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Author
Raia, Federica

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The temporality of Becoming: Care as an Activity to Support the Being and Becoming of the Other

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What does it mean to care for a person who has lost a sense of herself, a sense of meaningfulness and purpose and finds herself catapulted into a new world that is unfamiliar? Medical practitioners confront this complex and important question in the practice of high-tech medicine such as Advanced Heart Failure (AdHF) care practice where patients with malfunctioning hearts are possible candidates for heart transplantation or wearable mechanical circulatory support devices (e.g., a Total-Artificial-Heart).

The situation facing the patient, in this case, can best be understood by imagining that you have just woken up from a difficult operation on your heart. You are heavily sedated. It will take some time before you can recall that your heart had begun to fail catastrophically and that you agreed to an emergency operation to provide you with a mechanical heart pump. Now your heart is attached to or entirely substituted by a machine connected to a computer through two bulky tubes that protrude from your belly. The familiar, reassuring, yet unobtrusive rhythm of your heart synchronized with your mood and emotions is now replaced by a mechanical, pressing, intrusive rhythm. The machine's mechanical rhythm is impossible to ignore– too constant, too monotonous; it bears no relation to your mood and emotional state. You are told that you *must* move *now*, get out of bed, walk, but you are scared, it doesn't feel right to move with the machine attached to you, half inside and half outside your body. What if something goes wrong, what if the tubes get detached or tear your skin during an involuntary movement?

You lie there and wonder what kind of life you have been thrown into. Will you live with this machine for the rest of your life? It's unthinkable. In fact, it is unclear what sort of life would be thinkable. You are trapped in an agonizing present with no sense of a future and million leagues away from your life as you knew it.

How to care for you, to help you in a journey that shakes your understanding, your perception, your way of being with yourself and with others in this world? While for the reader, new to the AdHF world, patients' experiences are unknown and difficult to imagine, research on caring for AdHF patients shows that an understanding of patients' experiences is part of AdHF professional knowledge (Raia, 2018; Raia & Deng, 2015; Sharp, 2006). Ethnographic work on caring for AdHF patients points to the ideological contradictions emerging from the competing needs to –on one hand– personalize care for the patient as a whole person and –on the other hand–to objectify bodies and organs (Sharp, 1995). This research demonstrates the struggle it takes to care for patients who are living at the tension between losing their diseased heart—which despite malfunctioning is still rife with symbolic significance—and replacing it with a donor heart and/or a mechanical circulatory support device that patients regard as an intrusion into, an addition to, or a replacement of, one's self (Fox & Swazey, 1974; Haddow, 2005; Lock, 2002; Raia & Deng, 2015; Sharp, 2006; Shildrick et al., 2009).

In this article, I make visible the practice of *care* through the analysis of the moment-to-moment interactions between a patient and a doctor in the AdHF practice in an Academic Medical Center. I expand Heidegger's ontological understanding of *being-in-the-world* (1962) and develop *relational ontology* theory to study the practice of *caring–for-the-Other* who needs to develop a new sense of *being-in-the-world.*

In the following five sections, I first review some of the literature related to care from different disciplinary perspectives that help frame mine. I then describe the meaning of Heidegger's existential temporal-horizon to address care as an ontological question and how it may help in understanding caring practices. Then, consistent with the phenomenological tradition (Dreyfus & Dreyfus, 1988; Heidegger, 1962; Merleau-Ponty, 1962), I ground

relational ontology in the study of how care manifests in moment-to-moment interactions, showing it's dialogic character (Bakhtin, 1981). Specifically, after describing the research model, I present a sequence of talk-in-interaction during an entire medical encounter between a patient and his AdHF doctor and show the emergence of a dialogic pattern of care to help the patient develop a meaningful sense of his new life. I then discuss the relational ontological analytical framing, its' importance in studying practices of supporting the Other, and its implications for research of social interactions, and for sociocultural theories.

Disciplinary Perspectives of Care

Care has been examined from a variety of disciplinary perspectives that influence how care is viewed, studied, and situated within the scholarly discourses and practical care settings (Buch, 2015). In the embodied practices of talk-in-interaction, Goodwin & Cekaite (2018) studied the establishment and negotiation of intimate social relationships in the family. They highlight care as an intimate haptic sociality between parent and child using touch during family activities of grooming, reconciliation, apology, play, and comforting.

Noddings (2013) pproaches care as a moral and an ethical stance in the dyadic practice of teaching, a position adopted by a carer, the teacher toward the cared-for, the student. Anchored in ethics work, Kleinman (2009) argues that care is a moral practice of "empathic imagination, responsibility, witnessing, and solidarity with those in great need [...] that makes caregivers, and at times even the care-receivers, more present and thereby fully human" (p. 293).

Drawing from Science and Technology Studies and also with an ethics focus, Mol's (2008) ethnography of living with chronic illness expands the carer/cared-for relationship and points to care as shared work enacted in everyday materially heterogeneous practices involving

professionals, patients, their families, as well as technologies and all sorts of material elements.

In Heidegger's philosophy (1962), Care [Sorge] takes an ontological meaning. He considers acts of care as manifestations of the most fundamental way of being who we are: "In everyday terms, we understand ourselves and our existence by way of the activities we pursue and the things we care for" (1988, p. 159). He conceptualizes Care as an existential understanding of what matters to us such that we can be who we are. It is an existential positioning that is manifested in every moment in our way of being, of acting and of meaning making given by a cohesive sense of a person's past and future possibilities of always being *this person*.

Heidegger's fundamental ontology is of particular interest to me because in recording AdHF care practices, I have the possibility of analyzing pragmatic manifestations of caring for a person with AdHF who has lost a sense of self, a sense of meaningfulness and purpose. This loss can be interpreted, through Heidegger's philosophical lens, as the breakdown of such existential positioning, as a fragmentation of the cohesive sense of past and future possibilities of being *this person*.

The Ontological Meaning of Care and How it May Help us Understand Caring Practices

My point of departure situates care as an activity in a framework that I call relational ontology. I build this framework by extending Heidegger's temporal structure of care. I combine it with Bakhtin's concept of eventness (Bakhtin, 1993) –understanding and marking narrated life events as cornerstones in a person's life– and focus on encountering the *Other* in situations of asymmetrical power and knowledge distribution. In this framework, to *Care-for-*

the-Other means supporting this person to develop a new sense of self and a meaningful sense of life in the process of *becoming this* person, herself.

The Existential–Temporal–Horizon of Care

Heidegger conceptualizes Care as an existential understanding of who we are, emerging from the non-linear relations of existential time dimensions of *past, present,* and *future* as lived experience (Blattner, 2005; Dreyfus, 1991). Existential time, as illustrated in Figure 1, is non-linear.

[Figure 1]

A linear organization of time would see the past as having causal influence over the action of the present and the present over future action. But as shown in Figure 1, in an existential temporal horizon the present way of being in the world, what Heidegger calls "being-amidst," is organized by the past of being already socialized into, and already attuned to, shared accumulated practices (being-already-in) and by the future of being always pressing into possibilities of being *this person*[1].

Breakdown of the Existential–Temporal–Horizon

The death of a loved one is a clear example of what it means to be within an existential-temporal-horizon and to suffer its breakdown. If my loved one dies, my possibilities for the

[1] As Blattner (2005) discusses: "Dasein's [a person's] originary past is its attunements, the way things already matter to it. I am always already "thrown" into the world and into my life, because I am always attuned to the way it matters to me. These attunements are the "drag" that situates and concretizes the "thrust" of my projection [into possibilities] " (p. 315) of being this person.

future that have been built on my relationship with this person change. This person has been part of my life (past) and has shaped my sensibilities to things and the world. This person is part of my future of being me with this person. Anything I do (present) has this existential temporal understanding in my everyday life, including desiring to have dinner with this person every day and organizing my work life in a manner that allows me to spend time with this person. This person has been part of my life (past) and has shaped my sensibilities to things and the world. This person is part of my future of being me with this person. Anything I do (present) has this existential temporal understanding in my everyday life, including desiring to have dinner with this person every day and organizing my work life in a manner that allows me to spend time with this person. If I lose this person, I need to make sense of my life, in the "here and now," differently because my future of being me with this person is gone. My activities and actions change. For example, while spontaneously I tend to organize my day to have dinner with my loved one or to call this person to share something important to me, I have to learn not to do it any longer. I feel and act as if a part of me is gone. In this example, our relationality has been drastically and dramatically changed by the death of the loved one. Changes in temporal-horizon modify one's sense of being in the world and of the meaning-making actions one takes in the present (e.g., where pragmatic actions take place, or the "here and now" of being engaged in activities).

For a patient in AdHF waking up with the heart attached to or entirely substituted by a machine, means being connected to an outside computer through two bulky tubes protruding from the belly. Attending to any action with a mechanical heart pump or transplanted heart opens unfamiliar territories not yet embedded in the meaningful and familiar relational web where a person can recognize herself (Raia & Deng, 2015). In these situations, the relationality

of being-in-the-world has been changed by the tools mediating the person's life experience (Cole & Wertsch, 1996). The machine modifies the bodily perception of being in the world (Merleau-Ponty, 1962) because it opens hybrid spaces of existence located both inside and outside of one's body and suddenly thrusts a mediating tool into the person's life. An unrecognizable, medically designed, obtrusive object that the person cannot attune to in her/his already familiar world, disrupts the sense of self and meaning in the world. The ethnographic finding (Sharp, 2006; Shildrick, et al, 2009) that patients' and families' biographical accounts are punctuated by life events before and after the machine implantation/heart transplantation can be understood as moments of breakdown of their existential–temporal–horizon. In the context of caring for the Other, it is important to see if and how these breakdowns are recognized in medical encounters by the healthcare providers.

Existential-Temporal-Horizon: Eventful Events

Bakhtin extends the temporal horizon, shown in Figure 1, to understanding dialogic interactions when co-narrating life events. He argues (1981; 1993) that understanding narrated social events requires both understanding speakers' and listeners' contemporary and socio-historical positioning and the past, present, and future linguistic context. Crucially, Bakhtin points toward a temporality that must be understood as existential, because, conversational narratives "cannot be transcribed in theoretical terms in such a way that it will not lose the very sense of its eventness" (1993, p. 30–31). When discourse simply actualizes what happened, events lack *eventness* that gives that "surplus" to the meaning of the event, going beyond a predictable consequence of earlier events, and creating the foundation of experiencing the meaning of who we are, of who we are becoming, of our attuning to situations and life

(Mattingly, 1998; Morson, 1996). Here, I show that this "surplus" is given by the non-linear existential temporal horizon shown Figure 1.

Following Morson (1996), I call such events *eventful events*. The concept of *eventful events* is particularly relevant, because AdHF medical encounters are often characterized by interlocutors co-constructing accounts of life events carefully recruited by the practitioner to help the patient reconstitute a cohesive sense of self and meaning of the world.

Making Sense of the Existential-Temporal-Horizon in Dialogical Interactions

Figure 2 represents a translation of the philosophical concepts of existential *past* and *future* organizing a horizon for understanding the present, as shown in Figure 1. It represents, at the top, the phenomenology of what manifests in the world when a person inhabits it by meaningful actions (world), visible to an audience, and therefore particularly relevant when analyzing talk-in-interaction. At the bottom, Figure 2 shows the phenomenology from the perspective of the person's sense of being oneself[2]. This perspective is often investigated by the phenomenological interviewing.

[Figure 2]

The way I confront the existential demands of being me in the present situation (bottom of Figure 2) is organized by being already socialized into shared accumulated practices which modulate the way things already matter to me (*past* in Figure 2 bottom) and by being always projected into the *future*, into *possibilities of being this person (future* in Figure 2 bottom).

In the world, my way of being me manifests itself in the meaning-making actions in the

[2] As a reviewer of this manuscript pointed out, Figure 2 could be misinterpreted as a double structure creating an improper dualism (person-social world dualism); however, this is not my intent. The perspective of the person's sense of being "oneself" is not a mentalistic or psychological concept; it is the phenomenological perspective, a person's sense of being-in-the-world.

present situation (*present* in Figure 2 top). These actions emerge from the solicitations I respond to (*past* in Figure 2 top) and how I engage in *what intuitively makes sense to do* (*future* in Figure 2 top) for any action I take to have the potential to feel "right." These actions constitute what I am able to be (*being what I am doing*), as well as how I am able to live my life *(the way I am doing it*). Based on this most fundamental temporal structure, the world not only shows up as intelligible (thanks to familiarity with it) but as *mattering* to me, which allows with my emotional investment in the activities. This view implies that our emotional responses and stances (e.g., joy, fear, excitement, high and low spirits, anger, surprise, guilt, pride, helplessness, expectations, hopes) are existentially tied to our structure of being.

In dialogic interactions (*world*), as Bakhtin argues (1981, 1993), the positioning of one to another speaker is the foundation for the emergence of dialogue. A speaker's utterance within narrated social events *(present* in Figure 2) is always positioned in relation to *past* utterances, as a point of view, as an attunement to what matters and as a response to anticipated utterances by other speakers. As Wortham shows (2001), what makes sense to utter for autobiographical narrators is related to the possibilities of being *this* person with *this* interlocutor. As I show below, in the meaning-making actions of talking to the physician, a patient attached to a machine manifests fragmentation of a cohesive sense of past and future possibilities of being *this* person. How the physician responds to the patient takes us back to the question I pose at the beginning of this article: what does it mean to care for a person who has lost a sense of herself, and finds herself catapulted into an unfamiliar world?

Research Model

This work is part of an on-going ethnographic and participatory research project studying the practices of teaching, learning, and patient care in the high-tech medical practices

of an AdHF program in a large US university hospital (Raia & Deng, 2015; Raia. 2018) with more than 500 hours recorded medical encounters between Healthcare Professionals (n>25) and Patients (n> 125) (IRB#11-003590).

The research model developed to study this practice (Raia & Deng, 2015) proceeds iteratively in three stages of data collection and analysis:

Stage 1: Encounter Recordings of AdHF medical encounters are longitudinally audio/videotaped for a period of 1–4 years.

Stage 2: Co-generative dialoguing (cogen session). Weekly video/audio-taped sessions with participating healthcare practitioners whose interactions were recorded in Stage 1. Together participants and researchers review participants' taped interactions to make sense of their practices and discuss the emerging elements and themes. I report here parts of these weekly audio/video reviewing sessions (cogen session) in making sense of the data.

Stage 3: An ethnomethodological informed microethnographic (Erickson, 1996; Streeck & Mehus, 2005) analysis of the practice-recordings identifies the resources used by participants to organize their conduct and reciprocal accountability. Events identified by researchers and participants in Stage 2 are transcribed utilizing some of the transcription symbols (Sacks et al., 1974) reported in Appendix 1.

Although my analysis is based on collections encompassing multiple encounters from the data corpus, here I present a "single-case analysis" and show data of the medical encounters relevant to the path of recovery over four months of one the 125 recorded patients, Mr. James (pseudonymous) who is being treated by Dr. D, one of the AdHF-cardiologists. This choice, as also Lutfey and Maynard (1998, p. 323) discuss in their work on medical encounters, is consistent with Schegloff's organization of analysis in which a range of phenomena from a

larger corpus of "talk-in-interaction are brought to bear on the analytic explication of a single fragment of talk" (1987, p. 101).

Eventful Events Pointing to a Temporal Path of Becoming

This encounter introduces us to Dr. D, who is doing his rounds in the Cardio–Thoracic Intensive Care Unit (CTICU), and Mr. James, a 31–year–old patient, who is recovering from Bi–Ventricular–Assist– Devise (BiVAD) implantation (Figure 3).

[Figure 3]

While waiting for a heart donor offer, Mr. James had suffered multiple episodes of lethal arrhythmia. An emergency surgery had to be performed to implant a BiVAD machine. Before the operation, the BiVAD was offered to Mr. James as a "bridge to heart transplantation," but the implantation of this device required the healthcare team to temporarily remove Mr. James from the active heart transplantation waiting list until he had adequately recovered from this major surgery.

It is nine days since the surgery. During a weekly audio/video reviewing (cogen) session of this encounter, Dr. D reported that when he entered the room, he noticed that Mr. James was not as loquacious and energetic as usual and looked as if he was huddled in a bed that was too big for him. Mr. James' initial response to BiVAD implantation is consistent with how Dr. D described his experiences with other patients who have been removed from the transplant waiting list: "it often provokes considerable anxiety in patients and their families for fear of not having fully recovered when the 'right' heart becomes available."

The transcript that follows is divided into temporally significant chunks of the interaction interspersed with descriptive and interpretive comments. The objective of the

analysis is to demonstrate how the physician co-creates with the patient a non-linear existential temporal horizon by pointing to eventful events. As indicated by the temporal terms associated with each text segment, the sequence starts by building a shared, yet recent, past and progressively moves toward more future-oriented discourse before it ends with the participants returning to the immediate task at hand, Dr. D's assessment of Mr. James' current state of physical health.

Recruiting Events as Eventful to Constitute a Common Past

Segment 1: PAST

10	Dr. D:	and so it' s uhm
11		an uhm an an important thing to understand
12		how you:: ehm
13		you~know~make decisions
14		(people in general)~so for example
15		how did it feel when on Friday a week ago? when (1.2)
16		it came up friday morning was when- (1.7)
17		we said let' s do
18		the high emergency status? for heart transplantation (1.4)
19		LIsting
20		a::nd maybe we have an organ coming up
21		during the weeke[nd =That was
22	Mr. James:	[ok
23	Dr. D:	also when we first met (0.7)
24	Mr. James:	Yah
25	Dr. D:	a:::nd then we say ok
26		and Dr. Howe was alread::y little skeptical
27		and said maybe hmm (0.7)
28		if anything happens we have to go ahead
29		and this was in the nIght (1.2)
30		and so (0.8)
31		then from our perspective
32		it was clear to say ok
33		we have to recommend the e:h
34		Bi-ventricular Assist Device

Dr. D points to eventful events to constitute a common *past*

Dr. D begins by pointing to the importance of learning about patients' experiences in decision-making process that resulted in Mr. James's current situation (lines 10-14) and asks Mr. James to share his experience from having been listed for high emergency transplantation (line 15-16).

This first part of Segment 1 illustrates how, in response to Mr. James' initial silence and posture, Dr. D begins organizing the medical events starting from an existential shared past. There are different possibilities for Mr. James to continue the narrative: a question for Mr. James on line 15-16 and the long[3] silences in D. D talk (line 15, 16, 18) are providing space for Mr. James to talk. Mr. James is silent. Dr. D continues. Mr. James responds in monosyllabic words (lines 22, 24). Dr. D continues by pointing to moments in Mr. James' path of becoming: (line 23) meeting his AdHF doctor for the first time, with whom Mr. James in the future will follow up as a patient for his entire life; the steps that the doctors' team has taken including presenting the affectively charged question about the disruptive option of BiVAD implantation as a bridge to transplantation in case of necessity (line 25-34); and the shared, disappointing reality of having had to offer the BiVAD rather than a heart transplant directly (line 33). These moments are pointed out in the doctor's talk marking them as important, as eventful events for his narration.

Dr. D attends to the situation at hand by organizing and sharing a coherent story that includes the emotional engagement of the team (e.g. the hope to be able to have a heart offer, line 16-21, the disappointment of having to offer a BiVAD, line 33).

Mr. James' Attunement

Segment 2 PRESENT

[3] As Gail Jefferson (1989) showed, most long silence interval durations cluster around the one second interval (0.9–1.2)

35	Mr. James:	I like this thing
36		kind of (.6)
37		it' s a little bit cumbersome
38		but it' s a:h (.5)
39		I definitely notice the energy it' s g:iving me?
40		hmm (1.0)
41		a:nd the assistance is giving me
42		so hmm definitely
43		a good. Thing

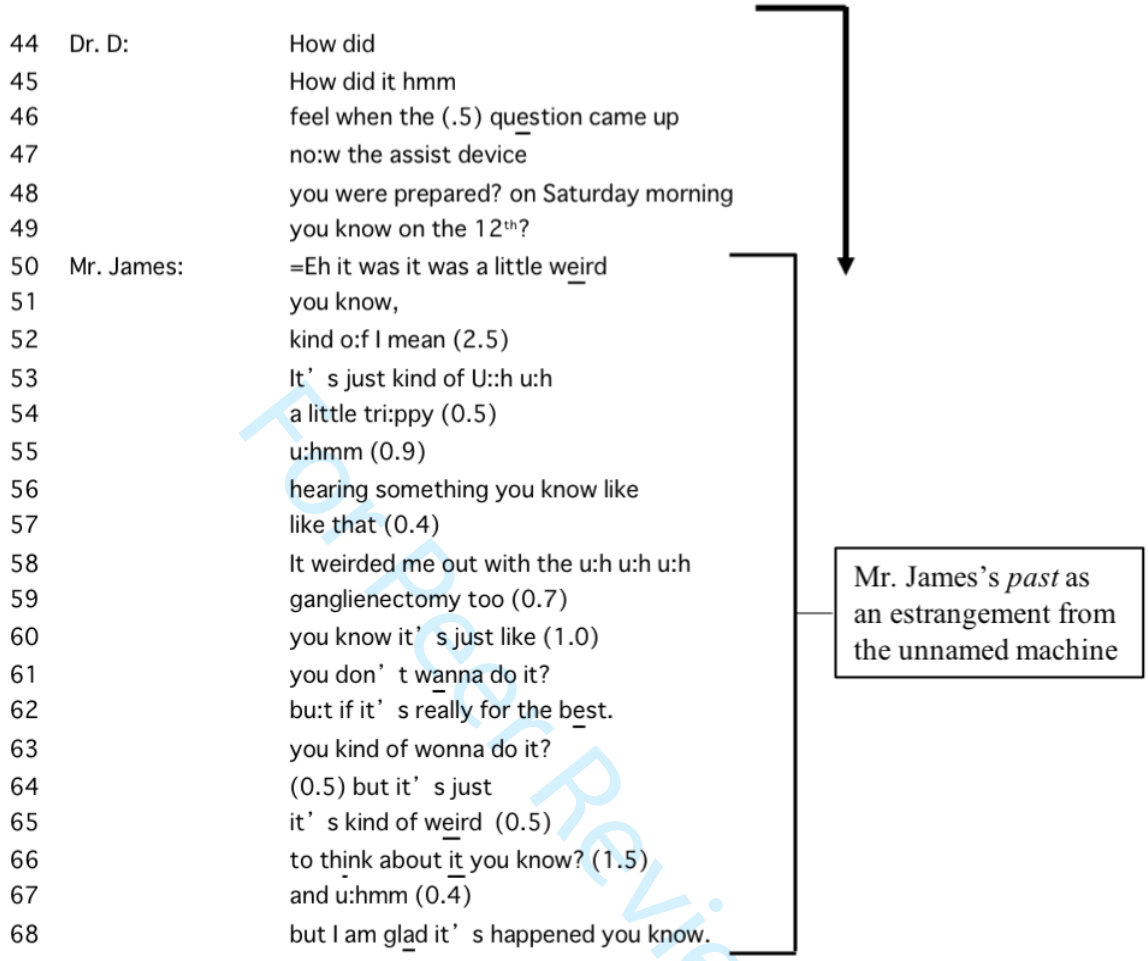
Mr. James's *present* points to an attunement to the functionality of the unnamed machine

Mr. James tentatively makes sense of the BiVAD within its own domain of existence – its functionality and efficiency (lines 35-43). His talk is full of hesitations and difficulties in naming the BiVAD, referred to as "it" (line 37, 38, 39, 42) or as "this thing" (line 35) and raising his intonation in making the assertions in line 39 as if asking a question.

The organization of sharing a personal story, a judgement or an assessment, as we see Dr. D performing in Segment 1, has shown to invite a second story (Sacks, 1995), a second assessment/judgment (M. H. Goodwin, 2006). In segment 2, Mr. James responds to Dr. D's invitation to share his experience. However, as pointed out above, this invitation has not been taken up immediately as we see Dr. D soliciting Mr. James' participation with a question and long pauses as to provide spaces for Mr. James to share his experience as an integral part of the medical encounter.

Grounding the Other in a Common Past

Segment 3: *PAST*



Similarly to what Goodwin and Goodwin (1992) show when a speaker who solicits another's participation is not successful, Dr. D produces on lines 44-45 a restart (how did/ how did uhm) that should act as a request for the recipient. But as shown in Segment 2, Mr. James has already responded to the request. What is more, Dr. D restates (lines 44-49) his opening question (Segment 1, line 15-16), making another attempt to co-constitute a shared past with Mr. James in sharing their stories. This repetition points to an unsatisfactory answer to Dr. D's request. In cogen session Dr. D commented on this interaction. He felt that Mr. James was not on a familiar life trajectory or recovery and identified this encounter as a "problematic time" for Mr. James.

In re-inviting Mr. James to share his story (line 44-49), Dr. D is attempting to move the focus from the functionality machine (line 35-43) to the experience of the person, meanwhile

not denying Mr. James's point about the functionality of the machine (line 47). In doing so, Dr. D maintains the conversational space open, as an invitation to continue building a shared narrative and Mr. James starts disclosing his experience (line 50).

It is an experiences of estrangement; Mr. James uses terms such as 'weird' (lines 50, 65), "weirded me out' (line 58), and 'trippy' (line 54). His talk is full of hesitations (line 53, 55, 58, 60) and long pauses (line 52, 55, 60). Dr. D neither interrupts Mr. James nor names the experience for him, maintaining the space open for Mr. James to develop his narrative.

A Pivotal Transformation

Segment 4: *PAST/PRESENT* Transformation

69	Dr. D:	yah (0.4)
70		yah (0.8)
71		ya:h I mean it' s uh (1.0)
72		it' s a bi:g (1.2)
73		thing.
74	Mr. James:	YES (0.9)
75	Dr. D:	a:nd
76	Mr. James:	VEry big thing

constituting a common *past* with a pivotal transformation in what it means in the *present*

When Mr. James comments that he is glad the BiVAD is keeping him alive (line 68), another tentative hint at the functionality and efficiency of the machine, Dr. D discursively transforms Mr. James's experience, turning it from "weird" and "tri:ppy" into "a bi:g thing" (Segment 4, line 73). Rather than an experience of estrangement among obtrusive things or an appeal to functionality, coping with 'big' things *becomes* an accomplishment for Mr. James.

In constituting a shared past, Dr. D and Mr. James transform "trippy" and "weird" things into big things: "YES A VERY big thing," continues Mr. James rhythmically (line 74,

76). [4]

The following segment marks a transition in the discourse. The prior discussion of the past and present transitions into a discussion of the present and the future.

Eventful Events bridging Past Present and Future

Segment 5: *PAST/PRESENT/ FUTURE Boundary*

77	Dr. D	=and it was even for us
78		we would have liked to see (1.0)
79		the heart (1.2) transplantation
80		as the single next (0.6) surgery
81		(0.9) but at the same time
82		Since no one knows how long the waiting time [is]
83	Mr. James:	[YAah
84	Dr. D:	(1.0) there was, (1.0)
85		Thi:s arrhythmia (0.4)
86		That that you ha[d
87	Mr. James:	[DEfinitely
88	Dr. D:	you were, at risk [of having
89	Mr. James:	[de:finitely
90	Dr. D:	so it was not possible
91		s[o
92	Mr. James:	[So I definitely think-I agree that
93		this was the best decision (0.7)
94	Mr. James	And uh I am very gla::d I went along with it (2.6)
95	Dr. D:	yah (0.8) ok now? (0.7)
96		You know I think now we are really in a good position
97		because the plan is clear so
98		when your parents come a little later?
99		we' ll just uh (0.7)
100		go through the (0.9)
101		kind of planning now
102		((singsong)) getting out of here? and uh
103		((singsong)) having a:: place? around
104		and hm (0.7)
105		you know the question when?
106		to start accepting heart transplant offers?
107		becomes next question
108	Mr. James	=Yeah

PAST / PRESENT transitions

Mr. James's together with Dr. D, is ready for next steps

PRESENT /FUTURE transitions

[4] Similarly, M. Goodwin and Cekaite (2018; describe a dyadically organized transformation in parent-child interactions and point to the skillful affective tenor of a directive in response to a child expressing affective opposition resulting in collaborative engagement rather than a dispute.

Dr. D expresses the shared disappointment of having to subject Mr. James to an extra major surgery and life with BiVAD rather than directly transplantation (line 77) and, while Kleinman (2009) argues that care is a moral practice involving solidarity with the Other, as discussed the literature section, we see it here as an inhabited practice of being a practitioner, a carer. Dr. D once again returns to the past anchoring in it the difficult problem of the current uncertainty about how long it would be before Mr. James could receive the heart transplant he was seeking. This time Mr. James joins into the narrative on the need for the BiVAD surgery, repeating three times the word, "definitely," (line 87, 89 and 92) but overlapping Dr. D's account with his own agreement. Mr. James's intervention becomes more pronounced from line 87 to line 89 with an elongation of the sound of the syllable "de" in definitely (lines 89). Mr. James also reuses "so" (line 92), drawing on the existing resources in the discourse, first uttered by Dr. D on lines 90 and 91, to build his contribution as a dialogic practice (Bakhtin 1993; 1981). The repetitions, overlaps, and contribution to the discourse seem to point Dr. D to Mr. James' readiness, acting as an incitement for Dr. D to move to current and future situations as shown below in Dr. D's response (line 95).

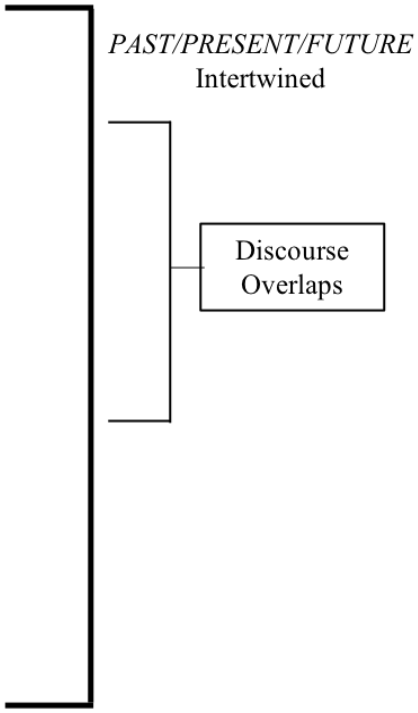
Picking up on Mr. James' shift in his understanding of the BiVAD implantation to be "the best decision" (line 93), Dr. D makes this recent event a relevant past for the present and immediate future (line 95) and begins to talk about future plans (line 97).

Mr. James' relationship with his parents, rooted in the past, plays an important part in the present-planning for the future. The future emerges in the form of short-term expectation: the parents coming to discuss plans for Mr. James' care while waiting for a heart offer (line 98) and preparing him for being on the transplant list again (line 105-107).

Mr. James Initiates a Future Projection

Segment 6*: INTERTWINING OF PRESENT, PAST, & FUTURE*

109	Dr. D:	and usually we wait
110		unti:l ehm 0.7
111		if you are well you know
112		You are kind (0.9) [(in)
113	Mr. James:	[well~I had major surgery
114		and its many weeks so
115		I definitely understand the set back there
116	Dr. D:	yah a little you know
117		a little time to: get (0.5) well [and
118	Mr. James:	[yeah
119	Dr. D:	But but but the time it takes
120		to get well is variable (0.4)
121	Mr. James:	Y[es
122	Dr. D:	[a:nd [and
123	Mr. James:	[it~varies from person to person
124	Dr. D:	=YAh
125		And you you: have been
126		since just the very beginning of this doing
127		very well getting going
128	Mr. James:	well I had a lot of encouragement (1.4)
129	Dr. D:	ya:h
130	Mr. James:	Doctors like you? a:nd the nursing staff and whatnot
131		just (0.5) makes me want to do better



Having safely initiated a projection into future possibilities for Mr. James living outside the hospital, and with his parents (line102-103), being on the heart waiting list (106-107), Dr. D now can bring in the discourse the time and efforts required to get there (line 109-112). It is a shared past, including Mr. James's accomplishments and the support of his family, a projection into the future preparing him for being on the transplant list again (line 105-107) that allows Mr. James to attune to what is meaningful for the present course of action. Although Mr. James recognizes the uncertainty that accompanies the course of his recovery and the unknown waiting time on the waiting list for heart offer as a setback (line 115), his acknowledgment of the eventful events firmly situates him in the present. Dr. D does not disregard but builds on Mr. James's reference to the setback by pointing to (a) immediate future possibilities of life outside the hospital including the uncertainty related to the time it will take him to become well

enough to qualify for a heart transplant (it takes variable amounts of time, line 119-120), and (b) his current progress (he has been doing well, lines 125-129). This move leads to a pivotal transformation for Mr. James, who for the first time initiates a future projection, "Doctors like you and the nursing staff and whatnot just makes me want to do better" (lines 130-131) what makes sense to do (Figure 2 top, *future*).

Shared Past and Projection into Future Possibilities for Making Sense of the Present

Segment 7: *COMPLETEING THE TEMPORAL HORIZON*

132	Dr. D:	Ya:h (0.6)	
133		and so: the question may come up you know?	
134		let's assume	
135		after the memorial weekend you can go home?	
136		Home, which ever place it [is	
137	Mr. James:	[yeah	
138	Dr. D:	Uhhh that we won't have too (0.5)	
139		lo[ng	*FUTURE*
140	Mr. James:	[yeah	
141	Dr. D:	And that's when we say ok (0.7)	
142		Now we can (0.6)	
143		Kind-of-go to the next step	
144	Mr. James:	Yeah	
145		definitely	
146		Yah	
147	Dr. D:	let me listen to you	*together in a shared PRESENT*
148		-when are your parents coming in	

Having built a shared past and achieved a common discourse about immediate future, Dr. D now projects Mr. James' release from the hospital to take up residence in a nearby house ("that we won't have too long"[to wait], lines 138-139). Agreed upon the trajectory of the narrative, the activity of building of a temporal-horizon of care comes to an end. The Dr. and Mr. James return to being in the present and the routine task of checking on Mr. James's heart resumes.

Caring–for–the–Other: Constituting a Temporal Path of Becoming

Throughout this medical encounter, a consistent pattern emerges. As shown in Table 1, the sequence of talk moves from past through present and future in a non-linear fashion, consistent with the process I represented in Figure 1and 2.

[Table 1]

These time dimensions are existential because they emerge from the person's experience. However, Mr. James's existential past is so far disconnected that it cannot ground him to make sense of the present engagement in local activities such as getting out of bed and walking attached to a machine in the unknown world he will need to inhabit. The grounding is created by Dr. D pointing to events, even if recent, as eventful events, with new significant relations including the healthcare team, with his doctor and with existing relations, e.g., with his parents who will also be part of his future as a person in AdHF. The physician builds with and for Mr. James an existential-temporal-horizon to make sense of a life with AdHF. Within this larger pattern, there are sequences of talk in which past, future, and present are clearly intertwined (Segment 7, line 109-131). These function as boundaries, passages from one qualitatively distinct existential time domain to another (Segment 6, line 77-108). These sequences are co-constructed, as shown in the segment in which Mr. James reuses words first uttered by Dr. D to build his contribution to the conversation (Segment 5, lines 83-96). Notably, Dr. D, while consistently pointing to eventful events to build with Mr. James an existential–temporal–horizon, only projects into future possibilities when the patient signals he is ready for the step (e.g., Segment 6, line 112-124). When both actions of grounding Mr. James in a common past and projecting him in future possibilities are in place the present actions emerge as meaningful.

To make sense of these actions, I take the phenomenon that shows up in the *world* (Figure 4), the medical encounter, as my point of departure. Figure 4 builds on Figure 2 to show the moment-to-moment interaction in the encounter.

[Figure 4]

Specifically, Figure 4 includes two segments in Table 1. The phenomenology from the perspective of the person (either Dr. D or Mr. James)retains the same sequences of Mattering, Being, and Becoming while from the perspective of the world, there is a different content to the mattering, contingent on the ongoing situated interactions. Specifically, at the beginning of the encounter (Segment 1), Dr. D's actions are organized by his attunement to what emerges as salient to him and by what makes sense to do in this specific situation and moment of the encounter. As soon as he enters the room, Dr. D attunes to Mr. James's mood, noticing Mr. James' silence and posture. His way of attending to the situation at hand is by pointing to past event as eventful events, in order to start building a shared past that opens a space for Mr. James to voice his experience as an integral part of the medical encounter (Figure 4 top). Dr. D's way of caring for Mr. James in the present moment is organized by what he feels and what he should do to be the kind of doctor he is (Figure 4 bottom). In Segments 2-4, Dr. D's actions point to a need to help Mr. James transform his attunement to what counts as important in Mr. James's path of becoming. Mr. James's attunement to the functionality of the machine is noticed as salient by the doctor, because he immediately moves to help Mr. James to focus on his past accomplishments instead.

Being able to build a solid sense of self in the unfamiliar world of AdHF is a complex process requiring the support and care of others. This is, however, only one early encounter in the process of care. Mr. James has not yet recovered from his BiVAD surgery and does not

know what it will take for him to be eligible for the transplant again. For the immediate future, he has to come to terms with living in a rented house with his parents as caregivers and wait.

Discussion

Care–for–the–Other catapulted into a new and unfamiliar world emerges in the *present* actions as support for this person to develop a new sense of self, of purpose, of mattering and a meaningful sense of the path of becoming, the process of *becoming this* person, oneself. In this context, I utilize Bakhtin's key concept of eventness (Bakhtin, 1993), understanding narrated events not as a predictable consequence of earlier events but as life events, and show that it's consistent with Heidegger's notion of temporal horizon. I interpreted the function of an utterance in relation to the physician's interactional positioning as care-giver and the patient as cared-for. I interpreted the physician's talk as engaging in an activity that helps the patient build a narrative, carefully recruiting eventful events to reconstitute for the patient a cohesive sense of self and meaning-making in the world. As summarized in Figure 5, creating a safe space for the Other to build a path of becoming requires recognizing and revealing events as salient in the Other's life and building a shared past connected to the person's life necessary to project the Other into future possibilities of existence.

[Figure 5]

Within the relational ontological framework, I make visible, in the moment–to–moment practice of care-for-the Other how the physician initiates and co-constructs an existential-temporal-horizon (Figure 5 top) with and for the patient, *a path of becoming*. As reported elsewhere (Raia, forthcoming), this pattern is co-constructed throughout the path of recovery of the patient until after transplantation four months later.

Dialogic Interactions

It is necessary at the point to call the reader's attention to Dr. Ds' position of authority as Mr. James's doctor, having the power to point to events as salient (*eventful*) and developing a path of becoming with Mr. James. As some reviewers commented, rather than a Bakhtinian dialogic, this doctor-patient interaction could be better understood by a Vygotskian dialectic, for example using the concept of the zone of proximal development. However, as Willian and Ryan (2019) discuss, the teleology implied by the idea of development, inherent in Vygotskian dialectic, needs to be understood within the institutional context. The targeted endpoint of developing a path of becoming is inherent in the practice of care but is built dialogically. The physician's account is not a biographical narration of the patient's experience. The physician points toward *possibilities* for the patient to develop *his* sense of the landscape where *his* path is unfolding, introducing a sequence of specific eventful events, as cornerstones upon which the patient can start orienting within the new existential horizon. This makes the interaction inherently dialogical. The data reveal a practice of care that, in the specificity of AdHF practice, for the patient, means the encouragement of "becoming" as learning to inhabit a new world of AdHF in which things matter, and one can orient towards Others and new ends. For the physician, this approach means the encouragement of "becoming" that gives meaning to what it means to be an AdHF practitioner and what it means to *care–for–the–Other*. It manifests as a social positioning (*world)* congruent the physician's *sense of self*, his existential positioning of what it means for him being a healthcare professional. In the relational ontological framework, care (Figure 5 top) is enacted through the creative co-constructing of a dialogue that transforms

life with a machine and an experience of estrangement into one of accomplishment, pointing Mr. James to the possibilities of a future outside the hospital.

Existential Temporality: Implication for Sociocultural Theories

The concept of existential temporality is part of Vygotsky's theory of play (Vygotsky, 1978) and Cole's notion of prolepsis (2007). In the first, when the child, confronting the existential demands of becoming, is put always in dialogue with her future. Cole uses the notion of prolepsis to make sense of how parents' expected goals for the future of their child constrain and guide their child's upbringing actions in the present. In Cole's work, the non-linearity of the process is introduced by the parents' culturally mediated imagined future for their child. Both approaches assume cultural continuity (Cole, 2007, p. 239). However, educators are facing more and more complex issues in which familial and/or cultural continuity is not a valid assumption, as it is reported in the experiences of homeless children (Tobin et al., 2018) and foster youth often moving among different foster homes and schools. In this article, I showed that to care-for-the-Other who is in need to constitute a new and integrated sense of self, a process of *learning as becoming* this person, projecting the other in future possibilities requires to ground the Other in a common existential past, to make sense of the present.

Implications for Social Interactions Research

From the perspective of research on social interactions, this work is particularly relevant because, as a researcher, I have access to the meaning-making in the world where participants' actions in local practice activities are visible. Based on the expansion of Heidegger's concept of care, I show not only participants' pragmatic actions of meaning-making in moment-to-moment

interactions, but how the existential demand of being one*self* manifests. I consequently interpret the existential *past* and *future* as the necessary dimensions organizing a horizon for understanding the present, from both meaning-making in the world participants inhabit (*world*) and from the *perspective of the person's sense of being*. However, I show also that in this existential-temporal-horizon both the *pas*t that modulates a person's sensibility to attune to what is relevant to this person– and the *future* –that modulates the sense of the possibility of being this person–organize how things show up in the world as mattering in the *present,* and what it makes sense to do for *this* person. Therefore, in understanding care as an ontological issue, I offer a perspective different from the epistemological perspective often foregrounded in talk-in-interaction investigations (e.g. Conversation Analysis). I show that inhabiting our actions and making sense of the world goes beyond an epistemological stance concerning what and how we know and what counts as knowledge of the specifics of any particular practice. It emerges from an ontological understanding of who we are and are becoming in a continuous process of making sense of the world we inhabit, learning to be who we are (Raia, 2018; Schatzki, Knorr Cetina, & von Savigny, 2005). My dialogue with an eminent scholar and a dear friend, now departed, Prof. Charles (Chuck) Goodwin on his seminal work on developing a professional vision (C. Goodwin, 1994) continues on the pages of this article and elsewhere (Raia, 2018). He showed that developing a professional vision (C. Goodwin, 1994) reveals the intricate relations of professional roles and equipment at the interactional level of pragmatic action. Through the lens of relational ontology, a professional vision is not understood uniquely as a professional epistemological understanding developed in a sociocultural and institutional context. Rather, it is also fundamentally tied to our historically and temporally situated being-in-the-world. A different understanding of being be *this person, this* kind of practitioner opens different ways in

which things matter and in which one can be and act orienting toward others and recognizable ends . It manifests not only in what we can do as members of a professional practice but also in how we do it and what is important to us (e.g., to be this teacher, this doctor, me). It is in this way that we do not arrive at a separation of our emotional responses —a disembodied sense of performing a role in the world.

Moral and Ethical Stances

In previous work (Raia, 2018), I gave an operational definition of existential spaces to identify activities (e.g., teaching/learning and patient care) in which participants manifest, develop and negotiate different identities. Caring for a learner (Raia, 2018), needs to take into account a safe development and negotiation of different existential spaces. In practices where practitioners encounter the Other in need of developing a meaningful sense of self, a moral stance, a sense of responsibility to care emerges as discussed in the literature. However, it needs to be developed by learners as a *way of being* a carer making the ethical imperative to care is a dimension of social positioning. As shown in moment–to–moment interaction (Figure 4), Dr. D operates pivotal transformations of Mr. James' experiences, disclosing them as Mr. James' achievements and grounding Mr. James in his past accomplishments and repeats his actions to help Mr. James talk about his experience. Figure 5 shows that Dr. D's actions cannot be separated from the ontological stance of what it means to be *this kind* of person, *this* doctor.

Concluding Remarks

This study examines AdHF practices of care during periods of complex medical and existential crises when a person –the patient– has been catapulted into unfamiliar circumstances

and is in need to develop a meaningful sense of self. I built on Heidegger's philosophical work on the temporal structure of care (Figure 1) and, extending it to a *relational ontological framework,* I show (Figure 2 and Figure 4) how the temporality of becoming is visible in the moment–to–moment interaction as existential demands of being one*self* in the *world.* By situating my work in the discussion of the dialogic (Bakhtin, 1981) character of everyday conversations, encountering the *Other* in asymmetrical power, needs, and knowledge distribution situations, I extend the focus from the person making sense of the *being-in-the-world* to *Caring for the Other in need to reconstitute a sense of self-in-the-world.*

Whereas in the context of this article the co-constructing the emergent dialogue stems from social and institutional positioning of the participants in interaction (Wortham, 2001), other professionals confront the complex and important question of how to *care*-for-the-Other in need to develop a new sense of self and a meaningful sense of life in a no less challenging way. For example, educators confront this issue, albeit in the specificity of each situation and community, as it is reported by youth who do not experience familial and/or cultural continuity (Miller et al., 2015); by first-generation students attending college, by immigrant and migrant youth (Suárez-Orozco, 2004). I showed that to care–for–the–Other in dialogic interaction, means building with the Other an existential–temporal–horizon: *grounding* the Other in a common existential past and *projecting* the Other into future possibilities of becoming with others. This is accomplished by pointing to events, as eventful events, in which both significant existing relations and new relations are called upon, and by recognizing the Other's action, in facing difficulties, as accomplishments. When both actions of *grounding* and *projecting* are in place the present actions can emerge as meaningful, in a process of *learning as becoming.*

References

Bakhtin, M. (1981). *The dialogic magination: Four essays* (M. Holquist, Ed.; C. Emerson & M. Holquist, Trans.). University of Texas Press.

Bakhtin, M. (1993). *Toward a philosophy of the act*. University of Texas Press.

Blattner, W. (2005). Temporality. In Hubert L. Dreyfus & M. Wrathall (Eds.), *A companion to Heidegger* (pp. 311–324). Blackwell Publishing Ltd.

Buch, E. D. (2015). Anthropology of Aging and Care. *Annual Review of Anthropology*, *44*(1), 277–293.

Cole, M. (2007). Phylogeny and cultural history in ontogeny. *Journal of Physiology*, *101*(4), 236–246.

Cole, M., & Wertsch, J. V. (1996). Beyond the Individual-Social Antinomy in Discussions of Piaget and Vygotsky. *Human Development*, *39*(5), 250–256.

Dreyfus, H. L., & Dreyfus, S. E. (1988). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York: The Free Press.

Dreyfus, Hubert L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time, division I*. MIT Press.

Erickson, F. (1996). Ethnographic microanalysis. In N. F. Hornberger & M. H. Long (Eds.), *Sociolinguistics and language teaching* (pp. 283–306). Cambridge University Press.

Fox, R. C., & Swazey, J. P. (1974). *The Courage to fail a social view of organ transplants and dialysis*. Monograph Collection.

Garcia, A. R., Pecora, P. J., & Aisenberg, E. (2012). Institutional Predictors of Developmental Outcomes Among Racially Diverse Foster Care Alumni. *The American Journal of Orthopsychiatry*, *82*(4), 573–584.

Goodwin, C. (1994). Professional Vision. *American Anthropologist*, *96*(3), 606–633.

Goodwin, C., & Goodwin, M. (1992). Assessments and the construction of context. In A. Duranti & C. Goodwin, *Rethinking context: Language as an interactive phenomenon* pp. 147–190. Cambridge University Press.

Goodwin, M. H. (2006). *The hidden life of girls: Games of stance, status, and exclusion*. Blackwell Publishing.

Goodwin, M. H., & Cekaite, A. (2018). *Embodied family choreography: Practices of control, care, and mundane creativity*. Routledge.

Haddow, G. (2005). The phenomenology of death, embodiment and organ transplantation. *Sociology of Health & Illness*, *27*(1), 92–113.

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Blackwell Publishing.

Heidegger, M. (1988). *The Basic problems of phenomenology*. Indiana University Press.

Kleinman, A. (2009). Caregiving: The odyssey of becoming more human. *The Lancet*, *373*(9660), 292–293.

Lock, M. M. (2002). *Twice dead: organ transplants and the reinvention of death*. University of California Press.

Lutfey, K., & Maynard, D. W. (1998). Bad News in Oncology: How Physician and Patient Talk About Death and Dying Without Using Those Words. *Social Psychology Quarterly*, *61*(4), 321.

Mattingly, C. (1998). *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*. Cambridge University Press.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. Routledge & Kegan Paul.

Miller, P. M., Pavlakis, A., Samartino, L., & Bourgeois, A. (2015). Brokering educational opportunity for homeless students and their families. *International Journal of Qualitative Studies in Education*, *28*(6), 730–749.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.

Morson, G. S. (1996). *Narrative and freedom: The shadows of time*. Yale University Press.

Neal, D. (2017). Academic resilience and caring adults: The experiences of former foster youth. *Children and Youth Services Review*, *79*, 242–248.

Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*. Univ of California Press.

Raia, F. (Forthcoming). *Rethinking power dynamics in globalized education contexts: Caring, learning, and becoming*. Routledge.

Raia, F. (2018). Identity, tools and existential spaces. *Learning, Culture and Social Interaction*, *19*, 74–95. h

Raia, F., & Deng, M. (2015). *Relational Medicine: Personalizing Modern Healthcare: The Practice of High-Tech Medicine as a RelationalAct*. Imperial College Press/World Scientific.

Sacks, H. (1995). *Lectures on Conversation*. Basil Blackwell.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language*, *50*(4), 696–735.

Schatzki, T. R., Knorr Cetina, K., & von Savigny, E. (2005). *The Practice turn in contemporary theory*. Routledge.

Schegloff, E. A. (1987). Analyzing Single Episodes of Interaction: An Exercise in Conversation Analysis. *Social Psychology Quarterly*, *50*(2), 101–114. JSTOR.

Sharp, L. A. (1995). Organ transplantation as a transformative experience: Anthropological insights into the restructuring of the self. *Medical Anthropology Quarterly*, *9*(3), 357–389.

Sharp, L. A. (2006). *Strange harvest: Organ transplants, denatured bodies, and the transformed self*. University of California Press.

Shildrick, M., McKeever, P., Abbey, S., Poole, J., & Ross, H. (2009). Troubling dimensions of heart transplantation. *Medical Humanities*, *35*(1), 35–38.

Streeck, J., & Mehus, S. (2005). Microethnography: The study of practices. In K. L. Fitch & R. E. Sanders (Eds.), *Handbook of language and social interaction* (pp. 381–404). Lawrence Erlbaum Associates Publishers, Mahwah, NJ.

Suárez-Orozco, C. (2004). Formulating identity in a globalized world. *Globalization: Culture and education in the new millennium*, 173–202.

Tobin, K., Bower, C., Andermann, R., & Moulton, M. (2018). *Conceptions of homeless education: The continuing importance of supporting and educating teachers* (. Social Science Research Network.

Williams, J., & Ryan, J. (2019). On the compatibility of dialogism and dialectics: The case of mathematics education and professional development. *Mind, Culture, and Activity*, *0*(0), 1–16.

Wortham, S. E. F. (2001). *Narratives in action: A strategy for research and analysis*. Teachers College Press.

Wrathall, M. (2000). Background practices, capacities, and Heideggerian disclosure. *Heidegger, coping, and cognitive science: Essays in honor of Hubert L. Dreyfus*, *2*, 93–114.

TABLES AND FIGURES

Table 1
Summary of the unfolding of a Relational Temporal Horizon in the conversation between Dr. D and Mr. James.

LINES	TEMPORAL HORIZON
10 – 34	*PAST*
35 – 43	*PRESENT*
44 –68	*PAST*
69 – 76	*PAST/PRESENT Transf.*
77 – 108	*PAST/PRESENT/FUTURE Boundary*
109-131	*PAST/PRESENT/FUTURE*
132-148	*FUTURE/ PRESENT/ Transf.*

Numbers represent lines in Transcript 1. Note the changing dynamics of the temporal horizon from past/present/future to being-in- the- present.

Figures

Figure 1. Temporal Existential Structure of Care

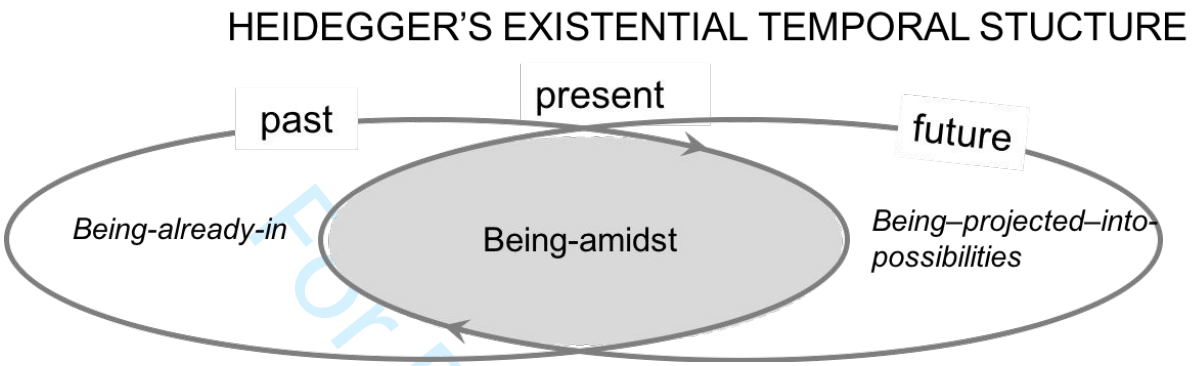


Figure 1. Care is an existential structure with a non-linear temporal horizon constituted by *Past*, *Present*, and *Future.* A non-linear understanding of time sees the way we inhabit our present life emerging from our being-already-in (being already socialized into shared accumulated practices) and from our being-projected-into-possibilities (of being ourselves). Note that I used Heidegger's wording: " the Being of Dasein [entity, e.g. a person] means: *Being-ahead-of-itself-Being-already-in*-(the-world-) as *Being-amidst* (encountering entities in the world). This Being fulfills the meaning of the title *care*, which is used purely existential-ontologically (1962 p. 192).

Figure 2. Phenomenology of the Person's Sense of Being in the World

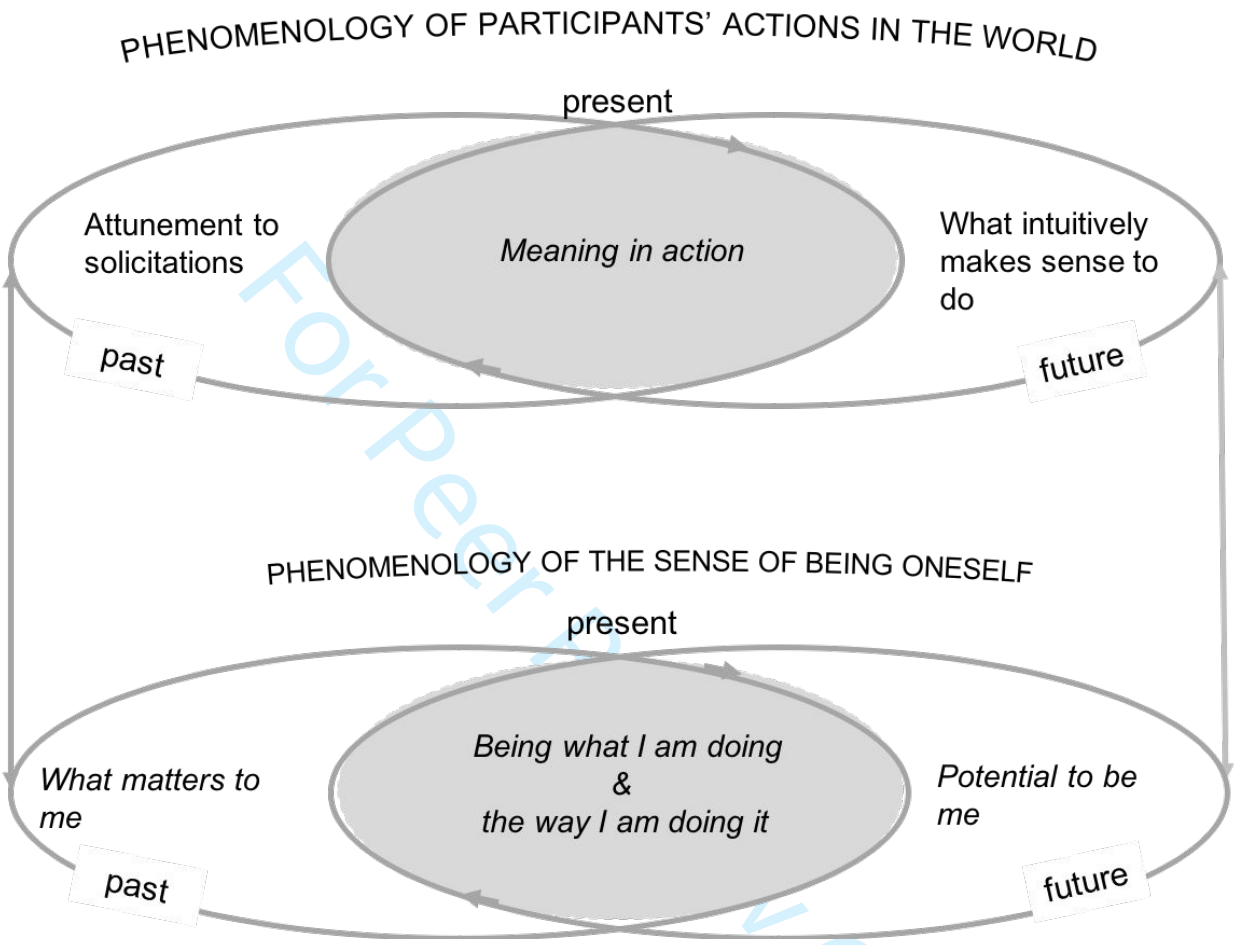


Figure 2. The bottom shows the existential temporal horizon *from the perspective of* person's sense of being- how does it feel from the perspective of the person in the world. The top shows the person's meaning making in the world (*Phenomenology of participants' actions in the world*). The *present is* shaded in grey to emphasize that it is emerging from the existential *past* and *future*. Note that what we observe as social actions of human activity (*top)* is linked to what the person's perspective (*bottom*) participating in the activity.

Figure 3. Mr. James Attached to the Biventricular Assist Device (BiVAD)

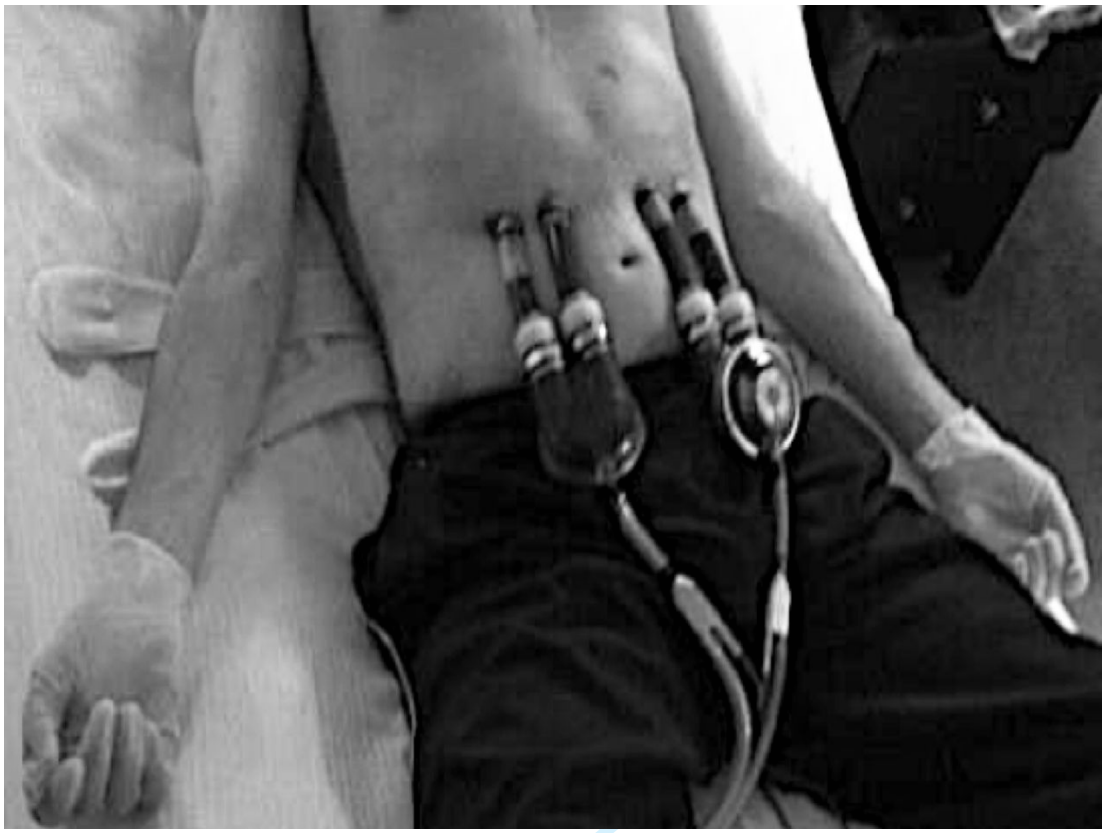


Figure 3. This mechanical circulatory support device requires an open-heart surgery to be implanted. The device helps to pump blood from the main chambers of the heart (the left and right ventricles) to the rest of the body. The part that is inserted in the patient's body is connected through a driveline out of the patient's belly to an external portable set composed of two rechargeable batteries and a small computer. Mr. James's BiVAD weighs 3 pounds (1–1.5 kilograms). The batteries have to be recharged every 2 to 4 hours. This mean that during the night Mr. James, as he reported, needs to be plugged in the electrical outlet "like a TV set." (Raia & Deng, 2015).

Figure 4. Phenomenology of the Existential Demand of Being a AdHF Doctor in Moment-to-Moment Interactions

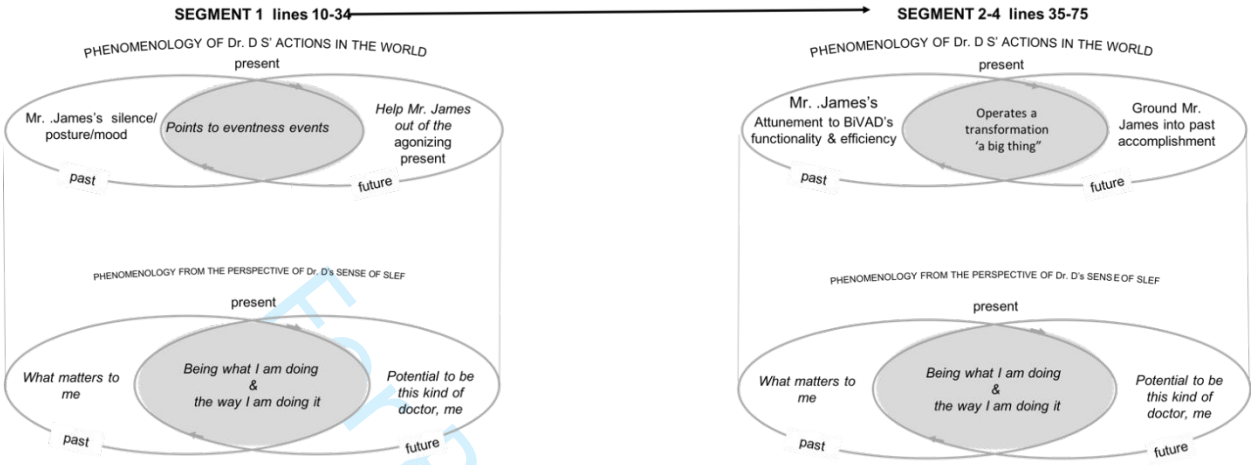


Figure 4. Dr. D's meaning making actions imbedded in the dialogic interaction with Mr. James in the present situation for segments 1 (left, top) and 2-4 of the transcripts (right, top). The present actions in segments 1 and 2-4 emerge from the solicitations the physician responds to *(past*) and what intuitively makes sense *to do* so that any action he takes has the potential to feel 'right' (*future*). The moment-to-moment (segments 1-4) utterances are not identical. However, they are related not only as a sequence of actions, but also by what it means to be an AdHF practitioner for Dr. D as an existential positioning (bottom). Note that the phenomenology from the perspective of the self (bottom) retains the sequences of Mattering, Being, and Becoming which manifest in the world (top) through different situated and sequential actions.

Figure 5. Existential Temporal Structure of Care in the Relational Ontological Framework

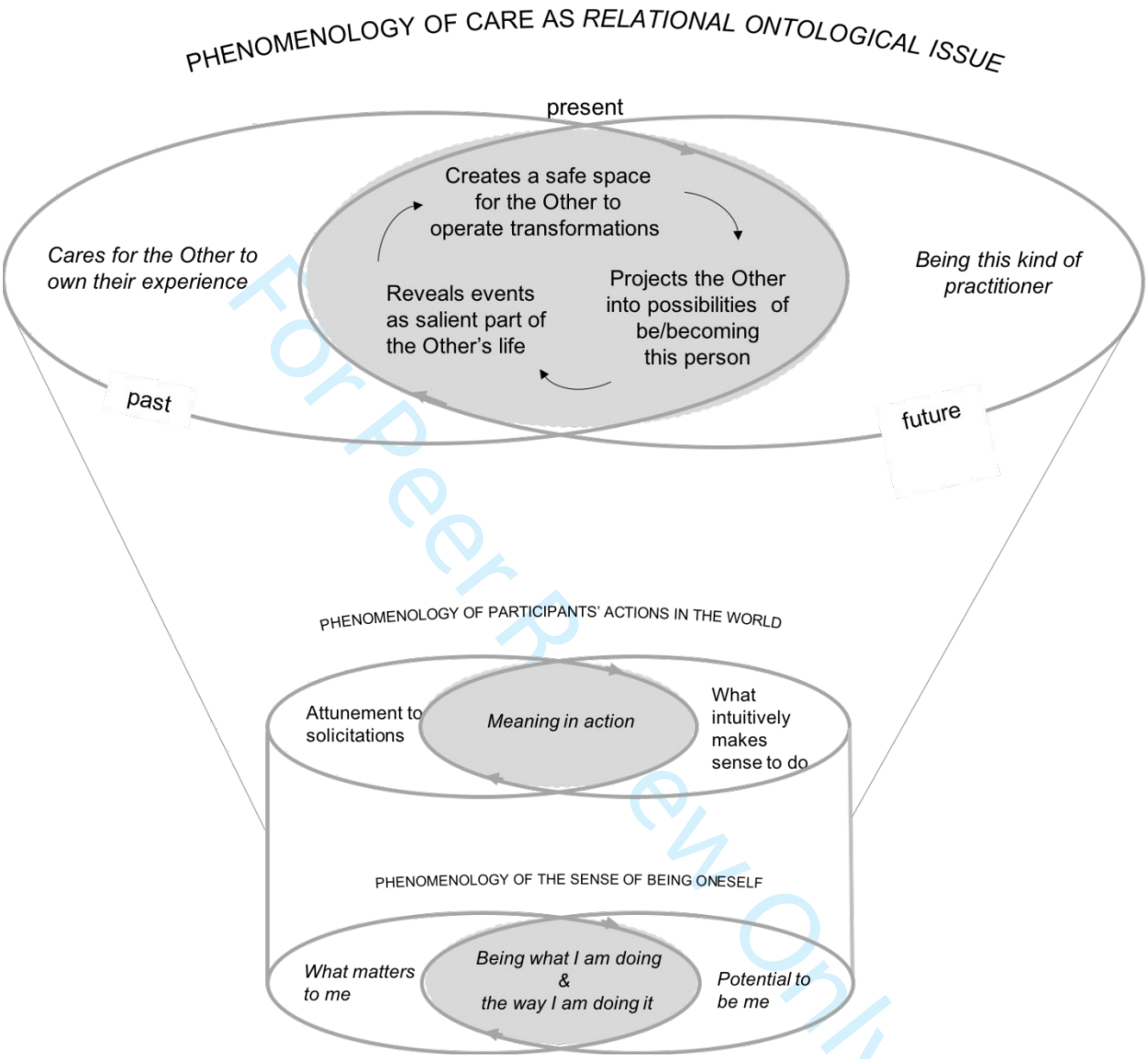


Figure 5. Care for Other (top) in need to reconstitute a sense of self-in the word, as an activity, emerges in the situated interaction between the carer (e.g. the doctor), and the cared-for, (e.g. the patient). For the physician, this approach means the encouragement of "becoming" that gives meaning to what it means to be an AdHF practitioner and what it means to care for others. Dr. D, taking a stand on supporting the *Other* to develop an identity, his own path of becoming, manifests a social positioning (world) congruent with his sense of self, his existential positioning of what it means for him being a healthcare professional.

APPENDIX A

Table A Transcript Symbols

[	Left square bracket, on two successive lines with utterance by different speakers marks the point at which the talk above is overlapped by the other talk a line below
=	Equal signs in pairs indicates that there is no discernable silence between the end of the first and the start of the next utterance, the first is '*latched*' to the following
(0.5)	Number in parentheses indicate silence in seconds
:	Colons indicates that the sound that immediately precedes the colon has been sensibly prolonged or stretched
word	Underlining indicates some kind of stress or emphasis
(( ))	Double parentheses enclose comment by the transcriber
ha	Indicates Laughter for each utterance

(Sacks, Schegloff, & Jefferson, 1974)

The notational conventions for transcribing talk reported here were developed by Harvey Sacks, Emanuel Schegloff, and Gail Jefferson (1974) who conducted detailed studies of the way people use language in everyday life, developing methods and notational conventions for transcribing talk.