The phenomenon of presence within contemporary nursing practice: 
A literature review

Introduction
The word ‘presence’ has usually been associated with the existence of a higher being, such as in references to ‘the spiritual presence of a supreme being’ (Osterman & Schwartz-Barcott 1996: 24) or in theological references to God’s presence. However, within nursing practice, the term ‘presence’ has been used to describe aspects of nurse-patient interactions. Nursing scholars have related the phenomenon of presence within nursing to the writings both of Buber (1987) and Heidegger (1962) and their interpretations of presence. Presence as proposed by these philosophers refers to the core of a person or the essence of one’s existence, and is experienced or shared with another. Heidegger argued that to experience presence, a person must be accessible to another person and willing to share in the other’s presence.

ABSTRACT
Nursing practice underpinned by humanistic values may promote presence experiences within nurse-patient interactions. These interactions are powerful and beneficial both to nurse and patient. However, the phenomenon of presence is surrounded by competing and confused definitions. Whilst presence is arguably a core aspect of nursing practice, current health care environments significantly influence nurses’ opportunities to experience presence.

Key words: Presence, Intersubjectivity, Nursing practice, Positive outcomes, Devaluation.

Caring relationships as described by Benner and Wrubel (1989) are closely linked to nurses’ ability to presence within nurse-patient encounters. Nursing care from this perspective occurs within patients’ subjective worlds (Hall & Allan 1994). Furthermore, nurses’ caring and ability to presence supports patients during times of anxiety, suffering, joy and sometimes death (Bishop & Scudder 1996). An examination of nursing literature in relation to the phenomenon of presence provides a context for understanding presence as is currently advocated for nurse practice.

Definitions of Presence
Presence is a complex phenomenon to define. Many scholars, researchers and writers use the term ‘intersubjectivity’ to describe the experience of presence (Cody 1995; Gilje 1992; Munhall 1993; Paterson & Zderad 1988). Definitions of the phenomenon within nursing literature include descriptions of differing levels of presence experienced by nurses. These levels extend
from the mere physical
presence of attending to an
individual, to the psychological
or spiritual experience of a
nurse being with another,
namely a patient.

Intersubjectivity according to
Paterson and Zderad (1988)
is known as presence or 'the
between' (p.22) of nursing
practice. The 'between' or
presence is the 'stream'
that runs through nursing
interventions, 'in which and
through which nursing can
occur' (p.22), and that conveys
the nutrients of healing and
growth.

Similarly, Munhall (1993)
discussed nursing practice
as bringing together two
perspectives of a situation,
those of the nurse and the
patient, requiring
intersubjectivity. That is, 'the
verbal and non-verbal interplay
between the organised world of
one person and the organised
world of another' (Munhall
1993:126) or, more simply, the
intertwining of two people's
worlds. Further, Cody (1995)
referred to intersubjectivity
as a shared understanding of
meaning between the conscious
minds of human beings.
This shared understanding,
Cody argued, develops during
interactions with a person
or indirectly over time or
distance via language. This
intersubjectivity 'makes meaning
possible' (Cody 1995: 52).
Within this context, 'the
between' (Paterson & Zderad
1988: 22) or presence of the
nurse-patient relationship
is intertwined, bringing
together the meanings and
understandings of both peoples'
subjective worlds.

Gilje (1992) identified a
confusing array of definitions
of the phenomenon of
presence. The dominant
definition of presence was
that it was the 'being' or 'the
essence', which was equated to
'the very personal, individual,
unique attribute, quality or
spirit which makes one human'
(Gilje 1992: 55). Other
definitions presented by Gilje
(1992) included 'presence as
being here and not elsewhere',
'presence as being and being with', 'presence as feeling or
believing' and 'presence as
caring' (Gilje 1992: 55-59).

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Based on these earlier
definitions, Gilje (1992)
proposed a theoretical
definition of the phenomenon
of presence for nursing as:
...an intersubjective and
intrasubjective energy exchange
with a person, place, object,
thought, feeling, or belief that
transforms sensory stimuli,
imagination, memory, or
intuition into a perceived
meaningful experience (Gilje
Further, when applied to
nursing, presence implies
embodiment of mind, body
and spirit, that is, a conscious
ability of the nurse to value
presence within nurse-patient
encounters as essential to
understanding patients'
experiences. Parse described
presence as:
...a powerful interhuman
convection experienced at all
realms of the universe. It is
being with the rhythms of the
sounds and silences, the visions
and blindness of the whole-in-

This concept of 'whole-in-
motion' and being in rhythm
reflects the embodiment of
mind, body and spirit as

As presence is an abstract
phenomenon to grasp, Gilje
(1992) suggested that it
is sometimes more easily
understood if the opposite
is examined—in this instance,
the absence of presence.

Gilje (1992) described several
examples of the absence of
presence: presence could be
absent in the physical sense,
and also in the psychological,
emotional and spiritual realms
(i.e. an absence of relationship
or soul). To further
differentiate between presence
and absence of presence,
Gilje contrasted two opposing
nursing interactions. The first
described a nurse-patient
interaction where presence was
experienced. In this interaction,
the nurse was conscious of her
own
...thoughts, feelings and actions...
mutually shared ... The
patient sensed the nurse’s
compassion and felt understood
(Gilje 1992: 57).

In the example of absence of
presence, the nurse is described
as competently attending to a
patient’s intravenous therapy,
yet failing to acknowledge the
patient either verbally or with
eye contact. In this interaction, there was no connection between the nurse and the patient in either the physical, emotional or spiritual realms of the patient's world. Gilje (1992) argued that the nurse was not cognisant of her own nor the patient's humanness, and therefore there was an absence of presence.

More recent research by Osterman and Schwartz-Barcott (1996) identified four levels of presence within nursing practice. These were titled 'presence', 'partial presence', 'full presence' and 'transcendent presence', and were:

- based upon the quality of being there, the focus of the nurse's energy, and the nature of the nurse-patient interaction; and ... possible outcomes of each type (Osterman and Schwartz-Barcott 1996: 23)

...of experience. The lowest level, simply titled 'presence', reflects the mere physical presence of nurses who are 'self absorbed' (Osterman & Schwartz-Barcott 1996, 25) in their own thoughts and actions. This lowest level of presence differs from Paterson and Zderad's (1988) and Gilje's (1992) definitions, in which presence was defined as not simply a physical attendance, but rather, a spiritual connection. Osterman and Schwartz-Barcott's (1996) lowest level of presence is similar to Gilje's (1992) notion of absence of presence, in that a nurse within this context has no awareness of patient needs and may inadvertently place patients at risk.

Partial presence, Osterman and Schwartz-Barcott's second level, is a combination of the physical attendance of a nurse who is focused upon the task at hand and the nurse's degree of awareness of the patient's responses. According to Osterman and Schwartz-Barcott (1996) at this second level, a nurse competently performs nursing tasks and is aware of the patient's responses; yet does not connect psychologically with the patient.

"... absence of presence ... a nurse within this context has no awareness of patient needs and may inadvertently place patients at risk."

The third level, full presence, is similar to presence as argued by Paterson and Zderad (1988). Full presence is a way of being with patients that encompasses the physical actions and psychological expressions of the nurse (Osterman & Schwartz-Barcott 1996). In this context, the nurse attends to the psychomotor tasks required in patient care and uses positive body language, touch and eye contact to focus on and meet the needs of the patient. As well, the nurse psychologically connects with the patient by way of therapeutic communication skills such as attentive listening and responding. Full presence has been equated to vivid presence (Bishop & Scudder 1996). Vivid presence occurs within a reciprocal relationship where both persons have an awareness of the other and are tuning into the other's presence, thereby creating a shared experience rather than two separate experiences (Zaner 1981).

The last level of presence, transcendent presence, is more difficult to define, given its broad abstract scope. Osterman and Schwartz-Barcott (1996) referred to energy exchange in the nurse-patient interaction that has a spiritual quality and a transformational effect within the relationship. They argued that this level of presence has an effect beyond the nurse and patient within the interaction in that it extends to other nurses and patients not directly engaged in the interaction. Feelings of peace, comfort and harmony pervade the environment as a result of transcendent presence. From a nursing perspective, transcendent presence involves being connected and sensing a oneness with the patient. This equates with Zaner's (1981) description of co-presence, which requires nurse and patient to have knowledge of each other and to share within the relationship with a degree of intimacy. Within this intimate relationship, Zaner argued, the nurse and patient 'make music together' (p. 236).

The work exploring presence in nursing suggests presence can be referred to as an inter-human connection between a nurse and the patient.
who exist in harmony with each other, who sense the experiences and feelings of each other, and who both grow through such experiences and feelings. It is through presence, or intersubjectivity, that nurses can connect with patients and gain understanding of and mutual meaning from nurse–patient interactions.

The Value of Presence in Caring Situations

Humanistic values arguably underpin presence in practice (Donna, Haggerty, Chase 1997; La Monica 1985; McKee 1991; Munhall 1993; Roach 1992; Watson 1985). These values provide a framework to facilitate the mutuality of the interaction, enabling nurse and patient to understand each other’s perspective within a shared experience. A nurse who underpins his or her practice with humanistic values will foster environments of sensitive interactions and openly demonstrate acceptance of the other as a unique individual who is valued within the interaction, and therefore value presence in their practice.

Embedded in humanistic values is the concept of caring for or having concern for another, and thus supporting the worth and value of that other person. Much has been documented regarding the positive influence of nurses’ ‘caring for’, ‘caring about’ and showing ‘attention to or concern for’ another person and the subsequent healing of that person (Benner & Wrubel 1989; Cohen, Hausne, Johnson 1994; Diekelmann 1992; Leininger 1984; Paterson & Zderad 1988; Roach 1992). It is through a nursing presence or ‘the between’ of interpersonal caring relationships that meaning is gained from the experience and healing may be promoted.

Caring that is underpinned by humanistic values focuses on reciprocity of care. However, Donna et al. (1997) asserted that a nurse must make a commitment to care, through a willingness and openness to enter another person’s world with a commitment to offer the gift of care. Caring within this context occurs ‘within the client’s world’ (Hall & Allan 1994, 110), which is unknown to the nurse. Nurses who interact within the patient’s realm of experience not only reflect this commitment to care but are also recipients of the gift of understanding. According to Benner and Wrubel, (1989) this understanding abolishes the walls of isolation often associated with suffering and illness. In addition, nurses who connect with patients’ subjective worlds, that is, who experience presence, centre care on improving patients’ quality of life in order to find meaning and purposeful direction within the patients’ lives (Hall & Allan 1994).

The humanistic values of hope, compassion, concern for the well-being of the other and relating to the other as a person are experienced by patients ‘as a caring presence’ (Bishop & Scudder 1996: 38) and are beneficial to healing. Therefore, Bishop and Scudder (1996) argued nurses who underpin caring with humanistic values are able to experience presence within their everyday clinical practice and thereby support patients in their experience of illness. According to Roach (1992), nurses who focus care on the humanness within the interaction and establish a caring presence with patients have the capacity to heal ‘a multitude of wounds’ (p.15).

Positive outcomes for patients as a result of the experience of presence within nurse–patient interactions include a lower heart rate, alleviation of patient distress, and diminished feelings of powerlessness and isolation associated with being hospitalised (Gardner 1992; Rogers 1996). However, these positive outcomes are not exclusive to patients, as nurses too experience the therapeutic benefits of presence (Bäck-Pettersson, Jensen, Segesten 1998; Mohnkern 1992).

Nurses who have experienced presence potentially understand and appreciate medical
diagnoses, treatment plans and care from patients' subjective worlds. In addition, nurses may experience significant professional affirmation and gratification as a result of the experience of presence (Mohnkern 1992). These feelings of self-affirmation heighten nurses' awareness of their professional role, enhance nurses' professional growth, and their sense of value within contemporary nursing practice (Bäck-Pettersson et al. 1998).

Both nurse and patient are nourished during the experience of presence. The patient responds positively in a physiological sense (Gardner 1992; Mohnkern 1992; Rogers 1996), and simultaneously senses feelings of worth, value and compassion from the nurse. These feelings that are experienced by the patients are reciprocated. Nurses also sense the subjectiveness of the experience; they too feel valued, enlivened and appreciated.

Presence within Contemporary Nursing Practice

Early in their professional careers, nurses are educated about the importance of developing caring relationships with patients. It is from these relationships with patients that nurses come to understand the subjective world of patients. Establishing caring relationships that facilitate the connectedness between nurse and patient in meaningful ways, Locsin (1995) argued, is the basis of nursing care. However, current health care settings focus strongly on technocratic values rather than humanistic values. Care has become standardised to facilitate high patient throughput and cost reductions within the services provided. This has led to depersonalisation of care within the health sector and is in direct conflict with the humanistic values of nursing practice (Barnard 2000; Bernardo 1998; Darbyshire 1993; Jackson & Borbasi 2000; Locsin 1995). Locsin (1995) further argued that within contemporary health care settings, nursing practice more than ever

‘The health care environment has become more technological...’

involves the scientific aspects of care, the documenting of procedures and the monitoring of complex technologies. The value of accomplishing tasks and procedures is deeply embedded within nursing culture and the health care environment (Telford 1992). Although these values are essential for safe, competent nursing practice, the enculturation of nurses continues to focus upon delivering care objectively for the purpose of containing costs, reducing excessive waste of resources and promoting high patient throughput (Barnum 1998; Hall & Allan 1994; Smith & Agard 1997; Tschudin 1997).

The health care environment has become more technological and nurses are expected to care for increasing numbers of patients with a high acuity of illness in an efficient and cost-effective manner (Bernardo 1998). These increased numbers together with the high level of patient acuity and reduced length of inpatient hospital stays may be stifling the humanism of nurse-patient encounters, thereby influencing the opportunities for nurses to connect with patients in meaningful relationships.

Nurses are discouraged in this type of health care environment from developing meaningful relationships with patients. The limits of their time and resources do not fit with the unquantifiable nature of caring relationships. One outcome of being unable to establish and maintain meaningful relationships with patients is nurse frustration and dissatisfaction. Other factors, such as shorter length of hospital stays for patients, workload issues of inadequate nurse–patient ratios, skill mix among staff (e.g. the high proportions of recent graduates or inexperienced staff), and diminished continuity of patient care have been identified as inhibiting nurses’ ability to experience presence encounters with patients (Clarke & Wheeler 1992; Cohen et al. 1994).

Contemporary nursing practice is situated within hierarchical health care systems that cause fragmentation of care and time for nursing staff (Tschudin 1997). Researchers have begun to question why nurses would continue to work within restrictive and
unrewarding health care systems (Darbyshire 1993; Hall & Allan 1994; Tschudin, 1997). Tschudin (1997) argued that nurses are increasingly required to focus upon cost reduction, support high patient throughput and undertake complex documentation to confirm patient funding. Within this context, where nurses continue to engage in meaningful encounters, to presence with patients, Tschudin (1997) argued that this results in a significant physical and emotional effect on these nurses. These included, but were not limited to, medical conditions, guilt, anger, shame, impotence, humiliation, detachment, depersonalisation, and the material costs of absenteeism and sickness.

Osterman and Schwartz-Barcott (1996) suggested that care is highly focused upon technology; high patient acuity and throughput rather than the meaning of the patient's subjective experience may lead nurses to unknowingly neglect to acknowledge the patient as a person. The resulting insensitivity, according to Osterman and Schwartz-Barcott (1996) augments the lack of recognition and understanding of the value of presence within nursing practice.

More recently, Barnum (1998) reiterated the difficulty for nurses of experiencing presence encounters with patients in the currently constrained health care systems, highlighting in particular, reduced staffing levels and increased patient acuity within hospitals. To cope with these stresses, Barnum suggested that nurses may develop strategies that focus upon distancing themselves from the patient, the nurse-patient relationship reflecting an objective 'I-it' (Buber 1987) rather than a subjective 'I-Thou' (Buber 1987). That is, nurses may choose to focus on the technology and tasks involved in patient care rather than demonstrate openness and availability to patients. The difficulties that registered nurses have encountered in health care systems in which priorities are not aligned with the humanness and the subjective nature of nurse-patient interactions have created many conflicts and tensions for many nurses, who yearn to care for and be with patients (Roach 1997).

Conclusion
Presence has been described in many terms, each exploring differing levels at which presence may be experienced within a nurse-patient relationship. These levels include presence as simply being a function or being recognised as a 'thou' (Buber 1987), as an equal, not an object within the interaction. The literature illustrates that nurses who do not respond to nursing situations with genuine intersubjectivity (ie. relating to another as a 'presence' or 'thou'), are usually unable to co-experience the patient's world. Conversely, the literature also indicates that nurses' who presence with all human senses are more able to experience the intersubjective transaction and gain understanding of how patients experience their subjective worlds.

The literature supports the importance of the phenomenon of presence to nurses, highlighting that presence requires the nurse to dwell in the patient's subjective world. The experience of presence allows the nurse to connect with and gain understanding of the patient's experiences. This connection with the patient has a strong healing benefit for the patient; however, establishing such a connection requires time and energy on behalf of the nurse. The literature also alluded to the difficulty of experiencing presence within current health care environments that focus upon objectivity and procedures.

From the literature reviewed, the authors established that registered nurses' perspectives of the experience of presence have not been fully explored. Through gaining an understanding of the experience of presence from the perspectives of registered nurses, researchers will be able to identify commonalities of meaning of presence as well as how nurses facilitate...
the experience despite the economically constrained current health care systems.

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