How can we remain attentive to otherness when theorizing in nursing and its modernist sequelae to erase difference still holds sway in our discipline? In a sense theorizing has left us bereft and weary. It is this ‘weariness with regard to “theory”’ (Lyotard, 1988; p. xiii) together with devastating world events that pose a claim on us to return to the originary space where nursing exists. It is in our turning to this originary space that we are able to develop a dialogue amidst conflicting positions.

Perhaps it is here that Lyotard’s (1988) notion of the différend comes into view. In addressing the incommensurable, Lyotard introduces the différend when he urges us to identify and bring into each of our discourses, the unpresentable. The différend is a ‘case of conflict, between (at least) two parties, that cannot be equitably resolved for lack of a rule of judgement applicable to both arguments’ (Lyotard, p. xi). Silverman (2002) further elucidates Lyotard’s différend:

> Différends butt up against one another and render understanding from either side impossible. The one side cannot explain its position to the other side and vice versa, for the positions are so radically incompatible that understanding is a misplaced category … the task becomes one of identifying the différend itself, where it is, what it is, how it functions what makes it operate, what underlies it, what gives it life. (Silverman, 2002; p. 2)

Often there are no words, no phrases yet that define the différend and this is where the identification of the différend becomes important in a discourse that holds opposing positions. ‘In the différend, something “asks” to be put into phrases, and suffers from the wrong of not being able to be put into phrases right away’ (Lyotard, 1988; p. 13). In our discussion here, it is the unpresentable that erupts within nursing practices that claims to be acknowledged. It is this ‘pressure of the unspeakable’ (Barthes, 1981; p. 19) that compels us to recognize and delimit the différend as a way of addressing the tension between presentation and representation and begin a dialogue with otherness as an integral thread.
of our emerging text. When we are able to begin a dialogue and weave our text with the text of otherness, we come to realize the impossibility of universal or hegemonic knowledge schemes that either ignore or assimilate the other (Santos Salas, 2005). In weaving our text with the text of the unpresentable, we give origin to a co-text where the totalizing effect of theorizing can no longer obscure the full spectrum of presentation itself.

It is this notion of the différend that invites us to be attentive to the continuous tension between presentation and representation that we as a practice discipline constantly face. It is a vital part of our ethical stance to weave co-texts in nursing that enable us to build a context (etymologically weaving together) where plurality and diversity are recognized. Practising nurses do this in the moment by moment drama of nursing. When nurses are impeded from embracing difference and must practise within the aegis of a universal technological framework alone, the co-text is lost. When univocal frameworks are imposed on nursing practices, nurses are marginalized as they are ‘collectively co-opted into “caring” that is incomprehensible to them’ (Hall, 2004; p. 51).

Here I seek through the philosophical stance of presentation and representation, to find out what makes understanding the unpresentable in our discourse difficult. We must continue to talk about the unpresentable, about those things in the stories above that must be read at an intertextual position. What stretches before us as a discipline is to be attentive to the living through and the acting out of the unpresentable in our midst, how it resists coming to presence, how we must move in and between and among presentation and representation as the practising nurse does. Nurses in their practices find ways to reconcile themselves to this tension as they nurse. We must include the unpresentable in our emerging texts to show the ineffability of nursing as it is enacted, performed perhaps? We must bear witness to the hiddenness of the being of the Other.

Gadamer (1981) exhorts us to take the ‘concepts that have become rigid and lifeless and fill them again with meaning’ (p. 89). This is not to say that all our concepts no longer work. It is to say, let us initiate a dialogue about them in light of the unpresentable and ethical attentiveness. We need to refurbish our discourse and take it to originary ground. We must resist hegemonic syntheses as we deal with individuals, families, communities, global areas where each have their own understanding of health and illness. In this coexistence, ‘comes the humbling insight that there is a lot that we don’t understand, that we lack even the adequate language to describe these differences’ (Taylor, 2004; p. 196). We must be able to respond to the différend.

The world situation invites us to develop ‘a particular constellation of instances which is as contextual as it is textual’ (Lyotard, 1988; p. 194). It is within a plurality of instances that we are able to coexist with difference. This is the ethical demand of our current social and political con-texts. For me, the profession of nursing is so precious, so remarkable in its nearness to being in its fullness of life that we can no longer stay with representation alone and forget alterity. The world moment is calling our frameworks into question. The world needs new air, new breath. Let us be attentive to the breath of the world.

References


References


References
