4 The moral relevance of lived experience in complex hospital practices

A phenomenological approach

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Jean Pierre

A young man, 29 years old, Jean Pierre Linsen, is brought into hospital after a serious accident with his racing bike: his bike overturned, causing serious head injury and other minor injuries. He was literally catapulted from an active and healthy life into the life of a bedridden patient on the neurology ward. He is a local carpenter; a large group of people around his age come to visit him; he is clearly 'one of them', they are all young local hardworking no-nonsense people who stick together. They hang around, talk to each other in dialect, surround him like a blanket. He is currently in a single room on the neurology ward. A number of medical tests have been run as he seems very confused, and he is unable to eat and drink. A neurologist and a neurosurgeon are on top of his 'case'. Jean Pierre's condition is rapidly deteriorating.

This morning, around 7.30 AM, two young nurses, Monica and Joyce, enter his room; as a researcher, I am 'shadowing' (Czarniawska-Joerges 2007) Monica during her shift. They have to wash the brawny young man and insert a tube to administer fluids and food.

The thought strikes me that "these two nurses are around the same age as he is" (I am twice their age). I jot down field notes as we proceed: everything they do and say, and my own sensations in the margin ("tension"), some observations ("2 women, one man, same age approx."), second-order observations ("repetitive! Important?", "she remembers after 20 min.") and insights from theory ("health care lingo on efficiency"), just in key words.

As Monica, Joyce and I enter the room, curtains drawn, we smell a bad odor: there is a smell of unwashed man and of feces. As soon as Jean Pierre becomes aware that we are there he starts saying, again and again: "oh, I have to go to the can"—he feels a constant urge to defecate. As Monica wants to wash him she tells him to spit out the sputum he is constantly hawking up. He was restrained to the bed during the night because he is very confused. The young man constantly wants to go the toilet and never stops telling the nurses. He speaks in local dialect, they reply in standard Dutch. The nurses try to convince him that he has to use the toilet chair that they placed beside his bed, since, over the course of a few days only,

he has become too weak to stand on his feet and go to the bathroom. He eventually comes out of bed but is unable to defecate though he feels the urge. When they have laid him in bed again he wants to go to the toilet again and cries out for help, cursing about how stupid 'you', the nurses, are. The atmosphere has become tense: a swearing young patient, odor, the necessity to intervene. They wash him as he curses. They try to insert the tube through his nose (this is their second goal), but the two types of tubes available on the ward turn out to be too big. Joyce suggests that they get another, narrower type of tube she knows is available on another ward, on the other side of the large hospital. The two nurses agree and ask a trainee nurse to go and get this tube; the trainee hurries away. Jean Pierre is constantly hawking, insists that he has to defecate. Suddenly 'it' happens and he actually defecates—all over the bed. The odor is intense. The nurses take turns to leave the room to get air, they spray the room, wash his bottom, clean the bed and want to try again with the tubes. The young man announces that he has to "take a shit." The nurses talk to the young man in a calming tone, and tell him that he does not have to worry about going to the toilet, his bowels are empty now, and there is no need for him to be so vocal, they understand that he feels the urge. When the thin tube is brought in, Rosalind, the head nurse, comes in; she is barely older than the two nurses and this male patient. Monica and Joyce talk to her about the tube. Monica tries again and again to get Jean Pierre to agree to have the tube inserted through his nose. The head nurse goes; it's a very busy morning. The young man resists the intubation, swears, and keeps telling them "why are you hurting me?", "why can't I go to the can?" Monica: "Please, Mr. Linsen, we are not trying to hurt you, the tube is necessary, you are getting weak."

Then Rosalind comes back into the room, puts her left hand under his right hand, her palm pressed against the back of his hand, supporting his hand, and all of a sudden starts talking to the patient in dialect: "Now listen Jean Pierre, Jenny your wife is soon going to have the baby, they need you, that child cannot live without you, you have to get better, you have to eat and drink, or you are going to die, surely you can't let it come to that, let us insert that tube". Jean Pierre seems to hear and take on board what she is saying. Monica reacts and says to him: "alright, could you sit up straight, please, let me know if it hurts, try to let the tube go down, please, please help us". The patient struggles, says "it's impossible to eat through my nose". They instruct him what to do, tell him he is doing well, and finally he cooperates while Rosalind every now and then says something soothing to him in dialect: "that's great, Jean Pierre, Jenny will come at noon and she'll be so glad to see you." Jean Pierre answers her in dialect. Monica and Joyce fix the tube so he cannot tear out 'that thing' (as he calls it). Then they hurry off: there are other patients waiting to be washed, or to be helped to wash themselves. And so it continues; care practice is never-ending.

Later, at noon, I watch Jean Pierre's wife as she waits in the corridor. She is clearly pregnant. Monica stops by and tells her how the situation developed overnight, touches her arm and brings her into Jean Pierre's room,

while she stands quietly at the doorstep for a few moments. Monica and I, her 'shadower', look each other in the eye, no words spoken. My field note, in the margin: trouble. I sense a tragic atmosphere. When I come back the following day for an evening shift, I hear that Jean Pierre has been moved to ICU, as his condition had further deteriorated.[1]

Introduction

The problem I will address in this paper is the difficulty to perceive with an open mind what lived experience (of a patient, of a nurse et cetera) shows itself, the difficulty "to let what is given appear as pure phenomenon" (Toombs 2001, 1, citing Husserl), more specifically to perceive and describe that lived experience as it occurs in a particular, highly complex organization during care practice. There are no extreme choices or huge autonomy issues at stake. Yet, the situation is full of concerns, of things that bother the patient and these professionals, of their "grasp of reality" (Sayer 2011, 37). In this sense, the situation is imbued with normativity, that is: we are at that level of everyday life where good and bad are at stake. Good and bad refer to how people behave in relation to others with respect to their well-being (Sayer 2011, 7), but also to what happens to them: injury suffered, intense pressure exerted upon them and life itself threatened.

I will do this in three steps. First, how can experience be given its proper weight in ethics? That it is, is by no means guaranteed in ethics. Drawing on critical insights from the ethics of care, I will critique aspects of ethics in order to create scope for this. I will point out the unrecognized adherence to presuppositions of Modernity in the ethical appraisal of experience. Second, I will discuss four phenomenologists and their critical insights into Modernity and bodiliness, resulting in the creation of what I call the 'sensorium', i.e. an approach that allows experiences to appear as phenomena. Finally, I will return to the hospital scene using this sensorium, to demonstrate what phenomena show themselves and what ethical impact they could have.

Conceptualizing experience

How can the experience of this patient and these nurses be taken seriously in ethical reflection? The experience of the three nurses in this and similar scenes is part of their nursing work (Hockey and Allen-Collinson 2009, 219), whereas the condition of the patient is intertwined with the hospital situation. In order to create scope for reflection, let me start by immediately discarding two tempting but misleading conceptions of experience: the first takes experience as a natural occurrence inside someone's mind, and the second regards experience as an I—Thou encounter. In scenes such as the one described above, the patient and the nurses have no 'natural' experience, natural in the sense of a 'pure, inward' idea of what experience is, as if experience were about consciousness *taken as a psychological occurrence*, unmediated by context, such as for instance time pressure (the nurses). Nor is

this a simple experience within a dyad of people, the romantic open-minded I—Thou. Thinking in terms of an "encounter" of nurses and patients as a "spiritual matter" in a complex clinical setting (Holopainen et al. 2014, 191) misses the point that it involves physical acts (cleaning up, inserting a tube), bodily proximity (stench, washing, touching) and the systemic limits of the encounter in space and time: there are many more patients, while this one is struggling for his life. These versions of *inwardness* and *relationality* are not resistant to the actual experience of patient and nurses in the complex hospital. The care organization (the architecture of the ward, medical devices, nurses' routines, successive shifts, efficacy pressure et cetera) molds the experiences, also in a moral sense. The intubation process in itself already reveals the way in which a Western care organization molds experience of care: the mere availability of different sorts of tubes, some of them more inconvenient to the patient than others. Experience occurs in "the whole complex of institutions in which the human being is steeped as soon as it is born" (Stavrakakis 2007, 55). The experiences in this scene are part of a 365/24 care practice. This is not to say that we should adopt a constructivist view of experience. But any attempt to "take refuge" from complexity, for instance by conceptualizing in terms of inwardness and I-Thou relationality, is a simplification (Peperzak 2000, 60). Experience in a complex organization is about people as bodily beings that find themselves together in time and space "amidst of irreducible complexity" (Dauenhauer 2000, 70). "The most important thing is not whether sentient existence is either 'naturally given' or 'socially constructed', but rather how we might come to appreciate the imbrications and resonances that cut across all layers of embodied experience" (Tonder 2015, 2).

Experience in ethics

One way of defining the problem of experience in a hospital setting is to try to capture experiences by drawing on ethical theory, by approaching them reflectively. Thus, there is the principle in medicine and nursing (which also applies to experience at some level) of avoiding harm as much as possible when treating a patient, in this case: when intubating. But this approach determines in advance which experiences count in ethics and which do not. This would mean that the range of experiences of the nurses, e.g. their disgust, would be ignored. Another way is to try to delve into the experience retrospectively, for instance by interviewing the nurses afterwards (and possibly the patient and his relatives and friends) about the moral relevance of the experience. But would this attempt to access experience penetrate the thick substance of experiences? Surely their voice is of utmost importance. The occurrences in the scene, however, seem to be richer than what a retrospective spoken account of the partakers is likely to yield. The living of the experience as it "appears in a lived, rather than directly reflected, way" (Svenaeus 2009, 62; Leder 1990) is more profound than reflection upon it, even if the reflecting is done by those who lived the experience themselves.

The advantage of observation is that it is spread out over time and that the observer, acting as a critical friend, can observe and recall to memory what is overlooked or dodged in a first person's verbal expression.[2] As the French phenomenologist Henry Maldiney puts it, "language is impotent to express the singular things according to their real being in the lived proximity" (Célis and Zumwald 2011, 434).

Now, how could in turn such an observation be qualified? During observation, I as an observer am at the same affected by the intrusiveness of the situation as I notice for instance the attempts to insert tube varieties *a* and *b*, the conversation about type *c*, and finally the insertion of this type *c* and the acts that accompany it (the talking, the touching). I observe the gurgling, the patient's resistance, the swallowing and the choking. I hear the way the patient expresses himself in dialect. Evidently these observations point to the difficult and burdensome nature of the experiences in question. And even the seasoned observer is struck by the strenuous nature of the experience, of both patient and nurses. What phenomena reveal themselves when this approach of continued perception is taken? Are these phenomena allowed then to carry moral weight?

Various reductions

How can phenomena in institutionalized care reveal themselves and how can we approach them carefully? What is the moral relevance of the trials and tribulations of people in the context of a public institution, a hospital? Despite the interest of policymakers and scholars in patients' and nurses' experiences, their weight and moral relevance are not all that clear. The conceptualization of experience in ethics suffers from the divide between the merely subjective and the socially recognized.

Before engaging in a conversation with bioethics on the ethical relevance of experiences, I want to make a more general point: on the one hand, there is the tendency to think that everything in an experience can be expressed and has to be expressed. On the other hand, there is the tendency to treat experiences in a reductive way. Falque has articulated the first point in a strong paradox: ethics only speaks of bodily experiences in order to evade them, as they are simply there, beyond anyone's grasp (Falque 2016, 53–54, drawing on Maldiney's reflection on 'grasp'). Falque has criticized, and I believe rightly so, the tendency to give meaning to everything, even if there is a divide between what can be said and what is inexpressible, what is there but resists grasp (Falque 2016, 54; cf Salamon 2012). There is something despotic in this effort to vocally make sense of everything.

Whenever, on the other hand, experience *is* valued in ethics, its moral relevance is often confined to the sphere of the local and the subjective. By contrast, the relevance of embodied experiences in care practice *as such* is hardly ever acknowledged in political life, i.e. life seen as living together as "fleshy connected selves" (Hwa Yol Jung 2000, 150), in an ordered way. Various reductions of experience take place in ethics. First, there is the

privatization and psychologization of experience. Even Eric Cassell's often cited and highly regarded argument for the recognition by physicians of the patients' suffering beyond the cause-and-effect rationality of medicine (Cassell 1982), contends that suffering is "ultimately a personal matter—something whose presence and extent can only be known to the sufferer" (Cassell 2004, 34). The experience is seen as something that occurs within an individual, more precisely in his (her) psyche.

Generally speaking, what can be observed is that in ethics, in order to obtain moral validity, experience is translated into a matter of appreciation, with certain aspects lost in translation. The *significance* of experience then depends on the possibility of presenting it as a specimen of a general ethical scheme, e.g.: "this is an example of how autonomy is lost, supplemented or regained." Experience acquires significance as an example of something else, of e.g. autonomy. The ethical scheme moves into the foreground, and experience is diluted. The ethical *validity* of experience then arises from a numerical calculation: if many similar experiences have been accounted for, the experience in question is assigned validity. A 'rare' phenomenon, such as a severely ill child who with composure faces the approaching end of living together with its family, is then interpreted as an early instance of autonomy, i.e. an experience that can be numbered. It is not recognized as the child's *conatus essendi* (Ricoeur 1986), its desire to live with the people who love it. A non-assumptive ethical approach to experience must defy the danger of such re-categorizations.

Bioethics

How are experiences in care practices framed in bioethics? Is it possible to preserve experience as such? Bioethics has been defined as the multidisciplinary reflection on "individuals (moral subjects finding themselves confronted with particular moral problems situations: biomedical dilemmas, for example, or instances of gross injustice)" (Zwart 2016, 606). Note the emphasis on the individual, and on dilemmas, the presentation of morality as involving either-or choices. Now, bioethics, to the extent that it is a value- and principle-based approach, clearly has great advantages. One advantage is that it uses a widely accepted, common language (even if it often degenerates into blurry ethical lingo). A principle-based approach has the benefit of generalization. General understanding and validity are important in any ethic.

But this approach is also risky if it cannot accommodate what emerges as morally relevant and even decisive in the trials and tribulations of *this* particular patient and *these* particular care professionals, within the complex hospital care practices. Principle-based ethics focuses on moral values and preferences, but bodily experiences as such lie outside its scope. With regard to experiences, applying the modern principle of patient autonomy, and even applying classical medical ethical principles that guide the work of the physicians and nurses, such as 'do no harm' (or more nuanced: 'any harm,

whether in diagnostics, therapy or life maintenance should be outbalanced by reasonably expectable benefits for this particular person') seems to produce a type of ethics that takes the 'high ground' (Kunneman 2016 drawing on the distinction and metaphor of D. Schön, 1983). The moral relevance of many experiences that occur in the chaotic, opaque context of a general hospital escapes the ethical gaze that is primarily focused on values, decision making and intervention. With regard to values, I subscribe to Jean-Pierre Wils's critique of a value approach (Wils 1996, 2005). Values are like labels that can be stuck onto the idea or thing that is valued. They involve ascription. This implies that the label can be removed, if the person who values decides to cherish something else instead. Values are a matter of the signifying reflective subject, whereas (moral) goods are properties of the action, and at the same time lie within the experience of undergoing an action and undergoing fate; they are contained within bodily experience. Goods have an emergent character (instead of being dependent on ascription). This is particularly relevant if we look at the practices of nursing and of healing, and the practice of 'patienting', of being a patient in a care organization.

This becomes clearer when we look at the bodily character of experiences. In bioethics, the bodily experience *as such* has no value. When bioethicist Barry Hoffmaster inquired into "the profound loss that impairs a life" (Hoffmaster 2014, 32) he noted that "prosaic, merely subjective matters of suffering are relegated to the margins of bioethics", as bioethics "is engaged primarily with the organizational values of health care": efficiency and productivity of the flow in health care. If bioethics were to start from the central role of bodily experience of partakers in care, it would "legitimize slowness, delay, and inefficiency" (Hoffmaster 2014, 32). Bioethicist Tom Koch, in his devastating critique of bioethics, has shown that bioethics, through its presuppositions with regard to humans as autonomous rational and choosing persons and to distributive justice, which takes scarcity as a given, and through its principle-based disinterested analysis of tough choices in health care "ignores the complexities (emotional and practical) of contested events" (Koch 2012, 117). In fact, this approach dismisses the individual patient as a being with bodily experiences—it is interested only in the rational and choosing being. A striking example of how bioethics recasts experience, abstracting from the patient's desires and suffering, can be found in Lynöe. Bioethics emerged from the divide between the 'I' and the other, and is keen to hear the explicit voice of the patient and to avoid 'modern' paternalism (defined as interference in the autonomy of another, not in the classical medical ethical sense of "governing people in a fatherly manner" (Koch 2012, 136–137)). To a great extent, Lynöe has identified autonomy and health care with each other: "the less patient's autonomy is respected the less healthcare lives up to its own norms" (Lynöe, Juth, and Helgersson 2010, 60). His attempt is to "reveal disguised paternalism" (Lynöe, Juth, and Helgersson 2010, 60). Yet "if autonomy is of intrinsic value, then it is important to preserve and enhance autonomy even against the patient's wish" (Lynöe, Juth, and Helgersson 2010, 64). Paradoxically,

the voice of the patient is apparently not as important as the 'intrinsic value' of autonomy, despite the idea that patients should speak up for themselves. As Verbeek has phrased it:

> When the actions of human beings are not only determined by their own intentions but also by the material environment in which they live, the central place of the autonomous subject in ethical theory needs to be put into perspective. It becomes "necessary to move the source of ethics".
>
> (Verbeek 2006, 121)

Taking the phenomenality of what is undergone seriously is part of such a program of resourcing ethics.

Bioethics requires experiences such as suffering, stress or being repulsed to be either 'translated' into the language of choice, preference, wish, need, demand, and thus to be made worthy for ethical consideration, or to vanish. Suffering as a lived experience disappears, leaving only the expression of a preference (patient's autonomy) (Green and Palpant 2014). This procedure is what I would like to call, drawing on Merleau-Ponty, "conquering experience" (Falque 2014, 67). The question is: is there an alternative? My contention is that there is something else, something more substantial and morally decisive about patients' and nurses' experience that can be fathomed to a certain degree. Experience resists application of a moral value or principle. There is a good reason for this: the passive side of any experience, its bodily character. Even if we understand the reasons that modern ethics has to emphasize incisive action, the responsible actor and his 'choices' and—in relation to care work—useful intervention, experience resists this approach, it resists being "capture[d]" and "domesticate[d]" (Zwart 2016, 608). This is so because it involves 'undergoing', or as Dubet calls it, "*épreuve*" (Dubet 2012). Ricoeur used a neologism, "*passibilité*," to indicate this experience of undergoing reality: the fact that creatures do not just act, but always also 'undergo' (Ricoeur 1986). They undergo the actions of other creatures, but also the context, atmosphere et cetera (Vosman, den Bakker and Weenink 2016). By bringing experiences under the denominator of a moral value, a principle and a theory of action, it is easy to suppress what is morally decisive, i.e. (i) sensing what is actually happening in my body and comes to the surface of bodily consciousness, and (ii) what what I actually experience as good, both in undergoing some action and in engaging in an action. Good, then, is what proves itself to be good for the person who participates in a practice: a substantive, concrete good-for-the-practitioner, a good that has proven to be good for the person partaking in a practice; this is not the same as what he or she claims or expects beforehand (Vosman 2001; cf. Verharen et al., 2015). But how can we know this if the partaker does not—or cannot—express it herself or himself? Is voice the only and ultimate criterium? There is one good reason to be skeptical of the idea that experience has a narrative structure (as in Lauritzen 1996). Words, memories, fragments of sentences

and stories permeate experience, but there is also another, bodily, meaningless zone of experience to which words have no access. This is exactly where phenomenology can be helpful because of its "rootedness in lived-experience" (Gordon 2000, 195). The phenomenological answer would be: the good as experienced by the partaker as this experience shows itself. By now it has become clear that in order to give weight to bodily experiences direct and explicit forms of ethics and its take on experience have to be avoided. Perception of experience takes precedence. The *actus apprehensivus* takes precedence over the *actus iudicativus*, precisely because of a normative orientation vis à vis an '*épreuve*', undergoing.

Becoming aware of the presuppositions of Modernity

We are already able to see at this point that there is both an epistemological issue at stake here and an ethical one (Conradi and Heier 2014). Summed up in one question: what experience counts as morally relevant and to whom? Having an experience involves knowledge. It is questionable whether there is a type of ethics that has ears to listen, that can discern and appreciate the kind of knowledge in the experience in question *as such*. A value- and principle-based approach is intimately tied to Modernity, molding ethics into modern preconditions with regard to subjectivity, actorship, efficient cause-and-effect chains and the idea that any kind of materiality basically can be altered, influenced. Having said this, our own endeavor in this article, the very idea of wanting to approach experience closely, is also an utterly modern program. This is a problem that we have to deal with in order to avoid a dangerous kind of scholarly naiveté: not to look at the epistemological place where the researcher stands before starting to do ethics. I want to specify this in two ways.

Being on the field

First, the researcher—in this case the ethicist—is always on the field of the practices she or he studies, as there is no position outside this field (on the primacy of practice in the phenomenological tradition, see Nicolini 2013, 33–37). Perception, categorization and reflection, i.e. activities of an ethicist, belong to the practice as it unfolds on the field. There is no position in the gallery, e.g. the gallery of some substantial ontology, which offers a superior view of the field, a view that would make it possible to ground ethics in metaphysics and strengthen the binding force of previous normative ethics. There is, however, this possibility of doing ethics 'from the field' by substantiating how one's approach works, as an alternative to grounding normative claims in metaphysics, while sitting on the gallery. The researcher observes *and* acts ("spectacting"): one cannot judge the condition of the soil or trajectories on the field, or assess the position of other players on the field without being on the field oneself, experiencing the forces that work with and against each other (Gill 2011; Hamington 2015). This is not an a- or

anti-theoretical stance. The ethicist informs himself with knowledge of the 'prudentes', who combine overview and insight. A practice-based theory is established by that knowledge (Vosman 2008, 28–29). Yet, the player on the actual field has a perspective of her own. An action that might seem possible from the spectator's gallery might not be possible to someone actually standing in the swampy field. As acting on the field is the business of ethics, the knowledge gathered on the field is what an ethicist is after (Walker 2007, 11).

Against denial

Second, and this also pertains to epistemology, researchers are liable to take up a position from which they decide what aspects of reality to consider ethically relevant and what aspects of reality to ignore (Perron and Rudge 2016, drawing on Daniel Lee Kleinman). I am not assuming that any ethical theory will be able to give an account of everything. The relation between experience and ethical categorization remains inescapably "precarious" (Zwart 2016, 608). But the negative criterion applies here: theories should not be in denial about anything that appears and that might be morally relevant. This is one good reason to choose care ethics as one's approach, because care ethics is sensitive to the implications of both epistemological and ethical categorizations of experience in care practices. Care ethics starts with an inquiry of the relational, local and contextual (Klaver, Van Elst and Baart 2014; and Collins 2015). Since Tronto's groundbreaking book *Moral Boundaries* (1993), care ethical inquiry is also about critically broaching the notion of the public and the private. Lived experience has been a point of entry ever since the very start of this young interdisciplinary approach. Thus, care ethics questions whether a lived experience, such as the difficulties of a patient in the seclusion of a hospital room, is purely a private matter or whether it is of public importance, indeed of political importance. Clearly, organized society invests enormous effort and money in caring organizations. In this sense society recognizes the importance of care. The issue, however, is which aspects of the lived experience of the sick and wounded are recognized and which aspects are not, and which experiential knowledge counts and which doesn't. There is some awareness in care ethics of the discarding of lived experience, as care ethicists reflect on the re-categorization of experience into categories such as need, want and preferences, thus translating experience into categories that can function in care supply (Van Heijst 2011, 85–86; and Barnes 2012, 11vv). People are not only doers (acting in a qualified, low-key sense of the word) but also knowers—there is knowledge in the experience (Fricker 2012, 142–146: "The very idea of a knower")—and 'undergoers', as people are 'passible' (Paul Ricoeur). Making lived experiences of patients and nurses care-worthy possibly means esterification of the experience: cutting experience into tiny pieces and reconstructing it in a desired downsized version. Whether care ethics is capable of reprocessing lived experience in a late modern complex

care organization without regressing immediately to a high-theory category such as power (in the sense of domination and a moral critique of organizations) is debatable (Vosman and Niemeijer 2017). How can the lived experience of both the patient and the nurse have a non-abated presence, i.e. not become immediately the object of classification-in-order-to-care (Abbas 2010)?

From an ethical perspective, it is possible to talk about principles, about autonomy, about distributive justice, costs and making choices. But the physician in charge and the head nurses have to go about their work with this co-actor complexity. Does what is morally at stake exist on another level than that of making choices and attaching value to things? The patient goes through the motions of possibly uncertainty, anxiety, tedium and the unexplained deterioration of his or her condition. This is on a level different to that of making choices and attaching value to things. Multifarious experience in a complex hospital resists a reductive kind of ethical approach.

Ethics restrained

Let me express this in a different, more critical way. An ethical approach that immediately looks for decisions, moral values and even for clear-cut moral experiences (Hunt and Carnevale 2011) turns out to be an enormous hindrance to seeing what is actually presenting itself. The phenomenon is not luminous as long as we are looking at it with ethical glasses. The ethical gaze as such is not mistaken, but it looks up at the sky, whereas in fact we should be looking to the basement, to use an expression of Merleau-Ponty ("*une phénoménologie du sous sol*"—quoted in Falque 2013, 67). In order to find what emerges as good in a first-person perspective it is necessary to abandon the ethical helicopter view that hovers over experience. This is where phenomenology and its constitutive method of the bracketing of categories is helpful, as S. Kay Toombs has phrased it—in a broad sense: "the setting aside of theoretical commitments and taken-for-granted common sense presuppositions" (Toombs 1992, xiii). In sum, it is necessary to suspend ethics, to refrain from adopting the ethical gaze: to abandon normative ethics so as to be able to see what might be morally relevant in lived experience, and to sketch out the kind of ethics that is capable of seeing what the phenomenon reveals, as well as conceals in its shadows. It will result in a modest form of ethics, rather like *minima moralia* than operating with the pretense of a superior moral judgment.

Phenomenology: uncovering modern presuppositions

We will now draw on insights from the phenomenologists Husserl, Merleau-Ponty, Schmitz and Bégout in preparation for our design of a 'sensorium' (§. 3). The term sensorium stands for the systematic phenomenological approach that involves all the bodily senses—vision, hearing, taste, smell, touch—; in short: the sum total of experience. In this way, it highlights the

bodily sensory perception of phenomena that reveal themselves, phenomena that are also physical. The point of entry is that of perception, by contrast with an approach that categorizes phenomena with possibly stifling concepts, including ethical concepts that emerge too early in this process of normative categorization. Phenomenology, especially the versions of Merleau-Ponty and Schmitz, emphasizes this bodily point of entry. I think it is also part of what the constitutive phenomenological feature of bracketing is about, besides distancing oneself from ethical categories in a reflective way: to give the senses their due. We should not regard them as introspective, but rather see them as faculties that make it possible for phenomena to appear. We will first consider briefly in what way bracketing, the constitutive feature of phenomenology, allows phenomena to appear. Second, we will reflect on phenomenology's critique of the darker sides of Modernity, as we will have to include that critique on Modernity in our own reflections on experience in the late modern context of complex hospital care.

Bracketing

The procedure of bracketing in phenomenology is a way of creating awareness of the engaged observer's presuppositions and categories of thinking, so as to permit the phenomena to speak for themselves. Concepts can be a hindrance, including ethical concepts. As we have seen in the previous section, an ethic that pursues a value approach seems unaware of its own Modern presuppositions: it is an individual subject who values. But bracketing is not only a matter of managing preconceptions that may "obfuscate, distort or truncate" (Tufford and Newman 2010, 85). Bracketing is about "purging" (Spiegelberg 1994, 61), but it is also about enabling "deeper engagement"; it permits one to "understand, embrace and surface the frames of reference" (Tufford and Newman 2010, 87, and 83). This is exactly my aim: to abandon a priori ethical distinctions so as to approach more closely what is good.

The reduction of concepts and presuppositions ('bracketing') is necessary to enable eidetic reduction, i.e. the identification of the phenomenon by means of a foreground-background operation. However, this kind of *epochè* is anything but a self-evident methodological device: it is a matter of intuiting, and of relying on elementary points of reference. It also involves *Gestalt*: the observer perceives forefront and background, a particular lived experience in a systemic context, in this case that of a complex hospital. *Gestalt* is not about one single essence, but rather about the relation between background and foreground: it is only in this relation that the form appears that Husserl called a "*figurales Einheitsmoment*" (Spiegelberg 1994, 133). The word *Gestalt* might suggest the world of vision, but it can also be described as the relation between keynote (background) and overtone (forefront). This kind of contrast is conceivable for all of the senses; the contrast between what is prominent and what is present as a substratum. Together with Merleau-Ponty we can say that *Gestalt* is not about physical

phenomena but is a "crack in being" (Spiegelberg 1994, 557–561). *Gestalt* is about the middle ground between a phenomenon showing itself, standing out from its background, and open-minded intuitive perception that is prepared to change its view, to switch from background to foreground and back again. The result is not: 'this is', but rather 'it appears as'.

Viktor von Weizsäcker used the expression *Gestaltkreis*, to indicate the "ongoing interplay between perception and movement" (Gadamer 1996, 85). It is helpful to realize that a *Gestalt* is not an image that is fixed forever: instead, a background may vanish, another may emerge and then a new foreground and background have developed in another *Gestalt*. The same is true for the foreground: this, too, may vanish, reemerge et cetera. The scene depicted above, taken from a longer story involving Jean Pierre, Jenny and friends, is about having an experience in a complex systemic context: it is not a 'natural' experience that happens by coincidence to take place in a hospital: an experience complete in itself, with something extra added. The circumstantial hospital setting, as we will see, is a background that is vital to see the experience of the wounded young man. That is what a *Gestalt* is about.

Modernity as a problem

In addition to the procedure of bracketing there is another feature of phenomenology that is important: its original analysis of the problematic character of Modernity. Phenomenology itself is a critique (Böhme 2008, 21). Husserl and Merleau-Ponty, both in their own way, began with an anti-program, criticizing Modernity and proposing alternatives to it. Their main objection is that Modernity implies a one-sided kind of rationality. This criticism in fact belongs to their most significant insights.

However, current qualitative empirical researchers who claim they are drawing on these critical insights, in fact ignore them with regard to Modernity. They are not taken on board in present-day phenomenological research of lived experience. A leading phenomenological researcher, Linda Finlay, has put it as follows. In her critical questioning of the use of phenomenological research methods in qualitative empirical research, Finlay takes exception to the fact that researchers often claim to follow a phenomenological line of thought even if there is no sign in their work that they have actually used any phenomenological insights: e.g. they claim to take a Husserlian approach, but the work in fact shows "no evidence of any reductions being attempted"; research has to be profoundly linked to "some phenomenological philosophy" (Finlay 2009, 8). Elizabeth St. Pierre is even more critical regarding the use of phenomenology without engaging profoundly with its presuppositions, and without a clear idea about one's own dependency on the emphasis of positive empiricism on knowledge production. Phenomenology is "being reduced to a 'how to', methods-driven empirical approach to knowledge production" (St. Pierre 2016, 115). If the problem Husserl and Merleau-Ponty were trying to rethink is ignored, and it is just a matter of making use of their devices, there is something fundamentally problematic

at stake. To me it is a matter of a twofold academic rigor, not only to use the 'methods' devised by philosophers such as Husserl and Merleau-Ponty (e.g. Merleau-Ponty 1968, 179), but also to keep working with their problematic, with their anti-program, with the problem they tried to solve. Bracketing is not enough, even "dogged questioning of one's knowledge as opposed to a suspension of this knowledge" (thus Vagle 2016, 74–75, in his "post-reflexivity" proposal) is unsatisfactory. Rather it is about "phenomenological asceticism" (Longneaux 2007, 61; my translation) and about a long-haul critique of Modernity's dark side. Surely, modern presuppositions are currently even more deeply influential than they were in the era of Husserl and Merleau-Ponty: the tendency to take reality as something to be disassembled; interventions that must be carried out in order to achieve a desired outcome, or—to put it differently—"decomposing unit acts into potentially independent (if empirically interrelated) components" (Martin 2011, 9). Phenomenological research becomes shortsighted when not taking into account that in Late Modernity experience gets "sequestrated" (Giddens 1991, 144). A life world approach that does not constantly take this sequestration into account, to my mind, is naïve.

We will now proceed to point out the critical insights of the phenomenologists and of their anti-program, in order to gather the elements we require for our sensorium. The selection of the four phenomenologists discussed here is prompted by our problem: how can bodily experience in complex late modern caring organizations be brought to light and its moral relevance be discerned. Attention to Modernity, bodiliness and the embeddedness of practitioners in the larger order of the organization are obvious aspects that merit further investigation.

Husserl: counter-thinking modernity

Husserl devised his phenomenology of experience because he was critical of the so-called Cartesian split and the positivist model of science derived from it. Even if we acknowledge that Husserl himself stayed within the paradigm of Modernity, we do well not to ignore his criticism, as it is still valid, and points to the worrying problem of the alienation of experience by the constant adoption of a third-person perspective, an objectifying approach, for instance in empirical psychology (Martin 2011, 5, and 75vv; and Spiegelberg 1994, 3, and 86). The experience from a first-person perspective is recast in non-personal categories, in descriptions that aim at intervening, aim at influencing the chain of efficient cause-desired effects. It was also for this reason that Husserl claimed that directness of experience was possible. Time, space and movement are the three main points of entry for perception by humans with their intentionality and consciousness. To Husserl the very possibility of human consciousness is "the wonder of wonders" (Husserl 2012, 71, 75). Even if Husserl did not expand on this as much as Merleau-Ponty would later, his starting point for consciousness is "*leibhaftige Wirklichkeit*" (Husserl 2012, 73), bodily reality, where the intuiting of

a phenomenon starts. The idea of intentionality in his design is meant to recover the possibility (from objectivation) that consciousness directs itself towards a phenomenon that comes to light. People have a "*leibhafte Selbstgegebenheit*" (Husserl 2012), selfgivenness, that enables them intuit a phenomenon in a direct way and come to a "*Wesensschau*" (Husserl 2012), a discernment of what the phenomenon is.

We will take from this the idea of the first-person perspective and the refusal to relapse into objectivation, particularly the relapse into psychology, which subjugates experience in its search for cause-and-effect explanations. We will also apply to the sensorium the insight that approaching experience is not about intervening, but about realizing what kind of movement is at stake. This means taking due account of "the coming together of speed and slowliness" in the bodily experience (Falque 2016, 67, drawing on Deleuze and Spinoza). This is what the *Gestalt* of the phenomenon that appears to the observer involves. We will return to the possibility of directness of experience and to *Gestalt* later on in this article.

Merleau-Ponty: experience in the flesh

Merleau-Ponty was worried by another aspect of the Cartesian divide, namely Modernity's emphasis on rationality. Diana Coole has summarized Merleau-Ponty's concern: rationalism is an "ontological choice that marks [modernity's] style of existence" (Coole 2007, 25). This rationalism suppresses the acknowledgement of openness, ambiguity and contingency. Merleau-Ponty analyzes the very phenomenon that rationality—despite its pretense to the contrary—does not in fact operate in a logical, continuous state. Instead, there are pieces of rationality, with irrational parts in between. He also worries that modern rationality has lost sight of the bodily nature of experience, whereas the body (in space and time) is in fact crucial to experience (cf. Murray and Holmes 2013, 345). Merleau-Ponty sees the body as consisting of two layers: the habitual body and the actual body. It is exactly because of these two layers that there is scope for ambiguity. A human being can experience his or her body, but not securely, it is not a matter of grasping. "It cannot be total and active grasp, intellectual possession, since what there is to be grasped is a dispossession" (Merleau-Ponty 1968, 266). Experience is rather becoming aware of a 'there is' that moves away from visibility. Merleau-Ponty is critical of Husserl's emphasis on consciousness, because it means phenomenology is still beholden to modern subjectivity. He does not assume that there is consciousness as a substance in the world. The world is a given before there is any act of consciousness, nor does the world depend on consciousness. Primordially, humans have a corporeal presence, they are corporeal beings and it is thus that they perceive, meet, relate and experience. According to Merleau-Ponty there is no such thing as naked experience, devoid of meaning. Bodily beings find themselves next to each other and become aware of this. This is where his notion of "chair," of the flesh, becomes relevant, not in reference to the

objective body, viewed from a third person's perspective but to the lived, heavy, material body that always finds itself amongst others. "There is this thickness of flesh between us" (Merleau-Ponty 1968, 127). 'The many' have precedence over 'the one', so to say. Merleau-Ponty thus decentralizes the modern subject. Experience is not a matter of individual consciousness but of the lived body (*corps propre*) (Merleau-Ponty 1968, 250), always among others. Meaning is always already there, it is not invented out of nothing by (spiritual) subjects. A bodily movement does not execute a previously formed thought. Bodies transform meaning: as we move and gesture we convey meaning, without expressing thoughts. "My body is the place, or rather, the very actuality of the phenomenon of expression. . . . My body is, at least with regard to the perceived world, the general instrument of my 'understanding' " (Merleau-Ponty 2012, 334). Merleau-Ponty explicitly rules out that when a phenomenon appears to perceiving bodily beings, the latter grasp an essence. He says: "We would err as much by defining philosophy as the search for the essences as by defining it as the fusion with the things, and the two errors are not so different" (Merleau-Ponty 1968, 127). And further on: "They are two positivisms" (Merleau-Ponty 1968, 127). His proposition is this: "fundamentally it is neither thing seen only nor seer only, it is Visibility sometimes wandering and sometimes reassembled" (Merleau-Ponty 1968, 137–138). This implies a critique vis-à-vis Husserl and—currently—against Dahlberg's method of identifying essences (for a critique on essentialism within phenomenology, see Gordon 2000, 204).

Based on these principles of bodiliness and of meaning that is already there, Merleau-Ponty began devising an elementary political phenomenology: finding oneself (without necessarily a higher, conscious 'self', without 'deep inner worlds') next to other bodily beings is a political idea (Coole 2014). This is, so to say, his idea of the political, where living together in some kind of order—not necessarily a just or attractive order—originates. Living together does not start with negotiation between self-aware egos directed by self-interest, or with a contract: the condition of being together is always already there, as is a world full of meaning (it is not necessary to adhere to these meanings, but there is no *tabula rasa*). Both empiricism and mentalism are thus avoided.

Merleau-Ponty was above all a reader of literature, as literary writers are far more capable—he thought—of approaching opaque yet decisive experiences. Among the books he read was Dostojewsky's *Notes from Underground* (Falque 2014, 71, and 93). It is from this book that Merleau-Ponty derived his idea of the phenomenology of the basement (Falque 2014, 67–110): looking at experiences of humans, who are possibly strong, but who live in dire conditions, "*état à la fois subi et voulu*" (Eltchaninoff 2013, 26), in a state that they undergo and want at the same time. Phenomenology has to reconquer *l'être brut*, "the human being that is not yet made into an object of a vision or of choice" (Merleau-Ponty, cited in Falque 2014, 67). This means that the phenomenologist must have the courage to go to the basement and accept the darkness of experience. Experiences are not

self-explanatory as in: 'this is me—that is outside, and it is called. . . '. Something has yet to come to light, to appear through the cracks of experience.

For our sensorium, we will take from this the concept of bodies that exist alongside others (there is always and primarily the plural), the notion of ambiguity and the opaqueness of experience, and the need to avoid relapsing into the consciousness of the self-centered subject and to avoid emphasizing inner worlds. We will also take the insight that there is no such thing as directly self-evident experience, but that it is through the crack in experience that a phenomenon shows itself.

Experience as taking part and being enveloped: Schmitz

The German phenomenologist Hermann Schmitz has pointed to the suprasubjective level of experiences, of the atmosphere and the moods (*Stimmung*) that people find themselves in. Later, Gernot Böhme, drawing on Schmitz, and Hartmut Rosa elaborated on this, too (Böhme 2013; Rosa 2016). A human being is not an 'I' who has a purely inner, original and completed experience. People who find themselves alongside other bodily creatures participate in an atmosphere that is either grim, joyful, alarming, dull et cetera. An atmosphere is an "affective quality of spatial contexts or interpersonal situations," as Schmitz's pupil, Thomas Fuchs, has phrased it (Fuchs 2013, §3, my translation). An atmosphere is real, but it is not disposable to direct construction. It is within such atmospheres, which can intensify, evaporate, expand, shrink that people take part in—rather than 'have'—an experience. This participation is physical: one takes part with one's bodily sensations: anger, sorrow, relief et cetera. "Being bodily means . . . being in the middle between narrowness and expanse and not getting away from either of them" (Schmitz 1989, 45; my translation). Schmitz points at phenomena in the body such as width, narrowness, direction, tension and swelling and at movements in the body, patterns of energy flows, like rhythm. He exemplifies this with regard to the anus: this is characterized by contraction of the sphincter and swelling of the bowels. Its sensation is subtle and surrounded by insecurity. This is reminiscent of Aristotle's phenomenology of the body, more precisely the vegetative state (Soentgen 1998, 26–31). Schmitz pays attention (as hardly any other phenomenologist before him has; see Rosa 2016, 83–142) to the state of the body and movements in the body: width e.g. of bodily orifices, being cramped (pain being a conflict between width and cramp), tension, relaxation. The senses and movements are vital in this respect. As Schmitz has critically observed, taste, sight, hearing, smell and touch all permit experience, not just sight. He has specified the most elementary sense of touch in relation to the skin: the dimension of the tactile (touch, pressure), thermoception (warm and cold) and nociception (pain). No wonder that Schmitz's phenomenology has been warmly welcomed by therapists of many kinds (Grossheim 2008).

Movements are about motion in the body (expansion, contraction et cetera) and of the body that knows it is alongside other bodies. Bodily

movement, as the partaking in a larger atmosphere (of pressure, anxiety, relaxation) is related to people in the plural, is relational in that sense, but materiality is part of this atmosphere as well. Examples of materiality are cold air fanned in someone's face, needles stuck into someone's body, someone going into a narrow MRI or CT scan tube, as he or she undergoes the diagnostic process. In a similar vein Van Manen has spoken about "the pathic sensibility of a . . . hospital" (Van Manen 2007, 21). Schmitz, in his battle against psychologism and reductionism (Soentgen 1998), has summed up six "parts of normal experience" that he thinks are vital to phenomenology and that are mostly "forgotten": atmospheres, situations, the felt body, communication by means of the felt body, semi-things (e.g. the wind, but also voices and silence, time (that is "passing vexingly slow") and space (Schmitz 2002, 491–494). In trenchant prose, Schmitz has contrasted his bodily, relational, participatory approach to phenomenology, the phenomenon appearing to bodily human beings, with "the typical subject of classical epistemology. This kind of subject is the master inside his own home (e.g. soul, consciousness, private inner world) but he does not know how to get out of it". (Schmitz 2002, 493). He has characterized his phenomenology as 'new' because he criticizes Husserl for remaining within the modern paradigm of the subject. It is not consciousness of a separate being that permits a phenomenon to appear. Rather, enfleshed relational beings, always already in the plural, take part in the movement of appearing phenomena. This always occurs in a field, an "*Erlebnisfeld*." Thus, Schmitz has revolted not only against a psychological scheme of pure inner experience, but he has also, in a very practical way, embedded experiences in relations, in materiality, time and space, and in the atmosphere in any given situation. This makes it possible to perceive a phenomenon on a non-intentional level: as that which envelops us. Thus, this approach radically recharacterizes experience, dismounting the representation that experience is of a strictly individual and subjective nature.

We will take from this the insight that experience is a form of partaking in atmosphere, and is thus deeply relational, although not in a psychological way. It is not about intentional encounter or empathy, but about sharing in an atmosphere in a space. Bodily awareness of width et ecetera is the key to perception.

The given that cannot be grasped: Bégout

Finally, the French phenomenologist Bruce Bégout has pointed to the feature of phenomenality, i.e. the fact that a phenomenon also constantly hides something (Bégout 2008). Bégout moves beyond perspectivism. Husserl stressed that an observer only sees one aspect of a thing; there is always something behind the thing, its back, that one cannot see. The implication of this kind of perspectivism is that it is never possible to have a total view. Bégout, however, in his reflection on the influence of technology on experience (he draws here on J. Patocka), has put it in this way: there is a shadow

inside, not just behind the phenomenon. Someone can change perspectives and have a look from a different angle at the aspects of a phenomenon that were at first invisible because that side was at the back. The side that was a shadow from the initial point of view, is now no longer dark. Yet one cannot see inside the phenomenon. To Bégout this is vital: a phenomenon does not exhaust itself, never fully explains what is. The implication is that the lure of consciousness ascertaining the essence of a phenomenon is over. A phenomenon will always keep something in the dark. It is a "lie," a "naïve support of a lie" to claim that one can nevertheless grasp an essence (Bégout 2005, 44, my translation). Phenomenality implies encountering the strangeness of a phenomenon, as this "agitates": the phenomenon emerges and at the same time hides itself, not allowing itself to be grasped. What is left then for human beings to experience? "It is not this simple and pure sensory experience, but rather a sensory experience [*une expérience sensée*] where practical, axiological and affective meanings are intimately interwoven with what the sensory provides" (Marchand 2013, 10, citing Bégout, my translation). In his phenomenological diaries Bégout writes: "a dimension that escapes us constitutes it as a multiple and ongoing object" (Bégout 2007, 146, my translation). The ever-remaining strangeness of a phenomenon is in need of 'hospitality', even if it is alien. Therefore, we should not presume, as Zwart does, that ethics "becomes increasingly able to articulate . . . the floating mass of experiences" (Zwart 2016, 608), but we should rather accept the inevitable shadow inside experience that calmly defies complete understanding.

This is very important: closely approaching an experience means—in a kind of self-restraint—always allowing there to be more than what is revealing itself. There is an extreme resistance in phenomenology to 'getting a grasp of' a phenomenon, to manipulating a phenomenon. Concurring with Abbas (and challenging Murray and Holmes) I would even say: we should keep at arm's length the urge to let experience be articulated, be put into words, be drawn into a story, and moreover investigate the politics that are involved in this urge (Abbas 2010). Instead, it is necessary to be hospitable to the strangeness of a phenomenon and to its silences which—to cite Coccia—have their "*evidence muette*," their silent evidence (Coccia 2010, 53).

For the sensorium that I will be proposing to approach the experience of the patient and the nurses, we will take from Bégout's work the insight that self-restraint is necessary to observe and to let the phenomenon be as it is; to resist the urge to use it. In a hospital, this is a unique thing to do: to leave scope for what cannot be seen, what cannot be explained, for what is beyond manipulation.

Looking at the scene with a phenomenological sensorium

Returning to the scene involving Jean Pierre and the nurses, we may now ask: what phenomena are emerging? Is there even a sign of any emerging goods? What I propose to do is to place a grid (Jones 2006; Küpers 2013;

Tønder 2015) consisting of a series of markers over the scene (via the text). I am calling this grid a sensorium. This term sensorium may be confusing, because it is also used to indicate the five senses. It is nevertheless a good term, because it underlines the importance of anchoring the bodily sensation of the phenomenon that "comes to us", i.e. indicating both the phenomenon *and* the perception. Although I can only demonstrate the importance of the grid for the case presented here, I think it will also be useful in many other care scenes. Perceiving a front and back layer, without psychologizing, is useful for caregivers in order to dwell in a relational, unassuming mode. It discerns the moral relevance of experience, thus creating space, even in a split second, and it postpones the *actus indicativus*.

Figure 4.1, which has two seven-pointed stars, illustrates the "in between" of bodily phenomenon and bodily perception, an '*entre-deux*', a '*réalité médiane*' (expressions of Coccia 2010). This 'together' is what I call phenomenality, with its powerful but simultaneously helpless appearing and perceiving poles, with its possibly aggressive hermeneutics (Mersch 2010) and possibly reluctant understanding of the perceiver.

The star in the forefront and the star in the background together show the *Gestalt* of the scene. The points of both stars correspond to the insights gathered from the phenomenologists consulted above.

The *light gray star* in the front represents the perception side of the in-between: that which comes first. It has seven points that correspond to the points of the dark gray star (which represents the phenomenon that is there but at the same time hides itself) (in Arabic numerals): (1) the relational,

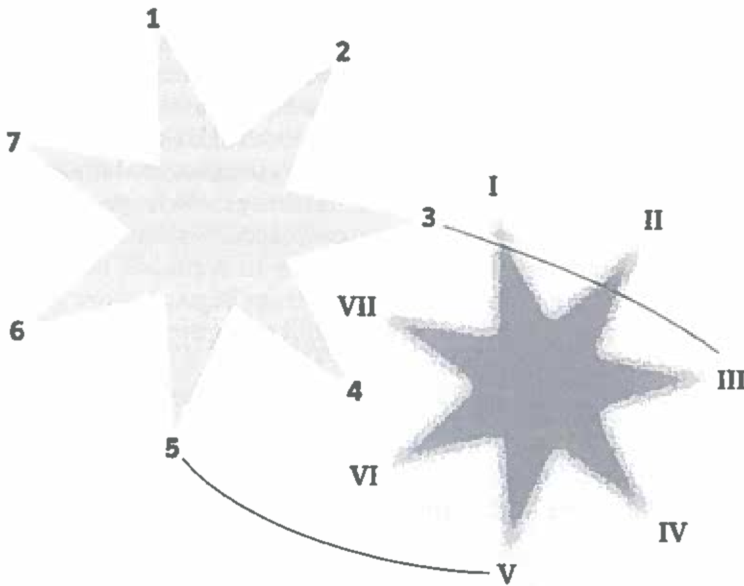

Figure 4.1 The Phenomenological Sensorium

(2) the physical (attraction, repulsion et cetera), (3) space (relating to the spatial character of the surroundings and of the body), (4) time (relating to the lived flow of time, but also to downtime), (5) ambiguity in coming together and perceiving, (6) the sensible, the judicious, and (7) mood.

Space and time (nos. 3 and 4) are not simply the walls and iron bedframe and clock time, but denote an intense threefold process of relating to space and time as an actor, an 'undergoer' and a knower. It is about lived space and lived time within the hospital industry, with a rhythm of its own, assigning a position to patients, family and caregivers.

The *dark gray star* also has seven points. The numbers (in Roman numerals) correspond to the numbers of the light gray star (no. I corresponds to no. 1 et cetera): (I) partaking (in a gathering that transcends the personal), (II) the vegetative state, the silence of the body, (III) extension of the body and of the material, (IV) the sequences and rhythms that simply take place, (V) darkness, the opaqueness of the phenomenon, (VI) the invincibility of reality, and (VII) atmosphere.

This sensorium with its two stars purposively installs a tension between the points of the two stars. A phenomenon emerges in this way, allowing the participant in the practice to fathom the *Gestalt*. By looking at the points of the star one can also clearly identify where the tension between background and foreground is overlooked: for instance, the important difference between *mood of someone* (7) and *atmosphere that envelops many people* (VII). At certain moments the tension is abrogated, e.g. 6 and VI, where the judicious mode persists with self-assurance while the real and the opaque aspects are denied: nurses keep concentrated on the foreground, talking nicely and reasonably, however, to a man who is confused. Abrogating the tension has its consequences: missing to acknowledge the background means denying the opaqueness of the background, e.g. the fear for losing one's life. Sustaining the tension creates possibilities in understanding, in action and in acceptance.

As an observer on the field I felt that there was tension in the room, as the patient and nurses initially failed to come any closer to each other. Then there was the very physical atmosphere of revulsion and nausea, so strong that one by one the nurses and I as an observer left the room until the chemical odor eliminator had done its suppressive work. Subsequently, there was an atmosphere of flow amidst of tension, as Rosalind touched the patient and surrounded him with his everyday dialect and ventured to touch upon the layer of life and death. Later on, there was another atmosphere: that of menace. These were not purely individual inner experiences, but they were experiences of partaking in an atmosphere. Once you realize that there *is* an atmosphere, you may not be able to change it, but facing it does give you greater freedom in the interaction.

The sensorium allows us to discern what kind of disconnect occurred between the two nurses and the patient, e.g. where Jean Pierre's insistence on defecating was ignored, or rather looked upon with a cause-and-effect point of view. The nurses knew more about cause and effect than the

patient—if you have just passed so much excrement, there is not much more left that could possibly follow. But from the first-person perspective, there is the habitual and the actual body. The nurses may be right (on the physical-mechanical level), but the patient is right with regard to his actual body awareness of tension and swelling. He is a disoriented man, this is how he is at the moment. He is a disoriented man vigorously expressing himself with regard to his awareness of his body. The physical experience of pressure does not get any meaning. It is an interesting question, once you are able to see it (without taking refuge to neurological cause-and-effect reasoning), how you could get into contact with that experience. But first, it is necessary to see, to acknowledge the disorientation (Harbin 2012, 266vv). Acknowledging this helps. Correcting him ("No you are not going to defecate now"; "Yes, you will get food through your nose") did not help. What did help were bodily touch and a shift in perspective, a shift towards this patient's first-person perspective. The head nurse effected a change in the atmosphere by starting to talk in his dialect, in a direct way, addressing him not as "Sir" but as "Jean Pierre." She 'leveled' with the patient, not only with regard to his medical needs (to get food and fluids inside of him as soon as possible to counter his weakness). "No, you cannot eat through your nose, but you can get strength through this nasty tube." Phenomenologically, this is not only about words spoken, but also about touch: her palm cupping the back of his hand. The change that then occurred was as much a result of this gesture as of her words, it "emerges out of intercorporeal exchange" (Weiss 1999, 158); Chau calls this "sensorial production of sociality"; and initiated by the head nurse, through her "attentive body" (Chau 2008), in this case through touch. She draws on the world of the patient (referring to his soon-to-be-born child and to his wife) but in a limited way: she literally only gives assistance, as Monica does later on. There is no deep involvement with his life, the involvement takes the form of seeing it, 'opening' it up and assisting it. There is much more to the patient's world than this, and she leaves that as it is. There is no need to grasp the unfathomable: it is possible to stay with what is presenting itself, with the visible movements. Ethically speaking, this "relational style" (Colucci and Pegoraro 2017, 12) uncovers the good that is at stake, however also guarding what is not necessary to encroach on, like fear of death.

It is through a crack in experience that something can come to light: in his own way Jean Pierre adheres to life as it is for him: in being with others, most prominently with his wife. Life to him is not biological survival or ego-consciousness, but the awareness of being with others. It is *Gestalt*-like: experience is not an inner procedure, but a matter of foreground-background; 'engaging with life' is the background that becomes visible. Interestingly enough, using the sensorium does not require extra time, on the contrary: it is helpful and saves time. You can often already observe nurses (and physicians) who are actually figuring out the prevalent atmosphere that is at play and take the atmosphere as a lead. In this sense, the grid is only an account of the practical wisdom caregivers already have, although it can also be

helpful on other occasions. But its use presupposes the willingness to consult one's own already existing experience in fathoming experience.

Finally, the nurses work amidst all kinds of systems. The patient, too, is in the middle of these systems. Time pressure, the ordering of experience through the material world of the single room beside the nurses' desk, but also the ward with an ICU as a backup, the presence of appliances such as the various tubes, the etiquette of addressing patients as "Mr" and "Ms" (a rule strictly adhered to and put in place for various reasons): these are but a few of the indications of the systemic limitations of experience. There is no such thing as a natural inner world experience. Experience happens within the enormous push and pull of systems. The subscene with the different kinds of tube demonstrates this, including the resistance and anxiety of the patient as intubation is attempted with the larger tubes. Only when you become aware of the limited character of experience, can you more closely approach the experiences of patients and nurses to a certain extent. To approach experience more closely means acknowledging its systemic limitations. In addition to people, there is another actor in the field: complexity (Barnard 2016). Ethics will have to rethink its categories, which focus on consciousness and desired effects, and will have to allow the field of action to be redrawn.

Maybe Jean Pierre's experience of width, allowing the tube to get down his nose, is the most remarkable phenomenon: it is bodily rather than intentional, and occurred through the extending of the circle, through him being permitted to adhere to life in his own way, rather than being seen as a difficult patient. The good that emerges is the acting together of patient and nurses, something made possible by a supportive background: the touching words 'please live', and a hand held under his hand.

Coda

From an ethical point of view it is difficult to stay with that which shows itself, and this is very understandable. Accompanying nurses and physicians and others in the paradox of the 'impossible deceleration' of action is hard. The pull towards intervention is extremely strong. The urge to act and intervene, that is in fact what medicine and nursing are partly about. For ethics however, and for practitioners even more so, perceiving differently, with all the senses, and being there in a different mode, an observing, restrained, relational mode, is of great practical importance. It is important to think of experience as something happening to doers, knowers and 'undergoers' all at once: not just as something related only to acting, waiting for intervention.[3]

Notes

1 The scene is taken from a five-year qualitative empirical research in Saint Elisabeth's Hospital, Tilburg, the Netherlands (2009–14). The ethical research code was observed, permission for the research by the hospital board was given and the

ethical committee concerned has reviewed the research. Names and identifiable data have been changed because of privacy. In this case permission by the family was given (informed consent by proxy). The research design was accounted for in Baart and Vosman (2015).

2 In empirical research, together with Andries Baart and Guus Timmerman, I advocate crossing two methods, like spectacting and participants in a care practice writing diaries, or critical discourse analysis and interviewing. See Baart and Vosman (2015, 181vv); and Baart and Timmerman (2016).

3 I am grateful for the critical remarks of two reviewers on this article and the comments of colleagues on a previous version. Many thanks to Dr. Brian Heffernan, Brussels, for the language correction.

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THE EXPERIENCE OF VALUES

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