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# Open-Hearted Flesh: Burn Injuries and Interpretation

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## Abstract

This paper aims to describe the interpretive nature of burn care nursing using an example from the first author's practice. It asserts how burn injuries are uniquely situated from a hermeneutic perspective as an embodied change that alters the way a burn injured person lives in the world. This paper was written for an assignment in a hermeneutic methodology class, focused on the role of the burns nurse, and further expanded in relation to the hermeneutic significance of burn injuries. It demonstrates the fit of hermeneutics as a way of understanding nursing practice and burn injuries and serves as a support to the use of hermeneutics in the author's Master of Nursing thesis project exploring the experiences of burn survivors.

## Keywords

nursing, burns, hermeneutics, embodiment

Hermeneutic philosophy rests on assumptions that interpretation is a fundamental way people make sense of their world and themselves. These interpretations are all situated in social, cultural, and historical contexts (McCaffrey et al., 2012). Burn injuries are an extreme form of human experience for the person injured, and for the care providers. The delivery of care from providers requires knowledge, services, and skilled practitioners to optimize outcomes. Burn injuries are complex, traumatic injuries that result in lifelong physical scarring and dysfunctional skin. The resultant embodied change after injury alters the way burn survivors are situated within the world with their scars as constant reminders of what occurred. In this paper, I (first author) will provide a rationale for the interpretive nature of burn injuries. I will draw an example from my nursing practice to demonstrate the interpretive nature of burn nursing practice. Ultimately, I will

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demonstrate how the injury itself to the person who suffers it and the nursing care that follows are always moving in an interchange of simultaneous interpretation.

## Burn Injuries

Burn injuries have a particular place within the interpretive nature of being. Burn injuries carry history and context that impact the ways in which people interpret them. Historically, men and women were burned at the stake as capital punishment for crimes such as heresy and witchcraft. Slaves were burned by branding to identify them as property. Modern villains in films such as Freddy Krueger are horrifically scarred from burn injuries. The modern portrayal of scarring in villains attaches it to fear and evil. These historical and contemporary meanings attached to burning or being burned, shape the way in which the public view burn injuries and the subsequent scarring.

Advances in burn care mean that more people live with the impacts of severe burn injuries than ever before (Capek et al., 2018). These injuries the lifelong sequelae are unimaginable to most people and even to many healthcare providers. Burn injuries are painful, traumatic, physiologically complex and result in lifelong physical and psychological recovery as burn survivors report having to adjust to a "new normal" (Burnett et al., 2014; Jeschke et al., 2020). Burn survivors suffer from physical changes including stiffness of burn scar that limits movement and burn scar pruritus (Burnett et al., 2014). They also experience emotional distress, anxiety, and difficulties with body image (Grieve et al., 2020). These injuries serve as everlasting reminders of traumatic events and their changed perspective and perceived place in the world.

Modern hermeneutic philosopher Richard Kearney (2015) offers a way of understanding burn injuries in a particular interpretive light. “Flesh is open-hearted; it is where we experience our greatest vulnerability. It is the site where we are most keenly attentive to wounds and scars, to preconscious memories and traumas, as even our navel reminds us” (Kearney, 2015, p. 105). He argues that hermeneutics begins in the flesh, in our skin, in our embodied being. He also asserts that it is interpretation of flesh that is what first allows us to differentiate between ourselves and others. Our skin is a medium through which we interpret and are interpreted in the world. The skin is an organ through which we interact through sensation of temperature, of pain, of touch, and of being touched. Our skin is an intrinsic element of how we interpret the world. Therefore, the appearance and function of our skin provides an instrument from which we interpret ourselves and others.

Burn injuries cause permanent change in the function and appearance of skin in burn survivors. Burn wounds are typically classified into four categories: superficial, superficial partial-thickness, deep-partial thickness, and full-thickness (Jeschke et al., 2020). Superficial and superficial partial-thickness injuries can heal without surgical treatment and usually result in no to minimal scarring. Deep-partial thickness injuries can heal without surgical intervention but may result in significant scarring with or without surgical intervention. Full-thickness injuries require surgical intervention to heal. The standard treatment for deep-partial thickness and full-thickness burn wounds is early wound debridement and autologous split-thickness skin grafting. Even though autologous grafting achieves wound healing, it results in permanently dysfunctional skin (Burnett et al., 2014; Jeschke et al., 2020). Burned skin replaced with a skin graft becomes

thickened and tight. The skin has irregular sensation such as sensory loss and temperature sensitivity (Holavanahalli et al., 2010). Burn survivors also report long term itching at their grafts and scars (Holavanahalli et al., 2010). If we follow Kearney's assertions that our skin is intrinsic to our interpretations and interactions with the world, burn injuries permanently change the way survivors sense and interact with their worlds (Burnett et al., 2014; Holavanahalli et al., 2010)

As Kearney (2015) writes: "It is my flesh that inserts me – body and soul – into the flesh world" (p. 110). Therefore, when the flesh is forever altered, one never fits their previous life and world quite the same. Burn survivors must adjust to a "new normal" post-injury and may find that they see their place in the "flesh world" differently as they return to pre-injury social and cultural contexts, and furthermore, others may see them differently (Burnett et al., 2014). This experience of the "new normal" speaks to the interpretive nature of our lives. The contextualised change in a burn survivor's viewpoint mirrors the ongoing search for meaning at the core of hermeneutic philosophy, and interpretive practice. Here, burn survivors are forced into reconceptualizing their identities and their lives and achieve the seemingly insurmountable task of making sense of the meaning of their injuries.

## Burn Nursing as an Interpretive Practice

Like the interpretive nature of burn injuries, nurses caring for burn patients engage in interpretive practice daily. I will demonstrate this with an example from my nursing practice. I believe several parts of this story have something to add to the conversation of the interpretive nature of burn nursing practice.

*When I first started working in burns, I felt that every time I came home, I smelt like the burnt flesh I had provided wound care on that day. I was surprised at what a human being could survive and could hardly fathom how people continued in their lives after such significant injuries. Over time, I stopped noticing the smell of burnt and raw flesh, but I never got used to the resiliency of the patients for whom I cared.*

*Still early in my nursing career on the burn unit but with gained familiarity of the patient population, I had a patient who had suffered severe burns from an automobile accident while working as a truck driver. He was middle-aged and had a wife and young children. His burn injury occurred over more than 70 percent of his total body surface area. After several months in intensive care, he was transferred to the burn unit, where he stayed for even longer. Over these months, I grew to build a strong working relationship with him and his wife. This was not the first patient I had cared for who had suffered such significant injuries, so I was somewhat familiar with what to expect.*

*This story takes place after one of the many surgeries this patient had undergone. He returned to the unit from the post-anesthetic recovery room to my care in the burn unit. I could see he was distressed. In the preceding hours, skin grafting surgery was performed in which he had a thin layer of skin shaved off both thighs and moved to his arms where it was now held in place by several hundred staples.*

*As part of his initial assessment, I recorded his vital signs, the first basic skill I learned in nursing school. Only I did not ask him to rate his pain as the vital signs flowsheet I would later have to complete would ask me to do. It was unnecessary. I knew his pain was "a ten out of ten" because I had seen him there before. The last time I saw him this way, it was during a 3-hour wound care session where myself and three other healthcare providers changed dressings on all four of his limbs and his back. His back at that time, was raw flesh. His pain during that wound care was seemingly impossible to control while maintaining any reasonable respiratory drive. After that shift, I cried for several hours over his suffering. By his next dressing change we were able to advocate for procedural sedation so that never happened again.*

*After this surgical procedure, his entire body shook as he said nothing to me. He looked at me with tears welling in his eyes, the same look I had seen before during his wound care I described before. His wife was in the corner of the room, looking at me with what I read as a similar sense of desperation for someone to help him.*

*I quickly reviewed my medication orders and considered his current vital signs. His heart rate was very high; most other vitals fell within normal ranges. I gave him the maximum dose of narcotic and every other adjuvant pain treatment I had on order, at doses one would not give to the average post-surgical patient, but I knew I could safely give to my patient because I had given him far more than that in the past. I also knew that it would not be enough, but it would not get us anywhere if I called the surgical resident responsible for his orders without trying with what I already had. Surely, what I could give in his order set was not even close to what would be needed to control his pain. Now I could demonstrate that to plead my case to the surgical resident, I called to advocate for more options and higher doses with eventual success. While waiting for the new medications to have an effect, I just sat with him. His wife sat in the corner of the room, and I sat next to him, my hand resting gently on his dressing-wrapped arm, exchanging eye contact with each other while we waited. I had done all that I could at that moment. He and his wife knew that, as I had kept them updated on everything I was doing to try help him. In the meantime, I sat with them in the pain. His pain from his raw skin and exposed nerve endings, her pain of watching her husband suffer, and my frustration of not being able to do more. His pain eventually decreased to a level that was bearable enough to rest after what was probably ninety minutes. It felt like a lifetime. He finally settled. His breathing relaxed, the distress in his eyes dissipated and he drifted into rest. His wife, who rarely spoke more than a few words, surprised me as she quickly shuffled across the room and wrapped her arms around me. "His pain is better when you are here," she said.*

Now, I do not share that story to show that I am a special nurse with the power to decrease pain with my mere presence. I share it as a single example to demonstrate the complexity of burn nursing that requires interpretation within context, with particular patients, at particular times. Firstly, his heart rate may have warranted serious concern for an arrhythmia in a different context. However, his tachycardia was a result of severe pain and persistent hypermetabolism following large burn injury. Because I knew this from experience with other patients and my experience with him, his tachycardia did not warrant concern where it might have otherwise.

Secondly, my experience in communicating with surgical residents told me that I needed to try with what I had first before I could convince them to give me more to work with. I often think of

why I would have had to prove this. Sometimes I have thought it is because maybe the physicians think they know better than the nurses. However, when I conceptualize it now, as I understand nursing practice to be interpretive, so is medicine. My experience as his nurse and knowledge of analgesic dosing allowed me to interpret his pain as beyond the capacity of the available drugs to manage. The surgical resident that happened to be on call that week was not equipped with this knowledge and therefore lacked the ability to anticipate the patients need. So the resident required more evidence before providing more drug orders for the patient. My interpretation was personal experience based on past knowledge. I had more "data" to work with. The resident was working with only current information to be supplemented by future report of the affects. I had not just pain ratings or medical history but also a relationship with the patient through which I understood the needs differently. This was the kind of knowing that allowed me to interpret his needs based on a few seconds of eye contact.

Interpretive practice occurs in partly transparent layers, one layer on top of the other to form a final picture of a particular patient in a particular time. Knowledge of pathophysiology and pharmacology which forms the basis of nursing knowledge sits as a foundational layer. Knowledge of the healthcare system and of roles and responsibilities of interdisciplinary healthcare providers and the navigation of those relationships is cultivated through experience and layers onto the foundation. Finally, the fundamental and existential kind of interpretation of a human experience formed through history, context, and relationship opens a layer which the picture could not be complete without.

When I chose to sit with my patient, I did not do it because he asked me to or because I or others had done that before. What I really wanted to do as an act of self-protection was leave the room because to be witness to that kind of pain is exhausting. Nevertheless, instead of what I wanted to do, I sat with him and his wife in the pain. To me, the only thing that seemed worse than being in the kind of pain he and his wife were in was to feel that way and feel alone. In that moment I offered him and his wife that which nurses are often known for – compassion. The etymological root of compassion is "com," meaning "with," and "passion," meaning "to suffer" (Compassion, n.d.). There I sat, suffering with him. In reflection now, I can see that I did that because it is what my mother would have done for me when there was nothing else left to be done. Here, I can see where my history of suffering affected my interpretation of what this patient and his wife needed.

## Conclusion

I added and removed, wrote, and re-wrote several sections to this paper, trying to describe how nursing is interpretive. Something I know it to be inherently true but it is harder to describe than I imagined when I started to write. When I used to describe to people why I wanted to be a nurse, perhaps rather than a physician, I described wanting to have time to be with the people I was caring for, knowing them in some way more than knowing their diagnoses and the appropriate treatment protocols. Treating the human body as a series of biological processes interacting together to form processes would never be enough for me. Now, this is not to say that practicing medicine is not interpretive. However, my early experiences with neurosurgeons and geneticists told me that physicians did not have time for the kinds of things that make people who they are beyond their health. Things like history, context, and emotions that play into people's health experiences. The kinds of things that allow you to see yourself in another and, in that recognition,

understand something new about them and, maybe, about yourself. This is the kind of knowing that is built in relationships and experiences seems inherently human, and critical to individualised care.

In this paper, I have offered a brief discussion of how burnsnursing is an interpretive practice. I have given an example of a story from practice to demonstrate the interpretive nature of burn nursing. Although nurses deal with the world of science and often objective goals for health, we consistently use our history and experience to interpret our work and the history and context of the person for whom we care. Moreover, using Kearney's insights into flesh as a medium of interpretation, I have suggested that burn injuries themselves should be understood as an interpretive event, forcing burn patients to reinterpret their interactions in the world. All nursing is an interpretive practice because being human in interaction with the world is interpretive. Burn nursing presents an especially deep instance of nurses needing to recognize the work of (re)interpretation that patients undergo.

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