BEING-WITH DYING: TACIT WISDOM EMBEDDED IN THE EXPERIENCES OF NURSES WHO ATTEND TO DYING

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DEDICATION

This project is dedicated to the memory of my father, Max Leon Young, who died at home in the loving care of his exceptional wife (my mom), with whom he had just celebrated fifty-five years of marriage; his children (me, my sister and brother, and our spouses), his grandchildren, and many friends. All of those caregivers knew how to be-with dying. Dad's wonderful being lives on in us. He died while I worked on this project, his nearing death called me home from an away Heidegger researcher's conference. It is noteworthy that Heidegger took his works on being-with dying to the bedside of his dying mother.

This project is also dedicated to those who died and their family members, whose stories the nurses told; and to the nurses who provided the experiences and knowledge we need to realize better ways of understanding and dealing with caring at the end of life.

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ABSTRACT

Dying persons and their family members have needs that are notably unidentified and unmet in the United States today. This is in large part due to health professionals' being unprepared to provide end of life care that assists persons in their transition from dying to death with personal dignity and peace. Martin Heidegger's existential, interpretive phenomenology informed this study, providing the philosophical background, structures, language and metaphors to interpret narratives for patterns of being-with dying. Semi-structured interviews elicited tacit knowledge imbedded in the experiences of nurses who attend to dying, and showed how they comport themselves toward patients, families and others. How the nurses' patterns of being-with helped persons transition peacefully from dying to death is also described in the findings. The patterns were: (a) accepting death is a condition of authentic being-toward death, (b) personal experiences with death and dying enable nurses to connect-with, engage, and attune to patients, (c) possessing an optimum state of mind that is clear, calm, open, unknowing and knowing is a condition of authentic being-toward-death, (d) being-with intervenes, calling forth what another knows, and (e) being-with intervenes, situating and regulating interpersonal space. The patterns are holistic, woven together, and emerge in a presence of authentic being-with dying. They are explicated in a five-point framework and a pyramid for attaining authentic acceptance of death, both of which parallel Heidegger's structures of authentic being-toward-death. This research could extend to include other providers and settings, viz. physicians and to develop more complete frameworks to understand and intervene in the cognitive and affective mechanisms of being with dying, especially those which help and hinder effective being-with dying.

CHAPTER I

CALLING FOR NEW WAYS OF BEING-WITH DYING

This chapter is divided into three sections. The first section provides a general introduction to the area of study, end of life health care; and it briefly outlines the problem under investigation; the purpose of the study, and the significance of the problem as well as justification for investigating it. The second section defines important terms and concepts; and the third section discusses the choice of research paradigm for the study, and the philosophical assumptions that make this paradigm appropriate.

Providing quality care to dying persons in the United States and elsewhere has become a major health and social concern in the last two decades (Arnold, 2004; Asch *et al.*, 2005; Field & Cassel, 1997; Lunney *et al.*, 2003; Zaner, 2004) Quality care at the end of life is care that assists dying persons and their loved ones in their transition from dying to death with personal dignity, relief from suffering, and with opportunities to find meaning and self-understanding in life's ending. Quality care must also be within acceptable professional and ethical standards (Chochinov, 2002; Field & Cassel, 1997; Patrick, 2003).

Professional caregivers are unprepared to provide end of life care in ways that meet the needs of persons dying and those anticipating bereavement (Booth *et al.*, 1996; Fallowfield *et al.*, 2002; Field & Cassel, 1997; Heaven & Maguire, 1996; Institute of Medicine, 1997; Maguire & Pitceathly, 2002; Wilkinson, 1991). Consequently the basic needs of patients and family members remain notably unidentified and unmet. (Andershed, 2000; Bottorff, 2000; Kruijver, 2000; Lunney, 2004; SUPPORT Investigators, 1995).

Being in transition can itself compose persons' vulnerability (Meleis *et al.*, 2000). Therefore, being-with is set in the context of vulnerability in transition for both nurses and for those they are being-with in end of life situations. Nurses, the person dying, and those anticipating bereavement experience multiple transitions within the time period from dying to death. Transition for the patient and family refers to a time of change when a there is a decline in health and when this decline is likely to lead to death within one year or less. Nurses' being-with entails providing caring service during these transitions as well.

Distinct end of life vulnerabilities set in these transitions for nurses include death apprehension, situation ambiguity, moral distress, hopelessness and lack of organizational support. Vulnerabilities for families and their dying members include unidentified and unaddressed needs. On many occasions they experience a lack of information and decision making support that harms them. Quality pain and symptom management, and helpful information to support decision making are also often unavailable. Dr. Christakis (1999) reviewed a poignant story of how such vulnerability and harm ensue:

> The Thursday before my husband died, I thought he was dying and he thought he was dying. But the doctor was talking about aggressive chemotherapy...I was with him at the time of his death, but the room was filled with eight other people hanging bags of blood and monitoring vital signs. It was about as horrifying as anything that could have happened. I don't think the doctors were trying to mislead us. They thought he might be the one case that would have a positive outcome. But if I had been told the truth, we could have spent days with the children, together, not filled with painful regimens in the hospital (p. xiii).

While current literature begins to capture the fundamentals of end of life care, health care researchers have not yet reached the deeper meaning of the troubled end of life state of affairs (Asch et al., 2005). Clinicians' attitudes, social influences, and organizational and technological constraints together shape patient and family experiences in end of life care, and have led to unintended negative consequences for families and their dying members. (Christakis, 1999; Field & Cassel, 1997; SUPPORT Investigators, 1995). The experience of death in America calls for thinking over again: What could we understand better and address differently regarding being-with dying?

Purpose of the Study

National studies and scholarly literature ubiquitously show that health professionals need to act with more thought and tact in end of life encounters, and that we have not yet got a hold of the basic constitution of quality end of life care. Therefore the purpose of this study is to explicate tacit knowledge, and to document insights imbedded in the practice of nurses who are experienced in being-with dying. Being-with is defined as how nurses who attend to dying *are* as they attend to dying (what they say and do, and how they are present). The study may also show how the nurses' being-with helps persons transition with dignity and peace, from dying to death; and the pathways by which the nurses arrived at such demeanor toward dying patients and their families.

Significance

Pondering death (which we inevitably do when someone else dies) can awake a new view wherein one understands existence as a whole. From this view, death determines self-hood -- one may realize the limits of a lifetime; grasp the wholeness of being and of what one can become throughout the course of a life. Thought of in that way, death makes one 'whole'; it is not an 'end' but a promise of possibility, completion, freedom and wholeness (Demske, 1970). This advancement in thinking brings new freedom which makes possible a peaceful accompanying of one's self and other beings toward a fulfillment (rather than toward a dreaded end) in death.

Such themes of human limits and freedom have a direct bearing on the current debate surrounding dignity and quality end of life care. An ontological (what is deeper within) perspective of death integrates it into the core of being where it functions as a fundamental defining phenomenon of life (Ireton, 2007). Dying as a universal experience embracing every part of existence almost universally arouses feelings of awe and reverence, and of fear. Therefore it is reasonable to think that understanding being-with dying is the preeminent locus of inquiry in end of life care.

Few studies on end of life care have asked what helpful being-with *means* in such intricate (Boston *et al.*, 2001) and obscured caring situations as dying. Wilson (2000), in a review of nursing research on death and dying, identified that prior to 1960 most reports in nursing centered on technical activities associated with care of the dying; and that formal nursing research between 1969 and 1984 was descriptive and lacked a central paradigm. Early studies were conducted in hospitals, and focused on nurses' attitudes toward death, family responses and the influence of social structure and environment on coping. The nature of support that was helpful to patients and families was not addressed. Today, researchers are exploring nurses' experience and perceptions of end of life care (Abendroth, 2005; Boston et al., 2001; Bruce, 2002; Kirchhoff, 2000; Tishelman *et al.*, 2004), but few studies examine the support nurses provide that improve situations for patients and families.

Moreover, researches primarily arise from empirical/rational structures and do not explore the deeper meaning of being and the being-with phenomena. With regard to that discrepancy, Heidegger remarked in *Being and Time* that "...it is one thing to give a report in which we tell about entities, but another to grasp entities in their Being."

Further, it is not easy to get at this concept since "This Being can be covered up so extensively that it becomes forgotten, and no questions arise about it or about its meaning" (p. 15/35[1]). This study undertakes the latter task of showing entities in their being. Using the phenomenology of Martin Heidegger, it explicates authentic being-with, and portrays nurses' modes of being that are thoughtful, sensitive and insightful, that which helps dying people and their families' transition with peace and dignity from dying to death.

Being and being-with are tacit, difficult to grasp concepts, which are not easy to describe. Deeper, sub-conscious matters such as being-with dying are understandably not developed in the medical and nursing research because they are nearly imperceptible. Yet thought and action emerge from that tacit ground, and any fundamental understanding or change will come from there also (Bohm, 2003).

If change is sought, one must get to the ontological ground of such indefinite matters. Heidegger believed that the indefiniteness of being itself was a phenomenon which needed clarification, his thought and categories for understanding the meaning of being (entities) and Being (of entities) provides clarification and clues for starting an interpretation (Heidegger, 1927/1962). Nurses' accounts of being-with dying and their thoughts about it provide important insights for those interested in helping others who are facing death.

This study may enhance awareness and understanding of what constitutes helpful being-with dying for nurses and other care givers. That could assist them to improve practices and self-regulation that they control. If nurses can identify their own patterns of daily thought that either interfere with or enhance helpful being-with dying, they may

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[1] Page references in Being and Time indicate the pagination of the interpreted edition/German editions.

fashion their own skills and attitudes to be more appropriate and sensitive in end of life encounters. For instance, reappraisal, a mental strategy that can alter emotional responses, gives persons conscious control of their emotions when used intentionally (Ochsner, 2002). Another example is attunement, which is attention that goes beyond momentary empathy to a full, sustained presence that facilitates rapport (Goleman, 2006). Further work in this area could give rise to a fundamental change of consciousness (from inauthentic to authentic being-toward-death), leading to more harmonious, peaceful, and dignified end of life experiences for everyone concerned.

> Caring for people who are dying can be an intense, intimate, and deeply alive experience. It often challenges our most basic beliefs. It is a journey of continuous discovery, requiring courage and flexibility. We learn to open, take risks, and forgive constantly. Taken as a practice of awareness, it can reveal both our deep clinging and our capacity to embrace another person's suffering as our own.
> (Alayan Institute, 2007)

Terms and Concepts

Initial definitions for important terms and concepts clarify the area of study. They are offered here in brief while more detailed definitions are provided in subsequent chapters.

End of life care

A current lack of agreed upon definition for ‘end of life’ complicates research in this area. End of life is primarily a temporal subject, hence the time frame denoting end of life for this study encompasses (a) eminent dying, (b) having a few weeks or months to live; (c) having no given, but a likely prognosis of one-year or less if the disease takes its normal course, and (d) sudden death. Care refers to the care provided to persons with life threatening illnesses facing end of life issues. End of life care is an expression usually associated with hospice services.

Palliative Care

Palliative care is more often associated with the broader primary health care system than with community or public health settings (i.e., home hospice). It aims to improve the quality of life for patients and families facing problems associated with life-threatening illness but focuses on active treatment of the disease. Both end of life and palliative care: (a) provide relief from pain and other distressing symptoms, (b) affirm life and regard dying as a normal process, (c) neither hasten nor postpone death, (d) integrate psychological and spiritual aspects of patient care, (e) offer a support system to help patients live as actively as possible until death, (f) offer a support system to help the family with the patients illness and in bereavement, (g) use a team approach to address the needs of patients and their families, including bereavement counseling; and (h) enhance quality of life. Palliative care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and investigations needed to better understand and manage distressing clinical complications (World Health Organization, November, 2006).

Philosophical Terms

Being (Sein)

The question of what being is, is considered the original philosophical question by many Eastern and Western thinkers (Farrell Krell, 1977, 1993; Gupta, 2000). Aristotle's (384-322 BC) broadest and deepest question, which demanded an account (logos) of the being of beings (onta), became known as "ontology." In the introduction to *Being and Time*, Martin Heidegger said that "Being," the basic theme of philosophy is the most universal and empty of all concepts. It resists definition because it cannot be derived from a genre higher than itself, nor can a genre lower that it (beings) be attributed to it (Farrell Krell, 1977, 1993).

For proper evaluation of Heidegger's thought, it is important to have a clear perception of the question of being as he initially approached it. First, Heidegger's question of being was not about being itself, but about the meaning of being. This makes the question a phenomenological one: inquiring about things as they appear to us; about the content and significance of concepts, and about the contents of consciousness. Heidegger applied the phenomenological question, not to a thing but to being itself (Demske, 1970). He acknowledged that being is not itself an entity but the being of entities. Being is an act, an event, a process (really the most primordial of all those, underlying all other possible acts). Being indicates the continuation of the 'action' 'to be' just as 'walking' indicates the continuing of the action "to walk."

Beings (*Seiendes*)

The way to realize what being is, is through beings themselves. Beings show being through their authentic coming to presence. Beings remember being in deep awareness and observation of another coming to presence. *Dasein*, Martin Heidegger's German term for being-there (a person, the human way of being) is the lighting up place of being. In Heidegger's later work, beings were denoted as mortals. In research, researchers question entities (beings) regarding their being. Heidegger emphasized a return to the central themes in philosophy—questions pertaining to the being (the ontological) of beings (the ontic).

Phenomenon and Logos

The word phenomenon means in Greek 'that which reveals itself.' A phenomenon is what shows itself in itself, (being in beings) what is manifest (Farrell Krell, 1977, 1993). Logos can mean *reason* because its function lies in letting something be seen straightforwardly, in letting beings be apprehended. Logos can also mean *ground* in reference to what is pointed to, what always already is at hand as the basis for every discourse and discussion. Finally, logos can mean *relationship* to or what is addressed (Farrell Krell, 1977, 1993).

Phenomenology

The formal meaning of phenomenology is 'to let what shows itself be seen from itself, just as it shows itself from itself (Farrell Krell, 1977, 1993). This term neither designates the object of its researches nor does it describe their content. It only tells something about the technique, method and treatment of what phenomenology considers.

Ontological Hermeneutics

Hermeneutics is the art or theory of interpretation as well as a philosophy that starts with questions or interpretation. Originally concerned more narrowly with interpreting sacred texts, the term acquired a much broader significance in its development and became a philosophical position in 20th century German philosophy. Heidegger views hermeneutics as an 'ontological event,' an interaction between interpreter and text that is part of the history of what is understood. It concentrates on the experience of understanding, focused on how people come to understand (Koch, 1995).

Overview of Method

The phenomenon under study is: the *being-with*[2] of nurses who care purposefully to meet the needs of those dying, and those anticipating bereavement. Heideggerian philosophy articulates an ontological (what is deeper within) understanding of being-with that can inform ontic (day-to-day) end of life caring practices. Heidegger's phenomenological approach guides this inquiry to uncover the "place holder" in being where the phenomenon of purposeful being-with dying arises and returns (Heidegger, 1927/1962).

Most end of life care research is associated with empirical-rational traditions while *being* must be associated with interpretative traditions. Empirical thought reflects how humans gain knowledge through the senses, whereas rational thought reflects how humans gain knowledge through reason or mental construction (Stewart, 1993). Those traditions form the foundation for outcomes health care, and they differ greatly from the traditions that underlie interpretative research. An overview of empirical and rational thought is presented in Chapter Three, *Method of Inquiry* the research paradigm section of this paper.

Phenomenology as the philosophical framework, and hermeneutics as the interpretative approach, makes it possible to get 'behind' and to the root of conceptions to render the thing (being) itself visible (Palmer, 1969a). The essence of being is mostly hidden behind day-to-day living; phenomenology brings into view previously concealed approaches to situations of concern; in this case, being-with in end of life care.

Phenomenology is the science of the being of entities – ontology (Heidegger, 1927/1962). An appropriate topic for phenomenological inquiry is one that questions a lived experience: a certain way of being-in-the-world (Van Manen, 1990). Some argue that phenomenological knowledge has no practical value because we cannot do anything with it. However, Van Manen paraphrased Heidegger saying that the more important question is: “Can phenomenology, if we concern ourselves deeply with it, do something with us?” Polkinghorne (1988) described the fruit of phenomenological inquiry this way: “Qualitative research does not provide information for the prediction and control of behavior; instead it provides a link of knowledge that individuals and groups can use to increase the power and control they have over their own actions.” (p. 10).

This project has the potential to reveal such an opportunity for nurses and others to hear the call “to open” to conscious awareness of attitudes, beliefs, emotions, and cognitive processes that affect behavior and reactions; to practice ‘hearkening’ in diverse contexts but especially in being-with dying, and to transform inauthentic into authentic being.

Overview of Dissertation

Chapters Two and Three present the justification for this study and the fit of the methodological choice to address the problem. The literature review in Chapter Two includes a hermeneutical analysis of themes in philosophy that relate to being-with dying, as well as common themes in the scholarly literature on the problem. Themes on relationships and communication between nurses, patients and families, and their vulnerabilities in end of life situations are also presented.

The design and methodology section in Chapter Three describes the pilot interviews, background understandings that situate the study in the philosophy of science; a description of the philosophical framework for the study, existential/interpretative

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[2] Means *being there-with*, alongside of others who are themselves the same as ourselves.

phenomenology, and on the method for the study, hermeneutics. The participants, data collection and hermeneutical analysis are also described.

Chapters Four and Five respectively present personal and professional profiles of study participants and the narratives representing insights (patterns) from the study. Conclusions, discussion of findings, implications for leadership and nursing practice, and recommendations for future study are offered in the final chapter.

This chapter began with a general introduction to end of life care as the area of study. It briefly outlined the problem under investigation; the purpose of the study, the significance of the problem and justification for investigating it. Terms and concepts were defined to clarify ideas and the underlying philosophy. An overview of phenomenology as the philosophical framework and hermeneutics as the interpretative approach was presented. Chapter Two explores knowledge development in end of life care.

CHAPTER II

EXPLORING KNOWLEDGE DEVELOPMENT IN END OF LIFE CARE

To explicate the findings of the literature search, this review begins with information on retrieval and analysis, detailed definitions for important philosophical terms and concepts, and a hermeneutical analysis of themes in philosophy that relate to being-with dying. The chapter continues with an historical overview of death-related nursing research and a comprehensive review of two national studies focused on improving care at the end-of life. The final section of this chapter provides hermeneutical analyses of studies on nurses' experiences and patient and family experiences related to end of life care. Themes on relationships, communication, and vulnerability in end of life care are woven into the review. A summary discussion provides the premise for this research demonstrating that current knowledge does not explicate the deeper causes of current problematic end of life care affairs.

At the dawn of the 21st century, end of life care discourse, research and the appearance of best practices have risen dramatically and inspired innovations in end of life care (Romer, 1999). The emerging discourse has disturbed the established, habitual ethos of caring for families and their dying members (Ferrell, 2006; Institute of Medicine, 1997). Those challenges, along with the shortage of nurses, tensions between care giving ideals and system limitations, as well as dilemmas imposed by technologically advanced, fast-paced health care environments (Heidegger, 1993; Kirchhoff, 2002; Tishelman et al., 2004; Zitzelsbeger, 2004) call for new ways to think about and understand being-with dying (Field & Cassel, 1997; Kaufman, 2005; Zaner, 2004).

A comprehensive literature search was conducted to identify studies that focused on (a) phenomenology of being-with dying, (b) experiences of nurses who care for dying persons and their family members, and (c) experiences of families and their dying members receiving nursing care at the end of life. These areas of study also included intervention studies to (a) improve communication and relationships between nurses and those in their care at the end of life, (b) improve patient and family satisfaction with end of life care, and (c) improve clinician coping strategies and attitudes to death.

Sources for the review included computerized databases: The Cumulative Index of Nursing and Allied Health Literature (CINAHL), Pub MED, MEDLINE, the Cochrane Database of Reviews of Abstracts, the National Consensus Project for Quality Palliative Care, and several recent systematic reviews from both Health Canada and the National Institute for Clinical Excellence, United Kingdom. The searches were limited to published articles in English between the years of 1990-2006.

To identify literature on nurses’ being-with dying, keywords such as (a) end of life, (b) nurses and nursing care, (c) death and dying, and (d) terminal illness were used. Those key words were coupled with terms such as (a) communication, (b) relationship, (c) being, (d) phenomenology, (e) ontology, and (f) the name Heidegger. A search in Pub MED on communication at the end of life, for example, revealed 1050 articles while a search combining the terms nurses and dying patients produced 479 articles, and a search in the same data base combining the terms Heidegger and death produced 13 articles, only one of which fit the criteria for inclusion. An ancestry approach was also used. In all, over 1,000 articles were screened.

Citations excluded were: (a) pediatric population studies (b) non-western population studies, (c) clinical trials of primary disease processes, (d) descriptions of ethical, legal or regulatory issues, (e) non-clinical histories and personal narratives, and (f) articles about organ transplantation or donation.

Citations that met the following criteria were included in the final review: (a) philosophy and scripture about being and being-with dying, (b) national studies about the state of the science of end of life care, (c) nursing and medical studies about communication and relationships between nurses or physicians, and families and their dying members, (d) nursing studies about "being," (e) studies about the experiences of nurses' vulnerability and care giving in end of life situations, and (f) studies about patient and family vulnerabilities and experiences receiving care at the end of life in any setting.

Themes in Philosophy that Relate to Being-with Dying

End of life scholars have spent little time examining how philosophy informs appropriate ways of being-with dying. No studies were located that address what underlies helpful being-with in end of life situations. It is clear though that more thoughtful and tactful ways to be-with dying are needed. Heidegger's philosophy reveals what is and what is not authentic being-with dying (Heidegger, 1927/1962). Good philosophical form clarifies language first. Heidegger's linguistics are defined to enhance conceptual and existential understanding of philosophical terms related to being-with dying:

Being – Sein

The original philosophical question, and Aristotle's broadest and deepest question, which demanded an account (logos) of the Being of beings (onta) became known as "ontology" but seemed to lose all meaning over the next two thousand years (Farrell Krell, 1977, 1993).

Martin Heidegger (1889-1976), whose philosophical investigation of Being and phenomenology was laid on ground prepared by an important teacher Edmund Husserl, followed the question of being with remarkable persistence. He identified the ground structures of being, the meaning of being, and also means for realizing its origin (Demske, 1970; Gupta, 2000; Heidegger, 1927/1962). Heidegger used the terms e*xistential and ontological* to refer to the original, deep, innermost level of intelligibility, being. The terms e*xisteniell* and *ontic* described how persons *act* on the immediate surface level.

How beings act refers to (a) authentic being which arises from deeper within, and (b) inauthentic being, day to day being on the surface level. Existential and ontological, deeper understandings of truth and freedom are lost in *fallenness* or every-day-living as persons are in a period of forgottenness. In other words, living in every-day understandings on the ontic level (in habits, assumptions, routines, dulled and vague awareness of living, and so on) often conceals understanding of the definitive inner ground of being (Demske, 1970; Heidegger, 1927/1962).

Nurses and all human beings live mostly on the ontic, surface level, and good work and caring occur on this level (e.g., W. Stohrer, personal communication, November 2005). Yet deeper meanings of being that transcend the tangible are often missed. In *Being and Time* Heidegger said:

> “Being, as the basic theme of philosophy, is no class or genus of entities; yet it pertains to every entity. Being and its structure lie beyond every entity and every possible character which an entity may possess. We can grasp upon it only as a possibility.” (p. 38-39).

Dasein (a person’s being coming to presence)

Heidegger’s project of arriving at the basic concept of ‘Being’ and of outlining its ontological conceptions and variations, proceeded by way of interpreting what he called a ‘certain special entity’, *Dasein* (Heidegger, 1927/1962, p. 39). Dasein is Heidegger's German word for "Being-there," the kind of being that self-conscious human beings uniquely possess. Dasein is an entity (a person) having awareness, or some understanding; no matter how vague, of its being in the world (Farrell Krell, 1977, 1993). Dasein is the underlying acting of any act, event or process. It is a ‘lighting up place’ wherein being comes-to-presence. For instance, human beings perceive when being comes to presence as someone is being-in a mood or being-in love.

All beings connect through Dasein’s consciousness (this is what we’re all in together). Being abides within Dasein, lives through Dasein, and speaks to Dasein. Dasein is self-conscious and has a responsibility for its own being, and an obligation to be significant and authentic. Dasein also possesses an understanding of other beings and of its connection to, and caring for them (being-with). These understandings are modes of being Dasein (Heidegger, 1927/1962). Persons are aware of themselves and of others; aware that they are responsible for their actions and they begin to realize meaning in being-with and caring for other beings. Dasein is any person who has such being and who is thus an ‘entity’ in him or herself. In this sense, physical appearances of everyday living can become spiritual awareness of and appreciation for the connection of all beings through Dasein's consciousness.

Heidegger believed that a*wareness and acceptance* of death, as Dasein's ultimate possibility, is the outlook which has potential to transform Dasein from its ontic, often inauthentic being into its ontological, authentic being (Demske, 1970; Heidegger, 1927/1962). Awareness and acceptance of death, in this sense, are critical means to authentic being-with dying.

Alētheia (truth)

Demske (1970) translated Heidegger's argument in *Being and Time*, that truth in the sense of 'correctness,' or the truth of the correspondence theory, phenomenologically presupposes another sense of truth, Alētheia, un-concealment (p. 244). Before something can be questioned as correct, it must "be"; it must appear, show up, or reveal it self. Alētheia is the un-concealment implied in Dasein. Gelässenheit (serenity) is Dasein's mode of listening that lays the field out for Alētheia (non-concealing) to show up.

Gelässenheit (serene awareness that hears with wisdom)

Truth shows up when and where there is a hermeneutical opening, a clearing silence, a field of tonality laid out for disclosure (Demske, 1970). An example is pure silence, a potential moment or extension of moments when all thought ends and when persons may recognize their ontological (deeper within) self. There is immense space here because the ontic 'self' or ego becomes inactive (nothing is behind existence) and this makes thought stop. In this space and silence something new can show up that is untouched by time and thought. "It is a whole unitary process, moving, living." (Krishnamurti, 1999).

Fursörge (Being relating to other beings)

Fursörge “caring for” is the fundamental characteristic of Dasein (a person) in relation to other beings in the world. Dasein, an entity, is in a world among other beings, with beings, and in the presence of other beings. Dasein *already knows* other beings and has some understanding with which it approaches them. This implicit understanding, attunement, is the particular antecedent that makes it possible for Dasein to encounter the beings around it at all. Dasein’s being-with” other beings takes the form of “caring about them” or “caring for them.” because it knows them as itself (Demske, 1970), it is able to attune to their subjective experience.

Inauthentic Being-Unto-Death (closed, denial)

Heidegger’s inauthentic mode of being-unto-death is not a value judgment but a description of ontic (immediate surface level) qualities lived in day to day life (Nelms, 1996). Heidegger calls this state of Dasein “Falleness” (Heidegger, 1927/1962). Persons often live in being states influenced by (a) the conditioning of custom, convention and habit, (b) closely held values, (c) emotions, (d) patterns of thought (e) cultural myths, (f) attitudes, and (g) conformance to the norm. In a state of fear, they are more likely to retreat to the familiar, or even to close down altogether (Goleman, 2006). Drawing on personal experience, nurses can recognize how their human capacity to be open and self-aware, to listen deeply and to be present, can be moderated or wholly occluded by apprehension and other such ontic states. Ontically, day to day, Dasein is blind to the existential reality of death as an ever present possibility of its own Being (Demske, 1970). Being blind this way makes it impossible to attend to dying as a matter of truth or certainty—even though it *is* true and certain.

Evasive Flight from Death

Ontic, day to day characteristics of inauthentic being-unto-death or evasive flight from death (Demske, 1970) include inconspicuousness (concealing reality), equivocation (hedging or prevarication), temptation (drawing to the ordinary), tranquilizing (using soothing clichés), and estrangement (separating). Evasive flight from death characteristic behaviors are found persistently imbedded in, if not directly stated in, end of life literature and anecdotes. Health care providers' attitudes, and focus on extending life at all cost while ignoring the threats to human fulfillment is but one example.

Authentic Being-Unto-Death (open, accepting)

Ontological, hermeneutical openness to and acceptance of death describes authentic being-unto-death. It is an unlikely yet achievable way to be with one's self and with others in the world. Heidegger claims to make no value judgments towards inauthentic Dasein. He counsels that falling is not bad and deplorable, nor is authentic being an advanced stage where persons have liberated themselves from falling. Rather, authentic being is only a modified way to be-with others (Heidegger, 1927/1962).

Heidegger conceived death not as an event which puts an end to life, but as an existential ontological determination of being, an element and a measurement of life itself. "It is not something occurring just at the end of...life, but something always present, from the very beginning..." (Demske, 1970, p.7). The view that death is always the ultimate possibility for a person serves as a potentiator of existence (Ireton, 1997). In authentic advancing-toward death, Dasein has a means to undergo stages of self-transformation in both thought and deed, a possible transformation to authentic being that opens a broader and deeper view of life which shows the meaning of being. In this way, death is the primary and definitive power-to-be that a person has. One understands oneself in relation to being, and by being in that awareness reaches authenticity. Standing outside of ones self and forgetting personal interests, to accept willingly one’s task as the place-holder for illuminating the meaning of being. Death determines selfhood, as a promise of possibility, freedom, and wholeness (Ireton, 2007).

Heidegger (1927/1962) believed that Dasein transforms from inauthentic to authentic being through the call of conscience, and by Dasein’s willingness to hear the call. The call of conscience resonates through Dasein’s ‘ontological guilt,’ which it notices as a feeling at the gut level (Gendlin, 2004); a gap between the way it is being (inauthentic) and the way it ought to be (authentic). The call entreats Dasein to accept death squarely, as its ultimate possibility. In acceptance, Dasein apprehends proper comportment of authentic being-unto-death. Authentic being-unto-death is a combination of actively accepting death and holding open to the ever-present possibility of the dissolutions of being in the world. This creates anxiety, which requires Dasein to be resolute in its advance toward death.

Being aware of a wide range of experiences enables persons to attend to and change undesirable responses, and to consciously develop qualities such as self-regulation (Bohm, 1992; Morin, 2004). Dasein’s experience in an authentic state, in the absence of death apprehension, is granted both freedom and truth with which to embrace life *as* it journeys (Gullickson, 1993). More simply, Dasein remembers itself as the

Source of everything that lives, it would be at peace, and having peace, would share peace with others (Demske, 1970; Fleischman, 1995; Schucman, 1975).

To have that experience Dasein needs a decisive, resolute sense of purpose that releases fear to find truth and freedom. Being this way facilitates service to those dying wherein one is no longer anxious. Rather, one is calm, composed and attentive in service of being (Demske, 1970), able to see beyond the self and to be open toward other beings.

Accepting death functions as a supreme affirmation of life, calling Dasein to live in such a way that it would wish every moment of existence could eternally recur. Authentic Dasein regards death as a long term process integrated into its personal existence rather than a single extraneous event over which it has no control.

Summary of Terms

The terms *Being (existence), Dasein (being-there), Alētheia (an experience of hearing truth with awareness), Gelässenheit (serenity, listening with wisdom), Care (being toward other beings* or Fursörge (caring for)*, Inauthentic-being (ontic, day to day being), Evasive Flight from Death and Authentic being (ontological being)* were defined and linked to the topic of this research. The next section of the literature review discusses common themes found in two national studies focused on improving care at the end of life.

Themes in Two National Studies on Improving End of life

An array of end of life studies can be cited in the past two decades. Two national studies were selected for this section of the review: (a) Approaching Death: Improving Care at the End of Life by Field and Cassel (1997) and (b) End of Life Care and Outcomes (Lorenz *et al.*, 2004).

Approaching Death

Approaching Death (Field & Cassel, 1997) was a study carried out by the Institute of Medicine (IOM). The IOM was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions to examine policy matters pertaining to the health of the public. *Approaching Death* arose in response to a request that the IOM conduct a project to develop guidelines for identifying and limiting futile treatments. The study group proposed to broaden the study to encompass end of life care. Its purpose was to examine what was already known about care at the end of life, what was yet to learn, and was known but not applied.

The goal was to understand what constitutes good care for the dying and to offer recommendations that address specific barriers to good care. The group examined end of life care dimensions including: (a) determining diagnosis and prognosis and communicating these to patient and family, (b) establishing clinical and personal goals, and (c) matching physical, psychological, spiritual, and practical care strategies to the patient's values and circumstances. Dying experiences in hospitals, nursing homes, and other settings, as well as the role of interdisciplinary teams and managed care were examined. Perspectives on quality measurement and improvement, the role of practice guidelines, cost concerns, and legal issues were offered.

In Chapter 3, *Caring at the End of Life*, the authors focused on the patient, family and those directing and providing end of life care. The experience and fear of unrelieved symptoms were found to be fundamentally important. Health professionals need to shift away from an attitude that “nothing can be done” for dying patients and become better prepared to care well for the dying. Through a series of vignettes, the chapter conveyed a variety of patients’ experiences with dying and how those experiences were shaped by the illness, patient/ family and other’s reactions to it, and the care provided. The report concluded “From the cellular to the social level, much remains to be learned about how people die and how reliably excellent and compassionate care can be achieved” (Field & Cassel, 1997).

There are important, unanswered questions about the symptoms that cause suffering among dying patients, and about the kinds of interventions that will relieve these symptoms. The influence of attitudes and beliefs on people's experience of dying, and on caring practices has not been studied sufficiently. Examining reasons that providers do not apply existing knowledge would help identify means to encourage more effective care at the end of life. The committee recommended a focus on extending the knowledge base for effective, reliable care at the end of life and on investigating effective educational strategies to change health professionals’ knowledge, attitudes, and behavior.

End of life Care and Outcomes

End of life Care and Outcomes (Lorenz et al., 2004) was commissioned by The National Institute of Nursing Research (NINR). The Agency of Health Care Research and Quality (AHRQ) created an evidence report as a basis for the State-of-the-Science Conference in December 2003 (Lunney, 2004). A total of 24,423 citations sources were identified and 5,216 went on to abstract review. Nine hundred and eleven articles were reviewed in detail including 95 systematic reviews, 134 intervention, and 682 observational studies.

The study focused on patient and family satisfaction outcomes regarding pain, dyspnea, depression and anxiety; behavioral problems in dementia, continuity, care giving burden other than bereavement, and advance care planning. Investigators conducted a systematic review to evaluate (a) The scope of the end of life population, (b) Outcome variables that are valid indicators of the quality of the end of life experience for the dying person and surviving loved ones (c) Patient, family, and healthcare system variables associated with better or worse outcomes at end of life, (d) Processes and interventions associated with improved or worsened outcomes and (e) Future research directions for improving end of life care.

Among the researches, the study group reported that cancer care was strong, reflecting the degree to which palliative care has been integrated into oncology practice. Further they reported strong associations between satisfaction and communication, pain control, practical support, and enhanced care giving. High-quality measures of quality of life, satisfaction, quality of care, and symptoms were also found among the studies reviewed. Strong evidence was found in cancer pain and depression treatment and there was evidence that opioids improve dyspnea.

Eleven research priorities were identified including the need to: (a) characterize the implications of alternative definitions of the “end of life” (b) test measures in diverse settings and populations; (c) emphasize specific process in studies of satisfaction, especially those less studied (e.g., non-pain symptoms, spiritual support, and continuity), (d) address methodological challenges in measurement, (e) conduct studies of the epidemiology and clinical significance of symptoms in non-cancer conditions, (f) conduct larger studies of interventions for dyspnea, (g) conduct studies of short-term as well as long-term treatment of depression, (h) conduct studies of care giving in populations other than cancer and dementia, (i) evaluate economic and social dimensions of care giving, (j) emphasize common settings (e.g., ambulatory care) and studies of nursing home-hospital continuity and involving multiple providers in continuity research, and (l) incorporate palliative domains and ensure that studies can be generalized to the sickest patients in studies of continuity in congestive heart failure (CHF).

Most of those recommendations focus on positivist rather than phenomenologist research strategies; but recommendations supporting the need for this study included emphasizing less studied areas of patient satisfaction i.e., non-pain symptoms; spiritual support, and related studies, studies of care giving in populations other than cancer and dementia, and studies to evaluate the social dimensions of care giving.

The researchers acknowledged several issues that complicated the review including lacking a definition of the “end of life;” lacking clarity concerning certain concepts and their measurement, and distinction among patient groups diagnoses (i.e. those affected by cancer, CHF, or dementia). Also, they did not review many symptoms, bereavement, or spirituality. They considered randomized clinical trials, interventions studies and prospective cohort observational studies as the highest-quality evidence. Those and other limitations may have created neglect of important associations among patient, family, the health care system and outcomes.

Another limitation in both of the foregoing reviews is that they primarily embrace the idea that technically, rather than judgment based practice approaches lead to helpful actions by practitioners (Maguire & Pitceathly, 2002). Technically-based approaches for practice or training hold that programs or techniques produces change, not the caregiver. Practitioners apply scientifically validated knowledge and adhere to progressions of techniques or laid-out programs that have been experimentally demonstrated to accomplish a specified goal. Judgment based practice approaches focus on the practitioner that produces change. Practitioners use personal and professional, situated judgments (social and emotional intelligence), and inform actions toward accomplishing a specified goal for a specific person, in a specific situation, and at a specific time (Polkinghorne, 2004).

Either approach used alone would limit perspective and truth finding. A view focusing solely in terms of what we *know* about the interpersonal world at the end of life ignores what we actually *do* in end of life encounters (Goleman, 2006). Practitioners need to use both technically-based and judgment-based actions.

Conducting tests and evaluations of programs and techniques provides knowledge of procedures that are generally helpful. Yet, simple implementation of empirically supported programs, techniques or lists of criteria and best practices is not enough to accomplish goals for better end of life care and authentic being-with-dying. Nursing judgment is needed to determine whether an empirically supported program is right for a particular group, or whether certain protocols are appropriate for an individual.

Meeting the needs of those cared for by nurses usually involves the inventions of new actions as well as creative responses (Polkinghorne, 2004). The present study does not eliminate technical-based approaches but seeks also judgment-based actions grounded in participant nurses’ knowledge, experience and preparation for being-with dying.

The shortcomings of the current health care system are well documented in the foregoing studies. Both studies identified needs for better continuity, communication, patient and family-centeredness, relationships and the need to examine the experiences of clinicians and patients and family. Yet, we’ve not yet gone deep enough (Asch et al., 2005). This study aspires to go deeper, to the ontological level of the being of nurses who attend to dying.

Historical Overview of Death Related Nursing Research

Benoliel (1987) identified that after 1960, interest in studying death spread across many academic and applied fields. Significant theoretical and empirical contributions were cited by investigators such as Glaser and Strauss, Kubler-Ross, Fulton and Kalish and Kastebaum. Benoliel’s search to locate nursing research in death and dying spanned the years 1969-1981, and included a Medline search of health sciences literature and *Indexes of Dissertation Abstracts International*. “Death-related research in nursing began to appear during the 1960’s” (p. 104), and before that the literature was meager and focused on technical tasks done at the time of death.

Nurse theorist Hildegard Paplau (1909-) stimulated ideas on the importance of interpersonal relations, and the nurse’s responsibility for offering emotional support at the end of life. Formal nursing research on death and dying was greatly influenced as nurses moved into other disciplines for doctoral study. “The fields of education, sociology, and psychology played a major part in the development of nursing research on death and dying.” (p. 105). The major contributions to nursing knowledge at that time fell into three categories: (a) nurses reactions and responses to death and dying, (b) patient and family adaptations to death and dying, and (c) environmental and social processes affecting adaptations.

The research produced evidence that (a) focused education programs contribute to changes in nurses’ attitudes and knowledge about death, (b) innovations in nursing practices can be facilitated when planned interventions take social system and work environments into account, (c) attitudes and behaviors of student nurses toward death and dying can be influenced by their basic educational experiences, and (d) death and dying is stressful for patients and families and nurses.

Studies on death and dying pointed to social interaction and a need to clarify interpersonal goals and operations of end of life nursing practice. Little was known about social support that would improve the situation for people “undergoing major transitions associated with death and dying” (p. 122). Current studies point to essentially the same needs, to focus research on (a) attitudes toward death and stress responses of nurses, (b) the meaning of dying to patients and families, (c) nurse-patient communication, (d) social characteristics of hospital deaths and (e) social interaction.

Themes in Nurses’ Experiences Providing End of Life Care

Being-with, as the topic of this dissertation is distinctly set in the contexts of (a) end of life experiences of nurses and (b) the experiences of dying patients and those close to them. Twenty-four studies that focused on nurses’ experiences in end of life care were selected for this part of the review. Thirteen of the studies were qualitative; eight were quantitative, along with one concept analysis, a commentary, and a literature review.

A hermeneutical analysis of those studies showed that common themes representing them include: (a) interpersonal experiences are the common ground of nursing care, (b) combined existential experiences (i.e. fear of death and moral distress) create vulnerability and can lead to behaviors of self-protection and consequent patient abandonment, and (c) experienced nurses are self-aware and comfortable being-with dying. Experienced nurses cultivate distinguished abilities to fine tune end of life care.

These are the situations that characterize nurses’ experiences with end of life care and which result in either barriers or possibilities to effective relationships and communication that enhance end of life care (Boston et al., 2001; Breitbart, 2003; Faber, 2002; Hearth, 1990; Kruijver, 2000; Tishelman et al., 2004).

There is no question that professional nursing care is grounded in patient and family centered interpersonal encounters. It is widely accepted that nursing identity lies in relationship. Every study reviewed affirmed this. Heidegger suggested that *Dasein* (being there), and *Gelässenheit* (listening authentically which lays the field out) allows *Alētheia* (truth coming to presence) to show up. Truth is whatever deep ontological knowing the patient and family hold about what best suits their needs. Being-with in a quiet manner, hearing with wisdom (i.e. *Gelässenheit*) lays out the field in presence, making it possible for patient and family to express their concerns. Similarly, nurses experienced in being-with dying lay out another field where they can negotiate for care and treatment that lead to the outcomes best suited to the patient and family wishes (Abendroth, 2005; Faber, 2002; Kelly, 1998; Robichaux, 2006; Tarzian, 2000).

First Theme: Interpersonal Encounters are Nurses Common Ground

Tarzian’s (2000) phenomenological exploration of 10 hospice, long term care, oncology or emergency medicine nurses who cared for dying patients with air hunger revealed themes of (a) being beckoned by the patient’s panicked look, (b) nurses surrendering and sharing control, and (c) fine-tuning care. Nurses in the study gave vivid accounts of patients’ panicked looks which evoked a strong response in them; even feelings of being out of breath themselves, or of becoming part-of the patient and wanting to breathe for them. Those experiences echo Heidegger’s account of nurses’ abiding-with, being living through and speaking to Dasein. Dasein is self-conscious and has a responsibility for its own being, and an obligation to be significant and authentic. Dasein also possesses an understanding of the being of other beings and of its connection to, and caring for them (Heidegger, 1927/1962). Similarly, the nurses in Tarzian's study gain awareness of themselves and of others, and of their responsibility for and meanings in being-with and caring for other beings.

The experience of surrendering and sharing control meant something different to acute care nurses than to hospice nurses. Acute care nurses were accustomed to using medical technology in medical crises (technical-based practice) and therefore often struggled with feelings of loss of control and helplessness when patients and families did not want the technology. Rather than intubations for example, nurses in the hospice setting were accustomed to treat such symptoms with morphine, oxygen concentrators, and relaxation techniques, as well as by being-present (situational judgment based practice).

Second Theme: Nurses' Existential Experiences Create Vulnerability

Combined existential experiences such as death anxiety (Deffner, 2005; Mitchell, 2003; Payne, 1998; Rooda, 1999), moral distress (Boston et al., 2001; Elpern, 2005; Ferrell, 2006) arising from perceived futile treatment, situation ambiguity, hopelessness and lack of professional support (Badger, 2005; Hopkinson, 2003; Thompson, 2006; Tishelman et al., 2004) inclined nurses' to protect themselves from suffering. Nurses unintentionally detach from the patient and family via withdrawing, reluctance to acknowledge their needs and 'doing' more than 'being' when they are with them. Those phenomena describe Heidegger's construction of inauthentic being-unto-death, and the characteristics of evasive flight from death. Moreover, they describe nurses who are vulnerable.

Vulnerability

Vulnerable populations or social groups are those who have an increased relative risk or susceptibility to adverse health outcomes compared to the general population on dimensions of morbidity, premature mortality and quality of life; or who are feeble and open to being attacked and wounded (Flaskerude & Winslow, 1998; Aday, 1993; Neatherlins, 2002). But the phenomenal basis for vulnerability in end of life situations cannot be addressed set in a frame of relative risk and outcome comparisons. Spiers (2000) set vulnerability in an emic or experiential frame that more readily exposes unique end of life concerns. She stated that vulnerability is a lived experience in which people perceive a threat to some aspect of their sense of self.

In this study vulnerability is an experience of transition situated in end of life encounters. Individuals become vulnerable in transition experiences, interactions and environmental conditions that expose them to potential harm (Meleis et al., 2000). For example some nurses believe that talking about death or dying may unleash an emotional response that they might not be able to handle (Wilkinson, 1991).

A transition is a passage or movement from one state, condition, or one place to another (i.e. movement from having control over a situation to uncertainty, or not knowing what to expect). The change is perceived on some level of awareness and contains meanings of threat to persons’ roles and self concepts (Meleis, 1994). Change destabilizes the familiar, threatens foundations of comfort and raises anxiety (Meleis et al., 2000). Suffering results in transition when circumstances tax coping mechanisms and resources beyond their effectiveness.

Feelings of helplessness and moral distress are common among nurses (Badger, 2005; Hopkinson, 2003; Thompson, 2006; Tishelman, 2004), particularly when they desire to take actions to alleviate suffering, yet an appropriate course of action cannot be found (Ferrell, 2006). Conversely, when the appropriate action is known but cannot be carried out, nurses also suffer moral distress (Elpern, 2005). They may withdraw from the suffering patient, or shield themselves to avoid further pain or emotional involvement (Morse, 1992).

End of life encounters make different demands on nurses' interpersonal skills than encounters surrounding less serious conditions. End of life encounters demand the ability to attend to one's emotional reactions as well as those of others. Being-with and being present imply that nurses acknowledge and enter into end of life encounters while accepting their own vulnerability (Boston et al., 2001; Heidegger, 1927/1962). To attain an in-depth understanding of others' suffering, nurses elicit and attend to patient and family needs on both a technical and personal level as they witness the ontological, existential, less evident meanings that are part of the dying experience.

For nurses, vulnerability in end of life situations arises primarily out of death apprehension (Faulkner, 1998; Parle *et al.*, 1997) and moral distress (Ferrell, 2006). Vivid, and covered-up memories of witnessed suffering may lead to nurses' natural "flight from death" which then results in diminished capabilities to elicit and address patient and family concerns, leaving the cared-for vulnerable to greater uncertainty, anxiety, pain and suffering in the vast flow of events in dying experiences (Kirchhoff, 2003, 2002).

Existential Experience: Attitude toward Death

Nurses have a critical role in meeting cognitive and affective needs of patients with cancer, to reduce patient and family suffering and to explore their needs. A review of the literature on communication between patients with cancer and nurses showed nurses often used blocking behaviors in circumstances they perceive as stressful. “They ignore patients’ cues or switch topics” (Kruijver, 2000, p.8), which prevents patients from talking about their problems. The principal explanation authors mentioned for the problematic behaviors is the complexity of communication in the oncology setting; that providers fear of their own death is intensified when they deal with patients who have cancer; and that uncertainty among doctors and nurses, if they talk openly with patients who have cancer, they could be faced with problems they will not be able to handle.

Researchers and commentators acknowledge a correlation between death apprehension, and blocking and avoidance behaviors observed in health practitioners in end of life situations (Heaven & Maguire, 1996; Institute of Medicine, 1997; Maguire & Pitceathly, 2002). Wilkinson (1991) found that nurses’ ‘fear of death’ was a significant predictor of their use of distancing tactics. She reported that nurses used blocking behaviors more than half the time during conversations with patients who have cancer. Those findings agreed with the studies of Heaven and Maguire (1996), Booth et al. (1996), and Maguire et al. (1996) who reported that nurses, despite communication training, were not successful in identifying what patients’ concerns were. The more patients disclosed feelings, the more blocking behaviors occurred.

Specific blocking behaviors identified in those studies exemplify Heidegger's *Evasive Flight from Death* structures: (a) *inconspicuousness*, denial of the seriousness of the patients condition, which results in neglect and poor symptom control; (b) *equivocation*, giving no response to patients' emotional, spiritual and information needs, abrupt changing the subject; (c) *temptation*, ignoring that the patients had spoken at all, concentrating intensely on the physical task at hand or introducing a joke; (d) *tranquilizing*, offering no response to the needs of the family and showing lack of respect for the family by not providing privacy for the patient and family, ignoring family need for information; and (e) *separating*, blocking their involvement with patient care, or judging the family behaviors toward their dying member.

Many practitioners view encounters with dying patients as personally threatening. They report lacking confidence in their ability to clarify patients' concerns and feelings because they do not want to cause harm to the patient or get themselves into difficult situations. They also report feeling responsible for problems over which they have little control (Heaven & Maguire, 1996).

Experiences of apprehension can set clinicians' ontic (day to day) bent toward cure, and further incline them to take for granted, a focus on the patient's physiological needs and to persistently rely on technological interventions (Boston et al., 2001; Callahan, 2000; Fox, 1997). Apprehension weakens empathy and concern as the amount of attentional space available to meet others' needs is decreased (Noteboom, 2001).

Mitchell and Bunkers (2003) also noted occasions when nurses face difficult choices to be with persons as they face intense experiences that involve pain suffering and dying. Nurses are called to enter the 'abysses' in these situations, to explore risk.

Since such experiences are unfamiliar, disquieting and transforming, Mitchell and Bunkers suggest that one way to approach them is with love.

Yet, nurses' usual experience and clinical training seldom demand the interpersonal skills required to 'think in' and act in the dying patients' world (or in the "abyss"). Being-with in this way is a process of learning and a therapeutic act that requires vulnerability and personal risk (Boston et al., 2001). However, it is not a simple matter of just doing it or willing it to be. In reality, nurses have negative experiences in some caring situations. Nursing literature is very clear in its mandate to care, and frequently, "loftily idealizes the nurse/patient relationship" (Maeve, 1998, p. 4). Maeve comments that the less than ideal nurse/patient relationships are rarely described even though they are a distinct problem in reality.

Nurses' vulnerabilities and the consequences of being authentically 'alive' with patients' experiences should be recognized and explored. Encouraging nurses to explore their personal reactions to caring may be one way to acknowledge such demands. But that may only be possible if sufficient emotional space is created where a range of feelings can be explored as they emerge (Kelly, 1998).

Recall the behavioral characteristics of the evasive flight from death:(a) concealing reality, (b) hedging , (c) drawing to the ordinary, (d) using soothing clichés, and (e) separating. Heidegger correctly characterized being-toward-death in contemporary life this way: in our hurry to tranquilize anxiety we are unable to *hear* or *hearken*, that is to dwell attentively and responsively in our environment (Thompson, 2001). Heidegger also articulates of a mode of being-with which enables others to open out into the fullness of their essence. "To embrace a thing or a person in its essence means to love it, to favor it...such favoring is the proper essence of enabling, which not only can achieve this or that but also can let something essentially unfold in its provenance, that is, let it be" (Heidegger, 1993, p. 214).

Plainly, approaches to death and dying, and end of life interactions are multidimensional and complex (Kelly, 1998; Rooda, 1999). Caring in life-threatening illnesses provoke unique demands for nurses. Determinants of attitudes encompass cultural, philosophical, societal and religious belief systems for giving meaning to death, as well as personal and cognitive frameworks from which individuals formulate and interpret attitudes toward death and dying. Evolving technology also plays a role in altering expectations and attitudes toward death and influencing healthcare professionals' behaviors.

Practical and emotional difficulties in talking about death arise because of patients' efforts to stay connected to living and because predicting a patient's death (no less talking face to face about it) is frightening, and something medical professionals wish to avoid (Christakis, 1999; Kaufman, 2005). Yet, avoidance harms patients and families by preventing them from taking steps to prepare for death and by complicating loved ones' grief or compromising their coping.

Kaufman (2005) reported that not a single nurse in her ethnography talked with patients or families about dying, presumably because they wanted to avoid overstepping their authority. Her conclusion agrees with Robichaux (2006) that nurses assume a limited role in end of life decision making and care planning. Kaufmann observed nurses talking to family members and responding to their questions. Nurses communicated with very sick patients who could barely speak, they monitored technology, gave intravenous medications, kept an “eagle’s eye” on patients’ (even while writing in the medical chart), organized the flow of patients and procedures and helped families understand what was going on. They also served as a conduit of information to doctors, *but they did not directly talk about death and dying*.

Existential Experience: Moral Distress

Seven studies examined moral distress among nurses. Moral distress ensues when situations in which an ethically appropriate course of action is known but cannot be taken. High levels of moral distress were associated with the provision of aggressive care to patients who were not expected to survive (Elpern, 2005), and when aggressive care was viewed as denying palliative care (Ferrell, 2006). For nurses, the most significant obstacles in providing end of life care were disagreements among physicians, family members and themselves, about prognosis and futile treatments that caused patients pain or prolonged suffering (Kirchhoff, 2000).

Cohen & Erikson (2007) noted that nursing students and novice nurses especially react with moral uncertainty and distress to futile treatment, but Elpern (2005) found that moral distress was positively correlated with years of nursing experience. That finding may reflect another understanding that nurses assume a limited role in end of life decision making and care planning (Robichaux, 2006), and therefore believe there is nothing they can do to change the situation.

Expert nurses in another study frankly identified ways they address unwarranted aggressive care. Nurses said they advocated for patients and families to prevent further futile treatments, promoted a dignified death, and helped families reframe their sense of the potential for recovery so that they could let the patient go (Robichaux, 2006). Both

Kelly (1998), and Boston, et al. (2001) suggest that providing care in these situations demands unique skills and experience beyond day to day realms, and that this is neither easy nor comfortable. Day to day experiences and professional training has not prepared nurses for caring in this context. Nurses need extraordinary support as they face their own vulnerabilities and personal risks to confront physicians, and as they try to help families reframe their understandings and make decisions that lead to a good death. Finally, Cohen & Erikson (2007) offered a process for analyzing and resolving such challenges beginning with increasing awareness and dialogue.

The Third Theme: Experienced Nurses Fine-Tune Care.

A majority of studies described nurses in some way being authentic (open to and accepting) toward death. They described nurses (a) being present, being accepting and open to mortality (Rittman, 1997; Thompson, 2006) (b) helping patients and families change lanes from cure to comfort care (Abendroth, 2005; Bottorff, 2000; Rooda, 1999; Tarzian, 2000), (c) preparing themselves and as using reflective practices to make meaning (Badger, 2005; Wilson, 1999) and (d) knowing what to do and how to do it (Boston et al., 2001; Faber, 2002; Kelly, 1998; Rittman, 1997).

Fine tuning care in Tarzian's (2000) study meant encompassing a perspective beyond the patient to include the patient's loved ones. Once a patient's episode of breathlessness was resolved, families often needed the nurses' attention more than the patient. Nurses described managing patient pain and symptoms, but also preventing unnecessary fear by preparing everyone for what to expect during the dying process. They helped family members resolve interpersonal conflicts when perceptions differed, and assured that the patient had resolution of interpersonal conflict. To accomplish this fine tuning, nurses needed to stay present during suffering as described earlier by Mitchell and Bunkers (2003).

Five hospice nurses participated in a hermeneutical phenomenological study by Abendroth (2005). The nurses revealed fine tuning care as they illuminated patient and family's needs. They were experts in pain and symptom management, but they also knew how to facilitate patient and family movement toward reconciliation and life closure, and how to work the system to get what the patient and family needed. The nurses attributed their success in being-with dying to (a) being 'called' to the hospice setting, (b) having early experiences with death, (c) being able to make a difference in relationships with the patient and family, and in pain and symptom management, and (d) having supportive relationships with their colleagues.

A Naturalistic inquiry of nine nurses examined the notions of relationship and embodiment in caring for the dying (Maeve, 1998). The notion of embodiment is different than empathy in that it is an experience of physical being-with and not separate from the relationship. Nurses in Tarzian's (2000) study illustrated embodiment in this way as they experienced shortness of breath along *with* their patients. To embody another's experience means one is 'alive' with the other's experience. Experiencing embodiment lends personal and professional changes and growth. One nurse noted that "watching people die gives you a lot of courage."(p.1140). Maeve encouraged nurses to understand the consequences of embodiment as a key for patient advocacy, a pathway toward relationship, and as one way to actualize a caring practice. Nurses honor patients when they allow patients' suffering and death to give dimension to their own lives.

Nurses' attitudes and experiences in providing end of life care have been examined, but a clear understanding of the delineation of ‘being’ inherent in care of dying people has not emerged (Thompson, 2006). Thompson used grounded theory to study the basic social psychological process (BSP) of nurses striving to provide high quality end of life care which was defined as “Creating a haven for safe passage” (p. 169), on an acute medical unit while being pulled in all directions. Thompson’s findings agreed with Tishelman (2004) where nurses identified strategies such as reflective practice, use of self and ethical reasoning to negotiate care giving in the direction of their ideals. Nurses in both studies repeatedly spoke of difficulties in negotiating between time restraints and their ideals about care provision.

Bruce (2002) examined care givers use of mindfulness meditation to enhance end of life patient care. Her study *Abiding in Liminal Spaces: Inscribing mindful living/dying with(in) end of life care,* explored the experience of dying in the context of Buddhist philosophy. She volunteered at Zen Hospice in San Francisco for five months where she engaged in unstructured conversations and open-ended reflexivity with caregivers who practice mindfulness meditation as the basis of their practice. Bruce used Koan constructions to analyze the data. The Buddhist interpretation of death is that both life and death are inter-mingled in an ongoing relationship. Death is interpreted as a momentary experience in a liminal space between this moment and the next.

According to Bruce, the challenge is to allow the experience of death to be valued as it is deeply felt (ontologically) and beyond (ontic) words. Bruce believes nurses should learn to support people in their death experience with out trying to explain (away) through language and perhaps other evasive flight-from-death activities. Her recommendations concur with Mitchell and Bunkers (2003) encouraging nurses to find ways to go beyond dualistic views to *abide* in the midst of suffering.

Nurses need to be comfortable with themselves about issues of death and dying if they want to be authentically present for families. Understanding more about nurses' experience (beliefs, emotions, and perceived barriers) in clinical communication encounters with families and their dying members may provide a basis for revisions of programs to amend death attitudes.

Particular means to influence death attitudes, primarily fear have not been found yet. However, in attempt to influence health practitioners' willingness and ability to assess their cancer patients concerns, Parle et al., (1997) developed a training model that included components of cognition and emotion as well as changes in skills and self-efficacy. In addition, cognitive scientists have found that specific mental strategies can help persons attend to their distress about death and shift their mental states. Heidegger's structures also offer means to achieving authentic being-toward death and being-with in end of life encounters.

While many education programs have emerged in response to the lack of quality in end of life care, researchers have repeatedly found that programs for practitioners and future practitioners are insufficient for preparing them to be effective attending to dying. Educational interventions improved experimental groups' attitude and behaviors toward care of the dying at first, but the effect disappeared over time (Billings & Block, 1997; Dunn, 2005; Fellowes *et al.*, 2003; Heaven & Maguire, 1996; Institute of Medicine, 1997; Parle et al., 1997).

Themes in Patient and Family Experiences as Recipients of End of life Care

This section of the literature review addresses how families and their dying members experience care at the end of life. A theme of the 1997 *Approaching Death* report (Field & Cassel, 1997) was that a significant number of people experience unnecessary suffering and distress at the end of life. It is clear that people nearing the end of life should be able to expect quality care. However, dying in hospitals has been associated with depersonalization, regimentation, and perceptions of unidentified and unmet needs on the part of dying patients and their family members (Christakis, 1999; Diekelmann, 2002; Kaufman, 2005; SUPPORT Investigators, 1995). Furthermore, anecdotal evidence that documents dissatisfaction with current hospital care of the dying is wide spread in the popular press.

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT Investigators, 1995) is considered one of the most comprehensive studies on dying in the United States. It was carried out in five university hospitals over four years beginning in 1989. The report documented serious problems in care of the terminally ill and their families. Patients (n = 4300) diagnosed with life-threatening illnesses were enrolled in the first, two-year phase of the project. The investigators concluded that dying in the hospital is not comfortable or supportive and may cause suffering for patients. Less than half of the patients reported that their physicians talked to them about prognosis or cardiopulmonary resuscitation (even though their deaths proved to be predictable), half of the patients were in moderate or severe pain in the last three days of life, and 38 percent of patients who died spent ten or more days in an intensive care unit immediately preceding death.

A successive two-year intervention phase of the SUPPORT study was planned to have a positive effect on medical care and the perceived quality of hospital deaths by improving the flow of information between doctors and patients. Approximately five-thousand additional patients were involved, half in a control group and half in the intervention group. Nurses were trained to carry out the intervention through various means such as providing information to physicians about patient preferences and by providing information to patients and families about prognoses and treatments. Nurses facilitated conversations between patients and physicians, and provided emotional support to patients and families. The results were unexpected, showing that no overall improvement was made, even where concerted effort was made to reduce pain and the use of high-technology. Those results caused researchers, health care analysts and consumers alike to call for major changes in end of life hospital care.

Family experiences were described by Kaufmann (2005) who observed family members construct hypothetical scenarios of recovery or decline that changed daily and often in a day. Family considered choices they might have to make soon. Sometimes they were capable and sometimes not of hearing and talking about the situation. Some family members were determined to do everything to keep the patient alive and some didn’t know what they wanted. They were called on to decide such matters as whether to amputate a limb, to give the patient more time, or to arrange for death. Over time family members slowly changed their minds about their relative’s condition, they realized, after days or weeks and after many conversations that their relative was in fact dying.

Despite compassionate and efficient professional caregivers, families perceived their experiences with hospital death overall as difficult or painful, harrowing or humiliating (p.3). Kaufman suggests that the way death is managed and transpires in the American hospitals is not inevitable. She opens up a path for thinking about new ways of handling the dying experience. Her work highlights the ways in which hospitals have become the most powerful framework in the United States for understanding critical illness and for approaching the dying. There is widespread public demand for control at the end of life through greater choice. But, she says, medicine both provides and constrains that choice. It offers an abundance of treatments but it also organizes how one can know the problems of the body, what the role of the family should be, and the relations among patients, families, and health professionals. It literally produces particular forms of dying.

> "Change is possible, I think, but only through a widespread recognition of our own engagement with, and commitment to, how naturalized this contemporary order of things has become. The culture of death will not remain static. It, like all cultural forms, will both shape and be informed by other features of contemporary society, not the least of which is the kind of politics and ethics we want to strive for next, in making the end of life." (Kaufman, 2006, p.326).

In November 2002, Last Acts conducted a national opinion poll about Americans satisfaction with end of life care. They issued a state-by-state report card on care of dying patients in the United States. The report highlights 'Islands of Excellence' but a dismal national picture. The opinion poll showed Americans are dissatisfied and seeking to reduce the financial burden, physical pain and emotional stress associated with the end of life (Patrick, 2003).

The National Hospice and Palliative Care Organization (NHPCO) pointed out that the study rankings reflect the *use* of end of life care, not the quality. NHPCO of course wants to uphold the idea that excellent end of life care is available, but that more terminally ill patients could benefit from the patient management and social and spiritual care that hospice offers, and that both patient and family would benefit from earlier referrals and use of hospice programs. They further call attention to that few Americans know that Medicare Hospice Benefit covers all aspects of end of life care. NHPCO supports the Last Acts study to the degree that it sparks public and professional discussion about the benefits of hospice care (NHPCO, 2003).

Finally, 26 studies were reviewed for additional information on patient and family experiences. A hermeneutical analysis of those studies showed that the situations influencing patient and family experiences with end of life care are that (a) their moods are characterized by uncertainty, anxiety, helplessness, hopelessness, depression and grief (Badger, 2005; Bottorff, 2000; Lin, 2003; Rasmussen, 1998) (b) uncertainty pervades family experiences while information is lacking or inadequate (Kirchhoff, 2002; Schofield *et al.*, 2003), (c) satisfaction with their care relates to clinician communication and connection with them (Andershed, 2000; Kruijver, 2000; Tarzian, 2000), and (d) they would like choices and to be included, informed and supported (Bolmsjo & Hermeren, 2003; Singer *et al.*, 1999; Wilson, 1999).

Vulnerable Families and Patients

Nearly 40 years after the birth of the hospice movement, and despite the rise of living wills and palliative care, end of life remains anxious, hyper-medical and technical (Marantz-Henig, 2005). End of life research portrays many problems for families and patients trying to get their needs met (Field & Cassel, 1997). It has already been shown that vulnerability for the recipients of end of life care arises primarily out of unmet needs for patients and families as they experience transitions from dying to death (SUPPORT Investigators, 1995). For nurses, vulnerability lies in their death apprehensions, overwhelming emotions, moral distress, and lack of organizational support while at the same time they are trying to help patients and families (Faulkner, 1998; Parle et al., 1997).

Nurses are the primary caregivers of clients and families who undergo such transitions and they should be able to prepare clients for impending transitions. Because of their own vulnerabilities related to death (Callahan, 2000; Maguire & Pitceathly, 2002; Wilkinson, 1991), they often miss important concerns that families and patients have. Such behaviors alienate patients, diminish the opportunities providers have to help, and exemplify being-toward-death that Heidegger calls inauthentic or ‘falling.’

Nurses and doctors often fail to assess and treat pain or they make technical errors such as miscalculations of medication dosages for pain and other symptoms; they often block patients’ emotional expressions, or give mixed messages about prognosis’ or use euphemisms for dying (Fellowes et al., 2003; Kaufman, 2005); and they have at times expected patients to face situations they were not ready to discuss (Hines, 2001; Morse, 2003). As a result of those inauthentic patterns, patients often receive treatments or hospitalizations which do not inform their care and which cause physical and emotional distress (Lo, 1995). Also, their referrals to hospice or other home supports are consistently too late for the greatest benefit (www.nhpco.org), and they perceive their hospital care experience as ‘harrowing’.

Imbedded in end of life literature and anecdotes lie characteristics of Heidegger’s constructions of inauthentic, evasive flight from death (Demske, 1970):
(a) inconspicuousness (concealing reality), (b) equivocation (hedging or prevarication), (c) temptation (drawing to the ordinary), (d) tranquilizing (using soothing clichés), and

(e) estrangement (separating). Research and stories raise questions about health care providers - nurses' and others' focus on extending life at all cost while ignoring the threats to human fulfillment that result from lost opportunities to forgive, say "Thank you" "I love you" and "Good-bye" in a meaningful way for dying patients and their families (Byock, 2006).

Summary

This chapter began with definitions of Heideggerian expressions. The terms *Being (existence), Dasein (being-there), Inauthentic-being (ontic, day to day being), Authentic-being (ontological being), Care (concern toward other beings), Gelässenheit (serene listening with wisdom) and Alētheia (an experience of hearing truth with awareness)* were defined and connected to end of life care. The next section reviewed two national studies: (a) *Approaching Death: Improving Care at the End of Life* by the Institute of Medicine (1997) and (b) *End of Life Care and Outcomes* (Lorenz et al., 2004). The studies highlighted national priorities in end of life research.

The chapter continued with an historical overview of death related nursing research and a hermeneutical analysis of 24 studies showing common experiences that characterize nurses' working with dying patients and families. The common themes were (a) interpersonal experiences are the common ground of nursing care, (b) combined existential experiences (i.e. fear of death and moral distress) create vulnerability and can lead to behaviors of self-protection and consequent patient abandonment, and (c) experienced nurses are self-aware and comfortable being-with dying, and they cultivate distinguished abilities to be present with suffering and to fine tune end of life care.

A hermeneutical review of two large and 26 smaller studies revealed that dying in hospitals is associated with depersonalization, regimentation, and perceptions of unidentified and unmet needs. In addition family moods were characterized by uncertainty, anxiety, helplessness, hopelessness, depression and grief; information to help decision making was lacking or inadequate; family satisfaction with their care relates to clinician communication and connection with them, and families would like choices and to be included, informed and supported. An experiential perspective on vulnerability was identified to expose unique end of life concerns, weaving together the whole experience of individuals who become vulnerable in transitions at the end of life, and in interactions and environmental conditions that expose them to potential harm.

While the literature begins to capture some basis of quality end of life care, health care researchers have not yet addressed the ontology of the troubled end of life state of affairs. Researchers have begun to explore nurses' experience and perceptions of end of life care but that research does not address the deeper meaning of being and being-with phenomena. Apprehension, being, and being-with are tacit concepts, difficult to grasp, and difficult to put into words. These deeper, sub-conscious matters are not well developed in the medical and nursing research since they are nearly imperceptible. But thought and action emerge from that imperceptible, tacit ground, therefore any fundamental understanding or change will also come from there (Bohm, 2003). If change is sought, we must get to the ontological ground of it. In Chapter Four, Research Findings, Nurses' narratives of being-with will provide important insights for anyone interested in being-with dying patients and families in ways that elicit and address their needs.

More attention should be given to examining how philosophy informs appropriate ways of being-with dying. No studies were located that address what underlies helpful being-with in end of life situations. The shortcomings of the current health care system and strengths of end of life research are well documented in the literature review. But we’ve not yet gone deep enough (Asch et al., 2005). Many of the studies examined arise from the rational empirical traditions which cannot explain how nurses who are successful in being-with dying comport themselves toward patients and families. This study aspires to go to the deeper, ontological level of being, to express what experienced nurses know about helping families and their dying members’ transition peacefully from dying to death

The next chapter covers design and methodology, the initial questions and objectives of the study, and specific phenomena that are not well addressed in current theory and research. A general description of the philosophical framework and method for the analysis is provided. Rigor is discussed and the participants are described as well as the researcher’s role as an instrument for data collection and analyses.

CHAPTER III

METHOD OF INQUIRY

In this chapter the design and methodology are divided into five sections. The first section describes the initial questions and objectives of the study, and specific phenomena that have not been adequately addressed in current theory and research. Background understandings situating the study in the philosophy of science are provided in the second section including a general description of the philosophical framework for the study, existential/interpretative phenomenology, and the method for the analysis, hermeneutics. In the third section rigor (phenomenological parallels to reliability and validity in measurement) is discussed. The fourth section describes pilot interviews and the insights which impacted the research itself. Finally, in the last section, the participants are described as well as the researcher's role as instrument, and data collection and hermeneutical analyzes are presented.

Focus of the Study

The impetus for this study arose from the author's years of experience as a nurse and program director in the hospice setting. Interest in further explicating the theme of being-with dying came from the desire to organize observations and experiences of being-with in end of life encounters-- where nurses and other care-givers were prepared to meet patient and family needs; and where families and their dying members expressed satisfaction, rather than distress with their life-end experiences.

Experienced nurses who reliably help families and their dying members and who have addressed the challenges of ontic (natural day-to-day) fears, as well as the often dispiriting health care environment, can reveal previously unsaid ways of knowing how to be-with dying. The research question “What underlies quality being-with in end of life care?” seeks what experienced nurses already understand, albeit tacitly, about being-with dying. What interpersonal knowledge and skills work to help families and their dying member transition peacefully and with dignity, from dying to death?

Philosophy of Science

The existential/ interpretative phenomenology of Martin Heidegger predominately inspired and informed this study. Heidegger, like his teacher Husserl, wanted a method that would reveal life in terms of life itself (a pure description of what is). But different from Husserl, Heidegger wanted a hermeneutic (interpreting being-in-the-world) approach rather than one transcendental (interpreting contents of consciousness). Heidegger held that human beings *always already* understand the meaning of being, and that this understanding has been forgotten or “covered over” by day-to-day (ontic), common patterns of being-in-the-world. Beginning with the pre-ontological, Heidegger asks the ontological question of being; however he does it with beings in the day-to-day, ontic world (Demske, 1970). In this way he aims to discover what human beings already know pre-reflectively, yet that which must be explicated through phenomenology because it is ‘hidden’ so to speak below the surface of day-to-day awareness.

As noted in the literature review, most end of life care research is associated with empirical-rational traditions while *being* must be associated with interpretative traditions. Empirical thought reflects how humans gain knowledge through the senses, whereas rational thought reflects how humans gain knowledge through reason or mental constructions (Stewart, 1993). Those traditions form the foundation for outcome and technically based health care (Polkinghorne, 2004), and they differ greatly from the traditions that underlie interpretative (judgment based) research. Since interpretative and empirical-rational research is philosophically different, a brief overview of the philosophical underpinnings of both traditions will provide insight into the merit of using interpretative traditions in this research.

Outcome traditions stem from early philosophical texts of the Greek philosopher Plato (428-347 B.C.) and his student Aristotle (384-322 B.C.). Plato put forth the idea that the world is ordered through forms (ideas) that are particular abstract objects (matter). That idea resulted in the notion of idealism in which later philosophers such as Immanuel Kant (1724-1804) and George Hegel (1770-1831) purported that reality is acquired through or by the mind. In other words the objects of our senses are (empirically) real within the necessary conditions of our faculties of thought and intuition.

Aristotle argued that humans use their mind to order the objects they sense. His philosophy resulted in the notion of realism. Later philosophers such as Thomas Hobbes (1588-1679), John Locke (1632-1704), and David Hume (1711-1776) also professed that truth/experience is acquired through the senses (Schick, 2000). The thinking behind idealism and realism differs in that one is based in variants of rationalism, mind-based idealisms, and the other in empirics, object-based realisms (Chalmars, 1999).

The predominant use of ‘empirical-rational’ traditions for health care research, education and practice lies in sundry use of those philosophical schools. Both offer a way to predict outcomes. Nursing theories, as idealisms for example, are often psychological and developmental and are used to help predict how persons learn or become ‘compliant.’ Nursing theories as realisms may be system or behaviors based, and try to predict how particular stimulus will elicit responses. Physical sciences and behavioral theories stem from views that the universe is an intricate complex of discrete measurable phenomenon. Those views are helpful, but only as they are part of a dialogue that includes existential/interpretative practices which uncover otherwise hidden meaning. While those views attempt to predict outcomes, the *logos* of phenomenology attempts to make manifest the way the things (phenomena) themselves show themselves to be (Farrell Krell, 1977, 1993).

Phenomenology is derived from the Greek words *Phainomenon*, meaning an appearance, or that which shows itself; and *logos*, (reasoned inquiry) the linguistic and discursive practices humans use to interpret the world around them (Stewart, 1993). Hermeneutics is the analytic method for this study and is derived from the Greek word *hermenia*, which means the art and science of interpretation. The following paragraphs describe interpretative phenomenology, its purpose, and its use as a method.

An alternative known as the ‘interpretative turn’ has grown out of the philosophical works of Martin Heidegger who contended that world-views integral to idealism and realism, ‘cover over’ or ‘hide’ understanding what it means to be human. They reveal understanding the human experience as what there is to know about being human rather than describing significant features of being human through attending to experiences as lived out by humans. Recall that Dasein is the human way of being-in-the-world, that entity whose being is the lighting up place of being. Using Heidegger’s philosophy as background, everyday practices of being-with show up as themes and patterns in narratives. These themes and patterns reflect what is always already there but not usually apparent (Diekelmann, 1998; Watson, 2006).

Existential/Interpretative phenomenology assumes that humans are self-interpreting, social, dialogical beings with taken-for-granted background understandings that are shared and common. These understandings are so historically and culturally integral to our everyday experiences that they go unnoticed. It is important to uncover these tacit understandings because they enclose what we find meaningful, and influence our interpretations and interactions with the world around us. Moreover, Heidegger's meaning question ultimately seeks for the interior, ontological ground which makes Dasein possible and understandable (Demske, 1970).

With existential/interpretative phenomenology as the philosophical background, hermeneutics provides researchers a way to interpret narrative accounts of participants' lived experiences. Researchers use hermeneutics to analyze narratives for themes and patterns. Themes are recurring or common practices that are situated in a particular culture or context. They are present in some but not all narrative accounts. Patterns are present in all narratives rather than only in selected narratives and are the highest level of interpretation. In patterns, interpretation shifts from specific contexts in themes, to meanings embedded in all human practices in patterns. When this shift occurs, deep, universal insights arise. Researchers using hermeneutics illustrate themes and patterns through exemplars and paradigm cases. Exemplars are short excerpts or examples of larger narratives that show particular themes. Paradigms are inclusive narratives that illuminate themes and/or patterns (Diekelmann, 1998).

Rigor in Phenomenology

Rigor in phenomenology is an important nursing research methods issue, and has direct implications for the legitimacy of nursing science. Nursing literature provides a broad range, and lacks consensus about criteria for judging the rigor of this approach. That places consumers of research (clinicians, publishers and funding agencies) in a dilemma regarding the legitimacy of phenomenology as a research method.

L. de Witt (2006) identified criteria of rigor in a critical analysis of published theoretical interpretative phenomenological nursing literature from 1994-2004. She adopted Sandalowski's (1986) qualitative criteria and refined it. Sandalowski's criteria had several obstacles that interfered with full expression of rigor in phenomenology. The new framework was derived from a synthesis of sundry sets of criteria for rigor.

L. deWitt suggests that those interfering obstacles conceal unique features of interpretative phenomenology findings and demonstrate philosophical inconsistencies. Also terms from various approaches are confusing and lead to methodological uncertainty in valuating. Imposed rules and rigidity in thinking can compromise researchers' creativity and attention to the art of interpretation. The generic rigor criteria, their defining characteristics and how they compromise phenomenological studies are listed in Table 1. L. deWitt's new framework follows the table.

Table 1.

Generic Rigor Criteria as Interference for Expressing Rigor in Interpretative Phenomenology

Generic Criteria ***(deWitt's new terms)***	**Defining Characteristics**	**Interfering Effect on Expression of Rigor in Phenomenology**
Credibility ***(Resonance Openness)***	Reading study findings produces recognition of an experience. A qualitative parallel for validity, a quantitative criterion of rigor.	Masks two unique characteristics of interpretative phenomenology: 1. The effect of reading the study findings is much deeper than verb recognition. Readers not only recognize, but feel the experience. 2. Suggests a temporal aspect (see Fittingness) Philosophical inconsistencies between the criterion of credibility and phenomenology make this term inappropriate as an expression of rigor. The underlying assumption of credibility is that the goal of research is truthfulness. The goal of interpretative phenomenology is to increase understanding of multiple interpretations of the meaning of human experience. There is no one 'true' meaning.
Fittingness ***(Concreteness)***	How completely the study participants represent the group of which they are members. How study findings 'fit' both the data and other settings. Readers appreciate findings as relevant to their situation.	Suggests a temporal aspect. Confines credibility to timeframe in which the study was done or when it is read. The future impact of credibility is concealed in this way. There is no mechanism for formal acknowledgement and recording of the future realization of credibility with in the research community.
Audit- ability ***(Resonance, Openness)***	Systematic process of decision-making. Readers may follow the rationale and reach the same or similar conclusions	Audit ability, an explication of rational for every step of the research process is congruent with phenomenology. However, preoccupation with applying rules, rigidity in thinking and lack of attention to the art of the method are caveats. Interpretative phenomenology has a hallmark of depth of insight evoked by reading study findings. Audit ability (explaining the research process) may compete with presentation and discussion of study findings that evoke deep insight.
Confirm-ability ***(Actualization, Balanced integration)***	Neutrality of study findings achieved by fulfilling all of the above criteria A qualitative parallel for validity	Philosophical inconsistency between the criteria of conformability (freedom from bias) and validity (a quantitative criterion of rigor). This reduces or eliminates researcher values and biases. Phenomenological studies are not neutral and values free. Rather, those preconceptions are explicated and become an integral part of the study findings.

L. deWitt's framework overcomes those philosophical and methodological inconsistencies. The new framework highlights interpretative phenomenology in a phenomenological way (criteria of rigor became expressions of rigor). She characterized the framework with practical rather than esoteric words to avoid awkward labels, to facilitate their uptake by readers and reviewers, and to make the framework portable--easy to remember and apply.

L. deWitt's proposed expressions of rigor are: (a) balanced integration, (b) openness, (c) concreteness, (d) resonance and (e) actualization: *Balanced Integration* articulates the general philosophical theme and its fit with the researcher and the research topic. There should be in-depth intertwining of philosophical concepts within the study methods and findings, and a balance between the philosophical explanation and the voice of study participants. *Openness* is an orientation and attunement to the phenomenon of inquiry which the researcher holds throughout the research process. Openness also reflects opening the study to scrutiny, accountability, audit ability, transparency, and an understandable, explicit process. *Concreteness* means the research is useful for practice. Concreteness is recognized when study findings are written in such a way that the examples given situate the reader concretely in the context of the phenomenon and also link with the readers experiences. *Resonance* means that an epiphany or reverberation results from the richness of data. Resonance is a 'felt' effect of reading the study findings upon the reader. This may be noticed as a sudden perception or intuitive grasp of the lived meaning under study. The effect may be described as striking, moving or something deeply apprehended. *Actualization* encloses potential and address future realizations due to the resonance of such study findings. Phenomenological interpretation does not end when a study is finished. Readers' interpretations of the study continue. L. deWitt noted that the research community does not presently have a formal mechanism for recording actualization.

A central practice of hermeneutics involves including other readers in interpreting study data. Researchers invite other potential readers to challenge, affirm, and extend the interpretations. The paradigm cases and exemplars should clearly show the reader where the interpretations presented arose in the text. If the interpretations reflect common experiences (recurring themes) the reviewers acknowledge or recognize these experiences as possible or familiar. In this way the interpretations encompass and reflect a plurality of perspectives on being-with dying. This study was reviewed by the researcher's committee, two Heidegger scholars, and three nurse participants. It was also presented to over 20 nursing students in research and community health courses. Feedback from the consumers was positive in terms of each of the five foregoing expressions of rigor.

Pilot Interviews

The author conducted pilot interviews [Summer 2006] to determine if the semi-structured questions would draw out the phenomenon of interest. Two nurses experienced in end of life care were recruited and signed the informed consent agreeing to participate in taped interviews. During the interviews the researcher realized that the original questions needed adjustments to 'get beneath' the phenomenon of being-with dying. For instance, instead of asking the participants to "Think about a time" when they wanted to find out what a patient and family needed regarding end of life issues and to "describe what happened;" the researcher set the context of being-with by describing *being* as: "not what the nurse was doing, but how she *was being*" in the encounter. In this way the study problem was not considered as a "subject" of knowledge but as a living experience of a historical encounter, or the that-it-is of an experience (Alētheia or truth) (Farrell Krell, 1977, 1993).

The researcher elucidated another important end of life dimension for participants: prognosis, or the time frame denoting end of life. Prognosis contains symbolism, and involves practical and emotional difficulties that matter to both patients, families and health professionals in end of life encounters (Christakis, 1999). "End of life" then, and the apposite time to talk about it may encompass (a) eminent dying, (b) having a few weeks or months to live; (c) having no given, but a likely prognosis of one-year or less if the disease takes its normal course," and (d) sudden death.

During the pilot interviews the researcher noticed the nurses' utter key phrases that resonated with Heidegger's structures of authentic being-toward death. Such phrases included "When I approach the family, I am very calm" or "I usually get them to tell me their experience" and "I go in [to the home or patient's room] with a blank slate, not knowing." When those cue phrases arose, the interviewer learned to go back and probe for the ontological meanings embedded there. Themes that emerged in the literature and the pilot study corresponded with Heidegger's themes on being-with dying. That supported further interpretative investigation and set sight on developing a model of the dimensions of being-with dying. In all of those ways the pilot interviews provided opportunities to develop interviewing and interpretative skills, to transcribe and to hermeneutically analyze narrative texts.

Procedure

Following Internal Review Board (IRB) approval and pilot interviews, letters of invitation were distributed to nurse managers of three local Intensive Care Units (ICU) and two local hospices. The nurse managers relayed the invitation through posting and announcements at staff meetings. No participants resulted from that effort.

Word of mouth was also used to recruit nurses, and if a nurse stated interest, a letter was sent directly. After the participants contacted the researcher, a time was set for the interview in a place selected by the participant. Informed consent was obtained prior to the interview and demographic information was solicited and documented before the tape recorder was turned on. The demographic data included age range, gender, geographic location, ethnicity, education level, years of practice as a nurse, and years of practice in the current setting of acute care, ICU, hospice or both

Participants

Six nurses participated in tape recorded, in-depth conversations with the researcher. The demographic information gathered on participant characteristics is presented in Table 2. The sole basis of ‘sampling’ in phenomenology is that participants are willing and able to articulate their experiences of a phenomenon (deWitt, 2006). Participants included two groups: (a) nurses presently practicing in hospice, (n= 3) and (b) nurses working in acute care, intensive or critical care situations (n=3). Of the three hospice nurses, two also had extensive critical care backgrounds with at least 12 years of experience in that setting. One nurse practices concurrently in both settings.

Table 2.
Participant Characteristics

Range and Mean for all	**Hospice Nurses n=3**	**Acute Care Nurses n=3**
Age ***Range 40-56***	66% were 40-49 33% were 50-59	
Gender & Ethnicity	100% were female and Caucasian	
Years in Nursing Practice ***Mean 21.8***	28 14 23	16 22 28
Years in This Setting ***Mean 20***	08 13 15	16 10 26
Nursing Education	1 Associate Degree 1 Diploma 1 MSN (Master in Science of Nursing)	1 MSN, CNS (Clinical Nurse Specialist) 1 MSN Candidate 1 MSN-PhD Student

Number of Participants

The number of participants was originally set at six with recruitment of up to eight possible Since phenomenological studies seek in-depth insight and experiences more than trends, patterns or commonalities in data (Van Manen, 1990), six were sufficient. The text was sufficient when saturation was achieved at 6 participants. Saturation refers to a point in time when information from the participants becomes repetitive, yet the number is large enough to provide diverse information about experiences to which the population can relate.

Data Collection

The study was approved by the Institutional Review Board at Marquette University, Milwaukee, Wisconsin (HR#1302). Data collection began in summer of 2006 with the pilot interviews. Pilot data was included in the dissertation interpretations and findings. During the interviews the investigator asked the nurse participants to talk about times when they cared for dying persons and their families in ways that helped them cope with their end of life transitions.

Concepts such as “being” and “prognosis” or “time to death” were clarified. The interviewer prompted the nurses to think deeper about what they meant by key terms that seemed to reveal that ‘place holder’ in Dasein where the phenomena of being-with arises and returns.

Researcher’s role as Instrument

Phenomenologist’ center on easily taken for granted phenomena, rather than on formulating hypotheses, explaining or predicting. A phenomenologist attempts to understand phenomena by not assuming the history, causality, inter-subjectivity and values ordinarily associated with experience. The investigator practices ‘unknowing’ (Munhall, 1993), leaving past ideas and concepts out of the interview. In this way the researcher tries not to anticipate what will be revealed, but waits for it to show up as it is. Emerging deep structures of daily being are examined carefully so that their *source and direction* may be grasped.

Being can be hidden so deeply that even the doers of that being remain largely unaware of it. In *Being and Time*, Heidegger said “This Being can be covered up so extensively that it becomes forgotten and no question arises about it or about its meaning.” (p. 35/59). The practitioner of phenomenology gets phenomenon to “show itself within itself” (p.32). This means that the researcher and participant need to be interactively linked. The researcher consciously serves as the “instrument” through which data are generated. In such an interview s/he skillfully encourages and guides the participant to reveal data that have depth and clarity (Gendlin, 1978; Levin, 1989; Sorrell Dinkins, 2005).

The researcher and participant engage in an open dialogue that involves questions and responses which encourage them to reflect together on the concepts that are taking shape within the interview itself. The researcher preserves an orientation toward openness (often through silence) in listening, and in responding to phenomena (Ironside, 2005). Silence resonates and imparts an openness and willingness. The resonance and openness allows awareness of a flow between participant and researcher. The participant reflects deeply and ‘feels’ the recollected encounter; and the researcher may ‘sight’ something in an utterance, gesture or sensation.

Generating Data

Approaches to generating data included in-depth taped dialogue, field notes, the researcher’s history of participation in end of life encounters, ongoing study of Heidegger and other philosophical texts, and ongoing study and practice of Vipassana meditation and deep listening[3].

Participants were eager to talk about their experiences of being-with dying and how their practice was shaped and understood. In-depth, semi–structured conversations lasting between one to two hours were tape-recorded and transcribed verbatim. The interviews were held at an agreed upon location and in all cases, a relaxed, private environment supported meaningful interactions and conversations.

In preparation for the first interview, a list of questions and a demographic sheet were available as prompts to initiate conversation. The list was too long and didn’t get at the phenomena being studied. Subsequently, those questions were at hand but the interviewer adapted by simply framing the context, suggesting that ‘being’ is not a ‘doing’ but a way of being-with. Also, participants were asked to clarify whether the situations they were telling about involved an immanent or future death. The interviewer usually started the questions then with “So, the tape recorder is on. When you are ready, tell me about being-with patients and families in end of life situations.”

The researcher’s role and style was deep listening (making sure she understood exactly what the speakers meant) rather than inserting questions except for clarification or affirmation. The intention was to explore the dynamic space of ‘being-with’ that their stories represented rather than talking about specific events or things. This exploration occurred intermittently and was accompanied by the researcher recognizing a term or metaphor used by the nurse, which if explored may open new insights...i.e. “crossing a bridge” or “going to that place” or “making that connection.” The researcher used follow-up questions using the participant’s phrasing and ordering to further invite articulation of ‘being-with.’ Conversations were dense and full, meeting sufficient ‘richness’ to answer the inquiry question as well as to achieve saturation where findings replicated earlier ones (Sandalowski, 1986). Within a day after conversations, the researcher listened to the tapes to ensure the quality of the recording and added additional thoughts and impression to reflective notes.

Approaches to Interpretation

The researcher used the computer software analysis program NVivo, and repeated reviews of the interview tapes and transcripts. Emerging themes and patterns were color coded and labeled on paper. Data representing the emerging themes was re-typed into an analyses chart and eventually full themes and a five-point framework emerged.

For linguistic transformations the researcher synthesized the data into phrases that described what was actually happening in the encounters between nurses and patients/families; and to describe Dasein’s authentic being-with.

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[3] If you set aside a period of time when you only listen, and indicate only whether you follow or not, you will discover a surprising fact. People can tell you much more and also find more inside themselves, than can ever happen in ordinary interchanges (Gendlin, 1981, p. 118).

CHAPTER IV

RESEARCH FINDINGS

The purpose of this study was to better understand being-with dying. Data came from experienced nurses who provide quality end of life care to families and their dying members. Quality care assists dying persons and their loved ones in the transition from dying to death with personal dignity; relief from suffering, opportunities to find meaning in life’s ending, and is within acceptable professional and ethical standards.

It is reasonable to think that experienced nurses’ unique perspectives and pathways may help others apprehend ways to be more authentic in end of life situations. The narratives reveal what nurses say and do as well as their affective characteristics in being-with dying. In addition, the affect of authentic presence as it helps persons transition from dying to death is also inferred.

Phenomenology does not claim to show cause and effect (Paley, 2005), but the ways in which nurses’ behaviors seem to meet the patient and family needs can be shared. Study findings can be useful to the degree that they (a) resonate with the readers’ sense of truth, (b) remain ‘open’ and integrated with Heidegger’s Philosophical themes, (c) are useful for practice and (d) sponsor progressive thought (deWitt, 2006).

This chapter consists of two sections. First, personal and professional profiles of each nurse participant are provided. The second section contains narratives and interpretations of being-with dying. The interpretations situate data patterns into perspective with Heidegger’s philosophical structures of Dasein advancing-toward death, and inauthentic and authentic being-toward-death.

The six nurses who participated in this study work at hospices and hospitals in a Midwestern city. A pseudonym replaces each participant's given name and any information that identifies a participant or patient has been omitted.

Participants

Amy has worked with families facing fetal demise for 16 years. She attends families who are expecting a child; and who enter the health system with knowledge that the baby has died, or that the baby's life is threatened. Sometimes families are expecting a normal delivery. Amy has a bachelor's and a master's degree in nursing and is a clinical nurse specialist providing direct patient care. Recalling her parent's stories of fetal loss and her mother's death helped Amy accept death and to be comfortable with people who are experiencing a loss.

The second nurse participant, Laurel, has worked concurrently in an intensive care unit (ICU) and in a community based hospice for 14 years. Her acute care practice is in a small, 100 bed hospital; and the hospice she serves is free standing and community based. Laurel has an associate's degree and provides direct patient care. Her interest in being-with dying came from "living life," caring about people and attending to her father while he was dying.

The third nurse participant, Hannah, is a unit supervisor and provides bedside care in an ICU situated in a 470 bed medical center. She has been a nurse for 23 years, 11 years in ICU. Her experiences also include trauma and life support. Hannah is currently enrolled in an accelerated BSN to MSN program. Her interest in working with death and dying came from witnessing her father's death at a young age.

The fourth nurse participant, Barbara, works in a cardio-thoracic ICU in a large medical center. She has worked in this setting for 26 years. She is both a direct care provider and a charge nurse. She entered nursing with an associate's degree and is currently enrolled in an MSN to PhD program. Barbara's interest in being-with dying, stems from a life-long spiritual quest and a 'natural' acceptance of death.

The fifth nurse participant, Caron, has practiced nursing for 30 years. 22 years were in the acute, intensive care and emergency settings. The remaining eight years have been in hospice. Caron entered nursing with a diploma and stated that her ability to be-with dying came from a life long spiritual awareness, and an acceptance of death that developed over the years. When asked where she learned to 'be' with people who are dying she laughed and emphasized "I don't *know*!" "I just think it came with experience. I think you learn it along the way, you know, I have no idea where I got it, or if it just came." To restore her serenity, Caron uses prayer and rest from the role of nurse.

The sixth nurse participant, Valerie, has worked exclusively in hospice and home care for 26 years. Her roles have spanned from independent practice to staff nurse and executive, in both community and hospital based settings. Valerie entered practice with an associate's degree and has completed her bachelor's and master's degrees. Death experiences early in life drew her attention to death and dying. Her contemplative nature and quiet, reverent family upbringing directed her to nursing in end of life care.

Patterns

Data were assembled following taped interviews, written transcriptions, and grouping into pertinent themes and patterns. The data was originally organized according to the nurses' passageways to authentic being, as well as what they said and did, and how they felt – their modes of being-with patients and family. These were later organized according to a five-point framework that emerged to express the patterns as they corresponded to Heidegger's structures.

Data patterns are represented and shown in correspondence to Heidegger's structures in Figure 1. and in Table 3.

Themes are recurring or common practices that are situated in a particular culture or context. They are present in some but not all narrative accounts. Patterns are present in all narratives rather than only selected narratives. Patterns are the highest level of interpretation. The level of interpretation shifts from specific contexts in themes, to meanings embedded in all human practices in patterns. When this shift occurs, deep, universal insights may arise.

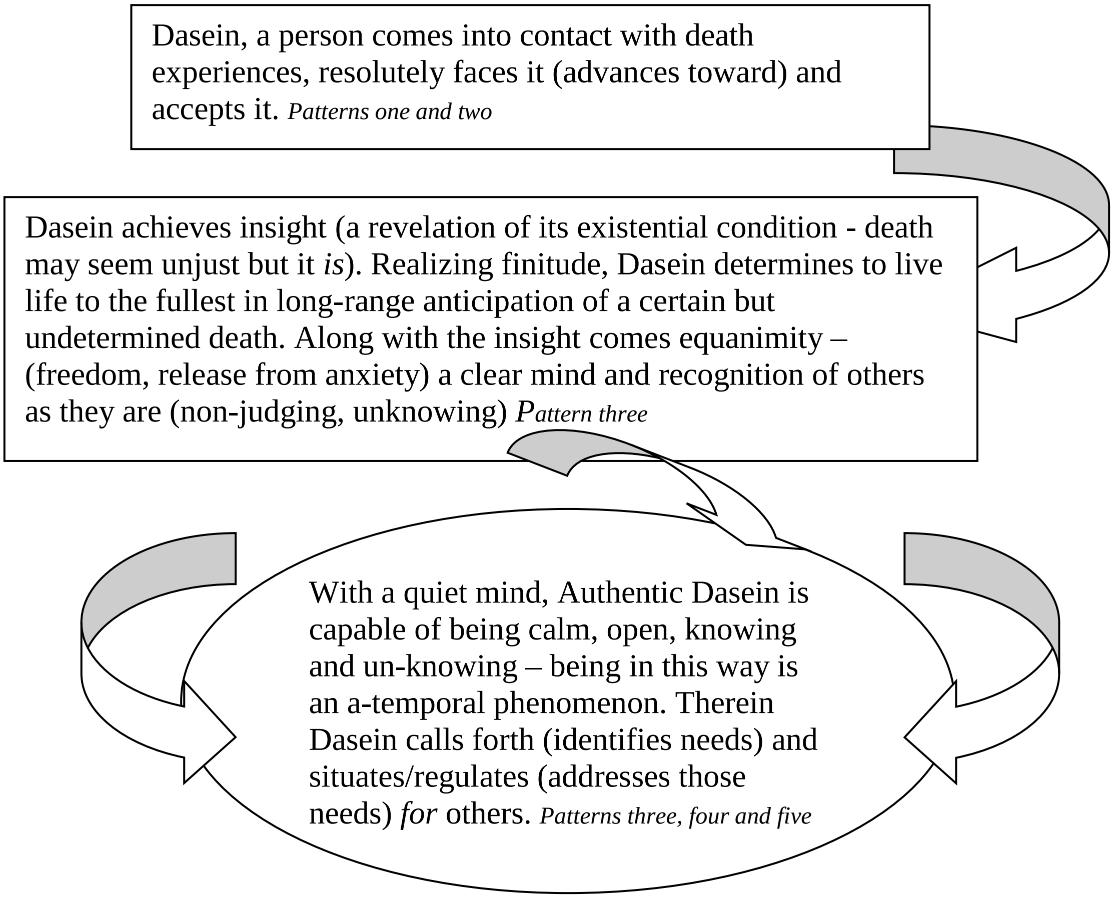
The findings emerged as patterns regardless of the setting, age of the person dying or place of dying or death. Researchers using hermeneutics may illustrate themes and patterns through exemplars and paradigm cases. Exemplars are short excerpts or examples of larger narratives that show particular themes. Paradigms are inclusive narratives that illuminate themes and/or patterns (Diekelmann, 1998).

Participants described their being-with patients and families in end of life situations. How they were (what they said and did, and how they felt) when being-with dying was revealed in the narratives as well as how their approach may have helped persons transition with dignity and peace, from dying to death.

The patterns that emerged were: *pattern one* - accepting death is a condition of authentic being-toward-death; *pattern two* - personal experiences with death and dying enable nurses to connect-with, engage, tune in (sense patient's wave length); *pattern three* - possessing an optimum, state of mind (clear, calm, open, unknowing and knowing) is a condition of authentic being-toward-death; *pattern four* - being-with intervenes, calls forth what another knows, and *pattern five* - being-with intervenes, situating and regulating interpersonal space.

The patterns are holistic, woven together in a presence of authentic being-with dying. They are explicated though in a five-point framework: pattern one (acceptance) and pattern two (experience which decreases anxiety and enables attunement), lead to pattern three (a calm, open mind) within which Dasein can authentically be-with and intervene: pattern four (calling forth) and pattern five (situation/regulating) to make matters better for patients and families (Figure 1).

Figure 1. Patterns (five-point framework) of Authentic Dasein, Being-with dying



Dasein, a person comes into contact with death experiences, resolutely faces it (advances toward) and accepts it. *Patterns one and two*

Dasein achieves insight (a revelation of its existential condition - death may seem unjust but it *is*). Realizing finitude, Dasein determines to live life to the fullest in long-range anticipation of a certain but undetermined death. Along with the insight comes equanimity – (freedom, release from anxiety) a clear mind and recognition of others as they are (non-judging, unknowing) *Pattern three*

With a quiet mind, Authentic Dasein is capable of being calm, open, knowing and un-knowing – being in this way is an a-temporal phenomenon. Therein Dasein calls forth (identifies needs) and situates/regulates (addresses those needs) *for* others. *Patterns three, four and five*

Table3 Patterns as they aligned with Heidegger's philosophical structures

Heidegger's Structure Advancing Toward Death & Authentic Being	**Existential and Intervention Patterns five-point framework**	**Nurses' Experience Narratives**
Purposive deliberation on death as an ever present possibility and on the truth revealed (Pronounced singularity and independence of Dasein being, *Da*).	Experience, becoming aware of death (pattern two – connecting through experience). Advancing toward acceptance of, finitude (pattern one).	*I understood it (what the family was experiencing) from my experiences in end of life care, and from my reflections on those experiences.*
Experience of Death and apprehending its truth (revelation of its existential condition) leads Dasein to apply the consequences of death's inevitability to its own potential. It accepts death and acts accordingly (authentically).	Achieves insight, death is the ultimate possibility, other ontic possibilities become secondary. Insight leads to freedom to exist authentically and for others (pattern two – connecting through experience).	*It is just in my gut and in my brain that through my experiences with my father's death, it convinced me that it is important [to help people with dying]... that challenge of bringing humanity to a setting that is that filled with technology was what brought me to intensive care nursing.* *And those existential crises might play it out in so many ways. You need to be there, and feel that and follow that thread.*
Recognizing the secondary, impermanent nature of ontic existence as it is overshadowed by ultimate death leads to letting go. Dasein's surrender offers a simultaneous realization of itself before it is no longer being-in-the-world.	Perspective – letting go leads to equanimity, release from anxiety – a clear mind and suspension of judgment about others In this authentic state, Dasein is capable of being calm, open, knowing and unknowing (pattern three, possessing an optimum state of mind for being-with).	*So, it's like relating one person to another, like we are all the same. And if that's true (that we are all the same) we have to help each other.* *It is true...at the end of the day and at the end of life, taking away the symbolism of the cross even, but just by where we are...you get to the point where you realize we are all in the same place. There are not –intelligences, money, power, position that's going to change a lot of things in life. It may work here or there, but at the end of the day, we are all the same.*
Authentic Dasein has both freedom and truth with which to embrace life *as* it journeys. Dasein remember itself as the source of everything that lives, is at peace, and shares peace with others Being this way facilitates service to those dying wherein one is no longer anxious. Instead one is calm, composed and attentive in service of being able to see beyond the self and be open toward other beings	Calls forth, identifies needs (pattern four, an intervention which calls forth what the other needs). To address those needs, the nurse situates and regulates interpersonal space - internal and external environments (pattern five, interventions).	*The husband broke down and folded over the bed sobbing. I heard a voice in my head that said "He wants to hold her." So I asked him "Do you want to hold her?" He looked up at me with a look I will never forget and said "Can I?"* *I was trying to make it as un-hospital like as possible.* *All of a sudden I realized that they are going to come and literally, she's' going to have to hand over this baby to the mortician and I'm thinking... I have to some how prepare this mother for what she's going to have to do.*

Participants had acquired an ontological (what is deeper within) authentic attitude toward being-with dying through unique, personal experiences. That they possessed and expressed such an attitude was a pattern in the data. This was the first pattern: *Accepting death is a condition of authentic being-toward-death.*

Before the discussion, I will illustrate Heidegger's structural moments of advancing-toward-death, and the structure of authentic being-unto-death. Doing so elucidates the authenticating characteristics Heidegger attributes to his project of death, and provides a better understanding of the composite determining factor of authenticity. Then parallels are drawn from those structures to the data, strengthening the study showing balance between Heidegger's thought and participant voices.

Heidegger answered the question of how Dasein should properly understand and comport itself toward death in two stages. First he outlined authentic being-unto-death in its *underlying* existential-ontological structures. Second, he showed that this projection could be realized on the ontic (day to day) level. In other words, authenticity arises from the deeper within ontological level, but it is possible to live and practice authentic being on the ontic, day to day level.

Heidegger's structure of advancing

Authentic Dasein's being-unto-death recognizes and accepts that death is the only assured phenomenon of life, it alone will surely come. Death is an undeniable certainty, not something off in the future or for someone else. Dasein 'advances' or 'runs forward' toward death, as long as it does not deny death's certainty. The notion of advancing or 'running forward' suggests some form of Dasein's spontaneity in the face of finitude (Ireton, 1997). Dasein's advancing is the opposite of 'flight from death' which characterizes the far more frequent inauthentic mode of inauthentic, every-day Dasein (concealing reality, hedging, and drawing to the ordinary, using soothing clichés, and separating), and which mode forfeits any chance of authenticity.

Dasein resolutely confronts the possibility of death with an underlying anxiety in Heidegger's beginning works. Later, authentic Dasein becomes relaxed and can accompany itself (aware of death as the ultimate possibility) toward its highest self-fulfillment. When Dasein calmly accepts and affirms the capacity for death it can let-go, let itself and other beings be what they are. The first 'advancing' is marked by anxiety and pressing on against death, the second by calm-self composure and attentiveness.

Dasein's first step toward recovery from the inauthentic condition (flight from death) is to confront death as an ever present possibility. This confrontation sponsors Dasein's insight that all of its own relationships (being-with), and all other beings that make up its world will fade away. With that insight, a path opens for Dasein to accept its responsibility for complete individualized being.

Along this new path, Dasein perceives all other possibilities in life as secondary and less important in the total picture of being. It is possible to look at death squarely, to see the life 'beyond' the embodiment of fear; the form death takes in inauthentic Dasein. Acceptance of death renders an authentic attitude, and that turns into a freedom in living, (from every-day fear and putting off death) toward the accomplishing good living and good dying (Demske, 1970).

Now, "Dasein regards death as a long-term process integrated into its personal existence..." (Ireton, 1997). In this view, all other possibilities are merely intermediate and fall under the finalizing influence of death. These limited possibilities, in a sense, are determined by Dasein existing-unto-death. Dasein is unlikely to view secondary possibilities as absolute or hard and fast. With increasing awareness that it cannot hold onto any one decision or situation forever, Dasein holds open to change. Dasein is a voyager then, continually open and *on the way* toward its ultimate possibility to be.

Acceptance of death also has a social function for Dasein which enables it to understand and evaluate the possibilities of its fellow beings, to have attunement to another's subjective reality. Seeing that death is the ultimate possibility for all beings, and that no other possibility is absolute, Dasein more easily resists the temptation to ignore the being-possibilities of others, or to attempt to use them to serve its own possibilities.

Contemporary psychologists refer to the social ability of understanding the possibilities of fellow beings as "attunement." That is, attention that goes beyond momentary empathy to a full, sustained presence that facilitates rapport. Dasein in such an authentic state offers others its total attention and listens fully, seeking to understand rather than just make its own point (Goleman, 2006). On the other hand, ignoring others' possibilities and using them to serve its own is termed 'agentic,' a cold approach to others, viewing them solely as instruments to be used toward one's own goals. (Goleman, 2006).

Authentic Dasein is free to embrace its own ultimate possibility, but also free for the sake of others. This produces a certain balance with respect to the individualization and the concord possibilities of Dasein being-with others (we're all in this together). Reflection on death can be life-affirming. Coming into contact with the continuous dissolution of life, Dasein begins to appreciate the importance of living now. It is persuaded to live more fully and to help others to live fully too.

Acceptance of death is sage advice found in all scripture and taught by all saintly persons. Gotoma the Buddha (563 to 483 B.C.) said "Impermanent are all compounded things. When one perceives this with true insight, then one becomes detached from suffering; this is the path of purification" (Dhammapada 277). Jesus (8–2 BC/BCE to 29–36 AD/CE), Sri Bhagavan Ramana (1879-1950), Mahatma Gandhi (1869-1948), Rabindranath Tagore (1861-1941), Mother Teresa (1910-1997) and others advise acceptance of death as a path to divine life. His Holiness the Dalai Lama (1935-) advises on living well and dying consciously:

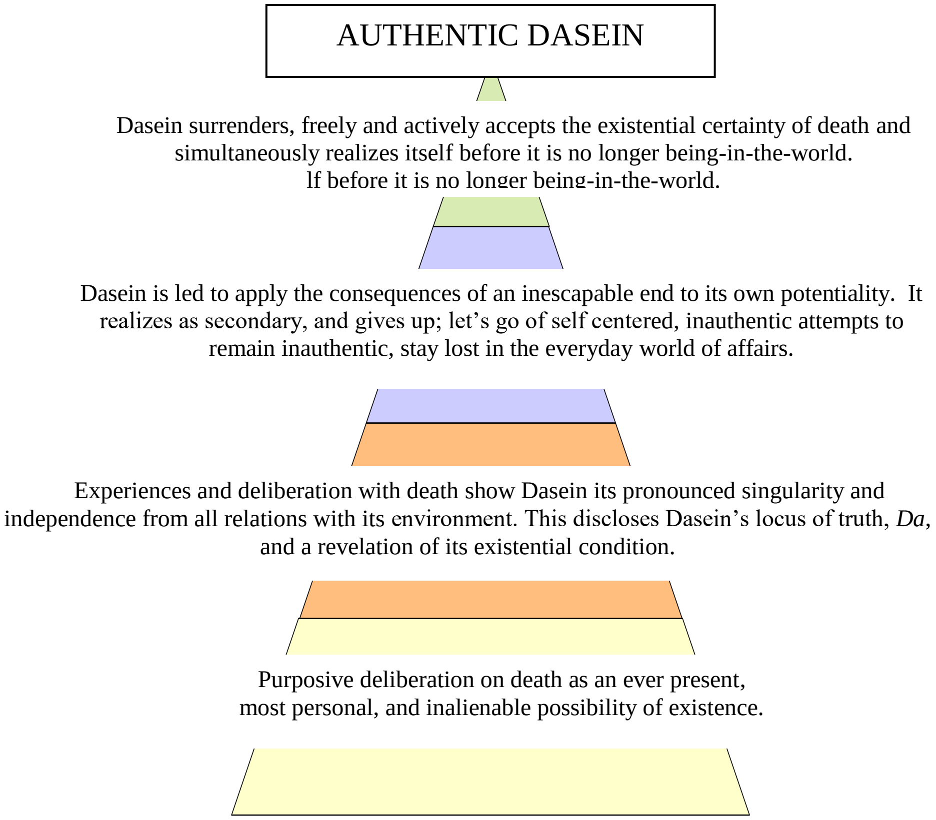
> May we realize that there is no time to waste, death being definite but the time of death indefinite. What has gathered will separate, what has been accumulated will be consumed without residue, at the end of a rising comes descent, the finality of Birth is death.
>
> (His Holiness the Dalai Lama, 2003, p. 210).

It is beneficial to be aware that we will die. If we are not aware of death, we are not mindful of our living; we spend time meaninglessly, not examining what sorts of attitudes and actions bring about suffering and which bring about happiness. Further if we are not mindful that we might die at anytime, we fall under the affect of a false sense of permanence; "I will die some day, but not now." Then, when it comes time, we will not have the energy to try and accomplish something worthwhile. A strong sense of the certainty of death, and of the uncertainty of its arrival, brings about an incentive from within. It serves as an inner voice that cautions "Be careful, be diligent, anther day is passing."

In sum, the formulation of the ‘advancing’ structure includes: (a) Awareness of death and willingness to deliberate on it as an ever present possibility, (b) Dasein becomes awareness that it is (on the ontic level) under a veil of illusion (thinking that death is external, off in the future, not yet for me), and that a more proper living is aware and attentive, faithful to one’s fullest potential; then (c) face to face with death, Dasein sees that ultimately, it will be cut off from all other relationships and beings that make up its world, so it must accept itself ‘alone’ - unsupported by the previously held ontic self which contains ego, personality, beliefs, values, and whatever constitutes the personal; (d) letting go of self centered, ontic possibilities, Dasein freely accepts its proper nature destined irretrievably for death, (e) that acceptance liberates Dasein from ‘popular illusion’ and frees it to accept death as its most distinctive possibility, (f) actively accepting the existential certainty of death as guaranteeing the totality of its existence, Dasein does not know when it will die so must hold that possibility open as ever present. This ontological structure is illustrated in Figure 2.

Figure 2
Illustration of “Advancing-toward-Death”

Dasein freely and actively accepts its true nature destined irretrievably for death. It does not know when it will die so holds that possibility open as ever present. The social function this surrender and its subsequent freedom opens Dasein to understand and evaluate the possibilities of its fellow beings. Seeing that no other possibility but death is absolute, Dasein resists the temptation to ignore the possibilities of other beings, or to attempt to use them to serve its own possibilities. Dasein embraces its own ultimate possibility; but also cares for the possibilities of others. A balance exists with respect to the individualization and the concord possibilities of Dasein being-with others (we’re all in this together). This is also empathy which entails a degree of emotional sharing “I see you, I feel with you and so I act to help you”(Goleman, 2006).



AUTHENTIC DASEIN

Dasein surrenders, freely and actively accepts the existential certainty of death and simultaneously realizes itself before it is no longer being-in-the-world.

lf before it is no longer being-in-the-world.

Dasein is led to apply the consequences of an inescapable end to its own potentiality. It realizes as secondary, and gives up; let’s go of self centered, inauthentic attempts to remain inauthentic, stay lost in the everyday world of affairs.

Experiences and deliberation with death show Dasein its pronounced singularity and independence from all relations with its environment. This discloses Dasein’s locus of truth, *Da*, and a revelation of its existential condition.

Purposive deliberation on death as an ever present, most personal, and inalienable possibility of existence.

Heidegger’s concepts of advancing in the face of death, and turning from an inauthentic to authentic attitude, are justified in the nurses’ narratives. Every nurse expressed an ontological authentic attitude toward death – acceptance of death. The nurses not only told stories about being-with dying, but they naturally reflected on the meanings of the stories, and on human attitudes, relationships, and how they had got to that ‘place’ of accepting death, being-with others and realizing unity (that we are all the same). We start with a narrative about this first pattern; *accepting death is a condition of authentic being-toward-death*.

> It’s all how comfortable you are with death yourself. Nursing staff are very uncomfortable with death, and that transfers to families sometimes... [Nurses aren’t helpful sometimes because they just don’t know how to respond]...Death is a part of life as much as living is. Our culture is a little bit lacking [in knowing that] we all face it.
>
> It’s been rewarding to see how some of the nursing staff has transitioned to being more open and being a little bit more comfortable. For a long time it was always if I was ever there, if there was a death or dying situation, my patient or not, I was the one they would come to, which was okay because it was a learning experience for them. – *Laurel*

Being comfortable with death is critical in quality end of life encounters. Laurel has an ontological (deeper within) understanding: she and all beings face death, and death is as much a part of life as is living. Laurel has witnessed that nurses, moreover most people are uncomfortable with death. That discomfort, she believes, affects people negatively because there is an ignorance in it (not knowing what to do), and therefore a lack of concerned response to others' needs in end of life situations. Nurses may provide good care but miss opportunities to attend to the underlying existential aspects of the situation.

Laurel expresses an ontological acceptance of death as well as an understanding of contemporaries as she witnesses and facilitates their 'advancing' toward death learning experiences. Her authentic actions for others originate in the freedom that arises with an acceptance of death. Her actions also demonstrate the positive social function that arises from her own acceptance of death. Laurel understands and evaluates others' being-possibilities and she is free and available for their sake. She demonstrates an optimum state of mind (pattern three) in which she is capable of creating an emotional surround that can influence those around her (patterns four and five).

Amy expressed her authentic being similarly. Through personal loss and recalling stories of her parents' profound experience of a still birth, she came to realize the importance of acknowledging life's meaning in fetal demise:

> Maybe some of where I come from is knowing what it can do to you later in life to not have the fullness of that [loss] experience...you can't get that back. You can't go back and see that baby if you don't have anything to look at. [Patients] really seem to relax and settle in when I let them know that this is their experience; that this is their baby, and that there are no expectations that we have of them and how they are supposed to respond (patterns four and five). They will have complete control over this situation—I just give them that because they are completely helpless at that point. - *Amy*

Amy attunes to and knows (shares) emotions, a prerequisite to truly understanding another’s inner world. That shared state (knowing and also feeling a feeling) stirs Amy to act for, to respond compassionately to another’s distress. That constitutes empathy and the social function of a free Dasein to evaluate and understand the possibilities of its fellow beings. Amy’s work repeatedly shows her the continuous dissolution of life, helping her appreciate how important living now is (patterns one and two). Believing a lost opportunity cannot be recovered, she attempts to give her patients the fullness of their experience. Amy also “attunes,” to her patients with a full, sustained presence (patterns three, four and five).

Caron knows that there are no magic recipes for being-with, for what to do in every situation of being-with (pattern three). The single measure of helping is whether the other persons’ emotions are stimulated into a better or worse state. This is true whether families are prepared, or whether they are ‘thrown’ into an acceptance of death, unasked for and unconsidered:

> Finding out what [the family and patient] need is different for someone who has a six months or less prognosis than for someone who is imminently dying. The imminently dying, you walk in the door and [the family] are telling you what they need. You don’t have to much ask. “This is happening, this helps me, please help me!” And then your assessment has started before anything...almost before the introduction. So that’s easy... although easy sounds weird, it is easy because your assessment just flows. I mean the need is there, there are no boundaries, none of that. [Assessment of] the person [who has] a six months or less prognosis, is a much slower process. - *Caron*

Caron’s use of the words “boundaries” and “flow of assessment” prompted an interview probe because those words potentially represented the phenomenon of advancing-toward-death where there is balance with respect to the individualization and the concord possibilities of Dasein being-with others (we’re all in this together).

> *Interviewer: Can you go back and talk about the “no boundaries” of the patient....where the assessment just flows, you walk in and it just happens there are no boundaries: What do you mean by “no boundaries?”*
>
> The person isn’t putting up boundaries that you normally would with a stranger in your home....They are not keeping anything back from you. They let you right in with your equipment, your supplies; yourself....They open the door and pull you into the situation (laughs). That’s what I mean by no boundaries—the natural boundaries we all have to a stranger entering our home.
>
> My feelings about that are actually of sadness, because it is more natural to have the boundaries. Their need is so great that the boundaries are not there. I feel very sad that it took that amount of fear and anxiety before they can have a little bit of help....If they had a little bit of help earlier in the process it might not have been so traumatic for them [where patterns one and two would help - having some experiences with death, and time to think about and accept it]. That’s something we face as hospice nurses, and probably ICU nurses too. It’s not until the freak out [flight from death] happens that people get their needs met. - *Caron*
>
> *Interviewer: Do you have a story where you were able to be with someone in a way that the boundaries came down, well before the freak out, the crisis?*

> There was a 3 year old in our program....When his parents realized he was terminal, they asked for hospice and they asked for me specifically...because they knew they would feel comfortable throughout the process. But especially when he came to the crisis spot... they were right there knowing what was happening. It was easier for me to tell them the things I needed to tell.... Probably [easier] than anybody I've ever had, and certainly easier than it would have been for parents [who had not accepted that death was coming].
>
> Sometimes patients live a long time in hospice....In hospice [someone who lives a long time] is someone who lives over a month (laughs). People [with a little more time] may, for example have a problem with pain. At the time they think it is a crisis but it is very easily managed. As time goes on, there is medical stability even though there is a decline. [The nurses] just make that weekly or twice weekly visit, depending on what was going on. So when the crisis comes they just, you know, they had that relationship...the relationship is what developed. Little by little there is a longer process that unfolds and that *allows everyone to get comfortable with what is coming* [italics added] as well as to realize that they have time to get things in order, to appreciate and live what life is left as fully as possible (patterns one and two). - *Caron*

In the case of the three-year old, Caron described parents who had already accepted that death was coming, and who faced it purposefully. In the second case, she described those who live long enough to establish a relationship with hospice staff wherein they could *work toward* accepting death. The hospice staffs work “little by little” to prepare patients and family members for death. Like a nurturing significant other, a nurse can become a safe base for people facing such an ultimate unknown experience as death. The nurse's authentic being gives others a sense of a secure base (trust) in part because a feeling of trust emits brain chemicals that evoke an inner sense that "everything is all right." (Goleman, 2006). In that presence, people can move forward, more prepared to live each day as it comes, and more prepared for death.

Time is required to establish that trust and secure base, and to assist in an advance toward death. Time is necessary for purposive deliberation, to establish awareness and to accept the certainty of death. According to Heidegger's structure of Advancing, that acceptance leads to freedom and fuller living. When asked how she helps people arrive at freely and actively accepting death and thereby fuller living she said:

> Again it is always helpful if you can have that period of time to help them understand that dying is not death - you can live while you are dying (patterns one)....I try to help people feel comfortable (pattern two) enough to live—to go and do what they want to do. To go to the zoo, to go on a picnic, to go to Hawaii, what ever it is that they want to do to live. I want them to feel comfortable enough to do that. That is part of dying - living. – *Caron*
>
> *Interviewer: You were saying, "I talk to people and one of the things I tell them is that living or dying is not death, it is living." And then you give examples. So part of what you are doing is helping them realize that they are living right now?*
>
> Exactly. - *Caron*

> *Interviewer: Whether it's the dying person or the people not wanting to let go of the dying person, or someone who isn't even faced with it yet; you want to help them realize "Oh I'm alive now-so I can just be." Is that right?*
>
> That is right. It is about making the most of your life while you have it...and helping people to understand they can do that. People are so afraid of dying that it makes them afraid to live (flight from death). Hospice nurses can help them let go of the things as they are ready to let go of the things (patterns three and four facilitating pattern one and two). Sometimes people go for trial treatments or whatever...and they have already been through horrendous side effects and are going through more.... [They] can live but have no life because it is filled with side effects of medication. – *Caron*

That narrative details a common 'flight from death' response: when persons seek or passively accept futile treatment. Clinging to life at all costs, *das Man* will put off the eventuality of death any way it can (Ireton, 1997). Constantly seeking to escape its inevitable extinction, *das Man* forfeits any chance of authenticity.

Moreover, inauthentic Dasein, in its flight from death, persistently attempts to counter death's coming by bringing its dying fellows back into the everyday world, whether by means of medical treatment or some form of spiritual or emotional consolation. Nurses' attempts to promote a dignified death, to help people reframe their senses of the potential for recovery are recurrently frustrated by the predominance of 'options' for cure over comfort. Yet, as Caron noted, and as the literature review showed, futile treatments prevent people from living their last days or months to the fullest.

In the next narrative Caron describes what happens when an alternative to futile treatment, living while dying is chosen:

> Others [patients]...who opt not to go through the clinical trial... they will go to Ho Chunk [to gamble]. When they are too tired to go to Ho Chunk, they don't want to anymore; then they spend time with family. And then they don't want to do that anymore. Then they tell the family to back off. And then they spend time with God. That's the transition, that's the dying process, it isn't meant to be suffering until you die through illness trying to live. It is *living*, it is *living*, [italics added] existing, more than existing physically.

As a hospice nurse, Caron is concerned with helping others overcome their denial and flight from death so that they can live their remaining life as fully and as comfortably as possible. She knows that on a deeper level, people know that they or a family member is dying. It's a matter of helping them open to that, and deal with that (getting them to pattern one).

> *Interviewer: You're trying to help people make decisions that will not interfere with living; but allow them to live by accepting that dying is at the end anyway (patterns one and two). They might make this choice for a higher quality of life (pattern three)....People [in denial] are not living their life because they are afraid of dying. There's an opening in there somewhere, an opening of realization that you might help them get a hold on (patterns four and five)...they know inside anyway – kind of a self knowledge, a self prognosis?*
>
> Oh, people know themselves and their bodies more than any of us ever will - more than a diagnostic tool will tell you! And the people that are close...they

> know it second best. Whenever someone asks “How long do I have” or “Do you think I’m dying,” or “Do you think I’m getting closer,” or whatever that version of the question is—the question they are asking is really a statement. They are telling you—and that’s when you have to ask the question back—“What do you think?” (Pattern four, calling forth what the other knows) - *Caron*
>
> *Interviewer: And so you are aware of that question being an opportunity to help them say out loud what they already know?*
>
> Yes, Exactly. – *Caron*

Patients and families, whose call for help is addressed by an assiduously attuned nurse, have a healing scenario. Often though their call is overlooked or ignored. Worse, they are often offered treatments that harshly take up what little time they have left. Just as anyone, especially in unfamiliar situations, learns to manage their own feelings in the safety of a trusting relationship, dying persons and their family members have a chance to do the same in the presence of attuned nurses who offer nurturing human qualities.

Sometime in a person’s life they begin consciously advancing-toward-death. Ultimately they may reach a level, as Caron has, where they can teach others to face and accept living and dying. *Experience* somewhere along the line accounts for the beginning of that journey; and for the social function of connecting-with (rather than abandoning) others in end of life situations. Such relationships can enrich the capacity for connection, which in itself has healing properties. This was the second pattern: *Personal experience enables connecting-with, tuning in and engaging*. Particular experiences influence nurses on their way to authentic being. Both Hannah and Laurel became acutely aware of death as they attended to the deaths of their fathers. They believe that those experiences opened up the way for rich connections later with patients and families; connections which they believe help other people transition from dying to death.

> The first dead person I saw was my father, and that was under tremendous circumstances. I was 23 years old, and he had a brain tumor. I remember him Cheyne Stoking,[4] and I was alone with him in a hospital hall and we hadn't found a room for him until a medical student came by...and helped me get him into a bathroom where he died. That experience has just been engrained in me. I should have probably sought counseling for that since it was so traumatic...it was horrifying.
>
> It is just in my gut and in my brain that through my experiences with my father's death, it convinced me that it is important [to help people with dying].... That challenge of bringing humanity to a setting that is that filled with technology was what brought me to intensive care nursing. And what works [to help people] is to always spend time at the bed side with patients and families. [Nurses need to spend] hours of communication with them, finding out what their needs are, where are they coming from, simply doing a lot of listening while you are doing your chores.... You find out where people are and what their fears and questions are. And that's how I think you can best meet their needs – *Hannah*

For Hannah, being-with boils down to a series of encounters with patients in which she is fully present "Why don't we just put down the stethoscope and listen a little? With experience we can do that and still keep an eye on the monitor." She gets in

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[4] Cheyne-Stokes respiration is an abnormal pattern of breathing characterized by periods of breathing with gradually increasing and decreasing tidal volume interspersed with periods of apnea.

synch, sensing how people feel and why. She's open, knowing and unknowing. Being that way she is able to identify and address patients' needs (patterns three, four and five).

Next Laurel describes how her life experiences open ways for connections with patients and families.

> *Interviewer: ...that connection that you just talked about, what is that from the nurses' perspective?*
>
> Well it's interesting because when I first started hospice...I'd only been a nurse for a year....My dad died the second semester of my starting nursing school. That was very traumatic because I was *very* close to my father. So...I discovered that being in [end of life] situations helped me with what I was dealing with. When I took care of a patient who was around my father's age, I realized I was still dealing with my loss. Over time I began to feel comfortable sharing that with families. So I was able to share my own story....You just put yourself there and I think that is part of what it is...just feeling what other people are feeling...knowing there might be family dynamics or issues or whatever -- that‘s not always that important right at the moment. It's the loss; you only lose one mother or father.... In sharing your own story, it's amazing how people feel comfortable with you. You can be empathetic because you have really been there. It actually allows them to open up and be more comfortable because you are just being you. It's not that I read this little section in this book on death and dying and this is what you say to people and this is how you should act and present yourself. It is really real when you can sit and share your own life story exactly with them. I mean most

human beings are intuitive and people know when you are being real and genuine.

– *Laurel*

Conversations operate on two levels: the rational, words and meanings, and the *felt sense* that runs beneath the words, holding the interaction together through an immediately felt connection. The *sense* of connection hinges less on what is said than on the more direct and intimate, unspoken, bodily felt emotional link. Such synchrony lets people connect and feel a positive emotional resonance with the other person. The more synchrony occurs, the more alike the emotions those engaged will feel.

Laurel describes empathy that entails a large degree of emotional sharing. Mirroring this way “sharing...exactly with them” gives empathy a richness, which makes seeing someone hurt really hurt you. The notion that empathy entails an emotional sharing has a long history in psychology, suggesting that understanding the emotion of another person requires that we experience the same emotion to some degree (Goleman, 2006).

Recall the nurses in Tarzain’s (2000) study whose air hungry patients evoked strong responses in them; even feelings of being out of breath themselves, or of becoming part-of the patient and wanting to breathe for them. Both Laurel and those nurses’ being-with air hungry patients illustrate Dasein’s understanding of other beings and its connection to, and caring for them (Heidegger, 1927/1962).

Interviewer: So you said, you just put yourself there. What does that mean?

Sigh—I don’t know if its’ just through life’s experiences or what ever...You just see each person and you just kind of can interpret you know, just

> by their face or what's going on sometimes just exactly what I'm seeing. It is interesting just studying people in life. Just by facial expressions, maybe how deep it is or maybe not so deep for some people, or bewilderment, you know, you can just kind of spot people that maybe are going to have a little bit harder time with what ever is going on. Those are the people I usually try to spend a little bit more time at that moment. Not everybody is open. you also have to be a little bit careful with that too, you don't want to become intrusive at that time, you want to offer yourself, you know we all have lines sometimes and know where to discern
>
> - *Laurel*

Hannah and Laurel opened to existential authenticity as they experienced the deaths of their fathers. Heidegger said that once Dasein begins the process of advancing, it begins to be authentically present for its day to day association with other beings. The moment when one achieves authenticity is a moment of vision, insight and understanding. Dasein senses its responsibility to be the 'there,' (*da)* of being (*sein*). Death is with Dasein as an ever present determination of (authentic) living.

Laurel continues, talking about the breadth of nursing practice and the requisite of liking people, not judging them, meeting them where they are. In dialogue with the interviewer, she shares deep insights which parallel with Heidegger's Advancing toward death structure (Figure 2):

> *Interviewer: So a lot of relationships (is an important part of nursing)?*
>
> It is! It is! And I think that having to deal with people (at the bedside) has helped nurses learn to deal with relationships. Just like nurses can talk about how

a procedure went, they can talk about how they dealt with family members and what is going on. That has kind of broadened things...and has helped everybody.

I guess I feel for people, you know and because I have been all over the map in my own life (laughs) you know-- I'm not better than anybody because you know, I mean we've all have our issues...and things we've been through. And yet on a human level and dealing with life, you know those issues aren't that important. It's just who you are now... not what you were.... I think that's a good place to be.

You can't hide behind things in your past....You can choose to harden and not really move forward or not get involved. I guess for any of us, we have two directions we can go, we can either be hardened by what we've been through or we can gain and grow through our situations. If you don't [grow], what a prison to live in, it really is! Take away of all the things that are your excuse in life for not moving forward it's just like taking a fresh breath of air! - *Laurel*

Interviewer: So you find this way of being that you take into caring for people, freeing? (Pattern three)

Yes!! I was just going to say, I think that's it – because when I look at people, you begin to be able to read, you know a little bit, just surface maybe where they are and it is like... "Okay; I can work through things and I've been there and I know where they are coming from." Experience really helps, and people know when your being judgmental and people know when you are being real, people know, and I guess it's just helped me to be able to project [being real] you know.

Interviewer: People read us as well.

> Oh exactly!! Who do we think we are you know because we have some title or professional something – Exactly.
>
> *Interviewer: So there's no hierarchy, we are all part of the same.... It's like our roots are in the same soil, even if we were from a different land, it doesn't matter, if we are together now, isn't that a metaphor that sort of ?*
>
> From a spiritual aspect somebody said... "At the foot of the cross we are all on equal ground." I have translated that into my life in many ways. It is true...at the end of the day and at the end of life, taking away the symbolism of the cross even, but just by where we are...you get to the point where you realize we are all in the same place. There are not –intelligences, money, power, position that's going to change a lot of things in life. It may work here or there, but at the end of the day, we are all the same.
>
> *Interviewer: We all die*
>
> And we do, we do, we all get sick and we all die, whether it is sudden or known, you know.

In that dialogue, we have an exemplary showing of the 'lighting up place,' authentic Dasein, a voyager continually open and *on the way* toward its ultimate possibility to be. Laurel and the interviewer understand that everything in life falls under the finalizing influence of death. They talk about knowing that what goes on in life on the surface (ontic) level is secondary, not absolute. Laurel says there are two paths we can take in response to what happens in life: one where you become hardened and the other path that keeps things open and is freeing.

Having set ontic issues in proper perspective (at the end of the day they don't matter) she is free to accept herself and others and to share an emotional understanding with them because she's "been there." She's translated being at the foot of the cross into her life in many ways and recognizes that all people are the same at the end of the day and at the end of life. Having freely advanced toward death, Laurel is a "real" or authentic presence for patients and families.

Laurel's expressions maintain Heidegger's distinction between two modes of existence, viz. authentic Dasein and inauthentic *das Man*. Faced with the prospect of certain death, authentic Dasein will enjoy life to the fullest (including being there *for* other beings) on the way to a certain but undetermined death. "At the end of the day, and at the end of life, we are all the same." Faced with the same prospect, inauthentic *das Man* will become hardened by what it has been through, losing any potential for authenticity. With anything in life, there are two ways we can go. Laurel chooses the path of Authentic Dasein, and lives accordingly for her, and for others.

The beginning of Valerie's journey toward authentic being-toward-death was marked by a quiet, contemplative childhood. She, like the other nurses uses related experiences to connect with patients and families in end of life situations.

> I just think it's important to have related experiences so that perhaps people know there is a way. So [patients and families] know they are not alone. Being with people in that way [sharing and understanding] is a very quiet space, very attentive, open, and whole. It has a subtle energetic buzz to it. It is like feeling the sensation of the connection that there is going on between people--that we know we are all the same. That I am here with you, I'm not going

> anywhere, and I'm here with you for the reason of being with you so that together it's easier for you. I hope to come to and through your process.
>
> Somehow...this way of being does seem to be natural, it's contemplative. I was this way as a kid. I liked' to be alone on a rainy day, maybe laying on a pillow beside a window watching the rain, not saying anything, just resting quietly and thinking... about what-- I don't' even remember. But also I noticed my mother sitting in quiet prayer and meditation every single day of my life since I can remember. And we shared that experience [of coping by contemplation] when I was going though my own life crises. So, I picked up a practice of prayer and meditation, and there is something so basic that it's key.
>
> If we can relate to other human beings as though they are our own.... In other words, when I was a nurse's aid and caring for aging people...I thought that they were my grandmother or my grandfather and how would I want them to be treated if they were in a nursing home. I've heard many nurses and nurses' aids say that over the years. I think that's key. So, it's like relating one person to another, like we are all the same. And if that's true [that we are all the same] we have to help each other – *Valerie*

All of Dasein's possibilities to be (and those of others) are touched at their core by the possibility and actuality of death. Valerie realizes peace and power in her world through her quiet caring. In the above narrative, she alludes to the third pattern: *A state of mind that is clear, calm, open, unknowing and knowing as a condition of authentic being-toward-death.* This pattern contains four tenets: (a) a clear, calm mind, (b) openness, (c) unknowing as non-judgment and (d) knowing as personal professional knowledge. All four structures show as Valerie talks again; this time about approaching a grieving family member after a death.

> I think [being in] the background is not grandstanding, and that listening is very intent. [That space] doesn't have anything in it that I as the listener need; it’s simply listening to them. Purely listening to them.... Listening without predetermined understandings....That doesn't mean I haven't had those experiences before or I have not heard patients and families mention the same things before. Having an experience just allows me to draw on that which is in the background. But listening at the time with an open mind means that I don't know what they're going to ask. I just wait to hear what it is and then respond.
>
> There is also a waiting in the listening, a quiet waiting which allows the person you are listening to; to reflect on a question you may have asked them so that they can find what's right for them, what resonates with them. An example of that and I have many.... Usually these conversations have long periods of silence in them because this reflection is going on and that silence needs to be held by the listener so that the person can be with their feelings and see what sets them feeling more right than umm all of askew (pattern three sets the mind for pattern four - calling forth).
>
> There was a young father of three [children] whose fourth child died about four weeks after her birth. The baby got sick about four days after birth with a heart problem. This dad’s grief was so heavy and so apparent...every day. I could just feel sadness, and I would be on my way to a meeting; stop in his office and ask him how he was and how his kids were and how his wife was. In those early

> days he would stop and look down and just be quiet for a while. And then an answer of some sort would emerge out of that. That experience is a lesson in quiet listening, in allowing someone to go deep inside themselves to find out how they are when they are in such formidable grief.

Valerie realizes that there are times when you simply forget yourself, your feelings, concerns, and fears so that you can focus just on the people who needs help getting through their situation. Irrelevant thoughts, personal desires and judgments would cover over this mode of being. Valerie elucidates a therapeutic presence in that encounter: The young dad’s voice awaited her silence. What he had to say was deep within his psyche and could not surface unless her mind was quiet. Valerie served as a safe, emotional surround for him. There is peace within her that she calls upon to help make her mind and the therapeutic environment suitable for such an exchange.

Amy similarly exemplifies a calm mind that is open and unknowing as she approaches parents in fetal demise situations. In this case a young woman came into the hospital to be induced for delivery. The woman had known for a day that her baby was dead since there was no heart beat at her fifth month prenatal visit. This was her third pregnancy. The first two pregnancies were electively aborted. The pregnant woman arrived with her boyfriend and Amy attended:

> When I approach a family...I am really very calm. I guess I do not have any premeditated ideas on how I am supposed to be. I go in without any expectations. I go in with sort of a blank slate. I am conscious of my body language and also the tone of my voice. The first thing I try to do is to sit down. I reach out and use touch; I do not touch the men right away, they are more reserved at that time at

the initial meeting. In fact I find they are very protective of their partner. So it is more guarded where she more wants to reach out and doesn't seem to mind the touch.

This particular girl... I really could tell right away, she wasn't ready to hop into the bed and put the patient gown on and become a patient. She needed some time to settle into where she was. So I sat down in the chair next to her and reached out to touch her hand. I initially say a comment to the women who come in and know their baby is dead-- to break the ice.... I usually get them to tell what their experience is. I think it is important to tell their story. By them starting to tell their story then I can start to connect with them a little more. That connection makes it easier for them when they can feel that I feel with them. I don't feel it as deeply but I do feel it with them.

So she told me her story about how it was hard to go home and wait a whole day knowing that the baby was dead. At that time I didn't know that her first two pregnancies had been aborted by choice. To me those [events] do not matter now, I don't place a judgment on people. To me the first thing wasn't to look at her prenatal record and see what the situation was or what her history is. I just like to go in and not really have any ideas about what I am going to say. I just want them to tell me their story and help me understand where they are.

I let them know that this is their experience and this is their baby and that there are no expectations that we have of them and how they are supposed to act or respond. I usually see them relax a little bit, this happened and her whole body language changed. She sort of sat back and had her melt down and she started

> asking me questions about what the baby would look like, how big the baby would be, will it be a boy or girl. And so I knew that we were at that place in the relationship within just maybe about 10-15 minutes. -*Amy*

Amy describes experienced being-with that connects her with the patient both physically (touch) and mindfully (presence). She is calm and confident in knowing how to be open and non-judging; in letting people be however they might need to be at that time, in that place. In this way she calls forth their words, words that tell just the story they have to tell. Amy knows how to "identify issues, clarify options, and get people to talk so she can help them." She calls forth (pattern four) and listens as the act of telling does its powerful movement toward 'getting through' a seeming cruel situation. Amy also situates and regulates the environment (pattern five) so that the patient has time to 'settle in to where she is.'

Both Valerie and Amy know that it is far better to listen than to talk. In listening they help get patient and family thoughts identified and addressed. Both find it easy to be quiet, to approach the encounter intentionally clear minded, calm, open and unknowing.

Being calm, quiet minded and mindful, being open knowing and unknowing – are complex notions. But they can be delineated: As a clinician I experience the quiet mind as empty of current streams of thought, yet full with potential – like a still pool waiting for whatever ripples across its surface or for what ever moves it from deep within its silent center. Having a quiet mind also opens an awareness of calm gentle subtle vibrations throughout my body. My body quiets down and does not disturb the environment in any way – with tasks, noisy breathing, heavy, stumbling feet, or negative emotions for example. Both my mind and body can wait quietly and calmly which calms

> the atmosphere too. I am attentive and alert with an expansive vision and awareness. I don't anticipate, plan or judge. I know I don't know...The reservoir of my mind is omnipotent. Such comportment is noticed (as a felt sense) by others who may enter the space where that is going on and it gets them to quiet down too.

Nurses' and others' listening often functions defensively as a way of coping with apprehension; as a way of protecting oneself; and as a way of avoiding overwhelming emotions (Heaven & Maguire, 1996; Institute of Medicine, 1997; Maguire & Pitceathly, 2002; Wilkinson, 1991). In the face of death we experience a 'deafness' which shields against a deep seated ontological anxiety - it is a deafness to silence, a listening which constantly insists on making noise (Levin, 1989).

Heidegger would say that we are unable to comport ourselves in a way that helps other people because fear and other matters narrow our ability to be open to the meaning of all there is around us. Defensive activities restrict or entirely block awareness of the peace and healing power of silence. There is another side to the experience of 'deathly' silence though. It can be experienced for its open quality, a clearing that is a resting place for quiet recovery of our deepest selves. A quiet, open, non-judging mind allows nurses to listen deeply, to assist patient and family to reflect and resonate with what it right for them, and to reflect back to them what they (can't see through the forest) they want. This state of mind precedes being-with as calling forth and as situating and regulating. Hannah talks about these notions in her interview:

> I was in a grad class recently and the professor asked us "How many of you have discussed death and dying with patients?" I was shocked that I was the only one raising my hand. The [other nurses] were honest and they said, "We really

> haven't." And so now they wanted to know how it is that you do that. But I said "The patient will lead the way. You just sit there and they start talking, and you say "How is it going?" And they say "It's not going so well." And you say "What do you mean?" And pretty soon you get it up. It's almost like any other thing in life, you want to talk about what matters the most to you, where you are. -
> *Hannah*

Pattern four: *Being-with, an intervention which calls forth what another knows,* and Pattern five*: Being –with, an intervention which situates and regulates interpersonal space* are both modes of being-with. Recall that patterns four and five are personal and professional interventions which are carried out in the state of mind described in the third pattern (calm, open mind that is knowing and unknowing) and enabled by pattern one (acceptance) and pattern two (experience).

Paradigm Cases

To show the nature of a holistic, interwoven being-with encounter, it is helpful to illustrate a case that includes all patterns and themes. Researchers using hermeneutics illustrate themes and patterns through exemplars and paradigm cases. Paradigms are inclusive narratives that illuminate themes and/or patterns while exemplars are short excerpts or examples of larger narratives that show particular themes.(Diekelmann, 1998).

A case Barbara described illustrated the five patterns:

> A woman was admitted to the unit with a 'cold leg' and physicians repaired it by taking a clot out. Barbara was working with a novice nurse who reported that 'something wasn't right' with the patient. The next day Barbara

cared for the same patient who had really ‘gone sour’ during the night and ended up being intubated[5] and on Vasopressors[6]. There was a ten-percent chance of survival with surgery and that the patient would die without surgery

It was clear that the family wanted ‘everything done’ to keep the patient alive. The patient was prepared for surgery. During those preparations, Barbara made sure that all the family was in as much as they could be. The family walked the patient to the elevator and kissed her good-bye because no one was sure if she was going to come back (*pattern five, situating/regulating*).

The physician told Barbara that if the procedure was short it would be bad news and if it was long, there was hope of survival. One-half hour later the physician called and said it was bad news; all but six inches of her bowel had died. The physician asked the family if they wanted to let the anesthesia wear off so that they could say good-bye. The husband replied “No, I don’t want her to be in pain, just bring her here and we will let her go.”

So the patient was brought back to the room. Barbara extubated her and began a morphine drip for comfort. Barbara then put the bed in its lowest position and made the lighting soft. “I was trying to make it as un-hospital like as possible” (*situating/regulating*).

The husband broke down and just folded over the bed sobbing. Barbara was crying too and heard a voice in her head that said “He wants to hold her.” So

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[5] Intubation is performed in various medical conditions to protect a patient’s airway. In Intensive care it is performed for patients who require respiratory support.

[6] Vasopressors are drugs used when a patient's blood pressure falls too low. They help increase blood flow to the heart so the heart can pump more efficiently.

she just asked him “Do you want to hold her?” (*Pattern two, a clear, calm mind/ and pattern four, calling forth*). He looked up at her with a look she will never forget and said “Can I?”

Knowing she could not lift the patient by herself and not wanting her head to wobble, Barbara sought a nurse whom she thought could walk into the room and be sensitive to the spirit (*situating/regulating*). Barbara said the novice nurse had not yet had the personal experiences in life that would fit him for this encounter (*pattern two, recognizing personal experience enables connecting*). Barbara and another nurse positioned the husband on the bed and put his dying wife in his arms. The husband continued to cry as he held his wife. Barbara turned the monitor off and walked out to the nurses’ station where all the nurses were now crying.

The patient died shortly and Barbara returned to the room to tell the husband “She’s gone now.” Barbara left the room again and the husband lay holding his wife for another 20 minutes or so. Barbara ‘peeked’ in periodically and called for a physician to pronounce the death.

The physician walked into the room, pulled the curtain and saw him holding her. “And he goes, ‘I can’t intrude on this. What time did she pass?’” Barbara told him what time and that’s what he wrote on the chart. The son also looked in and said “You know, this is my Dad’s time, I can’t go in there.” Barbara said that she was so proud of the physician because many times physicians overlook the spirit of a situation.

> Eventually the husband came out and Barbara walked with him to a room where they completed paperwork and then they returned to the room for final good byes and left thanking Barbara for everything she had done. Barbara remembers thinking "I didn't do much." Later she wrote a narrative for a class and used this story. In telling it she began to realize "You know what? I really did do something that day—I put myself aside and became a hollow vessel; and God, or whatever you want to call it, comes through, telling me what to do." (*Pattern two*).

Barbara shows the social function of accepting death which enables Dasein to understand and evaluate the possibilities of its fellow beings. Knowing that death is the ultimate possibility for all beings and that no other possibility is absolute, Barbara is free (of death anxiety) for the sake of others. She lays bare a certain balance with respect to her individual being and the concord possibilities of Dasein being-with others (we're all in this together). The situation pulls her out of herself, she becomes a hollow vessel able to hear what to do (for him) from the voice of being.

Laurel presented an equally compelling case about a new-born in her hospice program which also shows the holistic, interwoven authentic being-with encounter:

> Oh boy the things you see people going through. I'll tell you what; people say sometimes especially in the hospice setting "I don't know how you do what you do." Sometimes I think jeepers I get way more than I give (Gratitude[7]). There was a situation a long time ago and I hadn't been a hospice nurse very long. There was an infant involved that was probably the hardest for me and I truly don't know

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[7] Gratitude showed up as a theme in some but not all narratives.

how I got through it other than the fact I couldn't think of me, I could only think of the parents (*pattern two*).

This child was born with a heart defect, and the parents were told the baby had less than a ten percent chance of survival with surgery. This young couple opted to bring him home for end of life, knowing that it would be just days probably. And I marveled at them at such a young age, you know the little nasal-gastric tube that she would feed him with a little syringe.

The only thing they couldn't do, being a cardiac situation he would be short of breath, she wasn't comfortable with giving a little injection to make the baby more comfortable. So those would be the times (when the hospice nurse would visit).

Well it just so happened that the weekend this baby died, it was my time to be on call. I had been there earlier in the day, two or three times. They handled things so well it was just, it was amazing for such a young couple to be that together. I mean I still marvel at them to take on that responsibility which to me would be fearful for a young couple. But somehow they rose to the challenge just unbelievably, and I had been there a couple of times.

So you know again, you get very connected very quickly um knowing again the normal course of life is not for babies to die (*pattern three*). Babies are just born, now they have to grow up, and go through, so it was hard for me, but umhh, so they had called me back again. It was in the evening, saying would I please come and give him the shot because they felt that his breathing was kind of labored, would I come. Well by the time I got there he had passed away.

> So the grandfather met me at the door. So I went in and you know (soft voice) went to the mom who was holding the baby, held her and the baby both [the nurse is crying now as she recalls the story]... ***still*** [emphasis added] it's really hard. Anyway, so you know, even in the death they did beautifully though you know. But she sat there and held the baby, and as the baby started to discolor, she just kind of pulled the blanket up over him.
>
> When I got to the point where we knew I needed to call the funeral home. This is nothing unusual, because it's the normal course of what we do. But all of a sudden as I'm sitting there and she's sitting like we are sitting, she's sitting across from me holding this little bundle, [I began to think] um okay the funeral home is going to come, but you know what, for a tiny baby, I bet they are not going to bring in a cart. I don't know why. I didn't [think about this] I've never been through this before. All the sudden I realized that they are going to come and literally, she's' going to have to hand over this child and I'm thinking (laughter) I'm thinking I have to some how, I'm going to have to, I don't even know how because I'm having a hard time with it, how am I... I'm going to have to prepare this mother for what she's going to have to do (*patterns three, four and five, situating/regulating*).
>
> So I started to talk to her just I mean kind of like, you know, [saying] how things work, you know, the whole professional part of how things go when the funeral home comes. But I said "You know, when the gentleman comes... because he's so tiny, I'm sure he's going to come and he's just going take and hold your

> baby and take him." And I said "I need to know how you are doing with that and how you are feeling about that, and what you want me to do."
>
> So we talked about it and she just cried and held him. I think it goes back to that they were bringing this baby home and knowing that he was going to die (pattern one, accepting). I mean I think they were way ahead of me in the game (laughter). Not that it was easy for them because it truly was not easy for them. But again I was very humbled by that she knew that this is what she had to do. She knew [somewhere deep inside] from the time probably from the time that the baby was born or from when she was told that he was in a terminal state. So when the funeral home came I don't know which of us cried more—the mom or me.

Laurel's experience as a hospice nurse being-with parents, grandparents and a newborn baby boy, expresses one of the deepest ontological and most problematic paradoxes in life. Babies die. It is powerful and decisive. This unasked for and undeserved situation is unjust. It ought not to be. But since it is (pattern one) Laurel responds by doing all she can (patterns four and five) to help assuage the suffering that has now come upon her fellow beings - comrade mother, parents and grandparents (pattern three).

The situation is so powerful that it pulls Laurel out of herself and into concern only for the parents. The experience is deeply embedded in her ontological being and remains there years afterward. She has a deep sense that the dying baby, his parents and grandparents contributed to who she is, and that they taught her more about life than she would otherwise have – she is grateful.

Laurel ‘communed’ in a state of high mutual empathy where her patient’s feelings more than just mattered to her (empathy and concern), they changed her (transformation). While she is in communion, she stays in synch, in full authentic being.

Gratitude is a theme that showed up in many, but not all of the interviews. Gratitude fits into Heidegger’s structure of advancing toward death along the second step of the pyramid “Awareness of death can lead to fulfillment of life.” Laurel believes she receives way more than she gives as she accompanies people along the end of life journey. Coming into contact with death on a daily basis, she appreciates how important life is; she lives more fully because of it and helps others likewise.

Each nurse participant possessed a clear, open mind, one which is both knowing and unknowing; and one that calls forth what others know. As a primary and open-ended intervention, the nurses use what they know and don’t yet know to situate and regulate the interpersonal space *for* others. Hannah illustrated this by first talking about the similarities between talking to a child about sex and a dying person about dying.

> It’s sort of like a child asks you about sex for the first time; you don’t give them the whole story, because they are probably not going to want to know that. They probably just want to know that little part that they asked about. It’s an opening I think, I often say there are two things we often don’t feel like talking about it is sexuality and mortality. And they are both very connected. Most of us are going to have sex and we are all going to die (laughter). So as much as I work with – and try to talk about sex because I knew that is what they wanted to talk about, it is the same with the dying patient. There is an elephant in that room and

> they want to talk about it. But the challenge is they don’t want to all talk about it in the same way. *Hannah*

The interviewer probed on that last statement and Hannah filled in with a contrasting story about a former teacher who was dying and who was attended by her four sisters, with whom she had lived for 80 years. The sisters were utterly in harmony and ready for the withdrawal of life support. Hannah has used that case over the years as a blueprint for being-with when that harmony is not in place...

> ...But when that [harmony] is not in place, there are so many variables, not only do we lose harmony and that spiritual piece is gone; it becomes so traumatizing and so ugly that people cannot go on living. Do we always accomplish what we want? No. But I’ve always had intellectual and emotional curiosity. Instead of feeling threatened when there are 30 people in the room because they are [from a different culture] and they want to throw rice all over and put red bracelets on patients and do things that the nurses often think are weird. Instead we should ask them, “Tell me what this means...Please bring me into [your] process.” And you can often do that with families – you can ask them, questions and say “Let’s talk about that.”
>
> What I have done in the patients room the patient might be awake but not all the time...drifting in and out of sleep but always they are listening. You have families there who may be talking about something that is difficult ... issues like some kind of disagreement or simply inappropriate communication going on. Not that it’s inappropriate to talk about death and dying, but you don’t want to do that

about someone when they are in the bed and then someone is talking about the funeral and they can hear just fractions about it.

Either I'll tell them to step out and we'll have a little conversation about it in the hall or I'll talk to the patient about it and I'll say [different things]:

"You know, we have some questions that I think the family feels a little awkward asking you, and since you and I have been together for two days now, and I have already asked you some of these things, would you mind if we all have a conversation? I can just kind of be the mediator and I can be your lobbyist because you are tired and I know what your needs and desires and I can speak for you and you can correct me if I am saying something that doesn't seem to be consistent with what your feelings and needs are? Because your family clearly is very concerned about you but they all have different ideas about how they can help you."

And be absolutely very honest and bring it out in the open. Or it can be that the family is petrified and I will model the behavior. That is most effective—when I start joking with the patient, they start laughing... they say "He has done that his whole life." And then I say "Yes, doesn't that drive you crazy when he does that?" And they say yes, and I say it would drive me crazy if he did that and then we laugh and you know, make fun of the patient.

And that you have to be very comfortable before you can do. But it is amazing how often that works. You are not supposed to be the leader in the room but you can lead them to take that charge. If it is to give them a hug it is amazing how many don't want to touch because there are so many tubes and lines, or they want to be in that bed but they are not going to ask. Um and I just try to be natural about those things.

Interviewer: So if they want to be in that bed but they are not going to ask, um tell me how that has been, how you come to know that and what do you do about it. If you know they want to be in the bed or it is so common that they do but that they are afraid to ask, how do you handle that?

I had one couple in mind particularly. They were in their 60s and the wife was sitting there. Her husband was dying and she was always very attentive. She would bring in the lotions and rub his hands. It was obvious to me that they were very physical already, and that she was into that role. She always sat next to him and tried to get very close, and it was clear to me that he enjoyed her strokes.

But she was very intimidated and she was the old school, and she would say things to me you know like “It is hard for me to sleep at home now because I haven’t been, I’ve been together with my husband, we slept in the same bed for 40 years and now it is so lonely.” She’ll say things like that to me and I would say, “So do you want to be in bed with him, why don’t you, maybe you want to crawl into bed with him.” And she will laugh as if I’m joking.

I say “It’s a little crowded there but we could probably get rid of some of the lines and tubes...and I just gave him a bath, he’s probably cold, he probably needs someone to warm him up a little bit.” And I say “Right Tom? You probably would lie to feel your wife hold you.” And you know, he cried. Nobody had asked about that. He cried and then I cried too (laughter). It is so moving. He had wanted it so badly.

The wife said, I'm so shameful, what if the doctors come in. I said "We will put the sign on the door, that's okay." but hadn't had the time to do that. So she finally made it through the barriers she thought were there. Of course it is beautiful, it was so well received and then the wife.

He died a few days later and I was off. I heard later she told a nurse that it made a big difference. So it was an expression of love that she wasn't able to give him and I think that is what nursing is often about... is to see when that is needed.

But not to impose, because if you impose that on someone that really doesn't want that or if you say it is okay to touch and you make it sound as if you don't touch, you don't love. You have to really read into what other people's needs are. It is very focused on their needs, completely turning around our assessment skills; we carry our nursing knowledge along with us to intervene if we need or to teach. But our assessment is based in finding out what they need and want. And that is challenging because you never know when you are going to use what piece.

But when you are at that bedside, helping somebody die, with dignity and spirituality, then you need to be there, one second you need to answer pathophysiology questions and you need to be in control of that ventilator or you need to answer a technical question and the next minute there is this existential crises that you really need to deal with if you want to get deeper. And those existential crises might play it out in so many ways and you need to be there and feel that and follow that thread.

Hannah’s interventions are rooted in her knowledge, experience and training, rather than in “recommendations for practice” or technically based training which hold that a program or technique produces the therapeutic effect. Hannah, the practitioner intervenes and participates to produce change. She uses judgment about what to do to accomplish a specified goal and to determine what actions will accomplish a goal with a specific person, in a specific situation, at a specific time. Her practice is comprised of actions informed by situated judgments (Polkinghorne, 2004).

Below is an example from Caron’s practice informed by situated judgments:

> There’s a certain relationship that a nurse has with people that is unique. We have had other people, from other disciplines trying to teach us (a program or technique of) professional boundaries; and they realized that they didn’t know as much as we did, and that their relationships are completely different.
>
> Boundaries are not what we are talking about [in end of life care]....Yet there is still that clinical aspect to it. So what happens that is different between nurses and patients is that it is completely nonjudgmental on the part of the nurse. Our baggage stays outside the door and I’ll give you an example. A social worker and I went to admit a patient and the patient and his wife had a relationship in their marriage that was not what we felt comfortable with. They had a fight while we were there. We went back to our nurse executive director and said “This is not going to work (laughter). This is the primary caregiver and this is not going to work.” And our executive director told us to “Care Plan it.” And by using that phrase...she taught us: “Wait a minute, it doesn’t matter how we feel about their relationship; this is their relationship.” By saying “care plan” she reminded us that

> it is not our job to judge. It is our job to assess and to figure out what interventions we can put in place to help them in their specific situation.
>
> And we were able to, it was very much a collaboration with the social worker, the nurse and the certified nursing assistant (CNA) to ensure that the needs of the caregiver and the patient were met. And that is a case I am very proud of because he did die at home and she was his caregiver to the end. Care planning means you are coming up with assessments, you assess the situation, you implement interventions that may or may not work and you evaluate the effect of the intervention, none of that allows you to judge. - *Caron*
>
> *Interviewer to Caron: One nurse researcher found some nurses saying they get themselves ready before they go in to be with people, are you familiar with getting ready to be-with?*
>
> Yes, getting ready to be-with is when you drop your baggage outside the door, cleanse yourself, and go in as almost a blank slate for that person. Or that group – usually it's more than one person that you are going in to see.
>
> *Interviewer to Caron: Cleanse yourself, what does that mean?*
>
> Umm, you take a deep breath, and you empty your mind and you're so empty of what it is that are your needs, and usually I'm taking a deep breath while I'm doing it too, to reenergize that clarity so that I'm open for them. -*Caron*

Letting something appear as what it is becomes a matter of learning to allow it to do so (Palmer, 1969b). Heidegger called this meditative thinking. Meditative thinking contemplates, is quietly serene, thinks the truth of being, listens to being and belongs to being. It is a craft which demands great effort, practice and care. It also must be able to bide its time, to wait as does the farmer, whether the seed will come up and ripen. So this meditative thinking is a ‘way of being’-- a way of being we are not quite used to, is something we need to practice. Yet Heidegger also says it does not have to be high flown. “It is enough if we dwell on what lies close and meditate on what is closest, upon that which concerns us, each one of us, here and now”(Heidegger, 1966). So as we begin any endeavor, we can ask, and then listen in a quiet way – waiting to see what comes.

Each nurse described acceptance of death as part of life; and each described intentionally going into a state of mind where they were calm and quiet, open, ready, non-judgmental and entirely available *for* the patient and family.

> So the space that I was in...For being with this family, for talking to them about all of their various concerns, and for pointing up to them what was already apparent...I was in a background space where I knew what was happening but I was in the background... so I wasn’t *in* the chaos. I was observing (the chaos) and I understood it from my experiences in end of life care, and from my reflections on those experiences. So background I think, being in the background is important. Sort of holding a space for everyone, a clear space where questions can be asked and answered in a clear way. *Valerie*

Valerie describes being-with as being in a quiet, calm background space *for* the patient and family. In this background space, she observes the chaos but is not ‘in’ it. Her ‘clear mind’ does not project a meaning onto the situation; rather it is open, ready and waiting for needs and questions to arise and to be answered. She also listens intently from that space and consciously waits while patients and family reflect in periods of silence. Then whatever appears is an ontological manifestation of what is Alētheia, a truth found below the surface. In the same way a phenomenologist lets things become manifest as what they are, without forcing one's own categories on them (Palmer, 1969b), Valerie uses a way of being-with that is quiet and open as a fallow field which is cultivated for things to grow (reveal themselves) naturally (as they are).

Overall, participants comported themselves toward dying patients and family members in such a way that they cleared the way for people to be themselves, the way they are. Through personal experiences and their own acceptance of death, they were able to connect with patients, engage and tune in. They possessed calm, open, unknowing and non-judgmental minds and used that way of being to call forth what the patient and family members needed, and to address those needs by delicately situating and regulating the environment. If we have ever been aware of this ability, perhaps we have touched on what Heidegger refers to as the 'meaning' that hides within the very thing that it is. He says we can 'get' that meaning if we consciously and continuously heed that fact that such hidden meaning touches us everywhere in the world – we stand at once within the realm of that this hides itself from us, and hides itself just in approaching us.

This chapter presented participant profiles and their narratives. The researcher's interpretations were situated in Heidegger's philosophical structures of Dasein advancing-toward death, and inauthentic and authentic being-toward-death. Heidegger's language and metaphors were used to assist in revealing what is hidden, that we may not otherwise see.

CHAPTER V

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This chapter presents the study conclusions, implications for leadership and nursing practice, and recommendations for future study. The patterns in the literature review tended to follow somewhat similar courses constituting variations on the theme, inauthentic being-with dying. Consistent with Heidegger's structure of evasive-flight from death, they showed that, in many instances, flight from death and its associated ontic behaviors are repeated daily in health care. At the same time, a few nurses followed courses constituting variations consistent with Heidegger's structures of advancing-toward death (a pathway through experience toward an attitude of acceptance), and authentic-being toward death (shown in Figures 1 and 2). Participant's narratives were consistent with Heidegger's structures of advancing-toward death and authentic being-with dying (Table 3).

This study was neither a series of depressing stories of end of life failures nor of nursing valor, success stories that inspire imitation. I don't know of any case in which a good death can be attributed solely to authentic-being, nor do I know of a case where authentic-being is a continuous state of mind. There are always other contributing factors, and people are always developing, changing.

When I began this study I didn't appreciate those complications. Eventually I arrived at a five-point framework of appropriate, authentic being-with dying which I have considered in trying to understand how good end of life care happens. My five point framework has a social function, as does Heidegger's structure of advancing-toward death. That is, Dasein considers the possibilities of other beings, and cares for them in light of death as the ultimate possibility of life. If we are interested, we can use the framework to examine ourselves in all our relationships, encounters: teachers to students, nurses and others to dying and grieving persons, the well off and strong to the poor and vulnerable, the supremacist to the oppressed, and so on.

The literature review and the nurse's stories and narratives were both situated and considered within Heidegger's structures of being. They informed us of what changes are needed in personal and professional practice to support patients and families effectively in end of life care. And tenets of a newly developed model for authentic being-with dying were portrayed.

Implications for Nursing Leadership, Education and Practice

The nurses in this study self-identified as being comfortable in end of life encounters, and they were fervent about it. They were referred to the researcher by others who believed that they were experts who consistently identify and address patient and family needs. The data speaks for itself.

What nurses hope to understand about dying patients' experiences may be lost unless they can change their approach to being-with dying; unless they prepare open, quiet minds to be authentic, and to hear what is deeper within. Classic nursing theories describe those same values, and understandings, and show that nurses have *always already* known the essence of ontological caring.

For example, (Carper, 1978), identified four patterns of knowing as a construction of nursing knowledge (empirical, personal, ethical and aesthetic). Carper said that being a certain way involves becoming a certain kind of person, and not merely doing certain kinds of things. Becoming a certain kind of person requires a philosophical shift for nurses from a focus on concepts of cures, scientific facts and technical competence (empirical/rational knowing) to a more holistic approach that also incorporates values (personal, ethical and aesthetic knowing).

Carper elaborated that a fluid, open approach to understanding (existence) makes possible a wider consideration of conditions, situations and experiences in nursing and she named this *aesthetic knowing*. Knowing this way involves being in an attitude of responsive openness to allow another being to 'move into that open' and be addressed. Responsive openness involves waiting quietly and doing nothing with a 'wakeful openness to being' for something as yet unsaid and coming from the innermost core of a person (Palmer, 1969b). Here, Carper and Palmer describe the quiet, waiting silent comportment (Gelässenheit) described earlier as authentic being-unto-death.

An open state of mind also requires a condition of unknowing. "To engage in an authentic encounter, one must stand in one's own socially constructed world and unearth the other's world by admitting, "I don't know you."' (Munhall, 1993, p.125). To open this way, nurses 'de-center' from their own organizing principles to enable empathy to understand the actual essence of meaning the patients' experiences hold for them. These ideas agree with social psychologists' assertions that empathy entails some degree of emotional sharing, a prerequisite to truly understanding anyone else's inner world (Goleman, 2006); and also with tenets of patient and family centered care where the clinician's ego or the 'I' steps aside and allows the patient and family to lead the way (Jonas-Simpson, 1996).

Nurses are action oriented, they are doers who shape reality according to an articulate purpose and in light of means conceptualized in reality (Dickoff, 1968). Two action principles that assist in attaining that way of being are: to suspend prior knowledge (to become unknowing) about patients, families and their social context until they have been able to tell their story; and to allow patients to tell their story as a legitimate part of the assessment process (McCormack, 2003). Stated in another way, suspending prior knowledge silences the mind, and creates an opening, which invites patients to say what is important to them.

Nurse researchers study the wholeness or health of humans, recognizing that persons are in continuous interaction with their environments. Human characteristics and natural processes, such as consciousness, adaptation, health, self-determination, ageing, dying and relating give nurses their practical aim of optimizing human environments from the cellular to the social levels (Donaldson, 1978). In this way, nurses' expertise is visible in their ability to engage (be-with) the patient in exploring (hearkening) their experience while they work together (unity) to find interventions that resonate (knowing) with the patient.

Suffering and human existence are significant aspects of nursing and have been the focus of much writing by philosophers, theologians and nurses (Rogers, 1997). Rogers notes the irony in nursing that the role of the care provider often carries with it substantial responsibility for (unintentionally) adding to rather than relieving human suffering. She proposes that nurses use a whole-person approach, focusing on developing awareness of: (a) patient's feelings of completeness and purpose, (b) barriers to that completeness and purpose, and (c) the general importance attached to the experience of suffering in the context of the individual's entire being. Rogers says that nurses' hallmark perspectives and values already convey this comportment through emphasizing individualized care, the nurse-patient relationship, interpersonal skills, existential presence and empathy.

Nurses care and provide comfort as a human response to persons' suffering. Using processes of inference, intuition, identification and *compathy* (the physical equivalent to empathy) identified by Morse (1999). While the presence of compathy enables nurses to provide necessary care in the absence of a patient's complaint, serious or traumatic situations can overwhelm the nurse and disable care giving. Nurses learn to block the overwhelming response by steeling or shielding themselves or by depersonalizing the patients. Nurses who are burned out may be in a constant state of blocking their compathic response.

Hope is another important human response valued by nurses. Hearth (1990) identified seven hope fostering and three hope hindering categories based on interview responses. She provided nurses with a framework for selecting strategies to foster hope among persons facing the end of life. Some specific suggestions were to create a vision of hope through active listening and being present to support growth toward new awareness of 'being' through values clarification, that is, reflection on meaning and purpose and reminiscence.

There is large literature showing that nurses hold core values of being caring, competent and helpful to benefit others in their professional work. Yet, they unintentionally often add to rather than relieve human suffering. The next section considers reasons for such inconsistency. Nurses may understandably fail to elicit the needs of families and their dying members because of their fears and normal day-to-day ways of being. However, it is difficult to accept behaviors that prove ineffective and have unhappy outcomes. Perhaps if we understand the reasons why nurses and others often make bad decisions in end of life care, we could use that knowledge to guide them to make better ones.

One reason nurses and others make poor decisions is reasoning by false analogy. When we are in unfamiliar situations (and anxious) we fall back on drawing analogies with old familiar situations. That is good if the old and new situations are true analogies, but it can be un-helpful, and even dangerous if the situations are only superficially similar. For instance, using a standardized nursing assessment for a patient admitted to the hospital for diagnoses and treatment of pneumonia with air hunger and delirium will be inadequate for a person who is imminently dying of advanced lung cancer, suffering with air hunger and terminal restlessness.

Yet, those assessments are often similar or even identical, thus missing critical information on patient and family perceived needs. Using personal experience to face and accept death, then attain a practice of authentic being may not be easy because of common tendencies to see events or objects as things that we already understand. Yet, it is possible to hold one’s mind open through practices and attitudes of questioning, waiting quietly and listening. It remains important to understand deeper, ontological meanings of being to transform inauthentic end of life attitudes and practices.

Another reason nurses and others make poor decisions was addressed earlier. High anxiety decreases the amount of attentional space available to perform tasks needed to meet another’s needs, and it weakens empathy and concern. Persons lose their ability to be at their best when pressure increases. The more intense the pressure the more their performance and thinking will suffer, handicapping abilities to learn, react flexibly, create, focus attention, plan and organize (Noteboom, 2001). In this way, persons are simply not able to be open because anxiety constricts their ability to be the way they want to be.

If nurses perceive something that arouses painful emotion, they may suppress or deny their perception to avoid the pain, even though the practical results of ignoring it may be problematic. Fear is the emotion most often responsible for denial and refusing to think about the likelihood that some one loved is dying, or that we, ourselves will one day die (Diamond, 2005; Schucman, 1975); and coping with thoughts of death leads to self-regulatory fatigue (Gailliot, 2006).

Another reason nurses may fail to elicit patient's needs is that the origins of the problem are nearly imperceptible, naturally below the level of consciousness, or forced below consciousness as in psychological denial. Heidegger would say the hidden-ness of being extends so far that the concealment itself is concealed. Dasein, in relating to a being revealing itself, is so fully preoccupied that it pays no attention to the concealment. This double concealment (we do not know that we do not know) is "the mystery" of being (Demske, 1970).

A final consideration about why nurses and others often fail to deliver quality care at the end of life: Social Psychologists have enumerated countless answers to the question why, if the human brain contains a system designed to attune us to someone else's distress and prepares us to act to help, we don't always help (Goleman, 2006). One of the simple answers suggests that modern society works against it: we principally relate to those in need at a distance (Doctors and other providers do this because their presence at the bedside is not as continuous as nurses'). But while nurses are at the bedside around the clock, they often separate themselves from patients when they are uncomfortable. That separation means we experience “cognitive” empathy rather than an immediate, direct emotional sharing of feelings (a prerequisite to empathy and compassionate response). Worse, they may have mere sympathy, where they feel sad for the person but do not in the least ‘know’ their distress. The distant relationship weakens the innate impulse to help. There are, however, bases for hope.

One basis for hope is that we are capable of understanding why nurses have these problems. In other words, these situations are not beyond their control. Nurses, all persons create their own situations; and can choose or not choose to start changing them. Nurses and others need desire and willingness to apply approaches already available. Among the choices they must make to succeed is to courageously engage in psychological transformative practices to overcome their fear of death. Another is to practice listening, to the voice of being that comes through their consciousness, and to the voice of being that comes through others.

Recommendations for Further Study

The present study provided insight into health professionals and others’ apparent affective and cognitive un-preparedness to be-with dying. Apprehension casts many health care providers out of their zone of excellence and they lose their ability to be at their best. Their anxiety occupies attentional space needed to help patients and families transition from dying to death. Anxiety stimulates stress; forcing their attention onto the emotions they feel, weakening empathy and concern. In such low quality interactions, patients and families feel isolated and afraid, and perceive dying in the care of the American health care system is difficult, painful, harrowing and humiliating.

On the other hand, the study also provided insights into the experiences and knowledge of nurses, who *are* prepared to be-with dying; whose experiences and emotional characteristics have increased their capacity to be in an optimal, authentic state for making patient and family matters better. Participant nurses did not describe anxiety as part of their comportment toward dying patients. Instead they described absorbing inspired moments, full attention to patients and families, enthusiasm and internal harmony. In such high quality exchanges the nurses reported that the patients perceived their experiences more positively.

Although this study was not designed to develop a model of authentic being-with dying, the themes that emerged were consistent with philosophical, affective and cognitive structures about human experiences of being-with dying (Demske, 1970; Gardner, 2006; Goleman, 2006; Noteboom, 2001; Ochsner, 2002). For example it is well documented that anxiety accounts for reducing our ability to perform well. Anxiety takes up attention needed to notice important cues in the environment. That split attention causes us to tune out, missing essential details in assessment of patient and family needs especially emotional ones.

There are specific mental strategies that persons can use to attend to their distress about death and to shift their mental state. Emerging data on reappraisal (how thinking controls feeling) offers a correction to the misguided impression that persons have no control over their mental and emotional lives. Reappraisal alters one’s emotional response; and when it is done intentionally, one gain conscious control of their emotions. That has inspiring implications for the kind of atmosphere we can create to foster the transition from dying to death, for being-with in end of life care. Every nurse needs to remember that she or he can make matters either worse or better.

To discover what happens when persons consciously change their thoughts and feelings (from inauthentic to authentic being); to learn what it takes to do that, and to begin acting on the basis of that shift, a number of additional steps will be needed. One is to develop a more compete framework for understanding the cognitive and affective mechanisms of being-with dying. Future work may clarify more precise ways in which different types of cognitive regulation modulate different aspects of the emotions, especially those which hinder effective being-with dying.

Of special interest are the mental mechanisms, some learned and some potentially innate, that account for a person arriving at the bottom of the pyramid (Figure 2), moving upward and beginning to act on the basis of the new understanding at the top of the pyramid. I don't know of any attempts by researches to link reflection on death, coming into contact with the continuous dissolution of life, to appreciating how important living now is and to increasing compassion to helping others.

Another route is already funded that will extend the original interpretative research of hospice and ICU nurses' *being-with* dying to include other providers and settings viz. physicians, social workers, chaplains and nurses in other settings such as long term care. A composite picture will contribute to developing training and education programs that reduce the barriers to communication, symptom management and palliative (comfort) care. Further, large qualitative data is available for analyses at the University of Chicago. That data includes taped interactions between cancer patients receiving radiation therapy and the nurses attending them. The tapes could be transcribed and analyzed for the qualities of authentic being-with and for evasive flight behaviors.

Finally, I am aware that there are many different ways to approach Heidegger's thought, and I am also aware of the importance of a critical reading of it. I have barely scratched the surface of it. It is necessary to spend time and effort to work through the complexity and richness of Heidegger's own thought, as well as of other Existential philosophers on the meaning of life. This remains a task to be developed in a further study. Doing so will bring additional structural parallels between philosophy and Dasein's behaviors toward death and dying. Those will help further meet the purpose of this study – to better understand being-with dying.

Strengths and Limitations

Strengths of the study include that the nurses represented diverse settings such as hospices, and ICUs from both small and mid-sized towns to large university, teaching, research intensive hospitals and medical centers. Half of the nurses were experienced in both the ICU and hospice setting. This brought the perspectives of nurses from a variety of backgrounds and settings to the study. The study was strengthened as a balance between Heidegger's thought and the study participants' voices emerged. Another major strength of the study lies in the researcher's extensive end of life experience which enhanced ability to focus on pertinent current issues relating to the aims of the study. The researcher possesses a working knowledge of being-with dying which is tacit in the experiences of nurses.

Study limitations included that all of the nurses in it had many years of experience. They had already arrived at a level beyond day-to-day (ontic) common experiences of nursing in end of life care. They had many years of experience in nursing and in life. An experienced nurse’s intellect is packed with expert knowledge – information relevant to his or her clinical practice, and they store more “cognitive templates” or mental outlines of generic problems and solutions that can be tapped when confronting new problems. Nurses with less experience may have reported earlier steps in the journey toward authentic being-with dying, providing details that the experienced nurses took for granted and found difficult to express.

Phenomenology has its own limitations. First it is difficult to replicate findings using this method. Some believe that the absolute objective meaning of a text can be reproduced if one follows strict guidelines and procedures that would allow one to transcend all subjective limitations. However others hold that we can never reach a completely objective interpretation of a text; the text holds some meaning but our own situation and biases necessitate a conversation with the text in order to construct any real meaning. Many are suspicious of any claim to truth that involves deconstructing the text to show that all truth is relative. Others mix conservative and radical hermeneutics, focusing on exact speech situations and forming a consensus in order to reach agreement on what the truth is.

Reliability and validity issues of hermeneutical analysis involve the (a) subjective researcher-determined topic labels, (b) potential discrepancies between phenomenological subjective knowing and claims about reality (Paley, 2005), and (c) using individual narrative accounts of nursing practice as evidence of nursing expertise (Nelson, 2003). The study does not make claims about reality or nursing expertise and sample size or power. Those issues are not applicable to qualitative research.

The subjectivity of the research does limit synthesis of information since subjective results are not easily replicated. The researcher found one study where some of the findings matched those in this study (Abendroth, 2005). Even if the phenomena of ‘like’ studies are similar, the dimensions of those phenomena are usually slightly or very dissimilar, making it difficult to synthesize information.

Finally this study borrowed language, metaphors and structures of Martin Heidegger to show new ways of looking at situations. It should not be taken that the work is grounded in Heidegger’s philosophy, or that the researcher is re-founding any theory on the basis of Heidegger. Rather, some of Heidegger’s work resonated with the researcher’s experiences and thinking, and were made useful to show how nurses who attend to dying comport themselves toward dying patients and their families.

Gifts of Phenomenology

The chapters of this dissertation have discussed how and why our Western societies succeed or fail at solving their end of life care problems. The final chapter considered the dissertation’s practical relevance.

Future nurses have many reasons to be hopeful, first because there are many nurses who have solved the enigma of changing their minds to accept death in their own lives. Moreover, we humans are extraordinarily adaptable beings. We draw on an infinite assortment of coping skills to successfully manage adversity, even in the most trying situations. One of the most remarkable of these skills is another reason for hope: that we can control how we think and act, even when anxiety is present. This skill was described by Shakespeare’s (1998/1623, p. 216) Hamlet, “there is nothing either good or bad, but thinking makes it so.” Personally, our greatest hope may be in our students of nursing, whom we are privileged to teach. A twenty-year old man said it well: “Heidegger’s point of view is awesome because when people conclude that life is all we've got, they often decide that that means nothing matters (Nihilisms). But Heidegger points out that the same realization (that life is all we’ve got) makes life all the more important.” To the young man, that was a refreshingly positive outlook (viz, P.D. Meyer, personal communication, December 30, 2006).

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