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Touching From a Distance: Nursing and Carnal Hermeneutics

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Abstract

Carnal hermeneutics represents a new development in hermeneutic thinking, extending Merleau-Ponty's work on embodiment. It is potentially useful for applied hermeneutics in nursing, which is a discipline of caring for and with bodies. In this paper, I take up key essays by Richard Kearney and Brian Treanor that establish themes in carnal hermeneutics, exploring them in relation to nursing. In the first part, I focus on medical nursing using an example from a student nurse's practice to look at some of characteristics of nursing using a carnal hermeneutics lens. In the second part, the focus is on mental health nursing, considering how Treanor's field of "new realism(s)" can help to give a fuller account of the physicality inherent in what has become conventionally separated off as "mental" health.

Keywords

Hermeneutics, carnal hermeneutics, nursing, mental health

Carnal hermeneutics is a development in hermeneutic philosophy that holds great promise for practice professions, and certainly for nursing. All practices are bodily practices, performative expressions of a disciplinary identity that manifests in a particular setting at a particular time[1]. Nursing, even among health care professions, is centrally concerned with practices of caring for others; it is bodily, and carnal, in both directions, touching and being touched. In this paper, I set out an exploratory discussion of carnal hermeneutics, as applied to nursing, based primarily upon the essays by Kearney and Treanor in their edited volume, *Carnal Hermeneutics* (2015). I have taken two examples from practice as a basis for discussion, one to do with "physical" and the other with "mental" problems. My division and subtitles are designed to be read with a dose of

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irony. They follow the Cartesian division of mind and body around which hospitals are still organized. As I will argue in part two, carnal hermeneutics does not favour body over mind, leaving the division intact, but offers a way of understanding the mental-*as*-carnal that is ecological rather than reductionist.

Part I: Nursing the Body

Three themes that Kearney (2015) takes up in his account of carnal hermeneutics are sense, taste, and touch. All three are underpinned by his argument that carnal hermeneutics is primal, it is a condition of our embodied being. In this, of course, he is drawing on Merleau-Ponty's work, but in the shift from "embodiment" to "carnal" I hear an attempt to dispel the coolness of the former and to emphasize the natural, animal aspects of human life. In an earlier paper, where he introduces carnal hermeneutics, Kearney adds to Hermes disclosing "messages from above" the dog Argos, which "brings animal savvy from below" (2011, p. 2) to express the fullness of this version of hermeneutics.

Before discussing Kearney's themes in more detail, I will give a description of an incident from practice against which to test out his ideas. The example comes from the academic setting, but from a conversation with a nursing clinical instructor who worked with students in hospital, teaching them the complex integrative work of nursing, incorporating various kinds of information, practical actions, and interpersonal skills. The instructor had a concern about one student who was having trouble grasping the process of clinical reasoning, of putting the various pieces of nursing together into a coherent process of care. The student was looking after a patient with a urine tract infection, and the instructor asked her to go through the steps of how she would know it was a urine tract infection. The student's answer was to check the white blood cell count, because the body produces more white blood cells in the presence of an infection as part of the immune response. That is correct, but one trouble with that answer is that it is non-specific – a raised white blood cell count might suggest there is an infection somewhere in the body, but it could not tell you where. The instructor's advice to the student was to test the urine with a dipstick, a simple tool consisting of a plastic stick with coloured squares along its surface. The nurse dips the stick into a sample of urine and the squares will change colour, quickly indicating likely abnormalities in a number of chemical properties of urine, the most relevant one in this instance being protein, which is a sign of infection. Another trouble with both responses is that they beg the question of what would prompt you to take a blood sample or to dip-test the urine in the first place. My suggestion was even more basic, to look at the urine and smell the urine, to use your senses. Where there is an infection the urine is typically cloudy in appearance and has a strong smell. A nurse would also pay attention to the risk factors for urine infection to do with the actual patient; for example, older people are more at risk because the bladder muscle gets weaker with age, not drinking enough, being sedentary, all of which can contribute to reduced flow through the bladder. As well as such observable factors, a nurse should simply ask the patient about their own sensory experience, whether they had experienced a burning sensation on passing urine. A humble urine tract infection can have dramatic systemic effects in the body such as delirium, when the patient can quickly become confused, agitated, and hallucinate, so it is important to catch.

By itself, the above example is a relatively minor and simple part of learning nursing practice. However, it does contain elements, seen through the lens of carnal hermeneutics, that have interpretive richness for understanding nursing and becoming a nurse.

Kearney (2015) notes three different connotations of *sense* in English, referring firstly to sensation through the physiological workings of the five senses, then meaning as in making sense of something, and thirdly of orientation, where we would talk in English about having a sense of direction and in Romance languages the word for sense itself retains that idea of orientation in time and space[2].

My example of the urine infection includes all three of Kearney's senses of sense. First the physical sensation, of looking and smelling (also perhaps the patient reporting a burning sensation on passing urine), the meaning making based on these and other pieces of information, then the direction – what to do? – including a range of actions such as collecting a urine sample for microscopic examination, encouraging the patient to drink more water, monitoring their temperature, and taking a blood samples (where the student's white cell count would come into the picture).

Returning to the student's initial response, there is another way in which carnal hermeneutics reveals a truth in the student's line of thought, even though she was mistaken in terms of the immediate demands of care. Emphasising the sensory aspect of nursing throws into relief that the student's first thought, to check the white cell count, is perhaps the least directly sensory thing she could have done (though it would entail interacting with a computer, touching a keyboard and looking at a screen). Her response was misdirected because it was stripped of context and sequencing but not because white cell count does not have some connection to the presence of infection. In another way, however, her response reflected a deeper truth about contemporary nursing as subject to a kind of neo-Cartesianism. Examining how a white blood cell count is established reveals a sensory division of labour in the hospital; although blood has to be taken to obtain it, that physical task would be delegated to a phlebotomist, a technician coming by solely to take the blood sample and send it to the lab for examination. Both the order to initiate the test, and its result would be entered in the electronic health record, and what the student would have been thinking of would be looking up a number on a computer screen. The student's response, although still wrong, is saturated with beliefs in healthcare about the value of data over sense experience, and of social organization by specialization, including delegation of routine contacts with body fluids. The extended body is held at a distance and cognitive data processing becomes the most valued asset of the professional. One of my arguments for applying carnal hermeneutics to nursing is that it throws this tendency into sharp relief and at the same time makes clearer what remains indispensable about work with the senses.

Disgust

One of the primitive forces that may be in play in the tendency towards the rationalization of nursing, enabled by technology, is disgust, when we want to get away from what our senses reveal to us. Kearney (2011, 2015) follows his observation about the senses by going on to discuss the etymological roots of wisdom *sapientia* and knowledge in the sense of taste, the basic physical *sapere*. The association is audible in the English *savour* and the French *savoir*, and to

have *savoir faire* is more than just to know how to do something, but involves a sensitivity to where one finds oneself. Kearney's point is that "hermeneutics begins…in the flesh" (2015, p. 16) with our basic responses to the tangible. I add to this a track through another Latin word for taste, *gustare,* which remains closer to its bodily origins in modern English words like gustatory and from which we get *disgust*, a bad taste in the mouth.

Nursing is partly a practice of learning to manage disgust. Martha Nussbaum makes a distinction between distaste, which she says is a purely sensory reaction, and disgust which has a cognitive, or I would say hermeneutic, content in that "it concerns the borders of the body: it focuses on the prospect that a problematic substance may be incorporated into the self" (p. 202). Thus, disgust in the nursing situation has to be both felt and held in suspense to allow for interpretation of what is coming out of another's body. I hear new nursing students going through a phase of comparing disgust stories about encounters with body fluids as a way of acclimatising to a new arena of working with the messy realities of the human body. An accompanying phase is to try out these kinds of stories around the family dinner table; boundary crossing, pushing the limits of good taste. I sometimes wonder whether part of the "angel" stereotype of nursing is an over-compensatory denial of the blood, urine, excrement, vomit, phlegm, and pus with which nurses come into contact. Even if much of the basic work of cleaning up body fluids is now delegated to nursing aides, it is still part of professional practice to engage with the senses, to look, smell and touch in order to interpret.

As a point of reference to this sensory world of activity, to provide some interpretive leverage to the role of disgust, I turn to the artwork by Andres Serrano called *Piss Christ* (1987). This was one of those modern artworks that suddenly blew up in public awareness and became for a little while a battlefield in the culture wars in the late 1980s. It is a photograph of a crucifix in a jar of urine, but beautifully lit so that the crucifix appears suspended in a refulgent yellow glow. Part of the appeal or the disgracefulness of the piece, depending on your point of view, is the tension between the conventional appearance of beauty and the carnal realization of the title. Part of the common reading of the piece, which dates from 1987, is that it flaunted the use of a body fluid during the era of the AIDS epidemic when body fluids became a site of moral panic. Like student nurses at the family dinner table, but much more sensationally, you could say, Serrano mentioned body fluids where they were not supposed to be mentioned.

Nussbaum comments that "…in all cultures an essential mark of human dignity is the ability to wash and to dispose of wastes" (p. 203) but whereas it is a mark of individual dignity to be able to do so for oneself, it is highly ambivalent to do it for others. There is another border of disgust in social structures around the messy facts of bodily sickness, corruption, and waste. The tradition of nursing vocation, reaching back through Nightingale, whose vision of nursing was both modernizing and deeply Christian, has roots in the monastic infirmaries of the middle ages, where closeness to the filth of sickness was also closeness to God. If part of the impact of Serrano's work was to step across the border between the sacred and the disgusting, that impact was possible because he noticed that there is such a border. In a more mundane way, this ambivalence is played out in the division of labour in modern healthcare. As I mentioned previously, registered nurses now delegate much of the work of cleaning up to low status, untrained nursing aides, while their contact with the disgusting is framed around interpretive tasks associated with

quantifying and assessing the meanings of bodily wastes or delicate technical tasks like wound care.

Touch

After considering the senses, Kearney (2015) goes on to discuss touch, and the mediating character of touch in "exposure to otherness" (p. 19). He links *touch* to *tactile* to *contact* to the *tact* in con*tact* and says that, "to learn to touch well is to learn to live well, that is, *tactfully"* (p. 20). Nursing is a special case of tactility and the attendant call for tact in its social, historical, legal licence to go beyond the usual boundaries of both touch and tact. Another of the initiatory experiences for new student nurses is giving an injection for the first time. As a psychomotor skill, it is easily learned and not difficult to do but it has a symbolic value as one of the first steps across the normal boundaries of touch, whereby one knows better than to stab sharp objects into strangers. Students move on to putting catheters into urethras, needles into veins, not just muscle, nasogastric tubes into the pharynx, and so on demanding varying degrees of skill and specific knowledge of what goes where. One of the legal boundary markers of nursing is in very specific terms of intrusion into others' bodies. The regulations that govern the scope of nursing in the Health Professions Act of Alberta, for example state that nurses are permitted to:

> (b) … administer anything by an invasive procedure on body tissue or…other invasive procedures on body tissue below the dermis or the mucous membrane; to insert or remove instruments, devices, fingers or hands
>
> (i) beyond the cartilaginous portion of the ear canal,
> (ii) beyond the point in the nasal passages where they normally narrow,
> (iii) beyond the pharynx,
> (iv) beyond the opening of the urethra,
> (v) beyond the labia majora,
> (vi) beyond the anal verge, or
> (vii) into an artificial opening into the body (College and Association of Registered Nurses of Alberta [CARNA], 2005. p. 5).

This is not generally what we have in mind when we think about the soothing touch of a nurse, even while we know full well it is part of the picture. It is also not what we have tended to think of up to now when we bring hermeneutics to nursing. Most nurses who have taken up hermeneutics have tended to highlight the conversational structure of Gadamer's thought, which fits so well with the interpersonal core of nursing practice. We have turned hermeneutics to good account in thinking about subtle questions of relationship, of difficult conversations, or of the healing influence of words, when at times words are an adjunct to physical care, or absent altogether. This is where carnal hermeneutics opens a new way of thinking about nursing. Tact runs all the way through nursing practice, and the heightened technical skill that means the nurse gets the vein the first time, or does not put the nasogastric tube into the lungs, is another kind of tact, of touch done well.

Mediated Touch

Kearney (2015) goes on to discuss the idea, from Aristotle, of mediated touch. In contrast to a Platonic distinction between the senses of distance, sight and sound, which are held to be purer, all senses are mediated, by light, air, or in the case of touch by flesh. There is always a gap, even in the case of touch, between sense and object and it is in the mediated gap that carnal hermeneutics enters to make sense of the world around us. This conceptualization of the mediated gap, the space of interpretive discrimination, further helps to understand nursing using carnal hermeneutics. I have already suggested that for nurses, technical skill, having a good feel for something, is one expression of interpretive movement. But I also want to expand upon the idea of mediation to include a third element between sense and object, which is any kind of tool or technology that can be used as an instrument of touch.

The simplest and most prevalent example in modern health care is the disposable glove, that sign of the borderland between clinical and natural, or clean and dirty. In addition to needles and tubes that enter the body, there are also thermometers, blood pressure cuffs, heart monitors, and sensors that touch the skin but remain on the surface. These are the tools of the trade that nurses learn to use proficiently and easily, that like Heidegger's hammer, become part of their being-in-the-world. But unlike a hammer, they are instruments of touching another (except when a hammer is misued used and hits a thumb or is co-opted as a weapon) and mediate between nurse and patient, between oneself and another. This is the point at which the neo-Cartesianism I introduced earlier threatens to overwhelm the tactility required for carnal hermeneutics. The object, the clinical instrument serves as a mediator of touch but it also separates. The instrument can easily become the focus of the nurse's attention at the expense of the patient. The instrument can enforce distance that remains distance, and stand as an alienating barrier disrupting the relationship between persons. My argument, based on my reading of carnal hermeneutics, is that there is always a tension between the inherently alienating effect of the instrument and its presence as an object of mediation; it conveys meaning about purpose, security, confidence, all of those things we attribute in a positive way to professionalism, to someone who knows what they are doing; the object itself mediates between the institution and the patient, and of course there is the question of the sensitivity, or tact of the nurse not only in their ability to use the tool well, but in their wider apperception of the person on the other side of the instrument.

Part II: Nursing the Mind

Treanor (2015) in his essay in the *Carnal Hermeneutics* volume takes a different tack to Kearney and introduces further themes in carnal hermeneutics that have potential value for nursing. He begins by pointing out that the body in its materiality has been relatively neglected in postmodern thinking, in favour of attention to texts and language. He warns against overcompensating with a rush towards "scientism" and asserts "*both* the inescapable nature of our hermeneutic condition *and* its ineluctably carnal character" (p. 59). He takes up the theme of the gap to argue that hermeneutics is not confined to the interpretive space of gaps in language, between languages, between text and reader, but also belongs in the physical world:

> …gaps are also carnal, material, and earthy: the synaptic gap between nerves, the gaps between sense organs and the objects sensed, the distinction between body…and flesh…,

> the fold of proprioception, the reversibility or 'intertwining'…of sensing and sensed, the distance of alterity between the self and the other…, the spaces between bodies in the world…and so on. (p. 60)

Treanor's line of thought here extends the idea of the mediated gap into spaces between bodies, that are mediated by social and institutional forces as well as material technologies. Mental health nursing, amongst other things, entails the negotiation of bodies in space in the light of what shapes the space itself. I worked for a while as part of a service called psychiatry consultation liaison. Our function was to conduct mental health assessments and make recommendations for care and treatment of patients in a large general hospital who were there for some primary physical problem. In other words, we worked across the gap between mental and physical that is made concrete in the layout of the hospital itself. Our team represented an embodied gesture of the system having second thoughts about itself, thinking perhaps it might happen that someone could have heart disease and be anxious at the same time, both occurring within the same body when the design of the hospital expects these two phenomena to appear in two different places.

I went to see a patient one day who, we were told in our referral, was "non-compliant" which is healthcare jargon for someone who does not unfailingly do what we, the professionals, want them to do. He was refusing, some days, to attend his physiotherapy sessions. After talking to him for a few minutes, he smiled and confided, "Sometimes I say no just because I can." He was fed up with the discomforts of hospital, the sleep deprivation and unappetizing food, the surrender of control over his body, what would be done to it, where and when it was expected to be, so he asserted a little piece of control, some days, by refusing to move. This is an illustration, I would argue, of Derrida's neologism, "hostipitality" (2002, p. 358). Derrida derived it from the etymological tangle of *hostis* and *hospes*, of host, who may receive or refuse, and of guest, but it conveys beautifully the embodied experience of the hospital patient, pulled between gratitude and resentment, relief and fear. This tension is carnal, it is felt within the body and played out between bodies, expressed in the language of will in this case, or of emotional excess that brings the psychiatric consultation liaison team running. What was ostensibly a "mental" problem of will and motivation perceived as improperly aligned with a program of treatment was just as much, indeed inextricably also a bodily problem. One could go further and suggest that simply listening to the patient, and allowing him to vent his frustrations with the experience of hospital, which he knew at that same time was for his own good, was less a mental health intervention than an impromptu exercise in carnal hermeneutics.

There is more that could be said about the disposition of bodies and the spaces between bodies in mental health nursing. One of the tropes of compulsion in acute care hospital settings is holding down an acutely disturbed patient while a nurse injects an antipsychotic medication. This is a doubled physical restraint, manual force and chemical, external and internal, each working physically even if designed to achieve results that are perceptible in expressed mood, thought processing, and social attitudes. It is also another example of the social and legal permissions that frame the domain of nursing as it is enacted in touch.

Beyond these forms of bodies in space, Treanor reveals pathways to thinking about advances in neuroscience that might inform and enliven nursing practice with people in the world, without a kind of reductionist retreat into faith in inaccessible brain chemistry. He introduces a range of

thinkers in what he calls "the new realism(s)" (p. 60) who accept the existence of a world independent of human perception that can be accessed by science. This is not new in the sense that it is consistent with hermeneutic thought since Gadamer, who was always clear that he was not out to relativize science, but to articulate understanding that is not producible through scientific method and which is indeed anterior to scientific method. (Every scientist decides where to look, based upon some set of existing assumptions, before bringing to bear the methods of scientific attention on the object of interest). Caputo (2018) also addresses this turn in hermeneutics in his book about current developments in hermeneutics, both in a chapter about nursing and other practice professions, and in a chapter about the post-human. He raises issues including the density of human existence that is inherent in the body, not only the brain, and the interplay between genetics and environment as new elements in hermeneutic thinking. What is new, and what runs through both Treanor's and Caputo's discussions is the hermeneutic engagement with science, and most especially advances in neuroscience and genetics that tell us something about who we are, as a species and as individuals, how we come by our being-in-the-world and how we make sense of the world.

Conclusion

Carnal hermeneutics is an exciting direction in philosophy that only reinforces the well-established affinities between hermeneutics and nursing. It does not supplant or replace questions of language and relationship, but deepens them in important ways. It creates an ecological field of interpretation in which nursing encounters with patients are always conducted by, through, towards, and in interaction with physical beings in physical spaces. A lens of carnal hermeneutics affords powerful interpretive possibilities of addressing one or more features of the ecological field of encounter. From the cellular information contained in a sample of urine, to the social organization of who gets to take a blood sample; from a physical gesture of disaffection with hospital routine, to the carnal expression of neurochemical processes, carnal hermeneutics suggests that we are always already immersed in an interpretable, physical world. Carnal hermeneutics presents a new way of seeing nursing, with its manifold blend of knowledge and skills, as an interpretive practice.

Notes

[1] I make this claim well aware of the important question of technology that can, for example, furnish teaching or medical consultation remotely, across great distances, and asynchronously. Although outside the scope of the present paper, carnal hermeneutics may be helpful precisely in mapping the shifting boundaries between human and technology, in understanding the shapeshifting cyborgs we are.

[2] Jean Grondin (2003) has explored the multiple meanings of *sens* in French which is even richer than in English but as far as I can find, this has not been translated. He gave a wonderful version as an oral presentation in English at the Canadian Hermeneutic Institute in Halifax in 2015.

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