Journal of Applied Hermeneutics
October 25, 2016

Knowing People and Interpretive Practice

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Abstract

This paper is my response to the statement "All nursing is interpretive." Using an exemplar from my experience as an outreach nurse with the homeless population, I provide my perspective on how nursing is not only interpretive, but how interpretation is an integral component of nursing practice across practice settings. It is demonstrated that interpretation not only helps us to *know* people, but can also help us navigate our settings and at times keep us safe. It is written in the first person from the perspective of the first author.

Keywords

Hermeneutics, interpretation, nursing, mental health nursing, outreach nursing

I (Turcato) entered into my career as a mental health outreach nurse when I was a new graduate. I continued with outreach nursing until just recently. When I reflect back on the years I spent working alone in the community, I at times wonder how it was that I kept myself safe. There were many aspects of the job that were hazards to my safety. There were homicidal clients not wanting to take their medication, or unknown guests hiding under the bed. At times, violent pets would greet us at the door, along with intoxicated relatives. There may have been weapons in the home, and every once in a while a known drug dealer would make a cameo appearance during an in-home session. With little protection from these hazards, and the continuing presence of such hazards in current day outreach work, I have always found myself interested in how nurses maintain their own safety when working alone in the community. In conversation with these nurses, I have often heard that they keep themselves safe at work because in one way or another, they *know* the people with whom they work. In the following paper, I will focus on the outreach

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nurse's work as an interpretive practice, and how this relates to the outreach nurse *knowing* their patient. Throughout the paper, I will use an exemplar that is adapted from real practice in order to illustrate aspects of outreach nursing. The following is the beginning of my exploration of the outreach nurse using the lens of "nursing is an interpretive practice."

Marvin is Dying. Again.

The nurse glanced at the alarm clock on the side table. Three thirty a.m. She knew the culprit, the one who had woken her from sleep by bringing to life her worn blackberry that her workplace had provided. "Marvin…" she exhaled as she reached to answer the singing blackberry.

"Hello, you've reached the on call line, this is Whitney." She tried to sound inviting.

"Whitney, it's Marvin. I'm dying,"

The nurse took an exasperated deep breath before replying; "You're not dying Marvin."

To which he predictably retorted "Yes I am. I'm dying."

The nurse smiled a little. Marvin, a 45-year-old aboriginal man, had always been one of her favourites. Despite his weathered appearance, short temper, tendency towards alcohol and crack abuse and despite struggling with schizophrenia and fetal alcohol spectrum disorder, Marvin seemed to make friends wherever he went. She admired his spirit and his resourcefulness.

"Marvin, if you're dying, then how are we going to go bowling tomorrow?" She was grateful she had something to distract him with. Bowling happened to be one of Marvin's favourite activities, and the recreation group happened to be doing just that tomorrow afternoon.

"We're going bowling tomorrow! Yeah, sure, right, I'll see you tomorrow!" And with that, he left the nurse to finish what was left of her sleep.

Perhaps the reader is disappointed by this nurse's response. "She didn't even complete a mental status exam" or "she should have assessed his physical well-being" are some of the critiques you could be making. Perhaps the reader is afraid for this nurse's license. "You can't just ignore someone when they say they are dying!" Perhaps you are wondering about the efficacy of bowling as an intervention to prevent imminent death.

Before you rush off to perform an Internet search for scholarly articles pertaining to death and bowling, let me put these wonderings and worries to rest. This nurse was not acting negligently, she was not ignoring Marvin's concerns or mortality, nor was she slacking on her nursing duties. This nurse was providing excellent nursing care, utilizing an aspect of nursing that is ever-present and often overlooked. This nurse was interpreting.

The Interpretation of Dying

The next morning at the daily meeting, the nurse giggled and rolled her eyes when she told her coworkers about the phone call. They were all too familiar with the early morning calls from Marvin. Some of the team members reported being on the phone with Marvin for up to twenty minutes trying to convince him that he was not dying. Clearly, she had entered into a conversation that was there all along. The nurse shared her late night thought process.

"I think that he's becoming very lonely now that he's out of the shelter and in an apartment by himself. He's great at finding people to chat with during the day, but at night the on call line is his only source of human contact."

As stated in Moules, McCaffrey, Field, and Laing (2015), "Precisely because language is endlessly proliferative, any given word, statement, text or interpretation is finite within the world of meaning" (p. 36). The healthcare team was able to interpret Marvin's word "dying" to mean something that it does not conventionally mean. This was a man who was trying to convey his emotional pain to someone who could help - and was able to do so - because nursing is an interpretive practice.

The popular perception of nursing is that we are in the business of *knowing* the anatomy of the human body, the diagnoses that ail our physical being, and the treatments that can be utilized to save lives. The truth is that nursing encompasses much more than anatomy, diagnosis, assessment, and treatment. Nurses are in the business of *knowing* people. As nurses, we are constantly balancing what is tangibly in front of us, with what we are sensing, inferring, or interpreting. Using our previous experiences with the client in front of us, or using experiences from clients who have been in front of us before, we are able to interpret further into what may be lying just under the surface. This *knowing* of people is not static, and is forever changing. *Knowing* people is rife with interpretation. What we *know* of people now, or now, or now will contain different truths, and these truths will be different for each of us. These truths are contingent on context, histories, perspectives, and experience, and thus are ever changing and far from universal.

Listening to the Spidey Sense

Two months later, the nurse parked near the apartment building where Marvin lived. It was time for their first meeting of the week. Usually, they spent their hour catching up on what trouble Marvin found himself in over the weekend, or what he'd been watching on T.V. They usually chatted while the nurse helped him tidy up his apartment, using this time as an opportunity to assess his mental status and general well-being. As the nurse entered the building, and approached Marvin's front door, she began to feel that something was different. Something wasn't right. She subconsciously felt for her worn out blackberry, making sure it was near her if she needed it. She knocked three, maybe four times. Marvin wasn't answering.

The nurse remembered many conversations she'd had with her seasoned coworkers. They often spoke of that "spidey sense"- when they were certain something was not right, although they couldn't explain how they knew. They had encouraged her to always listen to those senses- better

safe than sorry, they'd said. The nurse called the front desk at the office "Hi, I'm just at Marvin's place. I'm going to try his front door, something's not right and he's not answering. Can you stay on the line with me? Just in case." The secretaries were seasoned in these sorts of phone calls. The nurse pushed on Marvin's front door- it was unlocked and opened just far enough for the nurse to see inside. Marvin was lying in front of the door face down on the tile. He was unconscious.

Each interaction that we have as nurses informs the next interaction that we have. We are in a constant state of gathering new knowledge and information, and it is with this new knowledge and information that our perspective is changed, and we are changed. Not only are we changing as these events keep happening, but the world around us is also changing and evolving. Our understanding is never static, and is always adjusting in relation to who we were then, who we are now, as well as what setting we were in then, and what setting exists now. This dance of temporality continues on; we collect new information and knowledge and thus a new perspective. All the while, new events happen around us, creating a new setting.

In nursing, it is through this process- through new interactions, new information, and new settings - that we begin to *know* people. Nurses are able to *know* that this heart rate is elevated due to nervousness, and not pathology or this baby's cry is telling us something is wrong, or that Marvin is lonely and not dying. We *know* these things not because we have concrete evidence. These things are not explicitly stated. We *know* these things because we are excellent interpreters.

The Emancipatory Event

Once the acuity of the event had subsided, and Marvin was away to the hospital to be cared for, the nurse had time to reflect on what had happened. At some point, she had sensed that something was different when approaching the apartment building. The nurse was addressed by an event of some proportion. This event made the familiar and comfortable world all of a sudden feel strange. The nurse's way of being was disrupted, and that which she had taken for granted- that she would arrive to Marvin's home and his home would greet her the same way that it had done for months prior- was suddenly something to be questioned. This sudden jolt forced her to step back from her deep absorption in the familiar world. The event ever so subtly asked her to examine from a different angle, and to interpret from a different vantage point. The event, however mysterious and evasive it may have been, revealed paths that she had not before noticed and she then exercised judgment and chose to explore a new path. This new path was illuminated only by the event. She was suddenly emancipated from the chains that she had been unknowingly bound by, and was able to keep herself safe.

At times, nurses perceive the intangible, and are interpreting at a level that is even below consciousness and is almost innate. Whether we call this our "nurses intuition" or the "spidey senses," we are often reflecting after the event thinking; "how did I know that?" We are able to *hear* the unsaid, at times being completely unaware of the process that our experience is guiding us through; for examples: when a client walks into therapy and without tangible reason, we sense that something has shifted within them; when a patient walks into the waiting room, and the triage nurse senses an emergency before he collapses to the floor; when the outreach nurse knocks on a door, and knows something is wrong on the other side. When we reach a place

where we are absorbed in our practice, the phenomenon of *hearing* the unsaid happens regularly, and at times appears to be an innate sense. These instances happen across practice settings and can be said to be the essence of nursing as an interpretive practice.

Conclusion

Outreach nurses pride themselves on *knowing* the people that they work with in the community. The way that we know our patients is innately interpretive and is based in language, historical context, current settings, experience, and conversation. While the subject of *knowing* our patients as outreach nurses requires further inquiry, perhaps in the form of qualitative research, the above may serve as a platform for such further inquiry. It is also worth mentioning that this is one representation of how outreach nurses keep themselves safe while working alone in the community. It is one possible response to the statement "Outreach nursing is an interpretive practice."

References

Moules, N.J., McCaffrey, G., Field, J.C., & Laing, C.M. (2015). *Conducting hermeneutic research: From philosophy to practice*. New York, NY: Peter Lang.