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Through the Lens of Merleau-Ponty: Using Existential Phenomenology in Understanding the Lived Experiences of Patients, Family Members, and Nurses During Critical Illness in the Intensive Care Unit

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Abstract

This article discusses how Merleau-Ponty's existential phenomenology may serve as the lens and theoretical frame in a qualitative research study of the lived experience of patients, their families, and nurses during critical illness in the intensive care unit. Merleau-Ponty's unique existential concepts of corporeality, spatiality, temporality, and relationality provide a useful foundation and serve as a unifying philosophy of science in understanding this nursing phenomenon that is grounded in philosophical beliefs about humans, and the holistic nature of professional nursing that is not amenable to experimental investigative research methods. The research sheds light on the patients, families, and nurses' embodied temporal, spatial, and relational horizons, and reveals a new conception of critical illness that will provide caregivers with knowledge about effective humanistic, and more holistic care, that opens new ways for coping amongst patients and their families, as well as caregiving possibilities for the nurses. Findings from this qualitative inquiry can help contribute knowledge about family engagement that would impact the provision of care in the intensive care unit, thus improving patient, family, and organizational outcomes.

Keywords: critical illness, lived experience, intensive care unit, nursing, phenomenology, Merleau-Ponty

Introduction

Patients and families are essential and active partners in health care delivery. The Institute of Medicine in 2001 identified the involvement of family as one dimension of patient-centered care that focuses on accommodating family and friends on whom patients may rely. However, family-centered care of critically ill patients remains an inconsistent practice and an understudied area of nursing science (Cypress, 2022, 2023; Hamilton, 2020). Further, there is an abundance of literature discussing how nurses can

meet the needs of critically ill patients and their families and the effects of their relatives' critical illness on the families themselves. However, when this phenomenological study was conducted, there was a scarcity of research investigations in the literature conducted on patients, families, and nurses in ICU looking at the experience of critical illness and their perspective of each from the other. Additionally, most of the studies in the literature are quantitative.

The purpose of this paper is to discuss how existential phenomenology may serve as the unifying philosophy of science, lens, and theoretical frame for exploring, describing, and understanding the lived experiences of patients, families, and nurses during critical illness in the ICU. Aiming to illuminate the meaning of critical illness to the participants, the study was informed by phenomenological research questions, (a) What are the patients' and families' experiences of the nurse in an ICU unit environment? and, (b) What are the nurses' experiences of the patients and families in an ICU environment? According to Churchill (2022), phenomenologically based qualitative research should proceed with a clear sense of the research questions from the outset. This helps inform the literature review, as well as target experiences to be studied qualitatively. To understand what the 15 participants perceived and felt, I invited them to describe their lived experiences in an unrestrained manner through interviews. Therefore, fundamental links between nursing and existential phenomenology in the context of lived experiences of critical illness in the ICU will be presented and discussed in the paper.

Discarding the Modernist, Reductionist, and Positivist Lens

I will first turn to the modernist, reductionist, and positivist lens of viewing illness and how it is researched or studied, and phenomenology and nursing research. Further, I will discuss the work of Maurice Merleau-Ponty's (1945/1965) antireductionist and anti-positivist stance, and how it provides an excellent lens, and theoretical frame in this study, thus advancing nursing research in this area.

The modernist conception of illness tends to solve medical problems using a linear hypothetico-deductive thought process and a lot of times researching it through quantitative approaches of operationalizing problems as discrete, measurable variables and statistical testing of the null hypothesis (Cypress, 2019; Thomas, 2005; Thomas & Pollio, 2002). Nursing's mechanistic lens of viewing phenomena for years has been like the discipline of medicine (Thomas, 2005). Complex human problems are framed as "diseases" and thus, patients become the 'objects' of medical practices. Disease has been viewed and analyzed based on explanatory models, and it belongs to a specialized culture of medicine, although it is appropriate also to some aspects of nursing practice and research (Cypress, 2019; Good, 1994). The medical-behavioral sciences, its medical model, and methodology for investigations are firmly rooted in a positivist or empiricist paradigm which they share with biomedicine (Cypress, 2019).

The empiricist paradigm and the positivist approaches to understanding critical illness and patients' suffering have been increasingly not sufficient or holistic enough, and have troubled me in deciding the approach for this research study. I realized that quantitative methodology was not suitable for my program of research which is focused on the participants' lived experiences of critical illness in the ICU. Using it will miss the

essence, essential dimensions, and meaning of the phenomenon of interest at hand. In caring for the ill person in the ICU, an open and sensitive approach to exploring the patients' subjective experiences of illness is necessary (Cypress, 2019, 2022, 2023; Pedersen et al., 2022). Critically ill patients are persons with personal suffering, not just 'objects of therapy,' human bodies, diseases, and physiological processes that clinical medicine constructs through its distinctive formative processes, practices, and knowledge (Cypress, 2019, 2022). People's experiences and narratives are intensely personal and unique and they deserve to be honored (Cypress, 2019; Frank, 2013). Thus, research in this context must be conducted using a naturalistic or qualitative approach.

In this research study, family members were greatly affected along with their critically ill loved ones during admission to the ICU. The nature of the multiple impacts of critical illness on both the patients and families, would not have been revealed if the research was studied using a quantitative approach. Nursing stems from a humanistic tradition in which the focus of practice and research is the experience of illness explored through qualitative inquiries (Cypress, 2015, 2022; Pedersen et al., 2022). Qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings, attempting to make sense of or interpret them in terms of the meaning people bring to them (Cypress,2015, 2022). It contributes to the humanizing of health care as it addresses contexts about health and illness. This realization led me to the phenomenological philosophical perspective and methodology for this study.

Phenomenological studies describe the meaning for individuals of their lived experiences of a phenomenon (Cypress, 2015, 2022). The philosophical assumptions are the study of the lived experiences of persons, the view that these experiences are conscious ones, and the development of descriptions of the essences of these experiences (Cypress, 2015, 2022). Pedersen and colleagues (2022) said, "The reality is not perceived in a purely objective way but presented as experiences that may include the result of sensory experiences, emotional responses, and prejudices" (p. 4). According to Fernandez (2018) when we try to enter the phenomenological attitude via the *epoche*, we often retain prejudices that we did not even know we had (p. 146). Additionally, it is now widely accepted that cognitive processes and states can be unconscious (occurring below awareness) or implicit (occurring without attention or intention) (Winkielman & Berridge, 2004). Thus, unconscious, or implicit emotion is a possibility. In other words, explicit emotion refers to the person's conscious awareness of an emotion, feeling, or mood state, while "implicit emotion" are changes in experience, thought, or action that are attributable to one's emotional state, independent of his or her conscious awareness of that state (Kihlstrom (1999).

Phenomenology and Nursing Research

Scholars agree that phenomenology is an approach to human research (Adams & van Manen, 2008; Cypress, 2015, 2022; Dowling, 2007; Earle, 2010; Munhall, 1994; Pedersen et al., 2022; Thomas, 2005; Zahavi & Martiny, 2019; van Manen, 2016). Phenomenology has been a popular methodology in nursing research (Cypress, 2015, 2022; Thomas, 2005). Some nursing scholars noted for grounding their research and theory in phenomenology are Patricia Benner, Rosemarie Rizzo Parse, Josephine Paterson, Lorraine Zderad, and Jean Watson. The discipline of nursing views

phenomenology as an alternative to empirical science that offers a discerning means for understanding nursing phenomena specifically about lived experience (Cypress, 2015, 2022; Earle, 2010; Giorgi, 2000; Norlyk & Harder, 2010; Rapport & Wainwright, 2006; Salmon, 2012). Phenomenological inquiry requires that the integrated whole be explored, thus it is a suitable approach for this phenomenon important to nursing practice. It also aims to describe phenomena in rich language as they present themselves. It is more realizing that insights come to us in the mode of reflective questioning, and understanding the meaning of lived experiences (van Manen, 2014).

Phenomenology is consistent with the values of nursing practice, specifically the holistic view of a person, the meaning of their experiences, and the use of the self as a therapeutic tool (Cypress, 2015, 2022; Earle, 2010; Koch, 1995; McConnell-Henry et al., 2009). Matua (2015), Biggerstaff and Thompson (2008), and, Pringle and colleagues (2011) also concur that phenomenology is attractive to nursing because it can help to improve care and understanding of issues critical to nurses and their clients, whether as individuals, families, or larger communities through understanding of patients' unique experiences, and how patients interpret them. Thus, phenomenology is a well-substantiated qualitative methodology that is highly valuable for addressing research questions specific to the discipline of nursing. It is also essential for the implementation of holistic, empathic, and individualized nursing care (Cypress, 2015, 2022; Earle, 2010; Pedersen et al., 2022).

Phenomenology serves as the methodological perspective in this nursing study as it is grounded in philosophical beliefs about humans and the holistic nature of professional nursing. Investigation of phenomena vital to nursing requires that researchers study lived experiences as they are presented in the everyday world of nursing practice. The phenomenological approach supports new initiatives for nursing care where the subject matter is often not amenable to other investigative and experimental methods (Cypress, 2015, 2022; Pedersen et al., 2022). A better understanding and description of the patients, families, and nurses' experience of critical illness in the ICU in this study revealed a more holistic subjective consideration of the person's narrative and lifeworld. The lifeworld is about the human experiences of a phenomenon, the individual's self-understanding, the lived body, and the meaning of suffering and well-being (Pedersen et al., 2022).

Applying Merleau-Ponty's Existential Phenomenology in Research Methods

Selecting Participants

In selecting participants for an existential-phenomenological study, the researcher must engage in purposive sampling for the identification of those who have lived through the experience of the phenomenon being investigated and are also willing to be interviewed, and be available for follow-up interviews for clarifications or elaborations of the data (Churchill, 2022). A purposeful sample of five nurses, five patients, and five family members in the ICU was included. The nurses were not matched with patients and families. Different family members visit the patient every shift and there are different nurses assigned to any patient every shift. Patients must be awake, alert, and oriented to time, place, and person. Those patients who were verbal were further assessed if they could be interviewed using Muphy and Cluff's (1990) cognitive screening instrument. A

demographic description of participants is presented in Tables 1-3. This research study was approved by the institutional review board and all the participants signed an informed consent.

Table 1. Patient Participants' Demographic Data

Participant	Age	Gender	Diagnosis
Patient 1	61	Male	Hemorrhagic Stroke
Patient 2	43	Male	Diabetic Ketoacidosis
Patient 3	55	Male	Asthma, Emphysema, Respiratory Failure
Patient 4	23	Male	Multiple Gunshot Wounds
Patient 5	70	Female	Exacerbation of Congestive Heart Failure

Table 2. Family Members (FM) Participant's Demographic Data

Participant	Age	Gender	Relationship to Critically Ill patient
FM 1	62	Female	Wife
FM 2	70	Male	Husband
FM 3	45	Female	Mother
FM 4	38	Female	Father
FM 5	60	Female	Husband

Table 3. Nurse (RN) Participants' Demographic Data

Participant	Age	Gender	Educational Level	Years of Nursing Experience	Years of Intensive Care Unit Experience
RN 1	40	Female	MSN	17	15
RN 2	38	Male	BSN	7	5
RN 3	36	Female	BSN	3	2
RN 4	52	Female	MSN	25	20
RN 5	50	Female	BSN	20	18

Applying the Concept of Intentionality (*Epoche* and Phenomenological Reduction)

The concept of "intentionality" encompasses the human experience of corporeality, spatiality, relationality, and temporality (Churchill, 2022; van Manen 1990, 2014). It refers to the integral interconnectedness between humans and the lifeworld that is always directed toward specific events, objects, and phenomena. All experience takes place in relation to something other than itself. As researchers, we must consider our own intentionality (i.e., what we find meaningful, and how we are connected to the topics that we study) (Thomas, 2005). How did I achieve intentionality in this study? It was important that I identified that my interest was not infused with bias and prejudice. I have achieved this through reflexivity and phenomenological *epoche.'*

The defining methodological character of existential-phenomenological research is embodied in the researcher's use of *epoche'* and phenomenological reduction (Churchill, 2022). Churchill (2022) stated, "The Greek term *epoche'* is the preliminary step whereby the researcher "brackets" or "takes out of play" things that are taken for granted to allow

something else to come into view. Phenomenological researchers first bracket the conceptual prejudices that they carry with them to the study and bracket the "natural attitude" or belief that the world is the way it appears to someone" (p. 9). Phenomenological reduction, on the other hand, means "restoring" the world of perception to see our subject matter as if for the first time, without distorting preconceptions (Churchill, 2022).

Through phenomenological *epoche*', I was always on guard for my own biases, assumptions, beliefs, and presuppositions that I might bring to the study, but was also aware that complete reduction is not possible. Van Manen (1990) stated that ''If we simply try to forget or ignore what we already know, we may find that the presuppositions persistently creep back into our reflections'' (p. 47). The only way to really see the world clearly is to remain as free as possible from preconceived ideas or notions. Merleau-Ponty (1956) presented that complete reduction may never be possible because of the intimate relationship individuals have with the world. He further suggested the impossibility of a complete suspension of perspectivity (Merleau-Ponty, 1945/1962, p. xiv). Merleau-Ponty (1945/1962) states that,

> The phenomenological world is not pure being, but the sense which is revealed where the paths of my various experiences intersect, and where my own and other people intersect and engage each other like gears. It is thus inseparable from subjectivity and intersubjectivity which find their unity when I either take up my past experiences in those of the present or other people in my own" (p. xxii).

During data collection and analysis, I remained attentive and was deliberately open, examined the data by employing phenomenological *epoche'* in understanding the lived experiences of patients, families, and nurses.

Data Collection and Analysis

Rigorous data collection procedures ensued over six (6) months through two in-depth face-to-face interviews of 15 participants to be able to fully explore the phenomenon. The patients were interviewed four days after they were discharged from the ICU. Family members were interviewed at any point that was feasible and easier for them in the setting that they preferred. Nurses were interviewed during their breaktimes, or in settings that they preferred while they were off from work. The interviews aimed to elicit a personal comprehensive description of a lived experience of a phenomenon as it is lived through without offering causal explanations or interpretive generalizations (Cypress, 2015, 2022; Patton, 2015). It was also guided by phenomenological principles aligned with Merleau-Ponty's (1945/1962) perspective about acquiring detailed first-person descriptions of the lived experience in question as the point of departure for how critical illness influences a person's subjectivity, agency, and sense of self. Further, the first-person perspective was understood as is or on its own terms described as embodied, enactive, and embedded subjectivity (van Manen, 2014). The interview for nurses started with a general lead question - ''Tell me about your experience with the patients and families in the ICU.'' The patients' and families'' interviews commenced with an open-ended question - ''Tell me about your experience of the nurse in the ICU.'' These questions put the interview in context for both the researcher and the participants.

An inductive approach to data analysis was used. Analysis of the data proceeded with the description of the lived experiences of 15 participants of critical illness in the ICU, followed by the interpretation of the overall meaning of individual interviews. The transcripts were approached with an open attitude, seeking what emerged as important and of interest from the texts (van Manen, 2014).

Merleau-Ponty's Existential Phenomenology – The Theoretical Frame for Understanding the Research Findings

Merleau-Ponty's (1945, 1962, 1945/1962) work is being rediscovered and used by scholars, not only in the discipline of philosophy but also outside of it (Beck, 2021; Cypress, 2010, 2011, 2022; Churchill, 2000, 2022; DeRobertis, 2017; Englander, 2019, 2020; van Manen 2014, 2016). His phenomenological philosophy has been useful to nurse researchers for many years as well (Benner & Wrubel, 1989; Cypress, 2010, 2011, 2022; Pedersen et al., 2022; Thomas, 2005). The specific aim of his phenomenology is to give a direct description, not a causal explanation of experience. Lived experience, given in the perceived world must be described, not constructed, or formed (Merleau-Ponty, 1956). He believed that it is through the life experience that the person has the potential to find meaning and understanding in life.

Themes were classified into two categories: integrating themes, and specific themes. The participants' lived experience in the ICU integrates the five themes: family as a unit, psychosocial support, physical care/comfort, physiological care, and transformation. The specific themes are uncertainty (patient-specific), advocacy (nurse-specific), and confidence in the nurse and healthcare team (family members-specific).

Integrating Themes

Family as a Unit, and Psychosocial Support

> *The nurses interviewed for this study perceived the patients and their families as one unit, while patients and families viewed the nurse as part of the family. The finding from the patients and family members that regard the nurse as part of the family is significant in family science literature. A daughter of one patient who had respiratory failure in the ICU said,*
>
> *With the nurses, it was like becoming a family. Every time we would go in, I would not look at them as nurses. They were all like part of our family because they were so caring and made sure that we as the family, knew what was going on and that things were going to be alright. It became like you know them, you come in and it is like part of you every day*
>
> *A nurse in this study stated,*
>
> *Usually, you feel what the family feels because you have a family of your own and you feel that they are in a situation that they cannot control. You feel that if you*

> *are in a situation that they are in, you will feel the same thing and you want your best to help them out. I look at the family as one unit because you know that the patient is physically suffering and the family is suffering emotionally because they see their loved ones going through the pain and most of the time, they do not know what the outcome is going to be. Either they are going to die or of course, get better. They want the family member who is sick to get better.*

The descriptors for the theme *family as a unit* were to involve the family in the plan of care or as an active participant, allow the family to bring pictures of the patient, and, empathize with the family. One of the nurse participants emphasized that allowing family members in the care of the patient is beneficial when she said:

> *If the patient's family is willing to assist and help in taking care of the patient, you encourage them to help, like wiping, cleaning the face, and eyes, and also massage the patient… Give them instructions and encouragement that they can talk to the patient… Encouraging the family to participate in the care is good especially if the patient is intubated, and connected to all the wires, catheters, and tubes.*

Allowing family members to put the patient's pictures in the room was a significant finding that helped the nurse, and the family to view the patient as one of them, and not another separate entity or "different" person. A nurse described her feelings on this when she said:

> *Sometimes patients are unrecognizable because of their critical condition. They look bad, swollen, and 'messy', By all means, allow the family to put a picture of the patient in the room or at the bedside when he or she is not sick. This way, you picture the patient as a person that you are taking care of and not just a sick patient connected to all these machines. You are taking care of this different-looking person rather than a sick guy who you cannot recognize with no face.*

The theme of *family as a unit* is intertwined or integrated with the theme of *psychosocial support*. When a patient is critically ill in the ICU, interactions with family, friends, and fellow workers are suspended and distorted. It was through communication that the provision of psychosocial support was fulfilled. A nurse described her experience of providing emotional support to family members and said,

> *Emotional support is crucial. I try to reassure the family on a lot of things. I reassure them that the ''tube'' in the mouth is not permanent there and that once the patient is ready to breathe on their own, the patient is going to be weaned from the ''machine.'' Doing this will help lessen their anxiety because they are not familiar with all the ''tubes'' that the patient has.''*

Another nurse commented that,

> *Family members have different types of roles - emotional and spiritual support are two of them. Even though I work at night and I have a short time with the family members, you can tell if the patient's family is supportive. Sometimes they*

> *would ask permission if they stay a little bit longer so they could gather around the patient and pray.*

The nurses, patients, and family members perceived spiritual support as one aspect of care that is important if we are to be holistic in the care we provide. A nurse spoke about being proactive in rendering care that includes spiritual support:

> *Nurses should offer services to family members, not just services regarding the care, but spiritual– offer whatever the hospital has. Caring is not only physical but also spiritual. Sometimes I forget to do that. Those with dying patients let them know that we have a chapel whatever religion they have. I think we should be doing that more.*

Physical Care and/or Comfort and Physiological Care

The study participants perceived that physical and/or comfort care, coupled with physiological care are vital during critical illness in the ICU. They identified bathing the patient, oral care, encouraging touch, treating the pain, and ensuring that the patient's room is clean, as ways of providing physical care to the critically ill.

Nurses in this study perceived that bathing the patient is one of the ways of providing comfort, and it is also a basic need that should be met when caring for them in the ICU. One nurse stated:*"I am always meticulous with my care to patients because I see family members and relatives visit… I don't want my patient smells, so I bathe them as needed."* Giving oral care not only affords physical comfort for patients but is also a means for the nurse to assess the condition of the oral cavity. Nurses also found that touch makes the patients feel that they are valued and makes them aware of their family members' presence at the bedside. A nurse spoke about encouraging touch when she said:

> *It is important in Critical Care that you encourage family members to hold the hands of the patient especially when they are talking to them. As a nurse, I usually do this to my patients. When I was a medical-surgical nurse, I had a demented and confused patient who said to me. Just hold my hand and I'm going to be alright.*

Relief of pain was perceived as an important aspect of physical care and comfort to critically ill patients in the ICU. One nurse said "*Patients in the ICU need to be free of pain. We must talk to them and ask them if they are in pain.* Another nurse stated,

> *In ICU we get all kinds of patients, all kinds of diagnoses. Pain is pretty much a very common problem among these patients. Even an intubated patient on mechanical ventilation can be in pain. Nurses should be able to assess them well for they are unable to verbalize. Patients should be comfortable and not need to suffer pain.*

Participants in this research study expressed that ensuring that the patient's room is *clean* is important. In this existential-phenomenological study, the patient's lived space is the ICU. The ICU is not the patient's usual environment. Critically ill patients, in a high-

technology environment such as the ICU, experience a threat to their lived space, as well as their physical and physiological being. A Hispanic patient who was admitted for hemorrhagic stroke expressed his perception of room cleanliness when he stated,

> *The ICU is the place where there are lots of these machines and equipment, a lot of procedures being done, and other things going on most of the time that my room is a mess! There are also a lot of personnel who check on you all the time. It could be chaos and when all of them are out of my room, I want to have my room clean and in order. But, despite all that, the nurse and housekeeping made sure that the room was cleaned.*

In addition to taking vital signs (blood pressure, heart rate, respiratory rate, and temperature, including pain scale), all participants identified taking vital signs feeding patients, and giving medications as other ways of providing physiological care. Nurses have an important role in meeting the basic physiologic needs of patients. One nurse spoke about the relationships between team members in fulfilling this common goal,

> *Of course, we monitor our patients and take their vital signs and other hemodynamic parameters. We treat them by giving medications and we insert invasive lines to be able to administer these medications. No matter how we do all these if we do not feed our patients, the care will not be that holistic because we must meet first the very basic need of our patients which is food, we must feed them.*

A patient with emphysema and respiratory failure shared his needs as an ICU patient stating,

> *Nurses are supposed to take care of you and provide you with medication and your other needs like your food, your shower, washing me, feeding me - everything. I was asleep and sedated and unable to do anything for myself that I did not need to ask for any of it. The nurses were good. They did their job.*

Transformation

The theme of *transformation* is a significant finding in this study. The concept of transformation among patients, family members, and nurses during critical illness in the ICU is fully explored and described in a separate publication and is not included in this article to avoid redundancy except for the following examples from two critically ill patients in the study. One patient who was admitted for respiratory failure, and poly-substance abuse, reflected on his experience in the ICU as he stated,

> *Being in the ICU with the "tube" but I was awake, I feel like I am "messed-up" because of what I did. I used drugs that I got "messed-up." They told me that I almost died. I know that it was not from my emphysema or asthma but because of the drugs. I was partying and partying – having fun! I am thankful because I have been up and down the ladder, and I am still alive. I thank God I am still alive (almost crying and sobbing). Life is beautiful. It was scary but I left death behind. It is scary when you go through experiences like that. It puts meaning to your life.*

> *I see, I can just go out and do it again, and it is true! - but I hope not, although I never say yes or no. After being in the ICU again many times of being there, thank God I feel much better now. I realized now not to take life for granted and that I was thinking, meaning that I should behave.*

A 43-year-old patient who was in ICU for hyperglycemia shared the meaning of his ICU experience and said,

> *Being in ICU makes me a little nervous; all the machines around and they must hook you up so fast. If the machine goes off, they are there immediately but I still feel nervous. Being there gives me something to think about like you start thinking of family members and loved ones. They come to see you with tubes lying all over - they get upset, and they do not know what is going on. I now realize to take better care of myself so that I do not have to go back to ICU and have my family experience that again.*

Specific Themes

The specific themes were categorized as nurse-specific, patient-specific, and family members-specific. The patient-specific theme of *uncertainty* refers to patients' perception of '*"I do not know what is going to happen," "Am I progressing or not?"* and *"Will I make it or not?"* One patient said,

> *Being critically ill in the ICU was scary because you do not know where your life is going to go - if you are going to live or going to die. I got kids and one on the way. It was scary just not knowing what was going to go on. I was surprised, all this stuff happened to me in one day. I was happy for one hour, and then the next hour I was in the hospital. I mean being in a position like this, everything is spontaneous you do not know what is going to happen.*

Another patient stated,

> *When I was in the ICU, I had this funny feeling of being both scared and worried. I was awake and I understood everything but my speech was not so good. I always thought, 'What if I won't make it,'' or ''will my condition get better or not,'' ''am I at all progressing or not?'' It was really a scary feeling.*

Advocacy and *confidence in the nurse and the healthcare team* are the other two specific themes.

Advocacy is a nurse-specific theme that refers to working with the family for the patient's well-being, privacy, confidentiality, and ethical issues, and offering information to the patients and their families. A nurse conveyed her sense of advocacy when she said,

> *Being a nurse itself, just the definition of a nurse is to advocate for the patient. One way of doing that is by advocating for patient confidentiality, issues like organ donation, advance directives, living wills, and DNRs should also be considered. The family has a very important role in cases like this, especially in*

> *the ICU. Patients deteriorate and they become very sick. So, the family members are the ones who will decide for them in case they do not have a healthcare proxy or living will or if they are not DNR. If the patient has no family, the nurse should advocate for the patient.*

The nurse who advocates for critically ill patients and their family members in the ICU assists in building the families' *confidence in the nurse and the healthcare team* which they described as *"peace of mind when at home,"* "*nurses giving care and are doing what they are trained to do,"* and "*teamwork/people working together.*" The daughter of a patient on mechanical ventilation stated,

> *When you have the best care and you have doctors and nurses telling you what is going on, I can go to sleep at night saying, "They are monitoring him. They are watching him. They know what they are doing." And that is peace of mind when you get home. I also saw that they worked as a team. I think working as a team is what makes it holds everything together. The doctors with the nurses working together and being there all the time, I think there's teamwork. I think that not having teamwork, would not work. I saw that things are being done in ICU and are being done positively."*

Discussion

Lived Body

In this study, the patient's corporeality, or embodiment (lived body) is threatened by a critical illness that has effects and meanings on their lifeworld and lived experience. Critical illness is a life-threatening disease or state in which death is possible or imminent affecting both the patient and family members A patient who is confined to bed and on extensive monitoring often experiences discomforts that include pain, confusion, anxiety, and delirium (Jaberi et al., 2020; Heydari et al., 2020; Kleinpell et al., 2019).

The themes *physical care and/or comfort* and *physiological care* correspond to Merleau-Ponty's (1945/1962) existential of corporeality or embodiment (lived body). He emphasized the sacredness of the body and explained that when the relationship between body and world is disturbed (e.g., when bodily capacities are changed related to critical illness), a person's existence is shaken. The lived experiences of critically ill patients in the ICU relate to Merleau-Ponty's discussion of the 'phantom limb' in which he states, "I am conscious of the world through my body. It is precisely when my customary world arouses me in habitual intentions that I can no longer, if I have lost a limb, be effectively drawn into it, and the utilizable objects . . appeal to a hand which I no longer have. Thus are delimited, in the totality of my body, regions of silence. . . . Correspondingly, my body must be apprehended not only in an experience which is instantaneous, peculiar to itself and complete in itself but also in some general aspect and in the light of impersonal being" (p. 95).

Lived Space

Ensuring that the patient's room is clean is one of the descriptors for the theme of physical care and/or comfort. The ICU is the critically ill patient's lived space. The term "critical care unit" involves images of very ill patients surrounded by the latest in biomedical equipment, noisy monitoring devices, emergency carts, and equipment. The ICU serves the most acutely critically ill of hospital patients. It is a foreign place where everything appears bizarre, from the critical nature of admission to the strange environment, unfamiliar caregivers, and obscure language. There are a plethora of unfamiliar sounds, smells, and sights. According to Zussman (1992), intensive care is not a technology. It is a place in which technology is applied daily to the most intractable of medical problems

Sounds and lights from equipment in the ICU affect sleep, sensory and perceptual deprivation, and overload (Younis, Hayajneh & Alshraideh, 2021). A classic ICU study conducted by Lusardi (2003) reported that the intensive care unit is a dichotomy: high technology versus high touch, object versus subject, disease process versus personhood, and experience versus relation. The ICU represents a concentration of the highest technological advances in the treatment and cure of life-threatening disease processes. On the one hand, it is a place of types of machinery such as ventilators, pacemakers, dialysis machines, and monitors, which assess and sustain life processes. It is also a place of disease processes and instabilities that demand great attention and technical experiences from the medical house staff. On the other hand, it is a place where humans with names and personhood come to survive life-threatening processes.

The ICU patient's experience of felt space relates to Merleau-Ponty's (1945/1962) spatiality or lived space (Merleau-Ponty, 1945, 1962). Bodily spatiality is the deployment of one's bodily being, the way in which the body comes into being as a body (p. 172). Understanding the meaning of some experience requires us to describe the intentional stance (or situated perspective – e.g., ICU) of the event from the point of view of the experiencing person. Space is existential (Merleau-Ponty (1945, 1962, p. 342). This existential skill of situatedness and dwelling in their lifeworld enables the person to experience life as meaningful even in the face of illness (e.g., critical illness), but how is the space (ICU) experienced differently from place (home)? In what ways does the ICU environment affect the patient and the family members? How does the ICU space shape the patients and their families?

The perception of a body implies the ability to change and to 'understand' space (Merleau-Ponty (1945/1965, p. 293-294). Merleau-Ponty states "The shrinkage of lived space, which leaves no room for chance. Like space, causality, before being a relation between objects, is based on my relation to things.... Clear space, that impartial space in which all objects are equally important and enjoy the same right to existence, is not only surrounded but also thoroughly permeated by another spatiality thrown into relief by morbid deviations from normal….he feels a threat hanging over him... Meanwhile, says the patient, "a question is constantly put to me; it is as it were, an order either to rest or die, or else to push on further" (p. 335). This second space which cuts across visible space is the one which is ceaselessly composed by our own way of projecting the world. Merleau-Ponty's example of a schizophrenic patient is like an ICU patient who no longer

inhabits the common property world, but the private world, and no longer gets as far as geographical space; he dwells in the 'landscape space,' and the landscape itself, once cut off from the common property world, is considerably impoverished. …It is not, so to speak, with his anguish or his joy and pain experienced are related to a locality in objective space in which their empirical conditions are to be found (p. 336).

Lived Time

The patient-specific theme of *uncertainty* refers to patients' perception of '*"I do not know what is going to happen," "Am I progressing or not?"* and *"Will I make it or not?"* Critically ill patients in ICU who are not awake, alert, and oriented (to person, place, and time) related to sedation, chemically-induced coma, and paralysis have no concept of time. Merleau-Ponty (1945/1962) states, "The ambiguity of being in the world is translated by that of the body, and is understood through that of time." (p. 98). …Time in its passage does not carry away with it these impossible projects; it does not close up on traumatic experience; the subject (e. g. critically ill patient) remains open to the same impossible future, if not in his explicit thoughts, at any rate in his actual being. . . it displaces the others and deprives them of their value as authentic presents."…Impersonal time continues its course, but personal time is arrested" (p. 69). Time is not a real process. It arises from one's relation to things (p. 478). Time is thought by us before its parts, and temporal relations make possible the events in time (p. 481).

Days, or sometimes weeks go by with the patient not knowing what day it is, or if it is night or day. Merleau-Ponty (1945/1962) states, "What does not pass in time is the passing of time itself… Time restarts itself: the rhythmic cycle and constant form of yesterday, today and tomorrow… as the fountain creates in us a feeling of eternity" (p. 492). Critically ill patients may feel their suffering is never-ending.

> The temporal perspective with its confusion of what is far removed in time, and that sort of 'shrinkage' of the past with oblivion as its ultimate limit, are not accidents of memory and do not express the debasement into empirical existence of a consciousness of time theoretically all-embracing but its initial ambiguity: to retain is to hold but at a distance. (Merleau-Ponty, 1945/1962, p. 491)

Patients in the ICU have no sense of when they will recover from the critical illness, return to their normal lives, or be admitted to a skilled facility because of permanent disability. Patients have little knowledge of when, how, or whether they will return to familiar surroundings. Merleau-Ponty (1945/1962) said,

> It is of the essence of time to be not only actual time, or time which flows, but also time which is aware of itself. For the explosion or dehiscence of the present towards a future is the archetype of the relationship of self to self, and it traces out an inferiority. (p. 495).

This begs the question, "Are the critically ill patients coming back this way to a kind of eternity?" Eternity feeds on time. Merleau-Ponty (1945/1962) further states,

> I belong to my past, and through the constant interlocking of retentions, I preserve my oldest experiences, which means not duplicates or image of them, but the experiences themselves, exactly as they were. But the unbroken chain of the fields of presence, by which I am guaranteed access to the past itself, has the essential characteristic of being formed only gradually and one step at a time; each present in virtue of its very essence as present rules out the juxtaposition of other presents and, even in the context of a long time past. (p. 491)

Critical illness is usually characterized by an acute incident that can be triggered by co-morbidities that can lead to multiple admissions related to exacerbations, and ultimately chronicity. Death is also a common outcome of fatal and complicated illnesses. Merleau-Ponty (1945/1962) said, "Time in our primordial experience of it is not for us a system of objective positions, through which we pass, but a mobile setting that moves away from us (p. 487). Since the time being and passing are synonymous, by becoming past, the event does not cease to be. Time maintains what it has caused to be, at the very time, which its fixed position lying beneath our gaze, is not to be sought in any eternal synthesis, but in the mutual harmonizing and overlapping of past and future through the present and in the very passing time. Temporality temporalizes itself as the future which lapses into the past by coming into the present (p. 488). We must understand time as the subject and the subject as time (p. 490). This primordial temporality is not a juxtaposition of external events, since it is the power that holds them together while keeping them apart.

Lived Relation

The nurses interviewed for this study perceived the *patients and their families as one unit*, while patients and families viewed the nurse as part of the family. The patients' experiences in this existential-phenomenological study as it relates to finding meaning during critical illness, are centered on obtaining support from their families, and professionalism from the nurse. Lived relations during the ICU experience for patients were with their critically ill loved ones, with each other, with nurses, physicians, and other healthcare staff, and with others who supported them. There is an implicit connection between the physicians, nurses, families, and the health care staff, and the ICU works as a whole because of this interdependence. ICU nurses are positioned to focus on caring for the patient. To provide holistic care, however, caring cannot be directed exclusively to the patient, especially in the context of critical illness. Care of the patient and family becomes intertwined in that what affects one member potentially impacts the entire family. Thus, the hospitalization of a family member has an impact on the whole family system's equilibrium The participants perceived that families should be involved in the patient's plan of care, be allowed to bring pictures of the patient at the bedside, and that the nurse and other staff should have empathy with the family. To be able to help the family function in a crisis related to critical illness, the nurse needs to promote adaptation and emotional stability. Psychosocial support was described as emotional support that includes encouragement, spiritual support, sensitivity to the patient's and family member's needs, treating the patient and family with respect, offering translation service, and referring to social service.

The theme *family as a unit* and *psychosocial support* relates to Merleau-Ponty's (1945/1962) existential of *relationality or lived relation.* Merleau-Ponty stated, "It is

through my relation to others, and through my relation to things that I know myself" (p. 383). "*I am given*, that is, I find myself already situated and involved in physical and social world . ... The physical and social world always function as a stimulus to my reactions, whether these be positive or negative" (p. 419-420). We must therefore rediscover, after the natural world, the social world, not as an object or sum of objects, but a permanent field or dimension of existence. Our relationship to the social is, like our relationship to the world, deeper than any express perception or any judgement…. The social is already there when we come to know or judge it" (p. 421-422). Further, he states, "I am necessarily destined never to live through the presence of another to himself. And yet each other person does exist for me as an unchallengeable style or setting of co-existence and my life has a social atmosphere just as it has a flavor of mortality" (p. 425). Simply, relationality refers to the fact that we always already find ourselves in a world and in relation to others (1962).

Limitations

This phenomenological study has limitations. As with any qualitative study with a small sample size, the results cannot be generalized to a broader population specifically all ICU settings as this is not the goal of naturalistic research. Instead, the findings can be applied to similar situations in critical care if they are modified to the context of the study. The demographic characteristics of participants such as age and gender were not delineated. Characteristics of the patients such as the severity of illness or admitting diagnosis, and duration of ICU stay were also not considered. For the nurses, the length of critical care experience and total nursing experience were not differentiated. The time frame and duration for the interviews also differed between the participants.

Conclusion

Using existential phenomenology from Merleau-Ponty's philosophical perspective, this study shed light on the phenomenon of the ICU lived experience during critical illness from the perspectives of patients, their family members, and nurses. Understanding the person's lived body, and the notion that the experience of critical illness is dependent on the individual's embodied temporal, spatial, and relational horizons, rather than only the naturalistic, biological, and physiological aspects, reveals a new conception of critical illness that will provide caregivers with knowledge about effective, humanistic care. A better understanding and description of these experiences was revealed towards a more holistic subjective consideration of the person's narrative and lifeworld, which opens new ways for coping amongst patients and their families, as well as caregiving possibilities for the nurses and other healthcare professionals.

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