

Hermeneutics as an Approach to Inform Spiritual Care-giving Practices at End of Life

by

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Bachelor of Science in Nursing, University of Victoria, 2007

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Abstract

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Hermeneutics, the art of interpretation, has traditionally been an integral part of nursing research; however, little attention has been devoted to nursing's pivotal role as interpreter in the context of nursing practice. Guided by a hermeneutic philosophy, nursing practice is informed through engaging in a dialogic or conversational journey, a way of *being*.

The aim of my project is to illuminate the possibility of introducing a modified four-fold hermeneutical model of interpretation as an approach to inform spiritual care-giving nursing practices at end of life (Charalambous, 2010). According to this model, a patient is perceived as a literary text and the process of interpretation unfolds with: (a) the object of interpretation, (b) the mode of interpretation, (c) the praxis of life-affecting response flowing from the interpretation, and (d) the change of life-world brought about through the interpretation (Charalambous, 2010). This model is illustrated through the presentation of a practice exemplar.

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Dedication

In loving memory of my mother,

Elda Marion Mayer

whose gift of her life and death has inspired my master's work.

(December 9, 1931 – October 17, 2004)

Hermeneutics as an Approach to Inform Spiritual Care-giving Practices at End of Life

Introduction

“Inquiry begins by being ‘struck’ by something, being taken with it . . . the unanticipated eruption of long-familiar threads of significance and meaning in the midst of a wholly new situation” (Jardine, 1998, p. 40). My inquiry emerges from a culmination of enlightening personal, professional, and academic experiences that gave rise to my ever-evolving sense of curiosity, opening space for wonderings and explorations regarding spiritual (see Appendix A for further explication) care-giving at end of life (EOL) (see Appendix B for further explication) and its relevance to nursing practice (Bruce, McDonald & McIntyre, 2006). From an academic perspective, I expanded my understanding in terms of spiritual care-giving at EOL during two clinical practice placements within the Fraser Health (FH) hospice palliative community. While fulfilling my placement hours, I was invited to work in collaboration with the FH spiritual care team on draft five of a proposed FH Hospice Palliative Spiritual Distress Guideline. Throughout the process of first reviewing and then completing the seemingly appropriate revisions, questions arose for me about how this prescriptive evidence-based guideline called for interventions congruent with practices informed by a modernist/scientific worldview—prescribed doing. As I continued on my academic journey, and more specifically, as I moved through the curricular content of a directed study—hermeneutics—engaging not only with the assigned text(s) but also many deep and profound classroom conversations, I came to understand that this ontologically-situated philosophy, in contrast, offers an opportunity to inform nursing practice through engaging in a dialogic or conversational journey, a way of *being*. Often during these

enlightening conversations I found myself in a place of wonder. Could hermeneutics (the art of interpretation), whose view acknowledges acceptance of multiple and subjective truths, actually lie at the heart of EOL spiritual care-giving nursing practices?

Called on to explore this possibility, I conducted a comprehensive review of the current literature wherein I discovered that while hermeneutics has been an integral part of nursing research, little attention has been devoted to nursing's pivotal role as 'interpreter' in the context of nursing practice. The purpose of my inquiry is to illuminate the possibility of introducing a modified four-fold hermeneutical model of interpretation (Charalambous, 2010) as an approach to inform spiritual care-giving nursing practices at EOL. According to the model, a patient is perceived as a literary text and the process of interpretation unfolds in the following four phases: (a) the object of interpretation, (b) the mode of interpretation, (c) the praxis of life-affecting response following from the interpretation, and (d) the change of life-world brought about through the interpretation (Charalambous, 2010; Daniel, 1986). In this paper, I will provide an historical overview of hermeneutics and its role in nursing. After presenting the implications of the model for spiritual care-giving practices at EOL, I will offer an in-depth explanation of the four interpretive phases and then illustrate its approach through a practice exemplar.

Project Approach

Philosophical Underpinnings: Hermeneutics

Historical roots: An overview.

The roots of the word hermeneutics lie in the Greek verb *hermeneuein*, generally translated 'to interpret' and the noun *hermeneia*, 'interpretation' (Chang & Horrocks, 2008; Dowling, 2004; Walsh, 1996). They refer to the mythical Greek God, Hermes,

who was considered the messenger associated with the function of transmuting what is beyond human understanding into a form that human intelligence can grasp (Chang & Horrocks, 2008; Smith, 1991; Walsh, 1996). The various forms of the words suggest the process of bringing a thing or situation from unintelligibility to understanding. Thus, the origin of the modern word ‘hermeneutics’ suggests the process of bringing or coming to an understanding through the art of interpretation (Chang & Horrocks, 2008; Gadamer, 2004a, 2004b).

What was traditionally the task of theologians—the task of understanding or interpreting scriptural texts—became known as hermeneutics (Chang & Horrocks, 2008; Smith, 1991; Walsh, 1996). An art and science backed by five centuries of evolution, hermeneutics was carved out by such notable philosophers as Schleiermacher, Dilthey, Heidegger, Gadamer, Derrida, and Ricoeur through groundbreaking and illuminating applications of hermeneutic theory to the social and human sciences (Anchin, 2006). Heidegger, a student who once studied under phenomenologist Husserl, formulated the concept of *Dasein*, a German word with no exact English counterpart. *Dasein* describes the situated meaning of a human in the world or a general way of *being* (Finch, 2004; Smith, 1991). Heidegger embarked upon a philosophical journey into the question of *being*—a journey resulting in a move from the epistemological emphasis of Husserl (knowledge or knowing) to an emphasis on the ontological foundations of understanding through ‘*being-in-the-world*’ (Annells, 1996; Heidegger, 1962). Gadamer, whose mentor was Heidegger, took the position as outlined by Heidegger and built upon it by focusing on the assumption that the actual situation in which human understanding takes place is always understood through language/dialogue and tradition (Gadamer, 2004a, 2004b;

Smith, 1991; Walsh, 1996). Gadamer (2004a) asserted that within this linguistic process/happening a new concretization of meaning (interpretation) is born during the interplay that goes on continually between past and present. In other words, understanding culminates as a fusion of horizons and happens in every shared transmission of meaning within what many philosophers (i.e., Gadamer, Heidegger, and Schleiermacher) refer to as the hermeneutic circle—no beginning, no end (Gadamer, 2004a, 2004b).

The horizon is a metaphor, which according to Gadamer represents “the range of vision that includes everything that can be seen from a particular vantage point” (Gadamer, 2004a, p. 301). He offered the following understanding regarding fusion of horizons:

the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices [or pre-understandings - biases of our openness to the world]. An important part of this testing occurs in encountering the past and in understanding the tradition from which we come. Hence, the horizon of the present cannot be formed without the past. There is no more an isolated horizon of the present in itself than there are historical horizons which have to be acquired. Rather, understanding is always the fusion of these horizons supposedly existing by themselves.
(Gadamer, 2004a, p. 305)

Hermeneutics therefore, aims for a fusion of horizons between interpreter and other (text) (Gadamer, 2004a). Ultimately, clarifying the miracle of understanding is not a mysterious communion of souls, but “sharing in a common meaning” (Gadamer, 2004a, p. 292). The notion of the hermeneutic circle entails that the part is always to be understood in the light of the whole (St. Augustine as cited in Charalambous, 2010). It is only through the movement between the parts and the whole that understanding is achieved (Heidegger, 1962). Schleiermacher (1978) suggested that hermeneutical

interpretation and understanding are understood as creative acts not just technical functions.

Hermeneutics as a system of interpretation is also based, in part, on the shared writings of Ricoeur (Allen & Jensen, 1990). According to Ricoeur (1981), textual interpretation is the essence of hermeneutics. Initially, Ricoeur proposed textual interpretation as the model for all meaningful exchange. In essence, Ricoeur saw hermeneutics merely as a process of interpreting symbols (Charalambous, 2010). However, subsequently, he refined hermeneutics into a theory of interpreting discourse as a whole, including, but not confined to, the symbols which any discourse contained (Ihde, 1971). Ricoeur described a text as any group of signs which can be characterized as a composition, a notion which he extends beyond literary works to include: (a) dreams, (b) meaningful action, (c) historical reality, and (d) the entirety of human existence. As an example, in my practice as a hospice nurse, I have had the honour of bearing witness to the intrinsic power of music on the human spirit (Magill, 2006). Findings in a recent study by Magill (2006) suggested that for many individuals facing the final stages of illness, it is in the lived moments or presence of the rhythmic movement of musical compositions that they are able to transcend their suffering and acquire deeper meaning/interpretation—preparing a path for a peaceful death experience. For the purpose of this paper then, I offer the following understanding regarding the term ‘text’: “any group of signs which constitutes a whole and which takes on meaning through interpretation” (Charalambous, 2010, p. 1284). Ultimately, in hermeneutics the interpreter must be present to the text, to be guided by the text, and to be open to where the text takes you (Gadamer, 2004a). In doing so, new insights will emerge allowing the

subject matter and all of its imaginable possibilities of interpretation/meaning (understanding) to remain fluid—no beginning, no end. In essence, and as offered earlier in this paper, the discovery of the true meaning of a text is never finished; it is in fact an infinite process (Gadamer, 2004a).

What relevance can the interpretation of texts possibly have for EOL spiritual care-giving nursing practices? Could nurses, like literary critics, practice the art of interpretation in their daily practice? Can nurses' encounters with patients be understood as a hermeneutical enterprise? Is it possible that patient's themselves be considered as 'text' and as such be interpreted in order to gain valuable insights in every practice encounter (Charalambous, 2010; Daniel, 1986; Dekkers, 1998)? I ponder the possibility of embracing the metaphor, "patient as text" (Daniel, 1986, p. 195), as an approach to inform spiritual care-giving nursing practices at EOL. This approach recognizes the fluidity of spirituality while opening capacity for engaging in spiritual connectedness (i.e., a connection with another human being that moves beyond the physical realm) in order to come to a shared understanding/meaning during each practice encounter (Bruce et al., 2006; Daniel, 1986; Pesut & Reimer-Kirkam, in press)?

Role of hermeneutics in nursing.

From the 1970s onwards researchers from the health sciences have been increasingly using hermeneutics to guide their research projects—the discipline of nursing is no exception (Charalambous, Papadopoulos & Bedsmoore, 2008). Over the years, numerous nursing researchers have supported the use of this philosophical approach in exploring and interpreting people's experiences of health and illness events, and aspects of professional practice. Munhall (1994) asserted that nursing care planning

requires an understanding of the various lived experiences which arise from persons sharing their descriptions of a life event experience. According to Munhall (1994),

understanding is perhaps one of the most important gifts one human can give to another. If we learn not only with our minds but with our spirits, the meanings of experience, we might better be able to say, 'I understand'. People reach out for this, bemoan that no one understands, [they] beg for understanding in their choices. Many practitioners . . . believe it is understanding or feeling understood that cures the person. Isn't that what we all wish for [-] to be understood? (p. 709)

Reeder (1995) suggested that research from a hermeneutic perspective "serves nursing well because of the dialectical nature of experience and 'the multiple levels of meaning' within the practice of nursing" (p. 709). Reeder argued that the benefits of using a hermeneutic approach include

an emphasis on the universality of language as relevant among and across persons receiving and giving care, a fostering of the skill of listening to the speaker and to the context/meaning of the expressed language, lived experience being seen to precede understanding, the ability to illuminate nursing questions, the multiple perspective (history, tradition, initial intention) in hermeneutic interplay and the deepening and understanding through the fusion of horizons of past, present and the future of persons in different situations. (p. 709)

Phillips (as cited in Wood & Giddings, 2005) described hermeneutics as a "not . . . [so] 'easy to do' research approach" (p. 12). For Phillips, utilizing a philosophical hermeneutical approach means leaving behind the supposed security of a scientific mode of inquiry and writing, which purports stable truths and certainties while offering a 'slippery ground' where personal and theoretical beliefs are challenged. Nevertheless, he believes that this particular inquiry approach offers an exciting research process which ultimately opens up new ways of engaging with individuals in daily practice (Wood & Giddings, 2005). More recently, Charalambous et al. (2008) emphasized that hermeneutic phenomenology is appropriate for the exploration of nursing phenomena. In addition, they suggested that hermeneutics in nursing can be

guided by many of the fundamental ideas set forth by Ricoeur such as his theory of interpretation that avoids the Cartesian subject/object split, thereby making it useful for the researcher seeking to explicate inter-subjective knowledge (Charalambous et al., 2008).

Drawing on Ricoeur's ideas, Daniel (1986) developed a hermeneutical model of clinical decision-making for medicine that led to the introduction of the metaphor "patient as text" (Daniel, 1986, p. 195). The hermeneutical model proposed by Daniel (1986) is based on the medieval four-fold sense of scripture. According to Daniel, this method, which is the outgrowth of centuries of biblical exegesis, has four senses of meaning including the following: (a) the literal, (b) the allegorical, (c) the moral, and (d) the anagogical or mystical. The literal sense teaches us the historical facts, the allegorical sense is what we ought to believe, the moral sense relates to how we ought to proceed, and the anagogical sense is the ultimate goal to which we ought to be moving toward (Daniel, 1986). Daniel suggests that with this interpretative model, a patient is perceived as a literary text which may be interpreted in the following phases: (a) the literal facts of the patient's body and the literal story told by the patient, (b) the diagnostic meaning of the literal data, (c) the praxis (prognosis and therapeutic decisions) emanating from the diagnosis, and (d) the change affected by the clinical encounter in both the patient's and practitioner's life-worlds (Daniel, 1986).

Expanding on the work of Daniel (1986), Charalambous (2010) conducted a study that explored hypotheses that the patient can be considered as text and as such, be interpreted in order to influence clinical nursing practice. Through the presentation of a case study, Charalambous demonstrated the process nurses can use in practice in order to

give meaning to written (i.e., chart document) and verbal texts—a process that opens possibilities for nurses to provide optimal patient care. The process unfolds through the application of the four-fold hermeneutical model of interpretation as developed by Daniel (1986). Charalambous modified phases (b) and (c) of Daniel's model to reflect interpretation from a nursing perspective—(b) became the nursing diagnostic meaning of the literal data, and (c) became the praxis (the nursing interventions) emanating from the nursing diagnosis. The modified hermeneutical model as presented by Charalambous informs nursing practice through an interpretive approach to both written and verbal (dialogic) text. In essence, the model serves to inform practice through the process of interpretation, a way of *being*—moving away from the traditional prescribed *doing* that underlies current nursing practice. While Charalambous's research illuminated the possibility of introducing a model of clinical interpretation to influence or inform oncology nursing practice, the focus of my inquiry/project, as will be presented ahead, will illuminate the possibility of introducing my own modified hermeneutical model of interpretation as an approach to inform spiritual care-giving nursing practices at EOL (see Table 1 on page 13 for a comparison of both models).

The use of hermeneutics as a paradigm to nursing research, however, has not been without caution (Charalambous, 2010). As an example, Reed (1994) offered a statement of caution to nurse researchers who use hermeneutic phenomenology, and more specifically those who use the interpretative scheme inclusive of Heidegger's notion of the three elements of *dasein* (attunement/mood, discourse/articulation, and goal/potential). In her Heideggerian phenomenological study, where text generation was intended to occur as nurses caring for elderly patients described critical incidences, Reed

found that nurses were unable to describe incidents which demonstrated their nursing practice expertise, critical or otherwise (Annells, 1996). According to Reed, an over-emphasis on discourse/articulation without balancing focus on attunement/mood and goal/potential was detrimental to her research. And yet, despite her words of caution regarding the use of hermeneutics as a research approach to nursing phenomenon, a considerable precedent now exists for the concurrence of hermeneutics and nursing research (Charalombous, 2010).

Database searching of published nursing research shows that researchers have been guided by a hermeneutic approach to explore a number of issues such as the experiences of nurses working hospice patients (Evans & Hallet, 2007), understanding maternal breastfeeding (Grassley & Nelms, 2008), understanding the nature of spirituality and spiritual care among hospice nurses (Carroll, 2001), understanding the experience of spirituality in the lives of hospice patients (Stephenson, Draucker & Martsof, 2003), the meaning of learning in critical care nursing (Little, 1999), understanding the meaning of residents' experiences of encounters with nurses in nursing homes (Westin & Danielson, 2007), understanding cross-cultural nursing experiences (Spence, 2001), and the experience/essence of spirituality in terminally ill patients (Chao, Chen & Yen, 2002). Noteworthy is that hermeneutic research is being conducted across a variety of countries (Australia, China, Finland, Sweden, United Kingdom, and United States of America), representing a growing global awareness of the positive gains to nursing which are possible through this approach to inquiry (Annells, 1996). Examples of the positive gains to nursing include the following: (a) a focus on the experiences of nurses and patients, (b) a valuing of whole persons who create personal meanings, (c) a

consideration of contextually meaningful experience, (d) a seeking to understand daily living and practical concerns, and (e) the consideration of nurses and patients as entities or beings of *being*.

Clearly, these researchers have used this philosophical paradigm to interpret research data (texts) derived from specific clinical situations (Charalambous, 2010). However, Finch (2004) goes further in claiming that hermeneutics provides a “new direction for study not only in philosophy but also across many disciplines, including nursing” (p. 253). She argues that through hermeneutics, nurses can gain an accurate understanding and interpretation of a patient’s beliefs, values, and situations that supports explanations of meaning. Moreover, Finch recommends that nurses should seek to clarify and understand the meanings that evolve from their patient interactions in order limit or prevent inaccuracies and misunderstandings in communications with patients. According to Finch, more positive patient outcomes will result from nursing practice that fosters meaningful nurse-patient relationships informed by the use of hermeneutics.

The nurse’s pivotal role as interpreter in practice has received minimal attention in the academic literature (Daniel, 1986). In fact, with regards to spiritual care-giving at EOL, nursing has no current published offerings that exclusively embrace hermeneutics (the art of interpretation) as an approach to inform practice. As a response to this gap in the existing literature, I offer hermeneutics, and more specifically my modified four-fold hermeneutical model of interpretation (see the subsequent paragraph for the modifications), as an approach to inform spiritual care-giving practices at EOL—an approach firmly anchored in the foundational hermeneutic principle of open dialogue and conversation. My proposed approach engenders an appreciation for the relational

dimension of spiritual care-giving nursing practices at EOL nursing and as such opens possibilities of engaging in spiritual connectedness (Bruce et al., 2006; Shafranske, 2005). It has been argued that nursing is fundamentally a hermeneutic endeavour and EOL spiritual care-giving nursing practice is no exception (Anchin, 2006). EOL patients, like scriptural texts ought to be considered as texts open for interpretation (Anchin, 2006). It is certainly not my intention to situate my approach in opposition to the current scientific/modernist way of approaching spiritual care in EOL care (i.e., spiritual care assessment tools—tools that ask questions [prescribed *doing*]). Rather, my intention is to offer a hermeneutic philosophical perspective that complements our existing practice. From this perspective EOL spiritual care-giving nursing practice is informed through engaging in a dialogic or conversational journey, a way of *being*.

Nurses are mandated by several organizations, namely, the World Health Organization (2008), Canadian Hospice Palliative Care Association (2007), and the Canadian Nurses Association (2008) to address the spiritual aspect of EOL care providing direction through the use of spiritual care guidelines (prescribed *doing*) and/or the Davies and Oberle Supportive Care Model (*doing/being*) (Canadian Hospice Palliative Care Association, 2002). Opening to the shared power of creative interpretation (*being*), hermeneutics may provide another opposing yet complementary direction (Smith, 1991). Therefore, drawing on the work of Daniel (1986) and Charalambous (2010), I propose a semi-structured method of interpreting the patient as text. The following is my modified version of the four-fold hermeneutical model of interpretation as discussed earlier in this paper addressing four interpretive phases: (a) the object of interpretation (corresponding to the literal or patient's spiritual story), (b)

the mode of interpretation or interpreter's way of coming to know the object (corresponding to the allegorical or nursing's interpreted meaning flowing from the literal), (c) the praxis of life-affecting response flowing from the interpretation (corresponding to the moral or dialogic pathway choices flowing from the interpretation/meaning) and (d) the change of life-world for both the patient and nurse brought about through the process of interpretation (corresponding to the analogical or new mystical perspectives in the shared interpretation of meaning).

Table 1: *The Four-fold Hermeneutical Model of Interpretation: A Comparison Between Charalambous's Model and My Modified Model*

Charalambous's Model	My Modified Model
The Object of Interpretation (corresponding to the literal)	The Object of Interpretation
Object—Patient	Patient's Spiritual Story
The Mode of Interpretation (corresponding to the allegorical) (Or Interpreter's Way of Coming to Know the Object)	The Mode of Interpretation
Mode—Nursing Diagnosis	Nursing's Interpreted Meaning Flowing From the Literal
The Praxis of Life-affecting Activity Following From the Interpretation (corresponding to the moral)	The Praxis of Life-affecting Response Flowing From the Interpretation
Praxis—Nursing Interventions	(or Dialogic Pathway Choices Flowing From the Interpretation)
The Change of Life-world For Both Patient and Nurse Brought About Through the Interpretation	The Change of Life-world For Both Patient and Nurse Brought About Through the Process of Interpretation

(corresponding to the analogical)

Change in Life-world—support/revelation

The experience in each phase is an interpretative one and can be analyzed according to the four phases in the interpretive process as suggested by the medieval four-fold sense (Daniel, 1986). A more in-depth exploration of each phase of my model will be offered following the presentation of its implications for informing EOL spiritual care-giving nursing practice.

Implications of the Model for Informing End of Life Spiritual Care-giving Practices

Currently, a variety of approaches exist that help inform spiritual care-giving practices. Included in these approaches are quantitative and qualitative assessment tools/instruments, and the Davies and Oberle Supportive Care Model (CHPCA, 2002). Examples of available and reliable assessment tools/instruments include the following: (a) Stoll's (1979) Guidelines for Spiritual Assessment, (b) Hess's (1983) Spiritual Needs Survey, (c) Burkhardt's (1989) Assessment Tool, (d) the "SPIRITual History" (Maugans, 1996), (e) Dossey's (1998) Spiritual Assessment Tool, (f) Paloutzian and Ellison's (1982) Spiritual Well-Being Scale, (g) Reed's (1987) Spiritual Perspective Scale, (h) Highfield's (1992) Spiritual Health Inventory, (i) Robert's Serenity Scale (Roberts & Aspy, 1993), (j) Carrigg and Weber's (1997) Spiritual Care Scale, and (k) Hermann's (2006) Spiritual Needs Inventory. While all of the aforementioned spiritual assessment tools/instruments help to inform spiritual care-giving practices, only Hermann's was developed specifically for patients positioned/situated at EOL. Despite its usefulness as a tool to inform spiritual care-giving at EOL, practitioners who embrace Hermann's (2006) tool may do so with the limitations of modernist or scientific prescribed *doing*. From this standpoint,

spirituality may be viewed as something to be resolved instead of openings of understanding and engaging in spiritual connectedness (Bruce et al., 2006). According to Sinclair, Pereira, and Raffin (2006), spirituality in EOL practice ought not become “another tool in our treatment repertoire, having been stripped of its mystery by empiricism” (p. 475). Therefore, rather than accompanying individuals on their EOL journey with the limitations of prescribed *doing*, nurses informed by my modified four-fold hermeneutical model, in contrast, would accompany individuals by *being with* them as they share their unique spiritual experiences. In other words, nurses with this view would open capacities for engaging in spiritual connectedness with patients (*being*). Similarly, Bruce et al. (2006) asserted that from this standpoint nurses do not need to possess broad understandings of religious practices, theology or cultural studies to provide spiritual care. Instead, nurses would be willing and able to engage patients with spiritual awareness about values, beliefs, and their experiences of dying (Bruce et al. 2006).

Adopted by the CHPCA (2002) as a framework for EOL nursing care, the Davies and Oberle Supportive Care Model, although not explicitly linked to spiritual care-giving at EOL, identifies six separate but interwoven dimensions that influence/inform EOL nursing practice. The model is comprised of the following six dimensions: (a) Valuing, (b) Connecting, (c) Empowering, (d) Doing for, (e) Finding meaning, and (f) Preserving integrity. Noteworthy is that the dimension of “Doing for” is included in the comprehensive model and yet *being with* is not. I do, however, ponder the possibility that the dimension “Connecting”, which includes building “a trusting relationship” (CHPCA, 2002, p. 11), “finding a common bond” (CHPCA, 2002, p. 12), and

“establishing rapport” (CHPCA, 2002, p. 12), may capture the essence of *being with*. EOL nurses assist patients (and their family) in addressing their spiritual needs through the dimension “Finding meaning”. While the Davies and Oberle Model, much like the four-fold hermeneutical model, engenders an appreciation for the relational dimension of spiritual care-giving nursing practices at EOL and as such opens possibilities of engaging in spiritual connectedness (*being with*), it differs in that it does not focus on the actual interpretive process as it unfolds during the relational connection (Shafranske, 2005). Hermeneutics, and more specifically my modified four-fold hermeneutical model of interpretation, as an approach to inform spiritual care-giving practices at EOL, offers an approach to complement all of the aforementioned existing practices—creating an openness to imagine possibilities.

Spiritual care-giving practices at EOL informed by my modified four-fold hermeneutical model of interpretation, offers nurses a heightened sensitivity to the way in which they approach others and the world. Through the process of fostering dialogue that advances understanding, the interpreted meanings may indeed be what the patient may need to support spiritual growth and perhaps reduce spiritual suffering (Anchin, 2006). My four-fold hermeneutical model informs spiritual care-giving nursing practices at EOL in several other ways. First, historicity’s (the past’s) centrality to interpretation is captured in the moment through recognizing that understanding meanings held by the patient relative to past experiences requires grasping historical circumstances that were operating when those meanings were undergoing formation (Anchin, 2006). And yet, in that same moment in time, the patient and nurse would also bring new or revised meanings to past circumstances through the lens of the patient’s present historical

situation (Anchin, 2006). Second, awareness of the influential effects of language encourages acute mindfulness of the words that one uses to express interpretations and other responses (Anchin, 2006). Third, because empathic attunement is fundamental to the interpretive process, whatever material serves as the context for dialogue and intervention, a nurse embraces and appreciates the patient's subjective experience and personal meanings, and then responds in part within those understandings (Anchin, 2006). While insights emerging from my four-fold hermeneutical model may not offer an exact roadmap of spiritual direction, they may provide healing possibilities for those situated at EOL—supporting an optimal holistic healing environment that eases suffering and enhances quality of life.

The Model

The Object of Interpretation

Based on the medieval four-fold sense of scripture, the initial phase of the four-fold hermeneutical model of interpretation is known as the literal sense—an objective phase wherein the patient is viewed as the object of observation (Charalambous, 2010; Daniel, 1986). In this initial phase of interpretation, the interpreter (nurse) must maintain a distance from the patient through a process which Ricoeur described as distanciation (Charalambous, 2010; Daniel, 1986). According to Ricoeur (as cited in Charalambous, 2010),

distanciation is not a quantitative phenomenon; it is the dynamic counterpart of our need, our interest, and our effort to overcome cultural estrangement. Writing and reading take place in this cultural struggle. Reading is the . . . remedy, by which the meaning of a text is 'rescued' from the estrangement of distanciation and put in a new proximity, a proximity which suppresses and preserves, the cultural distance and includes the otherness within the ownness. (p. 186)

Although Ricoeur acknowledged that the process of distancing runs the risk of diminishing the human dimension of the clinical encounter, he maintained that interpretation must, in fact, begin with distancing (Charalambous, 2010; Daniel, 1986). For Ricoeur, distancing is the prerequisite for enabling the interpreter to approach the text (patient) with an open mind. However, in order to preserve the values involved in nursing practice, it will be necessary for the interpreter (nurse) to overcome this distance later in the interpretive process (Charalambous, 2010; Daniel, 1986).

Another essential component of the literal phase is the spiritual story that the nurse elicits by both reviewing the patient's history from the chart and by conversing/dialoguing with the patient (Daniel, 1986). In other words, the literal phenomena are both written and verbal text. The goal then is to weave the narrative symbols (written text) with the verbal or dialogic text together into one coherent text that is not "necessarily a written text, [rather] the factual basis of the story of a particular human being in the context of the life cycle with [all of] its rhythms of health and illness" (Daniel, 1986, p. 204). The discovery of meaning within and among these texts (written and dialogic) happens as the process of interpretation continues to unfold (Daniel, 1986).

The Mode of Interpretation

As the interpretation evolves, the interpreter (nurse) moves through the process of considering the objective/literal signs and symbols (texts) of the initial phase. In essence, these signs and symbols (texts) become open to interpretation and as such they are transformed into meaningful information on a subjective level (Charalambous, 2010). During this critical phase, also known as the allegorical sense, it is essential that it "occur in a shared speech context whereby both the patient and nurse share an understanding"

(Charalambous, 2010, p. 1286) of the interpretation circumstances. According to Charalambous (2010), should difficulties of understanding arise during the shared conversation, this particular process allows the nurse to ask the patient for clarifications in relation to what has been said, and as a result misinterpretation is avoided. This aspect of the interpretive process values the significance of interpreting the patient as text in order to reach an understanding of their situation rather than merely basing understanding in the written text (chart documentation) (Charalambous, 2010). Informed by Ricoeur's notion of objectifying the text—distancing the meaning of the text from its author—interpreters (nurses) are then able to move beyond the notion that only one understanding is meaningful or correct, that of the informant-patient (Charalambous, 2010). This offers the interpreter “[*textual plurality*] (that pre-understandings lead interpreters to interpret the same text faithfully yet differently) and [*multiplicity*] (that texts have many meanings)” (Charalambous, 2010, p. 1286). The notion of *multiplicity* may pose problems for interpreters (nurses) of the literal text in that patients are susceptible to a multiplicity of interpreted meanings, many of them in conflict with each other (Charalambous, 2010; Daniel, 1986). As an example, a patient may share that they have abandoned their belief in God. Since anger towards God is a frequent response to the powerful emotions triggered by news of a terminal diagnosis, a nurse may interpret the patient's declaration as a typical response (Ciampa & Schafer, 2002). However, depending on the nurse's pre-understandings she/he may interpret the patient's declaration as a response to alienation from a previous faith tradition. Ricoeur (1991) asserted that truth has many different sides, although each being truth, represents a variant degree of truth. Moreover, he claimed that some aspects of the perceived truths

appear more probable than others and it is not meant in a statistical sense, rather, in the sense that the interpretations that are most probable to be true. The interpreter (nurse) must then, from the list of possible interpretations/meanings gathered, proceed appropriately based on a process of prioritization (Charalambous, 2010). In other words, the interpreter (nurse), as the process of interpretation unfolds, will, based on her/his priority, follow an appropriate open-ended dialogical/conversational pathway—a pathway that flows from the interpreted literal data.

A pre-understanding (as highlighted in the previous paragraph) includes all knowledge related to the subject matter at hand which the interpreter (nurse) has gained through both education and life experiences (Charalambous, 2010). Pre-understandings then bring before you “something that [would] otherwise [happen] ‘*behind [your] back*’ (Gadamer, 2004b, p. xviii). According to Charalambous (2010), pre-understandings play a vital role in determining which literal data get included in the text. In essence, this phase of interpretation becomes what Heidegger, Gadamer, Ricoeur, Schleiermacher, and other philosophers refer to as the point of entry into the hermeneutic circle (Charalambous, 2010). As discussed earlier in this paper, in order to interpret a text’s meaning, the interpreter must be familiar with the text’s parts and have at least some idea of what the text as a whole might mean (Charalambous, 2010; Daniel, 1986). Buoyant in the fluid movement back and forth from present to past experiences, interpreters (nurses) can be free to move back and forth between the part and the whole of the experience yet free to return to the beginning (Gadamer, 2004a, 2004b). Through ongoing conversations with patients new insights (understandings) will emerge allowing the subject matter and all of its imaginable possibilities of interpretation/meaning to remain fluid—no

beginning, no end (Gadamer, 2004a, 2004b). Understanding culminates as a fusion of horizons between interpreter (nurse) and other (patient) and happens in every shared transmission within the hermeneutic circle (Gadamer, 2004a, 2004b). In other words, clarifying the miracle of understanding is not a mysterious communion of souls, but “sharing in a common meaning” (Gadamer, 2004a, p. 292). Ultimately, each interpretation must be thought of as the nurse’s creative and imaginative preconception of what the truth (or truths) about the patient may be (Daniel, 1986). In essence, each interpretation is considered to be a judgment (Charalambous, 2010; Daniel, 1986).

Daniel (1986) asserted that

the word “judgment” should tell us that a diagnosis [interpretation] does not bask in the certitude of scientific fact [one absolute truth]. Rather a label like “ulcers” or “cancer” is a culturally relative symbol employed by the physician/[nurse] to convey herself/[himself] and the patient some idea of what might be wrong. Since an illness is always a particular experience of a unique individual, it can never be completely known. (p. 205)

The process of interpretation, although never complete or final, continues to unfold for both interpreter (nurse) and patient (text) in the moral sense or praxis phase.

The Praxis of Life-affecting Response Following the Interpretation

Once the interpretation has been made, the interpreter (nurse) moves forward into the practical response (praxis) to the interpreted meanings which ought to impact one’s life (both patient and interpreter [nurse]) (Charalambous, 2010). Daniel (1986) described this effect as a heightened sensitivity to the way in which we approach others. Without praxis, nursing would be rendered purposeless (Daniel, 1986). The whole point of

meaning-making is to inform nursing practice and as such open possibilities. As an example, the creative and imaginative decisions flowing from the dialogue/conversation (praxis or response) may open pathways in which the interpreter (nurse) and patient may engage in spiritual connectedness. In other words, the interpreter (nurse) understands through engaging and listening to the patient's subjective experience rather than gathering facts. The praxis or dialogic response then, happens in the very moment of the conversation. With this praxis or response comes understanding and empathic attunement—traits we look for in every good nurse (Daniel, 1986). It is through this empathic understanding that we can overcome the objective/scientific distance between text and living person which was discussed earlier in connection with the literal sense of interpretation (Daniel, 1986).

The Change of Life-world Brought About Through Interpretation

Even in the final aspect of interpretation, also known as the analogical sense, the interpretation remains incomplete and in terms of the hermeneutical circle, it remains open—no beginning, no end (Charalambous, 2010). According to Charalambous (2010), it is here at this critical juncture of the interpretive process that the interpreter needs to put all the parts into a unitary whole—a world of multiple and subjective truth(s) which includes patient, nurse, and ourselves as interpreter. If the interpretation is successful, the change in life-world should be a new reality for both the patient and nurse (Charalambous, 2010; Daniel, 1986). The patient, as beneficiary of the nurse's interpretation and praxis, ideally approaches life anew with a healed spirit. The nurse, on the other hand, through awareness of the other enters the "secret gardens of the self . . . where the shape of suffering and the power of the healer's art lie revealed" (Williams as

cited in Daniel, 1986, p. 201). In essence, the result of this process provides the interpreter (practicing nurse) with a new perspective of things which allow her/him in each individual case to view the world differently (Charalambous, 2010).

Practice Exemplar

Ethical Considerations

Originally, my intention was to complete a thesis for my masters; however, due to a series of unfortunate events (i.e., recruitment challenges/obstacles), I elected to complete a project instead. After seeking and securing ethics approval from both the Human Research Board at the University of Victoria and the Fraser Health Ethics Board, I was blessed with one willing participant for my study titled: *Opening Possibilities of Understanding the Experience of Spirituality: Hermeneutic Conversations With Adults Admitted to Hospice*. Recruitment of this participant was done by a third party recruiter (spiritual care provider at the hospice). Informed consent was received prior to our audio-taped conversation. Excerpts from our enlightening conversation will be presented in the practice exemplar that follows. My intention is to demonstrate how my modified four-fold hermeneutical model of interpretation informs spiritual care-giving nursing practice at EOL—a model that has potential to open possibilities for understanding and engaging in spiritual connectedness (Charalambous, 2010). Anonymity was/is assured by the use of the pseudonym Eve and non-disclosure of the hospice where the actual conversation with this remarkable participant took place.

Eve's Story

“Come on in Debra!” were Eve’s first words as I appeared at the open door to her private hospice room—a warm invitation to the personal space that had been her home

for the past four months. As I slowly entered her newfound “home”, I noted the rather minimalist yet quaint landscape. Aside from the basics found in every hospice room (i.e., television, padded rocking chair, single bed, bedside table, and an over-bed table), I noticed two floral arrangements, a box of Kleenex, a personal framed photo of children, and a few magazines—all of which seemed strategically placed on either her bedside or over-bed table. I immediately found myself in a place of wonder. Were these current surroundings reminiscent of her previous lodgings? Did this particular picture hold a special meaning for her? Reflecting on this specific moment in time, I recall feeling comforted with the knowledge that the hospice goal of creating a home-like environment may have indeed been actualized.

I can still vividly recall the image of Eve’s delicate figure as she glided across the shiny linoleum floor in what appeared to be a well-rehearsed dance with her oxygen tubing to her waiting neatly-made bed. Her soft gray hair was perfectly coifed and she was wearing a loosely fitted track suit. With oxygen via nasal prongs intact and a bright sparkle emanating from her light blue eyes, Eve was poised and ready to begin our conversation.

Prior to our conversation, I had reviewed Eve’s chart (written text). Eve was a 76 year old widow admitted to the hospice 4 months earlier with multiple co-morbidities. In the chart it stated that she had a diagnosis of lung cancer with metastases to her spine, diabetes, asthma, depression, breast cancer, chronic obstructive pulmonary disease, myocardial infarction, and seizure disorder. At the time of our conversation, she had been informed that due to a change in prognostication, she would be transferred from the hospice to a long term care facility. A more detailed collection of patient data will not be

presented in this paper as the focus of the four-fold model is in the actual interpretation process of the conversation itself—highlighting the pivotal junctures in our shared conversation that offered opportunities for me to engage in spiritual connectedness with Eve. Noteworthy is that although this specific conversation took place in the context of nurse as researcher, this conversation could just as easily have taken place with the nurse as caregiver during a patient bath, dressing change, subcutaneous injection or while settling the patient for the night. This practice exemplar is organized in a way that reflects and moves through the interpretive processes of object of interpretation to the change in life-world (Daniel, 1986).

Object of Interpretation to the Change of Life-world

The process of interpretation begins with the literal phenomenon (the object) related to the text's subject (Eve). In this phase of interpretation, I as interpreter (nurse) maintained the act of distancing—the creation of an objective distance between the text itself (Eve) and the human associated with the text (I as interpreter)—with the knowledge that this distancing was important in order to approach the text (Eve) with an open mind yet also risked diminishing the human/relational aspect of our initial encounter (Charalambous, 2010; Daniel, 1986). Distancing, in part, was enacted by holding the written text lightly as a relative truth found in her chart (A. Bruce, personal communication, February, 13, 2012). This distance, however, was at a later point in the interpretation overcome in order to preserve the human (relational) values ideally involved in nursing practice (Charalambous, 2010; Daniel, 1986).

In terms of the literal data related to the text's subject (Eve), her spiritual story was pieced together through weaving her narrative history (written text from the chart)

together with our conversation (dialogic text) (Daniel, 1986). According to Daniel (1986), we take time to learn the patient's history because we hope that it will provide leads for our interpretation of the dialogic text uncovered during the actual conversation. One way that the nurse can manage the literal data as laid out in the history is by arranging the data into clusters or groupings (i.e., biomedical realm, spiritual realm) (Charalambous, 2010). Some pieces of Eve's spiritual story (narrative history) became significant immediately while others only on the next level of interpretation (Daniel, 1986). As an example, in reviewing Eve's chart, I understood that she experienced the loss of her husband and that she suffered with depression. Aware that the literal text (Eve's history/story) was susceptible to a *multiplicity* of interpreted meanings, I pondered the possibility that her depression was a result of the experience of losing of her husband. This piece of information became significant later during our engaging conversation when Eve made the following declaration, "We had twenty good years". These words in the hands of an experienced and attentive nurse, can be interpreted in the moment and an appropriate dialogic nursing response can be initiated (Charalamous, 2010). I interpreted this declaration, to mean that she had missed her husband. Eve's expressed words offered us an opportunity to engage in further dialogue—opening a pathway for Eve to reminisce and reflect on past events/issues that she experienced during her life journey. For example, Eve, in response to my wonderings whether she had an eventful and fulfilling life, stated: "I don't know if it would be eventful or fulfilling, it was a life". With compassionate presence and a soft gaze, I listened intently to Eve's story as it unfolded. I was honoured that Eve shared the following pivotal moments in her personal life review:

I think the one point in my life would be . . . my mom passing away when I was six . . . and my dad remarrying again when I was eight . . . Life just went downhill from there. I had two brothers but once they got old enough to leave home, they left and I was the baby of the family so I was kind of stuck. Finally I got old enough and I quit school and got a job and yeah, life sort of took its course. I married [my first husband] in 1920 . . . and my father did tell me not to do it but I did anyway and he was a drinker. It lasted about . . . oh close to five years and I left. And, then I met my husband, my next husband . . . and he passed away and he was only sixty-five.

In listening and hearing Eve as she shared her story (verbal text), I interpreted these sharings to mean that she may have some grief that may need reconciliation before her passing. As such, I included this excerpt from the transcript in the spiritual cluster of literal data.

As our conversation continued, Eve expressed the following personal beliefs that I included in the spiritual cluster:

. . . people that have passed away . . . I hope that they had something with them when they passed away. Something that they could call on or . . . I don't know, be it religion, spirituality or whatever . . . We are all born to die and we're all going to go. . . . I just hope they found what they were looking for . . . peace, inner peace. . . . I am pretty sure when I reach that point, I will find it. Who knows.

Attuned to the nuances of Eve's sharing, I sensed that she was in a place of readiness to talk about spiritual matters. In response to my wondering how she had understood the term spirituality, Eve without hesitation stated:

I've never really been a church goer but I do feel spiritual things. I feel that everybody is spiritual whether they know it or not. . . . I just feel that spirituality comes from within. I think everybody has it but a lot of people don't know it. . . . it gets stronger as you get older.

In reflecting back on Eve's earlier declaration "It was a life", I pondered the possibility that she had indeed experienced moments that were meaningful in her life when she stated with excitement:

We [Eve and her second husband] could be together in the same room and not talk and still be with one another. . . . We weren't blessed with children but I got wonderful nieces and nephews and extended family. . . . I belonged to book clubs and we had a group called the three muskateers. Well, the three muskateers were two friends and myself and once a week we would meet for lunch and go shopping or whatever. The odd time we went to a movie but one does not get around very good any more, she's in her eighties and of course I'm incapacitated. . . . My girlfriend in Vancouver says "move to Vancouver", my niece in Burnaby says "move to Burnaby", and my sister-in-law says "move to Abbotsford". I chose to stay here [in the same building/city] and I am happy with that decision.

I determined, while engaged in conversation, that the preceding two statements also warranted placement in the spiritual cluster.

As the interpretive process continued to unfold, in our effort to find meaning for the clusters (in this case, spiritual cluster) of the literal data, Eve and I moved forward to the mode of interpretation (the allegorical sense) (Daniel, 1986). As noted earlier, the problem I was faced with was that the literal text of Eve was susceptible to a *multiplicity* of interpreted meanings all of which may conflict with each other. In returning to Eve's narrative history (written text) we find that her narrative past could have directed me to other possible interpretations (Charalambous, 2010). Other possible meanings were brought to the fore through my professionally acquired knowledge of EOL nursing care. As an example, I could have interpreted Eve's sign of depression as a response to her terminal cancer diagnosis. Or, as another example, I could have interpreted Eve's depression as a response to her hospice admission. Or, in another example, reflecting on the dialogic text, another interpretation is that Eve's depression was due, in part, to the experience of losing her mother when she was six years of age. In essence, the possibilities of interpretation were/are multiple. During this phase of the interpretive process, in order to prevent misunderstandings, I as interpreter, was able to seek clarification in relation to what Eve had shared regarding the loss of her mother. For

example, Eve, in response to my wondering whether it had been difficult for her to experience the loss of her mother at such an early age, responded with the following clarification: “. . . you know you are pretty young and you don’t remember a lot about it”.

My practice experiences with individuals at EOL brought forth a heightened awareness of my pre-understandings. A comprehensive list of my pre-understandings regarding the subject matter at hand, spirituality at EOL, will not be shared; however, a few examples that illustrate the notion are listed as follows: (a) spirituality is integral to our nature—the essence of our being, (b) we are all spiritual beings in this world, (c) spirituality is whatever people say it is, (d) I honour and acknowledge both my Christian and Jewish traditions (religiosity plays a factor in some people’s lives), (e) spirituality is acknowledged as an essential characteristic particularly evident at EOL, (f) entering the terminal phase of illness can be a time of spiritual searching, discovery, and renewal, (g) a strong support system is integral to the human spirit, (h) spirituality embraces finding meaning in one’s life, (i) spirituality embraces our relationships with others, and (j) inner peace is integral to the human spirit. These pre-understandings brought before me something that would otherwise happen behind my back and as such played a crucial role in determining which literal data I included in the text during this encounter (Charalambous, 2010; Daniel, 1986; Gadamer, 2004b). As discussed earlier, in order to interpret a text’s meaning, the interpreter must be familiar with the text’s parts (i.e., suffers from depression, lost mother at age six, lost second husband, hope to find inner peace at her life’s end, comprehensive support system, spirituality is something to call on at EOL, spirituality comes from within, and everyone is spiritual) and have at least some idea of what the text as a whole might mean (i.e., spirituality is integral to our nature,

spirituality can be expressed in a belief outside organized religion, spirituality embraces our relationships with others, inner peace is integral to the human spirit at EOL, unresolved grief affects the human spirit, and listening with empathic attunement and *being with* patients at EOL opens possibilities to engage in topics related to the spiritual realm) (Charalambous, 2010; Daniel, 1986). Buoyant in the fluid movement back and forth from the present to my past experiences (pre-understandings), I was free to move back and forth between the part and the whole of the experience and yet free to return to the beginning (Gadamer, 2004a, 2004b). Through my ongoing conversation with Eve new insights (understandings) emerged allowing the subject matter (spirituality) and all of its imaginable possibilities of interpretation/meaning to remain fluid—no beginning, no end (Gadamer, 2004a, 2004b). Understanding culminated as a fusion of horizons between myself as interpreter and Eve (other) and happened during our shared transmission within the hermeneutic circle (Gadamer, 2004a, 2004b). Clarifying the miracle of understanding was not a mysterious communion of our souls, but a “sharing in a common meaning” (Gadamer, 2004a, p. 292). As an example, and as discussed earlier, initially I pondered the possibility (interpreted) that Eve’s depression was a result of the loss of her husband; however, insights (meaning) gleaned within the hermeneutic circle offered the possibility that her depression may be due to unresolved grief associated with losing her mother when she was six years old. In another example, Eve articulated that she has “never really been a church goer but [she does] feel spiritual things”. Whilst in the hermeneutic circle of interpretation, Eve and I shared in a common meaning—spirituality captures a belief outside organized religion. In a third example, I can still vividly remember how Eve’s face lit up as she moved through her life review, and more

specifically as she shared her story of the three musketeers. Although she had stated, prior to sharing her musketeer story, “I don’t know if [my life] would be eventful or fulfilling, it was a life”, I interpreted her experience as a musketeer as one that had indeed brought deep and profound meaning to her life. Each interpretation was my creative and imaginative preconception of what the truth(s) about the patient was/were (Daniel, 1986). In essence, each interpretation was a judgment that did not “bask in the certitude of scientific fact” (Daniel, 1986, p. 205).

As the interpretive process continued to unfold, Eve and I entered the moral sense—the phase of interpretation that involved my practical response (praxis) to the interpreted meanings which impacted both Eve’s and my life. At EOL many of the questions with which a patient wants and needs to be engaged are spiritual in nature (Ciampa & Schafer, 2002). According to Ciampa and Schafer (2002), patients may manifest emotional or spiritual distress if no forum is provided in order to engage these questions. Furthermore, they suggested that if left unaddressed, spiritual suffering may complicate the dying process. Moreover, Ciampa and Schafer asserted that whether or not a person has religion or believes in a god, every human being possesses a spiritual dimension. An excerpt from Eve’s and my enlightening conversation (as highlighted earlier) clearly supports the aforementioned assertion when Eve articulated the following: “I’ve never been really a church goer but I do feel spiritual things. I feel that everybody is spiritual whether they know it or not”. As our conversation progressed, Eve, in response to my wonderings shared the following: “I just feel that spirituality comes from within”. The creative and imaginative decisions flowing from our conversation opened a pathway in which I, the interpreter opened possibilities of Eve and I engaging in spiritual

connectedness. In essence, Eve's sharing led me to an appropriate response—that of creating a safe space to engage further in spiritual issues (i.e., life review, current support system, hope of finding inner peace before her passing, and grief). Through engaging and listening to Eve's story, I, as interpreter, understood that Eve was in a place of readiness to dialogue about existential (spiritual) issues. With this interpretation came understanding and empathic attunement as illustrated by my soft gaze and our shared smile. Ricoeur (as cited in Daniel, 1986) regarded empathy as “the principle common to every kind of understanding” (p. 206). In essence, Ricoeur described empathy “as the transference of ourselves into another's psychic life” (Daniel, 1986, p. 206). It was through this empathic understanding that I overcame the objective/scientific distance between Eve and myself—allowing me to approach Eve (the text) with an open mind (Daniel, 1986). In other words, I kept myself “open to what is other—to other, more universal points of view” (Gadamer, 2004a, p. 15). As an example, and as presented earlier, Eve shared with me that her mom had passed away when she was six years old. Having lost my own mother, I was acutely aware of the difficulties that I experienced as a result of this loss. However, despite feeling the intense emotions related to my personal grieving, I kept myself “open” to the possibility that Eve had experienced the loss of her mother from a “more universal point of view” (Gadamer, 2004a, p. 15). In fact, during our conversation Eve shared “you know you're pretty young and you don't remember a lot”—Eve had indeed, experienced the loss of her mother from a completely different point of view. A practice informed by my modified four-fold hermeneutical model then, impacted Eve through my recognition (interpretation) of Eve's readiness to discuss the spiritual issues as articulated/expressed earlier—an acknowledged and essential aspect of

EOL nursing care. In pondering the possibilities, I wondered if our conversation had indeed opened a path for Eve to engage in spiritual wonderings. I, as interpreter, was encouraged when Eve shared that she was open to discussions with the spiritual care provider at the hospice, for at one time, she “was not very receptive to what [he] had to say”.

Interpretation has the additional effect (impact) of interpreting the interpreter (Daniel, 1986). In other words, an enhanced awareness of the other (Eve) impacted me as interpreter through gaining a deeper understanding of myself. As an example, the conversation with Eve aroused my responsibility to become an active advocate for enhancing our current more scientifically-based spiritual care-giving practices at EOL. Two examples include the following: (a) presenting Eve’s practice exemplar at several local hospices, and (b) making the necessary preparations to publish my offering in a nursing journal. Ultimately, my goal is to explicate knowledge regarding hermeneutics, and more specifically my modified four-fold hermeneutical model and how it informs spiritual care-giving nursing practices at EOL (Charalambous, 2010).

Interpretation of the patient remains incomplete until we “put all the parts into a unitary whole—a world of truth which includes patient, nurse, and ourselves as interpreter” (Daniel, 1986, p. 207). Daniel (1986) asserts that if interpretation is successful, this world should be a new reality for each of us. For Daniel, this new reality is the result of the dialectic movement between the parts and the whole and between interpretation and understanding within the hermeneutic circle—bringing a relative closure to the circle (Charalambous, 2010). However, as discussed earlier in this paper, all understandings that flowed from the interpretation of Eve as text were/are never final.

In this final phase of the interpretive process, my interpretation of Eve's story may be expressed as follows: Eve was a remarkable woman who had experienced both sorrow and joy prior to her admission to the hospice. Through listening and hearing Eve's story, I began to understand her unique lived spiritual experiences and had a glimpse of the meaning of these experiences. Behind these statements is the story of how one human being (I, as interpreter) came to understand another (Eve as text). This understanding evolved through my modified four-fold hermeneutical model of interpretation from both the written (chart) and conversational texts (Charalambous, 2010; Daniel, 1986). My drive to care for Eve directed me toward a hermeneutic sense of truth—a truth which is based on the relations between Eve's written text (i.e., depression) and her profound spiritual-related conversational sharings (i.e., life review, understanding of spirituality, hope of finding inner peace at EOL, current support system, grief) (Charalambous, 2010; Daniel, 1986). I as interpreter, acknowledge that the truth(s) I seek through textual interpretation will always remain somewhat of a mystery. For seldom are the answers in spiritual care-giving practices at EOL more than tentative (Charalambous, 2010; Daniel, 1986). And yet, in the case of Eve, I am hopeful that her spiritual issues were indeed explored—supporting an optimal EOL healing environment that eased her suffering and enhanced her quality of life. This optimism is based on a world that the interpreter has come to know through text, a world in which a nurse's "personal values inspire the dynamic use of her/his professional skills and human resourcefulness to be an instrument of caring" (Charalambous, 2010, p. 1289).

Critique

A practice informed by hermeneutics, the art of interpretation, is certainly not one

without risks, problems, or tensions (Charalambous, 2010). Engaging with individuals (patients) from this philosophical stance—a stance that acknowledges the acceptance of multiple and subjective truths—is unlikely to ever be free of tensions. First, Baron (1990) argued that the metaphor of clinical practice as textual explication creates the expectation that there is “text” somewhere to be found. For Baron, this expectation invites health care practitioners and patients to search for the “text” and runs the risk of conceptualizing patients as more static than they are. Patients, according to Baron, “are not bibles, static objects [texts] waiting to be interpreted by a reader with appropriate skills” (p. 28). In fact, the search for “text” may ultimately be a distraction from what nursing is really about—a complex, dynamic, and interpersonal practice.

Second, considering the “patient as text” and then reducing that “text” to what may be documented within a patient’s chart or heard by a nurse in conversation/dialogue, could be problematic. As an example, intuitive knowledge in nursing practice is an integral component in informing nursing decisions and promoting competent and compassionate care (Billay, Myrick, Luhanga & Yonge, 2007). However, the intricacies inherent in the intuitive process because of their abstract nature (i.e., a gut feeling), are often difficult to articulate and as such, are not necessarily documented by the nurse in the patient’s chart. The pen, so to speak, in this instance, may not be mightier than the undocumented nuances of nursing intuition. With respect to the actual conversation/dialogue, although both the nurse and patient as dialogic partners free to engage in an openness to the other, this is problematic in that they may only do so to the depth that each wishes to take it. In essence, interpreters (nurses) ought not to take all “texts” (patients) or their accounts (sharings) at face value in all circumstances.

Third, the role of distancing in the initial phase/aspect of the interpretative process is problematic in that it promotes objectification of the “text” (patient)—a process that shifts reality from a philosophical realm to a scientific one. And yet, in doing so, distancing becomes a pre-requisite to enable the interpreter (nurse) to approach the “text” (patient) with an open mind. In other words, while the process of distancing objectifies the text, it does, at the same time, create an openness to other “more universal points of view” (Gadamer, 2004a, p. 15). Noteworthy is that this distance, later in the interpretive process, is overcome in order to preserve the relational values involved in nursing practice—shifting reality back from a scientific realm to a philosophical one (Charalambous, 2010; Daniel, 1986). This shift in reality from the philosophical to the scientific and back again, in of itself is problematic but nonetheless, approaching “texts” (patients) with this openness offers interpreters (nurses) an opportunity to gain valuable insights into patients’ subjective health experiences. Ultimately, it is the development of a deeper, more meaningful understanding of the patient’s experience of, and response to illness, which is a crucial factor in the nurse’s (interpreter’s) engagement with the concerns of the patient, and, perhaps more fundamentally, in the development of the empathic understanding which is essential for the delivery of optimal care (Robertson-Malt, 1999).

Objectifying the “text” (patient) through distancing is also problematic in that “texts” are susceptible to a multiplicity of interpreted meanings/understandings, many of which may be in conflict with each other (Charalambous, 2010; Daniel, 1986). Baron (1990) asserted that the infinitude of textual variants may oblige one to accept that the metaphor of “text” as being “hopelessly inadequate to the task” (p. 27). Such

infinite/multiplicity opens the possibility of misinterpretation/misunderstanding during a shared conversation. However, should misinterpretation/misunderstanding arise during shared conversation, the interpreter (nurse) may, in this instance, ask the patient for clarifications in relation to what has been said and as a result misinterpretation is avoided. One must be aware that each interpretation is the nurse's creative and imaginative preconception of what the truth about the patient may be (Daniel, 1986). In essence, each interpretation is considered to be a judgment that "does not bask in the certitude of scientific fact" (Daniel, 1986, p. 205). Ricoeur (1991) argued that truth has many different sides, although each being truth, represents a variant degree of truth. Moreover, he claimed that some aspects of the perceived truths appear more probable than others and is not meant in a statistical sense, rather, in the sense that the interpretation(s) that are most probable to be true. White (1997, suggested that rather than viewing the existence of multiple understandings/interpretations/truths from a negative stance, one might embrace it as a potential asset. According to White, along with this ambiguity and uncertainty comes hope and possibilities of healing.

Forth, with respect to the co-created dialogic "texts" which become open for interpretation, questions are raised regarding whose interpretation and for what purpose? Nursing practice, and more specifically EOL nursing practice, is consistent in an interpretive, attentive dialogue (text) that is directed toward supporting an optimal holistic healing environment that eases suffering and enhances quality of life. If we understand the interpretive dialogue (text) as the merging of two horizons—the patient's perspective and the nurse's perspective—then the meeting of these two horizons means that each participant comes to see things from the other's point of view in order to reach a

shared understanding (Svenaesus, 2000). This shared understanding reaches beyond the sum of the two often differing perspectives. In other words, this fusion of horizons is not necessarily synonymous with the interpreter (nurse) reaching the same understanding as the text (patient). As an example, with respect to Eve sharing pivotal moments of her life story with me, I as interpreter, based on one of my pre-understandings, interpreted/understood/valued that the process of a life review was essential to Eve's spiritual well-being. Eve, on the other hand, may not have held this same understanding. And yet, despite the possibility that we each had our own interpretation/understanding, Eve and I had, for all intents and purposes, reached a shared understanding—spirituality is integral to our nature.

Fifth, in circling back to the problem addressed earlier in this critique—the problem of shifting from an interpretive philosophical reality to one that is considered medicalized/objective/scientific and back again—we, as nurses, ought to be aware of the influences that affect our practice. For example, we are influenced by the diagnostic (medicalized/objective) information that we receive from the written chart document. However, this written objective “text” provides significant leads for our interpretation of the dialogic “text” that may be uncovered during shared conversations in our daily practice encounters. In essence, shifting between the two realities/worlds, speaks to the complex nature of nursing practice—a practice that, in my opinion, defies all specificity. In another example, we are also influenced by the effects of language. As a novice hermeneut, progressing through this last leg of my master's journey—my project—I often demonstrated my vulnerability to and influences of the language within a scientific worldview. Whether through the written language/words/terms expressed in this paper or

through articulating the abstract concepts of my modified four-fold hermeneutical model of interpretation to colleagues, I caught myself on many occasions utilizing language that would be considered medicalized, objective, and scientific (i.e., case study).

Nonetheless, my decision to embark upon an inquiry journey underpinned by philosophical hermeneutics has indeed, encouraged an acute mindfulness of the words/language that I use to express myself within and amidst both the scientific and interpretive realms. For each time that I revisit the foundational philosophic hermeneutical tenets/underpinnings and engage with the written “text”, I understand differently if I understand at all (Gadamer, 2004a).

Sixth, Baron (1990) argued that the postulation of “text” in clinical practice “creates an expectation of a source document, a foundational transcendent reality from which interpretations spring” (p. 27). So, where then is text to be found in EOL spiritual care-giving nursing practice and what is the thing we are interpreting (Charalambous, 2010)? Classical hermeneutics “begins in the interpretation of Scripture—Scripture itself—and an accepted foundational reality—the voice of the Creator—to be interpreted” (Baron, 1990, p. 27). Finding a parallel in EOL spiritual care-giving nursing practice is and will not be easy but the very nature of nursing practice allows for “such an expedition to take place” (Charalambous, 2010, p. 1289).

Seventh, the abstract concepts of hermeneutics, and more specifically, the abstract concepts of my modified four-fold hermeneutical model of interpretation, are problematic in that they may be difficult to articulate and implement into EOL nursing practice.

Rapport and Wainwright (2006) suggest that practitioners need accessible means of engaging with these abstract ideas. I ponder the possibility that a painting, a poem, or a

piece of music may help us accomplish such a task as these examples resonate more with the everyday problem of making sense of our experiences through the art of interpretation (Rapport & Wainwright, 2006).

Despite all of the aforementioned risks, problems, and challenges, a practice informed by hermeneutics and more specifically my four-fold hermeneutical model of interpretation, offers a new way of engaging with others in practice. Firmly anchored in the foundational hermeneutic principle of open dialogue and conversation, my model engenders an appreciation for the relational dimension of spiritual care-giving practices at EOL—opening possibilities of engaging in spiritual connectedness. Through the process of fostering dialogue that advances understanding, the interpreted meanings may indeed be what the patient may need to support spiritual growth and perhaps reduce spiritual suffering (Anchin, 2006). Ultimately more positive patient outcomes will result from nursing practice that fosters meaningful nurse-patient relationships. While nursing practice informed by hermeneutics may be “useful in moving away from the traditional, objectified theory that underlies current [EOL spiritual care-giving] nursing practice [i.e., spiritual assessment tools/instruments]”, . . . (Charalambous, 2010, p. 1290), one must be cautious of the textual metaphor hermeneutics brings with it (Baron, 1990).

Epilogue

Since this paper has highlighted how my modified four-fold hermeneutic model of interpretation may inform EOL spiritual care-giving nursing practice, and the topic is not concluded but only just beginning, it would be inappropriate to use the term “conclusion” (Charalambous 2010). Rather, I have chosen the word “epilogue” which seems more appropriate for this hermeneutical attempt to interpret the patient as text for

the purpose of providing high quality EOL nursing care (Charalambous, 2010). Although the term epilogue offers an ending it simultaneously opens a door for further development and applicability of my proposed offering to EOL spiritual care-giving nursing practice (Charalambous, 2010).

At EOL, many of the questions with which patients want and need to be engaged are spiritual in nature (Ciampa & Schafer, 2002). Ciampa and Schafer (2002) suggest that if the patient has no forum in which to engage their spiritual questions, they often manifest spiritual distress. Hermeneutics, the art of interpretation, with its open-ended nature of understanding, offers such a forum (Anchin, 2006). The aim of my project was to illuminate the possibility of introducing a modified four-fold hermeneutical model of interpretation (Charalambous, 2010) as an approach to inform spiritual care-giving nursing practices at EOL. According to Charalambous (2010), this model was initially developed for medical practice. However, my modified hermeneutical model can be appropriate for EOL spiritual care-giving nursing practice as shown through the presentation of Eve's story (practice exemplar). Interpreting the patient as text is certainly not an easy task; rather, a complex one that can be considered on the following four interpretative phases: (a) the object of interpretation, (b) the mode of interpretation, (c) the praxis of life-affecting response flowing from the interpretation, and (d) the change of life-world brought about through the interpretation (Charalambous, 2010).

Insights/understandings gleaned through the interpretation of the patient as text (i.e., Eve's spiritual experience) may persuade nursing colleagues working with those situated at EOL to practice the art of interpretation in their daily practice (Charalambous, 2010). Charalambous (2010) emphasizes that the meaning(s) found when nurses choose

to practice the art of interpretation is the meaning of the individual human who is the patient. Moreover, she asserts that the praxis or practical response to the interpreted meaning(s) will, in effect, reflect the information received through the process of interpretation. In Eve's situation, possibilities for understanding and engaging with her more meaningfully in the spiritual realm were realized. However, it is noteworthy that this can only be achieved by nurses who are devoted to interpreting the fresh text that presents itself in each daily practice encounter (Charalambous, 2010). Underpinned by the philosophy of Ricoeur, my modified hermeneutical four-fold model of interpretation appears to be appropriate for use in spiritual care-giving nursing practices at EOL by those who seek not to reach for "one universal truth but the many truths that the text hides" (Ricoeur as cited in Charalambous, 2010, p. 1290).

If the truth be known, the journey to completing my inquiry/project was indeed one filled with a myriad of unexpected challenges—challenges that included a shift from thesis (hermeneutics as an approach to nursing research) to project (hermeneutics as an approach to inform nursing practice). The impact of this experience; however, precipitated my need to open for questioning current EOL spiritual care-giving nursing practices. Amidst a wholly new situation, I was "struck by something . . . [I was taken] with it" (Jardine, 1998, p. 40). As a result, I have come to understand the advantages for patients in my being open to more than one approach to spiritual care-giving practices at EOL. In essence, I appreciate more deeply the value of scientific *prescribed doing* and how it can be combined with a philosophical hermeneutical way of *being* to inform EOL spiritual care-giving practices. At the onset of my master's studies I was closed to the possibility of completing a project—I was only going to add to the substantive body of

nursing knowledge through my published research. I had, for all intents and purposes, deemed a project to be a less valuable contribution to nursing knowledge than a thesis. And yet, despite the challenges that I have encountered in shifting my thinking from hermeneutics as a research approach to hermeneutics as an approach that informs spiritual care-giving practices at EOL, I have come to understand that my project, in fact, does not “pale in comparison” to the thesis that I had my heart set on after all. I am truly optimistic that my practice approach anew, once disseminated, will foster further dialogue and open possibilities of actualization into spiritual care-giving practices at EOL.

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Appendix A

Spirituality: An Understanding

Current trends in healthcare discourse understand spirituality as an “individualized journey characterized by experiential descriptors such as meaning, purpose, transcendence, connectedness and energy” (Pesut et al., 2008, p. 2). In essence, spirituality is “whatever the person states it is” (Bruce et al., 2006, p. 441). Problem-centered spiritual topics may include the following: (a) fear of death, (b) abandonment, (c) hopelessness, (d) unresolved grief, (e) loss of meaning in life, (f) unresolved past conflicts or experiences, (g) why me?, (h) need for reconciliation with or forgiveness from other people, (i) need for comfort and peace, and (j) need to receive love from others. Other spiritual topics may include the following: (a) philosophy of life, (b) expressions of spirituality, (c) important past or current events, (d) feelings about God and self, (e) belief in life after death, (f) things uncompleted, (g) faith and hope, and (h) support systems (Dudley, Smith & Millison, 1995)

Appendix B

End of Life: An Understanding

Hospice and palliative are terms that often are used interchangeably to denote a philosophy of care. The term hospice is derived from the Latin root *hospe* meaning hospitality: the term palliative, on the other hand, is derived from the Latin word *palliare* which means to cloak (Smith & Nickel, 1999). While hospice care is more often associated with community programs that have usually developed as separate, voluntary organizations, palliative care has generally been associated with care in hospitals (Ministry of Health, 2006). Hospice palliative care is a term that has been adopted by many organizations, including the Canadian Hospice Palliative Care Association (CHPCA), to encompass both sets of programs and origins—unifying the overall movement and establishing common sets of principles and objectives (Ministry of Health, 2006). The CHPCA (2007) provided the following understanding of hospice palliative care: care that aims to relieve suffering and improve the quality of life for individuals living with or dying from advanced illness. The British Columbia Hospice Palliative Care Association (2008), on the other hand, referred to hospice palliative care as “the physical, emotional, social and spiritual care aimed at providing comfort and improving quality of life for those persons living with or dying from advanced illness. Hospice palliative care is based on a commitment to the whole person” (para. 1). In other words, hospice palliative care provides a comprehensive, holistic, multidisciplinary approach to individuals living with or dying from a terminal illness. Although hospice palliative care, in practice, has often been associated with a limited number of progressive terminal illnesses, primarily cancer, the use of the term *end of life* has emerged recently with an

intention to offer specialized holistic services to a wider group of individuals approaching death—including cardiovascular or respiratory diseases, diabetes, alzheimers, acquired immune deficiency syndrome, renal disease, and amyotrophic lateral sclerosis (Boutayeb & Boutayeb, 2005; Coyle, 2001; Ministry of Health, 2006)