The Face to Face is Not so Innocent:
Into Interpersonal Spaces of Maternal-Infant Care

by

Helen Jean Brown
B.N., Dalhousie University, 1988
M.S.N., University of British Columbia, 1997

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SUPERVISORY COMMITTEE

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ABSTRACT

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This qualitative inquiry sought to explore how relationships are experienced in every day moments of care provided to childbearing women, infants, and families. Fifteen health care providers and thirteen childbearing women were interviewed regarding the degree to which these relationships have impacts on women's health capacities and outcomes of care. These experiences were examined within the context of the broader social and cultural contexts of maternal-infant care.

All twenty eight participants in the study were involved with an antenatal home care program and a neonatal intensive care unit within the Lower Mainland Health Authority in British Columbia. The epistemological and methodological approach to the study combined relational and pragmatist perspectives on knowledge and a deconstructionist hermeneutic lens. Findings indicate that participants' experiences are created in each moment of interpersonal care, and the interactions between health care providers and child-bearing women are far from neutral in terms of their impact on women's health capacities and outcomes of care. Clear distinctions in perspectives among the two groups emerged: the child-bearing women dismissed the use of the term 'relationship' in describing their experiences with health care providers. In contrast, health care providers spoke of their assumption that the basis of engagement was a supportive relationship, the primary vehicle through which neutral and impartial health care is provided. The findings detail that relationships are sites of meaningful experiences

and can facilitate as well as constrain women's agency and self-worth; some of these experiences jeopardized the women's health capacities and outcomes of care as they endured health challenges in pregnancy and as they mothered their ill infants.

Although health care providers and childbearing women drew upon different discursive resources and features of two program contexts, a similar construction of knowledge and experience was evident within participants' accounts. Whereas health care providers tended to speak with the grain of instrumental and sentimental discourses through a veil of neutrality, the child-bearing women spoke against the grain by resisting the notion that interpersonal spaces are necessarily sites of one-on-one individual interaction. Rather, the data suggests that interpersonal spaces are not *individualized* spaces. Experiences of relationship were broadly situated and shaped through the relational complexity of each moment of the interpersonal, where the cultural 'scenes' of maternal-infant care shaped relationships and constructed the women's health capacities and outcomes of care. In this way, *the face to face is not so innocent*.

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I gratefully acknowledge the health care provider participants who allowed me to walk beside them in their daily work, willing to have me inquire into the complexities of their practice. The work was made more difficult and richer because of the nurses who gathered together to understand how to turn around and enhance their care to women -- they embodied the courage, heart and intellect of researchers and practitioners. The work is also in honour of the women participants who shared their struggles in honest ways to show me that the interpersonal is a site of both good and harm, and the infants of women participants who engaged with me in knowing ways.

This work also embodies the support of academic mentors, family, colleagues and friends who together made the space for hard questions, celebration, frustration and the necessary capacity to close the study. Albeit in different ways, all of the people who provided direct or indirect support confirm that being 'in-relation' is simultaneously about living and researching the questions that draw our attention and guide us to take action on the world.

It is also with deep appreciation that I acknowledge:

Andrew, Frances and Ben – who always believe and are the source of it all;

My mother, father and sisters -- whose lives and hearts continue to inspire;

Gweneth -- who shines in her ability to be and know 'in-relation' and exemplifies how academic work and nursing are creative and skillful acts;

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Gladys, Karen, Bernie & Sheila -- for their friendship, their practical and intellectual support in this project, and their inspirational passion as nurses.

DEDICATION

In memory of Tanner Douglas Brown MacDonald (1996-1997) whose brief earthly presence created life, tenderness, insight, and a politic of human relation.

CHAPTER 1: SITUATING RESEARCH INTO EXPERIENCES OF HEALTH CARE RELATIONSHIPS IN NURSING PRACTICE

Where the Research Begins

Born with cleft palate
Facial deformity,
Newborn baby girl
Lays in her bassinette

"How bad will she look?"
Her parents ask.
She is otherwise 'perfect'
Lays in her bassinette

Noticing, feeling worried
No cuddles, very few visits
Fed by oral gavage
Lays in her bassinette

Judged as "hard to love"
Is she cuddled less? By us?
Heavens no…heavens yes
Lays in her bassinette

I wrote this poem in 1999 to examine the connection between the nurses' comments about a baby being 'hard to love' and the impacts on this infant girl and her family. It is offered here to illustrate how my research questions are revealed within a practice context. Providing nursing care to this infant who had a craniofacial abnormality draws attention to how nurses', infants', and families' experiences and actions are shaped by dominant social values regarding physical appearance and judgments about 'love-ability'. My experience has been that much nursing theory, research, and practice ideologically and epistemologically turns social issues into individual problems. Such an individualist analysis obscures the fact that women's experiences of pregnancy and mothering (and indeed any patients' experiences) are mediated and sanctioned through dominant ideological forces and gender inequities associated with the social, economic, and political conditions as they are manifested in women's reproductive lives (Benoit,

Carroll, & Westfall, 2007; Campbell & Porter, 1997; de Bessa, 2006; De Koninck, 1998; Stein & Inhorn, 2002).

These ideas about how interpersonal experiences are constructed raise questions when considering the idea of being 'hard to love'. In what ways do the context of neonatal care and the dominant values of social worth (love-ability) interact with this infant's physical appearance to constitute particular nursing care-giving practices? In other words, is there a correlation among them that explains why she was rarely cuddled and why she received oral feedings through a tube in the absence of physiological need? Is there a connection between the judgments of the nurses and her parents' infrequent visits and hesitancy to cuddle her? A few months later, after the baby had undergone surgical repair and was discharged home, I brought this question up during nursing rounds. My colleagues were shocked and direct in their response, collectively affirming that such judgments would be unethical. I agreed. I thought about this for several years, wondering about how our ways of 'relating' to infants as nurses make a difference in how we go about providing care *in* relationship with women/families, and how that care was experienced by infants and families themselves in more or less ethical and health promoting ways.

What unfolded in the story of the baby girl who was considered 'hard to love' was more than just individual nurses interacting with an individual infant and family. A complex web of relations was occurring. Upon a closer reading, it became evident that the nurses' judgments of the infant girl as 'hard to love' have a social and ideological basis reflective of dominant ideas and values in relation to an infant's physical appearance, personhood, and social worth. As social theories about labeling and stigma suggest (see Goffman, 1959), judgments cannot be theorized at the level of individual attitude nor can they be determined to be solely socially or discursively constructed. Rather, a complex relationship exists between the sociality of individuals and the particular actions, practices, and behaviors of people. My reflections articulated through the poem above draw attention to the importance of connecting social ideologies to experiences of relationship in order to consider the impacts of such experiences on the physiological and psychological health. It is this relational complexity of experiences, of

living in the world as social and contextual beings, that created the impetus for this research on health care relationships and their impacts on childbearing women's health capacities, and outcomes.

The focus of the research described in this document is experiences of health care relationships; relations that unfold or take place between health care providers and childbearing women. Although there has been considerable theoretical inquiry and research into health care relationships across diverse patient populations, health care disciplines, and particularly within nursing, my experience of being *in* relationship with women, infants, and families suggests that the interpersonal domain of care is more complex than the dominant depictions within the literature. As a practicing nurse for twenty years, and also as a patient, I have experienced how dominant practices, policies, and ideologies produce ways of relating wherein health care provider - patient relations become market transactions at the expense of meaningful and influential human interaction. Although not implicitly inconsistent, market transactions are more consistent with a commodification of health and illness than one that focuses on experiences of vulnerability and power as relevant for shaping human interaction in a health care context. For example, when cost-containment strategies privilege economic efficiency, less attention is paid to the human experience of health care 'encounters'. This research begins with my belief, grounded in my experiences, that these conditions shape patients' experiences in ways that have not been adequately scrutinized in terms of their *impacts* on the lives and wellbeing of people seeking health care services.

In my twenty years in practice, I have experienced how nurses and physicians, through their ways of being and acting in relationship with patients, have made both the intolerable tolerable and the tolerable, intolerable. For example, I have watched how compassionate and respectful care can become the 'therapy' that is helpful when medical science has nothing left to offer. I have come to understand through this research that relational experiences and their effects are not benign and discountable, both in terms of their health promoting and harm inducing effects. From my practice experience, I believe that the interpersonal context of care shapes experiences in ways that have powerful impact on childbearing women, infants, and families.

At the same time, my experiences of being amidst relationships of care only partially resonated with empirical findings in nursing theories and nursing about how to 'do' relationships. Miner-Williams (2007) echoes this reflection and states that despite all that "…is written, taught, and discussed about the NPR [nurse-patient relationship], it could be expected that nurses would be both well versed and proficient in its details…[but] there exists a need to build upon current knowledge and improve the clinical process or application of the NPR" (p. 1215). My reading of dominant theories about the interpersonal was that they were abstract and not particularly helpful for *actually enhancing practices* in the moment of relationships. I question the very epistemological assumptions that underpin longstanding aims in nursing to "apply" theoretical knowledge of relationship to health care encounters. Therefore, my orientation to this research is that my substantive questions are inseparable from my epistemological questions of the literature; in other words, what I sought to know and how such knowing would be undertaken are inextricably intertwined. This assumption of inseparability among topic, epistemology, and methodology is described in Chapters 2, 3, and 4.

Questions from Nursing Practice

As detailed above, this research begins with questions from my nursing practice. Embarking on an empirical study and comprehensive review of the literature, several conceptualizations had a significant impact on the research as it developed. First is the conceptualization of the 'patient', the 'client', and the 'family', and the recognition that terminology reflects one's politics and ideology. Throughout this research, I use the term 'patient' to refer to the individual person who receives health care. I choose the term 'patient' over 'client' as I believe that the former does not obscure the vulnerability that can be associated with the need to seek/obtain health care and the material and discursive power differentials that exist between health care providers and people seeking/receiving care. In my view, the term 'client' invokes an ideological position of health care as a marketplace, wherein freely choosing 'consumers' of care willingly become 'clients'. Further, I use the term 'family' to reflect the diverse ways in which people's lives become connected, where family 'membership' is self-defined (Wright & Leahey, 1994). Yet, families are also more than differentiated forms of people who are connected. I align

with an *understanding* of family, more so than a definition, that resonates with Hartrick Doane and Varcoe's (2005) notion that family is a "complex relational experience…a complex process where economics, emotions, context, and experience are interwoven and multilayered"(p. 43).

Second is the conceptualization of 'relationship'. The terms 'health care relationships', 'interpersonal relations', 'nurse-patient relationship' and 'interpersonal context of care' are used interchangeably in the nursing and health care literature. 'Health care relationships', a term popularized in the 1980s, refers to the specific relationships between health care providers and patients/clients and their families across diverse contexts of care. 'Interpersonal relations' was popularized by Peplau (1952); it refers to relations between individuals and continues to be used by some researchers and scholars inspired by her work (Forchuck, 1991, 1992; Forchuck et al., 1998). The term 'nurse-patient relationship' gained prominence in the 1970s as theorists and researchers developed a theoretical basis for nursing grounded in human science perspectives (to be explored more fully in the next chapter). In the context of physician practice, the terms 'provider-patient relationship' or 'clinical-patient relationship' have been prominent (Kemp White, Bonvicini, & Iwema, 2005). Collectively these terms refer to the everyday encounters between health care providers, such as nurses and physicians, and their patients/clients and families within specific contexts of care. The everyday relations between care providers and women/families were the site of this research. Importantly, however, I do not consider relationships or interpersonal relations to be the 'research problem'; rather, *experiences of relations* and their impact on women's health capacities and outcomes has been the substantive research problem under investigation.

Relationships between patients and nurses have been described as the foundation for the practice of nursing. Several studies and theoretical inquiries propose that relationships are more than central to care, "they *are* care" (Robinson, 1996, p. 153) and that the "relationship is it" for health promoting practice (Hartrick, 1997b). Several contemporary authors in the field of mental health nursing (see Miner-Williams, 2007) describe the relationship between nurses and patients as *the* therapeutic process, a "formally theorized account of practice based on a therapeutic interpersonal relationship

between nurse and client" (O'Brien, 2001, p. 132). Hartrick (2002) proposes that in all nursing contexts "…relationship operates in all situations, spontaneously weaving between people…relationship itself may be ignored or may be recognized and responded to, but it is always present and influential. Consequently, relationships can have an empowering or disempowering influence on people and health" (p. 52). Recent studies and inquiries challenge longstanding views of relationships as "neutral channels through which health care services are accessed and information imparted" (Thorne, 2002, p. 59) where the nurse-patient relationship is a 'vehicle' for care-giving (Ramos, 1992). Relationships have been proposed as a critical site for ethical care (Bergum, 2004; Donchin, 2001; MacDonald, 2001; Rodney, Brown, & Liaschenko, 2004; Varcoe, Doane et al., 2003) and are increasingly associated with care provider-defined positive patient outcomes (Beach & Inui, 2006; Duffy, 2006; Varcoe, Rodney, & McCormick, 2003). It has also been proposed that the relationship-centered nature of nursing is responsible for the connection between positive health outcomes with professional nursing (Miner-Williams, 2007).

Because research in nursing also confirms that nursing practice is facilitated and constrained by the organizational context and institutional policies (Aiken, Clarke, & Sloane, 2000; Lashinger, Finegan, & Shamian, 2001), it is reasonable to conclude that relationships between health care providers and patients are shaped by intersecting structures, practices, policies, and contextual features. And, with contemporary concern for how an economic agenda competes with - and possibly trumps - the ethical and therapeutic goals of nursing, it is critical to examine how the structures and dynamics of health care organizations are actively shaping experiences and impacts of interpersonal relations in everyday care (Corley, Minick, Elswick, & Jacobs, 2005).

Despite such prolific and important theoretical writings in nursing and the research inspired by these works, there have been fewer studies focused on *patients'* experiences of relationships and their understandings of what makes a relationship 'therapeutic'. In addition, questions about the complex contextual dynamics in which relationships are experienced and lived have received less attention than the dominant focus on individuals engaged in interpersonal relations. The research questions in this

study were constructed to build upon the longstanding commitment in nursing to the centrality of relationship as critical to the therapeutic and ethical aims of nursing (Bergum, 1994; Gadow, 1999; Rodney et al., 2004) and to expand upon research and theoretical inquiry to examine experiences of relationships for their impact on women's health capacities and outcomes of care. Explicitly claiming a relational interconnectedness among self, other, and context is the epistemological and theoretical basis for this research.

The questions I have from practice are aligned with the pragmatist critique of the Cartesian divide: the view that creates a "deep split between theory, practice and experience" (Hartrick Doane & Varcoe, 2005). In everyday moments of care, I sensed that what I knew and what I did not know became evident in practice, and that my theorizing was already 'in' practice. This weaving of theory, practice and experience directly counters the Cartesian split of knowledge development. As I reflected back on the questions from practice that brought form to this research, I could see that some of the literature on relationships was not particularly helpful as I sought to envision ways of being that could enhance care for women, infants, and families. For example, I knew trust was considered to be one 'truth' of therapeutic health care relationships, but I did not find that helpful for knowing *how* to go about facilitating trust in specific moments of care. Drawing on the notions of shared meaning, intimacy, and mutuality (Scott, 2000) when defining the "heart of the therapeutic nurse-patient relationship" (Kirk, 2007, p. 233) my questions have focused on the experiences and impacts on patients in relation to such theoretical inquiry and related empirical research. In what ways do patients experience nursing practice? To what degree do nurses' understandings of empathy and intimacy facilitate and constrain their abilities to provide care that meets the needs of patients? To what degree are capacities for intimacy, trust and understanding embodied in individuals and to what degree are they influenced by specific contexts? These are the provocations that prompted this research inquiry.

The Significance of a Relational View of Experience in Research

> The idea of an individual, the idea that there is someone to be known, separate from relationship, is simply an error. As a relationship is broken, a new one developed, there is a new person. So, we create each other and bring each other

> into being by being part of the matrix in which the other exists. We grope for a sense of a whole person who has departed in order to believe that as whole persons we remain and continue, but torn out of the continuing gestation of our meeting with one another, whoever seems to remain is thrust into a new life (Bateson, 1972, p. 149).

A relational view of experiences is grounded in a view of human *being* (ontology). Bateson (1972) claims *we create each other*; that whether we are aware of it or not, we are contextual social beings who are always in relation Historically, however, Euro-western thinking has embraced an ontology that separates humans from each other and the human from the natural world (Bateson, 1972; Strum, 1998; Thayer-Bacon, 2003). Seeing human beings and human life as relational implies that we are always in relation to something: ourselves; others; the environment; knowledge; ideas; organizations; values; politics; the past; present and future; the forces of the universe as a whole; and so on. Seeing human beings in relation to themselves and others, what they know, how they act, the objects surrounding them, and the contexts in which they live, points to the idea that our world is experienced through our relation to it.

I see 'experience' as a dynamic web of relations between people, ideas, discourses, socio-cultural norms and institutional structures that constitute the experiences of both health care providers and childbearing women. The pragmatist philosopher Dewey (1960) describes experience as the "…undivided continuous transaction or interaction between human beings and their environment" (p. 71). For Dewey, experience includes not only thought, but also feeling, doing, suffering, handling, and perceiving, and is the 'organic' intertwining of living human beings and their environments. Dewey defines experience as the continually changing context of human beings in relation to one another and in relation to their environment.

This research took its current form based on a view of experience as a phenomenological existence in the whole of peoples' lives (Hartrick Doane & Varcoe, 2005). All experience is created through self-other relations in particular context. Working to make this connection explicit in nursing, Allen and Hardin (2001) call for greater attention to context for its influence on how experience is shaped through

discourse, wherein discourse is a social practice that both reproduces and changes knowledge, social structures, identities, meaning, and social relations:

> The discourses that we can access constitute our interpretations, perceptions and interactions in the world. Over time, the discourses become internalized and act as guides – necessarily creating and shaping our identities and our experiences. These are inherited guides, not privatized maps created in our heads…these products can be conceptualized as souvenirs of socially created categories (p. 169).

A view of people as contextual social beings implies that particular relationships in health care are themselves always context-bound. The relations between the nurses and the infant girl in the poem above, for example, cannot be viewed at the level of an individual nurse and infant/family despite the fact that individuals are the site where my concerns about care are raised. There is no divide between "a 'freely acting' individual and a 'constraining society' (Williams, Cooke, & May, 1998) as various critiques of liberal individualism confirm. How nurses interacted with the infant girl cannot be reduced solely to their individual behaviors and actions because ways of being in the world are relationally constructed. A relational view of experiences explicitly examines the connection between people and their world which brings into view how particular values, practices, knowledge, health, and structures influences ways of relating to others.

Hartrick (2002) writes of a relational view of experience by using the language of "dynamic interconnectedness" (p. 56) of people, structures, knowledge, policies, norms, history, values and practices. Being able to speak of 'dynamic interconnectedness' and see the relevance of a relational view in research evolved as I came to 'know' my practice in a more complex way through graduate studies and my involvement in research. Although I have believed for a long time that relationships are a powerful site of experience for both health care providers and women, I spent considerable time as a nurse not knowing exactly *why*. It is reasonable to say that my interest in relationships evolved when I looked back to moments where my own awareness was lacking; that is, my own ignorance at times led me to see how perspectives on relationships shape how we act and provide care. For example, caring for women and infants in an acute care context often meant that I focused on getting the tasks done with little time to reflect on all that was shaping my practice. As a new neonatal nurse I focused on my own personal

proficiency and competence and found it hard to imagine that there was more than my own individual knowledge and skill operating in each moment. Although relationship was always present, my own ability to know and scrutinize this complexity was only developed through having the opportunities to read, think, reflect, contradict, critique and engage in research and inquiry more broadly Yet, as I began to deliberately 're-search' my own practice after several years of being a nurse, I became convinced that a relational view of everyday experiences of relationships could generate critical insights into optimizing ethical and health promoting care for women, infants, and families.

As the subsequent chapters illustrate, a relational view or one that focuses on the dynamic interconnected of people and contexts was more than just the substantive focus of the research (Chapter 2); it was also the ontological and epistemological ground for the research (Chapter 3) which then informed the theoretical and practical orientation to the research methodology (Chapter 4). Thus, the entire research project was grounded in the assumption that people are social and contextual beings that live in relation to others and within particular contexts; their experiences of being in the world are subsequently constructed through this interconnectedness with other persons, objects, knowledge, ideas, environments, history, values, and power, as well as other aspects of human living. In the research and in this document, the term 'relational' invokes this dynamic interconnectedness between people and contexts.

The next chapter of this thesis works from a pragmatic understanding of knowledge to position my research's aim. Bringing a pragmatist view of knowledge to research and theoretical work on relationship in nursing and childbearing women's health lays the ground for arguing for the importance of studying the experiences of women and the quality of their care from their first voice perspective. My research joins with and builds on such efforts and contributes a distinct focus on how *relational experiences have particular impacts on childbearing women's health capacities and outcomes of care.*

Research Questions and Methodology

The purpose of the research was to optimize care for childbearing women by understanding how health care providers' and women's experience of relationship impact

women's health capacities and outcomes of care. The research questions guiding the study were:

1. How are health care providers' and women's health care experiences of relationship constructed?
2. How do experiences of relationships influence childbearing women's health capacities and outcomes of care?
3. How are perspectives on knowledge, qualitative methodology, and research topic related?

The methodology for the research was developed to bring practice-based inquiries and relational understandings of human experience to the study of relationships and their impacts on childbearing women. Given that efforts to gain a complex understanding of health care providers' and women's experiences of relationships are best served by an inductive approach to inquiry, I chose a qualitative methodology for this project. And, because I was interested in how contextual features impact experiences of relationship, I selected two distinct practice sites as representing two points along the continuum of perinatal care. Fifteen health care providers and thirteen childbearing women participated in the study. Both participant groups were recruited from an antenatal program where pregnant women received care in their homes and a neonatal intensive care unit where ill premature and full-term infants and their families receive intensive care. While a quantitative approach might have offered certain perspectives on measurable aspects of human encounters and health outcomes, as is clear from my research orientation detailed above, these were not the focus of my inquiry. Rather, I wanted to hear the stories of those who have lived these relationships in order to develop an understanding of what is significant and influential within those relationships. In nursing, the inability to quantitatively measure health and illness related phenomena has led to an intense interest in using other approaches to studying human experiences and social processes (Thorne, Kirkham, & MacDonald-Emes, 1997).

As elaborated upon in Chapter 4, qualitative research focuses on the socially-constructed nature of reality, the mutually informing relationship between researcher and the researched, situational context and the value-laden processes of inquiry (Schwandt,

2000b). This approach to research seeks to understand how social experiences are created and given meaning. In the qualitative tradition, epistemological orientation takes centre stage, as method flows from one's beliefs regarding knowledge construction and knowledge validation (Alvesson & Sköldberg, 2000; Kezar, 2004). In this study, I began with the assumption that methodologies are not 'selected'; rather, they are developed according to one's view of knowledge production and its connection to inquiry into human experience. My methodological starting point was shaped by how feminist scholars such as Harding (1995) and Lather (1991) challenge the assumed political neutrality of paradigm choices: ideology plays a role in constructing that which is investigated. Thus, my starting point for methodology began in this very idea that one's politics are inseparable from methodological choices, and my research questions reflect particular assumptions about people, experience, relationships, and knowledge. The methods used for data collection subsequently evolved to include semi-structured and open-ended interviews, informal conversations, observations, researcher and participant field notes, group discussion, and other methods that participants indicated would effectively convey their experiences and perspectives.

As noted above, I began this research with the assumption that a connection likely existed among the substantive focus (research problem), a perspective on the purpose of knowledge and how it is developed, and qualitative methodology. I assumed such interconnections existed, but was unsure of the nuances of *how* they existed. I developed my methodology by drawing on the ideas of writers who were asking similar questions about such interconnections and their methodological relevance. To close this chapter and to set the stage for the next three chapters, I will describe three insights that reflect my methodological starting point.

First, postmodern critique draws attention to questions of what it means to engage in scholarly inquiry (Mourad, 1997). Postmodernism can be defined as a rejection of the 'project of modernity', which Lyotard (1979) describes as the belief that logic and intellect direct human civilization toward a progressive realization of ideal forms of human existence and understanding that are universal, knowable, and achievable through discoveries and applications. In contrast, postmodernism rejects this recipe for 'progress'

and ‘growth’, instead focusing on how many layers of context, localized ‘knowledges’, and multiple perspectives on reality shape situation-specific experiences.

Principles of postmodernism merge well with qualitative methods because of the shared acknowledgement that how one enters into research, combined with the features of one’s political, moral, and social position, shape the connection between experience and inquiry. Postmodern consciousness encourages researchers to interrogate how power, knowledge, ideologies, values, norms, and practices are enacted in everyday practice, challenging the modernist view of knowledge that separates knower from the known, selves from others, and relationships from context (Alvesson & Sköldberg, 2000; Thayer-Bacon, 2003).

Further, the writings of Michel Foucault (1980; 1984, 1994) and Richard Rorty (1989; 1999) emphasize a commitment to expanding the meanings, possibilities, and purposes of what counts as legitimate scholarly inquiry. They call into question the existence of a unified foundation of human knowledge as a basic condition of inquiry. A modernist view rests on the idea of a permanent, transcendental foundation that can be relied on as an essential condition for knowledge. How one thinks about knowledge therefore shapes how one goes about being in relation to others and their values, practices, objects, environments, policies, among other aspects of experience.

Second, I engaged in this research to produce practical knowing to solve problems (Reason & Bradbury, 2006). I undertook the study assuming that research and experience are not separate entities and set out to develop practical knowing relevant to everyday experiences of relationships in a maternal-infant care context. Such a view counters how research in the West has traditionally been viewed through a positivist worldview, a view that sees science and everyday life as separate and “…the researcher as subject within a world of separate objects” (Reason, 2000, p. 5). My methodological aim was not to search for ‘truth’, but to construct knowledge about how experiences of relationships influence women’s health capacities and outcomes of care. This meant questioning the modernist notion that research is a neutral activity, a clear linkage with the postmodern way of thinking. I approached the research by seeing as interconnected “oneself as a researcher, research interests, living in the world, one’s philosophical assumptions and

commitments, and moral and political values" (Bentz & Shapiro, 1998, p. xvi). This research sees the *relatedness* between knowing and daily life (Leggo, 2002; Reason, 1998; Thayer-Bacon, 2003). In this research, I worked from the notion that how one sees the world, particularly how being (ontology) is related to knowing (epistemology), directs our decisions about what to ask about, what to talk about, and how to practice.

Dissertation Overview

This document is organized into 7 chapters. Chapter 2 expands the focus and significance of the research by questioning the extant literature to further position the research in relation to existing theoretical perspectives and research. Chapter 3 shows how the substantive claims made in Chapter 2 can be linked to underlying epistemologies that provided the basis for the methodological approach described in Chapter 4. Chapter 5 and 6 present the interpretations and analysis of the data. In Chapter 7, I discuss the significance and implications of the findings and pose future directions for research and practice within the interpersonal domain to enhance care for childbearing women.

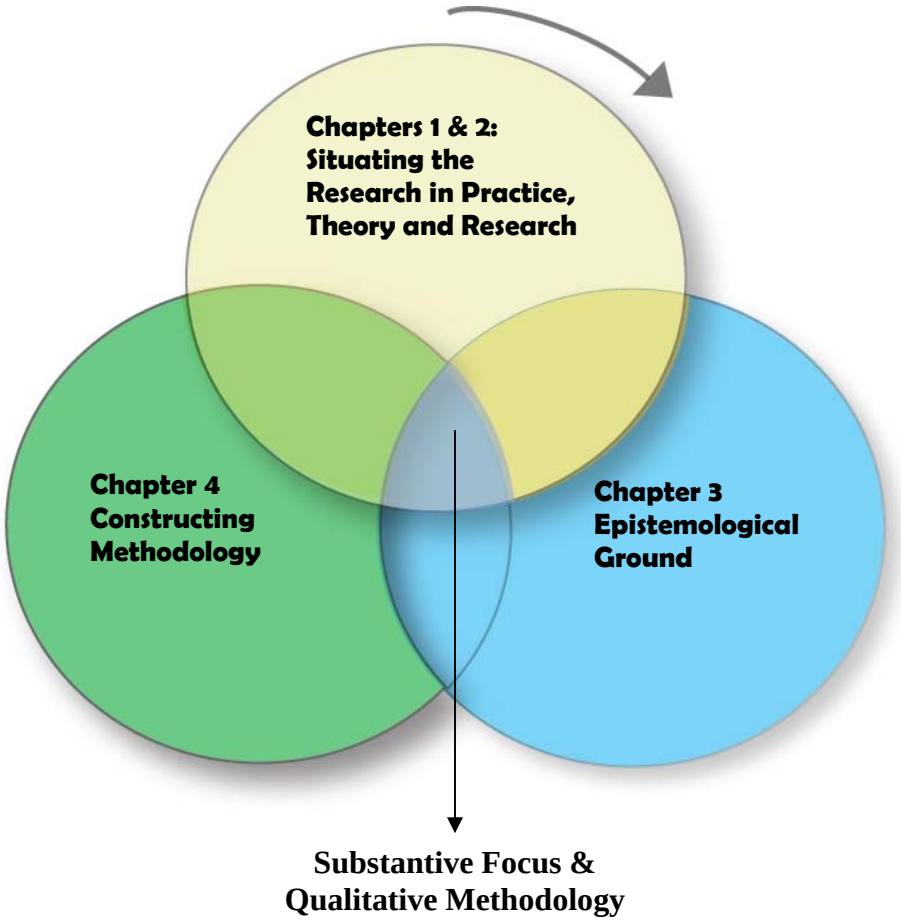

Figure 1. Theoretical and practical orientation to the project

CHAPTER 2: POSITIONING IN RELATION TO EXISTING THEORETICAL PERSPECTIVES AND RESEARCH

Different views exist on the value of an upfront literature review in qualitative research (Loiselle & Profetto-McGrath, 2007). Typically, literature reviews justify the need for the study by using 'gap logic' (Sandelowski & Barroso, 2003); that is, specifying areas where knowledge is missing and the reasons for this gap. Taking a pragmatist view of the purpose of knowledge meant asking different questions. Rather than asking about what was limited or lacking in extant literature, the intent of my review was to ask how extant theoretical ideas and research are useful and purposeful for answering our questions and solving our problems (James, 1907/1937) within the context of relational experiences, interpersonal relations and women's health capacities and outcomes.

Reviewing Literature: A Pragmatic Approach to Knowledge

When taking the questions from practice described in Chapter 1 to the theoretical and research literature, my questions about how the 'dynamic interconnectedness' of people and contexts impact[1] childbearing women's health capacities and outcomes were not fully addressed. From a pragmatist view, theories ought to be judged by their ability to put oneself into 'satisfactory relation with experience' (James, 1907/1937). Hartrick Doane and Varcoe (2005) suggest that a pragmatic understanding of knowledge leads to the belief that the value of knowledge and theory "lies in how it enhances our knowing of and response to people/families" (p. 12). I undertook inquiry into the literature from a pragmatist position by asking how extant theories and research about health care relationships were helpful and adequate for the task at hand—that of understanding the complexity of relational experiences and their impact on and potential for optimizing interpersonal care for women, infants, and families. The questions of adequacy I brought

[1] It may seem contradictory to critique an instrumentalist view of relationships later in this chapter while also claiming to be interested in the impacts of relationship. The term 'impact' could be construed as mechanistic and functionalist. I am using to the term 'impact' to evoke the pragmatic idea of the consequences of knowing as actions in the world .

to the literature focused on the degree to which particular research and theoretical perspectives explicitly accounted for the notion of people as relational contextual beings. The aim of the research was to develop knowledge that would make a practical difference for participants; that is, knowledge that optimizes care for women.

Specifically, I ask questions of the literature to see what perspectives and research would be helpful for studying relationships based on the assumptions described in Chapter 1 (page 18):

> (1) Relationships are situated and shaped by specific contexts;
>
> (2) Relationships are complex and multifaceted sites of human interconnectedness; and
>
> (3) Relationship shape health capacities and outcomes of care.

I did not undertake a literature review with the goal to outline strengths and limitations of various perspectives. Rather, my intention was to illustrate how a variety of perspectives on human relating within nursing and health care have historically evolved as the basis upon which questions can now be asked to achieve the goals of providing ethical and health promoting care for women. Although I scrutinize the literature in relation to the questions that framed the research, my intent in doing so is to argue for the ongoing evolution and plurality of theoretical ideas and research to ultimately enhance care for women in interpersonal relationships. Therefore, in line with a pragmatist orientation, the discussion is organized by asking *questions of adequacy* and *usefulness* in terms of my aim to examine the impact of experiences of relationship on childbearing women's health capacities and outcomes of care. I examined literature that focuses on human relating and relationship in nursing and health care[2] while also taking such questions into the literature on childbearing women's health.

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[2] As evident in Chapter 1, the research questions evolved from my nursing practice. In light of my aim to research experiences of relationship, I felt it was problematic to focus exclusively on nurses and patients. Since interdisciplinary relations constitute the interpersonal domain of maternal-infant care, and because relationships are often studied within specific disciplinary contexts, I decided that involving more that just nurses could provide additional detail and complexity to the study. The majority of provider participants, however, were nurses which likely reflect the resonance and relevance of the study for their practice.

Human Science as Context: Human Relating and Relationship in Nursing

In nursing, human relating is primarily theorized from within the human science tradition (Hartrick, 1997b; Kim & Kollak, 2006; Paley, 1997). Human science in nursing has been shaped by philosophical traditions of existentialism and phenomenology (Paley, 1997) and expressed in different writings on human caring science in nursing (Roach, 2002; Watson, 1988, 1999; 2005), and theories of interpersonal relations (Peplau, 1952; Travelbee, 1971). Although this literature and theoretical work is wide ranging, it shares a common focus on the meaningfulness of human experience within health and illness and the subsequent purpose and aims of nursing.

The human-centered focus is a strongly held value of the nursing profession. For example, the human-centered theory of life is easily recognized in the views of the earliest nursing theorists who described nursing as personalized, humanistic care, or a way of caring for the patient as a unique person (Wied, 2006). In 1948, Hildegard Peplau (1988) introduced her Theory of Interpersonal Relations, which focused on the human connection between nurse and patient. She explained, "…it seems to me that interpersonal relation is the core of nursing. Basically, nursing practice always involves a relationship between at least two real people, a nurse and a patient" (p. 18). Gastmans (1998) claims that Peplau made a

> …clear ethical choice by placing relations at the centre of nursing. She presents a balanced picture of the person which emphasizes autonomy and self-realization, but also regards fellowship as an essential aspect of being human. Peplau distances herself from the image of a person as an isolated individual confronting the task of self-realization outside of any relations with others…Peplau ascribes value to an essential aspect of being human: the fact that one's own personal development takes place with and for others. Relations with others can acquire an essential significance in the development of self (Paterson & Zderad, 1976; Peplau, 1994) (Gastmans, p. 1316).

A cornerstone of Peplau's (1952) work was a focus on the process where both the patient and the nurse contribute to and participate in promoting the relational process that unfolds between them. Gastmans (1998) claims that Peplau was the first nursing theorist to propose that the interactions between the thoughts, feelings, knowledge, assumptions, expectations, and activities of the patient and those of the nurse lay at the very centre of

the nursing process. Grounded in a multiplicity of relationships, Peplau argued that the development of nursing theory must take account of the meanings created in these "interactional spaces" (p. 57) and the relational connections between persons. Gastmans (1998) proposed that Peplau confirmed that "greater emphasis must be placed on the context of human experience which lies at the source of all knowledge in nursing (p. 1314).

Human science advances the notion that "effective health care is a relational activity; that is, it requires social relationships of trust and mutual understanding between health care providers and those needing and seeking health care (Gibson, 2003). As nurses worked to evolve the "traditional medical-scientific bondage" of their practice (Watson, 1988, p. 13) they began to articulate a concern for the centrality of human experience in practicing nursing from a holistic view of persons which counters the organismic concept of person in medicine and traditional psychology (Roach, 2002). Theoretical claims about the interpersonal foundation of nursing grounded in humanistic ideals have immense historical importance in nursing, primarily for how they challenged biomedical reductionism and expanded the dominance of behaviorism and positivism (Barker, Reynolds, & Ward, 1995). Theoretical perspectives informed by these ideals in nursing confirm that there is significant value in considering nursing practice as constructed through the connections among professional knowledge, lived experiences, and the caring values that construct the aims and care-giving processes of nurses as they are in-relation with patients.

In nursing, the traditions of existential and hermeneutic phenomenology have shaped human science and thereby the area of nurse-patient relationships and efforts to define the purpose of nursing, the practice of nursing, and methods of research and inquiry (Paley, 1997). These traditions emphasize the ontological nature of human life; one that posits that meanings arise in lived experience first and foremost, and not from the passive perceptions of disinterested sight but from our active and embodied involvement in a surrounding and resisting world (Merleau-Ponty, 1962). Existential phenomenology considers experience as ontologically primary to human existence, where human action occurs within the context of an open and engaged interaction between the

experiential worlds of various meaning-giving subjects (Husserl, 1936). The locus of phenomenological reflection, regardless of its specific classification as hermeneutic, existential, transcendental, or linguistic, in its beginning and end, is the intelligibility of lived experience (Van Manen, 1999). Experiences that arise through the life-world of the subject have occupied considerable importance in nursing when positing that nurse-patient interactions are the central event in nursing (Gastmans, Dierckx de Casterle, & Schotsmans, 1998).

Paterson and Zderad (1976) adopted the philosophies of existentialism and phenomenology which reject determinism, positivism, and reductionism to develop a theory described as 'ahead of its time' (Kim & Kollak, 2006). Nursing's continual inquiry into human experience for it meaningful connection to health and illness is reflected in Paterson and Zderad's (1976) view of humanistic nursing as "an experience lived between human beings" (1976, p. 3). Interest in how health and illness phenomena are situated and constituted (phenomenology) and a focus on the meaning of metaphysical dimensions of human existence (existentialism) informs much of nursing's historical and contemporary Western interest in human experience as it relates to nursing and health care practice.

The work of early human science nursing theorists is credited with the important focus on theorizing nursing through "…the world as we find it and live it" (Watson, 1989, p. 9). Several nursing authors claim that Paterson and Zderad in their book *Humanistic Nursing* have been recognized as bringing to the centre of nursing inquiry the salient contexts, processes and concepts of nursing; caring, human life, human relating, health, illness, and healing (Kim, 2006). In addition, human science in nursing has emphasized that the meaning and complexity of human experience must be understood through "relational inseparability of people" (Hartrick, 1997b, p. 525).

Human Relation and Caring in Nursing

Human science influences in nursing also underpin a collection of writing and research in relation to the concept of caring. This challenges the historical dominance of individualism, and the influence of the medical/technological paradigm and mechanistic worldviews inherited from the social sciences. A focus on meaningful experiences of

health and illness have been advanced based on caring science perspectives in research and theoretical inquiry in the area of interpersonal relationships in nursing (Kim & Kollak, 2006). Working to expand the dominance of such worldviews, nursing theorists began to articulate values that emphasize the human processes of caring to better reflect the central importance of subjective aspects of human experience as a central concern for the practice of nursing. The limits of traditional science and biomedicine for holistic understandings of health and illness provided the backdrop against which nursing theorists worked to articulate a focus for nursing centred on human care and relationship (Aranda & Street, 1999; Gadow, 1999; Hartrick, 1997b).

Caring science theories draw attention to how nurses and patients engage in meaningful relationships. The most developed theoretical ideas and research inspired by such writing are found in human caring science work of Jean Watson, (1988; 1999; 2005) and Simone Roach (2002). Both Watson and Roach aimed to create an alternative to the traditional biomedical notion of health care practice in favor of locating human caring science as the context for nursing. Watson's development of the concept of transpersonal caring espouses 'carative factors' that describe caring as a characteristic of the nurse, as an approach, and as a personal response; that is, the nurse acts on behalf of the patient. Watson (1988) describes *human relations* as a caring process that involves values, intent, knowledge, commitment, and actions. As one of the first nursing theorists who addressed the concept of caring, Watson drew attention to how nurses engage with patients in ways that "bring new meaning and dignity to the world of nursing and patient care" (p. 49). Her concern with how biomedical science limited the scope of care, particularly in relation to its dissonance with nursing's paradigm of "caring-healing and health" (p. 49), led her to outline nursing as a therapeutic interpersonal process that combines science with humanism. She also has drawn heavily on humanistic psychology, phenomenological philosophy, and existentialism and posits a structure and order for nursing phenomena based on these traditions.

Watson's (1988; 1999; 2005) concern for the human dimensions of nursing care emphasizes the human-to-human relationship, which she characterizes as a caring and healing relationship. Her work in 2005 places nursing within a metaphysical context and

establishes nursing as “human to human care with spiritual dimensions….which is aimed at helping persons gain higher degree of harmony within the mind, body and soul” (p.58). She extends the idea of human relations to one that locates caring as relational, where ‘relational’ implies a moral and philosophical commitment to existential humanity – an “interpenetration of selves, others, and environments in caring”(p 61). Watson advances the notion of the interrelatedness of human existence and its connection to the ethical imperative of nursing, thereby connecting inter-subjective experiences to ethical practice in nursing. She asserts and I concur that a focus on human beings as experiencing subjects who are dynamically engaged in ongoing interaction with other humans and the world brings us to question of morality and ethics within specific moments of nursing practice.

In summary, research and theoretical inquiry continues in nursing to locate human experience, caring and meaning as the central phenomena of concern of nursing (Benner, Tanner, & Chesla 1996; Bishop & Scudder, 2003; Paley, 1997; Watson & Smith, 2002). Theoretical inquiry and research informed by existentialism and phenomenology infused understandings and knowledge into nursing about the experiential worlds of meaning-giving subjects. Such perspectives in theoretical inquiry and research have significantly shifted Cartesian and positivistic influences and have greatly contributed to advancing the important notion that nursing is an experience lived between people. As chapter 1 illustrates, however, my questions about the interpersonal and intent to construct an understanding of their impact on women were based on an understanding of self-other relations *in-context.* In nursing, historical and contemporary attention to human relating in health care has drawn important attention to how all health, illness, and healing occurs in relationship. Yet, fewer questions and analyses in research have emerged about the broader array of relations and contexts that shape human experience and inter-subjective meanings from the perspective of patients, in ways that can enhance or undermine their health needs and capacities to achieve health on their own terms. Herein lay the intent to bring questions of adequacy to research and theoretical literature on relationships in nursing and health care.

Questioning Adequacy

> We cannot rest easy in the assumption that the Western heritage, with its emphasis on the single individual and its requisite institutions, can effectively participate in the world of thoroughgoing interactions. Required then, is a self-reflexive assessment of the traditions, an inquiry into the benefits and shortcoming of our beliefs and practices, and an exploration of alternative possibilities (Gergen, 1994, p. 5).

Questions that have received less attention in nursing within the domain of nurse-patient relationships are those based on a *relational* view of people; that is a view that focuses on the dynamic interconnectedness of self-other-context relations. Accounting for the 'inseparability' and dynamic connectedness that exist among people, experience, contexts, ideas, knowledge, and values (Hartrick Doane & Varcoe, 2005) raises important questions for theorizing and researching the complexity of relational experiences:

> Explicitly recognizing this dynamic connectedness underscores the importance of looking at the whole of peoples' lives. As nurses we have found this principle directs us to listen beyond the 'separateness' (or solitary nature) of the individual who may be sitting before us describing a health concern (Hartrick Doane & Varcoe, p. 53).

My questions about experiences of relationship work from this very assumption about self-other-context inseparability, particularly for its importance in meeting the health care needs of childbearing women. Because it is unlikely that any one view or model of relationships will adequately attend to questions about the complexity of human relating, my intent in examining the various perspectives is to ask how some theoretical views and empirical insights might move us closer – in both research and in everyday moments of care – to engaging in health promoting relationships with women, infants, and families. Although the ascendancy of human science has drawn attention to important questions of human relating, my reviews and analysis of the literature raise questions about the *adequacy* of dominant perspectives to address the relational whole of human experience in context. For example, critical theories[3] focus on how power operates to construct and

[3] When referring to critical theories I am highlighting the explicit focus on an analysis of power, social inequities in relation to gender, race, and class, and the structural context and social determinants of health. I recognize that some writers claim that critical theories are inherently realist in that they seek to 'get at' the essential oppressive conditions of society and 'unmask' taken for granted understandings. I have drawn upon critical theoretical ideas, however, to examine how power, ideologies, experiences of

sustain particular inequities in relation to gender, race, and class to theorize how particular disadvantages are socially constructed. From a critical theoretical perspective, it may be critical to examine how everyday moments of human relating are shaped by networks of power, institutional and societal structures, and dominant social norms and values.

Human science influences in nursing are primarily informed by the fundamental idealism of humanist analyses; humanism is broadly understood as a philosophy of life that considers the welfare of humankind and manifests itself in a set of claims made regarding the essence of humanity[4]. Within the field of sociology, it has been proposed that humanistic philosophies gained prominence in response to and rejection of behaviorist psychology (Raiser, 1997). Emerging beyond the discipline of nursing and health care are important critiques of humanism that illustrate the significance of conducting research into human relations by asking questions about the adequacy of human science perspectives to fully capture the complexity of interpersonal relations. For example, Raiser highlights the dangers of humanist analyses for how they tend to preserve power relations, or render them incontestable, particularly when they are obscured in the "rhetoric of egalitarianism" (p. 85). Lorenc and Bankowski (2000) draw on the critiques by Lyotard and Derrida to claim that the metaphysical roots of humanism "…assume a homogeneous approach to human nature in an effort to create a normalized vision of our humanity" (p. 135). These authors state:

> …Lyotard speaks out against a uniform approach to human nature. He contests the existence *of* an ahistorical human nature and maintains that the essence of humanity is the lack of a human essence. We are citizens of diverse cultures and this diversity is unconquerable…And all known paradigms seem to keep us away from experiencing the diversity of historical experience…the ills arising from traditional humanism's total subject concept lie in its attempts to restrict human

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race, class and gender, language, knowledge, practices, and values *socially construct* the interpersonal context of care.

[4] The roots of humanism are complex and its application too broad to provide precise statements about what humanism 'is'. Suffice it to say that what is meant by humanism today generally refers to all that enhances human values. Raiser (1997) contends a coherent system of understanding humanism, humanists, and humanistic is a thing of the past as contemporary times have developed a concept of humanism that is an enlargement on what is traditionally understood by the term.

> thought. Lyotard wants to find out something new about Man but comprehensive visions of humanity exert a certain pressure on our way of thinking. Moreover, in seeking to find out who Man is we frequently risk injustice as the choice of one answer is always made at the cost of others. This is why Lyotard believes that human freedom, tolerance, openness, and respect for others can only be considered in post-modernistic terms (Lorenc & Bankowski, 2000, pp. 133-134)

Mohanty (2003) writes from a feminist postcolonial perspective to draw a connection between the "authorizing signature of the project of humanism…as a Western ideological and political project" (p. 41) that she claims is both anthropomorphic and ethnocentric. Mohanty also posits that Western humanism discourse and ideology relies on binary logic where the first term denotes privilege and a colonization of the second term (for example self/other, male/female, public/private, agency/structure). Bringing Mohanty's analyses to the theoretical perspectives on human relating in nursing raises questions about how well theories informed by human science in nursing and health care allow for critical exploration of issues of gender, power, knowledge, difference, diversity, complexity, and difficulty in everyday moments of care. With the binary logic called into question, it becomes possible to see the connection among self-other-context in question, where theoretical ideas that depend on this separateness become questionable for enhancing the care provided to socially-embedded and embodied patients/people/families across diverse contexts of care[5]. Undertaking the research from a non-binary view of people, experiences, and contexts was understood to be a promising approach for optimizing care for women. And, in relation to humanistic influences in qualitative research, critical debates have also highlighted three areas where the discourse of democracy threatens to obscure the maintenance of the traditional direction of power in researcher-researched relations: relationship, equality, and participation. Such analyses and insights informing research and theoretical work are relevant in light of my intent to inquire into the adequacy of dominant theoretical discourses in nursing[6].

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[5] Although this research is focused on childbearing women and I worked from the assumption that social constructions of gender shape women's health capacities and outcomes, I theorized that the insights and findings would have relevance beyond this particular population of childbearing women to women more broadly.

[6] A full description of the history and development of humanism is beyond the scope of this chapter. My intent here is to locate human science influences in nursing as having a broader context that extends

Writing from within nursing, Mulholland (1995) claims there has been encouragement to concede the moral high ground to humanist principles and at least temporarily forego a "…critical analysis of issues of power and the social realities of practice" (p. 443). He writes of the limits of human science values in nursing by claiming that universalism creates a "sugar coating of ambiguity" (p. 443) that fails to adequately theorize power and the complex realities of health care practice. Mulholland critiques humanistic values in nursing by claiming such values "bracket out reality" (p. 442). He takes up this critique of humanism in that the humanistic basis of 'transcultural' nursing theories gloss over the social realities of practice and do not adequately theorize power and the impact of context on human experiences.

> The humanist literature within nursing reflects the fundamental idealism of humanist analyses generally. It manifests itself in a set of claims made regarding the essence of humanity. Within nursing literature there is encouragement to concede the moral high ground to humanist principles and at least temporarily forego a critical analysis of social realities (Mulholland, p. 443).

For my purposes, Mulholland's critique is important when considering what questions need to be asked in the complex and difficult space of human relating in health care. In nursing, research and theoretical inquiries that draw on critical and contextual perspectives to understand the interpersonal domain of care hold possibility for more adequately accounting for the complexity of theorizing human experiences.

As I brought 'questions of adequacy' to the theoretical literature and research in the domain of human relations and relationships in nursing, I constructed four key themes that justify the significance of the research, its epistemological ground, and methodological approach. These are: (1) inadequate explication of human experience/context inseparability, (2) limited practical guidance, (3) obscuring questions of harm, and (4) equating communication skills with the 'whole' of human relating.

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beyond the domain of health care literature, and to draw critical attention to how research into interpersonal relations can be more adequately undertaken than through the dominant paradigm of human science theories.

Inadequate Explication of Human Experience/Context Inseparability

Caputo (1987) writes of how placing our knowledge of how things 'really are' under scrutiny is a way to 'unfix' the essences that hold us captive. He refers to setting what we take to be the ultimate truths of human being aside and setting them into serious play. This is not a way to *do*, rather a way to *be*, a "way of staying on the move, remaining a moving target, roaming the streets, suspicious of every attempt….to take stock of where all of this is getting us" (p. 71). Caputo's insight illustrates the problem with giving authority to any one way to theorize and study relationships. In order to unfix particular dominant notions of relationships, it is critical to note how particular theoretical discourses become dominant in the first place. Fairclough's (1992) critical discourse analysis illustrates how discourses are texts (such as theories and research), talk (such as process of communication), and other semiological systems (such as gestures) that are human practices that shape the social world. Health care is a social practice embedded in a social world that itself shaped by the text and talk of everyday moments of care. When particular texts and talk become taken for granted as the 'truth' they become ideological -- other perspectives and meanings lose ascendancy in that they keep in place particular social arrangements that benefit from such dominant views. For example, the tendency to research nurse-patient relations primarily from the perspectives of nurses privileges their experiences over patients' and sets in place a particular arrangement that maintains the ideas that nurses set the pace and control the relational interaction with patients. Purvis and Hunt (1993) illustrate how particular discourses and ideologies (such as humanism) shape how people

> …participate in forms of understanding, comprehension or consciousness of the relations and activities in which they are involved…this consciousness is borne through language and other systems of signs, it is transmitted between people and institutions and, perhaps most important of all, *it makes a difference;* that is, the way in which people comprehend and make sense of the social world has consequences for the direction and character of their action and inaction (p. 474).

In Chapter 1, I suggested that how one 'knows' does not stand outside of and is not external to how one *is* with others. From this point of view it is then plausible to ask if any dominant way of knowing, such as humanism, creates the conditions for ideology.

An ideological form of individualistic humanistic values about individuals as freely acting and choosing agents can, for example, constitute particular oppressions in relation to gender, race, class, ability, sexual orientation and other forms of 'difference' that humanistic analyses obscure.

Despite calls for contextual and critical approaches to relationships (May & Purkis, 1995) questions *not asked* through research and inquiry in relation to interpersonal relations do ideological work (Ehrlich, 2001). The tendency to focus on human behavior without considering context has been linked to classic formulations of the transcendental self, one that Descartes pictured as standing "over and above everyday life" (Bernstein, 1991, p. 25). Such a view shifted when early American pragmatists such as James turned away from the "transcendental self of philosophical reflection, supplanting it with a radically mundane self" (Gubrium & Holstein, 2001, p. 71). This placed the self squarely in the midst of individuals' ordinary lives, where it was shaped and developed in relation to all manner of social influences. Similarly, Gergen (1994) claims that

> Cultural interests are virtually absorbed by the nature of individual minds – their states of being, their tendencies, their capacities, and their shortcomings. Individual minds have served as the critical locus of explanation…our beliefs about the single individual furnishes the rationale for most of our major institutions. It is the individual who acquires knowledge and thus we invest in educational institutions to train and expand the individual mind. It is the individual who harbors the capacity for free choice, and on these grounds we erect both informal practices of moral accountability and formal agencies of justice. Because the individual has capacity for reason and evaluation we place our faith in democratic institutions. Because the individual is motivated to seek gain and minimize loss we believe the free market can prosper. Because individuals harbor the capacity for love and commitment, the institutions of marriage and the family are claimed to form the building block for community (p. 4).

These insights and studies that account for the context of relationship illustrate the importance of researching how self-other-context relations are shaped by structures and systems that exacerbate vulnerability in illness and create social harms and situations of inadequate and unethical care (Armstrong, 1983; Carveth, 1995; Corley & Goren, 1998; Jewkes, Abrahams, & Mvo, 1998; Liaschenko, 2002). This research joins such efforts to create a critical account for how health care is 'delivered' within the *context of* relations

that are simultaneously influenced by systems, structures, policies, power relations, and practices.

Inadequate explication of the relational inseparability of human experience and context has meant that particular theoretical ideas informed by human science have limited their practical contribution to everyday realities of interpersonal relations in health care. James (1907/1937) claims that "experience has ways of boiling over and making us correct our present formulas" (p. 170). The questions and experiences from practice brought to theoretical perspectives and research led me to question and doubt whether or not human science perspectives are adequate for inquiry into the human experiences and context inseparability. I will now turn toward the second theme from scrutinizing the adequacy and usefulness of human science context for theorizing and research relationships in nursing and health care. This second theme is interconnected to the first claim about inadequate explication of the human experiences/context inseparability and focuses explicitly on the problematic tendency to obscure questions of harm.

Obscuring Questions of Harm

Watson (1988) states that "the ideas and ideals associated with my philosophy and theory of human caring are concerned with spirit rather than matter, flux rather than form, inner knowledge and power, rather than circumstances" (p. 77). Other theorists have described nursing in terms of the nurse-patient relationship and argued that nursing in fundamentally concerned with interpersonal caring (Aranda & Street, 1999). It is problematic in terms of addressing my research questions to uncritically accept the deeply held assumption that the role of caring implies that an unproblematic relationship exists between nurse and patient. In my view, taking such foundational claims grounded in a human science context in nursing is problematic in that the ideas and theories themselves become ideological. More importantly, not asking questions about power, experience/context inseparability, and structural conditions of care in my view significantly limits the possibilities to see human relations as a site where domination, harms, abuses, dehumanizing practices, and uncertainties do characterize human relations in everyday nursing practice. In addition, strategies and actions to enlighten, empower,

and transform the way in which care is provided are significantly limited, which ultimately impacts quality of care to patients.

I concur with Liaschenko (2003) when she claims that within humanistic and nursing ethics literature there has been a privileging of meaningfully positive and a relative lack of understanding of and inquiry into the 'social harms' experienced by patients. Barker, Reynolds, and Ward (1995) agree that producing a global concept such as 'caring' to define nursing is intended to "transcend the socio-economic ramifications of nursing" (p. 390). Barker et al. propose:

> There is an urgent need to extend our understanding of the forms of human interaction which represent the "stuff" of helping. Only through careful study of what people need nurses for, however, will the focus of work emerge. Our interest, therefore, is on the object of care: the subjective experiences of the people for whom we care. The almost narcissistic expression of interest in the experience of the use of self for therapeutic ends, to paraphrase Travelbee (2003) is, in our view, an unnecessary digression from the path of enlightening nurses and nursing (p. 395).

Barker et al. dichotomize self and other by claiming that the use of self is a separate focus than one centred on the subjective experiences for whom nurses care. Notwithstanding this binary, these authors do raise important questions about what people need from nurses that can focus attention on ways that nursing and health care contribute to both ethical/unethical care and that constitute particular differences in experiences of patients.

As it stands, nursing discourse continues to emphasize 'caring' with inadequate attention to how nursing practice also occurs in a context of health care systems that objectify and industrialize experiences of being ill (Lupton, 2003). For example, researching the relational experiences of nurses creates the opportunity to examine the connection between gender and power and the larger discursive context of nurses' caring work and its impacts on nurse-patient relationship (Bowdon, 1997; Nelson & Gordon, 2006). Although caring is a useful orientation within human science to theorize nursing as a moral imperative and way of being in interpersonal relation, the concept as it currently is conceptualized has not been helpful for advancing research and inquiry concerned with the 'conditions of its possibility' (Foucault, 1994) to *be* caring in everyday moments of practice.

Research illustrates how nurses' abilities to be moral agents and provide ethical care are inseparable from the socio-political contexts in which they practice (Chambliss, 1996; Varcoe, Rodney et al., 2003). Because of this, the adequacy of theoretical perspectives to advance understandings of how both ethical and unethical interpersonal care is experienced by patients must be the focus research into interpersonal relations. It is also not particularly helpful to assume caring is a natural 'attitude'; rather the question that requires attention is what does it take to be caring in the current context of health care? Respectful /disrespectful, humanizing/dehumanizing, and ethical/unethical interpersonal care are not dualistic categories of human experience, they are two sides of the same coin (Wilber, 2001). Human science perspectives that emphasize questions of consensus, sameness, and inclusion do so at the expense of examining the 'dark sided' behaviors of nurses that are both personally and socially constructed (Corley & Goren, 1998). Roach (2002) also writes extensively about the 'dark side' of human experience and writes of how human and environmental violence is common place and ought to be central in questions of human caring relations in nursing. When advancing her notion of caring as the "human mode of becoming" (p. 27), Roach takes a more critical and contextual stance on caring relations, explicitly connecting unjust political, social, and economic structures to the human capacity for caring. She advances caring as a mode of being that manifests itself in *concrete acts* that simultaneously attends to the experience of individuals but always does so by examining the relations among individuals and institutions. Roach writes of the rational-legal free market system and individualism in Western industrialized societies for how such economic and political contextual forces structure health care practice and the capacity to *be* caring. Roach argues that such institutional practices disconnect people from each other, the world, and meaningful experiences amidst health and illness. Roach's writing on caring as a way of knowing and relating to others does not obscure difficulty and harms in ways that more ideological notions of caring have.

For this project, research that scrutinizes the personal/social 'conditions of possibility' provides a more useful way of entering into research when concerned about both sides of the coin of relational experiences. Since the order of things in health care is

neither neutral nor apolitical, it hardly seems useful to theorize interpersonal relations without explicit attention to moral and social harms in experiences of relationship. I approached the research assuming knowledge is action; this implies that inquiry into the diversity of human experiences is the site from which to more fully account for how harmful and humanizing care is situated and constituted in the relational inseparability of people and contexts.

Equating Communication Skills with Human Relating

In nursing, human relating has also been theorized and researched based on the premises of structural-functional perspectives and behaviorist theory. These theoretical views are based on the assumption that if nurses use the behavioral skills of effective communication they will be able to meet the therapeutic needs of patients (Arnold & Boggs, 2007; Horsfall, 1998). Interpersonal nursing practice has historically been equated with the acquisition and employment of behavioral communications skills (Northouse & Northouse, 1998).Communication skills continue to be proposed as the medium through which nurses advance their therapeutic goals (Chambers, 2005).

Structural-functionalist views frame relationships as instrumental vehicles to therapeutic ends (Hartrick, 2002). The relationship between nurse and patient has come to be seen as an intrinsically therapeutic device through which remedies to the technological practice context can be delivered (May & Purkis, 1995). Reducing ‘good’ relationships to the successful deployment of communication skills renders inadequate attention to how the dynamics of human relating extend far deeper into human experiences than behavioral skill of communication (Hartrick, 2002). Theorizing interpersonal relations as mechanisms of communication has led to reductionist and instrumental views of relationships that objectify them as “a means to an end” (Hartrick, 2002, p. 51). A behavioral focus on communication has also been proposed as denying the experiential worth and health promoting potential of relationships (Hartrick Doane & Varcoe, 2005).

Communication also has been described as the essential medium for interpersonal interaction in the domain of physician-patient relationships; relationships are described as mechanism for ‘delivering’ health care. Research in the area of the significance of the physician-patients relationship has, for the most part, investigated the role of

communication for advancing the therapeutic goals of care and treatment regimes. For example, clinician-patient communication has been shown to impact health status (Adams, 2001) , diagnostic accuracy (Beckman & Frankel, 2004), adherence to treatment regimes (Hausman, 2001) increased trust in the clinician (Haynes, Mcdonald, Garg, & Montague, 2002), and improved patient satisfaction and clinician satisfaction (Haas et al., 2000). This body of knowledge, primarily located in medicine, approaches the study of communication in ways that also abstract human experiences and processes of communication from the context of care, while concerning itself less with issues of power, knowledge, language, structures, and policies as they shape what is communicated. Bringing poststructuralist insights about the complexity of language and insights from linguistic and discursive analysis could expand such research to focus on how communication may be a more complex process than that espoused within dominant depictions in the literature. Although this approach was not the explicit methodological approach of the study, I became convinced of the need for inquiry into the situated language practices of participants as a focus for analysis in the research.

Physician-patient relationships have also been primarily researched in the domain of ‘clinician-patient communication (Kemp White et al., 2005). Although studying communication has been the dominant way to examine the nature of interaction between patients and physicians (Duffy, 2006) there have been fewer studies investigating the way in which patients *experience* communication with physicians and the health care system more broadly. Beach and Inui (2006) cite outcomes of relationships measured in several studies as patient satisfaction and active engagement. Patients’ experiences of satisfying care and active engagement were seen to be constructed through the specific face-to-face dynamics of communication. Connecting communication to particular impacts on patients is important; however, the complexities of communication are significantly obscured without a critical analysis of how the dynamics of communication are socially and discursively produced. If language both reflects and constitutes reality, then approaches to studying therapeutic communication ought to similarly evolve. Writing from physician practice, Wied (2006) proposes that new possibilities arise when the context of communication is accounted for:

> …the more sober our view is of communication structures regarding interactions with patients, their relatives, our own, and other professions as well as the conditions under which things are organized, the more realistic the prospects are of being able to work effectively with all the valuable approaches that have been formulated in recent years (p. 64).

Analyzing patterns of communication provides insights into particular dynamics of relationships; however, a view of relating selves-and-others-in-context cannot be reduced to a singular focus on processes of communication. Hartrick (2002) proposes that considering the care of patients/families from a disease-care and mechanistic orientation to relationships leads nurses to: (1) engage in relationships as a "means to an end", (2) view interactions and relations with the infant and family as helpful but not "absolutely essential to the health care process", and (3) turn the nurses' focus toward effective communication skills as the foundation for his/her relational practice (p. 51). Duffy (2005) insists that despite prolific claims about the importance of realizing the therapeutic potential of relationships through communication, the theoretical basis for such recommendations remains sparse. Enhancing the care of the infant girl introduced in Chapter 1 and optimizing childbearing women's health capacities and outcomes of care – the goal of this research – would be poorly served by an exclusive focus on a structural-functional view of relationships and the related behavioral focus on communication. How might language such as 'hard to love' be reproducing dominant ideologies about social worth (love-ability), ability, and physical appearance? How are the infant's and family's experiences of care shaping their ways of communicating with nurses and one another? Hartrick (1997b) writes about the inadequacies of behaviorism in relation to human phenomena;

> Even though the limitations of a behavioral model of human relating have been expounded upon for over 30 years, the medical/technological paradigm and behaviorism continue to profoundly influence the conceptualization and enactment of interpersonal nursing practice…mechanism reduces human phenomena to that which is measurable, observable and knowable. In contrast, nursing's evolving values acknowledge the relational nature and complexity of human experience. There is recognition that human experience goes beyond that which is measurable, observable and knowable….mechanistic emphasis on the productive and functional elements of human action constrains nurses' abilities to experience and value the ineffable elements of human relating (p. 524).

Although effective provider-patient communication has also been linked to the specific outcomes of improved diagnostic accuracy (Beckman & Frankel, 1984), patient adherence (Haynes et al., 2002), health and functional status (Roter, 2000; Roter, Frankel, Hall, & Sluyter, 2006; Stewart, 1995), provider satisfaction (Haas, 2000), provider satisfaction and informed consent and malpractice risk (Levenson & Pettrey, 1994), it is critical to ask questions about how communication is a complex relational process that impacts more than just provider-defined outcomes of care. While these outcomes are critical for effective care and benefit health care providers and patients, my research aimed to create a broader and more critical and contextual understanding of human communication and their complex connections to women's health capacities and outcomes of care. This research was undertaken in concert with those working to expand the complexity of behavioral models of human communication. For example, Thorne (2002) locates the significance of communication in health care as a site of complex interaction that is a socially and contextually mediated process of human interaction. Ellis, Gates and Kenworthy (2003) examined both social and personal factors that constitute communication and locate the importance of communication based on human beings "…built in drive to relate to each other" (p. 3). Evolving understandings and approaches to theorizing communication that draw new questions into the foreground illustrate the significance of this research.

Limited Practical Guidance

A pragmatist perspective sees knowledge as action in the world (Thayer-Bacon, 2003). This implies that knowing is a practical activity that can guide more "conscious, intentional and responsive practice" (Hartrick Doane & Varcoe, 2005, p. 13). Taking this purpose of knowledge to literature on human relating and relationship in nursing, one key insight illustrates what questions and analyses still need to be pursued. Watson (1988; 1999; 2005) and others who write from human science perspectives in nursing have contributed substantially to countering biomedical discourses to bring awareness to *how* nurses engage with patients. The value of human science perspectives in nursing, and particularly Watson's work, is the explicit attention to 'interconnectedness of human beings' and co-construction of relationships. Questions not asked, however, focus on

issues of power and the social and cultural organization of health care. Yet, such features of context of health care are the everyday practice realities of nurses that shape how nurses engage with patients. The lack of attention to how experiences of being 'interconnected' are shaped in the context of care and the context of peoples' lives raises important questions about how human science perspective can provide practical guidance in everyday moments of care to optimize patients' experiences and health outcomes.

If one assumes that human science perspectives informing theories and research in nursing have broadly evolved from humanism, then it is critical to ask question in research about their adequacy for theorizing contemporary nursing practice. For example, Mulholland (1995) claims that humanistic theories are vague and idealistic and lack any rigorous analysis of power relations extant in society as a whole or within specific nurse-patient interactions in particular. This view is once again relevant to the research described here. He states:

> Humanism and humanistic nursing philosophies lack the concreteness…it has been recognized that such approaches are inherently vague, offering little in the way of guidance to the nurse practitioner…humanistic philosophies offer no guidelines or means of evaluating care (p. 443)

Practical guidance within the interpersonal domain of care requires adequate attention to the dynamics of the relationships and the relational inseparability of people and context. In addition, having practical value requires also being clear about the ends towards which nurses and health care providers are working. Barker et al. (2005) ask what is interpersonal human caring in nursing meant to achieve? Is caring as a means useful without asking about the practical ends nurses hope to achieve in relationships with patients? The relational connection between means and ends requires asking how useful particular theories and research are for optimizing safe, ethical, and health promoting care for patients.

Hartrick Doane and Varcoe (2005) indicate the importance of scrutinizing how both nurses and families are contextually situated as the basis for determining how to engage in practice; experiences and actions of *both* nurses and patients/families take place within a much larger set of relations that constitute nurses' everyday work and health experiences of patients. Inquiring into how people and relationships are

contextually situated accounts for the practical realities of being *in* interpersonal relation in specific moments of care. I will conclude this chapter by bringing the above insights and questions to another feature of the substantive focus of the research – childbearing women's health capacities and outcomes[7].

Childbearing Women's Health Capacities and Outcomes

> All illness, care and healing processes occur in relationship—relationships of an individual with self and with others…recognizing that the nature and quality of relationship are central to health care and the broader health care delivery system (Beach & Inui, 2006, p. 3).

As I have indicated already, research illustrates that relationships impact the health experiences of patients and subsequently shape particular outcomes of care Specifically, there is evidence to support the link between nursing practice and positive patient/client outcomes (Canadian Nurses Association, 2002). For example, patient outcomes shown to have been affected by nursing practice across a variety of health settings include: client outcomes (symptom management such as fatigue, nausea, vomiting, dyspnea, and pain); functional outcomes (such as physical and psychosocial functioning and self-care abilities); safety outcomes (adverse incidents and complications such as pressure sores, ulcers, and falls); and perceptual outcomes (satisfaction with nursing care and with the results of care) (Beckman & Frankel, 2004; Doran, 2003; Mead & Bower, 2000; White, Pringle, Doran, & McGillis Hall, 2005). Although research that links nursing practice and patient outcomes is critical, there is a concomitant need to examine how relational experiences and the interpersonal context of care shape such outcomes of care, and to expand how outcomes are predominantly defined based on a biomedical agenda of care and functionalist view of health.

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[7] As stated in Chapter 1, the research was focused on relationships between childbearing women and health care providers. The particular context of women's lives and the specific features of maternal-infant provide a social and political backdrop in relation to gender and power that create subtleties and nuances unique to the experiences of women. I see the insights and findings of this study, however, as holding potential value beyond a focus on women alone. Issues and experiences of power and gender shape the lives of both men and women and adults and children. The importance of the context of women's lives and health care providers perspectives cannot, however, be abstracted from the context in which the findings were constructed.

The outcomes cited above are shaped by the context of human interaction, yet the dynamics and experiences of relationships and the social context of care have not been adequately investigated for their influence on patient outcomes (Beckman & Frankel, 2004; Mead & Bower, 2000). Because research illustrates how the social organization of care impact patients' experiences, it is critical to examine how the dynamic interconnectedness between people and contexts impacts patients' experiences health capacities, and outcomes of care. Researching the complexity of relational experiences of the interpersonal can contribute to more adequate understanding of how experiences of relationships work to shape women's health capacities and outcomes from a critical and contextual perspective.

Researching relational experiences for impacts on women's health requires asking questions of adequacy in the domain of women's health capacities and outcomes within the context maternal-child care. There are four helpful insights from the literature on childbearing women's health that were critical for framing this research. First, childbirth has special status because it is an essentially female act, women's 'visible' contribution to reproduction. De Koninck (1998) states that "…how childbirth and pregnancy are treated in a particular culture often reveal interesting and significant aspects of social relations in that culture" (p.150). The biomedical response to pregnancy and childbirth has been marked by a rapid extension of medical knowledge and practice (de Bessa, 2006; Lagro-Janssen, 2007; Lock, 1998). Gender relations and medicalization[8] of women's bodies in pregnancy reflect dominant Western assumptions about women's place in society (see Jewkes et al., 1998). The Canadian Resources Institute for the Advancement of Women named the significant socio-political complexities as the context for childbearing women's health;

> Procreation has always been a social event and every society has legal, medical or ethical rules about birthing and childbirth. Unfortunately, the childbearers

[8] One of the roots of the concept of medicalization can be traced to the works of Foucault who saw medicalization as a technology of power that is implemented for the purpose of social control. Medicalization of human behavior aims to discipline and normalize the individual. Foucault argued that the disciplinary power of medical institutions is not simply repressive, but productive. Medicalization is defined as the process whereby an object or a condition becomes defined by society at large as an illness (either physical or psychological) and is thereby moved into a sphere of control by the medical profession (Lupton, 2003).

> (women) have usually not been the rule makers, and too often women's health and interest have been controlled by or subordinated by dominant interest (males) (CRIAW, 1989 p. 2).

Considering the interconnection between gender, medicalization of birth, and childbearing women's health, it is critical to undertake research that can adequately inquire into the complexities of women's experiences within the social, economic, political, and historical context of their lives.

Second, Oakley (1984) stated over 20 years ago that powerful social forces shape how women are cared for in particular interpersonal circumstances. She illustrated how the medicalization of childbirth structures the relationship between a pregnant women and a health care provider; the woman is transformed into 'patient' and this transformation has consequences. The consequences from women's perspectives have received less attention in research and indicate how social harms are experienced in interpersonal moments of care and have tangible impacts on women's psychological and physiological health. The current research was undertaken to contribute to knowledge of how the social context of maternal child health care structures relationships in ways that have impacts on women's health capacities and outcomes. Combining feminist and sociological critique in studies of antenatal and obstetrical care, Porter (1990) observes that:

> Research on women's experiences of reproductive health care suggested that the medicalization of reproduction was indeed experienced by some women as alienating, that some use of technology and intervention was seen as unnecessary, that there were tremendous problems in communication between women patients and their doctors, and that medical dominance over information and decision making in consultations was unsatisfactory for many women (p. 186).

Third, the politics of childbearing women's health -- the particular social, cultural, political and institutional and biomedical forces -- contextually situate and constitute women's embodied experiences of pregnancy, childbearing, and mothering. Because of the connection between gender and health and the fact that women do not share equally in the benefits of society, it was important to conduct the research based on the recognition of how manifestations of gender differences create patterns of disadvantage. And, it was critical also because of my research questions to be alert to how relational

experiences are also shaped by particular features of participants' life contexts such as social class, cultural location, ethnicity and race, ability, and sexual orientation. Research shows that experiences of relationships are shaped and reproduced through dominant thinking, social norms, and values that impact access to quality care for women (Benkert & Peters, 2005; de Bessa, 2006; Fisher et al., 2006; Giddings, 2005; Kabakian-Khasholian, Campbell, Shediac-Rizkallah, & Ghorayeb, 2000; Kaufert & O'Neil, 1993; Lagro-Janssen, 2007). Because of work that connects the quality of social relations to women's health experiences (Sadana, 2002), it is necessary to examine how experiences of health care relationships also have tangible impacts on women's health capacities and outcomes. Sherwin (1992) argues that the "social organization of health care does not only mirror the power and privilege structures of society; it also perpetuates it" (p. 228). Such empirical and theoretical insights from research provided an expansive array of questions and analyses to bring to the data and informed my thinking about particular implications and actions that have practice-value amidst relationships in everyday spaces of maternal-infant care.

Fourth and finally, in light of the connection between social relations and health, it is necessary to examine *how* women's health capacities are facilitated or constrained in relationships. Hartrick (1997) describes how the assumptions underlying a service model of health care places emphasis on problems, pathology, and deficiency, reinforcing the idea that people are 'half-full'. Such an approach directs would be attention away from women's inherent capacities and strengths. Often nurses or physicians define health outcomes which may or may not tap the inherent capacities for positive health outcomes for women themselves (Georges & McGuire, 2004). I engaged in the research assuming that optimizing women's capacities and outcomes of care could be best supported through facilitating their strengths, resources, and capacities for health (Hartrick, 1997a; Labonte, 1993; McKnight, 2001).

Returning to the infant deemed 'hard to love' in the opening scenario with these insights and assumptions about capacities and outcomes, new questions arise. Despite her relational ability to connect with her caregivers, this infant was rarely cuddled which ultimately undermined her emotional health. The less involved her parents were in

learning to care for her, the longer her hospital admission. A longer hospital admission had significant implications for her health, particularly nosocomial infections among other iatrogenic complications of hospitalization. She had fallen off the 'normal' infant weight curve; a lack of emotional and physical contact with her during feedings may have had tangible influences on her nutritional status. The inability to "prove" any of this from positivistic point of view (although examining such complex connections and impacts may be possible), illustrates the significance of researching interconnection between relational experiences, health care relationships and maternal-infant health capacities and outcomes of care.

I will close this chapter by noting how the questions in relation to inadequate attention paid to human experience/context inseparability, obscuring questions of harm, equating communication skills with human relating, and limited practical guidance can be linked to underlying epistemologies. The last section of this chapter locates the research in relation to epistemology to illustrate the connection between the research questions, existing research, and theoretical perspective and underlying views about knowledge. This discussion is offered in this chapter as a transition to the next to illustrate how the research phenomenon was understood to have both substantive and epistemological dimensions[9].

Locating the Research in Relation to Epistemology

It has been widely accepted that nursing's focus on human care and human experience cannot be explained or understood within a positivistic, deterministic, materialistic reality. I have raised questions, however, about the adequacy of human science theories to provide practical guidance in everyday situations of care, the obscuring of harms and the consequences of equating behavioural skills of communication with the complex experiences of self-other-context relations. Since it is evident that many 'truths' and theories dominate research and inquiry into the interpersonal level of health care, it may well be that the questions raised in this chapter

[9] The discussion could also have been used to open chapter 3, however, my intent in locating it here is to make clear how research and theoretical perspectives on human science and health care relationships are inseparable from particular view of knowledge that have informed such works.

could more adequately do justice to the diversity of human relational experiences while also lend support to the practical actions of health care providers to optimize ethical and health promoting care for women. I share Allen's (1992) claim suspicion that theory, or perhaps the way we use theory, tends to foster the replication of dominant culture, especially relations of domination and subordination. Holding this view of the connection between knowledge and power implies the necessity of examining in nursing how extant theories and research -- and their epistemological bases -- facilitate or constrain the relational experiences of women seeking and receiving maternal-infant care.

I concluded that these particular features of human science approaches to human relating and relationship in nursing are in fact reflective of underlying epistemologies; epistemologies that do not explicitly account for dynamic inseparability of people and contexts. Relational epistemologies work from a different ontological and epistemological basis:

> *We are contextual social beings.* All of us have unique contexts that affect who we are and how we interpret the world. We are situated people who are embedded in a particular setting as well as embodied within a particular body. With our unique bodies we experience the world around us in certain ways and not others. And, due to our embeddedness, we inherit a past at birth, and are affected by our environment, including our social environment. The social practices that surround us promote us to believe certain beliefs and not others. How people make sense of their world is due to their contextuality, including their own subjective experience as well as their social setting, and its past. This means that all knowledge is value-laden or interest-laden, and that cognitive pursuits and their social organization are not independent entities (Thayer-Bacon, 2003, p. 7-8)

From a relational epistemological perspective, interpersonal relations are sites of human experience more so than static 'things' that objectively exist. I determined that relational epistemologies (Thayer-Bacon, 2003) were required in light of my pragmatist intentions. The intent of this research was to cast its angle of gaze in the direction of *consequences* and *effects* of knowledge and practices in relationships. A relational view of people and knowledge described in the next chapter provided a helpful way to theorize 'experience' through the interconnectedness of people, knowledge, practices, structure, and contexts for research aimed toward optimizing women's health capacities and outcomes.

To close this chapter, I will note that Ellis (1969) who described, over 30 years ago, the notion of practitioner as theorist. She urged nurses to theorize from the complex, contextual, ambiguous terrain of practice. Ellis also challenged researchers to seek an ever expanding array of inquiry methods and creative ideas to open up new theoretical terrain and disrupt dominant thinking that is no longer adequate to enhancing the health of patients. I have proposed that adequate attention to human experience/context inseparability, recognition of the potential for interpersonal harms, a more complex view of human communication, and analysis of the connection between self-other relations shaped by context, power, and knowledge can inform research and theoretical work in this area. In order to conduct research to achieve these purposes, the epistemological ground described in Chapter 3 was necessary to achieve this particular task at hand.

CHAPTER 3: THE EPISTEMOLOGICAL GROUND

> Our beliefs about the world relevant to research are thrown into relief by three fundamental and interrelated questions. There is the *ontological* question, 'What is the form and nature of reality and, therefore, what is there that can be known about it?'; the *epistemological* one, 'What is the relationship between the knower or would-be knower and what can be known?'; and the *methodological* question, 'How can the inquiring person go about finding out whatever she or he believes can be known about?' In addition, there is the important axiological question which asks 'What is intrinsically valuable in human life; in particular what sort of knowledge, if any, is intrinsically valuable? (Reason, 1998, p. 45)

This chapter describes the ontological and epistemological ground upon which the research methodology was constructed. In the previous chapter, I indicated that the focus of the research was linked to both substantive and epistemological questions of adequacy. In this chapter I will begin by locating the philosophical context for the decision to undertake the research from a relational epistemological ground. I then outline several related and critical assumptions of relational and pragmatist views of knowledge that were deemed adequate for researching experiences of relationship and their impacts on women's health capacities and outcomes.

Chapter 1 and 2 link the research aims to underlying epistemology, positing that what we believe knowledge to be in the first place, and what we assume the purpose of knowledge to be lies at the very heart of how research and theoretical inquiry are undertaken. I approached the research from a view that how experiences of relationships are understood and how women's health outcomes are conceptualized could be expanded beyond the dominant individualistic notions and non-relational views. In this chapter, I will show why a relational epistemological ground provides a fuller and more complex account of the connection between interpersonal experiences and the health capacities and outcomes of childbearing women.

Returning to "Hard to Love", I claimed that theoretical literature in nursing on nurse-patient relationships did not resonate with the questions that arose for me when caring for the infant girl. What became evident when preparing to undertake the research was that the questions I had were not about my inability to 'apply' theory to practice;

rather, such questions could be understood through the dominant tendency in nursing to 'objectify theory' (Hartrick Doane & Varcoe, 2005).

> Although the development of theoretical nursing practice has been a central focus within the nursing discipline over the past few decades, the practice/theory connection continues to be in need of further articulation and exploration…the tendency to objectify theory – to separate it out from the everyday 'real' world of practice and think of it as a 'thing' to be applied and used, had profound implications for theory development and nursing practice. Not only has it constrained the theory development process but it has ultimately served to limit nurses' choices, clinical decision-making and their capacity for ethically responsive practice (Hartrick Doane & Varcoe, 2005, p. 81).

Bringing these insights back to Peplau's theory of interpersonal relations suggest that a problem may lie in how her work has been taken up in mechanistic and prescriptive ways; the phases have been misinterpreted as being 'the way things are' rather than a potential useful theoretical notion that might assist nurses to pay attention to interpersonal relations as they unfold in the context of practice. For example, using variables from Peplau's model of interpersonal relationships, Forchuck (1998) and. Kezar (2004) studied how long it took for nurses to establish each phase of the nurse-patient relationship. Rather than focusing the research on the model for how it can help nurses examine how to best use time with patients, they locate the theoretical phases of relationship as a 'truth' and then proceed to study their application to the realities of practice. Peplau herself wrote about how the phases were nonlinear and overlapped. She wrote about the importance of viewing the phases as "dynamic, iterative interaction, where in each encounter constitutes the notion of relatedness from the perspective of the patient and nurse" (Peplau, 1962, p. 52). This example illustrates why locating the research in relation to epistemology was particularly important in light of the pragmatist intention to enlist theoretical understandings to be more effective in optimizing health experiences, capacities, and outcomes for childbearing women in this research.

A Philosophical Location

As the example above illustrates, how one thinks about knowledge and undertakes its development is a philosophical endeavor. In light of the fact that research is a knowledge-generating practice of inquiry, it follows that how one approaches research is

always from a particular philosophical view of what knowledge actually is and how one goes about creating it (Harding, 1991; Kezar, 2004; Kvale, 1995; Lather, 1991). Kezar (2004) asserts that, more often than not, philosophical questions are poorly understood and integrated in research. She argues that engaging with philosophical questions is necessary to become clear about choices to proceed methodologically. Thayer-Bacon (2003) also posits that how one sees the world, particularly for how being (ontology) is theorized in relation to knowing (epistemology), gives rise to decisions about "…what to inquire about, how we inquire and therefore what our results shall be" (p, 272). This implies that what knowledge is taken to be has methodological implications. Engaging in a form of Rorty's small 'p' philosophizing led me to ask what was required to bring ideas, knowledge, and action into relation. Seeing research as related to everyday living was one way to see the connection between experience and inquiry, however, my research intent resonated with a pragmatic purpose to create practical knowing to solve problems (Bernstein, 1991; Reason, 2001; Rorty, 1979). Rorty outlines a position on philosophy and it practical relevance in social life that mirrored my pragmatist orientation to knowledge that held implications for how the study was conducted;

> We cannot regard truth as the goal of inquiry. The purpose of inquiry is to achieve agreement among human beings about what we should do, to bring about consensus on the ends to be achieved and the means to achieve those ends. Inquiry that does not achieve coordination of behavior is not inquiry but simply wordplay (1999, p. xxv).

The relevance of Rorty's (1999) statement on the purpose of inquiry illustrates the irony of how, in nursing, there have been and continue to be longstanding efforts to develop theories of the interpersonal, which means less attention has been paid to what can effectively enhance the experiences and lives of patients; that is, to create actions that actually optimize health capacities and outcomes in particular contexts of care. As mentioned previously, certain theoretical ideas have become fixed though dominant thinking that direct attentions away from examining alternative possibilities that could result in doing things better (such as facilitating responsive and health promoting care for childbearing women). Such questions are the concern of pragmatists who describe theory

as a way of becoming more responsive to people in particular situations (Hartrick Doane & Varcoe, 2005).

Rorty also proposes that 'redescription' is required when we want to argue persuasively for a new view of something and when we can no longer lay claim that our view is a better representation of reality. It is then that we are caught in a "contest between an entrenched vocabulary which has become a nuisance and a half formed vocabulary which vaguely promises great things" (1989, p. 9). Re-description refers to "a talent for speaking differently, rather than arguing well" as "the chief instrument of cultural change" (1989, p. 7). The entrenched vocabulary that was discerned to be 'getting in the way' was the epistemological basis of theories about interpersonal relations that limits and subverts a relational view of knowledge and human experience. Western epistemologies rely on dualistic distinctions between knower and the known, appearance-reality, matter-mind, made-found, self-other, private-public, etc. that lie at the heart of how particular disciplinary traditions arose. For Rorty (1999), these traditional dualistic distinctions have become an obstacle to achieving the consensus required to engage in more effective actions. In the current research, arguing for a relational epistemological ground and pragmatist view of knowledge was determined to provide a more adequate basis upon which to go about constructing insights in response to the research questions.

Assumptions of Pragmatism and Relational Epistemologies

The epistemological ground for the research is based on a view of knowledge grounded in relational epistemologies. Thayer-Bacon (2003) describes her relational epistemological view as "a pragmatist social feminist view, a relational perspective of knowing, embedded within a discussion of many other relational views" (p. 7.) Rather than describing one relational epistemology she brings together a variety of perspectives for theorizing the connection between the knower and the known from multiple points of view. The relational epistemological ground from which I conducted the research was primarily informed by Thayer-Bacon's work, but also draws upon Hartrick Doane and Varcoe's (2005) articulation of pragmatism and relational inquiry within the context of family nursing, philosophical pragmatism (Bernstein, 1991; Dewey, 1922; Rorty, 1979,

1989), and deconstructive hermeneutics (Caputo, 1987; 2000). Although these assumptions are articulated here, they became known and enacted in a more living form in the research described in Chapters 4 and 5.

The following assumptions were informed by and constructed through my reading of relational and pragmatist epistemologies articulated by Bernstein (1997), Dewey (1966) Hartrick Doane and Varcoe (2005), Rorty (1999), Thayer Bacon (2003) and Reason and Bradbury (2006):

1. People are social and contextual beings who live their lives in relation to others (Hartrick Doane & Varcoe, 2005; Thayer-Bacon, 2003).When we see ourselves as social beings-in-relation-with-others, we must turn our attention to the quality of these relationships (Thayer Bacon, 2003, p. 246);
2. Knowledge and human action are shaped relationally; theory arises from and is grounded in experiences and practices (Hartrick Doane & Varcoe, 2005b; Reason, 1999; Rorty, 1999). All knowing is socially constructed by embedded and embodied selves who are in relation with each other, knowledge is fallible, shaped by selective interests and is open to revision (Bernstein, 1997; Rorty, 1999; Thayer-Bacon, 2003);
3. Truth is a process through which lives are lived, from which is gained a better understanding as a basis for action; an intentional, relational process aimed at being more responsive in particular moments (Hartrick Doane & Varcoe, 2005);
4. Restoring original difficulty requires thinking against the grain of everyday conceptions (Williams et al., 1998);
5. Inquiry is more than methodology; knowledge development (and theory) is an active living process of coming to know (Reason & Bradbury, 2006);

These 5 epistemological assumptions imply several others that are specific to theorizing the maternal-infant health care context of the research:

6. Health care is social practice that exists in the relational spaces among health care providers, patients, families, communities, and the broader ideological and social scenes within which they are embedded (Lupton, 2003);

7. A pragmatic of knowledge requires attention to effects and consequences as they are lived in practice (Hartrick Doane & Varcoe, 2005);
8. A critical community of inquirers is required to act, negotiate, and re-negotiate inquiries and knowledge claims to open space for making practical knowledge and reflexive process and human action more likely (Caputo, 2000).

I will describe the interrelated assumptions 1-4 in more detail in this chapter, whereas assumptions 5, 6 and 7 will become evident through the analysis of the data. Assumptions 1-4 are collapsed into 3 main ideas: people are *social contextual beings*, *knowledge is a relational process*, and *inquiry is more than methodology*.

People are Social Contextual Beings

A relational view of knowledge is grounded in a view of human life where 'relation' is viewed as ontologically basic. Thayer-Bacon (2003) describes this as a theory of knowing that aims to show "…how connected we all are, not just to each other personally, but also to our social environments, our cultures, past, present, future, as well as our surrounding natural environments, and the forces of the universe as a whole" (p. 73). She goes on to illustrate how the word 'relational' is ambiguous since it is used in so many different ways; there is being 'related' to someone else by way of kinship or blood ties, or relating to others as friends or partners or as members of a community or group (such as religious communities), or having 'relations' with another person at an intimate level. The term 'relations' is also used to draw comparisons between objects, as one object is related to another while also referring to logical or natural associations like in the case of saying "I can relate to that story". Relations also can imply "dynamic or functional interactions" (p. 74) or the way in which one concept or idea relates to another, which helps creates the possibility to see things anew or make strange what has been taken for granted. For all of the different forms that the term relation takes

> …there is a common theme of *connection to others,* including people, ideas, or even inanimate objects. I do not mean to emphasize just logical interaction and existential connection. The connection is not just accidental or incidental, in the sense that we do not just bounce off of each other like marbles when they hit each other in a shooting game…I want to emphasize that relations are transactional in that we affect each other, dynamically and functionally, and each is changed as a

> result. As Martin Buber (1958) described this transactional quality, relations are mutual (Thayer-Bacon, 2003, p. 76).

In nursing, Hartrick (2002) describes the relational nature of human life as manifested in the idea that nothing exists independently of its relationship to something else, where the impact of this relation connection may be recognized in either subtle or profound ways. Explicitly noticing this dynamic connectedness is what underlies any efforts to look at the whole of peoples' lives, where people are viewed as contextual and social beings. Hartrick Doane and Varcoe (2005) describe 'relational' within the context of family nursing:

> Although the term relational seems to us to point to what we want to highlight, we have found that when we speak of 'relational practice' people do not hear the contextual aspects that we want to highlight. Many people think we are merely talking about and emphasizing nurse-family relationships. Similarly, when we use the term 'contextual' people think we are focusing on socio-contextual structures and somehow do not hear the interconnected relationality we are intending to emphasize….we use the term relational to describe the complex, relational nature of human life, the world and nursing practice…In describing our approach as relational nursing practice, we are saying that *we view and approach the world through a relational lens, always assuming and looking for how people, situations, contexts, environments, and processes are integrally connecting and shaping each other* (emphasis in original, p. 51).

A relational ontological notion is also expressed in writing that crosses diverse disciplinary traditions such as Gregory Bateson in the field of ecological relations and Martin Buber in existential philosophy. To illustrate, Bateson (1984) claims *we create each other*; whether we are aware or not, we are contextual social beings who are always in relation. As noted by many writers, historically Euro-western thinking has embraced an ontology that separates humans from each other and from the human made and natural world. Seeing human beings in relation to others, what they know, how they act, the objects surrounding them, and the contexts in which they live implies that experience is constituted relationally, just as any idea is "caught up within webs of related ideas" (Thayer-Bacon, 2003, p. 73).

In Buber's *I and Thou* (1958), he considers how we all begin in relation, in terms of a spiritual history of primitive human beings, as well as in terms of infancy. Buber claims that "…already in the original relational event human beings speak the primary

word *I-Thou*, before we can recognize ourselves as an *I*" (p. 22). Buber claims "in the beginning is relation – as a category of being, of readiness, grasping form, mould for the soul; it is the *a priori* of relation, the inborn *Thou* (p. 27). Particularly relevant for my research is Buber's distinctions between *I-It*, as objectified, indirect and irrelevant relations and the contrast to *I-Thou* direct relation and engagement, each holding different consequences in terms of human action. Thayer-Bacon (1989), drawing on Buber, states:

> We learn from Buber that the history of the individual and of the human race is a progressive augmentation of the world of *It*. Each generation has a more extensive world of objects, in general. *I-It* is a connection of *experiencing and using*. The world of causality has unlimited reign in the world of *I-It*. *I-Thou* is the world of relations. As we develop the function of experiencing and using we decrease our power to enter relation (p. 43).

Buber's (1958) writing on subject-object relations (although dualistic) points toward the idea that *how* we are in relation, both in terms of how we relate to ourselves and others, shapes what happens in particular relationships. And, he also suggested that the *I* who becomes formed in *I-Thou* relations is different than the *I* of *I-It* where the *I* of *I-It* is individuality, being differentiated from other individualities. The *I* of *I-Thou* is a person, subjectively, in relation with others, which does not require the giving up of *I*. Buber claims the *I* is indispensable to this relation, as it is to every relation. Buber's focus on how being in relation makes a difference to what is experienced in inter-subjective space does not account (nor was it intended to) for the impact of context on the possibilities and conditions necessary to transform *I-It* into *I-Thou* relations.

Ruddick's (1989) work on mother-child relations and maternal thinking exemplifies the more complex view of "I and thou" that informed the research. She posits that interpersonal relations between mother and child are influenced by the broader social discourses on mothering. She asserts that mothers are immersed in their public, social world and that social world affects their mothering behaviors, even before a child is born. Ruddick's work helps to assert that all knowing is an activity that develops out of relational practices on individual and societal levels that we participate in from the moment of birth. Greenwood (2007) draws upon the writing of Levinas in nursing to suggest that in the *I-Thou* relation to suggest an inequality is inherent since it is the "I" that creates and confirms the existence of the 'thou'. Greenwood states that "Levinas

(1967) believed that this reliance on the conscious reflection of the "I" prevented access to the rawness of human contact and affected the conception of 'otherness'. Working from a view of people as relational beings in this research was intended to raise these questions about meaningful relations as they are shaped by particular dynamics, such as the inequalities in knowledge and power that characterize relationships.

Evident in the works of Buber, Ruddick, and Bateson are intentional efforts to grapple with the consequences of a relational view of people and knowledge, albeit in different domains of inquiry, each with epistemological relevance. Bateson to a greater degree than Buber explicitly works from a view that relations are contextualized in complex and myriad ways. Buber's attention to the quality of relations extend notions of relational living to one that focuses pragmatically on the qualitative differences that arise from *how* one takes in the face of another person. These insights contribute to an ever-widening array of theoretical ideas from which to conduct research and to ultimately enhance interpersonal spaces of practice.

A relational ontological view in this research meant working from the connection between human *being*, experience, and knowledge. Thayer-Bacon (2003) states experience is subjective *and* objective, it is private *and* public, it is internal *and* external, it is thought *and* thing and is

> …a double barreled word….it includes what men do and suffer, *what* they strive for, love, believe and endure, and also how people act and are acted upon, the ways in which they do and suffer, desire and enjoy, see, believe, imagine – in short process of experiencing…It is "double-barreled" in that it recognizes in its primary integrity no division between act and material, subject and object, but contains both in an unanalyzed totality" (p. 18).

'Experience' in this sense is relational and our relations in the world are primary sources of experience. Researching human experiences means working from an assumption about *experience as relationally produced.* Although a relational ontological view sees people as interconnected social and contextual beings, it does not imply sameness as the basis for connection; rather, it considers differences between people as invitation to enlarge understandings of others and the social world. I understand this valuing of difference as a way of expanding the complexity of relational experiences in research. For example, as will become apparent in later chapters, I understood differences

in health care providers' and women's data as illustrative of the complex 'whole' of relational experiences; differences in the data were read as signifying particular nuances of how participant experiences were being constructed.

Relational experiences are complex

A relational ontological view of persons does not seek to obliterate difference between relating selves and others, but reorients thinking toward the practice of living within differences as a way for individuals to enlarge their understanding. Working from a view of persons as historical, locally situated beings, Thayer-Bacon (2003) claims people widen their lenses and perspectives by developing a greater understanding of differences. She explains:

> A relational (e)pistemology argues that we learn more about our own situatedness by having ourselves reflected back to us by others not like us. The more variety and difference we are exposed to, the more perspective we will be able to gain on ourselves…we are exposed to culture before we are able to critique the culture we are exposed to…thus when we begin to interact with others not like us, we begin with an assumption that others are like us, not even realizing the concept of difference. We become aware of our differences through our interactions with others, through our efforts to establish common meanings so that we can communicate and relate to each other…it is others not like us who help us become more conscious and aware of our own contextuality. They wake us up and make us notice what before we had taken for granted (p. 251).

A relational ontological view of people draws into the foreground the critical notion that an awareness of diversity highlights our own fallibility. It emphasizes that none of us has a privileged view of the world and that all of us are embedded and embodied with the world albeit with differing levels of disadvantage and privilege. It also underscores the importance of working against social deterministic views of individuals (Gergen, 1994), towards one that emphasizes limitations and contextuality of social-beings-in-relation-with others (Thayer-Bacon, 2003).

Asking about the pragmatic consequence of holding particular theories and ideas about 'difference' in interpersonal moments of maternal child care in research provided a way to enlarge perspectives that assume relationships are always the site of positive interactions and experiences. I approached the study ready to listen to harms, difficulty, judgment, and unethical care since dominant views of relationships (such as

unproblematic means to therapeutic ends) did not resonate with what I knew from practice. Noddings (2003) states that "some relational approaches obliterate difference by assimilating both parties to a 'oneness' of some sort, but a deeply relational account recognizes that those beings we call 'individuals' emerge from relations and enter new relations in which difference will always be present" (p. ix). A relational approach

> …seeks to make similarities and differences more transparent in order to learn from them…we are better able to attend to issues of meaning, experience, race, history, culture, health, and sociopolitical systems. In addition, as we relationally honour and attend to such differences, the potential for growth, change, and knowledge development is enhanced (Hartrick Doane & Varcoe, 2005, p. 9).

These insights about complexity and difference were helpful ideas to bring to data analysis. In Chapter 2, I claimed humanistic and caring theories in nursing obscure issues of power, difference, diversity, difficulty, and complexity. A relational view of people provided a helpful way to tune into difference as experienced and situated in relationship while also examining how relationships were shaped by the dominant social norms and values and intersecting contexts of health care and women's lives.

Knowledge is a Relational Process

From the point of view of a relational epistemology, *all* knowing is an activity that develops out of relational experience and practices in which we participate. From the moment we are conceived, human relatedness is central to subjectivity. We each develop our own sense of self through relations with other people who are embedded within a larger social context; as subjects we are acculturated social beings:

> Our self production is always a social enterprise…shifting the focus from personal micro level to a social macro level causes the boundaries between private relations and social ones to blur further. This blurring supports my efforts to describe the transactional, relational qualities of knowers and knowing (Thayer-Bacon, 2003, p. 82).

A relational epistemology moves beyond realist or objectivist orientations towards knowledge that assumes I need to stand outside of 'it' in order to know it – for I am related to 'it'. Seeing experiences constructed in interpersonal spaces of practice through a relational epistemology brings wholeness and contextuality into the foreground. One inquires and becomes a 'knower' through relation to world "…as a *part of it* since… as

soon as we attempt to stand outside, we divide and separate…in contrast, making whole necessarily implies participation" (Reason, 1998, p. 27). Thayer-Bacon claims that this split between knowers and the known "…works to sever us from each other and the world" (p.10) and argues that we cannot separate 'reality" from ourselves, since it is not possible for us to function as spectators who view and describe the world around us, we are embedded in 'it'. I used this idea to consider how the term *knowing* is a verb, rather than a noun. As a verb, knowing is always in process and has transactional qualities, while not attempting to define "it" as a finalized object or product. For example, the findings described in Chapter 5 are considered temporarily 'fixed' for the purpose of discussion and completion of the research; that is, they are contingent findings that are far from being considered the end of the story.

A relational epistemology works from a view of people as socially situated knowers; working in contrast to understanding ourselves as separate from what we know, with knowledge viewed as "out there", in an external, independently existing reality. Rather, a relational view of knowledge implies connection to experience, something in which we are implicated. As the opening chapter illustrates, I claimed that the research questions guiding the research arose from being in the midst of practice, and greater form was brought to the questions through inquiries into the literature. As the later chapters also show, my approach to analyses was based on the assumption that theories could be enlisted to know more about the nuances and complexities within the data. These examples indicate that knowing in the research was about being in-relation – with participants, the data, theories, and perspectives on knowledge – and by enlisting these relations through the process of knowing more. This connection also informed the methodological approach and data analysis. Finally, a relational view of knowledge draws attention to the consequence of knowledge in the lives and health of childbearing women.

One final feature of a relational view of knowing can be linked to social constructionism[10]. Social constructionism has been credited with expanding the

[10] It is proposed that social constructionism holds the social dimension of meaning front and centre, while the terms 'constructivism' arise from more individualistic origins that place greater emphasis on the instrumental and practical function of theory construction and knowing (Crotty, 2000).

individualistic tenets of constructionism to advance the social (relational) origin of meaning (Gergen, 1994). For example, Geertz (1990) speaks of a 'system of significant symbols' (p. 49) that constitute culture which organizes human experience and is indispensable to human action. Others, such as Fish (1990) tell us that the "institutions constituting our publicly available systems of intelligibility precede us" (p. 186). These notions imply we are *already* embedded, and it is only through this inhabiting or being inhabited that we have access to the sense such systems make. Knowledge and theory are therefore not a "transparent, culture-free zone, not a duty-free intellectual marketplace hovering between cultures, lacking all connection to embodied, lived experience" (Tedlock, 2000, p. 467).

Drawing on the work of Foucault, as Thayer-Bacon (2003) does, infuses a relational epistemology with an account of how 'experience' is relationally produced through discourse, dominant ideas, and taken for granted 'truths'. What is claimed to *be* knowledge, then, is discursively produced through a network of practices and institutions such as those operating in each moment of health care practice (Harding, 1992; 1999). These ideas became a backdrop against which I engaged in the analytic work of the study. This meant paying attention to *both* the ontological inseparability of people *and* the impacts of "socio-historical values, knowledge, practices, attitudes, and structures passed on through relational interactions…these socio-historical forces become so taken for granted that people often take them as the only reality, forgetting that they can be remade" (Hartrick Doane & Varcoe, 2005, p. 8).

Knowledge is Action

Relational epistemologies described by Thayer-Bacon are substantially informed by pragmatist philosophers[11] writing on the purpose of knowledge. The ensuing discussion of a pragmatic view of knowledge is based on both Thayer-Bacon's discussion of pragmatism as well as my own reading of the work of John Dewey (1960), Richard

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[11] Pragmatism has its roots in American analytic philosophy beginning with the works of Charles Sanders Peirce of the late 19th century and was further articulated by William James at the turn of the century, by Dewey during the early years of the 20th century, and more recently by the 'neo-pragmatists'[11] Richard Bernstein, Richard Rorty and Hilary Putnam, among others.

Rorty (1979; 1989; 1999), and Richard Bernstein (1997)[12]. In addition, my thinking has also been informed by Hartrick Doane & Varcoe's (2005) work to bring a pragmatist view of knowledge to family nursing.

From a pragmatist point of view, truth and knowledge are not abstract mental ideas; rather, they are a consequence of experience and emerge from human action enabling us to adapt to situations resulting in greater fulfillment and satisfaction – where the truth is not only the useful but the good. Rorty (1979) claims

> Thus, we do not discover the Truth; we make truths with our languages. And since no language is privileged over any other, all languages being contingent in their origins and not mediums for expression or representation, our "intellectual and moral progress [becomes] a history of increasingly useful metaphors rather than of increasing understanding of how things really are (p. 51).

From this point of view, truth and knowledge are not abstract mental ideas but rather are a consequence of experience that emerges from human action. Thus, knowledge enables us to adapt to situations resulting in effectiveness in the world. Rorty (1999) abandons the search for truth and claims it is neither necessary nor possible to distinguish a correspondent view of reality or a view of truth as 'what-is-good-for-us-to-believe'. He claims it is the "vocabulary of practice rather than of theory, of action rather than contemplation, in which one can say something useful about truth" (p. 54). What creates a more truthful view – or what gives theory its value – "is not how true it is but how it fosters increased responsiveness to people…enhancing our capacity to respond and practice in ways that promote the health and well-being of particular families in particular moments" (Hartick Doane & Varcoe, 2005, p. 12). In this sense, pragmatic philosophers do not regard thinking and doing as separate kinds of activities as has been the case particularly in the domain of nursing knowledge development (Reed & Ground, 1997; Hartrick Doane & Varcoe, 2006).

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[12] This discussion can neither address the full breadth of pragmatism articulated by Dewey and the neo-pragmatist views of Rorty and Bernstein, nor the full scope of controversies that such views and writings have generated. My intent has been to ask about how particular views on knowledge could optimize the chance that the research might lead to optimizing care for women. A pragmatist view that knowledge is about being more effective in the world helped me to frame the importance of epistemology for how the interpersonal is framed, studied, and practiced.

Dewey (1958, 1998) and Rorty (1979) outline a pragmatist view of knowing as needing to be flexible and adjustable to constantly changing circumstances; where 'truth' becomes what works in allowing us to relate to and be effective in the world. For Dewey (1966), the aim of epistemology is to study knowledge and to do this, one must inquire into how people relate to their experiences and to each other in society. Thus, knowledge is personal, experiential, contextual, and political – all at once. If our theories cannot make sense out of our experience, they evolve and are revised. Dewey claims we "know" as a result of inquiring into our experience. Polanyi (1907/1937) asserts that tacit knowing or personal intuition is not 'unscientific' since we have experience before language. Both Dewey's and Polanyi's assertions confirm the importance of experience as the basis for knowing since experience raises questions and directs us to ask particular questions of science. What we tacitly know compels us to research, scrutinize, inquire, disrupt, and re-describe. For example, I surmised that dominant depictions in the literature provided little practical guidance for being in interpersonal relation which provided the impetus for the questions asked in this research.

Contrasting a Descartes-Locke-Kantian tradition of epistemology with a Deweyan pragmatic conception of knowledge, Rorty (1979) proposes knowledge is about "…what we are justified in believing…where we will not imagine that there are enduring constraints on what can count as knowledge, since we will see 'justification' as a social phenomena rather than a transaction between the 'knowing subject' and 'reality' (p. 9). Dewey similarly opposes the notion of absolutes and foundationalism in terms of knowledge, and emphasizes human experience as the basis for knowledge and human understanding. Working to advance James' (Reason & Bradbury, 2006, p. 2) idea that "our beliefs are really rules for action", Dewey focused on the significance of experience and thought as guides to action, shifting philosophy's attention to what people *do* with their thinking and thoughts. For both James and Dewey, a theory of 'truth' is always grounded in practicality. James' (1907/1937) notion of truth rests on the question: what difference would it practically make to any one if this notion rather than that notion were true? James offered a view of 'truth' by asking which view is worthwhile to hold in terms of its practical values in the lives of people. By focusing on consequences, the purpose of

human thinking and conceptualizing are only considered significant to the extent of what they produce and what difference they make to our lives. Working to connect theory and practice, Dewey proposed that practice *is* the place where ideas are tested and ideas become true[13].

As I have indicated earlier in this thesis, a pragmatist view of knowledge provided an epistemological basis for inquiring into the practical consequences of knowing in interpersonal relations to examine impacts on women's capacities for health and health outcomes. I took Dewey's (1938/1955) concern about the value of knowledge in effecting human purposes and worked from a view of knowledge as "…an active, working aspect of life" (p. 59). Framing knowledge as not some kind of static reality but as something that constantly directs and orders the flow of events (or practices) shaped my intent to examine the connection between knowledge and experience for its impact on experiences of childbearing women. I recognize that the 'knowing' constructed in the research is fallible, temporary, and contingent upon the adequacy it can provide for a coherent understanding of the world as the basis for human action (Dewey). Therefore, I asked about the resonance and relevance of the constructed findings in later chapters to optimize interpersonal care for childbearing women and their infants.

Despite the fact that pragmatist philosophers such as Dewey (1938/1955), Bernstein (1991), and Rorty (1979; 1999) do not use the term 'relational', their non-dualistic way of theorizing knowledge and human inquiry resonates with how the term 'relational' is being used in a more contemporary context. In bringing a pragmatic and relational view of knowing to family nursing, Hartrick Doane and Varcoe (2005) claim "a pragmatic view of knowledge assumes multiple truths and interpretations and considers knowing to be a relational process…this means the knower is always central to the knowing process" (p. 10). Thayer-Bacon's (2003) relational epistemology draws together

[13] Critiques of pragmatism claim that it stands for nothing special in terms of values or ends in view, is instrumental in a reductionist sense, and is broadly reflective of a 'vulgar relativism' (Crotty, 1998). I take such criticisms to be a superficial reading of pragmatism and suggest that a focus on the practical consequences of knowledge and theory is not without an ethical or political intent. By specifically engaging in questions of "for what purpose", a pragmatist view despite its lack of commitment to one monolithic state of affairs, urges one to think through the consequences of ideas in terms of adequacy for action in the world and human flourishing (Rorty, 1999).

feminist, pragmatist, and critical social constructivist views of knowledge in light of a similar commitment to non-duality, inseparability between knowers and what can be known, and the idea that what is knowable at any point in time can be revised, improved upon, or corrected as we remain open to the perspectives of selves-in-relation to others.

In summary, a pragmatist view of knowledge draws attention to the purpose of knowledge in effecting human purposes to become more effective in the world, an orientation towards the practical implications of knowledge and 'truth'. Efforts to inquire into a means for representing reality are abandoned for the more practical purpose of "using reality". An orientation to knowledge that focuses on its practical implications and consequences mirrors the concerns and questions about the *effect* of knowledge as it is lived in the interpersonal moment.

The final feature of the epistemological ground for the research is drawn from Caputo's (1987; Caputo, 2000) deconstructive hermeneutics. A deconstructionist hermeneutic approach to research provided a useful way to inquire into extant literature and related the research to underlying epistemologies. Deconstructive hermeneutics brought a critical form of analysis by putting things such as meaning, relating, researching, being, and acting in flux. The "being in the midst of (*inter-esse*)" is necessary to "stick with the original difficulty of life…where the disruptive force of the question is not foreclosed…a radical thinking which is suspicious of the easy way out (Caputo, 1987, p. 2). The next section outlines briefly the epistemological contribution of deconstructive hermeneutics.

Thinking against the grain

In his critique of Western metaphysics of presence and rationality, Caputo (1987) draws on the work of Martin Heidegger to construct a radical and deconstructionist form of hermeneutics. Deconstructionist hermeneutics rests on the necessity of questioning how particular ideas and truths become fixed. Because of the earlier claims made about the necessity to examine the 'fixed' individualistic and de-contextualized ways of thinking within the context research and theory on the interpersonal, Caputo's notion of thinking "…against the grain of everyday conceptions" (p. 268) was a practical and relevant tool. Caputo's deconstructive hermeneutics "writes from below…and describes

the irregularities and differences by which we are inhabited…a critique of hollow assurances and tranquilizing powers of the metaphysics of presence and which by the fact restores the difficulty of things" (p. 6). Caputo advances the necessity of interpretation of our 'factical lives' (such as relational experiences) while claiming that hermeneutics ought to do away with attempts to 'know reality' thereby getting over the human obsession to define and still the experience of being itself. He contends that the way to get over a metaphysical obsession with *being* is to radicalize hermeneutics, putting 'being' and 'knowing' into play. It is precisely this putting into play which complicates life, draws us into difficulty and leaves us standing on 'the edge of the abyss'.

Caputo (1987) goes on to say that radical hermeneutics makes a pass at the human condition, which is not to incite humanism, but to evoke the notion of facing up to the "limits of our situation, to the illusions of which we are capable, to the original difficulty of our lives" (p. 97). He claims this is "hermeneutics" because he sees something liberating here, and not dehumanizing, where the question of human *being* is always underway. The value of Caputo's insights for this research was the importance of 'thinking against the grain' of everyday conceptions, to think through how mechanistic models of human relating and related Western individualistic underpinning of individuals and knowledge have created something akin to "insinuations of presence" (Caputo, p. 11) which deconstruction works to undo. His perturbing insights show the way to limbering up what 'truths' were taken as static and given which provided a way of thinking through alternative possibilities during the analysis.

Inquiry is More than Methodology

> We see action research as a practice for the systematic development of knowing and knowledge, but based in a rather different form from traditional academic research – it has different purpose, is based in different relationships, it has different ways of conceiving knowledge and its relation to practice. These are fundamental differences in our understanding of the nature of inquiry, not simply methodological issues (Reason & Bradbury, 2006, p. 2)

I will close this chapter by indicating that the research methodology was guided by the pragmatist, deconstructionist, and relational epistemological ground of the research. Approaching the study as a living emergent meant that I viewed methodology

as a collection of practices more so than a set of fixed techniques. I approached the study assuming that methodology is both a philosophical and practical orientation to inquiry, not a method to be picked up or put down as one moves in and out of 'the field':

> Knowing is rooted in preverbal, unmediated encounters with 'what is'; it is given its form as it is articulated in presentational form – verbal story, physical gesture, graphic art…and it may be developed as idea and theory, expressed more abstractly and symbolically in concepts and propositions. Our knowing then is consummated in practice, the skill or knack of doing things in the world, which of course gives rise to new encounters. We call this view of many ways of knowing an epistemology which is 'extended' beyond the usual narrow empiricism and rationality of Western academia (Marshall & Reason, 2007, p. 7).

From this point a view, research is more than methodology; it is an ontological-epistemological commitment that is realized in each moment of research.

This chapter has laid the groundwork for describing the methodological approach of the research. I have described the relational and pragmatist views of knowledge that informed the research and will now turn to describe how the methodology was constructed and several methodological principles that illustrate the practical activities of the project.

CHAPTER 4: RE-THINKING AND CONSTRUCTING METHODOLOGY

> Knowledge of technique needs to be complemented by an appreciation of the nature of research as a distinctly human process through which researchers make knowledge. Such an appreciation stands in contrast to the more common view of research as a neutral technical process through which researchers' simply reveal or discover knowledge. Such appreciation requires we reframe understanding and debate about research in a way that goes beyond the consideration of methods alone (Alvesson & Sköldberg, 2000, p. 7)

At the end of the previous chapter, I proposed that what one takes knowledge to be has methodological implications. In this project, studying relational experiences from the perspective of the dynamic interconnectedness of people and contexts, and informed by a pragmatic understanding of knowledge, shaped how I evolved the methodology. Inquiry into the difficulty and complexity of relational experiences and their impacts on childbearing women required a relational ontology and epistemology described in the previous chapter. In this chapter, the workings of such assumptions about people and knowledge are described as they were enacted in the research context. Consistent with emergent constructed nature of qualitative research (Schwandt, 2000a) the methodology evolved in light of the data collection and analysis that occurred concurrently in the research. The methodological approach that I assumed in this project was also informed by wider calls for more reflexive revisions of qualitative social science research by critical, feminist, and postmodern scholars (Alvesson & Skoldberg 2000).

A Qualitative Inquiry

The substantive context of the research and the relational ontological-epistemological assumptions provided the methodological ground for the research. As a plethora of qualitative researchers have written, qualitative methodologies challenge and expand dominant mechanistic (dualist or materialist) and positivist perspectives to a view that knowing arises through active participation in living. I began the research with a view that all qualitative inquiry is essentially interpretive. The 'interpretive turn' in social science research arises from a non-positivist orientation. Emerging from the work of Max Weber, an interpretive approach looks for culturally derived and historically situated

interpretations of the social world, and is primarily concerned with *Verstehen*[14] (Crotty, 1998; Gadamer, 1976; Rorty, 1979; Schwandt, 2000). I am using 'interpretive' research to evoke the idea that knowledge is constructed through negotiations and meanings that arise in and through *relations* between the knower and the known. I have chosen this in contrast to social constructivism, which points to the constructed nature of meaning. And, since interpretive methodologies have been significantly influenced by postmodern thinking and critical theory, there exist varying epistemological stances that cannot be reduced to one particular methodology or set of universally applicable rules or abstractions (Schwandt, 2000).

As I illustrated Chapter 2 and 3, the research questions and epistemological basis of the study assume that knowledge and knowing are experientially-based. Taking this position in research meant that my experiences as a nurse were considered formative of the impetus for inquiry into the literature and the research questions. Understanding the purpose of knowledge in maternal-infant care as about being more effective and responsive to patients, the study methodology was developed with that very purpose in mind. This meant that research methods were not necessarily chosen, but evolved based on what participants indicated was important about their experiences of relationships and their perspective on their impacts on women. The analytical approach was similarly informed by the connection between knowledge and experiences and a deconstructionist hermeneutic lens. In addition, as mentioned in Chapter 1, I began the research assuming that the context of care shapes and is shaped by experiences of relationships and that experiences of relationships evolve over time. Therefore, I spent two-hundred and twenty hours observing and engaging in conversations with participants in two practice sites in both an antenatal home care program and the neonatal intensive care unit; contexts that represented different and distinct points along the continuum of perinatal care.. And, as a neonatal nurse I was fully aware of how health challenges in pregnancy and critical illness in newborn brings significant fear, complexity, and uncertainty into women's

[14] *Verstehen* has been defined by Bernstein (1991) as "the name of the complex processes by which all of us in our everyday life interpret the meaning of our own actions and those of others with whom we interact" (p. 347). This study focused on the "complex process" of experiences of human relationships in health care from a relational view of human beings.

lives. The different features of the institutional and home-based program combined with the potential for vulnerability and harm experienced by women in the antenatal and neonatal period was predetermined to be a rich site for the research.

Involving Participants in the Interpretive Process

The interpretive process worked from the assumption that research texts are a window into human experiences (Ryan & Bernard, 2000; Tesch, 1990). Research texts were the words or phrases constructed within the experience and dialogue that took place during the data collection process. Research texts were from observation, open-ended conversations and reflective writings of my own and the participants; these were texts recorded by myself in field notes[15] and in research journals kept by several participants. My methods for constructing data included informal interviews, conversations during moments of non-participant observation[16], reflective field notes, and reading participants' written insights. In addition, about half-way through the project, I invited participants from both the provider and women patient groups to join in the interpretive work of the study. My intent was to invite participants into the analytic process as a way to deliver on my pragmatic aim to create meaningful insights that would be considered useful for participants. I later came to see that this was also a way to evolve my own reading 'in-between' participants' data.

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[15] I considered fieldnotes to be creative analytic and reflective writing practices in research (Richardson, 2000). My field notes were written for several reasons: to examine my process of constructing the data, to scrutinize my habits of thought, to give new language to different understandings and to challenge taken for granted ideas. I drew upon Glaser and Strauss' (1967) definition of four categories of field notes: *observation* notes (concrete details and renditions of what I hear, see and feel); *methodological* notes (insights about what next, what questions shut down conversations, what being ethical meant); *theoretical* notes (hunches, insights, poststructuralist connections, critiques of what I was doing/thinking/seeing, openness to alternative explanations); and *personal* notes (feelings, frustrations, and doubts for their influences on claims to know and a chance to know myself as a researcher).

[16] I recognize the distinction between non-participant and participant observation and its role in qualitative inquiry. In the research, however, being 'in-relation' with participants mean I was never really a 'non-participant' which implies we can stand outside the process of constructing data. I did not join the nurses in providing direct care to women and I did position myself alongside of women as a participant in their care. Yet, I also would not fully define myself as a 'non-participant' since I assumed my presence was always exerting some relational influence. My job then was to examine this influence in each moment of the research as the basis for engaging in reflexive research.

Inviting the participants into the interpretive processes also was initiated when a group of nurses from the antenatal program expressed interest in hearing what the women in the study were saying about their experiences of relationship. Since the women gave permission for their data to be shared with health care provider participants I suggested another meeting where I would share several of the women's transcripts. When I told the neonatal nurses about this idea 3 of them asked if they could join the next discussion where the women's transcripts would be shared. Although several women expressed interest and were invited to join the group discussions, all but 1 woman could not commit to being involved at this level due to the circumstances of their pregnancy and/or their infant's illness. If possible it would have been powerful to have brought more of the women into all four of these discussions. One woman participant, however, attended the first meeting with the nurses before her baby's birth but could not attend the remaining meeting during her postpartum recovery period. This 'participatory' strategy to bring health care providers and women together indicates a potentially powerful method for future research in this area.

In total I held 1 meeting with the antenatal nurses followed by another meeting with antenatal nurses, 3 neonatal nurses and 1 woman participant. From this second meeting I invited the participants to be involved in data analysis and discussion about the implications of the study for their own practice. Four nurses (2 antenatal and 2 neonatal nurses) came together for an additional 3 meetings until the end of the study. During the second meeting where I shared several of the women's transcripts, a few of the nurses appeared angry and defensive, almost as if they thought I might try to 'explain' the women's negative experiences by connecting these experiences with individual care providers. Several other nurses responded quite differently; they were curious to know more and spoke of feeling compelled to do something in response to the experiences shared by the women. Once it was clear that the focus of the study was to explore how such experiences of both nurses and women were being constructed and focus on the impacts on women themselves, 4 nurses indicated a willingness to go further in the data and make sense of what women were saying. The nurses who chose not to join the analysis conversations cited reasons such as lack of time, skepticism about the practical

value of research more broadly, and 2 nurses in particular denied that it was really as bad as it sounded from women's perspectives. The nurses who decided to engage in the analysis were motivated in different ways; one was embarking on a graduate degree and another one recalled her experience of being a patient and some difficulties she encountered along the way. One nurse said the women's stories and experiences were invitations to know more and she felt an obligation to read and imagine ways to make things better. I decided that the study would be complete once the analysis could help the nurses theorize their practice in useful and meaningful ways to turn around the experiences described by women and optimize their care.

Before I brought my early insight to the nurses, I did some preliminary work such as word counts (for example, like constant comparison and memoing the proportion of negative versus positive descriptions of experiences) to construct patterns in the texts. I initially attended to the words in context while I also distilled their positive and negative implications. Following an initial reading of individual texts, I then began coding based on principles described later in this chapter. With these codes within and among texts articulated, I then proceeded to inductively construct patterns and themes from my conversations with the nurses based on the data. My intent was to not to try to determine alone what held the greatest possibility to enhance women's health capacities, experiences, and outcomes of care but to do so in relation with the subset of nurse participants.

This above discussion is intended to illustrate where my thinking began in relation to an interpretive approach to qualitative methodology and to provide a general overview of my methodological approach. In the remainder of the chapter, I describe the basis upon which the methodology evolved and the related principles that guided the study.

Instructed by the Complexity of Relational Experiences

Caputo (1987) claims that the difficulty of human experience and the complexity of hermeneutic understanding is an invitation to inquire, requiring an attitude of openness to the mysteries of human *being* while appreciating that these mysteries can never be fully understood. Complexity and difficulty were therefore instructive in both the focus and the process of this project. Connecting the substantive topic to how the research was

undertaken created the link between form and function as the most adequate approach for studying relational experiences as they are lived in everyday moments of relationship. Trying to do this was akin to capturing a moving picture, one of trying to capture self-other-context relations in particular moments of care. Caputo claims that one has to be in the 'abyss' of human complexity and difficulty in order to see it; being in it to see it requires the tools and skills of inquiry responsive to the task at hand. How I was approaching methodology was progressively articulated in my field notes:

> Colleen and I were talking today about the various nursing courses we have taught. She said something like "I teach the same course everywhere I go". We both laughed at the irony of that statement. I realized she was referring to how she framed her teaching, one that *is* an orientation to the world and nursing that she has deemed as critical for teaching/learning. Colleen spoke of her orientation as anti-oppressive and anti-racist using the tools of critical, feminist and postcolonial theories, and these inquiries are taken up in various topics and within various sites of practice/research. I started to see during this conversation that her 'theoretical orientation' was not a static thing pulled out now and then, but rather it was living entity, forever 'in process', open to revision and expansion. I remember noticing in my years of being involved in research and other inquiries that, no matter what the topic research project or the specific form that the methodology took, I proceeded in the same way - a participatory and deconstructive approach, drawing on an ever-expanding array of theoretical ideas to open up and expand my own and others' thinking, questions, analyses, interpretations, recommendations, etc. Yet my questions about method are about how to bring such ideas into the practical steps of doing the research. Saying that knowledge is a relational experience is one thing but proceeding with this insight in hand feels like another thing altogether (Field notes, November 17th, 2005).

Caputo (1987) claims a view of method liberated from the strict adherence to technique, could lead to a posturing towards research methodology where the methods themselves are developed to serve the knowledge-generating process. Although she uses different language, Lather (1991) puts forth a similar idea that was helpful for bringing views of knowledge to methodology. Specifically, Lather writes of situated methodologies and by doing so reinforces the critical connection between how one views the purpose of research for how it is undertaken. Writing from a critical feminist perspective, Lather describes the political difference in engaging in research with a view of knowledge based on "dialectical theory building versus theoretical imposition" (p. 61). The result is that theory becomes "…an expression and elaboration of the progressive

popular feelings rather than abstract frameworks imposed by intellectuals on the messy complexities of lived experience" (p. 62). Situated methodologies rely on seeing how research practices arise from the specificities of situations. From this view, methodology cannot be prescribed ahead of time but is negotiated to respond to the diverse ways in which power, language, representation, politics, and ethics in research are understood. In my study, this meant being open to seeing how each moment of research is shaped by differences in power, perspectives on knowledge, language use, and views research ethics. I later came to see how the idea of 'bricolage' would be helpful for articulating my process.

Research as Bricolage

The concept of bricolage was originally articulated by Levis-Strauss' (1966) and has been described by Denzin and Lincoln (2005) and Kincheloe (2005). Understanding qualitative research as bricolage implies that the researcher employs methodological strategies as they are needed in the unfolding context of the research situation (Kincheloe, 2005). Research as bricolage works from the assumption that a dialectical relationship exists between knowledge and reality and that knowledge development requires research methodologies and methods that support multiple ways of seeing and making sense of complexity, unpredictability, and interdependence. Kincheloe refers to how pursuit of complexity avoids the development of "monological knowledge" (p. 326). From this perspective, researchers require something other than externally imposed methods since complexity demands the rigour of the bricoleur. Positing an 'active view of methodology' does not imply a lack of theoretical coherence, but locates epistemological innovation on a different basis. Kincheloe call for a re-thinking of methodology by moving away from

> …reductionistic knowledge of externally imposed methods, the bricoleur works in pursuit of complexity by sidestepping monological forms of knowledge. Monological knowledge is produced in the rational quest for order and certainty. In such a trek, a solitary individual, abstract from the cultural, discursive, ideological, and epistemological contexts that have shaped him or her and the research methods and interpretative strategies he or she employs, seeks an objective knowledge of unconnected things-in-themselves. Monological knowledge not only reduces human life to its objectifiable dimension…but also is incapable of moving beyond one's individual unilateral experience of the world.

> At its core, the bricolage struggles to find numerous strategies for getting beyond this one-dimensionality (p. 326).

In my field notes, I questioned what was methodologically required to see and make sense of complexity. For example, although interview provided rich text data, there were additional aspects of participants' experiences expressed in spontaneous conversation as I joined them during interactions with one another (such as accompanying women to and from the NICU or outpatient appointments or joining health care providers as they provided care to women and fetuses/infants). I worked from *within* the demands of the research to see how experiences were being constituted both individually and contextually. Researching experiences of health care providers and women required "…recognizing that the complex ontological importance of relatedness alters the basic foundations of the research act and knowledge production process" (Kincheloe, 2005, p. 334). Enlisting the idea of research as bricolage retrospectively helped me to see the basis upon which I re-thought methodology in order to proceed.

Re-thinking Methodology

I undertook the research from a view that methodology was more than simply aligning process with product (Crotty, 1998). In qualitative research, similar claims have been made about how particular research methods themselves arise from a predetermined fit with research questions. Thus, the fit between question and method is generally held as a primary goal (Speziale & Carpenter, 2007 p. 25). However, what this 'fit' actually looks like in terms of research practices is often less explicit. Holding that epistemology and methodology are inseparable (Alvesson & Sköldberg, 2000; Lather, 1991; Reason, 1994, 1997, 2000; 2006; Lincoln & Guba, 2000), I began the research with a view of methodology as more than a set of prescriptive techniques to be picked up, applied, and put down. Drawing on Caputo (1987; 2000), I began to understand that I needed a working methodological form in order to enact a relational epistemology and a deconstructive hermeneutic intent. The most obvious implications were related to the methodological choices and decisions I made as the research unfolded.

> Colleen and I were talking today abut how often methodology is written and spoken of as an "it" that one picks up or puts down when entering or exiting the

> research 'field'. In the early days of the research I actually had the opposite sense – that a research methodology had *chosen me*; that is it was already in use and was already underway and my task was scrutinizing it so as to be able to articulate it and continue to proceed in ways that were recognizable as both rigorous and ethical. We talked about the metaphor of methodology as skin rather than a coat as a ways to distinguish different ways to proceed. I spoke of research methodology as being 'enacted' rather than 'applied', and spent time showing potential participants by offering to walk beside them in their daily practice/lives. I spoke of the methodology as qualitative but felt a greater need to *show* potential participants what it might be like to be involved. I spent time tonight again in the NICU during evening shifts holding babies and helping out, so the nurse might have a sense of what being with me in research might be like. I assumed that this being with was about both recruitment and the active conduct of the research (Field notes, May 10, 2005)

Caputo (1987) warns that a preoccupation with method as fixed technique thwarts our potential for seeing method as "…an acuity that knows its way around" (p. 211). He writes of the instrumental aim of methodology as not being helpful in understanding the difficulty of human existence and calls for a view of method that serves and liberates inquiry rather than one that rules and constrains. Hartrick (2002) raises concerns about the authority sometimes granted to method in nursing research and practice "…as we have developed and given precedence to method, we have simultaneously lost and/or not developed the confidence and courage to open up to our own creative and scientific potential" (p. 54). This research was undertaken with this very idea in mind.

In thinking about and constructing the qualitative methodology, I have drawn on thinkers and writers who have explicitly worked to articulate the methodological implications already embedded in this epistemological orientation. Although a plethora of writing exists on the need to widen the philosophical grounding of research methodologies, I found little in the way of practical guidance for theorizing and practicing methodology and methods in the actual moments of the research. Caputo's (2000) deconstructive hermeneutics, however, as a philosophical text was particularly helpful in providing some practical forms of questioning and analysis in this project which is why I enlisted his writings for a methodological purpose.

I articulated four aspects of how I developed the research methodology. First, evolving epistemological assumptions into a methodology for proceeding was neither an

unstructured nor haphazard process, it flowed from a relational view of knowledge and its pragmatic purpose which has not yet been articulated in published literature in practical methodological form for research. I found the prolific and widely cited work of Bradbury and Reason (2006) on researching 'living forms of knowledge' generally lacking in practical direction for research, such as those involved with recruiting participants. Working from a view of the details in conducting research as anything but mundane, I saw that activities such as negotiating 'entry', budget decisions, writing publications, developing dissemination strategies were important for setting the tone of how participants and I would interact.

Second, making decisions about how best to proceed did not take the form of predetermined methods, rather, the methodology and specific methods were generated from an intentional critical and interpretive stance to inquiry. This resulted in an active mode of research, where I became the "mediator of structure and method" (Hartrick Doane & Varcoe, 2005, p. 264), a process wherein I determined the shape and structures of inquiry rather than being guided by – although I was definitely informed by – the structures and methods of others. It is critical to note, however, that in the development of methodology, my ideas and ways of proceeding drew on the work of others who share similar views of research methodology and were making similar efforts to articulate practical aspects of research (Alvesson & Sköldberg, 2000; Bentz & Shapiro, 1998; Kincheloe, 2005; Lather, 1991; Richardson, 2000).

Third, I undertook the research with a view that methodology is *enacted* rather than *applied.* This meant I understood rigour, quality, integrity and trustworthiness as creating in the relational processes of reflexivity. I did not consider myself a solitary researcher but one continuously influencing and being influenced by the research context itself. Fourth, seeing the value in research of *not knowing* (Hartrick Doane & Varcoe, 2005, p. 263) was an intentional strategy for becoming conscious of how my relational view may be obscuring my capacities to hear and listen to experiences that were otherwise. This required following the lead of participants as they showed me what they knew as they were continuously engaged in knowing.

The next section describes the methodological approach by indicating four working principles that informed the research. The 'naming' of these principles occurred while in the midst of the research; there were not *a priori* rules for proceeding. The following methodological principles were constructed based on the relational view of experiences and my research questions focused on experiences and impacts of relationship. Recall these research questions were:

1. How are health care providers' and women's health care experiences of interpersonal relations in a maternal-infant health care context constructed?
2. How do experiences of interpersonal relations influence childbearing women's health capacities and health outcomes?
3. How are epistemology, qualitative research methodology, and research topic related?

The connections between research topic and epistemology will become apparent as the following principles are described: (1) Methodology as folded into topic; (2) Methodological strategies created in research relations; (3) Researching original difficulty; and (4) Creating a complex account.

Working Methodological Principles

Principle #1: Methodology as Folded into Topic

The first principle reflects my research question about how epistemology, qualitative methodology, and research topic are related. When proposing the research, I described the possibility of methodology as implicit in the substantive topic itself. The idea of topic and methodology as connected arose from asking about how a relational view of knowledge was relevant for how the research would be undertaken. I did not consider the construction of methodology from a relational epistemology as a deviation from traditional research norms. Rather, such an approach to research calls for different criteria for rigour and a different way of relating form to function. The form of this research emerged from interests, themes, and assumptions outlined in Chapters 1-3 while the aptness of the form was evident in the extent to which it embodied the concerns of the research itself as the basis for proceeding.

The idea of form and content as inseparable (Richardson, 2000) became relevant when designing the initial practical steps of getting the research off the ground. The very idea of knowing as a relational process required attending to the implications of connecting what the research was about with how it was undertaken. Working from a relational epistemology provided a way: (1) to develop a methodology of "being in-relation" as the context for knowing, and (2) to theorize from health care providers and women's relational experiences for the impacts on childbearing women's health capacities and outcomes. These simultaneous and interrelated intentions that co-evolved through the research indicated the intersection of methodological and substantive aims of the research. Early in the study, I noticed this connection:

> I noticed something today about my 'methods in action'. As health care providers and women spoke about what they deemed to be important about their relations, I began to see how their insights are also practices of inquiry in research. Or, ways of engaging in research relations. One woman participant spoke of what makes nurses' trustworthy and these insights might also be related to how proceeding ethically in research might be viewed in this study; where the 'what' informs the 'how'. Might this inform my future interactions and conversation with her in a way to *create* the context for my insights, questions, knowing, etc? I can see how working from and with participants' insights about interpersonal relations is one way to shape methodological processes and interpersonal research relations – deeming both to shape the knowing context and inquiry tools to inquire more (Field notes, May 15th, 2005).

Research Participants in Two Practice Contexts

Two care-giving contexts were chosen based on my assumption that context matters for how experiences are constructed. Research participants were drawn from two maternal child care programs located within the same Lower Mainland Health Authority. The first program was an Antepartum Care at Home Program (ACAHP), an outpatient service for women experiencing health problems (maternal and/or fetal) in pregnancy who can be safely cared for at home. The second site was a neonatal intensive care unit (NICU), an inpatient service that provides care Level II newborn intensive care to critically ill neonates and their families (see Appendices A and B for program descriptions). Both programs are administered through the same hospital site in the Lower Mainland and both programs serve childbearing women, families, and infants

living in the geographical area which falls under the domain of service provided by the Health Authority. The population of interest for the research were health care providers (nurses, physicians, social workers, occupational therapists, physiotherapists, and spiritual care providers) working within these programs and childbearing women served by these services. Subsequent chapters also outline relevant contextual features of these programs during the description of the analytic process and discussion of the constructed findings of the study.

My decision to conduct the research in two clinical contexts reflected my assumption that the differences in context hold consequence for experiences of self-other-context relations. For example, interpersonal interactions between women and health professions within the outpatient program were often brief, such as during an antenatal ultrasound, whereas relations among care providers and patients/families in the NICU were longer and more intense, often lasting for weeks or months. One woman participant who received an outpatient fetal diagnosis of a congenital abnormality had very brief encounters with health care providers; she went home within 30 minutes of the diagnosis with instructions to return the following week. Women whose infants were admitted to the NICU spent long periods of time interacting with care providers – up to ten to twelve hours per day at their infant's bedside. These programs were selected as the research sites in light of this diversity which provided the chance to see the importance of differences in physical space, access to care providers, policies and practices, unit 'culture', differing ratios and skill mix of staff, program philosophy, and management/leadership structures.

The relevance of the notion of methodology and method as folded into topic also became evident when advertising and recruiting for the study. How I spoke of and framed the intent of the study and engaged with potential participants was critical for successfully recruiting participants. Being open about the fact that the research aims and process were only partially determined in advance, provided the opportunity to engage participants in discussion about what they believed was important about the topic itself, and what they understood as the best ways to proceed. Working from the pragmatic assumption that knowledge is living process, and not an abstraction from everyday experience, I proceeded by engaging *with* health care providers and women as we

inquired into their experiences as the basis for constructing insights about the impact of those experiences on women's health capacities and outcomes.

Within a few weeks of talking to both health care providers and childbearing women about the study, I began to see another layer of how the methodology and research methods fold into topic. I began talking to and recruiting potential participants with the idea that experiences in research are constituted in interpersonal space of inquiry; participants' experiences and mine as a researcher would influence what 'knowing' was constructed. The connection between researcher-participant relations and the quality of the research 'product' required continually connecting the quality of research relations (in terms of being respectful, responsive, and ethical) to the ultimate 'products' of inquiry.

Once I was able to see this connection between methodology and topic, I extended the advertisement and recruitment period from 3 weeks to 2 months before the research 'officially' began. Nurses in both practice settings and women themselves expressed an interest in just 'having me around' during their daily work or life activities (for some women this was periods of bed-rest, for others going to appointments or being in the NICU). I saw this as potential participants' way of 'trying out' the research (and researcher) before indicating a willingness to participate. In this early recruitment phase, I spent a total of 60 hours between the two programs and among health care providers and women from both programs. In my field notes I questioned whether or not these 60 hours were well spent, asking about the evidence in terms of "hard" data. What I did have were insights that would inform how I would proceed, insights that made clearer the interrelatedness between methodology, methods, and topic in this project. Recruitment strategies continued to evolve from relations with potential participants themselves, and my 'success' in recruiting participants lay in my ability to slow down and be tuned in without worrying how quickly my sample would develop. I also sensed this process as important for the nurses, as if they wanted to show me their practice before I set about scrutinizing it for my research purposes. Spending this recruitment time with the nurses and other health care providers and women as potential participants challenged me to

continually construct an interpersonal space that would create both the research context and construct the integrity and quality of the research 'product'.

The research sample was comprised of twenty-nine participants: fifteen health care providers, 1 cultural interpreter and thirteen childbearing women (see Appendix C for description of participants and assignment of participant codes). Of the fifteen health care providers, 9 were nurses, 3 were social workers, 3 were physicians and 1 was an occupational therapist. Of the thirteen women, 7 were enrolled in the Antepartum Care at Home Program (ACAHP) and 6 were mothers of infants in the NICU. All of the women's lives were shaped by the fear and uncertainty about their pregnancy and/or their fetus/newborn's health. Twelve of the thirteen women's life contexts were shaped by experiences of being new immigrants and living with health challenges in pregnancy and/or their infant's neonatal illness. These women's lives were uniquely situated through the intersecting impacts of migrational experiences and 'high risk' pregnancy which created particular vulnerabilities and strengths within the context of relationships with care providers. The women ranged in age from seventeen to thirty-six years. For the ACAHP program, criteria for being "on" and "off" the program are determined through a points rating system which indicates level of risk to mother and fetus posed by particular complications such as pregnancy-induced hypertension, fetal congenital abnormalities, gestational diabetes, premature rupture of membranes, and threatened preterm labour. Of the 5 NICU women participants, 3 had been discharged home from postpartum while their infants remained in the NICU, 1 of the women was still admitted to the postpartum unit and one woman's infant was 2 years old at the time of the research, having been in the NICU for the first six weeks of his newborn life.

The sample selection strategy was purposive, shaped toward achieving maximal variation for constructing an unfolding understanding of themes that emerged from the analysis process (Thorne, Reimer-Kirkham & MacDonald-Emes, 1997). Informed by the concept of theoretical sampling (Morse, 1995), I worked to create maximal variation in the data in order to create a sufficiently strong basis upon which to make confident claims about the commonalities and differences across the variables which are essential to the analysis (Thorne et al. 1997). Nurse educators, managers, and staff who were not

involved in providing direct care to women, infants or families helped to advertise the study by putting up posters Appendices D and E and providing information pamphlets to health care providers and women; those assisting me with recruitment were provided with an information script to guide their discussions with colleagues and women (Appendix F).

In a number of instances, nurses attempted to pre-select participants by noting that particular health care providers or women would be "good ones" for my study. My decision to follow-up on their suggestion usually was informed by my aim to generate maximal variation in the study in terms of participants' experiences, perspectives, etc. (Morse, 1994). At times, the processes of 'selection' and the politics of positioning certain people as "good informants" could have become an entire research study in and of itself. This insight highlights how much of the literature in the area of sample selection is, to some degree, overly simplistic, failing to account for the complexities and politics of 'sample selection'. I found it both remarkable and concerning how nurses, in particular, created criteria for distinguishing "good ones" for my study. For example, a number of nurses referred to the problems in interpersonal relations as "cultural", where culture is defined along 'racial' lines[17] or as synonymous with ethnicity. One nurse told me exactly which women I needed to recruit. Several nurses spoke of a particular women's culture as making relationships challenging to develop and sustain. I was struck by how nurses spoke of women as having culture but saw the systems within which they worked as relatively culture-less. Many of the insights developed through recruitment and sampling became another form of 'data' which is more fully described and analyzed in later chapters. Suffice it to say here that the very criteria used by nurses and other health care

[17] Putting race in quotation marks reflects my concern about the tendency to use this term as though it is not problematic. Since there are not unambiguous, water-tight definitions of "race" and "ethnicity" and given the strong relational and contextual determinations of their meaning, I have taken Rattansi's (1995) caution seriously when she states "…the inherent conceptual difficulties of strong classificatory programs (such as those attempting to define ethnicity and race) in the human science have, around these questions, been hopelessly exacerbated by becoming intertwined and having to come to terms with the astonishingly complex manner in which populations appear to draw and redraw, maintain and breach, and narrow and widen the boundaries between themselves and others" (p. 253).

providers to select women for my study was sometimes done of the basis of conflating culture and ethnicity and then using a particular understanding of difference as divisive to explain why relationships can be challenging. These criteria to some degree reflected their "theories in use" of interpersonal relations, the very theories that shaped the ways in which they understood (and acted upon) women's health capacities and outcomes. In this way, I could see that particular 'conditions of possibility' (Foucault, 1984) were being lived relationally in ways that influenced both relationships with colleagues and with women themselves as well as my research process.

Gaining Entry

Gaining entry is often only briefly mentioned in research studies and at times is spoken of in mechanical and simplistic ways. Yet, in this project, these initial engagements set the context for the research and powerfully anchored all research activities, relations, and processes. I quickly discovered that the processes for conducting research were as complex, shifting, and multifaceted as the relational experiences and their impacts I had set out to study. By working from a view of methodology as folded into topic, I approached the 'entry' work as setting the tone for research relations that would eventually constitute the insights, approach to analysis, and findings. For example, as I met with Program Directors and Clinical Leaders to explore their programs as potential research sites, their initial responses to the topic were critical for determining the success of my recruitment efforts. I spoke about wanting to study the impacts and effects of relationships on women by gathering the perspectives of health care providers and women. Their responses included: "now that's a can of worms", "better you than us", "that might really help us do some work we know needs doing"; "tough topic but critical in light of what has been happening in NICU" and "so this is more than patient satisfaction…which really doesn't get at the real issues". Nurses and childbearing women also provided some insightful responses: "I am not sure I will like what I see of me" (staff nurse); "I never thought anyone would care enough to ask" (mother in NICU); and "will this be useful to us?" (a social worker). Gaining entry, then, became a relational process that was about my ability to hear these responses and enlist them as I proceeded. I began calling these responses the "nod factor", a signification that health care providers

and women found the topic to be important despite the fact they perceived some personal risk in the topic itself. On a number of occasions nurses in leadership positions cited their own response to the focus of the study when encouraging program staff to participate. Examining these responses became the 'entry' point for the research itself. How I responded and enlisted their responses was an intentional methodological decision that contributed to data analysis.

Ethical Approval and Ethical Practice

The process of ethical approval provided a way of judging the research and its methodology and methods *a priori*, while the day to day engagement with participants and processes for doing the research was deemed the broader context for *being* ethical in research. After receiving ethical approval from the University of Victoria Human Research Ethics Committee and the Research Ethics Board of the Lower Mainland Health Authority within which the research was conducted (Appendix G), and after creating various research procedures for upholding the Tri-Council ethical principles (for example, consent forms, information pamphlets, etc), I began questioning what form 'being ethical' would take in the everyday moments of research. There was the obvious adherence to the protection of privacy and confidentiality. All participants were assigned a code and identifying features of their work and lives removed from the data and my research log entries. Verbatim quotes are only used by referring to "one woman" or "one nurse" rather than creating a potentially auditable trail that could reveal a participant's identity. Participant codes were developed for ease of transcribing and analyzing the data. Several women participants voluntarily chose to reveal their identity to other participants when they told nurses about why they chose to be involved. We discussed the benefits and harms of revealing identity in this situation, however, three women spoke about the "un-ethics" of remaining anonymous in light of concerns they had about their care. In these instances, I also referred these three women to the clinical leaders in NICU and ACAHP who could more appropriately help them to voice their concerns and be supported when taking them forward.

I also became aware that seeing a connection between methodology and topic might also shape my efforts to proceed ethically in research. Working from a view of

morality and ethics as lived relationally in everyday human experience and as a "deeply personal process that is lived in the complexity and ambiguity of everyday nursing work" (Hartrick Doane & Varcoe, 2005, p. 283) required continually asking what form "doing good" in the research would take. Specifically, I aimed to keep open the question of how the Tri-Council's Policy's (TCP) ethical principles become a resource in each moment of research. This seemed a relevant place from which to think about being ethical particularly in light of the TCP goal to

> …encourage continued reflection and thoughtful consensus….while not offering definitive answers…rather, it seeks (a) to outline guiding principles and basic standards and (b) to identify major issues, and points of debate and consensus, which are essential to the development and implementation of coherent policies for research ethics (Ethical Conduct for Research Involving Humans, 2005, p. i.3).

The Tri-Council's ethical principles of respect for human dignity, free and informed consent, vulnerable person, privacy and confidentiality, justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit were practical tools for asking myself in each moment of research what form upholding these values looked like. What this required was a fully conscious participation in and scrutiny of my own self-knowing as a researcher in every act of inquiry, while also keeping open the question of how the meaningfulness of those ethical principles is negotiated in the relational spaces of research. Holding this question open meant being able to see and ask other questions: Are my pragmatic ends in view ultimately of benefit to participants and whose definition of 'benefit' counts? I concluded that *being* ethical in research is enacted relationally through methodological decisions which are informed and reformed in each moment of inquiry, while also being open and clear about the purposes of the research with all those involved.

The Tri-Council's ethical principles became a resource for thinking through how I made particular choices in certain moments of research relationships. It struck me that being ethical was about the skillful traversing between knowledge of ethical principles in research and attention to the particularity of each moment of research. For example, all primary participants were given an information and consent form (Appendices H and I) to read and sign prior to participating in the study. Primary participants were also

provided with a copy for appropriate contact information and their own records. Secondary participants were those care providers or family members who were present during research conversations but who were not consenting participants. Secondary participants (Appendices J and K) provided verbal consent and were also provided with written information about the study for follow-up contacts and their own records. Because pregnancy and childbirth have been noted as a source of vulnerability for women in research (Loiselle & Profetto-McGrath, 2007), and women's vulnerability was heightened when experiencing physiological threats to their own and their fetus/infant's well being, I expected that the possibility of 'vulnerability' was relevant to both primary and secondary participants. Therefore, it was important to pay attention to how various harms could be experienced by participants in light of their various designations as primary or secondary participants, without predetermining more or less potential for harms. For example, one woman participant's husband, who was a secondary participant, became quite upset when hearing about how his wife was still suffering years later from what she described as dismissive care, and that this might be influencing her present willingness to attend appointments as an APAHP patient. I decided that the processes of respect for human dignity, privacy, confidentiality and informed consent were always active, requiring conscious attention long after the consent forms had been signed.

The vulnerabilities created for women within the context of fear related to pregnancy and fetal/newborn health was a critical consideration for proceeding in thoughtful, responsive, and ethical ways. The Chair of the Research Ethics Board in the health authority where the research was conducted commented on the 'ethics close out form' that I had inadvertently engaged 'vulnerable' women participants. I was asked to amend the form to confirm that this vulnerability was explained by the fact that 11 of 13 women described themselves (or who would be described by others) as new immigrants to Canada. Although I did not set out to construct such a sample[18] I was not surprised by

[18] I did not hypothesize at the outset of the study that my questions were more or less relevant to particular women, however, I was well aware of research evident of strong connection between the social determinants of health for their impact on women's reproductive outcomes, and the association between risk conditions in pregnancy and their social, political and economic context. In light of how the life experiences of particular women were described as inseparable from their experiences of relationship in

the demographic and experience of my sample since the geographic location of the research serves an area where a significant proportion of the population are new immigrants. I inquired about women's immigrations experiences as they became relevant for listening for the whole of women's lives. In light of how several nurses took a paternalistic stance by conflating ethnicity and culture and drew conclusions about how being a 'new immigrant' can explain why relationships are challenging, as a researcher I tried to mitigate these assumptions by reframing these conflations in our discussion. I shared with the nurses that some of the women spoke of feeling vulnerable for myriad reasons while a number of the women described themselves in other ways. I concluded that the most important 'special protections' of risk and harms for the women in my study was to construct a space in research for understanding the intersection among their life experiences (for many women their immigration experiences figured prominently in our discussions) and their interpersonal relations with health care providers. I later determined that it was a tendency of health care providers tendencies to, in some case, think they 'already knew' women as through assumptions about immigrant women based on race that negatively impacted women participants' experiences.

I identified known risks, benefits, and harms that might arise and included these in discussion of the research and processes for obtaining informed consent. In one situation, a participant's sense of risk changed as she made the decision to share a part of her interview transcript with her former physician. She felt compelled to write a letter outlining her concerns once she had read them as they were voiced in the transcript. This shifted her perception of risk as the study unfolded. The principle of balancing harms and benefits needed to be put into relation with the participants' experience of risk so as to keep the conversation open and active rather than static and closed.

The most ethically challenging aspect of the research involved protecting the anonymity of health care provider participants. Since I joined them in their daily work, home visits, and various care giving activities, nonparticipating care providers knew which care providers were involved in the study. I was, of course, visibly present in their

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maternal-infant care, it then became reasonable to conclude that particular women's life context creates a degree of vulnerability that is critical for accounting for within the interpersonal domain of care.

work lives and I was perplexed at how to get around this. I later realized the issue was less about my visible presence than about being a participant and their willingness to have me there while acknowledging the threat to anonymity my presence created.

A final example related to perception of risk, benefit, and harm that arose in the study reflects the importance of methodology folded into topic. Several ACAHP nurses called the research topic a "can of worms", which I interpreted as indicating there was some degree of personal and ethical risk to their participation. The NICU physicians and nurses appeared hesitant to join until they had a better sense of what form the research would take. Something about what the nurses and a physician believed about the study created caution. One nurse said (following our six-hour night shift together):

> You have to know a lot about the person doing the research on a topic like this before saying yes. I mean, like taking a look into our practice is one thing but to do so and also be talking to moms and families – I guess it might be good you can't ask the babies… [laughter]… I mean, what would they really say? [more laughter]. I think we will learn some things. Well…we know you, so in some ways we know we can trust you, 'cause when you are with students, everyone sees your real colors as a person. I would have to know that I am safe, especially with a topic like this, but then again, knowing you from before, I think I know I am. So, yes, sign me up. You know, things have been a little dull around here anyway…might be time to shake things up.

I came to understand how ethical practice in research was both a way of proceeding that arose from the integrity and the intentionality of methodology. Working from a view of method and topic as connected created a way to theorize ethical practice in research as it was informed and reformed by the connection between interpersonal spaces in research and interpersonal spaces of maternal child care. The next methodological principle illustrates how working from a view of methodology folded into topic meant that all methodological strategies and particular decisions about methods of data collection were created in the relational context of research.

Principle #2: Methodological Strategies Created in Research Relations

As alluded to above, the methodological strategies I used relied on assumptions that knowers are inseparable from what can be known and that knowing itself is a relational process and experience. I, therefore, needed to discern what methods would help me see, hear, and notice what participants were saying and pointing to in relation to

the research phenomenon. As I launched the study, I soon learned that understanding the influence of relational experiences on women's health capacities and outcomes could be both shown and described. I set out using traditional qualitative methods of interviews and participant observation and then expanded these data collection strategies to include the strategy of "following the lead" (Hartick Doane & Varcoe, 2005, p. 266) of participants. This idea of following participants lead implied that they knew best about what and how to share their experiences of the interpersonal. Assuming each participant already 'knew' meant shifting the responsibility to 'get the data' to a process where the space for their insights and experiences could be expressed; this meant being in places without always knowing why I was there! These "places of knowing" were as diverse as the participants themselves; data collection methods evolved to also include formal and informal conversation, participant and non participant observation, my field notes and those written by participants, and semi-structured and unstructured interviews.

Other methods arose based on unique experiences of participants as they decided what they wanted to tell me or show me. For example, one woman participant showed me photos as her way of recalling her birth experiences of her extremely premature son – this was a powerful 'visual' interview where the photos spurred me to ask questions I might never have asked otherwise. She showed me photos of herself, her son, and their primary nurse. She spoke about her son's primary nurse as the "best nurse" through her son's admission, which led me to ask what created 'best' in her eyes. This conversation and others with this woman always began with her photos and showing me the tangible memories of NICU. This woman spoke of how her son's nurse 'worked the system' in ways that help her get what she believed she needed to mother her son. Without being open to this photo interview I may have missed how to follow her lead into the places from which she wanted to speak. Conducting research from this point of view, it follows that one would not insert methodological decisions and particular methods for collecting data into the research but, rather, such decisions and processes would arise from the evolving relational flow of the research itself. I will illustrate two particular strategies to show how this happened: 'leading by following' (Hartrick Doane & Varcoe, 2005) and being an instrument of rigour in the research.

Leading by Following: Data Collection Methods

Leading by following was a methodological strategy intended to resist the authority often bequeathed to pre-determined methods of data collection. Approaching methodology by appealing to rules of method would have gotten in the way of being relationally responsive in research. As indicated above, data were collected through observations, my own and participants' written notes, taped interviews, informal conversations in various places such as cars, during medical/nursing rounds and in women's homes, and through email and telephone conversations (see Appendix L for overview of methods and data sources). In many instances my field notes were shared with participants as a way to respond to their questions about how I was coming to understanding the 'findings'. Much of my analytic work was depicted in these field notes and my weekly diagrams of what I was learning were often the best way to hold both the whole and the particular together. Yet, I also now realize that 'laying on' my analysis as it evolved may have also created an interpretive authority which constrained the development of alternative or competing conceptualizations.

One nurse participant (described by her colleagues as "super-critical") was a key person for helping to disrupt and provoke some of my 'tidy' schematics. She did not show any initial interest in the study, however, I did later seek her out to be a participant. She was the same nurse described by her colleagues as likely not interested in the project. My sense was for precisely this reason I should follow-up with her. This nurse joined the study and eventually the subset of nurses engaged in analysis. She became a rich source of counter-interpretations and critical questions. She often said "convince me". On two occasions I noticed that other nurse participants jumped in to tell her what "we" were learning and took on the task of explaining to her how we had arrived at certain insights and understandings. This created a methodological form of rigour (and a way for me to hear how participants were constructing insights and findings) that may not have been possible if I had located interpretive work solely within the researcher's domain.

When sharing field notes and emerging insights, both the nurses and women participants raised questions, often disrupting my emerging conceptualizations. In some

instances, they “rounded out” a picture that in their eyes was not yet complete. For example, one woman participant said

> Ok, so now I’ve told you and that’s right, you’ve got it right, but now I need to show you what its like, and then you can tell me if how I talk about it connects with what it looks like from your point of view.

The ethical response in this situation was to both honor the woman’s need to make sense of the emerging interpretation, while also holding my research questions in the foreground, believing that both can co-exist from a methodological point of view. This illustrates how some methods of data collection were partially known in advance yet many methodological choices and methods were field noted as ones that were shown to me. My ‘trigger’ questions, for example took a different form during car rides and walking between examination rooms. Seeing knowledge as something that lives in and through relating selves-others-in-context meant that I needed to be ready to see what participants wanted to show me. At no time did I abandon my questions or my research “hunch” about the power and influence of interpersonal space of practice, however, my questions grew in complexity and scope which gave rise to a wider array of methodological and analytic possibilities.

In different moments and for different reasons, the activities of leading and following participants created methods of data collection. For example, I realized that my need for interviews reflected my initial view that the transcribed interviews represent ‘real’ qualitative data -- then I would have a pile of transcripts that I could see and touch. Yet, as the research process unfolded, I found that taping conversation sometimes got in the way of conversation with some participants; in a few instances, when I turned on the tape, a kind of stillness came over the room. Sometimes I successfully pushed through this stillness, however, I noticed the informal places of conversation spurred a more spontaneous and thoughtful conversation – for both of myself and participants. I noticed that during taped interviews with the ACAHP nurses, there was a greater tendency (I think) for them to say the things that they thought I wanted to hear. This concern is articulated in this segment from my field notes.

> By the end of one interview, I was actually trying to still the flux, find an essence, theorizing interpersonal relations as an objectified ‘it’ so as to be able to peer into

> "them", and then package them and figure out how to make the other interviews resonate with this one. The interviews where this is did not happen occurred when I was with a participant, already in the midst of conversation, and then said 'can I turn on the tape?' When I pre-booked an interview or scheduled it in isolation of some experience together (riding in the car, visiting women, being in the clinic, on rounds, accompanying women to appointments, helping with household things for women on bed-rest) there was a stillness (in terms of insight and analysis) that almost created the very thing I was trying to disrupt (Field notes, June 23rd, 2005).

My efforts to inquire through and connect across cultural differences (my culture as an academic researcher and the various life contexts of women participants) required rethinking some prevailing research norms of getting "data". I recreated methods in each moment so as to rethink how "hard data" is defined by whom and for what purpose. One woman participant showed me how, through her relationship with her English speaking sister, we could have a conversation where the issues of 'translator bias' became irrelevant and antithetical to my purpose. The three of us created a common ground from which we could each speak, ask questions, and clarify insights relevant to the research. We met several times as a threesome and became increasingly able to 'hear' each other and, in fact, several analytic insights were developed in these three way conversations.

Another example of research methods created in research relation became visible as one woman/mother participant in NICU told me where I needed to be if I really wanted to know the effects of interpersonal relations and spaces on her capacity to mother her preterm infant. I had to come to medical rounds in the NICU. She told me that in the briefest of moments on rounds was where it "all showed up". She knew something was going on here as she struggled to be heard, particularly in light of her previous efforts to be allowed to be at her baby's incubator during rounds. She showed me and spoke about the dominant voices at work in both positive and negative ways. She wanted me to see how nurses advocate on rounds for infants/families, and physicians either respect or silence nurses' efforts. This woman spoke about her refusal to be passive during rounds, and to insert herself and her concerns into this two minute conversation. She wanted me to see that she refused a particular 'subject position' (I think). In one instance she was told following rounds that her questions had already been answered on rounds and she replied "but now I have more". This 'method' of being present in the

places deemed relevant by participants underpinned most, if not all, the data collection methods.

One final example illustrates how methods arose from research relations in context. One nurse participant asked me why I was the only one field-noting. She then reached over and took my notebook asking where hers was. I answered by asking about her favorite colour. At our next meeting, when she grabbed my notebook again, laughing as she told her colleagues about taking it the day before, I handed over her personal purple notebook. She said “ok, is this official, am I now the researcher?” She handed her notebook to me at the end of the project having written 47 pages of her own inquiries, insights and questions. As the study continued, I gave out three more notebooks; two to nurses and one to a woman participant whose infant was in NICU.

Researcher as Instrument of Research Rigour and Integrity

As already stated, my intent was to keep the methodology open and responsive to the emerging insights and analyses. Taking this approach also meant that I understood research rigour and integrity as created in each moment of relationship with participants. This implies that the quality and integrity of the study were created through being reflexive, where reflexivity was a relational process with participants. As the researcher, however, it was my responsibility to continuously pose questions about how the research was being conducted in ways that would value participants’ contributions and expectations while also move toward answering the research questions. I intentionally enlisted the image of myself as an ‘instrument of rigour’ to remind myself of my ongoing responsibility to create the rigour of the study from within rather than assuming that rigour was created by adhering to fixed techniques of method. Being an instrument of rigour was not thought of in a mechanical sense of instrumentalism; rather, it was/is intended to evoke the idea of a reflexive, skillful, and embodied way of being in relation with participants. In this way, the very idea of being an instrument was consistent with my pragmatic intentions and provided a way to be reflexive and responsive to the participants while also achieving my research aims. It was suggested to me that the

metaphor of a musical instrument that is played with skill and precision could expand the more mechanical idea that the term evokes[19].

In light of substantial critique of the application of a quantitative concept of rigour, and the related discussions of objectivity, neutrality, reliability, replication and validity (Davies & Dodd, 2002; Haraway, 1988; Harding, 1992/1999; Heshusius, 1994, 1995), I conducted the research by focusing on rigour as the intent to align purpose, epistemology, and methodology. Rather than dismissing the term rigour because of the ideological problems that plague it and the tendency to understand it in objectivist terms, I have sought to re-think and appropriate the term based on non-dualistic objective-subjective terms (as many others have) for my purpose of creating a trustworthy account that reflects the quality and integrity of the study. Davies and Dodd state

> …it is the acceptance of rigour as the universal standard by which quantitative and qualitative research is judged that obscures the need to rethink rigour in terms that are more appropriate to qualitative research. If rigour is understood only in terms of a structured, measurable, systematized, ordered, uniform, and neutral approach, then other research methods that allow flexibility, contradictions, incompleteness, or values will always appear "sloppy", epitomizing everything that is "nonrigour" and therefore lacking in credibility (2002, p. 280).

The rigour and integrity of the research was therefore created by approaching both issues as arising from criteria that would reflect the consistency and care taken in the enactment of research practices. Consistency and care can be determined through the articulation and clarity within which research practices are described, the trustworthiness and integrity of the analysis and interpretive process, and in the quality and credibility of the conclusions and discernment of relevant implications and future directions. A deconstructionist hermeneutic intent, however, adds another feature to rigour and quality of the research. My aim to construct an interpretive understanding that always hinges on "falling apart" (Caputo, 1987) means that coherence is both pursued in the methodological and interpretive process but 'conclusions' remain open to revision; thus,

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[19] This metaphor of a musical instrument was proposed by Peter Stephenson during my oral exam as a way to counter the mechanistic and objectivist notion the term connotes. The term 'instrument' may be predominantly understood in mechanistic ways, however, this does not imply that the meaning is fixed and could not be re-made or re-framed as conscious intentional action to enhance the integrity of the study.

the findings are an opening to ask new and different questions about relationships. Approaching the study of knowledge as it is lived means revising knowledge through asking about how the research findings ultimately can enhance women's health capacities and outcomes. Therefore, the rigour of the study was situated by *continuously* asking if I was creating an understanding or 'correspondent account' (Dewey, 1960) that enables health care providers to more adequately and responsively engage in practice with childbearing women.

To illustrate, I approached the construction of research rigour and integrity as being inseparable from ethics in qualitative research. Lincoln and Guba (2000) write about the "epistemology/ethics nexus" (p. 182) to suggest that "…the *way* in which we know is most assuredly tied up with both *what* we know and our relationships *with our research participants* [emphasis in original]" (p. 192). These authors and others (see Lather, 1993; Reason, 2000) claim that the ethical in research intersects the interpersonal and the epistemological and it is this nexus that criteria for quality, validity, and rigour are developed. If ethical research is therefore more than the application of rules or procedure outlined in advance, then Charlesworth's (1996) notion of ethical practice provides support to how I connected research rigour to the quality of research findings. He proposes that

> …when ethics exist in our actions and in our ways of doing and practicing our research, and when we perceive ethics to be always in progress, never taken for granted, flexible, and responsive to change….there should always be an emphasis on a sense of 'empathy and imagination' rather than on demonstrating a deductive and calculative reasoning (p. 13).

In this study, I attempted to develop research practices that approached ethics, rigour, and integrity as created within each moment of research, guided by my belief that each involves being trustworthy, open, honest, respectful, careful, and constantly attentive and vigilant in terms of my own intentions and the research participants' involvement in the co-creation of findings. From this point of view, research rigour was created through how I went about asking questions, responding, and as I reflected with participants on the data and emerging insights, understandings, and implications. Doing this required (not always successfully) a continuous "vigilance and presence of mind"

(Hadot, 1995, p. 84), the skill of dialogue or conversation where the question at stake is not only *what* is being said, but also *who* is doing the talking. My intent was to construct findings in both responsible and responsive ways that required making explicit the workings of power within knowledge and making accountable to what and whose purpose knowledge works. In Chapter 5, I provide several examples of this notion of power within and purpose of knowledge when describing why the study was extend by 2 months. I decided mid-way through the study that in light of what I was learning constructing the findings in collaboration with participants might better serve my research questions. Knowing that the meaningfulness of the findings and their ultimate relevance and impact could best be determined by engaging them in the analysis, several participants came together and we discussed how and the findings could enhance their everyday practice.

Rigour in the study can be illustrated in particular moments of research, but one in particular stands out. The nurse who received her sparkly field note book labeled it "things to talk to Helen about". She mentioned that after being together she sometimes thought of something in a new way. One day she asked me if this was "co-creating". We laughed and I said – if that's what *we* want it to be, then it is. A few weeks later she revised the notebook title to "things to talk to Helen/myself about" and she used this medium to write both negative and positive responses to what was being learned in the study. These experiences, among others over the 10 month period of data collection and analyses, helped me to see how reflexivity is relationally constructed (Doane, 2003).

The rigour of qualitative methods has been described as constructed through the use of a set of procedures that are simultaneously open-ended and that do justice to the complexity of the social setting under study (Denzin & Lincoln, 2000; Flick, 1989). I expanded this idea to include how the 'goodness' of my particular design also depended on the use of methods that would do justice to the research purpose as it become enacted through the process unfolding between myself and participants.

To illustrate how the above discussion is connected to rigour and integrity in qualitative research, I examined my methodological process in relation to Wolcott's (1994) nine points to satisfy the implicit challenges of validity and rigour in qualitative

research. I will list Wolcott's points in italics and provide examples from the methods in this study in brackets: *talking little, listening a lot* (lead by following), *recording accurately* (co-reading with participants to determine particular methods), *writing early* (writing to 'open up' conversation and expand data collection methods), *letting readers "see for themselves*" (sharing emerging analytic insights and being open/working with counter interpretations), *reporting fully* (not just the 'dramatic' insights, but even the seemingly mundane), *being candid* (methodological transparency), *seeking feedback* (trying out emerging insights and implications with participants) and *trying to achieve balance* (continuously asking if a relational epistemology/methodology is serving the research purpose).

A few instances illustrate how these nine points came together. The NICU and ACAHP nurses expressed a need for the research to be of some practical value. Several participants were skeptical of research as having any practical value and recalled some past studies where the findings were not shared with the nurses. Whatever I was creating had to help them in their work with women, infants, and families. We had several conversations about what 'practical value' meant in relation to the findings. The nurses told me practical value was something that began with their own practice but didn't stop there. It would be some form of insight into the effects of their ways of relating that would help them *do* things differently; for example, lobbying their manager for lower patient-nurses ratios in SCN or a more logical organization of home visits to reduce travel time and increase the time spent with women in their homes. The criteria for determining the 'truth' values of the insights lay in the nurses' ability to work with these insights in productive ways. For example, locating their experiences in-relation to the wider program and institutional context expanded their ability to analyze a wide range of contextual factors shaped by and shaping their practice. One nurse, who thought I was focused on individual nurses' practice, eventually spoke about wanting to look into her practice but also to analyze all the forces acting upon her as she went about her daily work. She called me on a Friday evening and said "I don't like who I am with this mom and I think you should come with me in the morning and then we can talk about what we both see". The willingness of this nurse to open up their own practice for my 'scrutiny' became 'safe'

when I elaborated on what a relational approach to the research implied; not an analysis of individuals and face to face relationships but an inquiry into all the relevant relations that contextually shape interpersonal spaces of practice. This nurse also joined the subset of participants who engaged in analysis. It was this coherence between function and form that I sought to achieve which also was the site for the study's rigour.

I became aware that the limitations to this work are my own self-authored constructions. I do not judge the 'quality' of the research data in terms of its ability to represent the ways things "are" in health care relationships since there are no greater or lesser truths to be judged there. Any issues of data quality are, and will continue to be, limitations of how I may have worked to fully create the conditions within which meaningful participation took place. I neither purport to define what health care providers and women's narratives/actions/insights 'really' mean, nor chart their 'development'. Rather, this inquiry was intended to be a critical, attentive, mindful listening of voices and experiences of relationships within the context of maternal-infant care.

The criteria for determining the strength and quality of the research emerged from the relational and pragmatist epistemological ground that created the interpretive methodological approach to research. Therefore, the yardsticks of more positivistic orientations of generalizability, reliability, and universality are counter-productive when applied to "multilayered, ongoing sense-making" of qualitative research (Meloy, 1994, p. 12). Although originally daunted by the task of developing criteria for rigour from within the research, I developed four interrelated criteria against which to retrospectively measure the quality and rigour of the analytical and interpretive process. These were aesthetics, critical reflexivity and analytic soundness, adequacy/usefulness, and dynamic viability.

Aesthetics: Do the insights/findings provoke and have an expressive authenticity in relation to the data? Authentic writing makes space for the irreducible complexity of the world while offering penetrating insights as to our experience of it (Reason & Bradbury, Reason, 2000, Richardson, 2000). Are the descriptions full, expressive, evocative and do they render the complexity of human experiences of self-other-context relations?

Critical reflexivity and analytic soundness: Is there evidence of critical reflexivity and intellectual soundness? Do the insights/findings move beyond simplistic and superficial or a "…no-findings report or topical survey" (Sandelowski & Barroso, 2003)? Have I challenged myself theoretically to transform data during interpretive processes (Wolcott, 1994)? Have I created an explanatory interpretive account that is both recursive and transformative in ways that holds self-other-context relations central to interpretive processes? Does the interpretive process challenge/disrupt dominant thinking or "fixed essences" (Caputo, 1987) and better account for the "web of interrelationality" (Hartrick Doane & Varcoe, 2005, p. 13) of relating people and contexts?

Adequacy/Usefulness: Are the insights/findings useful and upon what basis? Do these findings lead to doing things more effectively and ethically, in ways that enhance the health capacities and outcomes of childbearing women? Are the theorizing efforts rooted in the particulars of experiences? To what use will the insights/findings put?

Dynamic Vitality: What qualities of the research insights/findings promote Lather's (1993) catalytic validity or 'incitement to discourse', Mourad's (1997) compelling idea'[20], Gergen's (1994) 'revisionist possibilities' and 'cultural transformations' or Caputo's (2000) 'not-knowing'? Can the interpretive explanations generate pragmatic consequences/action that can limber up dominant decontextualized approachs to the interpersonal to enhance women's health capacities and outcomes?

Principle #3: Re-searching Original Difficulty

A pragmatist aim to access a living form of knowledge inevitably led me into the 'messy complexities of lived experience" (Lather, 1991, p. 90). A deconstructionist hermeneutic intent became a practical reason for going into complexity and difficulty; Caputo (1987) claims that it is in our efforts to unstill what has been stilled that we become better prepared to live. Yielding to the difficulty of life does not grind it to a halt but stops us from trying to prop up our beliefs and practices and institutions based on essentialist views of being and human life (Caputo). In this research, the complexity or

[20] Mourad finds an intellectually compelling idea valuable for its "enhancement of the inquirer's capacity to form and pursue meaningful intellectual experience…to serve as the basis for other intellectually compelling inquiries…to be useful in application toward enhancing the quality of human experience (1997, p. 95).

difficulty has been defined as the dominant non-relational, individualistic, mechanistic, reductionistic and decontextualized approaches to knowledge and human experience that underpin the majority of theoretical work in the area of interpersonal spaces of practice. The methodological principle of researching original difficulty[21], or what Caputo describes as the "flux', required turning towards complexity rather than away.

In several instances, I was shown and told by women participants of considerably more harmful experiences in interpersonal spaces than of anything I might determine to be 'good'. I spent a considerable time asking why I had attracted women participants who had long standing and current experiences of harm. Dismissing that 'sampling bias' might be at play here, I concluded that the nature of the topic, and the particular way I was approaching the study invited complexity and difficulty right from the start. I began the research with the view that much theoretical work in the area of interpersonal relations required expansion and more critical and contextual views of knowledge and human experience. This meant that researching 'original difficulty' was my way of going into the places that could help 'limber up' (James, 1907/1937) and potentially disrupt and expand such views, all the while believing that doing so was important when enhancing women's health capacities and outcomes.

> Field note entry September 15, 2005:
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> > In my proposal, I was informed by researchers' who wrote from a philosophical location about methodology, willing to take a stand against method as rules of 'fixed technique' (Caputo, 1987). I need to find a way to open up what I am hearing… How could my findings mitigate the social harm, the un-ethics and injustices and dehumanizing practices that arose in these messy and complex spaces of practice? Theorizing from a view of selves-others-in-context necessitates a more critical and complex account if I am concerned about enhancing women's health capacities and outcomes. All the women speak of harm and 'iatrogenic suffering' (Kuhl, 2002) that I can see is both individually and socially produced. So, now the pragmatic purpose becomes critical; how could this inquiry contribute to *doing things better*?

Bringing together the aim to research original difficulty with the intent to be a 'mediator of structure and method' (Hartrick Doane & Varcoe, 2005) required consciously

[21] When using the term 'original' I am not implying a naturalized state of affairs. I am using it as Caputo's (1987) does to denote the difficulty that inhabits and lives through all things, albeit differently experienced and expressed in everyday human efforts to cope with the' flux' of life.

choosing, in each moment of research, how to go about theorizing methodology and the research aims as the study proceeded. Making choices about how to proceed in data collection, analysis, and the interpretive processes required the skills of reflexivity.

The Skill of Reflexivity

Although practices of reflexivity are woven this chapter, in this section I provide specific illustrations of the enactment reflexivity in the project. Describing reflexivity in nursing practice, Hartrick Doane and Varcoe (2005) depict reflexivity as involving

> …a combination of self-observation, critical scrutiny and conscious participation. It involves paying attention to who, how, and what you are being/doing in the moment as you work with families, observing your own living experience of that being/doing and critically scrutinizing your experience, knowledge and actions. (p. 150).

In qualitative research, the practice of reflexivity is bound to the situated nature of research and knowledge while also demonstrating the trustworthiness of interpretive process and the construction of findings (Finlay & Gough, 2003; Heshusius, 1995). The etymological roots of the word reflexive, which means to 'bend back upon oneself', implies a thoughtful self-awareness and analysis of practices in research – self-awareness and analysis that illuminate and shape insights, understandings, findings, and claims to 'know'. Whereas reflection denotes a 'thinking about', reflexivity implies a "…more immediate, dynamic and continuing self awareness" (Finlay & Gough, 2003, p. xi). A reflexive stance in this research was about making explicit my location as a 'knower', and being clear and transparent about my selected interests, assumptions, and ethical and political commitments. I was informed by the diverse ways in which reflexivity is theorized, considering when the different forms might be more or less helpful in particular moments of research.

How I enacted reflexivity in the project was significantly shaped by several other experiences over the last few years: such as, dialogue with Gweneth Doane spurred from her writing on 'relational reflexivity' and our shared interest in the inseparability among qualitative inquiry, epistemology, and ethical practices in and relational experiences of research. In addition, my involvement in research on rural Aboriginal maternity care (2005-2006) with one of my committee members, Colleen Varcoe provided a reflexive

space to examine how interpersonal relations in research are always shaped by history, power, academic discourse and perspectives on what knowledge counts in research. In particular, the maternity care research and my current involvement with Aboriginal co-researchers Barb Cranmer and Vera Newman from Alert Bay has provided the chance to learn about how reflexivity is a way of being/knowing in-relation with research partners and participants. In this study critical attention to the connection between power/knowledge and the historical and ongoing impacts of colonization as the social and political context for our research relationships is the context for what can be known and communicated as the research 'findings'.

Such experiences informed how, for example, reflexivity took a relational form in the current research; it took the form of both inter-subjective reflection and as a way of interrogating underlying shared social discourses. I developed a view of reflexivity amidst the practices of inquiry and came to see it a way to engage in the practice of inquiry, as an "active mode of consciousness" that includes self-observation, critical analysis, and attention to the politics of interpretation (Fine, Weis, Weseen, & Wong, 2000). Alcoff (1991) offers a critical view of the politics of reflexivity.

> The desire to find an absolute means to avoid making errors comes perhaps not from a desire to advance collective goals but a desire for personal mastery; to establish a privileged discursive position wherein one cannot be undermined or challenged, where one is master of the situation. From such a position, one's own location and position would not require constant engagement in this emotionally troublesome endeavor and would be immune from the interrogation of others. Such a desire for mastery and immunity must be resisted (p. 22).

Reflexivity in the research required more than skillful effort to 'bend back' upon myself – I assumed 'bending back' needed to be in the service of something worthwhile. Alcoff (1991) writes of the tendency for reflexive efforts to be enacted by researchers in ways that sustain the "privilege of discursive positioning" (p, 22). I concluded that not all 'reflexive moves' can be articulated and that reflexive processes are themselves relationally constructed in each moment of research in relation with participants. Doane (2003) claims a more relational form of reflexivity is lacking in research discourse and cites one reason as being the methodologically – rather than experientially – based

language that pervades research in the human sciences. This may partially help to explain how 'being reflexive' is easier to point to rather than report on.

In summary, I began the research with a view that the reflexive processes of the research and related ethical responsibilities are far more than static descriptive accounts of methodology; both require far more than a neutralizing accounting of oneself as a researcher in self-other-context relations. Cutcliffe (2003) aptly reminds us of the fallibility of all reflexive efforts, where some are known in ways that are beyond telling/reporting:

> …even in the most rigorous and comprehensive attempts to engage in reflexivity and account for myself on how/what/when I know, it is not possible to describe or explain everything that I "know' in language form. Even the most complete and far-reaching reflexive account would not be able to account for the magic, for my creativity, for my tacit knowledge, and for the effect all of these have on data analyses, or for the full effect of the research on me (Cutcliffe, p. 144).

There is, therefore, a degree of irony in creating a subtitle 'reflexivity' in this document since it runs counter to how reflexivity was enacted in this study – and to even speak of it in the past tense makes it sounds as though I picked it up and then put it down at the end of the research. Allen and Hardin (2001) reminds us that experience, such as those reflexive experiences *in* research are neither transparent nor innocent and even the best reflexive efforts will never escape contingency and fallibility.

> We emphasize self-reflective and political processes because lingering humanist legacies often lead researchers to believe they can see and understand their influence of their subjectivity on research. History has repeatedly demonstrated the systematic self deception involved in maintaining structural privilege of the sort that researchers occupy. We cannot trust ourselves to be any more 'transparent' than our participants are…Even if the researcher is not evaluating the subject's experience s/he is still making a truth claim that it is their experience, and by publishing it as research, one is appealing to authorized conventions for sorting warranted from unwarranted claims. Buker (1991) argues that not all contextualized 'truths' are equal in power (Allen & Hardin, 2001, p. 166).

I will close this section by elaborating on what reasonably could be considered to be limitations of the research. These limitations will be further discussed within the context of the analytical and interpretive processes in subsequent chapters.

Methodological Limitations

The limitations of the study might be viewed as related to a tendency to theorize beyond or in a different direction than those that participants may have imagined. The issue of representation in research is important; however, the notion of misrepresentation was mitigated by the relational methodology and views of knowledge guiding the research. When knower and known are connected, the meaning(s) of misrepresentation and representation are negotiated within the research itself. My agenda was to have the research serve a practical purpose and I question if a shared understanding or consensus of a 'practical' purpose was possible and even appropriate. I realize that examining narrative and stories is a process "implicated with relational plays of power" where it might be difficult, if not impossible, to determine whose 'truths' are represented and for what purpose. I asked: is my pragmatic intent creating a form of instrumentalism that could be limiting? It may well be that health care providers and women themselves re-authorized their own positions depending on whose interests were at stake, depending on what subject positions were available. The limitations arising from this work are located in my constant efforts (not always successful) to move between and read data through the relational complexity of selves-others-in-context. This was difficult in light of the dominant ideas that work to separate people, places, practices, policies, and experiences.

Participants who joined the study were those most able and willing to speak about the connection between experiences of relationships and their effects. In some research paradigms this could be construed as 'selection bias', however I concluded that these features of the sample added necessary complexity and depth to the data. The particular life contexts of women could have limited the diversity of voices. The women's experiences of health challenges in pregnancy and threatened fetal/infant well being meant that their fear contributed to a vulnerability experienced in relations with care providers. Several of the women spoke limited English; however, all the women spoke effectively and thoughtfully about their experiences. As mentioned previously, I noticed a 'nod factor' as a sign of people who were enticed and provoked to explore this connection further. Yet, I did pre-select participants who nodded initially and later came to see the need to purposively seek out those who did not. This implies that a different

sample of participants and researcher would have created a different context and product of inquiry.

In spite of these limitations, I take the insights constructed in later chapters has holding relevance and implications beyond the study itself. The constructed findings, however, cannot be abstracted from the context in which they became knowable or the methodological processes of research. The final principle reflects this relational context and complexity of research relations, intentions and methods, which is to say that this complexity was precisely the context within which an analytical and interpretive approach was constructed.

Principle #4: Creating a Complex Account

The final working principle of a relational methodology refers to the analytical and interpretive approach to the research. My deconstructionist hermeneutic intent framed the questions brought to the data and interpretive processes, however, I also drew upon the work of Alvesson & Sköldberg (2000), Morse (1994) and Thorne, Reimer Kirkham and MacDonald-Emes (1997) who articulate particular processes of qualitative data analysis that connect epistemological positioning and methodological approach. All of these writers share in common a view that qualitative research assumes an active stance of inquiry and that all research acts are essentially interpretive. Alvesson and Sköldberg use the term reflexive interpretation, Thorne at al. write of interpretive description, while Morse explicates the cognitive processes inherent in qualitative data analysis. While Alvesson and Sköldberg and Thorne at al. describe how philosophical views of inquiry, knowledge, and practice respectively inform all analytic processes, Morse primarily describes dimensions of a "creative process of organizing data so that the analytic scheme will appear obvious" (1994, p. 25).

Turning back to my deconstructive hermeneutic intent, I worked analytically to create a complex account understood to be

> …a more sensible understanding of human affairs than the misguided aspirations of methodologists. By divesting us of a spelled out treatise on method which will assure our mastery over things …radical hermeneutics shows us how to cope with the flux (Caputo, 1987, p. 184).

Caputo (1987) speaks of the abyss of human *being* as the place where difficulty and complexity resides. I approached the research with a view of interpersonal spaces of maternal-child care as likened to the abyss of which Caputo speaks. The current research then became an occasion to be "…instructed by the abyss, to let the abyss be, to let it play itself out, not in passive gesture of surrender to destruction but in the sense of what Heidegger calls the openness to the mystery" (p. 278). Entering into the flow of research and the substantive complexity of interpersonal relations required a degree of non-knowing and non-analysis for a period of time, until such a time came when I began to know (in a partial and fallible sense) the abyss. For example, as I imposed meaning constructions on the data, I also tried to create alternative ways of understanding the data. The "super critical" nurse consistently disrupted some of the construction and at times provided the fodder for creating alternative understandings that led to new insights that I may not have reached alone:

> HB: I think the issue here is whether or not interpersonal relations are seen as powerful places or whether or not they are dismissed as somehow 'neutral'. That seems to reflect some kind of perspective….though, what? When they are neutral spaces they are harmful spaces… do you think? Is this idea of neutrality important?
>
> SC nurse: Well, I think that maybe yes and maybe no – it could be more about whether or not nurses ever connect their practice and its effects, so I guess that's a form of neutrality, separating how we work from the effects on our clients. That's the focus and I think explaining why is less important. Now if we can see the effects, we can hardly remain neutral right?
>
> HB: Or maybe it goes in both directions?

Moving into research with a deconstructive hermeneutic intent provided a way to examine traditional and historical events, such as how theories that objectify relationships as means to an end or a problem to be solved live in present modes of living and being (Gadamer, 1976). Rendering 'experience' problematic created a way to go into the complexity of human experience so as to see particular views that may be living in interpersonal relations:

> Theorizing from amidst 'experience'….requires problematizing 'experience' as Allen and Hardin (1991) suggest, within interpersonal relations; what happens when experience is seen as a natural and neutral state of affairs, as residing within

> individual women, nurses, social workers, physicians? What falls from view in terms of the social organization of health care practice for how it shows up in face to face relations? How meaningful experience is created is a very different question that assuming it can be 'found' and draws me to notice how experiences are discursively shaped at the level of the 'micro' which can never be abstracted from the meso and macro levels of analyses. (Field notes July, 13, 2005).

During the three month period of reading transcripts and field notes, analyzing written notes and focus group conversations, reviewing observation and discussions, I began looking for the 'ruptures and fissures of existence', place of tension, working to "stand the prevailing orthodoxy on its head" (Caputo, 1987, p. 6). The analytic approach required theoretical tools that could help me to attend to the connections among discourse, knowledge, and power in order to scrutinize how practices, beliefs, norms and taken for granted assumptions that underlie dominant ideologies and practices operate relationally to socially construct health care providers' and women's experiences of interpersonal relations.

Analytical Approach

Much of the above discussion also underscores the analytic and interpretive processes of the research. In general, consistent with a process of interpretive inquiry (Lincoln & Guba, 2000) the analysis took the form of a widening circle of understanding to allow for the construction of key ideas while simultaneously reading health care providers and women's data through each other. I constructed an analytical approach that would bring these sources of data into relation, where health care providers' and women's data would be juxtaposed in the spirit of bricolage:

> This tinkering is a high-level cognitive process involving construction and reconstruction, contextual diagnosis, negotiation and readjustment. Researchers' interactions with the research objects of their inquiries, bricoleurs understand are always complicated, mercurial, unpredictable and complex….acting as methodological negotiators, respecting the demands of the task at hand. In this mode of analysis, bricoleurs come to understand research method as also a technology of justification, meaning a way of defending what we know and the process by which we know it (Kincheloe, 2005, p. 325).

The analytic approach brought together the tools of deconstructive hermeneutic and critical discourse analysis in order to disrupt, provoke, enlighten, open up, and

contradict the various insights and interpretations developed along the way. The principles of discourse analysis[22] were used to expand the analysis of talk and text within the context of relational epistemologies, pragmatism and deconstructionist hermeneutics to expand the complexity of the specific social and contextual nature of relational experience. The analytical approach was an iterative process between myself and participants in the research context; my various insights and findings could reveal, conceal, disrupt, collude, collide, create, and spur further questions, inquiries, accounts, and analyses. The analytic process was progressively articulated by seeing it in my actions and processes. Meloy (1994) states "it is only at the point of closure…that the complex layered experience…begins to take shape as a sensible whole that can be organized, interpreted, and perhaps understood, where understanding follows doing (p. 12). These field note entries illustrate a progressive articulation of methodology.

> Field notes: After 4 months of writing I can now see that much of what I was writing about as my starting point was actually the findings of the research. I know this is a common feature of qualitative research; often the start is written anew, but it confirmed that the whole was completely altered by arriving at the end. I take this to be productive; my writing was an account of re-theorizing that enabled me to think of relationship as constitutive of both women's and health care providers' experiences. It was only after being shown the full range of how 'experiences' by participants that the notion of 'meaningful' became more complex, more uncertain, more difficult, and more fruitful for inquiry. Meaningful now is not solely equivalent to "good". Ken Wilbur's notion of the 'whole' is now relevant; pleasure and pain as part of the same whole; where one "draws boundaries, one manufactures opposites". Meaningful in the sense of more of what women considered humanizing, respectful and affirming or meaningful in the sense of more of what women described as dehumanizing, disrespectful and dismissive (Field notes Sept 21st, 2006).
>
> Richardson (2000) writes that much of what was "true" for the writer who began no longer grounds the one seeking closure. I do not take this as a flawed beginning but rather that the subsequent material and insights would cast the starting point in new ways. This reminded me of Bateson's (1990) notion that "…we are engaged in a day-by-day process of self-invention, not discovery, for

[22] As an analytical tool, I used principles of discourse analysis to enhance contextual and ideological analysis of the data to construct insights into the dynamics and multiplicity of meanings in relational to self-other-context relations expressed through experience and language.

> what we search for does not exist until we find it" (p. 28). (Field notes, November 3rd, 2006).

In summary, the approach to analysis/interpretation was one of an ongoing reformulation of my ideas as they were constructed and brought to life in conversations and the development of insights with participants. The findings of the research, therefore, are relational constructions that traverse my own and participants' insights and interpretations. Working to create a complex interpretive account was furthered by using particular theoretical tools to open up and expand emerging insights. Theoretical ideas were drawn from feminist geography, critical theories, postcolonial perspectives, and critical humanism as pragmatic tools to open up, expand, counter, disrupt, and provoke the theorizing work of the research.

The final point to make in this chapter is the importance of acknowledging that analytical processes continue even after this text is written. This implies that the analysis never reaches a final state. Although I eventually conclude this dissertation, I do so knowing that the thinking and living of the ideas and questions continue. With this in mind, I will press on to describe the temporarily 'fixed' findings in Chapter 5, portraying these insights as opportunities for understanding rather than established truths. Being 'ready' to present qualitative findings has been described as reaching a point where no new insights or understanding are possible from the data (Morse, 1994; Speziale & Carpentier, 2007). My analytic processes, however, were deemed to be only *contingently* complete, not in an effort to foreclose new understandings, but to discern the adequacy of the findings for the particular purpose of enhancing and optimizing women's capacities and outcomes.

> What does it mean to be ready to write 'the findings'? I noticed a shift today in terms of the analytical work of the project, a realization that what is 'in' the data does not, to some degree, exist until I make it, a point where closure now seems possible and desirable. Up until the last month, I contemplated how, where or when I would tie off the ends of an inquiry that has been underway long before the actual start of this research, make it coherent, create a narrow enough scope to write about. Today I wrote the introductory paragraph to the findings and discussion chapters, knowing what I was to say in these final chapters was a culmination of questions that, despite my need to keep them open, could be stilled and closed for a moment and for a purpose. I now know I can finish what there is to say. (Field notes December10th, 2006).

The analytic work began by reading in a deconstructive hermeneutic way, back and forth between the women and health care providers, treating the space as arising "mutually and spontaneously…not as opposites but as having an inner unity" (Wilber, 2001, p, 11). Similarities and differences in the data were articulated but were ultimately read in-relation to each participant groups' data and practice contexts.

Contingent Findings

Findings in this study are defined as "the data-based and integrated discoveries, judgments and/or pronouncements researchers offer about the phenomena, events, or cases under investigation" (Sandelowski & Barroso, 2003, p. 218). Despite controversy on whether or not a distinction can be made between data and findings, the interpretive work was undertaken by assuming that data are, to some degree, already constructed entities (Valsiner, 2000). Researching the interconnectedness of people, knowledge, and contexts to women's health capacities and outcomes meant the findings were constructed to serve a particular purpose; that being, the pragmatic purpose of doing justice to the social contextual experiences of both health care providers and childbearing women as they engaged interpersonally. When it became apparent that the insights and findings could lead to practices and actions that would enhance women's health capacities and outcomes in ways that are safe, competent, and ethical care (Canadian Nurses Association, 2002), the interpretive work was underway and the basis for its closure discernable.

The findings and implications described in the following chapters are offered as a 'maximally adequate account' (Harding, 1995). The claims are purposively tentative and are expected to evolve. The findings are considered a "little sitting device in a long line of such craft tools…to orient, provide a rough sketch for travel, by means of moving within and through" (Haraway, 1992, p. 295) interpersonal relations/relationships to engage in health promoting maternal-infant health care. This chapter brings the analytical insights of the research into a practical form for re-theorizing interpersonal relations in ways that hold possibilities for enhancing childbearing women's health capacities and outcomes.

CHAPTER 5: WOMEN'S EXPERIENCES OF INTERPERSONAL SPACES OF CARE

In this chapter it will become evident how a relational view of human experience and knowledge provided a way of connecting self-other relations to particular features of women's lives and the social, political, and cultural contexts of antenatal and neonatal care. It was this very complexity of relational experiences that was also critical for understanding how health care relationships impact childbearing women's health capacities and outcomes. I also came to see that participants' experiences of relationships and women's capacities and outcomes were all *constructions;* that is 'relationships' 'capacities' and outcomes' was neither static nor stable 'things' to be nailed down and defined. Rather, as more fully discussed in Chapter 7, interpersonal relations were constantly being shaped on a moment to moment basis within particular intersecting contexts of maternal-infant care and women's lives.

One woman's words "it all shows up in the face to face" (WP 05) aptly illustrated the complexity of human relating in everyday moments of care. The 'face to face' relationship symbolized the intersection of their lives and particular contextual features of neonatal and antenatal care. Health care providers' accounts of relationship exemplified how particular ways of knowing and relating can become taken for granted in ways that leave certain practices and power relations in place. Both of these participant groups' experiences illustrate how meetings of the 'face to face' reflect far more than individual interactions. This contextualized understanding of 'the face to face' will become apparent in this chapter and the next. In Chapter 7, I use the research findings to challenge existing understandings of relationship individual interactions and connect these insights to how rethinking the interpersonal can optimize childbearing women's health capacities and outcomes. Before I discuss the research findings, I will describe why I shifted from the terms *health care relationships to interpersonal spaces of care* as a more apt way to capture this contextualized notion of the relational experiences of the interpersonal.

Into Interpersonal Spaces of Maternal-Infant Care

At the outset of the study, I claimed that the term 'relational' implies how human beings live and know in the world as social, historical, and contextual beings. From this perspective, interpersonal relations are sites of experience among people who live their lives as contextual beings. Theorizing relationship as a site of human experiences implies that relationships always exert influence even when characterized by disinterest, disengagement or harm. To keep a relational view and critical attention to context in the foreground of the analysis, in this document I use the terms *interpersonal spaces of care*.

The decision to use the idea of interpersonal spaces also illustrates my questions about how language use might be contributing to defining relationship as a site of individual interaction. My decision to use the terms *interpersonal spaces of care* illustrates one of the first insights of the research; that is, the critical role of language for shaping understandings of relationship. I approached language and text as more than mere words on the page. I questioned how using different language could 'unfix' de-contextualized perspectives on relationship while also potentially transforming particular ways of knowing about the interpersonal. As a neonatal nurse I had experienced first hand how shifting language can change the way people think, know, and act towards particular infants. For example, the evolution of diagnostic terms such as 'congenital defects' to 'congenital anomalies' and 'intrauterine growth retardation' to 'intrauterine growth restriction' and from the biomedical dominance of 'delivery' to the healthy focus of 'birth' are a few examples of how language creates the realities in which people relate to one another. Early in the process of data analysis, I decided that a critical understanding of language use could expand my understandings of how particular meanings and experiences are constructed in interpersonal spaces of care while also illustrating how particular dominant ideas might be transformed.

I consulted writing in feminist geography on 'space' that previously informed my thinking about non-dual ways of theorizing self-other relations, among other binaries that construct either/or categories. Space is theorized in contemporary feminist geography as more than a static place: space is seen to be dynamic, generative, discursive, relational and performative (Bondi, 2005; Sioh, 2006). Therefore, the terms interpersonal spaces

evoked a contextual understanding of relationship that I deemed was necessary to expand dominant approaches to theorizing the interpersonal described in Chapter 2.

Overview of the Findings

Figure 2 below provides an overview of the research findings in relation to both the women and health care provider participants. The relational construction of experiences of interpersonal spaces was evident in both participant groups' accounts and was considered to be the *constitutive pattern* that joins together my analysis of participants groups' data. A relational construction of experiences of the interpersonal illustrates the main research finding that relationships can neither be theorized at the level of individual interaction nor from a view of separateness among self, others, and contexts. Rather, how 'self' relationally meets 'other' within the context of maternal-infant heath care is shaped through a complex array of relations that influence each face-to-face interaction. Specifically, the findings illustrate how human relations are powerfully shaped by broader social norms, cultural discourses, policies, and health care practices are enacted in interpersonal space to have discernable impacts of women's lives and on their health capacities and outcomes in particular.

The top of Figure 2 represents the findings from the health care providers' experiences and perspectives. Health care providers spoke of relationships as the *essence* of their practice in *instrumental* and *sentimental* ways. I posited that sentimental and instrumental understandings of relationships (elaborated upon below) were, in fact, ways of knowing about and being in interpersonal spaces of care. As will become evident, I understood these particular ways of knowing to have ideological effects; health care providers referred to being neutral and impartial participants in interpersonal care. The compounded effects of essentialist views of relationships in instrumental and sentimental understandings constructed the '*veil of neutrality'* that I also saw as shaping how they understood childbearing women's health capacities and outcomes as *choice-based* and their *individual responsibility*.

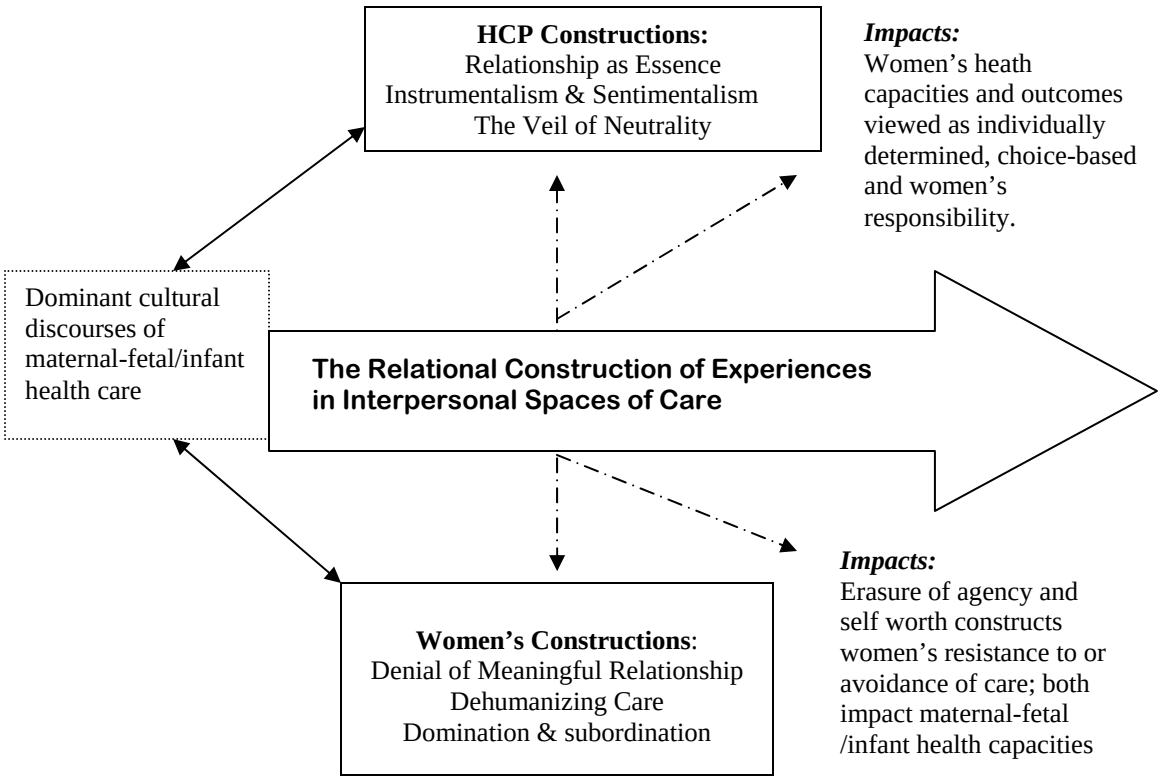

Figure 2. The Relational Construction of Experiences in Interpersonal Spaces

Along the bottom of Figure 2 are the findings created from the women's data. Women participants' experiences of interpersonal spaces of care illustrated how they knew about and engaged in interpersonal relations with health care providers. Almost all of the women spoke about the *absence* of relationship and experiences of *dehumanizing care*. The impacts were an *erasure of agency* and *avoidance of care* that compromised *maternal and fetal/infant health outcomes*. The solid arrow moving through the centre of Figure 2 represents the constitutive pattern that was constructed from a dialectical reading between the participant groups' data. The dashed arrows indicate the connection between participants' constructed experiences and particular impacts on women's health capacities and outcomes.

Reading dialectically, or back and forth, between health care providers and the women's data was helpful for analyzing differences in the data as productive contradictions and tensions that allow for new understandings and insights (Bentz & Shapiro, 2002). These differences illustrated that although people are relational beings, there exists a wide range of awareness of being in conscious relation. Rather than

viewing these variations and differences as dichotomous and oppositional, I took them as containing interconnections that would help me to see the complex 'whole' of the relational experiences and impacts on women's health capacities and outcomes.

I will describe women participants' relational experiences in this chapter followed by health care providers' experiences in Chapter 6. My reasons for presenting my analysis of the women's data first are threefold. First, as already stated, women's voices are under-accounted for in research in the area of health care delivery. Women's perspective are often marginalized in relation to those voices of health care providers through the ongoing dominance of gendered, biomedical and reproductive health discourses (Wisdom, Berlin, & Lapidus, 2005). Second, emerging research in the area of interpersonal relations, health care relationships, and patient-provider communication indicate that health care providers and patients often differ in their understandings of health and healing actions. Health care institutional systems, policies, and structures continue to privilege professional 'expertise' over the experiential knowledge and health needs of patients (May & Purkis, 1995; Thorne, 2002).

Third, and finally, in relation to the research process, health care providers often acted as 'gate keepers' to my efforts to access and recruit women from both the APAHP and NICU. Nurses who endorsed the project held power in a productive sense and enhanced my recruitment efforts. Others nurses limited my access to women who they deemed would have nothing to say of importance or who they thought lacked capacity for speaking about their experiences of interpersonal relations (for example, women who had an 'unstable home' or spoke limited English and required translation services). For example, the women who several nurses deemed "good ones" were described as being articulate and well-resourced in terms of social class. I decided to begin with the experiential 'truths' of the women to reflect the interplay of these insights.

Women's Constructions of Experiences of Interpersonal Spaces

In my initial observations and conversations I had two insights. First, several of the women searched my face before speaking to see if I was ready to hear about their negative experiences. Second, as we got to know one another and a safe space for speaking was created, women went into more depth about the particular difficulties and

harmful experiences they attributed to interpersonal spaces of care. Both of these initial impressions became more fully understood as twelve out of the thirteen women constructed a denial of relationship with their health care providers.

Telling It Like It Is

One woman said to me "make sure you tell it like it *is* [vocal emphasis on tape], don't leave anything out, I think that is really important that you know, I mean *really know what it's like* (vocal emphasis on tape)"(WP 05). WP 05 indicated a degree of risk for her in "telling it like it is". Another woman asked if I "really wanted to know what it's like?"(WP 03). I took these initial comments as the women's way of seeing if I was going to be able to listen as a nurse to stories that may not reflect positively on my profession or health care broadly. Several other women hesitated before speaking of their experiences of relationships with health care providers. Two women in particular only spoke openly about their experiences after I assured them that I did not intend to judge the truthfulness of their accounts. The early weeks of listening to women's experiences was difficult since almost all of the women spoke of negative experiences, some of which women carried from several years earlier. I explained that my research questions were not about comparing women's stories to health care providers. Rather, I was interested in understanding how their experiences came to occur.

In the early weeks of data collection, it was hard to determine if I was privileging the distressing stories as a way to illustrate my point about the obscuring of harms in dominant human science discourse. I questioned if I 'found' what I set out to look for. I was also aware of the temptation in qualitative research to 'cherry pick' the most dramatic of stories. For these reasons I decided to determine if, in fact, there were quantitatively more negative than positive experiences in the women's data. I read women's experiences as a whole to determine the proportion of negative experiences to positive ones: 18% of women's data reported positive experiences and 82% negatively. One woman reported only positive experiences while 2 other women spoke briefly of satisfying experiences scattered through description of negative ones. I understood the disproportion of negative experiences as being at least partly explained through the

compounding vulnerabilities in the women's lives in relation to threaten fetal/infant health and their migration experiences.

In these early weeks of the study, I was reminded of the critical importance of listening and analyzing women's experiences not in terms of their 'accuracy' or 'truthfulness' but for their capacity to evoke, disrupt, unsettle, transform and indicate possibilities for enhancing their interpersonal care. I assumed that being responsive to participants because of their expressions of risk meant paying attention to and being present in reflexive ways[23] that required more than adherence to method. I methodologically worked to create interpersonal spaces of research that would allow for conversation where women perceived some degree of risk. Once this process was underway, several women told me there was an irony to my study on relationships; my assumption that relationships existed came 'face-to-face' with women's experiences that denied the existence of anything they would describe as a real 'relationship'.

The Denial of Relationship

In the initial weeks of data collection, all but one of the 13 women participants used words and phrases to alert me to how what I was researching, in fact, did not exist. Their experiences of being dismissed and 'like I was not there' (WP 09) or "I wasn't really there" (WP 04) "they never saw me" (WP 06) constructed their denial of relationship. The similarities in their experiences were striking in that each of them spoke of negative experiences and linked these experiences to their construction of denial of "real relationship" (WP 11) with health care providers. Although all of the women spoke of how they were undeniably 'in-relation' with health care providers, a number of women specifically equated having a relationship with the assumption that 'something good was going on'. One woman said:

> Relationship? What relationship? Do you want me to tell it like it is? If it was there I would know it, feel it, you know? That assumes something good is going

[23] Although it may seem out of place to refer to reflexive processes here, it will become evident that the methodological insights of 'being in-relation' created a knowing/inquiring space that women participants described as lacking in their interaction and relations with health care providers. It was during the moment to moment inquiries in the research that I started to see connection between methodology and topic described more fully Chapter 7. For these reasons, methodological insights are woven through this chapter and the next.

> on, when really it's more like forced encounters….some days it takes everything I have to muster the courage to go into visit him (my son) because I never can be sure I'll feel, you know, respected for being his mom. I know I am young, and I can do this, I will do this. But I do worry about what's to come when I see myself not being strong with them or when I am in the unit (WP 07).

In another instance, the denial of relationship was based on one women's knowing of what a 'real relationship" (WP 11) would feel like; a place of meaningfully positive experience. WP 07 substituted "forced encounters" as a more apt description of her experience of interpersonal spaces of care. The notion of being forced was evident as she spoke of working against the dominant practices and policies in the NICU. She experienced having to forcibly work against judgments about her age and the related assumption that being a young mother implies a lack of competence for caring for a preterm infant. In order for her to be with her son in the NICU, she required persistence to navigate relations with health care providers. This woman spoke repeatedly about the expectation to be involved as equal participant in her son's care as being constantly undermined by judgments made about being a young mother. Her experience of trying *be* fully involved in her son's care were shaped by the degree to which health care providers believed that she could develop the skill to do so:

> I know I am supposed to be involved in all of this care. I try and then am made to feel like I can't do it. I mean some of the work the nurses do takes years to learn, so its hard for me come in there, act like I know it all and actually be good at things like taking temperatures, making decisions about his care (WP 07).

Other relationships in the women's lives led them to hold particular expectations of engaging with health care providers. Several women knew that differences exist between professional care-giving and personal relationships; however, their experiences framed their expectations with health care providers. One woman said "I know what it would be to call it a relationship. So that's why I can tell you I felt nothing like that" (WP 06). Another woman noted that despite differences in health care and personal relationships it might not be too much to ask for the kind of acceptance and respect that is meaningfully experienced in personal relationships.

Yet another woman spoke of experiences that led her to conclude she did not have relationships with care providers. She equated relationships with "something that helps

you rather than gets in your way" and spoke of relationships as "not there" (WP 09). This same woman denied having positive experiences of relationship by noting the absence of "feeling safe and seen". She spoke of the necessity of interaction and like another women (WP 06) indicated the lack of a 'real' relationship:

> I have to interact with them, but I don't get the sense of a real relationship, the kind where you know that you matter to the other person. I mean…they have their work to do so maybe it's not even realistic to expect they see you…at all. I know that at times, it doesn't matter that much, like when I am feeling good, and my baby's ok, but there are other times…when you really need it…and that when you know it's not there (WP 09)

Another woman described her encounters with care providers as often mechanical and oriented to the goals of providers, which constructed a similar denial of meaningful relationship. She spoke of the dismissal of her needs when she was seen as only requiring routine care;

> It's not that anything bad ever really happened, but it just never felt like an added bit of care. I know the baby was their focus. I felt as though I was lucky to be slotted into their busy schedule…which made me feel not seen, like as a person I wasn't really there. I think my care was considered routine, I couldn't actually have a problem….so when I did, I was not sure how to bring it up…it was like on their terms and my terms seemed to throw a wrench into everything (WP 06)

I found myself initially taking the denial of relationship as 'real'. I was intrigued by the irony of researching experiences of relationships only to hear that twelve or thirteen of the women denied having relationships with health care providers. As women spoke and showed me early in the research that 'good relationships' could neither be assumed nor taken for granted, I confirmed that a relational view of people does not say anything about the quality or meaningfulness of those relationships. This initial denial of relationship was important for seeing how people may not always be in conscious relationship (Hartrick, 2002).

The women's construction of denial of relationship and the lack of meaningfully positive experiences of interpersonal relations became a signifier of more complex questions and analysis to be undertaken. I theorized that the 'absence' of relationship was the women participants' way of showing me *how* they were experiencing relationships with health care providers were being constructed. The women's tendency to construct

relationships through claiming their absence helped me to see how the questions about how their experiences were constructed could have been subverted through leaving the analysis at the level of binary categorization of presence/absence of relationship. In other words, leaving my analysis here could have obscured the more important question about *how* women' relational experiences were being constructed in the ways that led to the construction of denial of relationship. What was initially cast as a denial or absence of relationship was having powerful effects on woman participants, which implied relationships were not 'absent' in a neutral sense.

What the women saw as the absence of relationship was through their negative experiences. For example, "not being seen, like as a person" (WP 06) was a common thread through several women's experiences and I presumed such experiences to negatively impact health promoting and ethical care. Resisting this absence/presence as 'real' analytic categories provided a way to go further into the complexity of *how* women were constructing relationships, on what basis, and with what effects. Once women showed me that relationship could not be taken for granted, they began to speak about and point towards particular experiences of harms and suffering. By following women's lead into this denial I heard about what I understood as dehumanizing care created in interpersonal spaces. The pattern of *dehumanizing care* was constructed from women's account which contains the sub-patterns of *domination: being dismissed and erased* and *resisting subordination: doing battle in contact zones.*

Women's Experiences of Dehumanizing Care

Another reoccurring pattern within the women's experiences was the common thread of dehumanizing care. Women used words such as "cruel", "unsafe" "hurtful" "inhuman" and "traumatic" to characterize their experiences. As the twelve women spoke of negative experiences, their faces registered anger, hurt, and frustration. They spoke of feeling dominated by and subordinate to the particular program policies and practices that frequently worked against their efforts to maintain their own or their fetus/infant's health and well-being. In several instances, women spoke of resistance to subordination by describing their fight against being "not seen as a whole person" or as being "not there". In my field notes I recorded women's statements during our conversations since several

of these statements were not evident in their interview text. In the interview data, however, there were examples of resisting subordination by "doing battle", "breaking through" developing "ammo" (ammunition) to become resistant. Women had various ways of expressing resistance to care they described as dismissive – some were visible to me and others were not. In other situations women showed me and told me about their resistance; they physically or symbolically "walked away" or by "not letting them get to me".

In contrast, one woman participant who described feeling supported and cared for during her pregnancy. She stated "I felt they knew me, like knew from my past pregnancy that I could manage bed rest and that I have lots of help at home…they already had a sense that I had what is takes to stick with the routine, the activity restriction and doing the assessments on my own" (WP 12). She also indicate that her positive experiences of relations with health care providers was the *basis* for her capacity to adhere to bed rest and mitigate the negative health outcome of preterm birth. Feeling as though the staff believed her to be capable meant that she also saw herself as capable thereby illustrating how such experiences – as positive or negative – construct the women's sense of agency and capacity. This woman's experiences of being in-relation were meaningfully positive. Reading her data in relation to the other twelve women's experiences of dehumanizing care and the particular impact on their agency, self worth and care-seeking actions, suggests that the women's experiences (both positive and negative) contextually shaped tangible impacts on their health capacities and outcomes.

Twelve women spoke of negative experiences of interpersonal relations and linked these experiences to a diminished sense of self-worth. They described these experiences as formative of compromised and/or obliterated actual and potential abilities to accomplish a wide range of health-related activities in relation to particular antenatal health challenges or when caring for their ill infants. Later in this chapter I describe the more specific impacts of women's relational experiences on their capacity for health and described the impacts primarily in relation to their diminished sense of agency and self worth.

Several women's described experiences of care that I recognized and named as dehumanizing and dismissive. The following three transcript excerpts illustrate different experiences that are joined by the thread of dehumanizing experiences and women's resistance to being dismissed:

> Anything that happens has a lasting effect, especially when you're feeling inadequate like when your baby is in trouble, you already feel like its your fault…. no matter what you are told, you always question if the problem is something I have or hadn't done… maybe this wouldn't have happened. I mean it all shows up in the face to face, really it does. I'll never forget when I asked to go to the bathroom during labour and my nurse told me just pee in the bed, I wasn't moving rooms to deliver my baby, what's the difference with all the amniotic fluid there anyway. She said that it didn't matter to her, this would be my bed and that getting one of those nice hotel rooms wasn't going to happen. I told her no, it mattered to me, I didn't say it but I knew I needed some dignity. I can't leave my dignity or let them take it away at the hospital and take my baby home…I knew they were really busy and probably that was the reason, but surely at some point my pride is more important than saving one pad? (WP 05).

The mother of an unstable preterm female infant described this story of her partner's experience prior to being admitted for chemotherapy for colon cancer. She named this the "end of the cuddle':

> Her colour was good, she was asleep on my husband's chest and the nurse said it was time to put her back. It was his first time holding her cause he has been really sick, and I knew he had to get re-admitted that night or he would keel over. His counts were low and he looked awful. He had really run himself down coming to the hospital to be with us. I begged them to leave her a bit longer because he might not make it back for long time. He held on to her so tight when the nurse started taking her from him… I said wait, he is really sick and may not make it back until after a treatment. She didn't even wince like…as if to ask what treatment? I put my hand on her arm and said…please just a few moments more. I remember she just scooped her up and said it was the best for her to get back in the incubator, that with all the stress *we were causing her* by cuddling her might make her have apneas. My husband started to sob right there in the chair… right there in the chair, like he couldn't handle that guilt. I told her she was wrong and I made sure she never had her again. I don't think he recovered from that for a long time, what a way for him to start another round of chemo… part of him died right there … right then (WP 06).

In this situation, the woman felt as though her husband's need to be with their baby prior to his admission for chemotherapy fell far from the concerns of the nurse. She later spoke about the unbearable image of seeing the nurse take her baby off her husband's chest. She

described knowing that there was considerable uncertainty about when their next time together would be.

Another woman spoke of how she and her partner resisted an experience and averted the harm that could have ensued:

> He told us that our baby would die. It would never make it to term and if it did, it would die by 24 hours later. We had to have a late abortion…he said it was the only humane thing to do. We said no. He told us we would be responsible for the rest of our lives for his unnecessary suffering and that would stay on our conscience forever and did we want that. We told him no again. We told him we'd love him for 24hours… that would be better than no life at all. Our baby was born and they were wrong. He never had the chromosome thing. I can't believe we might have killed him (WP 10).

I understood the above experiences using Freire's (1994) claim that dehumanization refers to an act that causes one (literally) to become less human. Drawing from the existentialist writings of Jean-Paul Sartre and Martin Heidegger, Freire defines dehumanization as any act that physically or mentally injures human beings and thereby turns them into objects. Dehumanization from Friere's perspective is any process that puts obstacles in people's paths as they attempt to articulate and pursue their own needs, hopes, and dreams. He also writes how dehumanization that takes place through oppressive human and institutional practices are acts of violence[24]. The collectivity of harm and suffering described by women participants in this study, combined with the few examples of supportive and compassionate practices, indicate how the women's experiences of dehumanizing non-care, suffering, and harm not only jeopardized the women's health capacities and outcomes but can be considered acts of violence. Suffice it to say that dehumanizing relations were expressed when women's moral integrity and worth as persons (and their fetus, infants, partners, family members and their lives more broadly) was threatened. Freire (1994) claims that the "concern for humanization leads at

[24] It might appear contradictory to claim that human science perspectives in nursing do not adequately attend to the inseparability of experience and context and then enlist the idea of dehumanization as a relevant insight from the research. Freire's (1994) writing on dehumanization is from a critical perspective and is a good example of the various ways in which humanist values and analyses pay attention to self-other relations in-context. Friere's work and research informed by 'critical humanism' (see Kleinman, Das, & Lock, 1997) expands individualist and decontextualized views and focuses on harm and suffering as socially produced (discussed further in Chapter 7).

once to the recognition of dehumanization, not only as an ontological possibility but as historical and political reality.

Each of these transcript excerpts above are powerful examples of the difficulty and complexity of relational experiences constructed in interpersonal spaces of care. Yet, in other ways they are the subtle everyday examples of what happens between people who are 'interconnected' with one another and the particular contexts in which they meet. In the first example, there is a backdrop of an efficiency discourse living through the nurse's actions to conserve incontinent pads and language about the luxury of hotel rooms. In the second example, the 'end of the cuddle' take place as unit routines and practices to maintain the infant's neurobehavioral instability trump the importance of the father's connection to and need to be with his baby. In this narrative, the discourse of excessive handling become ideological in that particular power relations are set in place that are experienced as harmful by this family. In the third example, the judgment of a care provider about the 'humane thing to do' was shaped by dominant social values in relation to congenital anomalies and quality of life. In each of these, dehumanizing experiences of care were felt through the particular actions of care providers in relation to women *understood in context*. This is not to say that individual health care providers are not responsible; rather, it implies that the particular interpersonal practices of providers are both socially situated and sanctioned by broader cultural discourses of care.

My intent in the analysis was not to categorize women's experiences of interpersonal spaces into oppositional pairs of good/bad, ethical/unethical or satisfying/unsatisfying. Rather, my aim was to show how such evaluations are reflective of an inner unity that says something about the complexity of *how* meaningful experiences (in both the positive and negative sense) are created. I resisted claiming an absence/presence of relationship initially since the "straightjacket of dualisms" (Wilber, 2001, p. 27) was not consistent with the relational ontological and epistemological ground of the research. My aim was to examine the relational complexity of human experience and interpersonal relations for how meaningful experiences are constructed through the humanizing-dehumanizing, affirming-dismissive, disciplinary-freeing experiences – assuming both negative and positive experiences are closely connected.

Wilber (2001) proposes a 'no boundary' awareness helps resist dualistic conceptualization by showing how, for example,

> ...the line between pleasure and pain becomes a boundary, and the illusion that the two are opposite becomes convincing. Not seeing that the opposite are two different names for one process…Most of our "problems of living," then, are based on the illusion that the opposites can and should be separated and isolated from one another. But since all opposites are actually aspects of one underlying reality, this is like trying to separate the two ends of a single rubber band (p. 34).

Wilbur suggests that separating what cannot be separated perpetuates binary analyses of human experiences. I took dehumanizing and humanizing experiences in this study not as "….independent entities, but rather different aspects of the same thing, they are terms of relating" (Wilber, 2001, p, 28). Wilbur should not be read as suggesting that harm/pain/suffering/evil in totality with joy/pleasure/good are morally equal human experiences. To do so can obscure the deep human suffering and atrocities associated with one side of his proverbial coin. In terms of this research, however, recognizing the totality of experiences opened up the possibility of seeing how interpersonal relations constitute a wide range of human experiences, particularly when issues of context, power, and harm have been obscured in dominant theoretical works. I placed emphasis on women's negative experiences because these were given greater attention and voice by the women participants, and because they point to possible re-forms and transformations in maternal-infant health care practices that shape interpersonal relations.

I was initially compelled to 'explain' how the women's dehumanizing experiences occurred. My original intent to inquire into relational experiences created the impetus to go deeper, to see *how* such dehumanizing experiences were being constructed by the women. As mentioned earlier, my intent was not to 'test' the truthfulness of these insights but rather to understand how such experiences came to be. I constructed the pattern of women's experiences of dehumanizing care and two sub-patterns to represent the complexity in the data: experiences of *domination* and of *resisting subordination.*

Domination: Being Dismissed and Erased

Women's experiences of being erased and dismissed were shaped by the particular practices and policies of antenatal and neonatal care that were being enacted in

face to face relations health care providers. Twelve of the thirteen women participants spoke of dismissal and/or erasure in one or more of three domains: dismissal of their *bodily knowledge*, dismissal of *their efforts to do what they had to for their babies/fetuses well-being* and dismissal of the *relevance of the context of their lives* for understanding their experiences, needs, expectations, and choices.

Several women spoke of how their assessments of fetal well-being were considered less valid and reliable forms of knowledge that the knowledge of nurses and physicians during antenatal assessment. One woman said "why bother doing my fetal (movement) counts when their counts are the ones that count" (WP 06). A mother in the NICU recounted feeling dismissed when she was told by nurses that it was her handling of her preterm infant that was causing periods of apnea, bradycardia and reduced blood oxygen levels. This mother felt that the opposite was actually the case; that her son's oxygen saturation levels were more stable when she touched him. The nurses operated from the general assumption that minimal handling was necessary for every infant and, in turn, this mother felt her own connection with her baby was not valued for its health promoting potential. She felt her presence and touch was interpreted as a threat to her infant's physiologic and developmental stability;

> They told me I was causing him stress. But they also tell me that it is my job to get good at his care so he can go home. I know they need the bed…they are on diversion, the nurses told me that today so it makes me think I am holding up a bed since I can't do his care yet. But when I do his care it's like I am the one causing him stress. Feels like a no win situation (WP 01).

To varying degrees, as the above examples illustrate, experiences of dismissal and erasure were evident in the multiple references to feeling faceless and invisible: "I was "not seen" or "like I was not even there" and "not a whole person in their eyes". Women spoke of dismissive experiences by referring to complex interplay among the specific behaviors and practices of health care providers (people) and dominant ways of doing things (policies and practices) in the both the antenatal and neonatal context. One woman recounted:

> You know it is hard to put a Pamper (diaper) on such a tiny baby. I've hardly put diapers on regular size babies. They make it looks so easy and sometimes when I am fumbling and messing up, I can hear the nurse sigh and get frustrated with

> how slow I am. Kind of like saying without saying just move over and let me do it. Once a nurse just went in the portholes of the incubator from the other side and moved her hands in and took over. I don't think they have any idea how this chips away at me…makes me think I should just walk away and let them do it all for him... sometimes it feels like he's their baby and not mine. Makes me feel like I can't do it (WP 07).

The woman above indicated in several interviews how her relations with nurses shaped her capacity for involvement in her preterm infant's care. I took the everydayness and routine practice of diapering as a particularly relevant site for examining the relational context of mothering capacities. This woman illustrates how the discrete skill of diapering a 1500 gram infant was influenced through relations with nurses that were also situated within a family centered care philosophy (families are at the centre of care) and the particular practices and expectations of 'family involvement'. This woman's experience draws attention to how the skill of diapering (or lack of) is created in-relation with nurses' embodied actions which are shaped by philosophies of care and taken for granted norms and practices. The 'expert hands' moved this mother's hands aside thereby dismissing her efforts to learn, be 'centered' and "involved". The dismissive bodily actions of the nurse effectively erased the integrity of this woman in her efforts to become skillful at diapering her tiny infant. Her capacity for being involved was threatened, if not obliterated. Theorizing how women's dismissal occurred in this study, it was evident that the nonverbal body language of nurses constructed the woman's experiences of *depleted* capacity; she was literally erased in that particular experience. The nurse's actions were experienced by this woman as a sign of the contested 'ownership' of her baby. 'Woman/family centered care' was practiced on nurses' terms rather than in response to this woman's need and desire to be involved. I understood her experience in this situation as illustrating how health 'capacities' were being shaped by the context of a discourse of family-centered care and the 'expert' practices of nurses.

WP 07 also connected her experiences of relationship with certain impacts on her confidence and competence in caring for her son. She spoke of how she knew what nurses "thought of her". As I sat with her beside her son's incubator, she indicated how through the nurses' body language, she knew what they thought of her ability to be his mother. Not spoken, but implied through rough and harsh bodily action, were particular

judgments about her mothering capacities. Her relational experiences led her to consider if she should just 'walk away" which ultimately would negatively impact her capacity and confidence and to provide care for her son.

Another woman spoke of seeing her baby turned like a 'piece of meat' which dismissed her baby's humanity:

> I know it's a crazy busy place, you can just feel it when you enter. But when they are so rushed, they just turn her like a piece of meat, it makes you say 'just wait a minute', that's my baby you are just flopping over. She's a person you know, no matter how small. I know it's not intentional and there are so many babies to be turned and settled, but for god's sake, she takes so long to settle afterwards that I am sure this just makes even more work, having to increase the oxygen, and other stuff. Just treat her like my baby, please (WP 12).

In this transcript excerpt, the mother is deeply disturbed at the dehumanizing infant turning procedures of the staff. She indicates that *how* nurses are 'in-relation' to her infant impacts her physiological stability. Based in this woman's experience, I understood how nurses' actions can be seen as enactments of particular values about the moral status of preterm infants. This mother connected the nurses' ways of relating to her baby as fundamentally connected to her physiological stability and the challenges of maintaining her precarious oxygen supply and demand balance. In this one example, it is possible to see the connection between how moral values about persons are enacted and specific impacts on preterm infants' physiological health and stability. I concluded from this powerful story that turning preterm infants could be considered a moral act that creates the context within which health promoting care can be provided.

Another form of dismissal was apparent in the women's data: several women described how their fetus/infants' needs were held in competitive opposition to their own needs. On a few occasions women and fathers were sanctioned for inflicting harm (cuddling too long, visiting at the "wrong" time of day, carrying a pregnancy to term with a life-threatening diagnosis). Often mothers were constructed as 'threats' to their fetus/infant's survival and well-being. In other situations, women deemed the staff as a threat to their infant's care in the NICU. When women were constructed as threatening it became next to impossible for themselves and health care providers to work towards the

same health related goals. One woman spoke about “getting disappeared” and becoming faceless:

> It’s like you get disappeared, like you have no face, and that just seems like the way it is. Other moms in the nursery tell me it is just the way it is. Like don’t bother unless you feel like you can see it through to the end. I mean I need to feel strong so I guess it’s a matter of protecting that strength rather than eroding it…cause’ when we get home…it will be just me and him and I’m gonna need all of that (WP 11).

Getting ‘disappeared’ and being made faceless was this women’s expression of being erased and dismissed. The costs of working against ‘getting disappeared’ were seen to place her capacity to be strong in the moment and in the future at risk. This woman recognized the cost of ‘eroding strength’ as holding consequences for her potential mothering capacities beyond the hospital admission. The women frequently spoke about needing to disengage in order to protect their much needed personal resources to take their babies home.

Several women spoke of differing levels of knowledge as creating unequal power relations that structured their experiences of dismissal and erasure. Domination was described as almost a “natural” consequence of being vulnerable and lacking in power. One woman said “when your baby is sick and so small, it changes everything…I means what really do I know about what she needs….what can I add to her care….it was like I might as well not have been there” (WP 12). Another woman spoke of how knowledge held by “them” is seen to be more important than the knowledge held by “us” (WP 05). Women spoke in ‘us-them’ terms which illustrated the specifics of how power dynamics shaped their experiences. On woman explained;

> WP 08: I don’t expect to interact with nurses and doctors in personal ways, but you feel all the effects in interactions in personal ways…cause this is all personal to me….like being with the nurse is great when things feel even, like you can look each other in the eye. I have had those [relationships], you know when you feel like no matter how badly you screw up, there’s no judgment that goes on and on. I had a teacher like that once. I haven’t had much of that in this pregnancy, but by not having it, I think I now know what it would be to have it…so it is fine to say this kind of interaction is different because after all they are the professionals and I am the patient which means the situation is completely different, like it’s hard ’cause they know more and have more say for sure, but I only know what it feels

> like through my personal reaction which means I want to say, hey, I know things too about him]my son] and yet it doesn't seem like there's any room for that.
>
> HB: Any room for…what are you working against?
>
> WP 08: I would say its more like a struggle, I mean I am up for it, and won't let the struggle take me down, but it does you know, some days I want to go in there and say, hey, I am his mother, now get out of the way…which I know is never going to work out well and then I will be marked as a loud mouth…which actually I am [*laughter*]…what I really want to say is…loudly [*more laughter*] can you make room for me? You should make room for me 'cause I am the one that will be here his whole life….and no one knows that better than me.

The "us/them" (WP 05) language of relationship evident in almost all of the women's data and was understood as originating in their experience of feeling erased through differences in knowledge/power. Feeling dismissed and erased meant that women perceived the social distance between themselves and health care providers as extensive: women held a distinctly different place than health care providers in the medical hierarchy. One woman spoke of having "nothing to offer" (WP 06) in terms of providing care to her infant. Feeling as though she had nothing to offer meant that she saw herself as lacking the capacity to learn about her son's tracheotomy care. All the women expressed a heightened vulnerability related to pregnancy complications and their infants' need for specialized neonatal care. I saw the women's vulnerability as creating situations where differences in knowledge/power would shape their relationships with health care providers. One woman, however, questioned why these differences had to be divisive more so than productive:

> I expect they know more and have more say in what's happening, but that doesn't mean that I become invisible. We should be able to work together and help me get him home. There sure are things that I know more about….like how to hold the bottle so that less air gets in his tummy…and other things….(WP 09).

While differences in power/knowledge shaped women's relational experiences, I decided it was necessary to examine how differences in power/knowledge were also produced through more than just individual differences in women's and health care providers' knowledge of antenatal and neonatal care. For example, several of the women spoke of relations of domination that I saw as shaped by the 'high risk' maternal-fetal discourse. One woman said:

> When you're told that your baby's health is in your hands, it's is so scary and makes you feel like if only things could have been different. Except that doesn't get you anything but guilt. I know that the program is about taking away any more risk to the baby, but still it feels likes it all on my shoulders which makes me feel bad and then I just go silent…[sigh] that is such a huge weight to carry. If I wasn't mostly strong this could tip me over the edge (WP 04).

WP 04 points to how knowledge and practices are constructed through the particular discourse of risk in ways that can sustain and reproduce unequal power relations and women's experiences of domination. The medicalization of birth and discourses of 'risk' in relation to maternal-fetal-infant care constructs health care providers as detached, expert observers who have the specialized knowledge to determine 'maternal threat' to fetal well-being. When women were seen as 'risk producers', they become reproductive objects of risk that determine the interventions and treatments delivered by health care providers.

One woman spoke of her experience of dismissive care as connected to people (nurses and physicians), practices (exclusion of parent from medical rounds), and policies (visiting policy);

> When I was there, it is like you are told who is an acceptable visitor and that you can't be on rounds, those rules and whether or not they makes sense for parents affect the interaction you have with the nurses. It makes me feel like I have to fight against the rules if I want to have someone come in and see him and it also made me glue my feet to the rocking chair when rounds were starting…kind of my way of saying, just try to make me leave. When they say 'it's policy', it's like that's the law, like it or lump it. It just doesn't make for anything else good to happen, I mean what was it like for the nurse to always be saying no…you can't have this or that person, or you will have to leave. I can't imagine that makes for an easy day. But it also feels like I don't matter as his mom, like why I would matter when all the rules tell me I don't (WP 11).

This woman spoke in ways that confirmed how dehumanizing care, domination, dismissal and erasure were created through a complex interaction of people, policies, and practices. These examples indicate that in this study there was a both a policy and practice context of human relating that in the example above had powerful impacts this mother's energy to "fight". Yet within this same policy/practice context, this woman resisted the domination and subordination: she glued herself to the chair. Although she described seeing her own personal strength when resisting the NICU policies, she spoke

about the significant costs of having to "fight against the rules". I saw this woman's determination to "glue herself to the chair" as her way of resisting a passive subject position. In this instance, her resistance was both capacity *enhancing* "seeing what kind of mom I will be" (WP 11) and capacity *depleting* in that she spoke of the significant costs to her own energy.

The women also described situations where their concerns about themselves or their fetuses or infants were not taken seriously. At times, the women's concerns were trivialized or dismissed by providers. This was frequently expressed by women as the dismissal of their bodily knowledge of pregnancy as it collides with the biomedical agenda and expertise of care providers. One woman recounted being told during an outpatient fetal monitoring that there was nothing wrong before a complete assessment of fetal well-being was undertaken. She had not felt her baby move for 24 hours and was not reassured that her own assessment of fetal well-being was accurate:

> I asked to have a long strip that day. I was awake almost all night waiting to feel something, but your mind plays tricks on you…was that a kick? What was that? I thought I will ask them to do a long strip and then I can see, you know assure myself they didn't just get the one movement in 24 hours. I was basically told not to worry, as it they can just tell me and I will stop. The belt was already on so how hard can than be? I needed to know but I guess the nurse decided I didn't. The nurse said all moms worry like that but I also knew that when you don't feel something it can be the first sign of problems. I mean they tell you that and then don't respect what you feel when you tell them (WP 02).

This women spoke about the paradox of being taught how to monitor her fetus' well-being at home and expected to know warning signs and when to call the hospital, only to then have her 'knowing' dismissed in specific moment. She described feeling judged as overprotective by asking for more indications of her growing baby's well-being. In fact, this woman spoke at length about the double-bind of being praised for developing the 'self-efficacy" required to adhere and be successful on the home care program only to have that self-efficacy undermined through an interplay of people, policies, and practices during fetal monitoring activities. I surmised that the discourse of 'self -efficacy' had ideological effects (Lupton, 2003). The ideological effects *produced* dismissive care and kept particular power relations in place that ultimately depleted this

woman's confidence and capacity to ensure her fetus' well-being and to bring her pregnancy safely to term.

Another woman recalled an experience of not being seen as a "whole person". She knew that her efforts to produce enough breast milk to nourish her preterm infant was inseparable from the critical importance of being seen as a whole person:

> …not being seen, that's like saying, you, as a person are not required or not welcome here but I need you to keep pumping, bring in your breast milk, and like be here when it works for them. I just wish the nurses could have seen me all at once, like I *am* [vocal emphasis on tape] a whole person, at least be curious, you know curious enough to see all of me, because for all of me is attached to the breast pump…. all of me matters even for producing any milk. Funny that they keep saying "you can do it" and then make it seem like its all on your shoulders…like don't get stressed because that will affect your milk and then they totally stress you out. Like it's all up to you, not seeing that what you can do depends so much on how they treat you (WP 09).

The statement "what you can do depends so much on how they treat you" (WP 09) illustrates how experiences and impacts are relationally shaped in interpersonal spaces of care. Producing breast milk has been determined to be a significant benefit to preterm infants; however, women's level of stress, fear, and worry about their infants' health and survival may significantly interfere with milk production. WP 09 illustrates how her success at producing milk cannot be disconnected from being cared for in ways that are respectful and responsive. Not 'being seen' by health care providers can hinder rather than enhance milk supply.

The antenatal home care program is also guided by a philosophy of woman-centred care that is intended to enhance women's self-efficacy to monitor their at-risk antenatal health condition. As was the case for WP 09, the relational context within which the antepartum women's capacities were enhanced or constrained was a key determinant of their self-efficacy. One woman said;

> When I was on bed rest for having broken my water, my mother was living with us…she needed me, and I know I needed help with her, but it's not that simple. It was like they couldn't see the connection between the two, like having to look after my mom was somehow not important in their eyes…except one nurse could though and when she came, she always did a hands-on fetal strip and kept saying what an amazing job I was doing growing my baby. Later in the day, I know I was more apt to say to my husband "get it yourself" and then ask about getting

> extra help with my mom. Seriously, it was really hard work to step out of my life for 5 months and just to have been able to talk about that more would have made it feel like I was all there…you know a full human being in their eyes kind of makes me one in my own eyes and way more apt to feel confident to ask for what I need (WP 03).

As in the above example, several women spoke of the erasure of their life context as relevant for understanding their adherence to the antepartum at home care program criteria. This particular woman spoke of how caring for an aging parent made 'adherence' to bed rest difficult. Pregnancy 'risk' necessarily occupied a central aspect of their relations with care providers however, several women spoke of how their lives were 'unseen' when the pregnancy risk occupied centre stage.

I noted another feature of how women's experiences led them to feel dismissed and erased from conversations with the nurses about one potential woman participant for the study. The staff described one woman patient on the antepartum program as not being a 'good one' for my study. Their reason was that her home was "unstable" and that I may be at personal risk if an interview was to occur in the woman's home. The same women patient had already made contact with me. As she spoke, I recorded our conversations[25]:

> I know they think I'm trash. I can see it every time they come here, scanning the room to see what might show something, like booze or drugs. I clean up before they come, I am not doing drugs but I am gonna need help to get clean…When I first had this trouble with leaking fluid, I thought, ok maybe this will be a way to get help, get clean, maybe even stay clean. My other kid got taken away, he was healthy but I don't know about this one. It's a girl and I feel like she might set me straight. I threw her dad out last week. He was a big part of the problem…now I can't pay the rent. They [the nurses] come here in pairs you know, and that's not regular. I know that and they think I don't know that. I can see it on their faces, except there's this nurse, she came alone last week….something about her, its like she knows that sticking to the program is hard for me, yet she makes me feel like I can do it and has brought me video…last week she stayed longer than she was supposed to she got this call from the office I think saying something like you why aren't you at the next appointment. I heard her saying, I need to be here a bit

[25] Based on past experiences of "not trusting the system" (WP 05), this woman preferred not to have our conversation taped in fear that her experiences would get back to the program staff and jeopardizr her future care. Even with privacy, confidentiality, and anonymity upheld she felt the details of her life would reveal her identity. I opted to take notes rather than record our conversations to acknowledge that her sense of risk ought not to be mine to minimize.

> longer, then she came out, seemed mad, packed up her stuff, finished the paper work and left (Field notes of conversation with WP 05 June, 4th 2005).
>
> This same woman later told me if I came on some appointments I could better see what it was like for her. We talked about how my presence might alter the interactions, but she still thought I would see something important. She told me today after a fetal monitoring visit, that she had never been treated so much like a person and joked about staying in the research until her baby came might help get her some respect. I noticed the fetal monitoring nurses had telling reactions when they saw us together. I suggested that being together would reveal her identity in the research to program staff who knew me, but it was now several months after our first conversation and she said she felt safe, and more "important" somehow with me coming along. Some knew that the difficulties she was experiencing in relation to nurses were relevant for the research and their acknowledgments came in an affirming way. Other nurses' faces looked surprised that I might be interviewing her…almost fearful about what she might say (Field notes July 28, 2005).

This woman's experiences of dismissal and feeling erased were constructed through what she understood as judgments about her life, social worth, and acceptance as a human being. She indicated how supportive, safe, and ethical care could mitigate the array of harms she had experienced when living with addiction. She told me that when the nurses approached her as worthy and deserving of care, she actually would *see* herself in the same way. She spoke about the connection between feeling worthy and her capacity to "stay clean". Feeling judged and labeled as 'trash' led her to think "I can't do it". She thought being on the program could enhance her efforts to carry her baby safely to term and stay clean only to find that her interactions with nurses worked against such hopes. She described how having 2 nurses come on each home visit implied they did not feel safe in her home. She asked "…if they can't trust me how can I trust me?" (Field notes, Sept 12, 2005). This woman spoke of how this one nurse "treats me as a person". From her descriptions, it was as if this nurse essentially worked against dominant practices to provide her with nonjudgmental care. "I think this nurse actually believes in me…..like I can stay clean" This nurse was described as practicing in ways that risked the sanctioning of her colleagues by "coming alone and staying longer than the others who came in pairs" (Field notes, Aug 20, 2007).

Evident in women's experiences of dismissal and erasure were several powerful examples of how women also resisted the subordinating practices, policies, and people that shaped their experiences of interpersonal spaces.

Resisting subordination: Doing battle in contact zones

Women's experiences of domination produced a subordination of their concerns, goals, choices, and decisions in relation to those of health care providers. Experiences constructed as domination, however, had different effects on the women. Eight women, for example, spoke of their efforts to resist the subordinating effects of particular practices and policies. Several women spoke of how they had to "do battle", "break through" amidst the "forced counters" or exist in the "contact zones" of care. Two women literally and figuratively walked away from their "fight" to "be seen" or to "have a face". I could see that women engaged in the battle and resisted subordination while others resisted in more subtle ways (for example, nonverbal ways). Almost all of the women, however, described the costs associated with their efforts. Some efforts were deemed worthwhile and others they saw as too risky in terms of their future interactions. As previously described, one woman resisted the subordinating intersection of dominant practices and policies of medical rounds in the NICU by "gluing herself to the chair" (WP 11). This was her effort to resist being displaced or subordinated during conversations that she knew were critical for her own and her infant's health and well-being.

One woman spoke about her experiences 2 years after her son was discharged after a six month admission to the NICU:

> I know when it felt good with the nurses, but it didn't happen very often, now and then, it's like sometimes I could let my guard down and that to me was a sign that I was safe with that nurse….like take off the armor. I think that is what isn't there in some situations, feeling safe for me to ask about things they assume I should already know…its stressful you know…I mean some days I think if only you knew how much it affects me…the look that says "you can do it" or "bet you can't" made a huge difference for how I saw myself. Sometimes it felt like I had to go through them to be allowed to be with him [my son]. It was like, I can't say a relationship was there, more like a barrier that I had to blast through or figure out how to break down (WP 11).

For this woman arming herself meant fatigue and compromise which depleted her confidence and capacity to "keep going back in there…the energy it takes to arm yourself probably creates stress that make me less likely to really feel like his mom" (WP11).

Another woman spoke about her experience of being seen as a threat to her preterm infant's stability each time she asked for skin-to-skin cuddling. She knew that skin to skin cuddling was an effective way to also increase her breast milk supply. She was told repeatedly that, for his own 'good', her cuddles with him should be short and limited to once per day. She understood her son's his risk for hypoxia and the connection to excessive handling but she was sure that cuddling was calming rather than stressful. She resisted the ongoing actions of care providers who subordinated her efforts to increase her breast milk production in the name of 'protecting' her son from stressful handling. She described trying to talk about it with the staff:

> If someone was just willing to tell me why, I think as his mum I can watch him really closely…but it seems like everyday they say its for his own good, I want to say yeah but what about the good that happens (for my milk production) when he can lay on me a few times a day? They keep asking where is the milk and I know this could help us (WP 06).

The tendency for women's needs and concerns to be seen in opposition to the health and well-being of fetus/infants' needs was a noteworthy source of women's efforts to resist subordination. This was evident to a lesser degree in the antenatal context where woman and fetus were both the focus of care. In the neonatal context, particular unit practices (such as parental presence of rounds and skin to skin guidelines) often constructed women as placing their own needs over those related to their infant's well-being or those of other infants/families in the unit. Recall the woman (WP 06) described earlier in this chapter who described the "end of the cuddle". She felt as though she was placing her husband's need to cuddle their daughter above the staff's concerns for her physiological stability. Her resistance to the subordinating practices was to 'work the system' so that the particular care provider was no longer assigned to care for her infant.

Another woman wrote in her research journal about how the intolerable intrauterine diagnosis of a life-threatening fetal anomaly was made further intolerable. She described having to keep her "guard up" (WP 02) to resist the subordinating

dominant practices of health care providers. Her story resonates with other women's stories who spoke of the long lasting effects of feeling subordinate to the knowledge/power of health care providers. Like WP 10, resisting the subordinating and dominant practices of the NICU led another woman to keep her guard up in ways that subverted her capacities for asking about "things I really wanted to know":

> You know, I was okay with not knowing, not having the test for trisomy. We had decided that it wouldn't change anything in the pregnancy. We would keep this baby no matter what. That is our faith, it's what we believe. Not to say I wasn't worried. But I was okay with the not knowing, but the staff couldn't imagine how not knowing was better than knowing it all, having all the reports they said was the right thing to do. We would regret it. I remember almost being scolded by one nurse, saying with all the technology nowadays it is just wrong to not get the information. Maybe that is just a function of their work, knowing all is better… always good maybe? I could almost understand that from their point of view (WP 02).

> When we decided not to have the Trisomy test, it was like they couldn't support that at my age and with my family history. It was like living with the fear of Trisomy was almost bearable, but the way they were with us made it hard for us to live with our decision, believe it was the right one. Like being worried about Trisomy is not enough but then to have to deal with the staff judging of us like we are crazy, like what were we thinking? I felt like they thought I was not attached to my baby, like I would be more attached if I could just know it was perfect. I am attached and nothing can change that. I think I actually stop asking about things I really wanted to know, like I had to keep my guard up…I think they already decided things about me which made it really hard to ask for anything (WP 02).

Like WP 11 who spoke of 'breaking through barriers', another woman spoke of breaking through walls:

> Some days when I come in it's like there is a wall to break though. It is just how the place feels, I can feel it from my head to my toes, sometimes is gets stuck like a knot in my stomach. Depending on who is on that day, I get through it easily or I am forced to do battle. I don't know, but its like I don't want to judge the nurses, I mean I can't imagine working there, they are always running, trying to do so much…I heard them talking about the doctors and how this new one thinks he's 'god', and that a 22 weeker was admitted last night even though they were not supposed to do anything. They were so upset, talking about those poor parents who have no idea what helping the baby breathe is going to do for their life, even if he makes it they are so upset about the how much he will suffer (WP 07).

In subsequent conversations during her son's admission, this woman about the NICU environment, particularly for how it shows up in individual nurses' and physicians' behaviors. This young woman spoke about people and places simultaneously, and connected nurses' ways of engaging with her to their work environment. She spoke of multiple relations simultaneously when constructing her story, and provided a complex and contextual view of interpersonal relations.

Like WP 07 who spoke of the need to "do battle" depending on who was caring for her baby, another woman dismissed the idea of 'relationship', and used "contact zones" as metaphor her experiences in the NICU:

> Well no, it's more like contact zones…I usually need to arm myself when going in there, like having all my bottles of milks labeled, but its like I am in a foreign land not ready or expecting to do battle…but I don't know even how to begin, you know its like hitting a wall where you cannot break through…which means no, I can't say I even have relationships because if there was one that was real I would know it, you know, that's something you can feel, like its there, and it becomes helpful. I did once a long time ago have a GP, I think we had a good connection….it felt like he was always in the room with me even though he only ever did 10 minute appointments. I could ask for more time, it's not like even he thought 10 minutes was enough. I knew I could ask for more (WP 09).

When I asked this particular woman about 'contact zones', she told me these words were an apt description for other aspects of her life. She spoke about what is was like to immigrate to Canada from her homeland 2 years earlier. She spoke of being isolated from extended family and the difficulty understanding Canadian immigration policies. She talked about these past 2 years felt like the invasion of many new cultures all at once -- Canadian culture and the culture of immigration. Becoming a patient added another layer to Canadian culture, another form of 'invasion' that felt alienating, hostile, and oppositional to what she had hoped life in Canada would be. Escaping political instability in her homeland, she spoke about the politics of navigating an array of immigration policies as compounding the challenge of making a 'home' and integrating herself in her husband's family and a new community.

Another woman participant mentioned that she believed something was wrong with the "way I was treated'. She spoke of never being "ok with that", and noticed that now she always has her "guard up":

> That's when we get put into boxes. It's like if the doctor knows I am new to this country, he might reach into his pocket and pull out a recipe card that says women from X country need this when they immigrate here". That make me have to put my guard up but then I am not able to ask what I really want… You know it's like I do need to be seen as a whole person when I go to my visit because everything else impacts this baby. I mean I know they need boxes now and then but maybe get better at knowing what you are doing with them. I think that's it, know how and when boxes help or hurt (WP 03).

All of the women who were recent immigrants (within the last 3 years) described how their health care interactions and encounters were reflective of broader enactments of migrational experiences and immigration policies. In different ways, these seven women described experiences which were both dismissive and created experiences of feeling subordinated by negative and racializing[26] stereotypes of immigrant women. One woman said being an immigrant woman and being a patient were experiences "cut from the same cloth…the staff act like they think they know you….or have already decided that you have a huge family so there is lots of support…there are lots of people in this house, but I am alone here….where you just get used to being faceless…" (WP 03 via interpreter). This woman described her relations with health care as exemplifying more of what she continues to experience in her day to day life:

> I actually thought when I got pregnant that things might be different. Like I wouldn't feel like I had to justify myself and then battle with everything. I mean I needed care cause my baby wasn't growing…. it sometimes feels like people don't understand how hard it is to leave home and come here, but for me it was not a choice. The first few months were tough but now my sister-in-law translates for me during their (home) visits but when I go to the clinic twice a week, there is often not a translator there unless I bring her. It has been hard to…I think my English is pretty good, I understand more than I can speak but you are judged

[26] In Chapter 4 I claimed that when nurses conflated culture with ethnicity they were in fact assuming that women of a particular ethnicity could be seen to share universal characteristics. In this research, these universal characteristics (for example, comments like "they have big families") were enlisted to 'explain' why relationships were challenging in some instances. I asked about what the negative implications were of such ways of knowing about culture. If racialization is understood as those instance where social relations between people have been structured by the signification of human biological characteristics in such a way as to define and construct differentiated social collectivities (Henry & Tator, 2006), then it was critical to question how essentialist notion of culture, when conflated with ethnicity, become stereotyping and dismissive in interpersonal spaces. Can the concept of racialization help theorize the complexity and difficulty of human relationship and expand how the impacts of interpersonal spaces of care on immigrant women are understood? I decided these were important questions for future research.

> more by what you say than what you understand. A nurse said to me once "why don't all of you learn to speak the English before coming here?" I was so insulted since my language is me, and I need to hold on to that especially here (WP 03, translated by sister).

Seven woman participants spoke of the intersection between their experiences of immigration and their experiences of interpersonal spaces of maternal-infant care. Dismissal and erasure was compound by women's experiences of being uprooted from their homelands and resettling in a new country. The women who spoke extensively of immigration experiences worked to show me the 'whole' of their lives and its relevance for knowing their story and for understanding their experiences. It became evident that the pervasiveness of the battle metaphor peppered throughout 11 of 13 women's accounts warranted closer scrutiny because of how these eleven women spoke of marginality, social isolation, and alienation in a foreign culture. I asked what might explain the pervasive use of the battle metaphor in how women were constructing their health care experiences through the lens of their knowledge of immigration?

Women's experiences were quite clearly being shaped by the connection between the whole of their lives as new immigrants and their experience of being 'high risk' antenatal patients and/or mothers of ill newborns. For example, a dominant anti-immigration discourse was living in the nurse's question posed to the woman participant about why she had not learned English before coming to Canada. She described feeling berated through being constructed as "unwilling" to learn English. Her effort to maintain her language -- an integral aspect of her cultural and religious identity – was subordinated by the dismissive comments of the nurse. This woman's experiences did not reflect a desire for assimilation into English speaking Euro-Canadian culture. She spoke of trying to inhabit an in-between space between Canadian culture and her distinct cultural identity and language.

Consulting research that connects transnational migration or diaspora to particular health experiences and effects (McGuire & Georges, 2003), I theorized that there may be a connection between diaspora and the construction of women's experiences of "battle"

"contact zones"[27] and "forced encounters". From a postcolonial perspective, it has been argued that contemporary borders are constructed from a distinctly Western essentialist cartographic view and are designed to protect White wealth, power, and privilege from excluded others (Ashcroft, 1998). From this point of view how do 'boundaries' divide people socially and geographically in ways that impact women's health? How are experiences of relationship also divisive along the lines of power and privilege in relation to gender, race and class? Bringing postcolonial theoretical perspective to literature and research on the essential role of boundaries for professional therapeutic relationships raises important questions explored in Chapter 7. This chapter now turns toward a description of the impact of relational experiences on women's health capacities and outcomes.

The Impact of Experiences on Women's Health Capacities and Outcomes

Women spoke of the effects and impacts of their experiences of interpersonal spaces with little prompting or encouragement. The impacts on women's health capacities and outcomes of care were expressed in both verbal and nonverbal ways; through gestures ("gluing myself to the chair"), through words ("makes me feel like I can't do it"), and through specific actions ("I walking away" and "I just stopped going"). One woman who spoke of being faceless placed her hand over her face as she started to speak. Another woman that the impacts of relationship are always "close to the surface" and said "…you feel everything, everything affects you, all of it affects how you see yourself as being able to do this (WP 06). These women's experiences of care were more than 'personal responses'. I concluded that the women's experiences and their impacts arose through a complex relational interplay of people, policies, and practices in both the antepartum and neonatal care context.

Women's experiences powerfully shaped their capacities to do what was required to enhance their own and their fetus/infant's health. All of the thirteen women spoke of the impact of interpersonal spaces. It was from the women's accounts that I named the

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[27] From a postcolonial theoretical perspective, contact zones have been described as what occurs when an invading culture colonizes the lives and experiences of another (Mohanty, 2003).

specific impacts: *erasure of worth and agency* and *avoidance of care* and increased *maternal/fetal/infant risks to health and well-being* (Figure 2, p. 111).

Erasure of Worth and Agency

The women indicated how their experiences of erasure – or in some cases obliteration -- of agency had the concomitant effect of depleting women's sense of social worth. In several instances, the women's agentic capacities were made invisible through their experiences of dismissive, dominating, and subordinating relations. Through their efforts to resist subordination and do battle several women spoke of a renewed sense of their own agency and capacity. One participant said that by seeing her own resistance she was better able to "see what kind of mother I will be". In contrast, other women's experience of dismissal ("they think I am trash") led them to devalue their own knowing in relation to pregnancy and mothering. Whereas some women spoke of an *eroding* agency, other women spoke of an *erasure* of agency[28]. In two instances women illustrated how an erasure of agency was the very thing that created their resistance to subordinating relations. What was clear from the women's accounts was that agency was not their individual possession; rather, it was created in the presence of care providers. Women's agentic capacities were therefore continuously influenced by people, policies, and practices which were shaped by specific features of the antenatal and neonatal programs.

Understanding women's agentic capacities as created within the context of maternal-infant care (where people, policies and practices shape this context) led me to ask how liberalist individualistic discourse tends to locate individual 'risk', capacities and outcomes in the hands of individual women while leaving harmful and unjust practices and policies intact. For example, excluding parents from medical rounds left the dominating and subordinating practices that women experienced in place. Paradoxically, family-centred care policy aims to place decision-making in the hands of mothers and

[28] I understood the difference between erosion and erasure as reflective of the distinction between a process and a particular consequence or impact. Whereas erosion indicates a slow depletion underway, erasure was communicated by the women as if it was a particular state of affairs. To be progressively "not seen" created the context where women experienced a sense of being completely absent, such as in particular moments of their own or their infant's care: "like I was not there".

fathers/partners in the NICU. The contradiction between exclusion and discrediting women's involvement while simultaneously requiring active 'partnership in care' in decision-making created an untenable situation. This untenable situation erased rather than enhanced women's agentic capacities.

One mother asked "why bother doing battle when it gets you nowhere?" Other women described a slow erosion of their involvement in their infant's care. An initial agency of resistance ("I glued myself to the rocking chair") eventually led women to question their mothering capacities. One mother spoke about feeling as though she had no choice but to stop breastfeeding her preterm infant. By doing so she relinquished her specific capacity to enhance her baby's health. She recounted being told there were "too many women for just four electric breast pumps" (WP 07). The problem was communicated to this woman as one of "too many mothers" (WP 07). In turn, she felt as though she had no choice but to stop pumping because she renting a pump was beyond her financial means. A lack of resources in this situation can be traced to dominant cultural discourse of efficiency that shape the decisions and practices of care providers. This woman's 'choice' to stop breastfeeding was not reducible to her personal capacity to pump but was constructed though an ideology of scarcity (Varcoe, 1997). Because of the evidence that confirms breast milk provides the necessary immunological support to prevent nosocomial infections and iatrogenic morbidities in preterm infants (Merenstein & Gardner, 2004), such analyses of ideology, relational experience, context and impacts are critical for enhancing women's capacities and outcomes in interpersonal spaces.

Another example of the impact of erasure on women's capacity can be seen one participant's statement when she said "they think I am trash" (WP 13). This woman spoke about how feeling dismissed and erased produced feelings of low self worth. She connected low self worth to her capacity to "stay clean" and keep her baby. It was clear that her health capacities and outcomes were *not* innate resources that were 'predetermined'. Her health capacities and outcomes were being discursively produced through an ideology of inferiority associated with a history of addiction". Being judged as inferior and inadequate, as if she were 'trash' created her low self worth that, in turn, practically obliterated her agency. These experiences and the impacts left her unable to

see herself has having the capacity to 'stay clean' throughout her pregnancy. Thus, her health capacities and health outcomes were not reducible to individualistic innate strength, 'free will', life choices or resources. Rather, it was her particular situation and life story that limited her choices and capacities to 'stay clean'.

Women's agency as relationally constructed and either enhanced or constrained their health capacities and outcomes. Capacities and health outcomes were neither 'external' to the social organization of health care, nor 'innate' to individuals but were constituted through self-other-context relations. Several women's experiences of dehumanizing care and domination led them to "put on their armor" to "blast through", while others withdrew or just "stayed away". The personal harms and suffering experienced by women were not 'just' individual experiences; they were produced through a complex array of relations. From the women's accounts I deemed that the very structures and systems designed to enhance maternal-fetal-infant health capacities and outcomes may in fact contribute to outcomes of care that create particular inequities in women's health. For example, the antenatal program philosophy espouses women's self-efficacy as the philosophical and practical end in view. Biomedical and liberal individualistic discourses that underpins 'self-efficacy', however, paradoxically worked against how self-efficacy is developed in relationship with others and within particular life and health care contexts. A different woman spoke of the burden of the needing to develop self-efficacy to remain on the antepartum program. She said "we have to show them we can monitor the baby at home, like we have to have all the records completed for their visits, otherwise we can't stay home and we get hospitalized" (WP 10). This woman's 'self-efficacy', measured through program adherence, was partly undermined by the fact that it was understood to be the conditions for receiving care. Yet, adherence to the program was never just reducible to a woman's capacity but had to do with how her whole life worked with the necessary limitations and restrictions. For WP 10, self-efficacy meant tuning into her bodily knowledge and indicators of fetal well-being as a way of reconstituting her capacity *for* agency. She later said "…if they asked me how I know my baby is ok, I could tell them" (WP 10). The women's capacity for efficacy and

agency were not merely their individual strengths but were always created in relation to care providers, policies and practices in the antenatal context.

Women spoke of having little control over their own participation in their infant's care. Several women described how their lack of capacity to be skillful in diapering, turning, or swaddling their baby diminished their self-worth and confidence in their mothering role. If women were not participating in skillful ways they could not find a way to *be* mothers in the NICU. Considering how parent participation is considered the central tenant of family-centred care, feeling unable to be a skillful mother shows how power is embedded in program philosophies in ways that subtly impact women's mothering capacities. For several women, this compounded the loss of control experienced during their recent immigration to Canada. I questioned if particular women's struggles to do battle amidst the geographic 'boundaries' of a new country were shaped by their migrational experiences and their sense of the "us/them" power dynamics in an interpersonal context. These boundaries spoken of by women demarcated, divided, and excluded and led women into 'contact zones' of care. These insights raise questions about the intersection of women's experiences of migration and their experiences of interpersonal spaces of health care discussed in Chapter 7. To close this chapter I will illustrate how women's experiences of an erasure of self worth and agency constructed several other impacts that influenced maternal-fetal-infant physiological and psychological health and well being.

Avoidance of Care and Increased Maternal and Fetal/Infant Risk

In the antenatal care context, women's efforts to reduce health risks in pregnancy were at times contradicted by the burden to monitor their growing fetus' well-being. In several instances, women described feeling judged as non-compliant with program protocols and practices (for example, activity restriction and in-home fetal monitoring procedures). In fact, women's 'non-compliance' was about avoiding care that they described as dehumanizing and dismissive. This insight is important also when accounting for how transferring care 'closer to home' became an economic imperative in Canada health care in the early 1990s. It is possible to see how 'home care' is an ideological tool that increases burden on individual, families, and communities. In this

study, it was critical to examine how burden and suffering are created through the very structures and practices intended to reduce pregnancy risk and treatment of critical illness in newborns. Although a woman-centred care philosophy explicitly states the central role of women's embodied knowledge of pregnancy and their capacity for self-efficacy, the contrary was reflected in women's experiences. Women spoke of how difficult it was to stay on bed-rest, pointing to how the complexity of their lives and their multiple responsibilities sometimes made 'adherence' impossible. Staying on bed rest was not reducible to a matter of will. Rather, it was a capacity produced through multiple experiences and relations which often created risk within a context aimed to reduce risk.

For example, one woman explained that her capacity to manage her fear in the antenatal period was directly shaped by how nurses acknowledged the burden she associated with monitoring her fetus' well-being:

> …monitoring the baby is what I am supposed to do but it also makes me feel scared, really scared about what will happen if I miss something. And things can change so quickly. When the nurses pick this up, I mean my fear, they help just be acknowledging that is exists and that actually help me live with it (WP 10).

Acknowledging how women's capacities were created in interpersonal spaces also provided a way to see how being dehumanized, dismissed, erased and subordinated depleted their capacity to advocate on their own behalf. Several women were reluctant to outwardly express any fear or uncertainty about assessing fetal well-being thinking that health care providers might think they couldn't handle the responsibility. The women described situations in which they intentionally missed appointments or withdrew from their infant's care in the NICU. Yet, missed appointments and withdrawal from care were also seen to *increase* risks that created the 'conditions of possibility' (Foucault, 1970) for negative impacts on maternal fetal/infant health outcomes. Although women spoke of avoiding care in diverse ways, their various actions were understood as symbolic of "staying away" (WP 09). Whereas some women disengaged as a form of avoidance, others intentionally missed antenatal appointments or stayed away from the NICU. By missing appointments, not visiting, and/or staying away, the social distance grew between women and health care providers.

Women also spoke of avoiding care as required to preserve their moral integrity and strength to eventually bring their babies to term or to bring their babies home. One woman spoke of how missing appointments potentially provides another reason for dismissal: "…not going to the unit [neonatal intensive care unit] just gives them more ammo (ammunition) for deciding that you are not able to do it after all". By avoiding going to the NICU or by missing antenatal appointments, one woman described how this reinforced the very thing that her resistance had intended to communicate. One woman did not judge the danger to her son as great as that to her self worth.

> By not going I want them to see that I won't take it, I can't take it. I can't just sit there and be treated like I am not there. One nurse said to me that he will never go home until I start doing more for him, but when I do try to get in there and do more, it is never good enough….my fumbling tries just don't convince them I can do it. When I don't go, I bet it is said that well of course she is a just a teen mom who was on drugs anyway. So when I go, it's not good but when I stay away its like they just get more ammo to use against me (WP 09).

This young woman (WP 09) eventually stopped going to the NICU. She described this was exactly what she thought "they" assumed would eventually happen. Within a few weeks of her infrequent visits and her lack of access to an electric breast pump, the infant no longer received breast milk for naso-gastric feeds. He began receiving commercially prepared formula. After one month of his mother's reduced visits, the baby developed necrotizing enterocolitis (NEC) and required surgery to remove thirty percent of his small intestine due to bacterial sepsis and intestinal perforation. One risk factor for NEC in preterm infant is the hyperosmolarity of formula as opposed to the more isotonic nature of and immunological properties of breast milk (Merenstein & Gardener, 2007). In this instance, although it may not be possible to posit a causal connection between social judgment and the physiological manifestation of NEC, the infant's chances for health and physiologic stability were significantly reduced when his mother's capacities to be involved in a consistent, supportive, and ethical way were obliterated.

One woman described how she contradicted adherence to program criteria. She wrote extensive field notes about how avoidance and risk are always understood as experienced in relationship with health care providers. She wrote about what *enhancing* her mothering capacity and her infant's health outcomes could look like. She wrote:

> I would feel like I should be there and even the signs on the wall at the NICU scrub station would say 'welcome', it would be in the faces and movements of the staff, and would trickle down to the visiting policies… it would be evident in every thing that the staff do (WP 07).

She also said during an interview that

> How I feel about being able to be his mother really depends on who is working that day. Some days it is like the energy in the air that I *am* his mother and I can do a lot for him. Other days, it is like I am just in the way with nothing to offer. You know at one point early after his birth, I would call and see who was had him and then decide if I would go in or not…..Now, that I am thinking about it you know what? They can't control me that much, about how I feel being his mother. I deserve to be there and he needs me. I just keep thinking that. I can't imagine ever explaining to him when he's older why I didn't come visit. We still have few more weeks to go and I am going to be there no matter what. …it's all connected – my ability to *be* [vocal emphasis on tape] his mother is connected to judgments about my mothering (WP 07).

"Being in the way with nothing to offer" although experienced in the face to face was reinforced through particular practices and policies. As she spoke about this with me she decided this was not okay, that she would resist this dismissal and erasure which produced her infrequent visits and denied him of her presence.

In summary, the women described how their relational experiences constructed an erasure of agency which depleted or obliterated their social worth as woman and mothers. The impacts reduced their agentic capacities for enhancing their own and their fetus/infant's well being and created situations in which they avoided care. Women indicated that in many cases, an erasure of worth and agency had tangible physiological and psychological impacts. In several instances their resistance or withdrawal negatively impacted their own or the fetus/infants' health and health being. The next chapter describes the findings in relation to health care providers' accounts of interpersonal spaces.

CHAPTER 6: HEALTH CARE PROVIDERS' EXPERIENCES OF INTERPERSONAL SPACES OF CARE

The sample of health care providers was drawn from the antenatal and neonatal programs. It was not a requirement that these participants be currently 'in-relation' to particular women in the study[29]. As stated in Chapter 4, it was not my intent to compare the 'truth' value of women participants' account with the perspectives of health care providers. There were 2 reasons for my approach. First, any attempt to connect experiences and accounts between participant groups would be unethical because doing so could also threaten anonymity, privacy, and confidentiality of participants. Many of the details of women's stories could violate their privacy and anonymity. Second, my aim was not to judge the truthfulness of either groups' data against the other to determine how things 'really are'[30]. In light of the dominance of negative experiences described by women, it was critical to consider how the research itself could create risks if women's identities became known to health care providers with whom they were engaged. Many of the women's stories were reflective of their present and past experience and were not about individual care providers per se. It was critical for me to be sensitive to such nuances in the data since potential risk and harms could have unfolded if I had tried to connect participants account. My intent was to enter into "Kierkegaard's 'inter-esse' which implies "be-in-the-midst of" (Caputo, 1987, p. 3) the difficulty and complexity of how these experiences were being constructed and their impacts on women specifically.

Health Care Providers' Constructions of Interpersonal Spaces

I present the insights and constructed findings from the nurses, physicians, social workers, physiotherapist, and cultural interpreter together as one group of participants. In

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[29] It was not possible (nor desirable) to connect the "who" in women's stories with particular care providers nor to connect particular accounts of health care providers with women who may have been in the study.

[30] It was suggested during several presentations of the research findings that the 'truth value' of the study would be enhanced if I had interviewed health care providers and women who were currently in specific care-giving relationships. It was proposed that I could then determine what was 'really going on'. My epistemological assumptions imply that each research participant held his/her own truth and more could be learned by examining how such truths were constructed and experienced.

specific instances in this chapter I do distinguish among health care providers where it seems appropriate to do so. Presenting the findings in this way is not intended to obscure professional differences within the medical hierarchies of antenatal and neonatal care, nor is this approach intended to render invisible the gendered constructions of professional roles and responsibilities and related positions of power. My aim was to connect the accounts of health care providers and read them in relation to women's data. A study about interdisciplinary relationships could have added additional complexities to this study of interpersonal spaces of care, but would have been a different study altogether than one focused on the impacts on childbearing women.

Because I was first struck by women's need to 'tell it like it is' and their outward denial of relationship, I paid attention to how health care providers spoke of relationship in ways that initially contradicted women's experiences. Health care providers described relationship as the unproblematic "essence" of their practice: they worked from the assumption that relationships existed with women. In contrast with the women, nurses and physicians characterized relationship as something to *'do'* more than as site of human experience. Nurses' and physicians' data mirrored much of the dominant script of theoretical ideas in the literature described in Chapter 2, while the social workers and the cultural interpreter spoke in ways that more closely resembled the women's data.

I will describe my initial impression of health care providers' data in relation to "*It's the Essence"* and *"Assuming Relationship"*. These initial insights were a signal for me to go deeper into how such perspectives on interpersonal spaces were being constructed. I suspected that these initial insights described below were manifestations of nurses' and physicians' ways of knowing the interpersonal as sites of *instrumental* or *sentimental* care. When using the term 'instrumental', I am referring to the idea that relationships are a means to an end; that is they are considered the vehicle through which the therapeutic aims of care are delivered[31]. I use the term 'sentimental' to refer to health

[31] The notion of instrumentalism can be traced to pragmatist writings on the purpose of knowledge, truth, and theories. Instrumentalism is the view that concepts and theories are merely useful instruments whose worth is measured not by whether the concepts and theories are true or false (or correctly depict reality), but by how effective they are in explaining and predicting phenomena (Dewey, 1922). In the domain of health care relationships, however, I have aligned an instrumental view with remnants of

care providers views of relationship that seem to evoke an exaggerated sense of sentiment and the skills of relationship with the virtues and emotional disposition of health care providers[32]. Both instrumental and sentimental perspectives on relationships were not in and of themselves problematic. They *became* so when read in relation to the women's experiences. Whereas the women spoke of complexity and difficulty in ways that expanded my understandings of how "it all shows up in the face to face" (WP 06), health care providers' accounts reduced and obscured this complexity and difficulty of which the women spoke.

I surmised that the instrumental and sentimental views were problematic in so far as they were also reflective of how health care providers constructed themselves as *neutral* and *impartial participants* in care. The idea of the dynamic interconnectedness and evident in the women's accounts ("it's all connected") was far less evident in the perspectives and experiences of care providers. Essentialist ideas about relationship created situations where health care providers took relationships for granted based on sentimental and instrumental perspectives. I named the instrumental and sentimental ways of knowing/being that were taken for granted as creating the *veil of neutrality*. I understood this veil of neutrality as shaping health care providers' ways of knowing and being in-relation with women. Health care providers cast themselves as neutral participants in care and this way of being functioned ideologically to maintain dominant individualistic understandings of childbearing women's health experiences, capacities and outcomes. These ways of knowing about relationship were seen to be impacting how health care providers understood women's health capacities as *individually determined* and 'choice-based' and health outcomes as their *individual responsibility*.

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mechanistic, functional, and behaviorist views that inadequately account with a relational view of knowledge and human living.

[32] Sentimentalism has its roots in theories of moral philosophy and is also considered a form of literary discourse. Sentimentalism as a moral theory aims to displace the instrumental rationalism inherent in moral philosophy and elevate the notion of feeling over thinking and passion over reason (Flew, 1979). Because my intent has been to transcend such binary ways of thinking about human experience, I questioned how instrumental and sentimental views were being constructed, and how such view were operating to shape women's experiences and impacts of interpersonal spaces of care.

It's The 'Essence'

Nurse, social worker, and physician participants all spoke of their experiences of interpersonal relations/relationships as the "cornerstone", "foundation", or "essence" of their practice. In doing so, each of the provider participants shared the assumption that relationships existed, although social workers claimed that relationships could not be taken for granted. All the health care provider participants shared the view that relationship was the context within which care is provided, treatments are delivered, and therapeutic effects are realized. In particular, nurses' and physicians' descriptions in interviews and conversations cast relationship as the essence of their practice in one of two ways. First, nurses spoke of how being a "naturally caring profession" (NP 04) implies the centrality of relationship in nursing work. Several nurses emphasized how it was reasonable to assume that they had relationships with all their women patients; relationships were taken for granted as an essential aspect of nursing.

One nurse said:

> We have relationships with patients, that's the essence of what we do…that has been drilled into me because nursing school…I guess you could almost say that it's assumed that's what nursing is about. I mean you can't care without a relationship, so that's just what you do….you set out to form a relationship with a mom and hope for the best. I think you either have it or you don't, like it's not something you can learn. Sometimes, I know that nurses get assigned to a difficult family they are just cut out for that, then another nurse for a dying baby…and then there are the rest of us, who do our work…and hope for the best….but effects of that, well, no, I don't think so… can't imagine how like as a person we could impact what they can do or need to do (NP 01).

Another nurse spoke of being intimate with women patients as foundational to care;

> You just can't have a relationship with the moms unless you are willing to be personally involved in some way…a kind of being intimate, where you are willing to give of yourself. There just isn't any good nursing without that. I think everything nursing is about should always be making it good for the mom's and babies. We know that not all nurses are good at building relationships but I think it all comes down to being willing to put your whole self into it, like really give. I don't think it's any more complicated than that (NP 08).

Health care providers spoke of relationship using totalizing language such as "it's as simple as that", "it all comes down to that", "it's all about" that created a rhetoric of

relationships. At times, personal involvement and intimacy in relationship was described as the sentimental foundation of care. At other times relationships were viewed as a instrumental means for advancing the therapeutic goals of antepartum or neonatal care. The tendency to reduce the complexity of human relations meant that the skills of relationships were considered 'natural'. The capacity to 'relate' was a matter of attitude and innate caring capacity.

To illustrate, one nurses linked the skill of relationship to nurses' capacities as women to be caring. Another nurse claimed that "…as long as a nurse is caring then the relationship is usually a good one, it as simple as that" (NP 02). Although nurses constructed themselves as 'naturally caring', which produced their 'innate' abilities for relationships with women, the result was that the particular contexts of self-other relations rarely were examined and rarely figured into their stories of relating and relationship. The nurses' focus was on individual interaction and the innate capacities of nurses to build relationships. Although nurses spoke of the multiple challenges for getting their work done and for providing quality care, they did not speak about these challenges as implicated in how they engaged with women.

> I think that good relationships with the mothers comes down to how well we can help them learn to get involved in the baby's care. My job is to show them what to do, get to know their baby and make sure they get their questions answered. I think some of us are good at those things and for other staff it's harder to, you know, look eye to eye with moms to help her. The place is busy so it's up to each of us to just make sure we do that (NP 03).

This particular nurse resisted my attempts to hint of a connection between being "run off her feet" and her ability to be in-relation with women in ways that facilitate the goals she described. I asked about her description of "the push to reach the end of the shift" as relevant in her engagements with mothers. She assured me that, for her, it was about personal capacity to do the work. I took this to mean she held herself accountable for her practice and relationships women. The notion of a 'context' of capacity for being in-relation with women was not something she considered. I determined there was a paradox at play; if the context of experience of interpersonal spaces of care was denied by this nurse then might this be connected to the same difficulty that women described about seeing their health experiences within the context of their lives.

I was struck by the phrases nurses and physicians used such as “it’s as simple as that” (NP 03) or “it “all depends on attitudes” (NP 05), and “its all about trust” (PP 01). Nurses and physicians constructed relationships with women through claims about the essence of relationship; however, this essence expressed a view of relationship as a vehicle for achieving the medical and nursing goals of maternal-infant care. Social workers also used this language when describing in a focus group that they were “human instruments of care” (SW 02). The social workers did not appear to take relationship for granted and spoke of the social distances to navigate in their daily work. Nurses and physicians however did tend to speak about relationships in taken for granted ways, and the more they were taken for granted, the less participants could see influence, connection, and impacts of self-other-context relations. Because of how human science perspectives in nursing characterize relationships in unproblematic ways, I questioned how dominant theoretical scripts might be impacting how nurses constructed this essence of relationship. Related to the idea of relationship as “the essence” was an assumption that experiences of the interpersonal existed in unproblematic ways.

Assuming Relationship

A closer reading of several transcripts and field notes alerted me to how words such as “essence”, “natural capacity”, and “foundation” were closing down my conversations with participants and leading me to construct initial insights reflective of the dominant script on nurse-patient relationships in nursing. For example, one nurse said:

> Interacting with the ladies, well it’s the core of what we do. It’s as simple as that, that’s the kind of thing a nurse is either naturally good at or not….It something that just can’t be taught. I pride myself on having good people skills so I think that’s why I don’t have problems. We are lucky enough to have lots of good nurses here, we are known as the star program of nurses, it’s hard to get hired here, and we have a philosophy that I think kind of weeds out the good from the bad…so that makes having relationship not very hard, makes it easier to get the work done (NP 05).

Taking the above words into account, it becomes possible to understand how the one woman’s (WP 12) positive experiences of relationship may have been constructed. She spoke of how the antepartum nurses already knew her from her first pregnancy.

During antenatal rounds (Focus Group Transcript, May, 2005), several nurses spoke of how having this same woman back in the program was a "piece of cake". The nurses knew that she was well aware of what was expected of her in terms of program adherence. They recalled she had done really well in her first pregnancy and was able to keep up with her fetal counts, attend appointments and never missed her weekly calls to the nurses. The APAHC nurses indicated to me that she would be a good participant for my study. I wrote about my response in my field notes:

> Now this is interesting, I am really being pushed to recruit her. She has been identified as a good one for my study, in that nurses are describing their 'success' of relating to her which implies something important about what they think makes for 'good relating'. She is white and of European descent, middle class, married with one child, articulate, knowledgeable, and experienced in the ways and requirements of antenatal care at home. She is one of two English speaking women while all the others "on the program" are of South Asian descent and have varying levels of English fluency. I was told today the other 'lady' may not be good because she has an 'unstable home', history of addiction…..they had decided to visit her in pairs for the sake of 'safety' (Field notes, May, 20th, 2005).

The nurses' constructed this woman as an 'adhering and knowing patient' which I could see as relevant to how they spoke about their relationship with her as 'good'. In this instance, assuming relationship was constructed on the basis of the relative ease of 'relating'. A shared ground existed about what was expected in terms of program adherence. This particular woman had demonstrated the ability, willingness, and skill to work within the expectations. Using this one woman's account in juxtaposition to the difficulty described by the other women, it is evident how particular 'terms for relating' are shaped by particular discourses of self-efficacy and patient adherence. When this woman was seen to be adherent on the same terms as nurses, relationships were described in unproblematic ways. Read in relation to the other women's data and the heath care providers' accounts, this woman's experiences draws attention to how the notion of 'easy relating' is discursively produced and constructs women in certain ways. These insights led me to question how relating through sameness/difference could be linked to specific impacts on women's health capacities and outcomes. In this one example, where there was sameness, acceptance, and adherence, both the woman and her care providers determined that relationship existed. But when difficulty and difference were present in

terms of values, experiences, language, social class, and culture, the women constructed a denial of relationship.

Another common feature of assuming relationship was the tendency to construct the skills of relationship as residing solely within the nurse. This tendency to equate the 'success' of relationship as reducible to nurses' capacities and caring attributes, undermined the complexity and skillfulness of their relational work that I observed in everyday moments of care. After spending a day together, we would debrief and I would say "what I noticed about your practice today". Often the nurses looked at me as if to say "really?" I questioned whether the way nurses were understanding relationship was potentially limiting their abilities to see the skillfulness and knowledge which I could see when walking beside them. For example, although two nurses spoke about how good relationships help them to educate women about the antenatal home care program I noticed that they spent time in ways that did not always fit the instrumental constructions they spoke of. One nurse told me about why she does not use an elastic belt for fetal monitoring in women's homes. Rather, she uses her hands to hold the fetal monitoring device since this way is less mechanical and provides additional assessment information about how a woman is doing. She also mentioned that her 'hands on' approach helps women relax and they end up telling her more about how they are coping with the fear and uncertainty in their lives.

My reading of health care providers constructions of the 'essence' became more nuanced when read in relation to women's accounts. While women participants spoke of multiple and expansive webs of relations impacting their experiences of interpersonal relations/relationships and pervasively *denied* relationship, health care providers *assumed* relationship, speaking primarily of individual face-to-face interactions with little attention to wider contextual influences. Both nurses and physicians tended to objectify relationships, indicating how interpersonal interaction was primarily a mechanism for achieving particular treatment or therapeutic goals.

One social worker spoke about being a "human instrument of care". She described how the terms for relating to women are always structured by women's fear of potentially having their baby apprehended. The particular social workers in this study

explained how relationships could *never* be taken for granted within this context of unequal power:

> We don't have drugs to give, dressings to do, orders to carry out. We are our care; we are the therapy which means the relationship is the centre of it all. All of who we are shows up there and most of the time patients think they have done something wrong when we are brought in to see them. Oh, the social worker is here…must be someone who is on welfare or something…that's what the staff think….then there are the moms who think we are coming to take their babies…..we start relating through all this negativity and fear. I think when you begin in relationship there it is automatically hard work where the social distance between us and patients can be huge. We have to work in that space, know that space and figure out how to make it one where we can do the best for moms. That's what our job is, you know, I see myself as making it happen. I need to always be asking how the interaction might be enhancing or getting in the way of my work, especially when you usually begin in negative judgment, like this always structures everything and dictates whether or not we can be successful (SW 01).

The social workers also described how their practice is understood as shaped through an understanding of how experiences are socially structured. One social worker described how the systems of child welfare and family services shape their interactions with their woman clients. Another social worker spoke about her work as being in the difficult place where systems collide and women are disadvantaged. It struck me that the social worker participants knew relationships in a way that did bring difficulty and complexity into our conversation. I found these differences in how relationships were understood intriguing and sought out several qualitative studies on social work expertise to see if I could understand this further. Fook, Ryan, and Hawkins (2007) in their study examined how professional identity is constructed through an ability to examine the social structuring of clients' experiences which requires an ability to deal with complexities. Fook et al. also found that social work expertise means being able to quickly prioritize relevant contextual features of their clients' lives and an awareness of constraints and resources. It may be that some differences among providers in this study can be theorized in terms of education and professional socialization. Since this was not a focus of the research I limited my exploration of professional socialization to this brief foray into this literature. What became critical for my study was the importance of

recognizing how diverse ways of knowing of relationship were, in fact, shaping ways of being "in-relation" with women.

The cultural interpreter spoke of her experiences of interpersonal relations by describing how her work is situated in the 'in-between' space between patients/families and health care providers[33]. She spoke at length about the vantage point afforded to her from this in-between space and referred several times to how this space was akin to a collision of cultures. This notion of collision of culture resonated with the social workers' understanding, the women's battle metaphors and one woman's metaphor of 'contact zones':

> You just walk in there and you can feel it, such misunderstanding and battle. And everyone thinks it is language but really it's the simple thing of basic human respect. I get called in only when language is an issue but really I could be there brokering every minute of interaction. We have a code of ethics as interpreters which is to be neutral, to be impartial, and to be objective because that is how good translation happens. But when you are standing between a woman lying on a stretcher and the staff you know that it's about way more than language. One time the nurses were trying to put an old man on a commode in the ER [emergency room]. I said I think I could help, like explain what was going to happen. They said they didn't need me that he understood everything that was going on. I knew from his face that he did not. So I went back to my corner in the ER, where I wait to be called, but never called on my terms but when the nurses think I am needed. And then I heard later that he was screaming when they put him on and that he had fallen. I could see it in his face that he was scared… that's not really translation work, but it is work to be done and everything going on in that ER, its like who is waving the flag for basic human respect?. I know the nurses do [wave the flag for respect] but then I see things like this and wonder what the heck is going on. I would say all is not well.

The cultural interpreter spoke at length about the essential importance of relations for their impact on patient care. Her experiences helped me to see additional aspects to nurses' and physicians' perspectives. The interpreter described how relations are

[33] The cultural interpreter participant was employed by the Health Authority to provide language translation for patients in several different program contexts on the research site. She provided services to women on the AHCP and the Emergency Room (ER), among several other programs. She spoke of how her role was facilitate or constrained by how the staff viewed the value of her translations abilities. During an interview she said that her role in the ER involved much more than language; it involved 'translating' between cultures which characterized the in-between space between patients' lives and health care. I decided to spend two twelve shifts with her in the ER to learn more about the idea of the in-between space and the notion of 'contact zones' between cultures.

structured through the ER and how the ER culture (particularly the issue of bed shortage and care of elderly frail patients in the ER) makes her work bout more than language translation. I posited that the degree to which health care providers were able to scrutinize both within and beyond their individual interactions with women, to analyze the intersection of the cultural context of care, and the context of women's lives created their potential for knowing of the complexity of the interpersonal. I also surmised that health care providers' capacities to know of relational experiences was significantly limited by sentimental and instrumental views of the interpersonal that cast themselves as impartial participants in care. It was this insight that provided an understanding of how health care providers' experiences of relationship impacted women's health capacities and outcomes of care.

Sentimental and Instrumental Constructions

When analyzing further the taking for granted of relationship, it became evident that providers 'knew' of relationship in sentimental and instrumental terms. Sentimental understandings constructed nurses' ability to be in health promoting relationship as relative to their "attitude" (NP 06) or capacities to be 'naturally' caring.

> …it just depends on your attitude, I mean you either have it or you don't, like you can connect with people or you can't. But as nurses that's why we're all here, 'cause we care. But I wouldn't say that it can affect the women, they get on the program and as long as they follow the program, their pregnancies turn out well. The interactions we have are all about getting them to stay on the program (NP 06).

One nurse made reference to the caring role of nurses by locating the skills of relationship in a paternalistic way. She described that being 'good' at relationships is about being "able to be intimate with and really love your patient" (NP 08). I questioned if this particular way of knowing/being in-relationship was shaped by gendered constructions of nursing work.

One nurse said "I try to have good relationships with women, we know it creates better program adherence (NP 01). Although relationships have been linked to improved patient satisfaction and outcomes of care (Beach & Inui, 2006), in this study I questioned how understanding relationships as instrumental for delivery care was shaping women's

negative experiences. When read in relation to women's negative experiences, these instrumental and sentimental accounts 'neutralized' the complexity and difficulty of relational experiences and thereby obscured nurses and physician's capacities to consider interpersonal harm. Although not entirely the same, I concluded that the instrumental and sentimental understandings of relationship were operating as normalized truths in terms of how several nurses knew about relationships with women.

The following discussion illustrates how knowing relationships in an instrumental way limits the possibilities for care that can meet the needs of families in the NICU:

> NP 08: We expect families to be involved, we empower them to make decisions and that is what our relationship with them is all about. We need to do everything to make sure they are involved and so what I do is interact in ways that can help them. That means getting them information, making sure they have what they need to make the right decision. Seems like for me anyway, we can't let anything else get in the way of family-centred care.
>
> HB: Do you have families that don't choose the centre, or have other terms for making decision? Are there instance when this philosophy might get in the way?
>
> NP 08: No, most families want to be involved. But their ability to be so is wide-ranging. We have a lot of young moms here and immigrant families so it makes sense they want to be involved.

A physician participant spoke of how his treatment plans tended to control how the interaction was structured, indicating a 'structural' element of being in-relation and communicating with women;

> PP 02: I am aware that depending on what needs to be achieved that all of this structures how I interact and even relate to the family. When we need to determine the infant's developmental progress, my way of talking, listening and asking questions is already being modified by those goals. So, I could say that of course the interaction is important but so is what needs to happen from a medical point of view which means the relationship is put in service of that.
>
> HB: That an interesting way of saying it "put to the service of. Would you say that is usually a positive structuring of interaction and communication?
>
> PP 02: Well, I can't really say because I just know that's how it has to be to get where we need to get to. I assume it is if the family and I are working in the same direction, like meeting the developmental milestones is what they want to. But I suppose it doesn't leave room for much else, like what might be on the family's

> mind. But it does ultimately serve the purpose which means it is the way it has to be.

The tendency to take relationship for granted was evident through transcripts and my written field notes and observations. Multiple forms of relationship "put in service" to the instrumental ends of neonatal and antenatal care were evident in both nurses' and physicians' accounts. Through the taking for granted of relationship, the physician above spoke about "what needs to be done" and "what we need" *through* the process of being in-relation to women. Therefore, communicating and interacting with women was structured by medical expectations and a discourse of normal growth and developmental milestones. This physician participant's way of being in-relation therefore cannot be internalized as a personal process but one structured through what needs to be determined in the therapeutic process. He questioned the possibility of effects on families, but then concluded the dominance of professional goals has to eventually trump being responsive to families in the neonatal follow-up program. It was evident in our conversation that this physician did not consider that the possibility for good medical care and being responsive to families could *co-exist.* Herein lay an important difference in the 'speak' of experiences of relationships with women; how nurses and physicians spoke of relationships with women patients appeared to be related to how they are professionally socialized and positioned as gendered 'subjects' (Lupton, 2003).

Nurses were constructed and constructed themselves through a feminine virtue of being 'naturally caring' (NP 07) while the physicians spoke from positions of privilege and power produced through the gendered discourses of professional expertise. In both physicians' transcripts there were numerous references to how "professional goals" structured communication and interaction during neonatal illness, where medical goals "trumped" the particular goals of families. It has been suggested that "medical authority and depersonalization is functional for both health care providers and patients (Lupton, 2003). In fact, it is likely that biomedical discourses shape understandings of women's reproductive health in ways that produce a form of instrumentalism. I proposed in the early chapters that relationships are constructed in biomedical discourse as a means to an end, a vehicle in this study for processing women's bodies as a form of medical

surveillance (Barker, 1998; Oakley, 1980; 1984). Constructing relationship in instrumental ways was not inherently problematic but became so when read in relation to women's experiences of dehumanizing, dismissal, erasure and doing battle within the context of medicalization of women's reproductive care.

One nurse described how being instrumental was necessary to facilitate the discharge of an infant:

> It is crazy for me to see myself as having any say in the matter, helping mums get discharge stuff – it's up to the discharge nurse and CHN's [community health nurses] to get things lined up, services and special formula, only they can sign for those. I tell them [families] I can only speak for the diapers in the bassinette. Here, I say, Merry Christmas (NP 06).

In this example, the nurse's sense of lack of access to the necessary resources for discharge shaped how she then engaged with the family. Her sense that she lacked power to secure the necessary resources for discharge shaped how she then engaged with families which, in turn, created a situation that families could experience as dismissive.

There were also instances where nurses reduced the complexity of the struggles with patients to 'just miscommunication'. These instances tended to reduce and objectify relational encounters to instrumental and functional transactions. And, in many instances health care providers judged the effectiveness of the relational encounter based on how information was communicated and how much evidence existed that a particular women "got it" (NP 07). And, the transactional effectiveness was determined on the basis of health care providers' goals for the interaction. One nurse spoke about the need to write questions down as a way for women to make their needs known:

> NP 04: I always tell them, write your questions down and bring them. Sometimes I find out that they did write them down but never actually pulled them out and asked them. I don't know why they don't…I mean they have a right to ask.
>
> R: What do you think is going on for them that they don't pull out their questions and ask them?
>
> NP 04: Well I guess it might be that they may not have good English and I have heard he puts the fear of god in them. Having the questions is important but (pause).
>
> R: Feeling able to ask is another?

NP 04: Well I tell them it's their right to ask, I don't know, maybe its cultural.

As previously indicated, several nurses pointed to culture to 'explain' women's decisions and actions. Nurses at times engaged with women based on essentialist understandings of culture that could be linked their instrumental understandings of relationship. Rather than seeing culture as ways of living in the world and as an opportunity to connect with and learn more about the women, the very idea of culture created closure and a lack of curiosity about women's lives and experiences. In interpersonal spaces of care, culture was also created through the social context of care that bumps up against women's lives. The ability for nurses to see culture as a relational experience, where the culture of maternal-infant care shapes their own ways of being, appeared to be limited by static and instrumental understandings.

I concluded that sentimentalism and instrumentalism sustained and reproduced 'realities' that impacted women's health capacities and outcomes. Yet instrumentalism itself was only problematic in relation to the women's experiences; instrumentalist views became so when in particular moments of care women sought something different – "to be seen", "to have a face", "to see the whole of me". Nelson and Gordon (2006) claim that the holistic rhetoric that dominates so much of nursing discourse means that it is almost impossible for nurses to talk about their work in any other ways. In addition, a sentimental language of relationship dichotomizes the human care of nursing and the instrumental cure of medicine. A dichotomous representation of relational experience in interpersonal space does not advance understandings of the complexity of experiences constructed in interpersonal spaces nor does draw attention to the inter-play of skillful physical, medical, technical and emotional care.

The particular descriptors of relationship used by health care providers were not theory neutral but theory-laden constructs inseparable from cultural and institutional contexts of neonatal and antenatal care. When reading health care providers' data in relation to women's accounts, I determined that sentimental and instrumental ways of knowing had ideological effects; that is, such understandings constructed health care providers as impartial participants in interpersonal spaces of care. The impact was that, in general, health care providers did not locate women's health capacities and outcomes as

created in particular moments of care. It was as if a *veil of neutrality* obscured the difficulty and complexity of which the women spoke and was contributing to the very experiences of harm and dehumanizing care described by the women.

The Veil of Neutrality

The veil of neutrality signifies that how health care providers 'knew' relationship functioned ideologically[34] and had particular effects. By casting themselves as impartial participants in care, they reproduced particular social arrangements in everyday moments of care that shape women's experiences. When health care providers assumed relationship, they were not in 'conscious relation' (Hartrick, 2002). One nurse spoke at length about how "I treat all my patients the same…so my ways of relating do not change, that's the trick to make sure all the women get the best care" (NP 05). While nurses and physicians implied a veil of neutrality, my observations from walking beside them and observing their practice indicated they were anything but neutral and impartial. Their ways of being in and knowing of relationship shaped how they engaged with women. When relationship was taken for granted as a vehicle for care, health care providers found it difficult to comprehend that there were impact of relationship on women's health capacities and outcomes. And, there was something about the language of relationship that appeared disconnected from their living knowledge and experience of being in-relationship. When the subset of nurses described in Chapter 4 tuned into this paradox in the data, they began to understand relationships differently, which repositioned them in relation to sentimentalism and instrumentalism and the veil of neutrality of which they initially spoke

Particular cultural discourses of maternal-infant care created the context within which health care providers' experiences and perspectives' were constructed. Working from the view that discourse is a social practice that both reproduces and changes

[34] Fairclough (1992) claims that ideologies are created in societies in which relations of domination are based on social structures such as class and gender. Ideology therefore is conceived as a practice that operates in processes of meaning production in everyday experiences. Ideologies work as a 'social cement' that binds dominant ideas together in the service of maintaining a particular social order.

knowledge, social structures[35], identities, and social relations (Fairclough, 1992) I paid some attention in the analysis to how experiences are partially created in discourses. I questioned how language both reflects and creates particular experiences, and ways of knowing/being in interpersonal spaces. I concluded that a focus on being in relation to discourse is critical site for inquiry into the complexity of relational experiences. To illustrate, biomedical discourse implies that health care is a scientifically neutral enterprise (Lock, 1998; Sherwin, 1992). Biomedical discourse in the neonatal program was evidently operating through the ideals of objectivity, rationality, individualism, and linear notions of progress in many of the women's descriptions of neonatal care. When biomedical knowledge of neonatal care is established as offering the true and rationale approach to caring for critically ill infants, it limits the possibilities of seeing how the non-biomedical knowing of mothers can assume a rightful place in an infant's care. Nurses' work in this study was frequently structured by biomedical discourse that limited other ways of knowing as legitimate and critical for recovery from neonatal illness. In addition, the structuring of nurses work in both contexts of care created limited opportunities for them to inquire into the *effects* of their practice on women themselves. This, in turn, limited their capacity for agency and professional recognition in similar ways as the women described.

A veil of neutrality illustrates how health care providers' ways of knowing about relationships could be linked to broader Western individualist and rationalist discourses on human subjects that shape contemporary health care practice. For example, in maternal-infant care, ideological assumptions of motherhood and the medicalization of women's reproductive health are partly shaped by liberal values and the growth of market-driven political ideologies (Health and Welfare Canada, 2004). In this study it was possible to see how in the broader context of maternal-infant care, health care providers were cast as neutral participants that created their inability to see how they

[35] I define *social structure* as social relations in society as a whole and in specific institutions. Taking a critical view of discourse and ideology in the research was consistent with a deconstructive hermeneutic approach. I approached the language of participants as a way of speaking which gives meaning to experiences from a particular perspective. According to Fairclough (1992) discourse and language construct social identities, social relations, and systems of knowledge and meaning.

were influencing women's health capacities and outcomes. I surmised that the health care providers' ways of knowing/being in relationship were, to some degree, discursively produced. Features of particular discourses (for example, biomedical, self-efficacy, 'high risk', family-centred care) had consequences and impacts for how they engaged with women.

Both neutrality and impartiality are described as central assumptions of Western neo-liberal ideology (Kymlicka, 1989; McGregor, 2001). Knowledge of relationship in this study was seen to be an instrument of power that, in some instances, reinforced Western neo-liberal individualistic (non-relational) ideologies. Kymlicka (1989) claims that "neo-liberal individualistic values neglect the ways that individuals are formed in social contexts…whose lives, hopes, goals, abilities and health are pursued through communal attachments (p. 883). For example, self-efficacy practices and program policies in antenatal and family-centred discourses in the NICU worked as a 'social cement' to a particular social order of professional dominance that impacted the experience of both women and health care providers – albeit in different ways and with different ideological effects.

The tendency to reduce the skill of being in-relation to an individual's "bedside manner" (physician participant), "attitude" (nurse participant), skill of personal intimacy (nurse participant) or from an ethos of being 'naturally caring" (nurse participant) resonates with individualistic understandings where autonomous individuals act according to good intention and individual well-being. One social worker spoke against the ideal of neutrality by claiming impartiality to be a myth (SW 02). She suggested that each situation

> …demands you see what of your caring nature will show itself or not. It is not a given and if we think it is, we are in trouble. I mean we all make judgments of clients but what you do with them and your awareness to them influences everything….there is nothing like being able to be the same with everyone…but we can hold ourselves accountable…we know that because most often when we come to see a woman they think we are going to call child welfare and take away their baby. So we have to work from there, not get offended but understand that this is normal and after all that is what we often are called in for (SW 02).

In this instance, where impartiality and neutrality were deemed impossible, this particular social worker imagined and could anticipate particular impacts on women. She was consciousness of a lack of neutrality constructed through an awareness of unequal power and knowledge of women's fear of their infant's apprehension. In contrast, one nurse spoke about "not getting through to the mother" as if the impacts on relating to women this way were likely neutral and benign:

> NP 03: It hard you know….for some mothers it's like I think, why can't I get through to her? She knows what her baby needs and yet she comes when its suits her. I have tried and can't seem to impress upon her the importance of being here. She is so hard to talk to…coming at the change of shift is just *never* going to help us with her. I can relate to almost all the families….but I can't seem to get through to her.
>
> HB: Why do you think she comes at the change of shift?
>
> NP 03: Maybe we are all too busy to talk to her. She can't just keep doing that if she wants to take him home.

A physician similarly stated;

> All things equal, it all comes down to trust and if you get that then things are usually fine. I mean there is only so much you can do, bedside manner is usually something that doctors have or don't have (Physician Participant).

Without hearing the physician's text above, one woman participant said "all things are never equal it can never only be about trust". References to 'trust' by physicians and nurses implied that trust un-problematically existed as the 'master key' to good relationships. It may be that theoretical work on trust in nursing and health care draws critical attention to its importance in respectful and responsive relationship however, it has been proposed that experiences and meanings of trust for patients is not well understood (Hupcey & Miller, 2006). I concluded that trust became "true" in particular moments of care. Claiming 'trust' as the answer to meaningful and health promoting encounters tended to further deny the complexity of what it takes to be trustworthy, what is required to trust, and the discursive conditions that create the possibility of trust. Because trust has been linked to issues of access to care (Tibandebage & Mackintosh, 2005), inquiry into the meaning of trust is critical for transforming practices and policies to "support the construction of decent, inclusive health care" (p. 1385). In this study, the

women participants did not speak of trust as a foundational value of relationship; rather, but they spoke of what is required to 'trust in' health care providers.

When examining how trust is created discursively through assumptions about a level playing field, the subset of nurses began pointing to a more complex notion of trust. One of these nurses said:

> It's so much harder to show trust, actually I am not sure the moms and dads would even point to the same things that we might to indicate trust…now that's interesting, I kind of thought we were all thinking it was the same thing" (NP 08).

The subset of nurses and I agreed that a neutralized account protects privilege through the assumption of equity and obscures issues of race, class and gender, all of which were at play in interpersonal spaces of care. In many situations differences in power were obscured which exacerbated women's vulnerability. Physician participants spoke of encouraging mothers' participation in care in the NICU and responsibility for women's self-management of 'at risk' pregnancies. In both instances, a discursive practice of medical surveillance was produced through language and practices when physicians used language of neutrality. Medical dominance or surveillance was necessary for 'ensuring women's good outcomes' (PP 01). Discourses on women's self efficacy ideologically produced individualist definitions of risk.

Several nurses in the study who referred to their experiences of relations as arising from impartiality spoke about being 'burned' in the past for being focused on relationships. One nurse who participated in the analysis spoke about being sanctioned by her colleagues for being a 'relating type' and how that needed to change since there was "no time for that" (NP 04). She recounted how now that experience means she now treats "everyone the same". Being impartial was understood by this nurses and being necessary for getting the work of the shift done; impartiality was seen to be held in high regard as a way to function within the "no time" discourse and related ideologies of efficiency and progress. The subset of nurses and I talked about what is taken as objective and natural (such as the sanctioning of nurses for being consciously involved and focused on relationship) are not cast in stone; rather they temporary understandings which can be articulated differently. The nurses and I concluded (albeit temporarily) that relational experiences and interpersonal spaces of care are in fact shaped through dominant

discourse; there are no ‘externals’ to relationship. Therefore we agreed that a critical insight form the research was the awareness to how the ‘cultural scene’ of maternal-infant care “shows up in the face to face” (WP 05). It was this process of “showing up” that was the focus on our conversation during the analysis phase of the research since we decided that this insight was critical for turning around women’s experiences of dehumanizing care. From these conversations, I concluded that the ideological constructions of neutrality within interpersonal relations are not problems of individuals but of the wider socio-political cultural context of health care. This chapter now concludes with health care providers’ experiences of the influence of interpersonal relations on women’s health capacities and outcomes.

Health Care Providers’ Perspectives on Women’s Health Outcomes and Capacities

When I asked health care providers about the impact of experiences of relationship on women, I was met with a puzzled response. A number of participants said: “what impacts?” Or “Effects? What effects?” It was as if the nurses and physicians could not imagine that their ways of being and knowing might create and sustain particular situations of care. Neither nurses nor physicians indicated that relationships could have tangible effects on women’s experiences of care or their health capacities and outcomes. It became evident that women’s capacities and outcomes were theorized along the lines of women’s internal psychological conditions and individual capacities, strengths, and resources rather than as being produced and constrained in moments of interpersonal relations.

Assuming relationship on individualistic ground and through a veil of neutrality further obscured the connection between relational experiences and women’s health capacities and outcomes. The most significant effect of this invisibility was the reinforcement of dominant practices that women participants deemed problematic. For example, 7 of the 9 nurse participants stated they never imagined *how* their ways of being in-relation could influence women’s sense of capacity or what they were able to achieve on their own terms. During the analysis and conversations with the subset of nurses towards the end of the project, the nurses examined a wider web of relations (as was evident in women’s accounts) that influenced their experiences, knowledge, practices

which create a space where they began to see how relational experiences has impacts in women. One of the nurses said:

> So this policy really keeps families from being empowered and that's so ironic because it was created to put them at the centre of decision making for their babies. I know that some of us treat visiting policies and other one about skin to skin cuddling like 'the bible' and when this happens, maybe it shuts down our ability to really listen and work from the family agenda in combination with what we know has to happen to get this baby home (NP 08).

Although nurse participants spoke about the critical importance of seeing women's health within the social context of the lives, they had not considered 'socializing' their own understandings of their practice. Their own capacities to scrutinize their practices and the contextual forces of maternal infant care meant it was almost impossible for them to imagine how the particular experiences of women came to be created in interpersonal spaces of care. The tendency to 'de-socialize' their practice meant it was challenging for nurses to inquire into the effects of their practice on women's health capacities and outcomes as their professional and ethical responsibility.

Health care providers who spoke about women's health capacities and outcomes implied that these were 'external' to interpersonal spaces of care. Women's health capacities and outcomes were understood as reflective of women's innate strengths, abilities, life choices, and individual will. A physician participant said that women' health capacities and outcomes "…come down to the individual woman, like what kind of family she has, how well she can manage the risk in the pregnancy" (PP 02). A nurse concluded that generally health outcomes are determined in relation to length of stay, iatrogenic complications, and gestational age, physiological stability and behavioral and developmental capacities of preterm infants. A sense of separateness between self, others, context both obscured the impact of relational experience on women while simultaneously constructed women's health capacities and outcomes as individually determined.

The inability to imagine 'effects' of knowledge, practices, ways of being, policies, and dominant discourses also served to reinforce the power inequities and the veil of neutrality constructed by health care provider. The subset of nurses became skillful at seeing influences when given the chance to read their data in relation to women's

expressions of erasure of agency and self worth and the social harms of dehumanizing care. The nurses could see how the physician's statement "it's about trust" obliterates power and difference along the intersection of race, gender and class, while also reinforcing the notion of a level playing field. What is taken for granted constructs the state of affairs as "the way it is". In this study, the 'way it is' was an understanding of women's health capacities as individually determined and outcomes as women's individual responsibility.

Representing Capacity as Individually Determined

Health care providers described women's health capacities in individualistic terms. For example, one nurse said:

> If women adhere to the program criteria they will do well. Their outcomes are usually good because the program is very clear what needs to happen to reduce the risk for each condition. How much women adhere to the program, well that's a matter of choice. Some respect what needs to happen and others make their own decision about how well they can stay on bed rest and manage the rest of their lives. So, where women get to is usually determined by how willing and able they are to do what is necessary (NP 05).

Health care providers' understood women's capacity as arising from their 'natural' psychological potential. Capacity was therefore defined as an individual determined potential for health. Women described their lives as a complex interplay of individual and innate resources always in tension with various 'capacity-depleting' contextual features of antepartum and neonatal practices and policies.

Assuming capacity was reducible to women's 'free will' and abilities to adhere to program criteria undermined women's capacities which in some instances led them to avoid care and increase maternal-fetal-infant risks. Women spoke of their lives as limited in very real ways in relation to gender, race, and class. Therefore it hardly seems adequate to reduce capacity to a solitary focus on women's innate abilities while leaving the context within which such capacities are enhanced or constrained under-analyzed. Self-efficacy and self-management discourses placed significant burdens on women in both antenatal and neonatal contexts. The consequence is a failure to connect the context

of particular woman's lives to the situated and relational context in which capacities and outcomes are realized in each moment of care.

In several nurses' transcripts, it was evident that liberal individualistic assumptions about particular women were equated with unconstrained autonomy and agency. These assumptions constructed women's choices, capacities, and motivation in ways that did not recognize their situated nature. For example, recall the women who "always came at shift change". She was described as not behaving in ways expected by health care providers in the NICU. This was described as her resistance and failure to do what care providers deemed was right, without questioning why her visits and participation in her son's care were decreasing.

Women who had recently immigrated were also seen is certain ways by nurses and physicians that impacted their health capacities. Nurses spoke of how their woman patients were often not employed beyond the home which meant adhering to bed-rest was possible. Culturalist assumptions made about particular women's capacities led to assumptions about 'their' ease in adhering to the program. A view of capacity as individually determined obscured important questions about women's experiences of leaving their homeland. It also made it harder for the nurses to consider how women might feeling isolated and estranged when creating a new home; these were factors that the women deemed highly relevant to their capacity for program 'adherence' and abilities to monitor their fetus' well being. When capacity is seen as reduced to women's innate resources, abilities, and unconstrained choices, this very process of constructing women's capacities thwarts the possibility of enhancing women's capacities and outcomes.

Representing Outcomes as Women's Individual Responsibility

The impact of health care providers' assumptions of relationships and the related ideology of neutrality gave rise to notion of being impartial in interpersonal relations. In turn, this created a situation where health outcomes were either defined in terms of the goals of nursing or medicine's therapeutic goals and/or through the ideological framing of women's health outcomes as their individual responsibility. One basic assumption of neo-liberalism is that individuals are assumed to act independently of others and assumed to be restricted only by one's natural surroundings and not by any other human being

(McGregor, 2001, p. 3). As the nurses and I examined the effects of our knowledge and practices in interpersonal space in relation to the experience of the women, one nurse wrote:

> Ok, now that this is on my mind, that how we relate might not be so innocent, I can see that much of what we assumed to be not affecting women just might be the biggest sources of stress. I had never thought of the 'therapeutic use of self' stuff I learned in school possibly having a down side, like when you lay your values and judgments on another person. Last week, I wondered about what might be showing up in my interactions with the women, so I thought it would be good to write about it (Nov. 2005, NP 07).

> I treat all my patients the same….or at least that has been what I am trying to do, so that they can each get have the best chance of achieving what they need to take their babies home. I hear the staff labeling and predetermining which moms will do well, and I know that the basis of saying stuff comes from whether they are like me or not, like as if we could really ever know. Maybe their capacity is already being determined each time we assume this…it happens all the time "he will do well", "that baby won't" and it is so hard to hear (January, 2006 NP 07).

In summary, the subset of nurses and I determined that women spoke from the *experience* of relations while health care providers primarily spoke of the *function of* relations and that each speaking location reflected the differing power relations and vulnerability that constitute relational experiences in health care. Health care providers expressed varying levels of critical analysis regarding to the consequences and effects of interpersonal relations for their impact on women's experiences. The social workers spoke of the daily challenges of negotiating social distances when women feared apprehension of their infants. This was described as a complex social space between social workers and women that required critical awareness of the impacts on women themselves. The cultural interpreter 'knew' also from a distinct vantage point how struggles and power differences impact the health of patients. Nurses who were willing to engage with and learn from the experiences of the women began to challenge their own taken for granted understanding and began to disrupt some normalized truth about experiences of relationship as beyond individual interaction alone.

I will close this chapter by describing the understandings constructed through reading back and forth between the participants' accounts. Although I have mentioned several aspects of a reading the participants data together, I will outline several key

insights about the *relational construction of interpersonal spaces of care* as the constitutive pattern that draws together the findings of study (Diekelmann, 1989).

The Construction of Experiences in Interpersonal Spaces: Reading In-Between Participant Accounts

I have 'temporarily fixed' this finding of the relational construction of interpersonal spaces to achieve what Harding (1992/1999) describes as a "maximally adequate account" (p. 159). It is not the end of the story, so to speak. Rather, I have named this process to serve the purpose of discerning implications and directions for future inquiry, research, and practice.I have contingently concluded that experiences of relationships and women's health capacities and outcomes can be theorized as meaningfully constructed and shaped by the practical social and discursive conditions and contexts under which they unfolded.

As was my initial intent, I read back and forth between care providers and women's data. I assumed that a more complex understanding could be constructed by doing so. It became apparent that the experiences of both participants groups were constructed through a similar relational process and the findings themselves are situated in this in-between space. In particular, a dominant feature of this relational construction was how the cultural context of antenatal and neonatal care shaped participants' experiences of interpersonal spaces of maternal-fetal/infant care and health care providers' perspectives on and women's experiences of health capacities and outcomes.

Women in the study described how their experiences of interpersonal spaces were constructed in relation to the complex and multiple connections and influence of people, practices, and policies that reflected the dominant cultural norms of maternal-infant care. Health care providers' constructed their experiences, for the most part, on the basis of individualistic and de-contextualized understandings that were linked to instrumental and sentimental ways of knowing about interpersonal spaces. When women's experiences were considered in relation to the health care providers' data, it was possible to see how the experiences of both groups were being constructed through similar cultural discourses of maternal-infant care. Yet, this cultural 'scene' of care (e.g.

policies, practice and people) was not “out there”; it lived through the particular practices and interpersonal relations in each moment.

As mentioned in Chapter 4, I brought a subset of four nurse participants and one woman together to co-construct the research insights, findings and conclusions. This was the most appropriate way I could see at the time to deliver on my aim to create findings that would actually enhance and optimize care for women and infants. The nurses who decided to engage in the analysis were motivated in different ways; one was embarking on a graduate degree and another one recalled her experience of being a patient and some difficulties she encountered along the way. One nurse said the women’s stories and experiences were invitations to know more and she felt an obligation to read and imagine ways to make things better.

As the subset of nurses and I read between health care providers’ and women’s data, we recognized that how women spoke of their capacities being eroded was similar to how the nurses understood the impact the structuring of their work on their own capacities for human relating. In their practice context, they pointed to evidence that their ability to be in-relation with women was impacted by dominant values of efficiency that provided little space for relating in more than sentimental or instrumental ways. For example, one nurse recognized that she was doing much of the same type of ‘battle’ as women in relation to “fighting” (NP 06) to reorganize the structure of home visits to women, in ways that would allow her to spend more time with the women and less time in her car. She spoke about her own ‘erasure of agency’ in relation to what we identified as an efficiency discourse that structured her everyday work (for example, the workload measurement system). Rather than working from the conventional view of member checking to a ‘validate’ the findings with participants, I saw the potential to tap their own sense of what was going on in the data as the basis for discerning practice-value. I was informed by the pragmatist notion that knowing is embedded *in* the particular practices and actions of participants. Therefore, I set out to enlist the nurses’ ‘theorizing’ efforts as they worked to make sense of the data. Constructing insights about the relational construction of interpersonal spaces therefore was not undertaken as the basis for

developing a specific theory but as basis for ongoing theorizing as a 'program for more work' (James, 1907/1937).

These nurses also began to talk about the importance of accounting for what they described as a disjuncture; one between believing that nurse-patient relations were central to therapeutic work while working within systems and structures that value the contrary[36]. One nurse questioned how the NICU structured interactions, another questioned whether 'self-efficacy' theories might get in the way of meeting women's antepartum health needs. These conversations, brought to my analysis, opened up discussion of the 'conditions of possibility' (Foucault, 1980) of both sentimental and instrumental terms for describing health care providers' experiences of interpersonal relations. During one of the conversations, a nurse said;

> I don't know, it's like there is no room anymore for relationship, either that or every thing else gets a higher priority, like getting things done faster and quicker. I know that I am more productive at work when I make time for connecting with the mom's and really listening and making sure that no one judges my time spent in this way. Sometimes I hear and see people pointing at me saying oh there she goes again… but I know that there is the "no time" thing, that I have to work against that for the good of the moms and babies...but you are out on a limb when you do because its not the norm….it's a lonely place to be out there fighting for time to connect, it just doesn't stack up as a good way to spend the limited time we have. This leaves me feeling like I am dammed if I do but damned by myself if I don't and yet it is me that I have to live with after the shift is over (NP 09).

Another nurse (NP 08) called me after one of the 'analysis' conversations and said:

> I think you should come with me tomorrow. There is something going on when I am with this woman, something in me that I don't like. I find it so hard to drive up that long driveway to that huge house seeing all those kids and women picking blueberries, its like the caste system is right there before me and I have this kind of anger when I go through the door… I don't know what it's all about but I think this is what you are studying. Can you come tomorrow and we talk more about this. I am now convinced it affects my way of being with her and now wonder about the effects of what I need to do…maybe I hurry, and not listen just to get out of there? I don't know but….I think you should come (Field notes from phone conversation and participant's field notes in journal, September 8th, 2005).

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[36] These conversations led me to question the ethical responsibilities in research associated with engaging participants in deliberation about going about changing particular features of their practice contexts. In some case the strategies and actions discussed could be perceived as having risky consequences, however, for the most part the nurses were focused on embodying a scrutiny of their practice that could transform particular contextual features that were already harm-inducing.

These nurses illustrated the courage required to examine their own practice and thereby set the tone in our first conversation for a space to inquire into the uncertain places of human relating. From these conversations I constructed two features in the words of participant to describe several nuances of the relational construction of interpersonal spaces. These are: *relationships are not so innocent* and *it all shows up in the face to face.* I used the words of participants to uphold my reflexive commitment to be conscious of the temptation to theorize beyond the data and create abstractions that drift from the critical insights participants offered to this study. And, the participants' words and insights seemed to hold the attention of the subset of nurses to a greater degree than the language I sometimes used to represent such insights!

Relationships Are Not So Innocent

> Ok, now that this is on my mind, that how we relate might not be so innocent. I can see that much of what we assumed to not be affecting us and the women just might be the biggest sources of stress. People say that's just politics but those things obviously really matter. Like when we do things for the wrong reason, like when it makes out work easier to say it just the policy, rather than saying it should be changed, or have the guts to say, this does not work for families, and know that, I mean really know that. I had never thought that the 'therapeutic use of self' stuff I learned in school could possibly have a down side, like when you lay your values and judgments on another person. I know that in the unit some ways of doing this probably are about what happens when we all don't question how things are. Last week, I wondered about what might be showing up in my when I meet women face to face, so I though it would be good to write about it (NP 07).

The idea that relationships are "not so innocent" (NP 07) implies that relationships were not neutral spaces, but had potential for both harm and for good. The idea opened up a productive and positive space to read back and forth between participants' data and examine how particular experiences were being constructed. Our conversations were deconstructive in the sense that we examined how certain perspectives, such as the taken for granted instrumental and sentimental views of relationship, came to be 'fixed' in health care providers accounts. I invited this disruptive tone of conversations as a way to enlist the nurses' help for transforming how health care providers could 'know' about relationship. My original intent to examine how certain ideas about relationships become 'fixed' guided my analysis -- fixed in ways that reduce

the complexity of relational experience, pay inadequate attention to human experience/context inseparability, provide little practical guidance, obscure the possibilities of interpersonal harm, and reduce human relating to behavioral skills of communication. In the idea that relationships are not so innocent, the nurses seemed to be bumping up against the same questions I had at the outset of the research. My selected interest led me to foreground "not so innocent" here, although I will show how this insight represents many of the findings altogether.

For the nurses, the idea that relationships are not so innocent pointed to how interpersonal spaces of care are neither neutral nor uncontested sites of human experience. If *not* 'so innocent', the nurses asked, on what basis then might we understand our practice in interpersonal spaces? How might this 'rethinking' about interpersonal spaces transform dominant ways of knowing/being that get in the way of health promoting and humanizing care for women? They questioned if this idea was another way to 'know' about relationship, one helpful for theorizing the interpersonal as the context for working against dehumanizing and the dismissive care of which the women spoke. I understood the power of 'not so innocent' as signifying the nurses' way of articulating a need for critical and contextual analysis of relationship and for theorizing how to optimize care for women as it takes place *in* relationship.

The findings from this study illustrate how understanding, researching, and theorizing the interpersonal primarily in the context of human science does not adequately provide the basis from which to inquire into experiences and impacts of the interpersonally. More specifically, the idea of not so innocent calls attention to the limitations of reductionistic accounts that align "good relationships" with shared values, involvement, sameness, and consensus. In this study, differences in participants' experiences and accounts were viewed as critical for understanding the relational complexity of experiences where "…indissociable relations exist between experience, truth, power, domination and resistance" (Mulholland, 1995). The complexity of relational experiences was created through these inescapable relations between experiences, power, domination, subordination, ideologies and dominant practices. It was these very relations that constructed particular impacts on women. Going into the

complexity of differences between how women and health care providers 'knew' relationship provided the basis from which to question, for example, how particular ideological assumptions of neutrality and impartiality could be constructing women's experiences of dismissal and dehumanizing care.

The idea that relationships are 'not so innocent' also raises questions about the adequacy of theories of the interpersonal that do not explicitly focus on the interpersonal as a site from which to bring about social and contextual transformation. In this study, the interpersonal was site of action where ethical and humanizing care for women can be realized. Although not explicitly focused on interpersonal relations, Mulholland (1995) claims that "…a fundamental limitation of transcultural nursing models is their inadequate theorization of power, a limitation that has in its humanistic foundations constituted a substantial limitation for the analysis of 'race' and racism" (p. 446). Mulholland claims that inadequate theorization of power and "essentialist multicultural frameworks" emerged within humanism and are particularly problematic for the oppressive realities and complexities inherent within contemporary health care and nursing practice; those very complexities that also led the nurse to conclude that relationships are not so innocent. Mulholland states that:

> …nursing appears committed to a transcendence of power; to an a-political model of professional practice and education. Fundamental to the problem is an unwillingness to confront the question of power in any rigourous manner because to do so would involve confronting the reality of conflict as an inextricable component of the entire nursing arena. Such recognition would threaten to burst the bubble of consensus central to much nursing philosophy and practice (p. 445).

The nurses who joined in the analysis were anything but hesitant to "burst the bubble of consensus". They just required a space to inquire into the complexity of relational experience and some specific tools from which to "look in and look out" (NP 07). They were well equipped to see how their individual practices, personal history, and their social and contextual *being* in the world was relevant for also seeing the same in women, infants, and families as the ground from which to optimize their care.

Not so innocent also implies a need to account for the difficulties and complexities of experience of interpersonal spaces, and to critically account for how women's health outcomes and capacities are situated within networks of policies, power,

practices, structures and other contextual features of specific programs of care. For the nurses, the idea of relationship as "not so innocent" served as a powerful reminder to the importance of looking both within themselves and their moment to moment practice while also looking "up and out" as the broader contextual forces. This "looking in and out" (NP 09) was suggested as a way to disrupt the "innocence" and "essence" of relationship that characterized health care providers' data. The nurses spoke of how a less innocent view of relationship draws attention to the connection between their own practices and ways of engaging and the contextual impacts of policies, program structures, unwritten rules, and taken for granted norms of providing care.

Theorizing the interpersonal as "not so innocent" also provides a way of seeing how the nurses' experiences were constructed through the same cultural discourses as were the women's experiences. Moving beyond the dichotomizing tendency to separate people and context and resisting the 'blaming' of individual health care providers for women's experiences invited the subset of nurses into a contextual analysis of the challenges in their interpersonal practice. The nurses noted that the skill of critically examining the *interconnections* between their own ways of being and knowing in interpersonal spaces in light of the 'dominant think' (NP 04) and 'unquestioned practices' (NP 07) would be a practical tool for navigating amongst (and potentially transforming) the structuring of their work and the interpersonal context of care shaping women's health experiences, capacities, and outcomes. These nurses indicated that meaningful 'findings' were those that would help them to be more critically conscious of *how* dominant ways of knowing and ideological assumptions become embodied in their ways of relating and engaging with women/fetuses/infants in interpersonal spaces. That is, to more adequately account for how "it all shows up in the face to face" (WP 06)

It all Shows up in the Face to Face

The notion that relationships are 'not so innocent' (NP 07) reflects one woman's insights that "it all shows up in the face to face" (WP 05); that is, all influences, dominant ways of knowing, ideologies, structures, policies were always acting upon to shape every face to face encounter. The idea that 'it all shows up in the face to face' illustrates how

relational experiences are not reducible to *individual interaction* but rather are shaped by the *cultural scene* of antenatal and neonatal care.

Beyond individual interaction.

The term 'interpersonal' typically conjures up images of what is happening between individual persons. The women in this study, however, in one way or another, implied that experiences of the interpersonal were *not* reducible to individual interaction. The women indicated that what is experienced although it shows up "in the face to face" (NP 07) is influenced by far more than just the face to face. That is, what shows up in the face to face is not just what is happening between the two people but also the specific and tangible impacts of practices, policies, spoken language, nonverbal actions, unwritten rules and norms of the specific programs, program philosophies. Although health care providers assumed the dominant individualistic (and non-relational) understanding of interpersonal, by carefully examining the 'face to face' in this study it was possible to re-theorize interpersonal spaces as sites where both women and nurses resisted the dominant cultural scene that tended to disvalue the complexity.

The interplay between self-others in context also implies that how health care providers and women knew about and engaged with one another cannot be theorized through the dichotomizing tendency to 'explain' knowing and being as *either* socially and discursively constructed *or* subjectively embodied. It was the connection between what women and health care providers knew of the world "out there" and their knowing of the world "in here" that illustrated how "it all shows up in the face to face". And, it was precisely this complex 'whole' -- such as the intersection of women's migrational experiences and their views on relationship -- that showed up in the face to face. The face to face was therefore a complex site of contextually situated human contact that powerfully influenced women's health capacities and outcomes. This notion that the cultural scene of health care practice 'shows up' in the face to face calls into question the adequacy of research and theorizing interpersonal relations -- and their centrality for constituting and providing direction to everyday moments of maternal-infant care -- as reducible to what take place when one individual engages with another. Experiences of

the interpersonal in this study were precisely situated within the complexity of self-other-context relations.

The cultural scene shows up

When articulating how the cultural scene shows up in the face to face, the women spoke of how antenatal and neonatal program cultural norms had a powerful impact on their experiences of the interpersonal. They repeatedly made reference to how the "whole" of the unit or program was experienced in the "face to face" and how particular policies were given purchase and power when they were embodied in and given authority in the practices of health care providers. Women also spoke of the irony of becoming faceless ("not seen", "like I was not there") in the face to face. They generally did not attribute their experiences to particular individual care providers, but to a greater complex whole of antenatal and neonatal care expressed in the local cultural scene. For example, the visiting policy for the NICU was referred to by women as a living force, not only something in a book or pasted on the wall but a powerful device that could work for or against their need for the supportive presence of the significant people in their lives.

Another important notion evident in the idea of the face to face was how women spoke of myriad relations they believed were relevant for understanding their experiences of dehumanizing and dismissive care. Some of the features of the "whole" of maternal-infant care struck me as ineffable and complex enough to be beyond description. The woman who spoke of watching her baby being "turned like a piece of meat" indicated how she actually felt nurses' judgments about her infant's personhood showed up in nonverbal ways. The absence of linguistic content did not detract from the power of communicative action. She spoke of being able to read the body language of nurses as communicating something about their views on moral status of infants.

Another woman indicated that "what they think of you [as an addict]" was embodied in particular care providers' actions as they came through the door of her house. Several women repeatedly emphasized that what health care providers think about women, particularly in terms of their social worth, was felt in a moment to moment basis and powerfully impact their capacity for achieving health outcomes on their own terms. In their literature review of potential connection between nonverbal expression,

therapeutic relationships and health outcomes, Roter, Frankel, Hall and Sluyter (2006) state that "considering its centrality to the care process, nonverbal behavior has received surprisingly little attention" (p. 528). Roter et al. refer to cultural anthropologist Edward Hall's (1976) distinction between high to low-communication contexts to claim that nonverbal ways of engaging in health care both shaped and are shaped by the environmental context of care.

When the nurses in the study worked with idea of 'not so innocent' and the 'face to face' I could see they were engaging with particular ideas they found to be meaningful in the need to understand what was happening in interpersonal spaces. Together these insights share several overlapping ideas and together can be read as "the face to face is not so innocent". The tools of discursive and critical analysis of existing ideologies became relevant in our conversations to discern practice-value. Returning to the problematic tendency to equate human relating with communication skills, it is possible to expand current understandings and research to account for how dominant ideas are expressed in language and reflect particular ideologies that socially organize interpersonal spaces of care. That is to say, research into how health care providers and women know about and engage with others in interpersonal spaces may be advanced by examining everyday use of language that cannot be reduced to the "…mere transfer of information" (Lingard, Reznick, Espin, Regehr, & DeVito, 2002, p. 728). Focusing on the specifics of verbal communication without a critical analysis of how meaningful experiences are constructed in language and through nonverbal actions, written and unwritten policies and the dominant cultural scenes of care provides only limited account of the complex relational construction of experiences of relationship.

In closing this chapter and by way of transition to the next, it is important to be clear that my effort to 'theorize the interpersonal' is not proposed as a new 'theory' of the interpersonal; rather, it is proposed the basis for ongoing inquiry into the relational complexity of experience constructed in interpersonal space for particular impacts on women's health capacities and outcomes. Interpersonal spaces of care in this study were powerful sites of meaningful human experience -- in humanizing and dehumanizing ways -- that cannot be theorized at the level of individual interaction. Rather, experiences of

relationship were influenced by the cultural ‘scenes’ of maternal-infant care and constructed the women’s health capacities and outcomes in each interpersonal moment. In this way, *the face to face is not so innocent*.

CHAPTER 7: THEORIZING THE COMPLEXITY OF INTERPERSONAL SPACES: OPTIMIZING HUMANIZING AND HEALTH PROMOTING CARE FOR WOMEN

In this chapter I draw upon the findings from Chapters 5 and 6 to discuss how experiences of the interpersonal are *relationally constructed* to illustrates the critical importance of understanding how the *face to face is not so innocent.* Because I believe that the findings of this research warrant the same scrutiny of pragmatic adequacy undertaken in earlier chapters, I show how the insights from the analysis can create more health promoting and humanizing care for childbearing women. Specifically, this meant I asked how the research findings are practical "instruments, not answers to enigmas, in which we can rest" (James, 1907, p. 147). In other words, a pragmatic approach to knowledge that characterized where I began provides direction for the very task of discerning the implications of the research.

Revisiting Questions of Adequacy in Relation to the Findings

As mentioned in the preceding chapter, the idea that the face to face is not so innocent alerted several nurses and one woman to how relationships are far from neutral places of care and are always in the making in ways that constitute both harm and good. The idea of the complexity of relational connection further alerted them to *what* required their scrutiny in interpersonal spaces of care and *how* to turn around those harmful experiences described by the women. Therefore, the findings articulated in the previous chapters and my intent to scrutinize their significance for optimizing women's health capacities and outcomes provide the structure for this chapter. Through the process of asking about the implication of the research, I also drew upon Hartrick Doane and Varcoe's (2005, p. 14) 'pragmatic questions of adequacy' to inform my process for determining the substantive significance of the findings. I asked:

- To what do the findings draw attention?
- What is taken for granted?
- What becomes doubtful?

- What is questionable?

I was also concerned with asking how the findings could lead to better care (more humanizing, more ethical, more just, more responsive, more health promoting) for women (for example, optimize women's health capacities and outcomes) and how the findings can support nurses to be effective and responsive to women in their interpersonal practice.

Theorizing the Complexity of Relational Experiences in Interpersonal Spaces

As my closing comments in Chapter 6 indicate, participants' experiences of the interpersonal were seen to be relationally constituted through the complexity of relations that take place in everyday moments of care. Recognizing the inseparability of people, experience, and context indicates a way of knowing and being amidst interpersonal spaces of practice and a ground from which to research the powerful and health-related impacts of relational experience. From the findings in this study, I propose that humanizing and health promoting care for women is made possible through research and practice shaped by a relational understanding of women's lives, their experiences, and their health capacities and outcomes. It may be that as health care providers develop a critical consciousness of the whole of women's lives they, in turn, will understand their own experiences of relationship as similarly constructed. This is an opportunity to turn around the dehumanizing and dismissive experiences articulated by the women in this study. This could be achieved by accounting for, in research and practice, the inseparability of self-other-context as the basis for, in research and practice, the inseparability of self-other-context as the basis for knowing/being in relationship in humanizing and health promoting ways. I will discuss two features of this relational inseparability of self-other-context that are specific to the findings: The *interpersonal is a site of contact, connection and difficulty* and the *interpersonal constructs women's health capacities and outcomes of care*. What follows is a discussion of the implications for optimizing interpersonal care for women.

The Interpersonal is a Site of Contact, Connection, and Difficulty

As previously indicated, the findings led me to call into question understandings of relationship as reducible to neutral spaces of individual interaction or instrumental vehicles for the therapeutic interventions of health care providers. When reading back and forth between the various participants' accounts, I constructed an understanding of experiences of the interpersonal as complex sites of human connection and difficulty. In other words, there were few instances where shared humanistic values appeared to be functioning in ways that made for unproblematic relating among care providers and women. In actual fact, to some degree, in the analysis the findings echoed what I knew from practice, yet there were details and nuances that I learned of in the research – that human relations in health care powerfully impact experiences of care and may to greater or lesser degrees be critically acknowledged by health care providers as influencing how care is provided and experienced by women. As the study progressed, it seemed that this very awareness of complexity was connected to the degree by which participants worked from a view of inseparability of experience and context. The women in particular showed me how the whole of their lives was relevant in their experiences of care. Health care providers had varying degrees of insight about the idea of self-other-context connections. Towards the end of the study, as the nurses engaged with these ideas, their capacity to see how their own experiences and that of the women's were constructed through the relational complexities of everyday moments of care was enhanced.

Therefore, I came to understand experiences of interpersonal spaces in this study as sites of complex human contact, connection, and difficulty. Bauman (2003) writes of relationship in a way that illustrates the diversity of human experience and indicates how interpersonal relations can be experienced in both deeply felt and troublesome ways;

> In our world of rampant 'individualization', relationships are a mixed blessing. They vacillate between sweet dream and a nightmare, and there is no telling when one turns into the other. Most of the time, the two avatars cohabit though at different levels of consciousness. In a liquid modern setting of life, relationships are perhaps the most common, acute, deeply felt and troublesome incarnations of ambivalence. This is, we may argue, why they are firmly placed at the very heart of the attention of liquid individuals-by-decree and perched at the top of their life agenda (2000, p. viii).

This ‘mixed blessing’ to which Bauman refers resonates with how I understood women participants’ experiences as reflecting the difficulty and complexity of relational experiences in this study. I understood this difficulty and complexity to be originating from what it means to live in the world as social contextual beings, knowing the potential for both good/harm. Much of the difficulty and harm experienced by the women was structured through a complex interplay of dominant social values and discourses on high risk pregnancy and mothering enacted in particular program ‘texts’ and ‘talk’ that were embodied in people, policies, and practices. Future inquiries in research and practice must account for this connection and difficulty and locate both as fundamental features of what it means to live as social contextual beings. Health care providers have a professional and ethical obligation to provide humanizing, ethical and health promoting care which implies a responsibility to examine how their particular practices and specific contexts of care facilitate positive experiences for women. In addition, theorizing interpersonal spaces as sites of connection and difficulty implies that in both research and practice, critical scrutiny must be paid to how dehumanizing and dismissive care is produced through the dynamic interplay of people, structures, social values, dominant cultural discourses of care, and systems of care. All of these are ‘external’ to human relations or specific relationships. This dynamic relational construction of experiences is embodied in the very practices and ways of knowing in self-other relations.

Women who used words such as ‘forced encounters’ and ‘contact zones’ also illustrated how interpersonal spaces of care were sites where their own lives bumped up against the cultural scene of antenatal and neonatal care. It was as if a form of ‘cultural collision’ (Mohanty, 2003) occurred in interpersonal spaces, one obscured by health care providers’ tendencies to take relationship for granted and view maternal-infant care as ‘culture-less’. In fact, health care providers’ very ways of knowing and being in-relation created a ‘culture’ of interpersonal spaces of care that had implications I connected to women’s experiences of dehumanizing care. This culture was created by how health care providers “knew” of the interpersonal in instrumental and sentimental ways and understood women’s capacities and outcomes as their individual responsibility. These ways of knowing relationship were seen to have particular ideological effects that shaped

how health care providers were in-relation with women in ways that also collided with the women's lives and experiences. And, as the subset of nurses began to illustrate, the dominant cultural scene could be transformed through language, practices, policies, unwritten rules, verbal and nonverbal actions, and ways of knowing about and being in face to face relationship.

The phrase 'contact zones', although used to express multiple forms of 'invasion', is not offered here as an exclusively negative portrayal of interpersonal spaces. Rather, the notion of contact zones is intended to focus critical attention on how interpersonal relationships are not neutral places of human contact. The nurses and I concluded that the idea of contact zones stood as constant reminder of how women's experiences of the interpersonal construct their health capacities and outcomes. I concluded that a critical awareness of the potential of 'cultural collision' in contact zones could disrupt the veil of neutrality and impartiality that appeared to function ideologically to contribute to the dismissive and dehumanizing experiences described by the women[37]. Accounting for interpersonal spaces as complex sites of relational 'contact' provides a way to expand the dominant conceptualization of professional-patient relationships, such as those establishing boundaries or dividing lines between care providers and patients. It was evident that boundary conceptions of relationship (us/them) were connected to unequal power relations that constructed women's experiences of domination and subordination.

The terms 'contact zones' also illustrates how bringing diverse theoretical possibilities for research and interpersonal practice could expand dominant understandings of relationship. For example, theorizing 'contact zones' as a place where cultures collide (Mohanty, 2003) can expand current understandings of relationship as sites of one-on-one interaction. Inquiries in research and everyday moments of care can be expanded in critical ways to examine how interpersonal spaces of care are situated within historical and contemporary oppressive practices that continually impact structures and systems of care. Health care broadly, and maternal-fetal/infant care specifically, have

[37] Ideological ways of knowing were not concluded to cause the dehumanizing and dismissive care of which women spoke, however, how health care providers "knew" of relationship constructed the cultural scene of care that showed up in the face to face.

not escaped such influences; rather, both are influenced by such historical and contemporary forces.

To render understanding of the interpersonal more complex and to provide health care providers with a wider array of ideas for theorizing this complexity, research and theoretical work informed by critical, feminist, and postcolonial perspectives provides insights as to how inquiry can be undertaken. As the women's accounts in my study illustrate, moments of dehumanizing and dismissive care take place within the everyday practices and routines of maternal-infant care in myriad ways, and cannot be abstracted from the social contexts of their lives. For example, Fiske (2000) claims that Aboriginal women's health, health outcomes, and specific health inequities cannot be abstracted from the impacts of colonization on contemporary socio-political context of care for women. She goes on to claim that "…analysis of patient/provider encounters should not overlook historical and political economy forces" (p. 16). Similarly, Browne (1997) examines how Aboriginal concepts of respect are interpersonally denied by practitioners and relates this dynamic to the complex interaction and consequences of social attitudes toward Aboriginal people that impact their access to culturally safe care. Postcolonial perspectives will be described in more detail later in this chapter for their potential to expand theoretical possibilities for research and practices to optimize care for women.

Although colonial relations were not the explicit focus of this research, a focus on *how* interpersonal spaces of care are situated within broader social, historical, and institutional systems of care in ways that construct particular impacts on their health outcomes was central in the research. The problematic tendency to 'de-socialize' relationships from the broader context of women's lives and particular contexts of care can inform how research is conducted and the particular ways in which health care providers "know" of the interpersonal in everyday moments of care.

Constructing interpersonal spaces as a complex place of contact, connection, and difficulty offers a site from which to tell a new 'story' or create a different discourse of the interpersonal, one that has implications for expanding understanding of the interpersonal. Speaking differently about relationships has the potential to create new understanding and practices that can expand those ways of knowing/being that in this

research were seen to be linked to women's negative experiences. Razack (1993) claims that efforts to tell a 'new story' are what it takes to create a more just world.

> In the context of social change, storytelling refers to an opposition to established knowledge, to Foucault's suppressed knowledge, to the experience of the world not admitted to dominant knowledge paradigms…the complex ways in which relations of domination are sustained, lived, and resisted call for a more careful examination of how we come to know what we know as well as how we come to work for a more just world across our various ways of knowing (Razack, 1993, p. 36).

In this research, theorizing the interpersonal as a site of contact, connection, and difficulty provided a new language and space from which to see how experiences of the interpersonal are inseparable from a complex array of relations. Future research based on these notions of complexity and difficulty of human contact and connection in nursing can set the stage for a new story by enlisting research and theoretical inquiry from disciplines grappling with rethinking and reframing the personal/social binary. For example, Farmer (1997), a cultural anthropologist, writes that insidious assaults on human dignity (such as those described by women in this study) requires inquiry into the complex connection between individual experience and the larger social matrix in which it is embedded to see "how large scale forces come to be translated into personal distress and disease" (p. 261). Farmer asks "by what mechanisms do social forces ranging from poverty to racism become embodied as individual experience? He writes of how the "texture of dire affliction" (p. 261) is perhaps best felt in the gritty detail of biographies of people's lives and experiences. Farmer goes on to say that when people do not share personal and psychological attributes, when they do not share culture, language or race, what they *do* share is a social structuring of human experiences.

From this point of view, despite the fact that women/infants requiring antenatal and neonatal care and health care providers occupy different places in the health care hierarchy, they relate to each other within the context of a world often divided along lines of privilege and disadvantage. The way in which the world is divided along lines of privilege and disadvantage is a relevant feature of the context in which care is provided and experienced. Therefore such analyses and insights about how experiences come to be are critical for optimizing care for women and for empowering nurses to "make room for

relationship" (NP 07) in ways that adequately theorize issues of power, privilege, and disadvantage for how such experiences construct women's experiences, capacities, and outcomes of care. I now turn to the more specific insight regarding how experiences of the interpersonal constructed women's health capacities and outcomes.

Experiences of the Interpersonal Construct Women's Health Capacities and Outcomes

I concluded from this study that women's experiences of the interpersonal constructed their health capacities and outcomes in ways that either enhanced or constrained their existing and potential resources, abilities, and efforts to enhance their own health and well-being of their fetus/infant. To illustrate this point, I will return to findings relating to how the antenatal home care program philosophy, language, and practices of 'women-centred care' were intended to enhance and empower the health capacities of women. What was evident in this study was the importance of accounting for how particular program philosophies can be taken up in everyday moments of relating in ways that create unintentional harms. When women *chose* to be 'centered' in their own care in ways that met with the approval of health care providers (for example, program adherence, enhanced self-efficacy), they had positive experiences of 'woman-centered care'. For many of the antenatal women in this study, however, the very philosophy of woman-centered care became ideological. Women's self-efficacy and capacity to be at the centre of care shifted based on their life circumstances or when they felt unprepared to monitor their pregnancy based on biomedical indicators. The ideological effects of discourses of risk subverted their own bodily knowing that, in turn, depleted their capacities to manage 'risk' in pregnancy on their own terms. A reduced sense of efficacy and confidence was situated in specific moments of care and constructed the context in which potential impacts (and harms) arose. These insights illustrate the importance of examining how particular practices, embodied in care providers ways of being/knowing, are shaped by dominant discourses that can have ideological effects that impact women's experiences of care. In nursing, it is critical to examine *how* patients experience relationships in ways that enhance or constrain access to appropriate, effective, and responsive care that ultimately enhances their capacities for health and positive outcomes of care.

Recall also how women's experiences were constructed within the complex context of their lives as they also were dealing with health challenges and fear in pregnancy and mothering related to threatened fetal and infant well-being. The women described how the language, policies, and actions of health care providers discounted their realities as they occupied the subordinate position of patient, magnified through their unequal social status as women and the complex and diverse factors affecting their lives as immigrants. The women's lives and health experiences created the context in which in some moments they were vulnerable and in other moments they were resistant, strong, and resourceful. The life circumstances of the women were also the source of their insight about the integral importance of respect and recognition of their worth as women and mothers. From experiencing a lack of respect in several domains of their lives (such as alienation and isolation they felt as immigrant women), they were particularly attuned to what respect looked and felt like in interpersonal spaces of care. The women 'knew' respectful humanizing care through experiences of disrespect, dismissive practices, and dehumanization that was not specific to health care alone. And, in fact, the women knew it through a form of hyper-vigilance developed through the particular circumstances of living with 'high risk' pregnancies, as mothers of ill newborns, as partners, and as new immigrants. In turn, each of these features of their lives shaped individual women's capacities and outcomes in each moment of care.

From the women's accounts, I deemed some of the very structures and systems designed to enhance woman-centered care and maternal-fetal-infant health capacities and outcomes may paradoxically work in the opposite direction. When childbearing women's health capacities and outcomes are defined through the ongoing medicalization of women's bodies, reproductive outcomes are framed in biomedical and individualistic terms. Individualizing and depoliticizing women's health issues and the history of biomedical and predominantly male intervention on women's reproductive issues have long been documented by feminist writers such as Sherwin (1992), Benoit et al. (2007), and Oakley (1986) and continue to construct how women's capacities for health, health outcomes, and health equalities are currently defined. Health care and biomedical discourse are powerful means of social control, particularly in terms of women's

reproductive health mothering, childrearing and images of family life (Varcoe & Doane, 2007). Such discourses and dominant social values operate as taken for granted ideas, policies, and practices within systems that are based on the values of biomedicine, liberal individualism, and a free-market economy (Allen, 1999; Hartrick Doane & Varcoe, 2005; Sherwin, 1998). Interpersonal spaces of care were shaped in relation to these dominant forces; such forces were not external to how women and health care providers knew of and engaged in interpersonal spaces (for example, unit policies) and were seen to be shaping women's capacities and outcomes. When considering how maternal-infant outcomes were shaped by everyday moments of relationship, it was also possible to see the importance of relationship as a critical site for turning around particular negative impacts on women's agency and self worth that created avoidances of care, additional maternal-infant risks, and specific negative outcomes of care.

The findings in this study also illustrate why childbearing women's health capacities and outcomes ought to be re-situated beyond dominant biomedical discourses that frame what counts as evidence in relation to women's reproductive health. An expanded view of outcomes must account for how capacities and outcomes are not reducible to individual women's innate strengths; rather, they must account for how they are relationally shaped in each moment of care. What the women in this study were able to achieve in terms of reducing risk in pregnancy happened, for example, because "how they treat you makes you believe you can do it" (WP 08). Specifically, ongoing analysis of *how* cultural discourses of medicalization of pregnancy and birth become enacted in interpersonal spaces could be undertaken using an analysis of language that can connect the social world to the relational experiences of individual women. As pregnancy and birth are viewed as a technical means to a medical end, where processing women's bodies is a form of "medical surveillance" (Barker, 1998, p. 105), it is critical to examine how language use sustains particular practices that have ideological effects that are implicated in the dehumanizing and dismissive practice spoken of in this study.

Finally, the tendency for nurses and physicians to view women's health capacities as about making good personal choices and their outcomes of care as their individual responsibility became a critical insight when juxtaposed with how women spoke of their

capacities and outcomes as created in each moment of interpersonal care. And, women's construction of a denial of relationship reflected their negative experiences which were created, in part, by health care providers' tendencies to take relationships for granted and hold women responsible for their capacities and outcomes. Health care providers' perspectives on women's capacities and outcomes as choice-based and as their individual responsibility were not at all surprising in light of the dominance of neo-liberal individualistic values that permeate health and health care. Imagining that women's health outcomes might be viewed as socially constructed also runs counter to contemporary 'evidence-based' discourses that privilege maternal-fetal/infant health outcomes in biomedical and functionalist terms to a greater degree than capacities and outcomes defined by the women.

Approaching the analysis from an understanding of the dynamic interconnectedness among people implies influence and connection (Thayer-Bacon, 2003), and illustrates how experiences are constructed in humanizing/dehumanizing, responsive/dismissive, and respectful/harmful ways. The key point here is that by focusing on the dynamic interconnectedness of people, it is possible to see a wider range of influences and impacts on both health care providers and women. Optimizing childbearing women's health capacities and outcomes therefore ought to take place precisely in this in-between space where women's lives, needs, health concerns, and expectations meet the people, practices, and policies that relationally construct their experiences.

Implications for Optimizing Care for Women in Interpersonal Spaces

Theorizing the interpersonal as a site of contact, connection, and difficulty that constructs women's health capacities and outcomes indicates several future directions for research and practice within the interpersonal domain and in the care of childbearing women. In the remainder of this chapter, I will describe implications for research and practice in relation to interpersonal spaces of care and then show how these are relevant for expanded understandings of women's capacities and outcomes to optimize humanizing and health promoting care. Specifically, I propose that optimizing care for women in interpersonal spaces requires *expanding ways of knowing/being in relationship*

in nursing, re-thinking boundaries and *re-making the cultural scene in interpersonal moments.* And, (*re)situating maternal-infant health capacities and outcomes* requires accounting for their relational construction as the basis to *enhance women's experiences, capacities, and outcomes in each interpersonal moment.*

Expanding Ways of Knowing/Being in Relationship in Nursing

Claiming that interpersonal spaces of care are sites of complex relational experiences requires that research and practice be informed by a greater array of theoretical ideas and perspectives than has currently been enlisted in nursing and health care. In this study, it was evident that each moment of the interpersonal was shaped in relation to people, practices, and policies – all of which shaped the context in which health care providers and women came face to face. Widening the epistemological, methodological, and theoretical terrain to engage in research and theorize the interpersonal spaces is not proposed as an abstract idea to 'apply' to practice; rather, it is offered as a practical insight intended to help nurses and health care providers theorize their practice ways that examine the consequences and impacts of experiences of relationship that are integral to providing humanizing and health promoting care.

Interpersonal spaces as sites of human connection and difficulty in both research and everyday moments of practice therefore can be informed by those scholars who write 'against the grain' of sentimentalized and romanticized ideals of relationship that provide little practical guidance for being amidst connection and difficulty (Armstrong, 1983; Browne & Fiske, 2001; Canales, 2000; Corley & Goren, 1998; Henderson, 1995; Liaschenko, 2002; May & Purkis, 1995; Mulholland, 1995; Stevens, 1994; Varcoe, Rodney et al., 2003). Being attuned to and focused on connection and difficulty means that it is possible to see both harm and good, aware that to be interconnected is 'treacherous' terrain:

> Perhaps the very idea of 'relationship' adds to the confusion. However hard the hapless relation-seekers and their counselors try, the notion resists being fully and truly cleansed of its disturbing and worrying connotations. It stays pregnant with vague threats and somber premonitions; it tells of the pleasure of togetherness in one breath with the horrors of enclosure. Perhaps that is why,….people speak ever more often of connections, of 'connecting' and being 'connected'…speaking of 'networks'…Unlike 'relations', 'kinships', 'partnerships' and similar notions that

> make salient the mutual engagement while excluding or passing over in silence its opposite, the disengagement, 'network' stands for a matrix for simultaneously connecting and disconnecting; networks are unimaginable without both activities being simultaneously enabled…An undesirable and yet unbreakable relationship is the very possibility that makes 'relating' as treacherous as it feels. (Bauman, 2003, p. xii)

Drawing on a wider and more critical array of theoretical ideas as tools of inquiry in research and in everyday moments of care had practical relevance in this study. Expanding the nurses' capacities to *see* the connection between what they knew about relationship and how action in and of itself created a 'space' in which they engaged with women. In this study, the harms women experienced were not seen to be solely embodied in individuals but were constructed through the way in which the dominant practice and policies created a cultural scene that lived through the practices of care providers. Expanding beyond the dominance of the human science traditions means that different sites of action come into view for turning around the harmful experience described by women. For example, consider Young's (1992) claim that humanism emerged against the backdrop of the dehumanization of colonial peoples and that an *inseparable* connection exists between humanizing/dehumanizing experiences. He writes of how the dehumanization of colonized peoples, rather than being accidental or marginal to the emergence of Western humanism, was fundamental to its formation. When recalling women's experiences of dehumanizing care and the impacts of an erasure of agency and self worth, it becomes relevant to consider how, in research and in everyday moments of care, taken for granted human science 'truths' construct relationship. Taken for granted 'truths' about sameness, shared values, and consensus might actually obscure health care providers capacities to *simultaneously* consider power, divisive forms of difference, 'othering', and essentialist understandings of culture and immigrant women. Being aware of and willing to act *within* difficulty and dehumanization and to examine how particular ways of knowing/being sustain and reproduce particular realities opens up a space to ask, as the nurses did in this study, how to disrupt and begin to transform their ways of knowing/being in interpersonal spaces. Undertaking research that focuses on changing particular practices that both undermine and enhance care from the perspective of patients can expand understandings of what being ethical, being health promoting, and

being responsive means in particular relationships. For example, conducting research that brings care providers and women together so that they can hear one another and see how their ways of knowing and being are culturally bound and could expand understandings of relationship beyond sites of one-on-one interaction.

Similarly, Noonan (2004) cites that a belief in a 'shared humanity' may be ultimately responsible for the injustices that are experienced by disadvantaged peoples. He calls for a critical form of humanism to more adequately theorize differences between selves and others in ways that do not romanticize sameness and deny the very injustice and harms experienced by people who are not similarly situated. In this study, health care providers and women were situated differently along multiple axes of gender, race, and class that constructed differences in power. Evident in the data were frequent references to "us and them" which constructed lines that divided health care providers and women along such differences in knowledge and power. These differences also were a feature of the relational context in which they engaged with one another. If, as Mulholland argues, humanism constructs a "…dialectic of inclusion and exclusion; a boundary-building" (p. 17) then it is imperative to examine how particular dominant notions of the interpersonal may perpetuate injustices through the very us/them practices that create divisive forms of difference.

Based on the insights of this study, I suggest that human science perspectives on relationship have not been adequate for helping nurses to raise questions about ways of practicing amidst such complexities of their interpersonal practice nor have they been helpful for seeing the potential for injustices and inequities in interpersonal spaces of care. I propose that the care of women might be better served by research and inquiry informed by such epistemological and theoretical perspectives as used in this research. The findings of this study indicate the value of accounting for how meaningful experiences, knowledge/power, policies, and context have tangible impacts (both positive and negative) on their health capacities and outcomes. Gilson claims (2003), for example, that traditional health policy analysis provides only limited and partial insights into human relationship. She suggests that examining patient outcomes through their

interconnection with policies ought to occur by studying relationships as they are shaped by health systems.

Because I began the research with an epistemological view of knowledge as action, an expanded array of theoretical possibilities is offered as a practical tool to enhance care for women research and practice in interpersonal spaces of care. For example, enlisting the theoretical ideas of discourse analysis in my conversation with the nurses provided a way of talking about how dominant discourses function, and how particular arrangements are ideologically sustained. Although the nurses did not take up the particular language of discourse analysis, they worked with the idea of dominant 'think', and asked about whom it serves, and the potential to create new discourses and new arrangements to serve different ends in view – more humanizing and health promoting care for women. It was evident that enlisting these particular ideas meant also examining how nurses might call into question and work to change prevailing norms and institutional practices. When one nurse spoke of feeling obligated to challenge "the way things have always been done" she did so on the basis of seeing a connection between a particular unit policy and one woman's experience of dismissive care. Thus, expanding theoretical possibilities was not an activity of increasing abstractions about relationships, but was a way of moving closer to what they deemed necessary to change. To illustrate, the subset of nurses spoke of how being alert to the possibility of harm demanded they have courage to look at their own practice and be more fully present in each moment of care. They agreed that such a way of being would be risky if undertaken alone. They did not, however, imply this was an onerous responsibility but affirmed their own capacities to be the centre of their practice with the support of their colleagues and a program leader who valued their engagement in this sort of questioning and practice.

Research conducted in the critical paradigm that undertakes an explicit sociopolitical critique of the context of health care and an analysis of power relations brought to the study of relationships can also inform future directions in research on relationships and the questions nurses can bring to their practice about all the influences that shape their practice and the experiences of women. For example, Crowe's (2000) research on the discursive context of the nurse-patient relationship illustrates how the

subjective experiences of nurses and patients are shaped by managerial discourses; that is, text and talk about efficiently processing patients through systems of care shapes how nurses 'know' and subsequently engage with patients. This research illustrates how the particular social practice of discourse contextually shapes relationships between nurses and patients. Her conclusions are aimed at enlightening nurses about the discursive context of care that ought to be brought to an understanding of how such dynamics of practice impact patients' experiences and outcomes of care. When the nurses in this study saw how they influenced and were influenced by others and their practice context at the same time, a wider array of *what* to scrutinize and to act to change came into view. One nurse noted that she had not considered unit policies influential in how she engages with women. With this insight in mind, she set out to focus on some particular policies that did not serve families in the NICU; a site of action for transforming interpersonal spaces of care that she may have not previously identified. These insights point to the importance of research that examines the intersection of women's experiences, institutional and program policies and women's health outcomes (Wisdom, Berlin, & Lapidus, 2005).

Another implication of the findings of this study illustrates how power was embedded in everyday moments of interaction. An area for future research and inquiry based on this insight could draw upon Foucault's work for theorizing power within interpersonal spaces of care. For Foucault, power relations are not structural but are "rooted deep in the social nexus" (Foucault, 1980, p. 159). Power, moreover, is not solely a function of institutions; while institutions represent one important manifestation of power, Foucault claims they are not the fundamental point of the anchorage of power relationships. Rather, power emerges from the starting points of local conditions and local needs or everyday experiences such as those in this study. Nor does Foucault understand power as a dichotomous relationship "between those who exclusively possess and those who do not have it and submit to it" (p. 98). Power from this point of view is not an objective 'thing' or force; it is a social or relational phenomenon that is always specific and local and best understood in concrete practices and embodied in individual persons. Foucault's writing on power brings a practical view to the dynamics of the interpersonal. He describes power not as unfolding in large scale events, but rather

through how power operated on the human body, where the body is subjected to the 'gaze' and practices of the institutional environment. Henderson (1994), and others, brings Foucault's notion of power to nursing practice and claims that the 'micro-practices of power' are implicated in what is taken to be knowledge and that "the nature and form of knowledge is instrumental in establishing the quality of the nurse-patient relationships" (p. 935). Connecting knowledge, power, and relationships brings further awareness to how the interpersonal is not a neutral site of care.

A more explicit analysis of connection between knowledge and power offers health care providers a specific way of asking questions to see how everyday moments of care are opportunities to be conscious of how power becomes embodied in specific practices and ways of relating to women. Ways of knowing and being are living forms of power and are far from benign. In this study, power relations ('not being seen', 'like I was not there') created the conditions of possibility within which both humanizing and dehumanizing care were experienced. Thinking about interpersonal practice in this way implies that power is not 'out there' or solely embodied in structures and systems. Such an understanding of power informed by Foucault's writing challenges the notion that nurses are merely 'discursive marionettes' (Allen & Hardin, 2001). Tuning into how power and knowledge are subtle mechanisms or 'disciplinary technologies' (Foucault & Rabinow, 1997) helped the nurses in this study to think about how certain practices and actions become normalized. Examining how power operates in an interpersonal context provides a way to also examine how power can be used to resist and transform normalizing practices that create and sustain negative impacts on women, such as those described in this study. In this research it was evident that paying attention to how power is enacted relationally helped the nurses to see the *relevance* of power in constructing both humanizing and dehumanizing, respectful and harmful, responsive and dismissive, and emancipatory and subordinating experiences of care for women. Methodologies (such as participatory action approaches) that can engage nurses in inquiry to transform their practice have significant promise for conducting research in the interpersonal domain of maternal-infant care.

Transforming practices in interpersonal spaces also requires critical attention to language for its influence in constructing relational experiences in ways that can undermine or enhance women's capacities and outcomes. The complexities of human communication and human relating ought to be expanded beyond a behavioral focus on skills to account for how language is also a form of verbal and nonverbal relation; a form of relating that can constitute relations of domination and subordination (Purvis & Hunt, 1993) that in this study were found to have tangible impacts on women ("just pee in the bed….I was told you won't be getting one of those nice hotel style rooms").

Undertaking research and engaging in practice with a more critical understanding of language also holds potential to deconstruct dominant ways of knowing relationship as a way to turn around the harms and optimize the experiences described by women in this study. Take for example, discourses on 'risk' in childbirth. In this study, the paradox of creating risk in a care context intended to reduce risk echoes insights in other studies that examine how the epidemiological constructs of risk in childbirth construct women's experience. For example, Kuafert and O'Neil (1993) illustrate how the language of risk "…affirms or challenges existing relationships of power and control…and expresses deeply held feelings of vulnerability and responsibility" (p. 32). An ideology of risk in childbearing and the language of self-efficacy and program adherence in this study both characterized and influenced the experiences of the women involved. Language and its use in interpersonal spaces was seen to be more than words, reflecting and producing dominant values, social norms, normalizing truths and concepts and symbolic forms that relationally construct interpersonal spaces. When one physician referred to "just the interpersonal" in a conversation with nurses, he dismissed what nurses took to be central in their care for women. He created a moment where, with just a few words, the notion of relationships *as* care was undermined. Therefore, inquiry into how language constitutes the realities of women and health care providers (for example, discourse analyses of various written texts and practice for their impact on how care providers and women interact) merits ongoing attention in both research and everyday moments of practice. One way to undertake this task in both research and practices is to re-think the boundary metaphor for theorizing how health care relationships are made 'therapeutic'.

Rethinking Boundaries

The idea of interpersonal spaces as contact zones or sites of cultural collision indicates several specific implications from the research. I propose that enlisting postcolonial perspectives is useful for expanding human science perspectives and for rethinking how boundaries and metaphors in nursing create divisions that demarcate differences in ways that negatively impact experience not specific to this study. Browne, Smye, and Varcoe (2007) suggest that postcolonial theories are best represented as a collection of theories that explicitly share a concern for the social, political, and moral relevance of the "history and legacy of colonialism – how it continues to shape peoples' lives, well-being, and opportunities" (Young, 2001 cited in Browne, Smye, and Varcoe, p. 125). These authors claim that postcolonial theories are connected by a central emphasis on:

> …the need to revisit, remember, and interrogate the colonial past and its aftermath in today's context; to critically analyze the experiences of colonialism and their current manifestations; the need to deliberately decentre dominant culture so that the perspectives of those that become marginalized becomes starting points for knowledge construction; and the need to expand our understanding of how conceptualizations of race, racialization, and culture are constructed within particular historical and neocolonial contexts (Gandhi, 1998; McConaghy, 2000; Reimer Kirkham & Anderson, 2002) (p. 20).

Anderson (2004) claims that postcolonial theory is relevant in nursing research in that these discourses "focus our attention on the processes of dehumanization and human suffering throughout history, and gives us a context for understanding health inequalities" (p. 240). Bringing these ideas into relation with the findings of the research expands the complexity of what 'contact' represents in interpersonal spaces of care. For example, postcolonial writer, Anzaldúa (1990) writes that

> … "cultural collision" involves a struggle to resist limiting and confining borders…where political forces construct borders to divide and conquer those least empowered. The fact that the borders are in a constant state of transition gives impetus for movements for social change (p. 25).

Anzaldúa's postcolonial perspective on cultural collision is signified by a struggle to resist confining borders. The idea of cultural collision was relevant when reading back and forth between women's and health care providers' accounts. As the women spoke of

denying relationship, they constructed a particular culture of the interpersonal. As health care providers assumed relationships, they too created a culture of relationship. The complexity of these different understandings was evident in how – in specific moments – these cultures collided. Bringing a postcolonial perspective on contact zones as sites of cultural collision was a way to theorize the complexity of contact between these two understandings and helps consider how these understandings are inseparable from power relations between a dominant group of 'expert' providers and a subordinate group of women as patients. What happens in the relational space where dominant and subordinate groups meet is constructed through how people, cultures, ideologies, practices, norms, social values, physical environments, and institutional structures meet – a place that joins the multiple arrays of relations that shape human experiences. Wilber (2001) claims:

> The point is that all of the lines we find in nature, or even construct ourselves, do not merely distinguish different opposites, but also bind together in an inseparable unity. A line, in other words, is not just a boundary. For a line, whether mental, natural or logical doesn't just divide and separate, it also joins and unites. Boundaries, on the other hand, are pure illusions –they pretend to separate what is not in fact separable (p. 26).

Bringing Wilber's (2001) idea of boundaries as places that join and postcolonial theoretical perspectives to the tendency in nursing to theorize the therapeutic relationship as focused on demarcating boundaries between nurses and patients (Horsfall, 1998; Peternelj-Taylor, 2003) raises important questions for future research and everyday practice. For example, question such as: do boundaries create divisiveness and difference that can result in the dehumanizing and dismissive care experienced by the women? In this study, the entrenchment of boundaries expressed through the "us and them" references in the data did anything but make interpersonal spaces therapeutic and health promoting, and actually had negative impacts on women. Postcolonial perspectives on borders as divisive, exclusive, and marking off dominant groups from 'others' has been shown to have deleterious impacts on the health of racialized people (Anderson, 2000; Browne et al., 2007; Browne & Fiske, 2001; Henry, Tator, Mattis, & Rees, 2000). These theoretical ideas expand the questions brought to interpersonal spaces of care and

challenge the adequacy of taken for granted truths about relationships in nursing and health care practice.

Yet the establishment and surveillance of professional boundaries are considered essential for therapeutic relationships between nurses and patients. The College of Registered Nurses in British Columbia (CRNBC) (2006) state:

> It is the responsibility of the nurse to be aware of power-imbalances [in the nurse-patient relationship], to recognize the potential for clients to feel intimidated and to create a therapeutic relationship. This awareness is a prerequisite to taking further steps to establish and maintain appropriate therapeutic boundaries. It is always the nurses' responsibility to maintain the integrity of the boundary with clients and their significant others. The appropriate use of power in the nurse-client relationship ensures the client's needs are foremost and the client's vulnerability is protected" (p. 6)

CRNBC (2006) describes a boundary as a dynamic line of demarcation in the nurse-patient relationship between professional and therapeutic, and nonprofessional and personal. Although being able to distinguish the difference between a therapeutic and professional relationship from a nonprofessional and personal one is an ethical obligation in nursing, what becomes obscured through the notion of boundaries is the interconnectedness and influence of human 'contact' in interpersonal spaces. Even a dynamic line still implies a line that marks 'in' and 'out' and divides nurses and patients in ways that, in this study, likely contributed to the difficulty nurses experienced in connecting with women and influenced particular experiences of women. When the line between nurses and women is taken to be literal and not just a tool for thinking through various complexities of relationship (for example, power), it may perpetuate the binary notion of 'us/them', 'in/out', and 'self/others' that underlie particular exclusionary practices that may constitute the 'dark side' (Corley & Goren, 1998) of the interpersonal. Future research can focus on how particular health inequities for women may be shaped in interpersonal moments of care in ways that significantly impact their access to safe, competent and ethical care.

The notion of boundaries and the need for "border control" (Razack, 1998, p. 88) can be theorized by asking about how lines that divide between dominant and subordinate groups create divisiveness and are implicated in the "us/them" practices linked to women's experiences of dehumanizing and dismissive care. The idea of contact zones

from this study calls into question whether or not the concept of therapeutic boundaries is at all helpful for nurses coming to know the complexities of relational experiences in their everyday practice with women. The idea of relational contact in interpersonal spaces also draws critical attention to how the conceptualization of boundaries in relationships between care providers and patients generally creates separateness, division, demarcation, and difference. A reframing of boundaries also can be undertaken by considering Wilbur's (2001) notion of lines as "places that join". Imagine if in each moment of interpersonal care, nurses looked for points of joining rather than lines of demarcation, and consider how such a shift in knowing might create a shift in being in ways that could positively influences women's capacities and outcomes of care.

Seeing interpersonal spaces as sites of human contact or places that join also raises critical questions for future research in relation to immigrant women's health experiences. For example, consider that the very possibility that 'therapeutic boundaries' experienced by immigrant women in this study exemplify the multiple other boundaries to be crossed amidst the cultural 'contact zones' of their lives in relation to pregnancy complications, childbirth, and neonatal care. I determined that the language of 'doing battle' and the construction of interpersonal relations as contact zones could be theorized as reflecting women's need for military-style efforts to insert themselves and resist the assimilation, domination, and subordination of 'exclusionary othering' (Canales, 2000). Viewing the women's need to 'do battle' through the lens of the postcolonial experiences of diaspora opens up a more critical array of questions for both research and practice than those evoked through the lens of therapeutic boundaries. One question I asked in this study was whether or not being born and raised in Canada constructs women's experiences of 'us and them' differently in light of how borders from a postcolonial perspective are thought to be

> ….geographic regions of contestation by the world's transnational migrants and their advocates, especially when those borders are designed to protect White wealth, power, and privilege from excluded others. As rich countries tighten their borders with dubious rationalizing discourses they increase their measures of surveillance, another characteristic of colonial practice. Contestants might conceive of borders as obstacles and stumbling blocks, but they are also fluid and permeable, able to be changed, reconfigured or disappeared, to be transgressed and crossed, leaped over, or slithered under. They can be regions of negotiated

> life and metaphoric of social constructions. In this sense borders are also liminal spaces, presenting transitions and suspended "spaces between" past and future, home and wandering, for those who feel compelled, without "authorization" to cross over a geographic border for survival (McGuire & Georges, 2003, p. 185).

These particular theoretical ideas brought me to question whether the women may be living between the world of 'home' and an alien uncharted territory (health care) that characterizes both their daily lives and interpersonal relations in a health care context in an ongoing way. Several women describing their experiences of immigration spoke of an unrelenting confrontation with a world of differences. The women faced multiple demands as they navigated new ways of living/being amidst loneliness, disorientation, and isolation that were exacerbated by language barriers, separation from family, and the socio-political context of maternal-infant care. They spoke of these intersections as the context in which they held expectations of care providers. Herein lays the critical importance of examining how childbearing women's health is shaped through the intersection of gender and their experiences of International migration (Vissandjée, Thurston, Apale & Nahar, 2007).

I enlisted one other postcolonial idea to discern implications and future directions based on 'rethinking boundaries' as a practical strategy to optimize health promoting care for women. The postcolonial concept of 'exclusionary othering' (Canales, 2000) opens up questions about how essentialized understandings of culture (as conflated with ethnicity) have tangible impacts on women's access to and experiences of care that meet their needs, and enhance their self-worth and agency as mothers and women. Re-thinking culture in interpersonal spaces requires that health care providers become curious about the diverse lives of women – in ways that ultimately enhance their care and are responsive to their lives. When 'culture' is known in ideological ways in interpersonal spaces the chance of women 'being seen' are significantly diminished. Sullivan (2006) writes of the 'end of cultures', and posits a new post-liberal view of culture beyond divisions that resonated with the nurses' inquiries into the place of culture in their everyday work:

> Replacing the abstraction of separateness with new terminologies of embeddedness, interrelation and co-construction, may allow a productive rephrasing of old questions. Networks replace structures. Performance, belief,

> behaviour and need become more important indicators for appropriate governance than essential characteristics or membership of essentialised groups (p. 82).

In particular, cultural assumptions mark 'others' and name people and events in certain ways ("that's cultural" NP 09) that directs attention to some things and deflects it from others (Burke, 1966). Theorizing relationship as a site of demarcated lines that divide health care providers and patients does little to help health care providers consider alternative ways knowing and being in-relation with women. Min-ha (1990) provides another way of thinking about "inside and outside":

> The moment the insider steps out from the inside she's no longer a mere outsider. She necessarily looks in from the outside while also looking out from the inside. Not quite the same, not quite the other, she stands in that underdetermined threshold place where she constantly drifts in and out (p. 374).

As Min-ha (1990) reminds us, however, the notion of 'inside/outside' is a constructed dichotomy itself; dominant social ideologies in relation to marking 'differences' between people can have the impact of being experienced as inclusive, humanizing and respectful or as exclusive, dehumanizing, and dismissive. Interpersonal spaces of care therefore are a critical site of inquiry in both research and in everyday practice where "what shows up" can also be resisted and transformed. Interpersonal spaces as sites of contact, connection, and difficulty therefore also can also be viewed as place where the cultural scene of maternal-infant care can be re-made.

Remaking the Cultural Scene in Interpersonal Moments

In this study, the harms women experienced were not seen to be solely embodied in individuals but were constructed through the way in which the cultural scene of care lived through the practices of care providers. One nurse spoke of "looking in and out" (NP 05) to remake what she perceived to be beyond her control, resituating herself and her own power to challenge existing practices that facilitate or constrain care for women. I surmised that theorizing interpersonal spaces as sites of experience/context inseparability implies that the ability to inquire into the complexity of relational experiences might be the strategy for transforming the cultural scene to optimize care for women and to empower nurses to "make room for relationship" (NP 09). When the nurses in this study were able to examine the array of relations situating and constituting

the cultural context of their practice, it became possible for them to see how particular structures, practices, and policies might also be changed.

Based on these insights, the interpersonal was reframed by the nurses as a critical site from which to work toward impacting the cultural scene of their program by zeroing in on the interconnections among their ways of being and particular policies, structures, and practices. In this analysis, the subset of nurses focused attention on how unit policy and routines were neither "out there" nor external to their way of relating to women, but rather are continuously embodied in their actions amidst the face to face. In response, the nurses identified specific unit policies (those both written and unwritten), discourses, and practices as targets for action for enhancing women's experiences of interpersonal spaces of care.

Questions to ask in future research therefore can be informed by writing in critical medical anthropology and feminist postcolonial theory. For example, consider the importance of how Stephenson (1999) argues that narrow definitions of culture in health care underestimate culture and define traditions that are seen to be outside or 'other' than those of dominant groups. Similarly, Razack (1998) describes how culture can be used in ways that create harm rather than greater understanding of people lives. She claims that when culture is understood as difference and inferiority, it discriminates. Yet she claims it is critical to understand how disadvantaged groups' experiences are culturally situated in relation to the benefits experienced by dominant groups. When, in conversations with the nurses, I turned the 'cultural gaze' toward their own practice and programs they resisted my tendency to 'explain' everything about their work through 'biomedical culture'. They showed me how their program was about woman-centered care, valuing women's bodily knowledge and other important ideas to counter biomedical assumptions. Within our interpersonal spaces of qualitative inquiry, the nurses started to remake the 'culture' of their program and then rethink how their interpersonal practices might similarly evolve. Remaking the local scene, through even the very ways they used their bodies, engaged in practice, and positioned themselves within particular contexts were all seen to be transformative actions in the research and point to areas for future research that aims to evolve interpersonal nursing practice.

To illustrate what form remaking the cultural context in interpersonal space can take in everyday moments of care and research, I will point to Fisher, Huack, and Fenwick's (2006) research on women's views on the culture of fear in childbirth. In their qualitative study with 22 women, they learned that the social context, explored within the framework of the medicalization of childbirth, and the intervening circumstances in which the women gave birth, impacted how and why they experienced fear. Fisher et al. argue that "fear of childbirth has social as well as personal dimensions" (p. 64). Women's fears were mitigated by relationships with midwives who took it as their responsibility to work against the grain of dominant biomedical views. The midwives worked to make a new socio-cultural context of care through their relationships with women. Such analysis of childbirth and psychological discourses on fear created the space for resistant constructions to mediate and transform women's experiences of fear. In my study, the nurses indicated how analyses of the cultural scene of neonatal and antenatal care provides a window through which to examine broader social discourses on mothering, 'high risk' pregnancy, and birthing as practical tools for enhancing their own capacities to engage with women.

With the help of some insights from the field of discursive analysis and the idea of remaking the cultural scene, the nurses furthered their analysis of their own accounts beyond the language of sentimentalism and instrumentalism with which they initially spoke. These particular nurses showed how different interpretations of research texts can create other potential meanings and ways of being. Different meaning potentials created through conversation with the nurses began to transform and resist the ideological neutrality that characterized the earlier ways they spoke. I saw that the nurses were

> …ideologically positioned, but also capable of acting increasingly to make their own connections between the diverse practices and ideologies to which they are exposed, and to restructure positioning practices and structure (Fairclough, 1992, p. 91).

While women did not distinguish among specific individual health care providers when describing experiences of dehumanizing and dismissive care, they located the specific resistance and efforts to *remake* and *transform* the cultural scene in moments in the specific practices of individuals. Recall the woman who spoke of experiencing respectful

care by seeing how one nurse did not (as she felt other nurses did) discriminate against her on the basis of her history of addiction. She described how this "one nurse" met her as a person trying to "stay clean" and cited this example of helping her to believe she could do so and mother her baby. The subset of nurses who engaged in a critical analysis of all that "shows up" (such as judgments about social worth and mothering within the context of addiction) in relationships were also able to see *how* to resist and transform their own practices in relation to women's experiences. The capacity to resist the normative cultural scene is possible within the face to face.

Returning to the complexity of the interpersonal site of contact and the potential to remake the cultural scene in the face to face, the postcolonial notion of acculturation indicates an area for future research; that is, inquiry into how the culture of maternal-infant care shapes particular practices and politics that 'white-wash' (racial metaphor intended) the lives, needs, experiences, agency, and self-worth of racialized women. Questions for research can put postcolonial ideas to work in everyday experiences of care, thereby inquiring into how cultural collision between women's lives, expectations, and needs and the culture of care is implicated in tangible health impacts for women. When the nurses began to theorize *all* that shows up in 'the face to face', the possibilities to critically shift their thinking to engage with women within the whole of their lives contributed to constructing different language and discourses to create, sustain, or challenge constructed social realities in particular situations (Van Dijk, 1997).

(Re)Situating Maternal-Infant Health Capacities and Outcomes of Care

> What happens to childbearing women, infants and families matters deeply. A vast body of evidence is accumulating about the short and long-term implications for babies secondary to the medical, physical, and social environment they are in during this crucial period. Windows of heightened sensitivity for promoting many dimensions of optimal human development or generating harms…though less studied in mothers, growing evidence suggests that experiences during childbearing have a long term impact on maternal well-being (Sakala, 2007, p. 183).

In this study, it was evident that women's health capacities and outcomes were facilitated and constrained within each moment of care which is consistent with claims made in theoretical and research literature about the critical impact of relationships on

patient outcomes in general (Barker, 1999; Beach & Inui, 2006; Chambers, 2005; Duffy, 2006; Hausman, 2001; Varcoe, Rodney et al., 2003). Yet, the health enhancing/constraining effects experienced in relationships in this study were created and produced in the very systems and structures designed to alleviate suffering and promote health. As I have argued in my analysis, women's capacities for health and outcomes of care were relationally constructed in each moment of care, and were not reducible to their individual 'innate' strengths, resources, and ability to make good choices.

Furthermore, neonatal outcomes of care are defined, measured and evaluated primarily driven by a biomedical agenda that focuses on neurodevelopmental, neurosensory, and functional outcomes (Vohr et al., 2000). Biomedical and outcomes research undertaken from this perspective is critical for determining effectiveness and appropriate care and long-term health impacts for preterm infants and critically ill term newborns. The insights of this study, however, contribute to those voices in outcomes research in maternal and neonatal care that call for a more effective analysis of the "…social and environmental factors associated with particular biomedical outcomes" (Vohr et al. p. 1216). In one study, it was determined that factors significantly associated with decreased morbidity as a neonatal outcome included "increased birth weight, female gender, higher maternal education, and white race" (Vohr et al. p. 1221); however, an exclusive focus on biomedical outcomes of care was found to obscure the connection between the social and political contexts of women's lives. This 'connection' can also be rendered more complex when accounting for the relational complexity of interpersonal spaces of care and maternal-neonatal outcomes.

Neonatal outcomes research in the area of biomedical indicators and functional status is critical; however, it is also critical to expand neonatal and maternal outcomes beyond their current 'de-socialization'. Advances in reproductive and neonatal technology have expanded possibilities for survival of preterm infants, improved recovery from critical illness in the newborn period, and have mitigated particular impacts of health risks in pregnancy for women. While medical management plays a role in women's reproductive and infant health, there is now a call for research investigating how social factors and care-giving processes are predictors of women's and fetal/infants

health outcomes (Davis, Mohay, & Edwards, 2003). This study indicates how such research could be undertaken by calling for an expanded and critical understanding of outcomes beyond their current context. As it currently stands, health outcomes research is linked to and driven by what constitutes 'evidence' in specific domains of health care practice (D. Pringle, personal communication, Oct 19th, 2007). Defining evidence within the biomedical paradigm privileges particular understandings of maternal-infant health and marginalizes others. In nursing, health outcomes generally are measured in 4 domains: functional status (e.g. mobility, toileting); therapeutic self care (e.g. activities of daily living, medication administration, and symptom management); symptom status (e.g. pain, dyspnea, nausea, fatigue) and safety concerns (e.g. patient falls, ulcers) (Doran, 2003). Several authors in nursing have argued for an expanded notion of evidence to capture more diverse outcomes of care that are relevant for understanding health in more holistic terms (Fawcett, Watson, Neuman, Hinton Walker, & Fitzpatrick, 2001). This study indicates that the interpersonal context of care powerfully shapes the women's outcomes of care suggesting that a broader view of outcomes is required, and that they be measured differently.

The insights from this study suggest that *how* health care providers know about and engage with women creates the context within which health outcomes are achieved and has lasting effects over time. The findings from this study also call into question the assumption that the mechanics of communication, as conceptualized based predominantly on biomedical and human communication roles (Kemp White et al., 2005), alone can improve health outcomes from the perspective of patients. When communication is viewed as a dynamic relational process that has both verbal and nonverbal dimensions *and* is socially structured through dominant health care cultural norms and practices, a broader and more patient-focused array of outcomes come into view. To adequately account for the complexity of communication, it is critical to engage in analyses regarding how language constructs experiences and knowledge (Björnsdóttir, 2001), and particular 'realities' in everyday moment of interpersonal spaces. And, although effective provider-patient communication has been linked to the specific outcomes of improved diagnostic accuracy (Beckman & Frankel, 2004), patient adherence (Haynes et al., 2002),

patient and provider satisfaction (Haas et al., 2000), and informed consent and malpractice risk (Levenson & Pettrey, 1994), it is critical to construct an understanding of how communication is a complex relational process that impacts more than just provider-defined outcomes of care.

As already stated, the women's capacities to do what was needed for their bodies and their babies were created in moment to moment self-other interactions, and particular outcomes were either achieved or not within that context. This is not to say that women's personal histories and experiences were not relevant; rather it is to say that the social context of care that shaped interpersonal spaces powerfully impacted women's actual and potential resources for achieving particular antenatal and neonatal outcomes of care. For example, I suggested that avoiding antenatal care, experiencing dismissal of the importance of their bodily knowledge of pregnancy, and withdrawing their mothering involvement in their ill infants' care had tangible impacts on women and fetal/infant's physiological and psychological health. Particular questions need to be asked in research to resituate women's health capacities and outcomes as relationally constructed. Questions need to be asked such as: how can inquiry into the relational construction of experiences contribute to understanding how specific vulnerabilities and health inequities are constructed for women in interpersonal spaces? If women avoided care based on their negative experience of relationship, than how can 'care-seeking' behaviors continue to be conceptualized as an individual phenomenon? If outcomes for women are socially constructed through their experiences of being in-relation with care providers and the broader context of care, are there untapped strategies for improving childbearing women's outcomes of care? Resituating women's health capacities and outcomes as relationally constructed requires expanding current understanding and ways of knowing that account for the inseparability of women's experiences, their lives, and their health.

The importance of examining the context of relations raises important questions in relation to this research; however, questions also need to be asked about how interpersonal moments also shape the context of care. While acknowledging that any particular theoretical perspective is limited and fallible, and "in need of continual scrutiny" (Hartrick Doane & Varcoe, 2005, p. 11), critical and postcolonial perspectives

are relevant for asking questions about experiences of relationship that have not been asked within the human science context in nursing. The nurses who spoke of looking 'in and out' found a way to set particular critical ideas to work in the stream of their experiences from practice and in the research; they began to notice aspects of their practice that impact everyday ways of being in relation with women as a site for resistance and transformation, a form of 'self-authoring' interpersonal practice. Both the nurses and I then had an expanded vantage point from which to engage with new questions, with new sites of action, and with a new language of relationship for knowing/being in interpersonal. And while theoretical perspectives that focus on the socio-political context of care are useful for "looking out" to some degree they reproduce the notion of 'context' as external to human experience; rather the interpersonal is a site where health care providers can interact to resist, and transform structures, systems, practice, policies, and knowledge. In this study, those features of the program context were seen to be created in each moment of interaction. This points to the critical idea of how the 'context' of care can be transformed – through the interconnections among people, through examining ideological effects of knowing/being, through verbal and nonverbal actions, through individual bodies (gluing myself to the chair), through the courage it takes to say "this policy is not working for families" and through the collective spirit of inquiry shown by nurses that was in and of itself resistant and transformative action.

A final insight about resituating construction of women's capacities and outcomes is about the policy context of human experiences. At the end of the study one nurse referred to how the visiting policy in the neonatal unit structured her capacity to be ethical in her practice. She spoke of feeling put in the position of needing to be the "visiting police". She spoke about the stress that came with saying yes and no to parents on a regular basis and how the lack of logic in relation to visiting policies left her in an untenable situation. Rather than constructing this as her 'inability' to make sense of the policy in everyday situation, we cast a critical gaze in the direction of the policy-making and its powerful role in constituting the context within which parents and nurses engage. We discussed the idea that there is a policy context of interpersonal relations.

If one considers the conventional intent of policy to be “the disciplined application of intellect to [public] problems” (Pal, 1997, p. 17), two insights from this study indicate areas for future research. First, dominant understandings of policy are based on a certain epistemology or system of knowledge. That system is rationalism, the characteristic form of Western knowledge and has been described as central to policy-making and analyses. The rationalist model presumes certain patterns of thought: it is linear, systematic, self-conscious, purposeful, and efficient. It could be that the historical ‘cultural baggage’ of policy meant that nurses and health care providers did not see policy as implicated in their practice; rather, it was external to it. When the nurses and I talked about how the “facts” of policies are always constructed through social values, norms and perceptions, or through taken for granted ways of knowing in everyday moments of maternal-infant care (e.g. biomedical understandings of women’s reproductive health that shape construction of health outcomes as individually determined) they re-imagined their connection to policies and could see the possibility to transform those that got in the way of providing health promoting and responsive care to women.

Second, when the nurses located policy in-relation to their immediate experiences, it was evident that their experiences and those of women were relevant in the policy-making process. These particular insights indicate the importance of seeing policy as shaping and being shaped by everyday relational experiences that create the context in which policies are enacted. Examining and transforming the policy context requires working from a view of policy as created and enacted in every interpersonal moment. The insights of this study contribute to theorizing the politics of policy making in local program contexts by drawing attention to the role of policy in shaping the relational construction of the interpersonal. For nurses and health care providers to ‘see’ the policy context of their practice it may be that dominant truths of rationalist models need to be disrupted to more adequately account for how any particular problem is defined as inseparable from the everyday experiences of patients and care providers. Nurses engaged in re-authorizing their practice can make important contributions to how policies can meaningfully support and enhance their practice. Asking questions such as: What

features of the context of care are influencing how I engage with women? How do specific policies impact my practice? What are the impacts of policies for how I engage with women, infants and families? How might policies be changed?

Enhancing Women's Capacities and Outcomes in each Interpersonal Moment

The nurses spoke about the practical power of 'looking in and out' to examine *how* to enhance maternal-infant outcomes of care. Looking in and out was suggested by the nurses as a practical reminder to look within themselves for particular influences on how they engage with women while simultaneously questioning how the context of care is shaping their ways of knowing and being. Expanding ways of knowing about women's health experiences, capacities, and outcomes based on the insights from this study indicate the critical importance of examining how the practice context shapes ways of relating to women.

Warren (1988) points to how women's reproductive choices, experiences, and decisions cannot be explained through liberal ideologies of free will and choice, but rather are conditioned by societies in which they live. Nor can women's capacities for health and outcomes of care be abstracted from the dominant social norms and ideologies that shape each moment of health care practice. Warren claims that "patriarchal society with its pro-natalist ideology makes it difficult for women to make free choices" (p. 40). In this study, ideologies of free will and choices did not reside "out there" in social norms and institutional structures but were enacted and lived in relationship in ways that tangibly impact women's access to ethical and quality care.

As mentioned earlier, the postcolonial concept of 'exclusionary othering' (Canales, 2000) was helpful for thinking through how particular representations of women were produced and reproduced through unequal social relations. Enhancing care to women requires examining how particular ways of relating have tangible impacts. Canales described the consequences of experiencing an exclusive form of 'othering' as "alienation, marginalization decreased opportunities, internalized oppression and exclusion" (p. 19). Corley and Goren (1998), among other nursing scholars working within the critical paradigm, claim that stereotyping and stigmatizing practices of nurses impact patient outcomes. These theoretical and empirical insights from postcolonial

theory illustrate the critical importance of inquiries in research and practice to examine the complex connection between dominant social values that mark and marginalize 'others' and their enactment 'in the face to face'. In this study, examining how health care providers and women's experiences of the interpersonal were relationally constructed through the inseparability of people and context meant that specific practices (such as, "turning my baby like a piece of meat", "like I was faceless", "why bother showing up as a person" "just pee in the bed") were understood to be enacted in the face to face in ways that had deleterious impacts on women's health and mothering capacities and outcomes.

This study indicates the importance of future research into how experiences of the interpersonal construct women's capacities for health and health outcomes on a moment to moment basis. It is likely that such research and inquiry into everyday practices could be informed by social epidemiology, critical humanism (Kleinman et al., 1997; Noonan, 2004), and critical medical anthropology (Browne & Fiske, 2001). These theoretical perspectives could be put to work in interpersonal spaces to examine how the social, economic, political, and historical determinants of health and health care affect the experiences of women in relationships with care providers. For example, Krieger (2001) describes different theoretical approaches to inquire into how the social (relational) is implicated in particular inequities in health. Bringing these insights to bear on inquiries in practice and research may expand the current tendency to de-contextualize interpersonal relations and reconstitute ways of knowing about relationship that can more effectively account for and optimize childbearing women's health capacities and outcomes.

Understanding of women's health capacities and outcomes as relationally created in the moment raises another question about how issues related to women's health are predominantly framed as unequal access to services (Andrulis, 1998; Bennett, 2000). Although access is of critical importance for understanding inequities in women's health, it may also be access to more than just "services". An issue of equal importance is women's access to positive and meaningful experiences of relationships in everyday moments of care. Gadow (1993) raised this question over 14 years ago claiming the critical importance of

> …women's access to their experience, access to meanings that establish women at the centre of their own health. It is naïve to assume that moral wrongs will be righted merely by increasing access to services. The mystification and alienation that many women experience as recipients of those services is itself an ethical problem of the same magnitude as limited access to care (p. 1).

Inquiry into relational experiences and interpersonal spaces of care are critical for future research to examine both their subtle and profound impacts on the construction of women's health capacities and outcomes of care.

Connecting Topic and Qualitative Methodology

The third question guiding this study was to examine how epistemology, qualitative methodology, and topic are related. In Chapters 2 and 3, I implied that the epistemological ground was constructed through the assumption that a relational view of knowledge and human experience was both the substantive focus of the research and a methodology for qualitative inquiry. This means I approached the research assuming that studying relationships might have both methodological and substantive implications.

In the research, I claimed that the relational complexity of experiences of interpersonal spaces of care shaped the women's capacities and outcomes. I drew upon this 'finding' in the midst of the emergent qualitative design. For example, as women spoke about the 'in the moment' shaping of their capacities and outcomes, I could see how the 'knowing' (findings) from the research was also being constructed through the relational complexity of interpersonal spaces of research. Therefore, interpersonal spaces of research were the context in which knowledge was constructed; how this process unfolded was integral to the rigour of the 'product' or outcomes of the research. This implies that the interpersonal spaces of research became the context for a transformed way of knowing in interpersonal spaces of practice and vice versa. In other words, the transformation nurses committed to making, in their ways of knowing about and being in interpersonal relations with women, were embodied in the very moments of being co-inquirers in research. My methodological approach was created for the same reason; that was, to engage in research with the intent to create knowledge that could enhance care for women in interpersonal spaces.

In my conversations with the nurses, the process of inquiry in research may have provided the nurses with insights into what a similar process of inquiry might take in everyday moments of interpersonal spaces of care. As I sought to enhance *our* capacities for relational inquiry to construct findings that would enhance women's capacities and outcomes, it was possible to see how the reflexive process of research might also enhance the inquiries of nurses in interpersonal spaces. As I worked from a relational epistemological perspective on inquiry, my interpretive stance was expanded to see the complexity of how language, practices, policies, verbal and nonverbal actions are sites of living knowledge that create particular realities for both health care providers and women.

In fact, the research discussions with the nurses often took a form of dialogue that closely resembled what we concluded might also enhance women's health capacities and outcomes. Are the human 'dialogic encounters' of research connected to the human 'dialogic encounters' in everyday interpersonal spaces of care? How might the intentional practices of being rigorous and ethical in research relations also indicate how to be intentionally rigorous and ethical in interpersonal spaces of care? From this perspective, methodological scholarship in the qualitative paradigm may contribute to the research question of the influences of relations on women's health capacities and outcomes. For example, Richardson (2000) asks how qualitative researchers might "…release the censorious hold of science writing on our consciousness, as well as the arrogance it fosters in our psyche" (p. 518). Might it also be that such a process and awareness informs the ways in which inquiry in the interpersonal takes place? Might there be a release of a censorious hold of objective, authoritative knowledge on our consciousness and the unequal, disembodying and gender-neutralizing impacts of objectifying relationships as sentimental and instrumental transactions?

In this study, being able to see the complexity of how the cultural medium of antenatal and neonatal care lived through the people, practices, and policies was possible due to the methodological approach of the research. And, the intention to theorize from the data without aiming to solidify a new theory of the interpersonal and the aim to theorize with an end in view (optimizing women's health capacities and outcomes)

reflected the epistemological location of the research. Drawing on the central tenets of qualitative research within a social constructionist frame, the methodological ground became more nuanced and intentional within a relational, pragmatic, and deconstructionist approach. Herein is the connection between topic and method, where the way of inquiring constructed my capacity (and the nurses later on in the study) to seek out complexity and difficulty in interpersonal spaces of care and to enlist this inquiry to draw forth insights and understandings for the everyday relevance for enhancing care to women. The capacity to construct findings happens on a moment to moment basis in research.

What showed up in my ways of being 'in-relation' with participants was another form of seeing "it all show up in the face to face". What knowledge is taken to be, what ethical practice in research implies and what meaningful and rigorous findings were created was known in relational ways. Several women indicated that to know their experiences meant showing me what it was 'really like'. In other words, "what shows up" might be as amenable to observation as what can be communicated through speaking. This insight implies that efforts in research or in everyday moments of practice to "know" the complexity of relational experiences created in interpersonal spaces requires more than attending to what is spoken and evident in text-based data. For example, multiple forms of 'data' in research could include images, art-based forms of expression, photo voice, among other aesthetic forms of expression. In everyday moments of practice, aesthetic forms of expression (such as, writing and images) may tell health care providers more about women's experiences than asking them about their satisfaction with care post-discharge. I found that representing the research data in text-based form at times created a 'stillness' that only offered a partial glimpse into what it felt like to sit with women and hear about their experiences. As women indicated that they knew more than they could tell about what showed up in the face to face, I also sensed that my text-based data provided only a partial glimpse into the ineffable complexity that constituted their experiences.

When the nurses assumed a stance of inquiry into the connection between the women's experiences of the interpersonal and their capacities and outcomes, they

engaged in a form of 'relational inquiry' (Hartrick Doane & Varcoe, 2005).The nurses tapped their own capacities to inquire into their practice and imagined ways to resist and transform the cultural scenes of care that were implicated in their own practices and program policies. This qualitative research was also constructed to be "…a practice of critical and thoughtful knowing as action upon the world" (Reason, 2000). If both were relational processes of inquiry, might the most health promoting and humanizing possibilities for women lie in connection to nurses' abilities to be in an involved process of respectful, compassionate and authentically interested inquiry?

Consider the following texts from philosophical and methodological inquiries to see the connection between practices of inquiry in research and practices of health promoting inquiry in interpersonal spaces of care.

Lather (1993) calls for a view of validity in research that is

> …an open-ended and context sensitive modus operandi and advocates anti-foundationalist practices of validity….a kind of validity in which legitimating depends on the researcher ability to explore the resources of different contemporary inquiry problematic and, perhaps, even contributes to an 'unjamming' effects in relation to the closed truths of the past, thereby freeing up the present for new forms of thought and practice (p. 676, quoting Bennett, 1990, p. 277).

Replace 'researcher' with physician or nurse and the possibilities for new forms of thought and practice might arise. How would inquiry aimed at new forms of thought and practice be as Foucault suggests be "an incitement to discourse". Once relationships are foreclosed, stilled, and taken out of play, their health promoting potential may be significantly reduced. Yet this is not to say they there are particular ways of being that are more or less health promoting, as the women in this study would attest. Could the research-based ideas of 'incitement to discourse' also inform a way to 'be' and 'know' interpersonal spaces of care?

Lugones and Spellman (1983) also illustrate the connection between how we engage with others and the particular ways of knowing and being that are sustained through such practices:

> What are the things we need to know about others, and about ourselves in order to speak intelligently, sensitively, and helpfully about their lives? When we speak, write, and publish our theories, to whom do we think we are accountable? Are the

> concerns we have in being accountable to "the profession" at odds with the concerns we have in being accountable to those about whom we theorize? Do commitments to "the profession", method, getting something published, getting tenure, lead us to talk and act in ways at odds with what we ourselves (let alone others) would regard as ordinary, decent behavior? To what extent do we pre-suppose that really understanding another person or culture requires behaving in ways that are disrespectful, even violent? Why and how do we think theorizing about others provides an understanding of them? (p. 30).

How does a concern with method and efficiency in everyday moments of maternal-infant care delimit the questions asked amidst interpersonal spaces of care? Do questions of "how" trump questions of "why"? Are obsessions with technique possibly obscuring how the dynamics of human relations are shaped in complex ways? Working from the connection between research methodology and interpersonal spaces draws explicit attention to how knowledge is both created and lived in relations among people and contexts, where both shape the insights and findings of research and the experiences health capacities and outcomes of care for women, infants, and families. To close this final chapter, I will briefly highlight the idea of *liminal space* as a possibility to extend the findings of this study in ways that illustrate their inseparable connection from the project's methodology.

Into Liminal Interpersonal Spaces of Maternal-Infant Care

This project showed the limits of understanding 'relationship' or the 'interpersonal' as a single 'thing' or a unified set of practices; they were sites of complex experience of relating selves-others-in-context. As I conducted the research 'in-between' health care providers and childbearing women, the postcolonial notion of 'liminal space' indicated possibilities to more adequately theorize, research, and practice within interpersonal space. When working to attend to the complexity of relational experience, a new language could unfix dominant understandings that were seen to have deleterious impacts on the women in the study. The notion of 'liminal space' implies an in-between place where "…boundaries dissolve a little and we stand there, on the threshold, getting ourselves ready to move across the limits of what we were into what we are to be" (Bhabba, 1994, p. 27). Bhabha's postcolonial notion of liminal space is also considered a 'third space' which is a mode of articulation, a way of describing a productive, not

merely reflective, space that engenders new possibility. It is an “interruptive, interrogative, and enunciative” (Routledge, 1996, p. 400) space of new forms of cultural meaning and production blurring the limitations of existing boundaries and calling into question the established categorizations of culture and identity.

The idea of interpersonal spaces as liminal spaces also implies there is nothing ‘fundamental’ or inevitable about the form relationships take, they are not ‘made’; rather they are experienced. Any efforts to define, fix, make static, or map out ways to ‘do’ interpersonal work will very likely get in the way of their health promoting potential for women. Liminal spaces are places rich with ambiguity, uncertainty, and the possibility of creative formation. Routledge (1996) writes of a ‘third space’ as a site for critical engagement where the purpose is to “open up legitimate spaces for practical actions creating networks of ideas, strategies, relations and alliances (p. 407)”. This third space involves a simultaneous coming and going in a borderland zone:

> The third space is thus a place of invention and transformational encounters, a dynamic in-between space this is imbued with the traces, relays, ambivalences, ambiguities and contradictions, with the feelings and practices of both sites, to fashion something different, unexpected (Bhabha, 1994). It is about defining a politics that enables new radical alliances to evolve, creating an alternative of space, identity, and politics (Routledge, 1996, pp. 406-407).

Interpersonal spaces in this study were neither static nor reducible to individual selves and others; they were seen to be continually ‘produced’ (Lefebvre, 1991) through the dynamic interconnections between and among people and contexts. Thus, the concept of liminal or third spaces is proposed as useful for analyzing the oppositional positioning (e.g. us/them, self/other, people/context) and transgression of dualistic categories to provide a “spatial politics of inclusion” that opens up space of/for re-articulation of negotiation and meaning. Considering the “how” in the face to face is not so innocent, it is possible to reconstruct understandings of relationship based on complexity, connection, difficulty, contact, and cultural collision. A way to bring these ideas into new spaces of research and practice might be to think of the interpersonal as a liminal space where maternal-infant health care culture can be remade, where dehumanizing experiences can be turned around, and women’s health capacities and outcomes are optimized amidst the complexity of relational experiences.

Conclusion

It is somewhat daunting to imagine the prospect of writing conclusive statements about a study into experiences of human relations. My sense is that I have touched a small tip of the proverbial iceberg of human relating within interpersonal spaces of maternal-infant care and within a research context. My intent was to engage such questions and inquiries at the level of epistemology and ontology, and to argue that particular theoretical ideas and perspectives on knowledge, human experiences, social context and relationships shape how we 'know' and 'be' in relationship with others. It seems that trying to fix any last word on the topic is at best, illusive, and at worst, naïve. Research into relational experiences inevitably requires conclusion but denies the possibility of conclusion. This research has reminded me of why experiences of human relating have held and continue to hold my attention: to be reminded of the "…unencompassable…that sphere that eludes, which outplays, any effort to hold it captive" (Caputo, 1987, p. 214). This conclusion then rests on the idea that theorizing the interpersonal is, at its very heart, bound together with the difficulty and complexity of relational experiences. Although Caputo does not write about relationships, in my reading of his text, the difficulty and complexity of human relating is his powerful subtext:

> …there is the prior mystery of persons, that outstrips whatever we think we know of them and commands our respect… that is where hermeneutics lead us: not to a conclusion which gives us comfort but to a thunderstorm, not to a closure but to a dis-closure, an openness towards what cannot be encompassed, where we loose our breath and are stopped in our tracks, at least momentarily, for it always belongs to our condition to remain on the way (p. 214).

'Being on the way' effectively indicates how closure to this research has been interpreted; as a momentary stopping point for the practical purpose of closing this study while simultaneously constructing related lines of future research and inquiry. I close this document by returning to the infant deemed "hard to love", assuming that in some way this research may contribute to more health promoting, humanizing, respectful, and responsive care for this baby and her family, one that accounts for relational construction of experiences within interpersonal spaces of maternal-infant health care.

Loved

Newborn born with cleft palate
Facial deformity
Turning away, turning toward
Brings us to judgment

To see beyond the abnormality
Her parents ask.
Her eyes are soulful
Lays in her parents arms

Noticing, knowing
Her temperament is engaging
Fed by oral gavage
Lays in a nurse's arms

Surgical repair possible
Family prepares
Nurses stand guard
In collective arms

Discharge is planned
No one is ready
Nurses push back
Possibilities In-relation

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APPENDICES

Appendix A: Program Description -- Antenatal Program

The following pages are a copy of the Antenatal Program's description of the services it provides.

FOUNDATION

Making life better.

[redacted]

Family Birthing Unit

- Opened in 2001 as part of [redacted]s Children's Health Centre
- The Family Birthing Unit is the biggest single-room maternity care facility in western Canada
- 33 bed unit
- 29 labour, delivery, recovery and postpartum (LDRP) rooms
- 4 antepartum beds
- 2 Post-Anesthesia Care Unit (PACU) beds
- 1 operating room
- 5 bed triage and assessment area
- Obstetrician, Pediatrician, Obstetrical Anesthetist and Clinical Resource Nurse available 24/7
- [redacted] is the second busiest maternity hospital in BC, delivering between 3400 and 4000 babies a year
- By 2023, the hospital is projected to see more than 4500 births a year
- High-risk perinatology moving to [redacted] by 2010

Support Programs

Antepartum Care at Home Program (ACAHP): At home care for women with certain pregnancy complications instead of hospital care. The ACAHP serves women living within 30 minutes of [redacted]

Outpatient Fetal Monitoring: Provides care for women who have a pregnancy at risk but are able to maintain normal activity, includes assessment, teaching and non-stress tests and interpretation.

Nausea and Vomiting of Pregnancy Clinic: Provides care to women with excessive nausea and vomiting during pregnancy who require care and treatment but do not meet the eligibility requirements for ACAHP Care includes assessment, teaching, IV hydration, medication and coordination of support services as required (social work, public health, healthiest babies).

Maternal Fetal Medicine Clinic (MFM): includes Diagnostic Obstetric Ultrasounds (U/S), Amniocentesis and Amniocentesis consults, Perinatology consults and High risk diagnostic obstetric U/S.

Cervical Ripening Clinic: The cervical ripening clinic is a nurse-run clinic ensuring appropriate dating, health and fetal well being for women whose pregnancies have become overdue (reach 41+ weeks gestation and a bishop score of less than 5).

SERVICES PROVIDED

For women receiving Antepartum Care at Home:

- Daily home visiting and/or telephone contact by nurses with high risk maternity experience. Included are assessment and monitoring, teaching, counselling, and coordination of professional and support services as required
- Home support (homemaker) services for those with minimal support at home (maximum 4 hours per week)
- Access to travelling lab service
- Consultation/referral to other disciplines and programs as required, e.g. Handy Dart Transit Service, social work, physiotherapy, nutritionist, Healthiest Babies Possible etc.
- In hospital (SMH,LMH and PAH) teaching to encourage patient self assessment and foster understanding of the pregnancy condition

Outpatient Fetal Monitoring – assessment, teaching and non stress test

Nausea and Vomiting Clinic – IV hydration and medication, assessment, teaching and coordination of support services as required (social work, public health, Healthiest Babies)

NB: (regular maternity care by physician and diagnostic tests provided outside of home, e.g. U.S.)

OPERATION

- **Office hours:**
  8:45 a.m. – 4:15 p.m. seven days per week
- **Staff:**
  - 1 regular full-time Program Coordinator
  - 4 regular .76 nurses and 1 regular .52 nurse
  - 2 nurses work Monday to Saturday and 1 nurse works on Sunday
  - Vacation/sickness and approximately .75 of an FTE to be shared between a casual pool of 5 RN's.
- **Capacity:**
  Maximum 12 women (capacity adjusted depending on acuity of combined conditions and driving time required)

to maintain normal activity.

The Nausea and Vomiting Clinic provides care to women with excessive nausea and vomiting of pregnancy who require intravenous re-hydration and anti-emetic therapy.

Appendix B: Program Description -- Neonatal Program

The following pages are a copy of the Neonatal Program's description of the services it provides, including a detailed description of Levels of Perinatal Care.

Overview of Levels of Perinatal Care

1. Rationale

The rationale for establishing a common classification system for levels of perinatal care across BC is that a common classification system:[1]

- Identifies standards for the provision of specified levels of care;
- Facilitates transfers of patients from one centre to another through a common understanding of the relative capabilities and expectations of each centre;
- Streamlines planning and allocation of resources;
- Facilitates comparisons of regional resource utilization and outcomes; and
- Supports the availability of appropriate funding and other resources for care centres.

2. Definitions

The levels of perinatal care described in this document outline the scope of services and treatments that are required to provide care to women and infants with varying levels of need. These requirements are guidelines and may need to be adapted to accommodate issues of geographic distances and/or isolation. Such factors may result in decisions by Level 1 and/or 2 centres to provide a component(s) of care that is normally provided only at higher level centres. These decisions are made on a planned basis for specific patients and follow consultation with specialists at Level, 2 or 3 centres (shared care).

Ideally, centres designated as Level I will provide both Level I maternal and Level I newborn care; similarly, hospitals designated as Level II centres will provide Level II maternal and Level II newborn care and Level III centres will provide Level III maternal and Level III newborn care. In cases where this is not feasible, centres should be located as close together as possible and will operate as a single system of care.

Level I Centre

1A: Normal singleton births; ≥36 weeks gestation & infants ≥2,500 grams; no on-site cesarean section capability available.

1B: Normal singleton births; ≥34 weeks gestation & infants ≥1,800 grams; on-site cesarean section capability available.

[1] Lee, Shoo, Canadian Pediatric Society, Fetus & Newborn Committee Statement, *Levels of Neonatal Care* (Draft), 2004

Services provided at Level I maternal and newborn centres are designed to meet the needs of women with healthy pregnancies and their newborns. In the event of unexpected outcomes, services at Level I centres allow for stabilization and transfer of women and/or their infants to higher level centres. Needs at Level I centres can be met without specialist support, although arrangements are in place to access specialists during times when such services are required. Caesarean section capabilities may or may not be available; if not available, protocols for emergency transfer to a centre with caesarean section capabilities are in place.

Community residents are aware of the level of services offered at Level I centres, and the system of care of which the local service is part. Women and their families are informed of the advantages, limitations and risks of utilizing local maternity care services, as well as those of traveling for care. Appropriate community and social support services, including discharge planning, are available to women and their families.

The provision of services at Level I centres involves collaboration and participation with Level II and III centres to facilitate the provision of coordinated and planned services within each health authority and across the province. Level I centres may participate in the education of health professionals and in research.

It is expected that Level I maternal and newborn centres will accept timely and appropriate referrals/transfers of women and infants from home births and transfers from Level II and III maternal and newborn centres, when appropriate.

Level II Centre

IIA: Singleton and some twin births; ≥32 weeks gestation & infants ≥ 1,500 grams; may have low risk medical/obstetrical/neonatal complications; 24/7 on-call specialty consultation & intensive care beds available.

IIB: Singleton and some twin births; ≥30 weeks gestation & infants ≥ 1,200 grams; may have moderate risk medical/obstetrical/neonatal complications; 24/7 on-call specialty consultation available; in-house staff skilled in intubation (MD, RN, or RT) available if infant on assisted ventilation.

Level II maternal and newborn centres have all of the functional capabilities provided at Level I centres. In addition, Level II centres offer support from specialists and are capable of managing the care of women and/or infants at low (Level IIA) to moderate (Level IIB) risk. Level IIB maternal centres have the resources available to carry out detailed fetal anatomy ultra sound examination and have access to biochemical screening. Infants with suspected fetal anomalies may be cared for by Level IIB centres, following consultation with a Level III centre.

Appropriate community and social support services, including bereavement counseling are available to women and their families at Level II centres. Level II centres participate in the education of health professionals and may participate in research.

The provision of services at Level II centres involves collaboration and participation with Level I and III centres to facilitate the provision of coordinated and planned services within each health authority and across the province.

It is expected that Level II maternal and newborn centres will accept timely and appropriate referrals/transfers of women and infants from home births and transfers from Level I and III maternal and newborn centres, when appropriate.

Level III Centre

The classification of Level III centres distinguishes between the risks of mothers, fetuses, and infants.

IIIA: Investigations and care of moderate to high risk maternal (medical, surgical or obstetrical) and/or neonatal complications; investigations of potentially high risk fetal complications; multiple births of any gestation & infant weight; 24/7 in-house medical coverage; access to 24/7 on call obstetrician, and pediatrician/neonatologist; day time access to maternal fetal medicine specialist and access to subspecialists on a planned basis.

IIIB: Investigations and care of high risk maternal (medical, surgical or obstetrical), fetal and/or neonatal complications; multiple births of any gestation & infant weight; medical coverage as per IIIA with the addition of access to on-call 24/7 maternal fetal medicine specialists, selected adult specialists and subspecialists (internal medicine, general surgery, gynecology, urology, medical genetics), selected pediatric subspecialists (surgeons and cardiologists) and daily access to adult infectious disease specialists and other pediatric subspecialists.

IIIC: Investigations and care of very high risk maternal (medical, surgical or obstetrical), fetal and/or neonatal complications; multiple births of any gestation & infant weight; medical coverage as per IIIB with the addition of access to all on-call adult and pediatric specialists and sub-specialists that may not be available in Level IIIB centres; 24/7 access to sub-specialty intensive care beds (highly complex ICU, CCU, neuro ICU, dialysis or oncology management).

Level III maternal, fetal and newborn centres have all the functional capabilities provided at Level I and II centres. In addition, Level III centres offer on-site 24/7 specialist support and are capable of managing the investigation and/or care of women, fetuses, and/or infants at moderate to high (IIIA), high (IIIB) or very high risk.

Level III maternal centres provide specialty care to women with high-risk pregnancies, including multiple pregnancies and singleton pregnancies of all gestational ages. The level of investigation and care provided to women and their fetuses progressively increases between Levels IIIA and Level IIIC to the point where Level IIIC centres provide care to women and their fetuses either or both of which may have severe complications or require complex diagnostic/therapeutic/surgical procedures. Diagnostic/therapeutic/surgical procedures for the mother may include but not be limited to dialysis, CCU care, ICU care, neurology ICU and oncology management. Diagnostic/therapeutic/surgical procedures for the fetus may include but not be limited to laser ablation for twin-twin transfusion syndrome, in utero thorocentesis, in utero bladder shunt and cordocentesis.

Level III newborn centres provide specialty care to unwell, unstable infants. Level IIIC centres also offer support from sub-specialists and provide care to fetuses and infants with anticipated complicated antenatal genetic or fetal anomalies that are anticipated to require immediate neonatal or surgical interventions.

In collaboration, Level III centres are responsible for organizing education programs tailored to meet the needs of their maternal and newborn health professionals, and those in facilities within their health authority, and beyond. Level III centres are expected to initiate and participate in research.

Appropriate community and social support services, including bereavement counseling are available to women and their families at Level III centres. The provision of services at Level III centres involves collaboration and participation with Level I and II centres to facilitate the provision of coordinated and planned services within each health authority and across the province.

It is expected that Level III maternal and newborn centres will accept timely and appropriate transfers of women and infants from home births and transfers from Level I and II maternal and newborn centres.

Level III centres will transfer women and infants back to Level II and I centres when appropriate, and in a timely manner. Level III centres will continue to provide all levels of care for residents living in their immediate community.

Obstetrical Services

Type of Maternity Patient	L1A	L1B	L2A	L2B	L3A, 3B, or 3C
Healthy pregnant women expected to deliver at ≥36 weeks where infant weight is expected to be ≥2,500 gm.	X				
Healthy pregnant women expected to deliver at ≥34 weeks where infant weight is expected to be ≥1,800 gm.		X			
Women experiencing low risk medical/obstetrical complications expected to deliver at ≥32 weeks where infant weight is expected to be ≥1,500 gm.			X		
Women experiencing mod risk medical/obstetrical complications expected to deliver at ≥30 weeks where infant weight is expected to be ≥1,200 gm.				X	
Women experiencing low, moderate or high risk medical/obstetrical complications expecting to deliver at any gestational age and any birth weight.					X
Twin pregnancies.			X		
> Twin pregnancies (e.g., triplets).				X (uncompl)	X (compl)

Neonatal Services

Type of Neonatal Patient	L1A	L1B	L2A	L2B	L3A, 3B, or 3C
Healthy infants at corrected gestational ages ≥36 weeks; some infants may have transient conditions that are expected to resolve quickly.	X				
Healthy infants ≥2,500 gm; some infants may have transient conditions that are expected to resolve quickly.	X				
Infants at corrected gestational ages ≥34 weeks who may have mild illnesses with problems that are expected to resolve quickly.		X			
Infants ≥1,800 gms who may have mild illnesses with problems that are expected to resolve quickly.		X			
Convalescent infants with chronic lung disease needing long term O^2 & monitoring and/or infants convalescing after a more intensive level of care.		X			
Infants at corrected gestational ages ≥32 weeks who have moderate illnesses with problems that are expected to resolve quickly but do not require ventilation.			X		
Infants at corrected gestational ages ≥30 weeks who have moderate illnesses requiring short-term ventilation (12-48 hrs) or continuous positive airway pressure.				X	
Infants of all gestational ages & weights, including those requiring ventilation.					X

Note:
The full document describing *Levels of Perinatal Care* is available on the BCRCP website. The document includes scope of services, tests/treatments, personnel, and diagnostic capabilities that are expected for each of the designated levels of care.

Appendix C: Description of Participants

Participant (n = 29)	Age (years)	Gender	Program Context	Relevant features of their work/lives
Nurse Participants (NP) (n = 9)				
NP 01	47	F		
NP 02	30	F		
NP 03	53	F		
NP 04	28	F		
NP 05	49	F		
NP 06	60	F		
NP 07	50	F		
NP 08	41	F		
NP 09	52	F		
Physician Participants (PP) (n = 3)				
PP 01	47	M		
PP 02	64	F		
PP 03	58	M		
Social Worker Participants (SW) (n = 3)				
SW 01	47	F		
SW 02	39	F		
SW 03	42	F		

Participant (n = 29)	Age (years)	Gender	Program Context	Relevant features of their work/lives
		Woman Participants (WP) (n = 13)		
WP 01	27	F	NICU	
WP 02	24	F	ACAHP	
WP 03	34	F	ACAHP	
WP 04	29	F	ACAHP	
WP 05	36	F	ACAHP	
WP 06	29	F	NICU	
WP 07	17	F	NICU	Described herself as a ‘young mom’
WP 08	31	F	ACAHP	
WP 09	36	F	NICU	
WP 10	30	F	ACAHP	
WP 11	29	F	NICU	
WP12	25	F	NICU	
WP 13	19	F	ACAHP	Lives with history of addiction

Note: F = female, M = male. NICU = Neonatal Program, ACAHP = Antepartum program.

Appendix D: Advertisement Poster for Women

Studying Relationships

between Childbearing Women, their Partners and Families, and Obstetric and Neonatal Health Care Providers

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing

•Would you be willing to share your past and present experience of the relationships you have or had with your health care providers during pregnancy, birth, and following birth?

•How were the interactions and relationships with your health care providers helpful or not helpful in preparing you during pregnancy, birth or following your baby's birth?

If you are receiving health care as a pregnant woman or have given birth within the last 6 months and would like more information about participating in this study, please contact:

Helen Brown, RN, MSN, PhD(Candidate)

[redacted]

Appendix E: Advertisement Poster for Health Care Providers

Studying Interactions

between Childbearing Women, their Partners and Families, and Obstetric and Neonatal Health Care Providers

"Poor communication can render ineffective all the good in medicine, as it has the potential to cause suffering" (David Kuhl, 2002)

•Do you think the 'people factor' is poorly understood by those delivering health care?

•Do relationships with health care providers have health effects? Do they make a difference to health status for childbearing women? If so, how?

•Could we improve our health care system if we knew more about the impact of health care relationships on both short and long-term health outcomes?

If these questions interest you, please consider participating in a research study about how health care relationships influence a woman's experience of quality health care.

To learn more, please contact:

Helen Brown RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing

Appendix F: Script and Information Sheet

Script/Information Sheet to Assist Advertisement of a Nursing Research Study

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

Study Title:
Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

Study Purpose:
To learn how childbearing women's interactions with their health care providers affect their efforts to be healthy during pregnancy, birth or following birth.

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing

WHAT IS THE RESEARCH STUDY ABOUT?
The study explores how health care providers' and childbearing women's experience of interactions or relationships influence their ability to be healthy during pregnancy, birth and recovery following birth. The researcher hopes to learn how relationships themselves either promote or constrain childbearing women's access to and experiences of health care that they would describe as meeting their needs. This study is being conducted by a graduate student as part of the requirements to complete a PhD in Nursing.

WHO IS PARTICIPATING IN THE RESEARCH?
I will be observing and talking with women who are receiving health care in this clinical site and health care providers providing women with their care during pregnancy, birth and following birth. I will be observing in this clinical setting at different hours of the day and on different days during the week for a period of up to 6 months. I will be making notes of my observations, interactions, and conversations with the research participants and interviewing health care providers and women who volunteer to participate in the study. I will also be taking photos of the clinical environment.

WHAT SHOULD I DO IF I AM INTERESTED IN PARTICIPATING?
If you have questions about the study or about what being a research participant involves, and would like more information, you can give your nurse permission to give your name and contact number to the researcher or contact her directly at:

Helen Brown @ XXX-XXXX

Appendix G: Ethical Approvals

University of Victoria

Human Research Ethics Board
Office of Research Services
University of Victoria
Room A240 University Centre
Tel (250) 472-4545 Fax (250) 721-8960
Email ovprhe@uvic.ca Web www.research.uvic.ca

Human Research Ethics Board
Certificate of Approval

Principal Investigator	Department/School	Supervisor
Helen Brown **Graduate Student**	**NURS**	**Dr. Gweneth Doane** **Dr. Patricia Rodney**
Co-Investigator(s):		

Project Title: **Facilitating Childbearing Women's Capacities for Health through Health Care Relationships**

Protocol No.	Approval Date	Start Date	End Date
538-04	**25-Jan-05**	**25-Jan-05**	**24-Jan-06**

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

Dr. Richard Keeler
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of a "Research Status" form.

538-04 Brown, Helen

fraserhealth
Better health. Best in health care.

Fraser Health
Research Ethics Board
Office of Research Services
#300, 10334 152A Street, Surrey, BC V3R 7P8
Phone: 604.587.4436 Fax: 604.587.4666

CERTIFICATE OF FHREB APPROVAL

Official Notification - FHREB Number *(to be used on all future correspondence)*: **2005-09**		
Principal Investigator: Ms H Brown, PhD Candidate	Hospital/Facility & Department: University of Victoria School of Nursing	
Institution(s) or Geographical Areas where research will be carried out:		
Co-Investigator(s): none		
Sponsoring Agencies and/or Corporate Sponsor: none		
Title: Facilitating Childbearing Women's Capacities for Health Through Health Care Relationships		
Approval Date: 08Mar05	Term, if less than one year:	Type of Approval: __X__Expedited ____Full FHREB Review
Documents Included in this Approval: Consent (Mothers), Consent (Providers), 25 January 2005. Interview. Group Discussion Consent (Family and Providers). Script. University of Victoria Approval 538-04, 25 January 2005.		

CERTIFICATION:

With respect to clinical trials:

1. The membership of the Fraser Health Research Ethics Board complies with the membership requirements for research ethics boards as defined in Division 5 of the Food and Drug Regulations and the Tri-Council Policy Statement.
2. The Fraser Health Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices.
3. The Fraser Health Research Ethics Board has reviewed and approved the clinical trial protocol and the informed consent form for the trial which is to be conducted by a qualified investigator named at the specified clinical trial site. This approval and the view of the Fraser Health Research Ethics Board have been documented in writing.

A board co-chairman of the FHREB has reviewed the documentation included for the above-named project for expedited review. Full FHREB review of documentation was completed for non-expedited review as defined in the Tri-Council Policy. The documentation presented for all aspects of this study has been found to be acceptable on ethical grounds for research involving human subjects. Any required modifications, as noted in written demands from the FHREB, must be done prior to this approval certificate being in effect.
This form is modified from documentation used by the University of British Columbia.

The FHREB approval for this study expires one year from the approval date.
Investigators must submit a Request for Annual Renewal for projects to receive official re-approval.

08 Mar 2005

~~APPROVAL OF THE FHREB BY ONE OF:~~
DR A BELZBERG or DR MR FOULKES
CO-CHAIRS, FHREB

DATE OF SIGNATURE

Appendix H: Information and Consent Form For Women Participants

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

You are being invited to participate in a study entitled **Facilitating Childbearing Women's Capacities for Health through Health Care Relationships** that is being conducted by Helen Brown. Helen is a Graduate Student in the School of Nursing at the University of Victoria and you may contact her if you have further questions by calling 604-671-2220 or by email hbrown@telus.net.

As a Graduate Student, I am required to conduct research as part of the degree requirements for a PhD in Nursing . It is being conducted under the supervision of Dr. Gweneth Doane and Dr. Patricia Rodney. You may contact either of my supervisors at 250-721-6191 (Dr. Doane) or 604-601-7176 (Dr. Rodney).

This research is being funded by the Michael Smith Foundation for Health Research and the Social Science Humanities Research Council of Canada.

The purpose of this research project is to explore your experience of the interactions and/or relationships you have with your health care provider, particularly for how these interactions and relationships may influence your ability to be healthy (as you define 'healthy'), and that results in, and meets your expectations for, quality or 'good' care during pregnancy and/or following your baby's birth. The questions I hope to answer in this study are the following:

1. What makes a health care relationship good from the perspective of childbearing women?
2. How do relationships between health care providers and childbearing women influence women's capacities for health?
3. How do relationships promote or constrain childbearing women's access to and experience of good health care?
4. How do relationships between health care providers and childbearing women shape the context within which such relationships take place?
5. How are relationships between health care providers and childbearing women shaped by the context within which they take place?

Research of this type is important because very little is know about how interactions among childbearing women and their health care providers actually influence health care received, particularly from the perspective of women themselves. This information is

important if we aim to create and reform existing health care systems for women that are responsive to their childbearing health care needs. There has been relatively little research into how relational experiences actually influence the quality of care received and health outcomes from the perspective of women patients and their families. We also know very little about how health care providers themselves see their relationships with patients, particularly for how they may influence the quality of care delivered to women. This study aims to understand perspectives from both women and health care providers.

You are being asked to participate in this study because you are receiving health care through the Perinatal/Neonatal and/or Child and Youth programs in the Fraser Health Authority. The people being recruited for the study are childbearing women and their adult/family members and perinatal and neonatal health care providers who choose to participate. This means women who are seeking to become pregnant (such as fertility clinics), are currently pregnant (such as receiving antepartum care, or other forms of ambulatory care), and women whom have given birth to their infants up until the infant is 6 months of age (for example, neonatal intensive care unit or women receiving postpartum care) and their self-defined partners/families are eligible to enroll. The decision to interview your adult family member or partner in the study is your decision and is not required for you to participate. Only women and health care providers who cannot provide informed consent on their own behalf and those who cannot speak or write English (as either a first or second language) will be excluded from the study.

If you agree to voluntarily participate in this research, your participation will include being observed and interviewed either within the clinical area of in another location that you select (such as your home). The interviews will be guided by 4 questions that will act as ‘triggers’ to our conversation. You are free to see these questions in advance if you wish to do so and can refuse to answer any of the questions during the interview itself. The questions are derived from the research questions presented at the beginning of this document. I will request to observe, write field notes, and informally and/or formally interview you and your adult family member(s) or partner based your decision to request their involvement. I will also be taking photos of the clinical area in which you receive care, but will not be photographing you or other people in the area.

Interviews can take place either on or away from the clinical area. I will negotiate times with your that are least intrusive and convenient. For example, you may find that an interview following their discharge from hospital may be less intrusive and more convenient that during their hospital admission. Or, you may be willing to talk and engage in an interview during observational periods or during your hospital admission. I will follow your lead during observations and interviews so as to ensure they are least intrusive and most convenient to enable your participation during a period in which you may be experiencing some degree of upheaval and stress. I will request from 1-3 interviews (approximately 1-2 hours in length) throughout the over the 6 month data collection period. I may request, if the opportunity arises, your participation in group discussion but you may refuse and limit your participation to observation and individual interviews only. A separate consent form has been developed for group interviews should you choose to participate.

The potential benefits of your participation in this research, as shown to be the case with this type of research, that arise during interviews and informal conversations are opportunities to make sense of past experiences, see current experiences in new ways,

and imagine productive ways of moving forward in your future interactions/relationships with health care providers. You can also be assured that contributing to knowledge about how health care relationships and health care systems can be more responsive to women's needs and experiences hold a potential benefit for society in general.

Participation in this study may cause some inconvenience to you, primarily in terms of time to participate in informal and formal interviews and/or observations. There are some potential risks to you by participating in this research and they include possibly feeling fatigued or stressed, experiencing some emotional and psychological discomfort or feeling as though you have lost some privacy depending on what you choose to speak to me about during to the research. There is only a small chance that you may experience the above risks due to the nature of the topic being research, for example, if health care providers or women participants are experiencing unsatisfying relationships with one another, speaking about these and contemplating the effects may create a sense of emotional discomfort.

The following steps will be taken to prevent or deal with these risks:

- ✓ Sharing the semi-structured interview/trigger questions with participants prior to formal interviews (Appendix 3)
- ✓ Inform participants that at anytime during the research, either during observation, conversation or an interview, that if they become upset that I will attend to their experience by offering a break, rescheduling the research activity or by stopping the conversation/observation/interview altogether.
- ✓ If the participants become emotionally fragile or upset, I will offer to debrief with the person or call a support person (friend, partner, family member) and stay with the participant until he/she/they arrive.
- ✓ I will provide a list of referral support services to the participants
- ✓ By being transparent and ethical in all research activities and processes

Your participation in this research must be <u>completely voluntary</u>. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. You will receive information in a timely manner that may concern your participation in the study (for example, if the researcher seeks approval to extend the data collection period beyond 6 months). If you do withdraw from the study and you do not want your data to remain in the study, all attempts will be made to destroy the data immediately by:

1. Shredding any hard copies made of the data, including transcripts and fieldnotes.
2. Erasing the segment(s) of the audiotape where you spoke.
3. Erasing the data from computers, floppy disks, and related storage devices (e.g. Floppy discs, CD's and ZIP drives).

To make sure that you continue to consent to participate in this research, I will ask you about your continued consent monthly during the 6 month data collection period. During these times you can raise questions about the study. I will also ask you to initial the consent form during subsequent research activities during the 6 month period.

In terms of protecting your anonymity, I will provide you with a participant code and you will not be identified by your name in the study nor by your responses, my observations

and data that you are involved in producing. Your confidentiality and the confidentiality of the data will be protected by assigning you a participant code name and number so that you can never be identified. Your code number will be used in all typed transcripts, field notes, reports or publications. All of your biographical data will be masked to protect confidentiality (such as changing the number of children in the family). I will make every effort to uphold confidentiality unless a situation arise that I am required for legal reasons to report (i.e. physical abuse to adults or children).

The data will be kept by myself and will be used to compile the final dissertation report. It will also be used for future presentations and publications, and for possible secondary analysis in other related research. No data will be kept that identifies individuals or agencies. No data will be released to anyone outside the researcher's supervisory committee. I will have regular access to the data (audiotapes, photo's fieldnotes, and transcripts). All data will be stored in a locked cabinet in my home office. Any person involved in transcription will sign a form promising that all data will be returned to me and will be kept confidential. The one exception to confidentiality that could arise is if particular research data is subpoenaed for legal purposes. Such subpoenas of research data are extremely rare. Only those data directly requested by the court would be made available, and only individuals involved in the legal proceedings would have access to the data. Data from this study will be disposed of after a 10 year period. During this period, I understand that my data maybe used for secondary analysis for related research projects .After the 10 year period, data will be destroyed, audiotapes will be erased, and transcripts and fieldnotes will be shredded and electronically erased.

It is anticipated that the results of this study will be shared with others in the following ways: through the written dissertation report to complete the PhD in Nursing, in written publications in professional journals, through publications and educational materials for childbearing women and through conference presentations to health care providers. Some of the findings may also be used in educational programs that prepare nurses to work with childbearing women.

In addition to being able to contact the researcher and the faculty supervisors at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545). As a research participant, you do not waive any of your legal rights by signing the consent form.

Your signature below indicates that you consent to participate in the study described herein, that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers. Your signature also indicates you have received a copy of this information and consent form.

Name of Participant	*Signature*	*Date*
Name of Witness	*Signature*	*Date*
Name of Principal Investigator	*Signature*	*Date*

If you would like a summary of the final report, please indicate how you would like it to be received –

_____

Thank you for your time and interest.

A copy of this consent will be left with you, and a copy will be taken by the researcher.

If you have concerns or questions during this study, you can call Helen Brown at anytime (24 hours a day, seven days per week) at XXX-XXX-XXXX

You may also contact the Fraser Health REB located through FH management at XXX-XXX-XXXX with concerns or questions related to this research study

Appendix I: Information and Consent Form For Health Care Provider Participants

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

You are being invited to participate in a study entitled Facilitating Childbearing Women's Capacities for Health through Health Care Relationships that is being conducted by **Helen Brown**. Helen is a Graduate Student in the School of Nursing at the University of Victoria and you may contact her if you have further questions by calling xxx xxx-xxxx or by email hbrown@telus.net.

As a Graduate Student, I am required to conduct research as part of the degree requirements for a PhD in Nursing. It is being conducted under the supervision of Dr. Gweneth Doane and Dr. Patricia Rodney. You may contact either of my supervisors at 250-721-6191 (Dr. Doane) or 604-601-7176 (Dr. Rodney).

This research is being funded by the Michael Smith Foundation for Health Research and the Social Science Humanities Research Council of Canada.

The purpose of this research project is to explore your views on how interactions and/or relationship with childbearing women influence women's access to and experience of health care that lead to health outcomes they would describe as 'good'. The questions I hope to answer in this study are the following

1. What makes a health care relationship good from the perspective of health care providers and childbearing women?
2. How do relationships between health care providers and childbearing women influence women's capacities for health?
3. How do relationships promote or constrain childbearing women's access to and experience of good health care?
4. How do relationships between health care providers and childbearing women shape the context within which such relationships take place?
5. How are relationships between health care providers and childbearing women shaped by the context within which they take place?

Research of this type is important because very little is know about how interactions among childbearing women and their health care providers actually influence health care received, particularly from the perspective of women themselves. This information is important if we aim to create and reform existing health care systems for women that are responsive to their needs thereby leading to positive health outcomes. There has been relatively little research into how relational experiences actually influence the quality of care received and health outcomes from the perspective of women patients and their families. We also know very little about how health

care providers themselves see their relationships with patients, particularly for how they may influence the quality of care delivered to women. This study aims to understand perspectives from both women and health care providers.

You are being asked to participate in this study because you are providing health care to childbearing women through the Perinatal/Neonatal and/or Child and Youth programs in the Fraser Health Authority. Participant being recruited for the study are childbearing women and their adult/family members as well as perinatal and neonatal health care providers who choose to participate. Women who are seeking to become pregnant (such as fertility clinics), are currently pregnant (such as receiving antepartum care, or other forms of ambulatory care), and women whom have given birth to their infants up until the infant is 6 months of age (such as neonatal intensive care unit or women receiving postpartum care) and their self-defined partners/families are eligible to enroll. Any health care provider interested in this topic is eligible to enroll. Only women and health care providers who cannot provide informed consent on their own behalf and those who cannot speak or write English (as either a first or second language) will be excluded from the study.

If you agree to voluntarily participate in this research, your participation will include being observed and interviewed either within the clinical area of in another location that you select (for example, your office, staff room, conference room). The interviews will be guided by 4 questions that will act as 'triggers' to our conversation. You are free to see these questions in advance if you wish to do so and refuse to answer any of the questions during the interview itself. The questions are derived from the research questions presented at the beginning of this document. I will request to observe, write field notes and informally and/or formally interview you if you choose to participate. I will follow your lead during observations and interviews so as to ensure they are least intrusive and most convenient to enable your participation while you providing care to women patients. I will request from 1-3 interviews (approximately 1-2 hours in length) throughout the over the 6 month data collection period. I may request, if the opportunity arises, your participation in group discussion but you may refuse and limit your participation to observation and individual interviews only. A separate consent form has been developed for group interviews should you choose to participate. I may also request to be present for observations of your health care interactions at a time that is convenient and agreeable to you. I will also be taking photos of the clinical area in which you receive care, but will not be photographing anyone who could be identified.

The potential benefits of your participation in this research, as shown to be the case with this type of research, that arise during interviews and informal conversations are opportunities to make sense of past experiences, see current experiences in new ways, and imagine productive ways of moving forward in your future interactions/relationships with patients and their partners/families. You can also be assured that contributing to knowledge about how health care relationships and health care systems can be more responsive to women's needs and experiences hold a potential benefit for society in general.

Participation in this study may cause some inconvenience to you, primarily in terms of time to participate in informal and formal interviews and/or observations. There are some potential risks to you by participating in this research and they include possibly feeling fatigued or stressed, experiencing some emotional and psychological discomfort or feeling as though you have lost some privacy depending on what you choose to speak to me about during to the research. There is only a small chance that you may experience the above risks due to the nature

of the topic being research. For example, if health care providers are experiencing unsatisfying relationships with one another or with women patients, then speaking about these and contemplating the effects may create a sense of emotional discomfort.

The following steps will be taken to prevent or deal with these risks:

- ✓ Sharing the semi-structured interview/trigger questions with participants prior to formal interviews (Appendix 3)
- ✓ Inform participants that at anytime during the research, either during observation, conversation or an interview, that if they become upset that I will attend to their experience by offering a break, rescheduling the research activity or by stopping the conversation/observation/interview altogether.
- ✓ If the participants become emotionally fragile or upset, I will offer to debrief with the person or call a support person (friend, partner, family member) and stay with the participant until he/she/they arrive.
- ✓ I will provide a list of referral support services to the participants
- ✓ By being transparent and ethical in all research activities and processes

Your participation in this research must be **completely voluntary.** If you do decide to participate, you may withdraw at any time without any consequences or any explanation. You will receive information in a timely manner that may concern your participation in the study (for example, if the researcher seeks approval to extend the data collection period beyond 6 months). If you do withdraw from the study and you do not want your data to remain in the study, all attempts will be made to destroy the data immediately by:

1. Shredding any hard copies made of the data, including transcripts and fieldnotes.
2. Erasing the segment(s) of the audiotape where you spoke.
3. Erasing your data from computers, floppy disks, and related storage devices (e.g. floppy discs, CD's and ZIP drives).

To make sure that you continue to consent to participate in this research, I will ask about your continued consent monthly during the 6 month data collection period. During these times you can raise questions about the study. I will also ask you to initial the consent form during subsequent research activities during the 6 month period.

In terms of protecting your anonymity, I will provide you with a participant code and you will not be identified by your name in the study nor by your responses, my observations and data that you are involved in producing. Your confidentiality and the confidentiality of the data will be protected by assigning you this participant code name and number so that you can never be identified. Your code number will be used in all typed transcripts, field notes, reports or publications. All of your biographical data will be masked to protect confidentiality (such as changing the number of children in the family). I will make every effort to uphold confidentiality unless a situation arise that I am required for legal reasons to report (i.e. physical abuse to adults or children).

The data will be kept by myself and will be used to compile the final dissertation report. It will also be used for future presentations and publications, and for possible secondary analysis in other related research. No data will be kept that identifies individuals or agencies. No data will be released to anyone outside the researcher's supervisory committee. I will have regular access

to the data (audiotapes, photo's, fieldnotes, and transcripts). All data will be stored in a locked cabinet in my home office. Any person involved in transcription will sign a form promising that all data will be returned to the me and will be kept confidential. The one exception to confidentiality that could arise is if particular research data is subpoenaed for legal purposes. Such subpoenas of research data are extremely rare. Only those data directly requested by the court would be made available, and only individuals involved in the legal proceedings would have access to the data. Data from this study will be disposed of after a 10 year period. During this period, I understand that my data maybe used for secondary analysis for related research projects .After the 10 year period, data will be destroyed, audiotapes will be erased, and transcripts and fieldnotes will be shredded and electronically erased.

It is anticipated that the results of this study will be shared with others in the following ways: through the written dissertation report to complete the PhD in Nursing, in written publications in professional journals, through publications and educational materials for childbearing women and through conference presentations to health care providers. Some of the findings may also be used in educational programs that prepare nurses to work with childbearing women.

In addition to being able to contact the researcher and the faculty supervisors at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545). As a research participant, you do not waive any of your legal rights by signing the consent form.

Your signature below indicates that you consent to participate in the study described herein, that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers. Your signature also indicates you have received a copy of this information and consent form.

Name of Participant	*Signature*	*Date*
Name of Witness	*Signature*	*Date*
Name of Principal Investigator	*Signature*	*Date*

If you would like a summary of the final report, please indicate how you would like it to be received -

_____

Thank you for your time and interest.

A copy of this consent will be left with you, and a copy will be taken by the researcher.

If you have concerns or questions during this study, you can call <u>Helen Brown</u> at anytime (<u>24 hours a day, seven days per week</u>) at (604)671-2220

You may also contact the Fraser Health REB located through FH management at 604-587-4690 with concerns or questions related to this research study

Appendix J: Information and Verbal Consent for Secondary Participants during Observational Periods

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

This handout provides information and verbal consent for women patients and partners/family members about being secondary participants in a study being conducted in this clinical site by a nurse completing a PhD in Nursing from the University of Victoria

Study Title:
Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

Study Purpose:
To learn how childbearing women's interactions with their health care providers affect their efforts to be healthy during pregnancy, birth or following birth.

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing
Contact 604-671-2220

WHAT IS THE RESEARCH STUDY ABOUT?

The study explores how health care providers' and childbearing women's experience of interactions or relationships influence their ability to be healthy during pregnancy, birth and recovery following birth. I hope to learn how relationships themselves promote or constrain childbearing women's access to and experiences of health care that they would describe as meeting their needs.

WHO IS PARTICIPATING IN THE RESEARCH?

I will be observing and talking with women who are receiving health care in this clinical site and health care providers providing women with their care during pregnancy, birth and following birth. I will be in this clinical setting at different hours of the day and on different days during the week for a period of up to 6 months. I will be making notes of my observations, interactions, and conversations with the research participants.

HOW MIGHT THIS STUDY AFFECT ME?

This study involves as observational period (one month) and a period of data collection with women patients (over 5 months) and health care providers who consent to participate. Since you are receiving care in this clinical area during this period of observation I require that you consent to have me present for this observation period. For these reasons I am seeking your verbal consent to have me present which indicate that you agree to being a secondary participant in the study. This means you consent to have me present during observations and when making notes about what I see and hear. During the observational period, I will be present in the clinical area observing, interacting and talking with women and health care provider providers. During the data collection period, you will see me talking directly to consenting research participants either individually or in groups. I may also be taking photos of the clinical environment, but will not at anytime be photographing yourself or other people in the clinical area. In the course of observing you and your health care provider, you may refuse to have me present at anytime. There are no known risks or inconveniencies associated with being a secondary participant in this study.

I will record your consent in my research journal based on a code number identifier. I will check with you to see if you agree to my presence or if you refuse to have me around you or your family members. I will understand if you would rather not have me present. You can speak with myself or your nurse to inform me of your preference.

- ✓ Your decision to participate or not in the study as a secondary participant **will not** affect your treatment or care you receive as a patient in the clinical area.
- ✓ Taking part in this study is voluntary
- ✓ You can change your mind about participating at any time, ask me to leave and refuse to talk to me

HOW WILL THE PRIVACY OF PATIENTS AND OTHERS BE PROTECTED?

For women patients who are too stressed, anxious, ill or too weak to be observed, I will obtain verbal consent from a family member, guardian or caregiver. If that is not possible, or if the family member, guardian or caregiver refuses then I, the researcher, will not make notes on any observations or interactions that I have with women patients her partner/family.

- **I will not be keeping records of anyone's name or the name of the hospital at any time. All photos will be stripped of hospital identification**
  - The research information *with identifying information (codes but no names)*
    - will be kept by myself, the researcher
    - will be locked in an office that only I will have access to
    - will only be released to myself and doctoral supervisory committee (Dr. G Doane or Dr. P. Rodney)

- The research information *without identifying information (no names and stripped of specific details):*
    - will be used to write the final report
    - will be used for future publications and presentations
    - will be used possibly for secondary analysis in other related research

If you would like more information about the study, feel free to speak with myself, Helen Brown, at
(xxx) xxx-xxxx. You have the right to request that I do not include observations of you in the study.

You may also call any of the following people below if you have concerns or questions:

Dr. Gweneth Doane, University of Victoria, School of Nursing
(xxx) xxx-xxxx
Dr. Paddy Rodney, University of Victoria, School of Nursing
(604) xxx-xxxx
University of Victoria, Associate Vice-President Research
(xxx) xxx-xxxx or ovprhe@uvic.ca.

Appendix K: Information and Verbal Consent for Secondary Health Care Provider Participants during Observation Periods

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

This handout provides information and verbal consent for women patients and partners/family members about a study being conducted in this clinical site by a nurse completing a PhD in Nursing from the University of Victoria

Study Title:
Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

Study Purpose:
To learn how childbearing women's interactions with their health care providers affect their efforts to be healthy during pregnancy, birth or following birth.

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing
Contact xxx xxx-xxxx

WHAT IS THE RESEARCH STUDY ABOUT?

The study explores how health care providers' and childbearing women's experience of interactions or relationships influence their ability to be healthy during pregnancy, birth and recovery following birth. I hope to learn how relationships themselves promote or constrain childbearing women's access to and experiences of health care that they would describe as meeting their needs.

WHO IS PARTICIPATING IN THE RESEARCH?

I will be observing and talking with women who are receiving health care in this clinical site and health care providers providing women with their care during pregnancy, birth and following birth. I will be in this clinical setting at different hours of the day and on different days during the week for a period of up to 6 months. I will be making notes of my observations, interactions, and conversations with the research participants.

HOW MIGHT THIS STUDY AFFECT ME?

This study involves as observational period (one month) and a period of data collection with women patients (over 5 months) and health care providers who consent to participate. Since you are providing care in this clinical area to women during this period of observation I require that you consent to have me present for this observation period. I am seeking your verbal consent to have me present during this period which implies that you consent to becoming a secondary participant in the study. This means you consent to have me present during observations and for making notes about what I see and hear. During the observational period, I will be present in the clinical area observing, interacting and talking with women and health care provider providers. During the data collection period, you will see me talking directly to consenting research partcipants either individually or in groups. I may also be taking photos of the clinical environment, but will not at anytime be photographing yourself or other people in the clinical area. In the course of observing you, you may refuse to have me present at anytime. There are no known risks or inconveniencies associated with being a secondary participant in this study.

I will record your consent in my research journal based on a code number identifier. I will check with you to see if you agree to my presence or if you refuse to have me around you in the clinical area. I will understand if you would rather not have me present. You can speak with myself to inform me of your preference.

- ✓ Your decision to participate or not in the study as a secondary participant, **will not** affect your employment status in this organization or clinical program.
- ✓ Taking part in this study is voluntary
- ✓ You can change your mind about participating at any time, ask me to leave and refuse to talk to me

HOW WILL THE PRIVACY OF PATIENTS AND OTHERS BE PROTECTED?

For women patients who are too stressed, anxious, ill or too weak to be observed, I will obtain verbal consent from a family member, guardian or caregiver. If that is not possible, or if the family member, guardian or caregiver refuses then I, the researcher, will not make notes on any observations or interactions that I have with women patients her partner/family.

- I will not be keeping records of anyone's name or the name of the hospital at any time. All photos of the clinical practice area will be stripped of hospital identification

  - The research information *with identifying information (codes but no names)*
    - will be kept by myself, the researcher
    - will be locked in an office that only I will have access to
    - will only be released to myself and doctoral supervisory committee (Dr. G Doane or Dr. P. Rodney)
- The research information *without identifying information (no names and stripped of specific details):*
  - will be used to write the final report
  - will be used for future publications and presentations
  - will be used possibly for secondary analysis in other related research

If you would like more information about the study, feel free to speak with myself, Helen Brown, at
xxx xxx-xxxx. You have the right to request that I do not include observations of you in the study.

You may also call any of the following people below if you have concerns or questions:

Dr. Gweneth Doane, University of Victoria, School of Nursing
xxx xxx-xxxx
Dr. Paddy Rodney, University of Victoria, School of Nursing
xxx xxx-xxxx
University of Victoria, Associate Vice-President Research
xxx xxx-xxxx or ovprhe@uvic.ca.

Appendix L: Overview of Methods and Data Sources

Method	Frequency	Data
Taped semi-structured interviews	12	Transcripts
Tape unstructured conversations	9	Transcripts
Informal conversations	Phone - 4 Email - 3	Field notes, emails
Observations	220 hours	Field notes
Home visits with ACAHP Nurses	13	Field notes
Home visits to women participants	10	Field notes
Group conversations (focus groups rounds, lunch room, staff meetings)	6	Transcripts
Researcher field notes	March 2005 – January 2006	Field notes
Participant field notes	May - November, 2005	2 nurse's journal 1 woman's journal
	Total	27 transcripts 3 participant journals Researcher's field notes

Appendix M: Information and Consent for Group Discussion: Women Participants

Study Information and Verbal Consent to Participate in Group Discussions: Women Patient Participants

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

This handout provides information and verbal consent for women patients and partners/family members to participate in group discussion for a study being conducted in this clinical site by a nurse completing a PhD in Nursing from the University of Victoria

Study Title:
Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

Study Purpose:
To learn how childbearing women's interactions with their health care providers affect their efforts to be healthy during pregnancy, birth or following birth.

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing

WHAT IS THE RESEARCH STUDY ABOUT?

The study explores how health care providers' and childbearing women's experience of interactions or relationships influence women's ability to be healthy during pregnancy, birth and recovery following birth. I hope to learn how relationships themselves promote or constrain childbearing women's access to and experiences of health care that they would describe as meeting their needs.

HOW IS THE RESEARCH BEING CONDUCTED?

This study involves observing, talking with, and interviewing health care providers and women who are receiving health care in this clinical program over a 6 month period. I will also be taking photos of the clinical environment in which health care is delivered to women. I am also observing and talking with women and health care providers when they come together in group conversation to learn about how health care relationships impact women's health during pregnancy and the period following birth. Group discussions are one way of collecting data for the overall study and involve note

talking, observations, and audiotaping if all group members provide verbal consent. Group discussions usually take 1 hour, depending on the nature of discussion. I will seek consent from group members for each discussion I join. Each group member's privacy will be protected by having the opportunity to review transcripts from the discussion and have the option to delete their comments and statements from being recorded as data.

WHAT IS EXPECTED OF ME?

In the case of group discussion, where anonymity cannot be ensured, all efforts will be made to uphold confidentiality and protect the privacy of group members. At any time, you have the right to withdraw your comments from transcripts and/or refuse to continue in the group discussion without reason or consequence. You have the right to withdraw any or all of your responses that are offered in group discussion. You may also ask that I leave the group discussion at anytime.

If you would like more information about this study, or are interested in becoming a primary research participant, please contact:

Helen Brown, RN, MSN, PhD (Candidate)
xxx xxx-xxxx
hbrown@telus.net

You may also call any of the following people below if you have concerns or questions:

Dr. Gweneth Doane, University of Victoria, School of Nursing
xxx xxx-xxxx
Dr. Paddy Rodney, University of Victoria, School of Nursing
xxx xxx-xxxx
University of Victoria, Associate Vice-President Research
xxx xxx-xxxx or ovprhe@uvic.ca.

Appendix N: Information and Consent for Group Discussion: Health Care Provider Participants

[Logo]

[Health Authority]
Clinical Research Ethics Board
Office of Research Services
[Address and Contact Information]

This handout provides information and verbal consent for health care providers to participate in group discussion for a study being conducted in this clinical site by a nurse completing a PhD in Nursing from the University of Victoria

Study Title:
Facilitating Childbearing Women's Capacities for Health through Health Care Relationships

Study Purpose:
To learn how childbearing women's interactions with health care providers affect their efforts to be healthy during pregnancy, birth or following birth.

The Researcher:
Helen Brown, RN, MSN, PhD (Candidate)
University of Victoria, School of Nursing

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Appendix O: Interview Trigger Questions

Interview Trigger Questions

Question 1a (*Women Participants*)

> Can you describe to me your past experience of interactions with health care providers, both positive and/or negative?

Question 1b. (*Health Care Providers*)

> Can you describe to me your past experience of interactions with women patients and their partners/families, both positive and/or negative?

Question 2a. (*Women Participants*)

> How have your interactions with health care providers influenced your ability to receive health care that you would describe as “good” (for example, meeting your needs)

Question 2b. (*Health Care Providers*)

> How do you think your interactions with childbearing women shape how they experience health care and get what they need during pregnancy and the postpartum period?

Question 3.

> What makes a relationship between a health care provider and a women patient/family ‘good’ in your view?

Question 4.

> How does the environment in which you provide/receive care influence the care you provide/receive?

Question 5.

> What impacts the way you act in relation to patients/ your health care provider(s)?