

Embodied Ethics: A Phenomenology of the Neonatal Nurse's Touch

by

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## Abstract

This phenomenological study explores the lived experience of the nurse's touch in the neonatal intensive care unit (NICU). Touch is deeply embedded within NICU nursing, sometimes so taken-for-granted as to seem invisible, but implied in nearly every nursing gesture and pursuit. Inserting an intravenous line, bathing a baby, assessing vital signs, holding and rocking a baby to sleep, and more; all are rich with the immediacy and intimacy of bodily contact and dependent on sensitive, capable gestures of touch. The manifold meanings of human touch may also go unrecognized, obscured within the tasks and work of nursing. Interpreting touch as simply the medium for nursing tasks may fail to capture the more originary meaning of touch between people as an ethical encounter, that quietly inheres in everyday moments of contact. In this study, I reflect on the nurse's touch as a site of relation, revealing the felt sense of ethical demand experienced in the interface of touching contact.

The project is situated in the qualitative research methodology *phenomenology of practice* (van Manen, 2014). Given to cultivating rich and ethically sensitive understandings of human life as it is lived, this form of interpretive inquiry is a strong fit with exploring the subtleties and sensualities of contact in an investigation of the embodied nature of the nurse's touch. This inquiry is set primarily in the NICU where it is hard to imagine a human being that requires more delicate, nuanced, and skillful touch than the premature and ill newly born baby. By attempting to describe these practices and their possible meanings, my intention is to show that the ethical significance and contribution of touch might be realized as the corporeal wisdom of the nurse. This understanding may have a formative effect on our individual and professional consciousness, conversations, and curricula.

Findings, insights, and explorations of the research are collected in three manuscripts. In the first paper, I consider the phenomenological interview as a means to gather detailed experiential description of the phenomenon under study. Using examples, I emphasize the methodological importance of detailed concrete descriptions of experience in phenomenological inquiry. I grapple with *how* to practice the phenomenological reduction during the interview, in service to setting aside preconceptions and assumptions about the focus of the study, including how to recognize concrete descriptions. In an important sense the researcher is trying to be invited into the participant's world and to stand alongside them in a lived-through moment.

In the second article, I have composed the research text around the following interpretive themes: the learning touch: finding a way to hold the baby; the marking touch: when touch lingers long after physical contact; the missing touch: or touching without physical contact; the gnostic touch: the possibility of knowing an other and ourselves; and the call of touch: drawn to hold. Exploring the touching gestures of the NICU nurse discloses the relational ethics at the heart of these caring practices. We reveal and appear to each other, baby to nurse and nurse to baby, through the proximity and closeness of touch. I explore further the experience of the nurse's touch in the third manuscript, through phenomenological reflection on descriptive accounts of the nurse's touch from poetry, fictional prose, neonatal nurse interviews, as well as scholarly and personal accounts. These examples help to cultivate insights into the nurse's touch as a site for an ethical encounter, while contemplating the normative character of a good touch. The human connection of intimate contact -- both touching and being touched -- holds the possibility of transformation for the nurse.

## Preface

The dissertation is the original work of Gillian Lemermeier. Ethics approval to conduct the dissertation research study was received from the University of Alberta Research Ethics Board, Project Name *Relational Ethics of Touch*, No. pro 00079444, April 10, 2018. The questions that inspire and ground this research study germinated during my clinical nursing practice in three neonatal intensive care units, two of which are situated in Edmonton, Alberta and the third in Denver, Colorado.

A version of Chapter 2 is in preparation for submission to *Qualitative Research* as “Lemermeier, G. The Unique Intimacy of Phenomenological Research Interviews”. I was responsible for the conceptualization and drafting of the manuscript.

A final version of Chapter 3 was accepted for publication in *Qualitative Health Research* (Sage Publications) and is currently in press as “Lemermeier, G. (2021). Embodied ethics: Phenomenology of the NICU Nurse’s Touch”. I was responsible for the conceptualization and design of the study, recruiting participants, gathering phenomenological data via interview and observation, analyzing and reflection, and drafting the manuscript.

A final version of Chapter 4 has been submitted for publication in *Medical Humanities* as “Lemermeier, G. In good hands: The Phenomenological Significance of Human Touch for Nursing Practices”. I was responsible for the conceptualization and design of the study, recruiting participants, gathering phenomenological data via interview, observation, and other sources, analysis and reflection, and drafting the manuscript.

A version of Appendix A: *Relational Ethics of Mediated Touch: A Phenomenological Inquiry into the Nurse’s Glove* was a preliminary study for the dissertation and is being prepared for submission to *Phenomenology & Practice*. This paper was written during the coursework for my doctoral degree. I was responsible for the entire study, with feedback and guidance from my classmates and professors.

The dissertation has benefited greatly from overall guidance and feedback to all manuscripts from my supervisors and supervisory committee members. It would not have been completed without their dedicated support.

## Dedication

for my mother

Ann Boustead Lemermeyer

1938-2015

and in her memory

the finest nurse I have ever known

her spirit lives here, in every word

## Acknowledgements

Although I was the one at the keyboard, this dissertation is the result of many good hands and hearts along the way. I am foremost grateful to the nurses who volunteered to participate in this study, for their interest and their time, sharing thoughtful stories that drew me back into the NICU. And for the babies who entered this study through the nurses' accounts, everything here is for them.

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## Embodied Ethics: A Phenomenology of the Neonatal Nurse's Touch

### Chapter 1: Introduction

Birth brings with it a radical transition between two worlds. The by now cramped and completely filled space of the uterus narrows even more, drains its liquid buffer, and the baby is squeezed and pushed through the birth canal. From the perspective of the senses, this experience is the most intense touch a human being will ever experience:

the walls of the birth canal close up around the baby and mold skull and limbs into the shape of the passage, as if giant hands would reshape the form the fetus had received.

(Simms, 2008, p. 33)

The birth of a child is an inherently meaningful part of life. As a witness to a baby being born, one may be struck by the mystery of our own existence as an individual and as a species. Imagining the experience of the baby, we can speculate that being born, either through the birth canal or by Caesarean section, is a *radical*, all-encompassing, all-over experience of sensation. Does a human ever feel touched like this again? The newborn human is born into the world and into their own needfulness of physical, emotional and social care.

After birth, the baby's skin is exposed for the first time to air, their limbs free from the tight constraint of the uterine walls. The little one immediately needs to be warmed and dried, drawn close to their mother's body and covered in warm blankets. They are hungry and need to be fed, the most gentle brushing touch to their cheek or lips causes their head to turn and their mouth to ravenously root for the nipple. Within moments of being born, the baby is already a strong suckler intimately connected by the length of their little body pressed against their parent. The small babe needs help to burp air after feeding, by steady pats or rubbing their back.

The newly born baby is bathed and dressed, their diaper changed, hair washed, tiny nails kept short. Perhaps after the bath, lotion is massaged onto damp skin and diaper cream is applied to help heal a rash. A parent rocks them, the calming repetitive motion lulling the baby (hopefully) to sleep. The tactile expressions of comfort and love, kisses and caresses, hair stroking and affectionate inspections of tiny toes and palmar creases and umbilical cord stumps

are intermingled with one another. Sometimes nothing will soothe the baby's cries, and so the little one is held and bounced and consoled. The caring relationship between baby and their parents is borne out in close physical contact. Through touching contact, gestures, and movements the growth of a family is embodied.

Unfortunately, not all babies are born into the arms of their parents, but rather into the world of the neonatal intensive care unit (NICU) for the first days or weeks of their lives. NICUs are filled with sophisticated life-saving technologies for the babies: incubators warm, humidify and quiet the environment, ventilators support and supplement breathing, intravenous pumps infuse hydration and medication, pressure transducers measure arterial blood pressure, phototherapy lights reduce jaundice. The machinery of these technologies can seem to dominate the NICU, fostering a technological environmental surround with their sounds and material presences. In the centre of it all lies a small babe who, despite the constant contact of technology, remains in need of human contact, in need of being touched by another.

The newborn in the NICU still wants for the tender nurturing touches given to a healthy, term newborn (Field, 2014), but these connecting moments of physical contact become much more difficult or impossible in the NICU. The NICU touches, those ones required to protect and treat the tiny patients to keep them alive, reconstitute and replace some of the usual parent-newborn gestural care. For example, many regard the mother's body as "home" to their newborn baby. However, in the NICU, even with care becoming more oriented to parental involvement and promotion of skin-to-skin contact, neither parent has the same easy access to touch their child as when the family is at home. In the course of assessment and treatment the baby in the NICU may be touched by many health professionals; but most frequently it will be the bedside nurse occupied with caring for them.

Touch becomes difficult to disentangle from the tasks themselves, although physical contact inheres in nearly every nursing gesture and activity oriented toward the baby. The nurse touches the baby's little chest through a stethoscope to hear their heartbeat and breath sounds. Their skilled fingers palpate the small belly and search for peripheral pulses tucked against tiny biceps. The nurse inserts intravenous lines, cleanses wounds, changes dressings, and inserts feeding tubes and urinary catheters. But the nurse also soothes and consoles the baby, bathes them, and pats them to sleep. The manifold purposes (gnostic, comfort, communicative, etc.) of

the many touches overlap and intermingle. They are hard to differentiate because they are indistinguishable in the actions of touch.

It is important to consider the normative ethics of right touches and wrong touches. However, before these deliberations of right and wrong, before ethical decisions can be made, before ethical actions can be determined, are the ethics I seek to uncover and reveal in the touching encounters between baby and nurse. The originary ethics of touch may be sought in its lived bodily experience, rooted in relation and responsivity to the needs of the Other. Within these moments of physical contact, the subtle and overt gestures of touching and holding, feeling and responding, exist ethics.

### **Background**

Not long ago, philosopher Stuart J. Murray issued “a critical call to researchers in nursing and health sciences to reflect anew on the relation between bodily and ethical life” (2012, p. 289). He suggests that a phenomenological understanding of the body might make possible a different kind of ethical practice, one that is able to grasp the lived dimensions of health and illness and offer an ethical response. An ethical practice is made different from a rational or theoretical one by questioning the dominant principles of modern bioethics and instead inventing a “language for ethics that makes sense of lived-bodies, and that animates them ethically” (p. 292). By claiming the need for a phenomenological understanding, we are orienting to the ethics always already present in our day-to-day interactions as embodied beings in the here and now.

Murray (2012) emphasized an embodied understanding of the ethics of a patient’s experience. For example, he wonders what sort of bodily memories may emerge when a person who has previously been victim to sexual assault finds themselves being physically restrained as part of their treatment. Embodiment brings, or rather demands, an immediacy, a direct and unavoidable attention to the ethical moment as it arises. I support Murray’s call, and add to it. We cannot arrive at a rich embodied ethics unless we simultaneously recuperate the vital dimensions of the lived body of the health practitioner as well as that of the patient.

There is an enormous amount of research and clinical focus on the patient’s biomedical body in health care. People in care and their bodies are regularly observed and tested and measured and assessed; catheters are inserted, skin is cut open and stapled back together. Bones are realigned, internal organs are visualized, resected and dissected, genes are altered and pain is relieved. The focus on the physiological, medical body-as-object has brought life-saving and

improving advances to the field of medicine and health. Qualitative aspects of patient and caregiver subjective experience have not been ignored. Over the last few decades, there has been a growing body of qualitative inquiry conducted to better understand the experience of patients and health care professionals (see Pope & Mays, 2009). The resulting increased awareness and understanding of what patients and their families experience when living with illness has fundamentally contributed to nursing and medical knowledge.

By suggesting the need for a phenomenological, embodied approach to ethics in healthcare, I do not suggest we dismiss or disregard the accomplishments of biomedical research, the understandings garnered by qualitative research, nor the heuristic value of bioethical philosophies and principles. However, when such models and practices are consistently presented as the dominant and most valid ones in society, they may shape our *habits of mind* (Adams, 2006). Habit comes from the Latin *habēre*, meaning to be constituted (Habit, 2021). We come to be our habits; they inform and shape the way we look after patients, they make it possible to move through the world with relative ease. However, when dominant ways of knowing become sedimented in habit and taken for granted, it may become harder to recognize any alternative as also viable and important. In this case, it is hard to recognize ourselves and each other as embodied, subjective beings and to be sensitive and responsive to the ethics which are always present in our interactions with others.

### **Embodied Ethics**

In order to orient our view of ethical life in health care, what seems to be largely missing in health and nursing literature are rich, vivid, sensual, resonant, phenomenological descriptions of the embodied encounter between healthcare practitioners and the people they care for. There are notable exceptions. For one, Havi Carel (2016) movingly and powerfully describes her experience of being diagnosed with a chronic lung condition and being completely thrown off balance, in her book *Illness: The Cry of the Flesh*. As a young woman, everything she had organized her life around, expectations of becoming a mother and spending her pension seemed to be slipping between her fingers. As a philosopher, she turned to the philosophy of medicine, hoping to make sense of her anxiety and anger, only to find what she calls a serious oversight: “a failure to address the thing that matters most to ill people: how they feel, what they experience, how illness changes their lives” (p. xiii-xiv). So, she wrote her own; vividly describing her own illness and experiences of clinical encounters with health professionals. She describes coming to

understand that when a doctor asks her “How are you?”, they mean “How is your body?” (p. 48), and that no one asked: “How are you coping? Can we help you in some way? What have you lost through your illness?” (p. 50).

American author Virginia Woolf (1993) suffered from illness most of her life and laments the same disembodiment in literature. She shares a writerly insight:

... it becomes strange indeed that illness has not taken its place with love and battle and jealousy among the prime themes of literature. Novels, one would have thought, would have been devoted to influenza; epic poems to typhoid; odes to pneumonia; lyrics to toothache. But no; with a few exceptions ... literature does its best to maintain that its concern is with the mind; that the body is a sheet of plain glass through which the soul looks straight and clear, and, save for one or two passions such as desire and greed, is null, and negligible and non-existent. On the contrary, the very opposite is true. All day, all night the body intervenes (p. 199).

Both Carel and Woolf beg the same question: why? Why is the body in illness disregarded in these ways? Why is the lived body of the person so often ignored and de-emphasized? Woolf speculates that the reader of such a text might wonder where the plot went, and besides, she says, “there is the poverty of the language. English, which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver and the headache. It has all grown one way [toward the mind]” (p. 200). Carel recounts a memory of being very saddened by the result of a lung function test. Although she knows she will not get better, the confirmation of her decline in the test result is overwhelming and devastating.

I try hard not to cry, but panic and despair get the better of me. I choke on my tears ... I sob quietly, bitterly, the way defeated people cry. I lament my helplessness, my body’s betrayal. I can’t do it. I can’t breathe properly. I cannot breathe ... I look at the physiologist. She stands there, stony but for her slight impatience. Now I’m crying and can’t do other tests. I’m spoiling her day, getting her behind schedule. I collect myself; ask her for a glass of water. A sulky hand presents me with a dripping paper cup. She doesn’t look at me or say anything. I am alone (2016, p. 47).

Carel believes she has broken an unwritten law, where everything is impersonal and bad news should be met with calm. “And within this world, my human failure will be held against me, while her failure to be human does not even have a name” (p. 47).

Over time, things become easier as Carel comes to know and be known by the members of the healthcare team. She still wonders why the encounters have to be cold and impersonal, and notes, as Woolf does with the English language, that health care delivery seems to have developed with attention to the bodily life of the ill person atrophying as biomedical objectivity is privileged. Others have characterized the milieu of health care as obdurately informed and influenced by Cartesian dualist philosophic claims, including the work and profession of nursing (Carnevale, 1995; Draper, 2014; Marchetti, Piredda, & Marinis, 2016). Carel believes phenomenology's capacity to describe and attend to the lived bodily experience of illness would be transformative to the relationships between health professionals and the patients they look after.

Even more rare are evocative accounts of the full bodily life of healthcare practitioners. An exception is Austin and her colleagues (2013) who, in their phenomenological study of compassion fatigue, devote a full chapter to the lived body. In an eidetic sense, the bodily experience of compassion fatigue is expressed in part by the *lack* of embodied response. For example, the authors relate an account from a nurse who describes holding a child during the insertion of a central venous catheter into her neck. The little child is flailing and screaming as if for her life, and the nurse realizes that these cries should be piercing her, that she should be feeling empathy, instead she feels nothing. In the moment of her absent response, she recognizes her own compassion fatigue, she says she has "*become hardened*" (p. 73). We imagine, along with the authors, "a body hardening, its skin becoming callous, stiff, unyielding, and within, a hardened heart" (p. 73). Evocative images of the body help us to deepen our understanding of the impacts of the ethical divide that may occur in the experience of compassion fatigue.

This phenomenological study is an effort to relocate ethical attention onto the body of the practitioner as a perceiving, gesturing, knowing, moving, relational being and away from the common and comfortable perception of the body of the practitioner as purely a tool or machine in service to the duty of efficiency, quality improvement, critical thinking, outcomes, and tasks. To understand and begin to grasp the meanings of the ethical encounter as lived, I attempt to animate the abstract notion of embodiment and come back to the body itself. My investigation is located in a recognizable human experience, the site of physical connection between the neonatal nurse and newborn child: the nurse's touch.

### **The Questions Are Born**

The first very ill child that I was fully responsible for, with no instructor, nurse educator or preceptor directly involved, was a very premature baby transferred in from far away in the Northwest Territories, Canada. His parents did not arrive with him and were unable to join him in the NICU, and the little one was yet unnamed. I arrived in the unit for the first of four twelve-hour night shifts. I was nervous, but exhilarated. After months of orientation: finally, my own intensive care assignment, in a corner of the unit. As I arrived at the bedside, I saw the tiny baby lying on his back on white hospital flannelette, nestled between small rolled up cloth diapers for support, amidst ventilator tubes, intravenous lines, pumps and poles, temperature probe, wee diaper, urinary catheter, blood pressure transducer, and other neonatal accoutrements. Initially, the baby was very unstable, and the first two nights were spent drawing and analyzing blood gases, titrating inotropic drugs to maintain blood pressure and heart rate; administering antibiotics, adjusting ventilator settings and generally responding to the baby's physiologic needs of the moment. On the fourth day, the baby was diagnosed with an intraventricular hemorrhage – bleeding in the brain -- a risk associated with extreme prematurity. He would not recover. By the time I arrived that evening, many of the medications had been discontinued, although the ventilator remained connected to support the baby's breathing. The social workers were trying to reach the parents, and for the moment he was stable.

As I washed and repositioned him that evening, I realized that he had not yet been held. The baby had been so unstable and with neither parent able to visit, there had been no opportunity. Aside from being transferred into and out of the transport isolette, he had never been cradled in the arms of another. It can be a complicated maneuver to move a tiny baby who is intubated and connected to monitors and intravenous lines. The nurse working next to me helped to lift the baby and put a pillow under my arm and sort the lines and move the ventilator tubes, taking care not to dislodge the endotracheal tube. Once he was settled in my arms, we stayed that way for about an hour in a rocking chair, as the unit buzzed and rang and bustled around us. By the time I returned for my next shift a week later, the baby was gone and no one could tell me what happened. By then other babies had come and gone from that same space.

Since those days of clinical practice, my questions have become more refined and better articulated, but their urgency comes from the days and nights working with sick and premature babies and their families. I have wondered about the little baby in the corner spot over the years, but during the course of the research I have come to reflect on that night differently. Throughout

my investigation of the nurse's touch, I have asked myself why I wanted to hold the baby, why it felt necessary. The nursing colleague who helped me with the tricky transition of moving the baby from bed to my arms and back did not once ask why; she seemed to recognize and endorse my impulse. Given the baby's medical situation, it was not that I thought the touch would help him get well, or foster his development, or necessarily affect him in any way.

The touching gesture itself was not especially skillful, although the transfer of a baby attached to the medical accessories they need for life does require some careful attention and confidence. At face value, it might seem as if I felt the need to provide him some comfort, yet he was quiet and calm, on medications for pain and gave no physical signal that he was uncomfortable. Still, I was addressed by the baby in his needfulness before me--but even to say that implies an asymmetry that I did not experience. The urge to hold him did not originate in an effort to be a good nurse or to prove something. It was not a sacrifice or beneficent gesture. I think I held him for me as much as for him. I was present to him, and he to me. The baby and I rocked in a stiff hospital rocking chair and then we put him back to bed and finished the night shift. I held him not because it was the rational thing to do, but rather because it was the fitting, ethical, embodied thing to do: a baby ought to be held.

### **Situating Myself in the Research**

It might be helpful to situate my position in relation to the research study. Estabrooks and Morse (1992) asked nurses about their "touching style" as nurses. They found that a nurse's touching style was informed and influenced by their family and cultural practices, long before their nursing education or employment. I was raised in a physically affectionate family; my siblings and I kiss our father good-bye and my teenage children greet their dad and I in the same way. People who know me would likely describe me as a person who hugs easily. I find comfort in being close to friends and family members. All of that said, I am a woman in the world, and carry the weight of all of the implications that entails, including a taken-for-granted but vigilant awareness of the dangers that make women vulnerable, in terms of unwanted and violating touches by strangers and those they know.

In the NICU, I comforted babies by holding and touching them and if a mother cried, I would put my arm around them, or squeeze their hand, mindful of their preference and receptivity, to comfort or encourage, to provide solace or fortification and to celebrate milestones and accomplishments. I recall that I was less likely to comfort a grieving or fearful father by

touching them. I would take any opportunity to develop my tactile skills, finding hard-to-find veins, feeling hard-to-feel peripheral pulses, and more. My former ten-year clinical experience in the NICU informs me with both an insider and outsider perspective on this research. As a former NICU nurse, I have somewhat of an insider's understanding of the language and practices of the nurses who participated in the study. Being able to share my own experiences as a NICU nurse and my interest in the research topic may help to reduce the status differences that can be a part of research interviewing (Corbin & Morse, 2003). In many instances, my experience facilitated shortcuts in appreciating their stories and understanding their gestural language. I did not often have to interrupt them to ask the meaning of a diagnosis, treatment or product. My perspective of an insider may have facilitated a depth of reflection unavailable to a researcher without NICU nursing experience.

Simultaneously, the distance from clinical practice also meant that I needed to pay extra attention to my own assumptions about the way care currently proceeds in the NICU, influenced by an understanding of how it used to proceed. I did not assume to understand their references, and asked for clarification and explanation when necessary. Indeed, my position as removed from practice seemed to encourage the nurses to explain practices to me in detail, facilitating my phenomenological quest for experiential material. Ultimately, my orientation to the research is my *intentionality*, or inseparable connectedness to the world (van Manen, 1997), that is, as a nurse, mother, researcher, woman and more.

In Canada, the nurse's touch happens within the framework of legislation that allows the privilege of profession-led governance. The semi-autonomous regulatory structure is made possible by virtue of public trust. Nurses have been given society's sanction to touch people in private and intimate ways, bound by the concomitant responsibility to uphold public trust by demonstrating trustworthy behaviour that never takes that confidence for granted.

### **Literature on the Nurse's Touch**

In a paper-based thesis format, each paper is an independent document formatted as a manuscript for submission to a journal. Therefore, each paper includes a review of the literature relevant to its purpose. Such a manner of organization necessarily results in some degree of repetition. What follows is a focused review of the academic literature of the nurse's touch. The purpose of a literature review in the introduction to the dissertation is to lay out a path to the research questions and methodology that follow. The second paper of the dissertation, *Embodied*

*Ethics: A Phenomenology of the Nurse's Touch*, includes a similar but abbreviated form of the general literature review. The third paper, *In Good Hands: The Phenomenological Significance of Human Touch for Nursing Practices* includes a brief and focused review of the nurse's touch literature.

The touch of the nurse has received uneven attention in the nursing literature. The literature review begins with published accounts of touch in nursing across specialties, followed by a review of the research and commentary on the nurse's touch in the NICU. Since my interest follows the everyday and ordinary touches of the neonatal nurse, touching "techniques" that require additional education or training, such as Therapeutic Touch, Healing Touch, reiki, reflexology, are not included. Databases Cinahl Plus with Full Text and Medline (1946-present via Ovid) were searched using the following search terms (MESH headings and keywords) in various combinations: touch, nurse, nurse-patient relations, neonatal intensive care, skin-to-skin, phenomenology, research. After an initial review of titles and abstracts, further searches were completed using search terms: male, instruments, scales and measure added to previous search histories. Many articles were further retrieved using Google Scholar's "cited by" function for articles retrieved via tradition searching. The literature extends back 45 years, largely because papers published in the 1970's, 80's and 90's are still frequently cited in current articles. The search produced a large amount of research into the mid-2000's. An uptick in research on touch in nursing and other health practitioners can be seen from the mid 2010's.

### ***Touch in Nursing***

As regulated professionals, nurses receive society's sanction to breach the otherwise normative prohibitions preventing people from touching each other's bodies. Nursing is perhaps one of the last professions where touching, including intimate touch, is expected and routine (Connor & Howett, 2009; Gleeson & Timmins, 2005; Pedrazza et al., 2017). Intimate touch of patients' bodies is a routine part of accomplishing many of the tasks of nursing and happens in the nurse-patient relationship (Adomat & Killingworth, 1994; Chang, 2001; Estabrooks & Morse, 1992). Touch is generally regarded as inherent to nursing practice (Adomat & Killingworth, 1994; Chang, 2001; McCann & McKenna, 1993; Routasalo & Isola, 1998; Routasalo, 1999; Warwick, 2017). The notion of touch is not clearly defined in the academic literature and has been interpreted in diverse and ill-described ways over time, in different

contexts, and by various authors (Connor & Howett, 2009; Estabrooks, 1987; Gleeson & Timmins, 2005; Warwick, 2017).

**Physiological and Psychological Effects of Touch.** Touch between nurse and patient affects the patient in both physiological and psychological ways. In their review of eleven intervention studies investigating the effect of specific and intentional contact touch techniques on physiological outcomes in critically ill patients, Papathanassoglou & Mpouzika (2012) found significant effects of interpersonal touch. Interpersonal touch seemed to contribute to lowering blood pressure, lowering respiratory rate, improving sleep and decreasing pain. Specific touch interventions were linked to decreased pain, lower blood pressure, decreased feelings of nausea and feelings of anxiety across a broad range of clinical contexts including bariatric surgery (Anderson et al., 2015), obstetrics (Bischoff & Buckle, 2014), cataract surgery (Moon & Cho, 2001), geriatrics (Edvardsson et al., 2003), and in general nursing care (Field, 2010). Comforting touch, such as hand-holding and shoulder patting had a significant effect on the self-esteem and well-being of elderly female residents, improving how they felt about themselves (Butts, 2001). Nurses tend to feel their touch has a calming effect on the people in their care (Mulaik et al, 1991; McCann & McKenna, 1993; Adomat & Killingworth, 1994)

**Non-verbal Communication.** As well as its physiologic effects, touch by nurses is widely considered to be an important form of non-verbal communication (Chang, 2001; Gleeson & Timmins, 2004). Nurses may express compassion and patients may receive compassion through both incidental and deliberately comforting touch (Durkin et al, 2021). Similarly, trust can be conveyed through touching gestures of comfort, or when touching for interventions (Benbenishty & Hannink, 2015). Patients with cognitive impairments tend to respond better to the nurse's verbal communication combined with touch and eye contact (Kramer & Gibson, 1991). There are few studies that do not consider touch as a part of the nurse's non-verbal communication; it is an assumed, rather than explored, meaning.

**Categorizing the Nurse's Touch.** Earlier touch research in nursing tended to classify and categorize types of touch, although there is a lack of consistency in terms and meanings between authors that becomes quite confusing. A predominant distinction is made between touch that is necessary and touch that is non-necessary to nursing care. Necessary touches (helping a patient to sit up or checking a pulse, changing a dressing, giving a bath, inserting an intravenous line, and many other situations) happen more frequently than comforting touches (Gleeson &

Timmins, 2004; Schoenhofer, 1989). They are also called procedural (Barnett, 1972; Mitchell et al., 1985), task touch (Estabrooks, 1989), work/task (Adomat & Killingworth, 1994), instrumental touch (McCann & McKenna, 1993; Watson, 1975), or working touch (Bortorff, 1993), to name a few.

All touches not considered to be necessary are designated as *non-necessary* or *non-procedural*, described as more spontaneous and comforting (Barnett, 1972; Gleeson & Timmins, 2004). These touches may be purposely therapeutic and deliberate, but not task or procedurally based (Connor & Howett, 2009), more affectionate (Schoenhofer, 1989) and spontaneous. They are also called caring/social touches, which encompass encouraging, fun, and reassuring touches (Adomat & Killingworth, 1994; Bortorff, 1993); and expressive touches (McCann & McKenna, 1993; Routasalo & Lauri, 1996; Schoenhofer, 1989; Watson, 1975).

Touch can be connected to and part of other nursing tasks such as providing comfort, teaching self-care, explaining procedures, mobilizing patients, talking to families, and so forth (Routasalo & Isola, 1998). Many of the intensive care nurse-participants in Estabrooks' (1989) qualitative study referred to this kind of touch as "real touch" (p. 394), implying nurses' interpretation of the possible meanings of touch. Although the benefits of non-necessary touching are recognized, its widespread adoption is not well-supported by research (Gleeson & Timmins, 2005).

Any specific instance of touch may have both instrumental and expressive significance (Watson, 1975), and the taxonomy of touch that exists in the literature is somewhat arbitrary. For example, patients do not tend to classify the nurse's touch as performing a task or offering comfort, but see them as flowing from and dependent upon the relationship between themselves and the practitioner (Leonard & Kalman, 2015). Deeming task and procedural touch as "necessary", and comforting touch as "non-necessary" emphasizes the physical care of a patient over all other aspects of social, emotional, and spiritual care. Such distinctions risk the possibility of the language shaping and promoting the importance of certain touches over others.

Chang (2001) identified touch as a "means to influence the body and the mind as an integrated, interconnected entity" (p. 825). Chang (2001) emphasizes that it is the intention of nurses in their approach to touching a patient that provides a critical element in understanding touch. Chang defines intentional touch as *physical touch in caring* and describes touch as a process (versus an event) that is oriented toward addressing discomfort. "It is an intentional,

shared, and mutually understood process, which has specific social role meanings and is based on a specific framework of the caregiver” (p. 824). Intentional touch is considered a way to reassure and encourage the patient, alleviate physical and psychological distress, convey confidence, and enhance the patient coping capabilities (Connor & Howett, 2009; Kruijver et al., 2000; Moon & Cho, 2001).

**Continuum of Touch.** Connor and Howett (2009) recognize that nurses intentionally use touch “to offer comfort, promote healing and demonstrate caring” (p. 127) in their development of a conceptual model. They theorize touch as existing on a continuum from non intentional, procedure-centred, and objective on one end to intentional comfort, patient-centred, and subjective on the other. This conception of touch may more closely reflect touches in practice, where therapeutic and comfort may blend and cross over, with even the nurses themselves not knowing exactly what “type” of touch they are using. The model recognizes that both physical comfort and discomfort may result from touch, that feelings of both connection and disconnection are possibilities, and so on. Seemingly missing from outcomes in the model are beneficial physiological outcomes of touch (as described above), however this conceptual model in nursing may begin an understanding of the rich *relational* potential of nursing touch.

The continuum itself is situated within a multi-variable context, including personal, environmental, and professional influencing factors. Other researchers have reported that touch is influenced by many factors. Some are relatively constant such as the personality, life experience, and cultural background of both nurse and patient, but other aspects are contingent on the moment of care, such as the emotional state of the patient and nurse, and the current condition of the patient (Estabrooks, 1989; Routasalo & Isola, 1998). Using Ricouer’s interpretive philosophy, Routasalo and Isola (1998) investigated touch between specific nurse-patient dyads, identifying that each dyad navigated their own unique pattern of behaviour and that the interaction between each nurse with their patient varied within and between each encounter, “from smooth to awkward, from fluent to clumsy” (p. 177). The changing nature of touch in relation is an observation that offers insight to touch as dynamic, changing and adaptable.

**The Nurse-Patient Relation.** In their phenomenological hermeneutic study, Edvardsson and colleagues (2003) reveal intentional touch as *transformative* for both the nurse and the patient. Nurses providing intentional touch may recognize their value as a person and profession

in situations where they previously felt powerless to ease suffering. Intentional touch (such as massage) was described as creating a “bubble” where nurse and patient are equal, and the experience of touch becomes mutual, providing feelings of well-being to both (Edvardsson et al., 2003, p. 605).

Nurse and philosopher Sally Gadow (1984) emphasizes that the possibility for *intersubjective relation* begins in touch. She suggests that the purpose of touch in nursing “is not palpation or manipulation [which she notes to some degree can be taken over by technology and even an instrumental touch] but expression—an expression of the caregiver’s participation in the patient’s experience” (p. 67). In this way, touch breaches the objectiveness to which persons in health care can be reduced, while also acting as a mediator by preventing the isolation of pure subjectivity (a withdrawal into oneself or one’s suffering).

A *disclosive* space may open within a human relationship where it is possible to reveal and notice some things and not others (Benner, 2004). A disclosive space in a nursing-patient relationship makes it possible for patients to divulge their fears, symptoms and worries to the nurse who is available to be receptive and attentive. The patient’s open communication allows the nurse to notice subtleties of their condition. Benner (2004) argues that touch and other measures that provide comfort are crucial in the development of disclosive spaces.

Estabrooks (1989) describes touch as a sometimes necessary “strategy” in the intensive care unit. As well as task and caring touch, she identified a third component of touch, “protective touch”, such as restraining a patient if required to control them. It is a type of touch that protects the patient from physical harm and is meant to protect the nurse from emotional harm, but also has the risk of dehumanizing patients. Protective touch may occur when the nurse is emotionally depleted, suffering from burn-out or compassion fatigue (Austin et al., 2013). Sometimes when the nature of the patient’s illness is life-threatening, or otherwise distressing, nurses may choose to emphasize task and procedural touch while also using blocking behaviours such as withdrawing or avoiding affective types of touch (Kruijver et al., 2000). Blocking behaviours such as ignoring patient cues or switching topics may prevent the patient from talking about their symptoms and other experiences.

### ***Nursing Touch in the NICU***

The issues of nurses’ touch in the NICU have significant crossover with those in adult nursing, but also are somewhat different. The importance of touch on human development is

emphasized. The adult issues of embarrassment and misinterpretation of touch are not present in the NICU with babies. Even for babies that do not require NICU treatment, it is normal and expected to touch and hold a baby to provide care. Nurses have the privileged role of facilitating touch between babies in the NICU and their parents, and in turn promoting attachment and supporting development. As well, a caveat: most of the published research and scholarly comment that exists in regard to care in the NICU focuses predominantly on prematurely born babies, rather than ill babies born at full term.

**Sensory Overload or Sensory Deprivation.** Premature infants often lack tactile stimulation and comforting touch, beginning with their early birth and subsequent loss of the gentle pressure of their mother's womb and the amniotic fluid (Abdallah et al, 2013). Following admission to the NICU, and especially if unstable, the babies may not be touched in ways that are supportive to their development and comfort (Álvarez et al., 2017; Benner, 2004). Paradoxically, babies in the NICU may simultaneously undergo sensory overload and become stressed (Zeiner et al, 2016), due to invasive procedures for diagnostic and therapeutic purposes, in an often brightly lit, loud, and otherwise inappropriately sensory overloaded environment (Abdallah et al., 2013; Brown, 2009; Im & Kim, 2009; Lidow, 2002; Smith, 2012). Even in NICUs designed with more careful sensitivity to the developmental needs of the infant and family, the atmosphere is jarring when compared to the womb of the mother (White et al., 2013).

Policies of using *minimal touch*, that is limiting the touching of the baby in order to prevent infection and to minimize unpleasant or procedural touch may contribute to both sensory deprivation and overstimulation (Fallah et al., 2013; Leonard, 2008; Smith, 2012). These restrictive policies allow for the necessary life-saving procedures – the touches more likely to be painful and disruptive and contribute to sensory overload – while curtailing more comforting and supportive touching that may in fact provide beneficial tactile stimulation to the baby as well as opportunities for closeness with their parents (Álvarez et al., 2017; Leonard, 2008; Smith, 2012).

**NICU Nurses and Kangaroo Care.** Originally begun in Columbia as a method to free up incubators in an under-resourced area, “kangaroo mother care” (Charpak & Ruiz, 2011), skin-to-skin care (also just kangaroo care), has increasingly become an accepted practice in modern NICU nursing care (Gao et al., 2015; Kymre & Bondas, 2013b). The benefit of holding one's baby directly skin-to-skin has been described and is obvious to most parents. The medical benefits of kangaroo care for the baby and parent are numerous and the safety of the procedure

even in very preterm babies has been shown (Carbasse et al., 2013; Hunt, 2008). Kangaroo care may reduce procedural pain (Cong et al, 2009; Sen et al, 2020; Gao et al., 2015; Johnston et al., 2017; Seo et al, 2016), stabilize temperature (Ludington-Hoe et al, 2000), improve sleep (Ludington-Hoe et al., 2006; Smith, 2007), improve oxygen saturation levels (Carbasse et al., 2013; Hunt, 2008), and increase breastfeeding success (Hunt, 2008; Smith, 2007).

The attitudes of nurses affect the use of kangaroo care and may be dependent in part on hospital and nursing culture (Gepilano, 2014; Kymre, 2014). Nurses tend to value skin-to-skin care in the NICU and are aware of its benefits to the baby and parents (Mörelus & Anderson, 2015; Stelmak et al, 2017). However, attitudes of nurses towards almost continuous kangaroo care showed ambivalence, resulting from mingling of beliefs, norms and evidence (Kymre, 2014; Mörelus & Anderson, 2015). Although nurses were aware of the benefits of almost continuous skin-to-skin contact, they remained worried about losing control of the baby, being unable to provide adequate care; and that the mothers may feel trapped by being unable to move without help to transfer the baby. For these reasons, the practice remained underused (Mörelus & Anderson, 2015). The lived experience of the nurse enacting skin-to-skin care may be one of a double focus, based on the cues and signals from both parents and their babies (Kymre & Bondas, 2013). For dying babies, nurses seemed more confident that skin-to-skin care was preferred and experienced some urgency for the parents to hold their baby while still alive (Kymre & Bondas, 2013a). NICU nurses influence the access that parents and babies have to each other and, in turn, their ability to be in physical touching contact.

**NICU Nurse's Touch.** The benefits of touch to parents and their babies are both intuitive and well-documented, however it can be difficult for parents to be in the NICU all the time. Even given very involved families, NICU nurses will always need to touch the babies in order to provide care. The nurse's touch has been researched and reviewed as an intervention, separate from the normal and everyday touching an infant would otherwise receive from care by their parents or NICU nurses and other practitioners (Field, 2014; Smith, 2012). A recent systematic review by Álvarez and her colleagues (2017) provides evidence to support massage as a safe intervention that contributes to the health and development of neonates in different ways including stabilization of vital signs, weight gain (most frequent), neurological development, and decreased length of stay. Given astute assessment of individual babies, their severity of illness

and physiologic stability, even some babies in level III NICU will respond favourably to methods of comfort touch (Smith, 2012).

### ***The Nurse's Experience of Touch***

**Learning to Touch.** Little is known about how nursing students learn about touch during their education (O'Lynn & Krautscheid, 2014) and nurses have acknowledged a desire for more explicit education on touch (Estabrooks & Morse, 1992). In their grounded theory study, Estabrooks and Morse (1992) asked intensive care nurses how they learned to touch. They found that nurses identified that the way they touch in their nursing practice begins much earlier than formal nursing education. The "touching style" developed in their practice is informed and shaped by influences of culture, personality and family upbringing. These norms and habits come to nursing education where students learn professional socialization. In their grounded theory study, Estabrooks & Morse (1992) identify the workplace as where an individual style of touching for individual nurses was developed.

**Touch as More Than Physical Contact.** In what may be the first study exploring touch from the nurse's point of view, Estabrooks and Morse (1992) acknowledged that in the provision of care, nurses enter into a "reciprocal equation, the nurse-patient relationship" where touch is central (p. 448). The nurse participants of this study did not define touch in a simple way as skin-to-skin contact. Instead, touch was described as more than physical contact, including a "multi-dimensional gestalt" that included other observable aspects such as voice, posture and affect (p. 450).

**A Nurse's Comfort with Touch.** Physical touch involves closeness and intimacy and it cannot be assumed that nurses will always be willing to employ touch in their practice, beyond what is necessary for care. To feel comfortable touching patients, nurses may require a sense of inner balance and a supportive environment (Airoso et al, 2016). Nurses do not always feel comfortable physically touching patients (Pedrazza et al, 2015). In their survey research, Pedrazza and colleagues (2017) describe relationships between touch, worry and the attachment style of the nurse. Nurses were more likely to worry about providing touch to promote physical comfort, and felt more confident focusing on task related touch. Male nurses feel even less comfortable with providing touch aimed at emotional containment. Whiteside & Butcher (2015) note that in general male nurses are worried that their touch may be misinterpreted, particularly

in relation to female patients. This concern was mitigated to some degree through targeted education to male nursing students (O'Lynn & Krautscheid, 2014).

### **A Gap in the Literature**

As a health discipline, nursing has given some attention to the nurse's touch. There seems to be a general trend in the research literature towards investigations concerned with more nuanced and experiential aspects of touch. The nurse's experience of touching the babies and their families is a relatively unexplored subject, despite the fact that touch is considered inherent to nursing practices, and the widely accepted benefits of skin-to-skin care with parents for physiological, developmental, and bonding benefits in the NICU. There is little attention paid to the taken-for-granted and mundane touches that make up a bulk of the nurse and patient experience in the NICU. The nurse's touch as an ethical encounter with the baby in NICU, or patients across clinical settings, seems to have received very little consideration in the nursing research literature.

### **The Research Question**

The abiding concern underlying this research is that when touch is understood from within a physical-sensory model, as a technique, by its quantity or location, or by its outcomes, the breadth and depth of its embedded and embodied meanings, the nuances and subtleties of its effects remain elusive. Focusing on touch as primarily a technique, as a communicative gesture, as a producer of outcomes, as a skill, even though it is all of these things, may not help us to fully realize its significance in nursing care or deeper human meaning.

The research study is set primarily in the NICU. It is hard to imagine a human being that requires more delicate, nuanced, and skillful touch than the premature and ill newly born baby. My investigation is guided by the following questions:

1. What is the NICU nurse's lived experience of touching their patient (baby or parent)?
2. What is the ethical significance of a nurse's touch? What ethical implications can practitioners draw from a phenomenology of the nurse's touch?

Understanding the nurse's lived experience of touch in the NICU, and the originary ethics therein, requires a methodology with the capacity to cultivate rich and ethically sensitive understandings of human life as it is lived. I turn to phenomenology of practice (van Manen, 2014), a form of interpretive inquiry well-suited to exploring the subtleties and sensualities of physical contact and the embodied ethics of the nurse's touch.

## **Methodological Orientation**

Phenomenology of practice has its origins in the philosophies of Husserl, Heidegger, Merleau-Ponty, Sartre and others, as well as the phenomenological texts of academics with professional practices, such as psychologists, physicians, psychiatrists and teachers (van Manen, 2014). Phenomenology of practice draws together the philosophical concern of understanding life as lived with the orientation of practice, an understanding rooted in ordinary and everydayness. It is a philosophical, qualitative approach to inquiry that makes possible and invites the cultivation of vibrant and sensitive understandings of the nurse's touch as lived in practice. Phenomenology of practice includes a blending of philosophical, human science and philological methods. It originates in the researcher's attitude of wonder, an application of the philosophical reduction, in an attempt to recover the world as pre-reflectively as possible, in its lived immediacy. My purpose is to explore the nurse's touch as it happens and to describe and reflect upon the embodied ethics always already present in our day to day encounters with others.

Pre-reflective experience refers to the data, or evidence, of phenomenological human science inquiry: experience as it is lived through in the moment, before we have conceptualized, summarized or theorized it afterwards (van Manen, 2014). I generated data through in-depth phenomenological interviews with ten neonatal nurses, all of whom currently work in one of four NICUs across a western Canadian city. I observed the practice of three of these nurses, and garnered additional descriptions of lived experience from literary, academic, and personal sources. This body of experiential material serves to orient phenomenological analysis and reflection on the neonatal nurse's touch. Thematic and existential analysis is employed to explore the underlying meaning structures of the nurse's touch. Phenomenological themes are developed to organize the experiential material and act as heuristic themes to help the researcher reflect more deeply on the meanings that reside in moments of touching encounters.

Phenomenological analysis and reflection happen in the actual process of writing the research text (van Manen, 2014). Phenomenological writing is partly an analytic endeavour through which the researcher systematically explores the meaning of a phenomenon. But it is also an endeavour of craftsmanship; the phenomenological insights are embedded in and evoked by the words, rhythm, resonance of the writing, the texture and tone of the text itself. There exists a tension in phenomenological writing where we recognize that phenomenological meaning and understanding is shared through language and at the same time, as writers, run into

the constraints of language when trying to express ideas and insights that may be ineffable. The phenomenological text is successful when it addresses the reader and elicits a resonating response through conveying a sense of the lived meaning of the phenomenon (van Manen, 2014). I hope that the final phenomenological texts of this research will not only speak to the reader, but that the reader will be “touched” by the text in a tact-ful way.

Given that this is a paper-based dissertation, further detailed descriptions of phenomenology of practice and the human science research methods employed are provided in the manuscripts. A close exploration of the phenomenological interview as a data collection method and the philosophical reduction is described in Chapter 2, Paper 1, *The Unique Intimacy of the Phenomenological Interview*. More details of the methodology and research methods used are described in Chapter 3, Paper 2, *Embodied Ethics: A Phenomenology of the Nurse’s Touch*, and Chapter 4, Paper 3, *In Good Hands: The Phenomenological Significance of Human Touch for Nursing Practices*.

### ***Quality of the Research***

Traditionally, the principles of validity and reliability have been used to measure the quality of quantitative research. Early use of these principles to address the quality of qualitative research studies and how it might be determined has been the subject of much debate. In their model of trustworthiness, Lincoln and Guba (1985) may have been the first to offer some means of assessing the quality of qualitative research. Lincoln and Guba are grounded theory methodological scholars, though their evaluative criteria (credibility, transferability, dependability, confirmability) is posited as appropriate for qualitative research in general. These criteria were a good beginning, but unfortunately, a general approach disregards the wide diversity in the traditions of qualitative research, that use different methods and seek different outcomes. In particular, the criteria may not make sense for phenomenological research. For example, *credibility* refers to confidence in the ‘truth’ of findings, which begs an understanding or definition of “truth”.

Instead, phenomenological researchers aim to describe possibilities of the meanings of experience, and may hesitate to call these ‘true’ in the sense of certainty or righteousness. Van Manen (2014) refers to Heidegger’s distinction of this notion of truth as *veritas*, a Roman word for truth as justice. *Aletheia*, originally from the ancient Greeks, on the other hand, is another notion of truth revived by Heidegger that means truth as disclosure and unconcealment. The

goddess Aletheia personified truth and sincerity, as opposite of trickery and deception. The truth of *aletheia* “is derived from the study of meaning and meaningfulness” (p. 342).

“Phenomenological truth operates largely as presentational *aletheia* rather than as representational *veritas*” (p. 344). It is not clear that Lincoln and Guba’s *credibility* refers to this more nuanced and changeable sense of truth. Similar differentiations could be made for all of Lincoln and Guba’s criteria. In short, they are neither appropriate nor adequate to assess the quality of phenomenological research.

Phenomenological researchers and readers are best able to evaluate the phenomenological depth of a study “by meeting with it, going through it, encountering it, suffering it, consuming it, and, as well, being consumed by it” (van Manen, 2014, p. 355). Van Manen (2014) has developed seven criteria to appraise the quality of a phenomenological study: heuristic questioning, descriptive richness, interpretive depth, interpretive rigour, strong and addressive meaning, experiential awakening and inceptual epiphany. The criteria relate to moments of the reduction as well as to philological methods. Extending van Manen, these criteria are paraphrased below as questions for the reader to ask themselves when considering the value of this dissertation text

- Heuristic Questioning. Does the text induce a sense of wonder and questioning attentiveness in the reader? *Is the touch of the nurse made strange, while maintaining its connection to the nurse’s world?*
- Descriptive Richness. Does the text include concrete descriptions of a recognizable experience? *Can the reader ‘picture’ in their mind the ways in which a nurse might touch an NICU baby, or other person in their care? Are the descriptions plausible and do they retain the sensuality of lived life?*
- Interpretive Depth. Does the text offer reflective insights that go beyond the taken-for-granted understandings of everyday life? *Is the reader surprised by the way the meaning of a nurse’s touch is articulated because they had never thought of it that way?*
- Distinctive Rigour. Does the text remain constantly guided by a self-critical question of the distinct meaning of the phenomenon or event (distinctive rigor)? *Does the text remain oriented to the nurse’s touch?*

- Strong and Addressive Meaning. Does the text “speak” to and address our sense of embodied being? *Does the reader feel moved by, or drawn toward, the experience of the nurse's touch as described in the text?*
- Experiential Awakening. Does the text awaken prereflective or primal experience through vocative and presentative language? *Is there a mood-creating tone and rhythm to the text?*
- Inceptual Epiphany. Does the study offer us the possibility of deeper and original insight, and perhaps, the possibility of an ethical or inspired grasp of the ethics and ethos of life commitments and practices? *Is the reader inspired to take action because of a deep understanding of the nurse's touch?* (pp. 355-356).

These criteria are not meant to act as a checklist. Achieving all of them throughout an entire phenomenological text is impossible. It is more fruitful to regard them as aspirational for the researcher and guidelines for the reader. Ideally, one can respond “yes” to one or more of these questions throughout significant portions of the text.

### **Significance of the Study**

It is a sober responsibility on the part of researchers to be mindful of the many urgent and compelling demands for the attention of nurses and other healthcare professionals as they care for sick and vulnerable people. We must ask, what is the meaningfulness of this study? How can we justify the time and effort of the participants, the researcher, and in the case of doctoral education, the supervisors, faculty, and university?

The value of a phenomenological study on the nurse's touch is realized in the return to the phenomenon as lived. Touch is foundational to nursing practice; a potent and powerful gesture between humans. Its effects may often go undocumented and unrecognized in many nursing situations, rendering it nearly invisible in practice. The significance lies in the exploration of the ethics of the nurse's gestural and tactile encounter with the baby.

This research aims to facilitate knowledge development by cultivating insightful understandings in nurses and practitioners in the NICU. A more meaningful and nuanced appreciation of the significance of the nurse's touch and the embodied wisdom of the nurse might be recognized and brought forward to the disciplinary consciousness and conversation. Ultimately, this study aims to cultivate sensitive and ethical touching practices of the nurse in the care of the newborn child.

## Overview and Organization of the Papers

This dissertation gathers three related papers, as parts of a whole research project exploring the phenomenology of the nurse's touch. A fourth paper is appended to the dissertation. As typical for a paper-based thesis, parts of the literature review and methodology of the research are described across the papers. A critical and up-to-date review of the literature is in the introduction to the dissertation; more concise versions are in papers 2 and 3. The methodology of this dissertation research is described in different ways in all three papers, most in-depth in paper 2. The papers are crafted for different but overlapping audiences.

The first paper, *The Unique Intimacy of the Phenomenological Interview*, describes and reflects on the eidetic qualities of the phenomenological interview. This paper serves to emphasize the ground for the research project: concrete examples of the phenomenon under study. I consider the philosophical reduction as a research practice and explore meaningful ways to animate the dual gesture of epoché and reduction in the interview. Its audience is both novice and more experienced phenomenological human science researchers; everyone who grapples with the practicalities of gathering experiential material through interview for the purpose of phenomenological reflection. Versions of this essay were presented at the *Qualitative Health Research Conference* held in Quebec City, Quebec, October 2017 and the *International Human Science Research Conference* in Spartanburg, South Carolina, June 2018. The paper is being prepared for submission to *Qualitative Research*.

*Abstract.* For phenomenological research studies, interview often serves the purpose of assisting the researcher to gather descriptive accounts of lived experience. Phenomenological reflection rests on having experiential material, however, it can be more difficult than it seems to obtain concrete accounts of phenomena. Whereas participants often share opinions, perspectives, or beliefs about their experiences quite readily, phenomenology requires them to recount and articulate actual moments of experience in their lives. In an important sense the researcher is trying to be invited into the participant's world, to stand alongside a lived through moment. Many of the questions and ideas in this discussion article were generated by my own experience of trying to elicit descriptions of lived experiences during phenomenological interviews and subsequent conversations with other novice and experienced researchers. These experiential examples are interwoven with insights from the literature and other researchers, as I reflect on the nature and significance of detailed concrete description in phenomenological studies,

practical ways to practice the phenomenological attitude in the interview and the unique intimacy of the phenomenological research interview.

The second paper, *Embodied Ethics: A Phenomenology of the Neonatal Nurse's Touch*, represents the beginning of my phenomenological exploration into the experience of the nurse's touch, situated in the neonatal intensive care unit. The ethics of touch are investigated in an attempt to understand ethics as lived in encounters between the nurse and baby. This paper includes a concise review of the literature and description of phenomenology of practice as research methodology. It is written in a traditional research format and is oriented to an audience of nurses and other healthcare practitioners. It may be of particular interest to those with a neonatal specialty. Portions of this article were presented at the *Qualitative Health Research Conference* in Vancouver, Canada, October, 2019 and the *Nursing Ethics Series* through the John Dossetor Health Ethics Centre and Unit for Philosophical Nursing in Edmonton, Alberta, October 2019. It was accepted for presentation at the *International Human Science Research Conference* in New York, New York, June 2020, which was cancelled due to the COVID-19 pandemic. The final version of this article is published in *Qualitative Health Research*.

*Abstract.* This study was a phenomenological exploration of the ethics of the nurse's touch in the Neonatal Intensive Care Unit (NICU). I explore several examples of touching encounters as gathered from NICU nurses through interview and observation and organize the lived meanings around several thematic statements. These include: the learning touch: finding a way to hold the baby; the marking touch: when touch lingers long after physical contact; the missing touch: or touching without physical contact; the gnostic touch: the possibility of knowing an other and ourselves; and the call of touch: drawn to hold. Exploring the touching gestures of NICU nurses discloses the relational ethics inherent to caring practices. By attempting to articulate these practices, the hope is that the significance and contribution of the nurse's touch might be recognized and brought forward to our individual and professional consciousness, conversations, and curricula.

In the third paper, entitled *In Good Hands: The Phenomenological Significance of Human Touch for Nursing Practices*, I broaden the context of the nurse's touch in healthcare settings beyond the NICU. Experiences of the neonatal nurse research participants are included and augmented with examples from poetry, academic, memoir and personal accounts. In this paper, I briefly describe anatomical features of our touching bodies and include examples from

more artful and literary sources in an effort to build on my explorations of the nurse's touch. I conclude this paper with an account from my clinical experience that has served as a contemplative motivation for this dissertation research overall. The audience for this paper is similar to Paper 2 but may also include practitioners interested in the use of humanities in health research. The paper has been submitted to *Medical Humanities*.

*Abstract.* The nurse's touch has been studied and discussed intermittently in the academic literature for decades. Prevailing understandings of the nurse's touch tend to be focused on its consoling, instrumental, and communicative utility. What seems to be missing is an exploration of the ethical and existential significance of the nurse's touch. As an aspect of nearly every human experience, touch has a depth and breadth of meanings that are hard to compass. We experience the world through our bodies; feeling our way through our lives. In the nurse's world, touching contact with the person in care is often considered to be a fundamental gesture, inherent to nursing practices. Still, touch is often hidden, subsumed by the tasks of nursing themselves. In order to explore the meaningfulness of the nurse's touch, I start with considering the sense of touch itself, to arrive at an exploration of possibilities for the nurse's touch. The experience of the nurse's touch is explored further through phenomenological reflection on descriptive accounts of the nurse's touch from poetry, fictional prose, neonatal nurse interviews, as well as scholarly and personal accounts. These examples show insights into the nurse's touch as a site for an ethical encounter, while contemplating the normative character of a good touch.

A fourth paper is included in Appendix A. One of the originally proposed research questions was "How is the lived experience of the nurse's touch mediated, varied, or changed through the use of medical technologies?" Given the technologic ecology of the NICU, I included this question to make room for the nurse's possible experiences with technologies influencing their touching practices. The nurses' responses did not tend to come easily. It seemed difficult for them to find the words or recall examples. The difficulty the nurses had with articulating the possible effects of technologies on their touching practices exemplifies exactly what happens with technologies in the NICU and in our world in general. As we use them and become proficient, the technologies largely disappear to us, and become nearly transparent as they are woven into the lives and practices of the nurse. In an attempt to address the question of the nurse's mediated touch, I have included a preliminary study on the nurse's touch, which considers the modest technology of gloves: *Relational Ethics of Mediated Touch: A*

*Phenomenological Inquiry into the Nurse's Glove.* The paper is in preparation for submission to *Phenomenology & Practice*.

**Chapter 2: Paper 1. The Unique Intimacy of the Phenomenological Interview**

Gillian Lemermeier

Being prepared for submission to Qualitative Research

### **The Unique Intimacy of Phenomenological Research Interviews**

Many qualitative researchers, using diverse methodologies, have come to rely on interview as a primary method of gathering the “data” of human experience (Gubrium et al, 2012a). There is an inherent respect underlying the use of interview in qualitative research, buoyed by the core assumption that people are authoritative of their own subjective experiencing of the world and are also capable of describing their own experiences as they are lived through. The words of the participants become the foundation for developing the eventual insights and revelations of the research. Weiss (1994) illustrates the wide spectrum of rich opportunities afforded the qualitative researcher through interview:

Through interviewing we can learn about places we have not been and could not go and about settings in which we have not lived. If we have the right informants, we can learn about the quality of neighborhoods or what happens in families or how organizations set their goals. Interviewing can inform us about the nature of social life. We can learn about the work of occupations and how people fashion careers, about cultures and the values they sponsor, and about the challenges people confront as they lead their lives.

We can learn also, through interviewing, about people’s interior experiences. We can learn what people perceived and how they interpreted their perceptions. We can learn how events affected their thoughts and feelings. We can learn the meanings to them of their relationships, their families, their work, and their selves. We can learn about all the experiences, from joy through grief, that together constitute the human condition.

Interviewing gives us a window on the past. We may become aware of a riot or a flood only after the event, but by interviewing the people who were there we can picture what happened. We can also, by interviewing, learn about the settings that would otherwise be closed to us: foreign societies, exclusive organizations, and the private lives of couples and families.

Interviewing rescues events that would otherwise be lost. The celebrations and sorrows of people not in the news, their triumphs and failures, ordinarily leave no record except in their memories. And there are, of course, no observers of the internal events of thought and feeling except those to whom they occur. Most of the significant events of people’s lives can become known to others only through interview (p. 1).

Weiss provides a broad understanding about interview in qualitative research, emphasizing its general utility as a method of gathering data for qualitative researchers. For any individual study, the interview is likely meant to retrieve only a subset of these possibilities, as shaped by the research question and the methodology.

In this essay, I explore and reflect upon the eidetic quality of the phenomenological research interview. In phenomenology, the research question is framed to ask what something (an event, experience, phenomenon) is like as it is lived through. It expresses a concern with the meaning and significance of an experience. Phenomenological researchers attempt to understand the phenomenon as it shows itself to the everyday world. Therefore, the interviewer in phenomenology does not look for the opinions, views, or suggestions of the participant. My focus here is specifically on an important and distinctive purpose of the phenomenological research interview: to gather the concrete detail of pre-reflective experience from someone who has lived through the experience, situation or event. Pre-reflective experience is the manner in which we find ourselves in the world, as it is lived in the moment. Phenomenological data is “what is given or what gives itself in lived experience” (M. van Manen, 2017, p. 810).

In contrast, an ethnographic interviewer tends to seek details particular to specific cultural groups and practices; a grounded theory interviewer stays tuned to features of social processes; the survey interviewer tends to gather opinions on a specific topic, and the narrative interviewer aims to collect rich stories of individuals and their lives. The methodological particulars of interviews are rarely described in detail in academic articles, which may give the impression that there are no important differences between methods. All of these are variations of explorations of human experience, and participants may share elements of their experience in story, but none require pre-reflective detail of the experience, and instead may rely on the reflections and attitudes of the participant.

To begin, I briefly consider what others have written about the phenomenological interview and share an experience of an interviewing experience, in an attempt to ground the concerns and ambitions of this article. To clarify the specific mandate of the phenomenological interview, I situate it in the context of phenomenological inquiry, specifically that described by M. van Manen (2014). To better understand employing interview as a method of data collection for phenomenological research studies, I consider the practice of the phenomenological reduction in service of becoming radically open to the phenomenon under study. To this end, I explore in a

questioning manner how one might cultivate a sense of wonder, in order to set aside or push through preconceptions, pre-knowledge and assumptions when entering into a phenomenological interview. Using examples, I emphasize the methodological importance of the concrete description of experience in phenomenological inquiry. Finally, I describe the unique intimacy that may occur during a phenomenological interview.

## **Background**

Others have noted that methodological aspects of the phenomenological interview have been underemphasized (Bevan, 2014; Englander, 2012; Giorgi, 2009), and its difficulty underestimated (M. van Manen, 2014). Wimpenny and Gass (2000) reviewed research articles to compare interview as a method of data collection in phenomenological and grounded theory qualitative research. They describe that what appears to be happening in the articles they reviewed is a generic use of interview as a method of gathering data, without much consideration of its congruence with a particular methodology. The lack of method-methodology alignment could result in inappropriate discussions of how interview was used within a specific methodological orientation. Some of the phenomenology articles did mention asking participants about experience, but none specified pre-reflective experience or concrete detail (Wimpenny & Gass, 2000). Englander (2012) similarly noticed inconsistent descriptions in the literature that indicate the research interview was not aligned with phenomenological criteria.

The otherwise fine resource *The Sage Handbook of Interview Research: The Complexity of the Craft* includes only a few paragraphs on “phenomenologically informed” interviews in a chapter on postmodern trends (see Borer & Fontana, 2012). The text includes no real reference to the interviews of phenomenological research, amidst full chapters on the research interview dedicated to other qualitative methods such as grounded theory, narrative inquiry and ethnography. Others have written extensively on interview as a method of data collection in qualitative inquiry, but not as it appears in specific methodologies (see Brinkmann & Kvale, 2015).

Guerrero-Castañeda (2017) and his colleagues define a phenomenological research interview as a dialogue between two people that “permits the apprehension of a phenomenon via language” (p. 2). The experience is recounted after it is over, when it may be hard not only to recall, but to relate without reflecting on or interpreting the experience. The difficulty of gathering pre-reflective accounts in interviews is due in part to the need to use language to

convey the experience, which means the experience is already abstracted and interpreted in its articulation through language. This presents a unique ontological conundrum for phenomenological interviewers – the desire to collect something that is admittedly impossible to collect, meaning one collects a proxy, a best attempt to the closest thing possible.

Using examples from interviews for two phenomenological research studies, I attempt to illustrate and animate how the researcher might practice the reduction to make it more possible to become close to the research phenomenon, through the words of the participant. Practically, this means guiding the participant to sharing experiential accounts of their experience that are detailed and concrete in nature. The first research study, *Embodied Ethics: Phenomenology of the NICU Nurse's Touch* is an exploration of the ethics of the neonatal nurse's touch (Lermeyer, *in press*). Participants for this study are neonatal nurses, who helped me to generate descriptions of their lived experience in such a way that I was able to reflect on moments of the nurse's touch such as cultivating an ethical receptivity to the baby through touch, and more. The research questions of the second project, which I will refer to as the *NICU baby study*<sup>1</sup>, are concerned with what it is like to have a baby with a congenital anomaly (an abnormality of structure or function at birth), a baby who might be seen as different, or other to oneself as a parent. Participants for the *NICU baby study* are mothers or fathers of babies born with a congenital anomaly.

As previously mentioned, the research interview needs to be specifically oriented within the particular methodology of the study. This is also true about phenomenological human science research; different traditions may require different approaches to interview with different intentions. Both of these studies were undertaken from the methodological perspective of Phenomenology of Practice, as described by Max van Manen (2014). Therefore, the interviews I focus on here are conducted in that context. I appreciate different considerations may exist for individuals pursuing other approaches to phenomenological inquiry such as Interpretive Phenomenological Analysis as described by Jonathan Smith et al (2009), or the descriptive phenomenological method of Amedeo Giorgi (2009).

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<sup>1</sup> I was fortunate to serve as research assistant to Dr. Michael van Manen, Principle Investigator of this study. He has my thanks and appreciation.

### *An Interview Experience*

This exploration of the phenomenological interview is founded in questions and ideas that began to germinate shortly after holding my first interview with a mother for the *NICU baby study*. As a mother and former neonatal nurse with several years of experience having intimate and difficult conversations with parents of babies in the neonatal intensive care unit (NICU), as well as families whose loved one died suddenly from traumatic brain injury, training in phenomenological research (Adams & M. A. van Manen, 2017) and experience in qualitative research interviews, I felt capable of speaking with sensitivity to the mother who had agreed to share her experience.

We had a quiet and private conversation. The exchange flowed quite easily as she shared recollections of receiving the prenatal diagnosis, through the baby's experience in the NICU, and ending with the present last few days in the hospital. She was thoughtful and disclosive; at the end of the interview, she expressed gratitude for being able to "talk about it all". Despite the gratifying gestures, I felt a niggling worry as I was packing up the digital recorders and paperwork: had I garnered concrete descriptions of specific experiences? Reflecting on this concern, I also wondered about my own uncertainty. How could I know if the interview conversation had generated experiential material in concrete detail? How could I not know?

Reviewing the transcript, the researcher and I identified several instances when different follow-up questions might have drawn out more concrete description. For example, after the initial ultrasound, the mother said she felt nervous and texted a friend. My next question was about the drive home from the ultrasound. In retrospect, I wish we had dwelt longer in the moment of her texting. The words and the conversation she shared with her friend may have taken us both back to the specific moment of her initial inkling that something might be wrong with the baby. I would have asked "can you recall what you texted?", or "can you tell me more about that conversation?" in an effort to bring her back to that moment in time as she was living through it. Attending more carefully to this moment might have helped to draw nearer to the dawning moments of the lived experience of discovering, anticipating, or otherwise beginning to sense the possibility that her baby had a medical diagnosis. I was surprised by how difficult it was to elicit concrete descriptive accounts in phenomenological interviews and assumed that missing out on these moments was a function of my own inexperience doing phenomenological research interviews.

My lack of practice was surely part of the story. But after speaking to colleagues, mentors and scholars (all phenomenological researchers), they agreed: regardless of practice, eliciting lived experience descriptions in an interview can be a challenge. One counselled that a researcher has to enter a phenomenological interview recognizing the possibility of finishing without a single usable descriptive account. This may be particularly true when speaking to parents of children with medical needs, if they find themselves unable to talk, being appropriately preoccupied with other aspects of their own or their child's life. The advice reflects the inherent difficulty that participants may have not only recalling specific elements of an everyday experience, but also they may be hard to remember in rich, lived-through detail, especially when the phenomenon being investigated is seemingly ordinary and embedded in life practices. Finally, there is an ethics to asking individuals to speak about the meaningful moments of their lives. The ability to recall details of an experience can depend on many other things such as the topic, recency of the experience, or the individual's memory.

Remembering moments of touch with newborn babies could be quite difficult for the neonatal nurse participant because the touching contacts, gestures, and movements are often subsumed within the daily tasks and routines of nursing practices. It was a different situation for parent participants in the *NICU baby study*. Having a child born with a congenital anomaly is neither an everyday nor ordinary experience and the interviews usually took place within a few weeks of the baby's birth. However, one must take into account the physical and emotional state of a new parent, which may also affect recall. The ability to describe past experience in concrete detail may further be thwarted by the human impulse to opine, analyze and make sense of their experience. That is, the NICU nurse may be more inclined to share their views on the importance of touch, and the NICU parent may be more inclined to talk about general worries for their baby's future.

The difficulty may also reflect the challenge for the researcher to push aside their own preconceptions about the phenomenon itself or to register a participant's experience in the moving space and time of the interview. The phenomenological research interview needs to be conducted while the researcher is practicing the philosophical attitude, that is, having pushed through as much as possible their own assumptions and judgements about the phenomenon (M. van Manen, 2014). The interview must be regarded as a specific mode of data gathering

integrated with the research method and process. The orientation of the interview is reliant on understanding the methodology of the research study.

### **Situating the Interview in Method: Phenomenology Human Science Research**

Phenomenological research comes from a rich philosophical tradition, most often said to begin with Edmund Husserl in the early 1900's. Any student of phenomenology will soon discover that rather than a unified, coherent school of thought, distinctive phenomenological traditions can be identified, described by different philosophers and according to differing scholarly inclinations, each offering insights to method particularities. As such, phenomenology may be thought of as a living tradition, constantly reinventing itself (M. van Manen, 2014). The methodological focus is one of reflecting on experience as lived through, and the meanings that inhere in experiences that allow us to give them labels that reflect human meanings such as worry, loss, love, and so forth (M. van Manen, 2017).

Husserl's call, "to the things themselves," expresses attentiveness to the rich meanings of experiences as they show up to us in the world, and before we abstract, theorize, or otherwise distance ourselves from them in the act of "naming" things (Merleau-Ponty, 2012, p. xxi). The phenomenological understanding aimed for is one of reflection on *pre-reflective* experience. As previously described, pre-reflective experience is the manner in which we find ourselves in the world, as it is lived in the moment. Accessing pre-reflective experience is not always easy, given our nature to live in a mostly unreflective and taken-for-granted way. The philosophical reduction is the method of turning reflection back to experience in its lived immediacy.

#### ***The Philosophical Reduction***

The philosophical reduction is often described as the central method of phenomenology. It is itself the subject of rich philosophical discussion such that the notion of the reduction is variably articulated and discussed by different phenomenological authors, including by Husserl (1913/2014) himself, who originated the idea of suspending preconceptions about the world (bracketing). In a broad sense, we can say that the philosophical reduction does not mean a simplification or diminishment in meaning (reductionism). It is not the reduction or simplification of an experience and not even the removal of confounding factors. Just the opposite, this methodological movement makes room for different understandings and the questioning of meaning (M. van Manen, 2014). In line with the etymological roots of the term "reduction" (to come close or restore to a previous state), the phenomenological reduction aims

to restore, resemble, or reassemble the originary phenomenon in its lived wholeness (Reduction, OED, 2021). Phenomenologists tender the “reduction” in an effort to make closer contact with the world, to lift up the phenomenon just enough to see it more clearly while remaining firmly in its world, never severing its connection to the “intentional threads that connect us to the world” (Merleau-Ponty, 2012, p. xxvii).

The intentional threads that Merleau-Ponty speaks of characterize the inseparable nature of human being with the world. It is never the intention of phenomenology, nor of the philosophical reduction, to rupture this relationship, but rather to lift up just enough to see, or shine light upon, the taken-for-granted aspects, things, and experiences of life in the world. Merleau-Ponty (2012) counsels and consoles by reminding us of the most important teaching of the reduction: it can never be completed. We cannot fully release, or even be aware of, all of our preconceptions and theoretical understandings, and we cannot fully grasp an experience in its pre-reflective state because it is always too late after the moment itself. It is the attempt to *move toward* this possibility that opens up the world as lived, a striving to be open to the phenomenon itself.

Taminiaux (2004) has described the reduction as opposing but complimentary gestures of the epoché and the reduction proper, orienting to phenomenological meaning as it arises in experiences themselves. The epoché opens space, by “setting aside,” or placing in abeyance anything that obstructs access to the phenomenon and may be seen “as a critical-position-taking attitude that requires the phenomenologist to adopt and accept a resolve to take nothing for granted” (Bevan, 2014, p.139). These obstructions might include questions of physiology, psychology, any knowledge we have about everyday life, and other more theoretical ways of looking at the world. They are our habits, our assumptions, our beliefs, the “knowing” of our everyday lives. Through the epoché, we attempt to put these presuppositions into question. This creation of space makes it possible to try and “draw nearer” to the experience as it appears with the gesture of the reduction proper, so that we can begin to grasp meanings that inhere within experiences as they are lived through. The reduction has perhaps best been described as an attitude of wonder; in the words of Eugen Fink, “‘wonder’ before the world” (Merleau-Ponty, 2012, xxvii).

### *A Sense of Wonder*

What is meant by wonder? Wonder is not exactly a feeling of awe, curiosity, surprise, amazement or bewilderment, but perhaps a mix of these impressions and more. “Wonder admits a range of possibilities since it is an experience of self on the way to and groping for an attitude with regard to the reality with which we are confronted” (Verhoeven, 1972, p. 26). Through “wonder, attentiveness, and a desire for meaning” (M. van Manen, 2014, p. 220), we are opened to finding something entirely new or strange in the familiar, a radical openness to possibilities. Even before the research question is uttered, phenomenological research is sparked by wonder about the world and this attitude is intentionally sustained throughout all of the project; through data gathering and reflection and writing. The unique character of the phenomenological interview may be revealed by exploring its connection and purpose within the dual gesture of the reduction: the phenomenon is considered with a sense of wonder. Yet how do we come to wonder? Is it possible to cultivate such a disposition? How might the researcher animate this central method of phenomenology during the interview? It is one thing to “resolve to take nothing for granted”, but another to actually take nothing for granted. Cultivating a sense of wonder, that is, applying the epoché, is not an intellectual or conceptual endeavour, it does not seem graspable through thought. We cannot think our way to wonder.

Cultivating wonder might happen with help from our imagination. Upon first considering an experience for phenomenological consideration, I begin to imagine possibilities of that experience. I have chosen the phenomenon because I have some sense of fascinated absorption with it. I am captivated by it and captive to it. Yet, fascination is not a sense of wonder (M. van Manen, 2014). Often in phenomenological research, we are looking at what we normally “pass over”, that is, the ordinary and everyday phenomena of the world. A sense of wonder may be cultivated by looking closely at what is usually quite transparent to us in our busy, distracted attitude, for example, by attempting to put the experience into words. When first considering a study of the nurse’s experience of touch and an embodied ethics, I thought back to moments from my nursing practice in the NICU and intuitively recognized their meaningfulness. But, when I attempted to answer my own questions -- what *is* the nurse’s touch, what are its meanings, where are the ethics in touch -- language escaped me and I became unsure, pausing to pay attention.

The questions themselves took on new meaning; it was the manner of asking that seemed different. I was experiencing the questions in a questioning way. Verhoeven (1972) notes the

similarity in the etymology of wonder and question and claims the question as already “seeking an outlet for wonder” (p. 34). If questioning opens the way to wonder, it is not to say that wonder is composed of questioning. Wonder is ineffable, it remains the “other” in philosophy, or its enlightening character is lost. Perhaps then, it was my questioning that led to wonder, by bringing me to pause in the thinking of questions. Halting “is the involuntary break in a rhythm not only of thought but of the whole of life” (Verhoeven, 1972, p.35). A fellow researcher shares this story:

As I walked away from one of my last interviews, I felt sick. I didn't know what to do and really thought I might quit my PhD studies, or as if I had no choice but to quit. During the interview, I felt the structures of meaning that I had relied upon fall away. These new examples before me did not fit, and without my usual frames of reference, I did not know what would happen. Sure, I had written down my bias, but I was confronted with my own assumptions and they did not hold up (anonymous, personal communications).

In this instant, the researcher becomes shaken by the realization that there is more to the phenomenon of study than they realized. They are opened to difference and made momentarily inconsolable by coming face to face with a turning point, a crisis, in the research process. This is the crisis of wonder, with all “the dangers inherent in a crisis. A crisis exists when a person is formed to review the structure of his existence and break out of his closed circle into a greater openness” (Verhoeven, 1972, p. 29). The researcher is addressed by their own vulnerability as it dawns on them that everything they previously thought was coming under question. Yet, the vulnerability may be just where the possibility for the epoché, for wonder, can happen. In the moment of vulnerability it becomes possible to ask, “am I being true to the phenomenon in its fullness?”

During the first interview for the nurse’s touch study, just after we had said “hello” and discussed the consent process, the very first participant paused as I asked them to describe a moment of touching a baby that stood out to them. Upon thinking for a moment, the participant asked me: “Well, I can remember the last baby I couldn’t touch. Would that be okay?” They caught me off guard, I had not considered such a situation. For an instant I was stuck for what to say, and in a rush the meaning of the eidetic, seeking variant experiences of the phenomenon, came rushing back to me, and I realized that “Yes, of course that would be a good place to start.”

We may still be left unsure of how to evoke a wondering sensibility in ourselves or others. There is likely no sure answer, nor sure technique, and to be certain about wonder would seem to occlude the openness and vulnerability of wonder. Verhoeven says we *plunge* into wonder and that it is “a purely passive attitude, allowing oneself to be overwhelmed” (p. 41). We might think of being passive in the sense of not resisting openness, or attempting to control or make one’s attention overly orderly. Ultimately, opening to wonder may be helped by remembering the purpose of the reduction, that is to gain access, through interview, to the participant’s world of pre-reflective experience for phenomenological reflection.

***In the Context of Wonder: Practicing the Epoché and Reduction***

Max van Manen (2014) emphasizes that phenomenological research has no prescriptive method. There is no list of steps or procedures that can bring a researcher from question to inceptual insight as if by guarantee. More critically, imposing a fixed methodological procedure on the investigation of the phenomenology of human experience risks obscuring and blocking its originary meaning. The phenomenology requires us to put everything into the research question, including the route through the study itself. As we go forward into the exploration of the phenomenological interview, we are best not to hold too firmly to any heuristic or technique. We are better served by undergirding the research process with a continual reminder that any methodological choice must be made with attention to the requirements of the phenomenon itself.

There are conflicting suggestions regarding the “best” format for the phenomenological research interview. An unstructured format, that is an interview with no standardized questions, is often suggested as appropriate for phenomenology (Koch, 1996; Vagle, 2018; Vandermause & Fleming, 2011). Unstructured interviews are meant to allow the participant to describe the phenomenon in their own words (Guerrero-Castañeda et al, 2017). A minimal number of questions are asked in an attempt to let the participant respond without being overly influenced or “led” by the interviewer. In a study on the meaning of caregiving, Wood (1991) describes that in “true phenomenological research” (p. 196) the interviewer only asks one question but notes the use of a “semi-structured” approach in their research project. Semi-structured interviews consist of open-ended questions to which the participant may respond freely (there are no prescribed options for answers), and all questions are asked of all participants (Morse, 2012).

Although interview is a method of data collection drawn from qualitative research, it is important to remember interview in phenomenological research has a different purpose (M. van Manen, 2014). Rather than relying on a certain format, the interviewer may be best served by maintaining their own clear orientation to the phenomenon, and the phenomenological purpose of the interview. This requires some preparation such as covered above regarding the cultivation of wonder. Being oriented to the phenomenological purpose also guides us to the practical consideration of the questions themselves. For example, I prepared a list of guiding questions for the *Embodied Ethics* study interviews. The questions were crafted in a way that did not ask for opinions or reflections, but rather discrete moments: *Can you remember when you first touched a baby in the NICU, during your early days of working there? Can you tell me about a recent physical exam you have done? Can you recall a time when you put in an IV?* These questions were not required, and oftentimes I did not refer to the list at all, when the interview flowed as a conversation. Re-reading the list of questions before entering into the interview served another purpose that I did not anticipate: preparing my state of mind by reminding and reviving my sense of wonder at the nurse's touch.

Finally, we might consider the format of the interview to be “conversational”. Hermeneutic phenomenologist Hans-Georg Gadamer (1975/2004) describes conversation as something we might fall into or *become involved* in and says “a genuine conversation is never the one that we wanted to conduct” (p. 385). Surely, the phenomenological interviewer always *wants* to conduct a certain conversation, that is, to gather the pre-reflective details of a lived experience. To reconcile Gadamer's description of the conversation with the research interview as conversation, we might consider his idea that “no one knows in advance what will ‘come out’ of a conversation” (p. 385). The point may be that even with some predetermined topics, it is the conversational *tone* that creates space for the unexpected in any conversation, including a phenomenological interview. In this way, space is created for the unexpected to be said in the interview, in turn sustaining the ongoing cultivation of wonder and renewing the phenomenological reduction as a setting aside of expectations for the interview.

### **Phenomenological Foundations: Description of Lived Experience**

Phenomenology as human science research begins from experiential material expressed in concrete detail. Physician Buytendijk has called phenomenology “the science of examples” (M. van Manen, 1997, p. 121) referring to the move to revive living contact with the world. As

researchers we “borrow” the experiences of others as a way to vicariously become more experienced ourselves (M. van Manen, 2014). Examples in phenomenological research are descriptive accounts of lived experience. The term “lived experience” has become quite common not only across other qualitative research methodologies, but also in the media and popular language. It is used particularly in contexts of social justice as a way to emphasize understanding what life is like for those other from ourselves. For phenomenological researchers it is a technical term, aiming for a more precise translation of the German *Erlebnis*, since the English word *experience* does not bring with it the meaning of “lived”. “The notion of ‘lived experience’ announces the intent to explore *directly* the originary or prereflective (sic) dimensions of human existence” (M. van Manen, 2014, p. 57). The attempt to recover pre-reflective moments of experience distinguishes phenomenological inquiry and is necessary for its aim: to dwell and reflect upon the meanings of life as lived.

In order to more clearly see the potent effects of concrete description to illuminate an experience that can then be reflected upon in a phenomenological study, I will consider phenomenological examples from two research articles. I note that anecdotes such as these are not meant to illustrate or prove the researcher’s insight. The example in phenomenology “provides access to the phenomenon in its singularity. It makes the ‘singular’ knowable and understandable” (M. van Manen, 2017). In their study of the experience of learning in a massive open online course (MOOC), Adams and colleagues (2014), share an anecdote of the experience of a learner being surprised by:

What ended up being a high degree of intimacy, or rather my sense of intimacy between me and the instructor. Surprising, because initially I think 150,000 people signed up for the course and it seemed like it should have been impersonal (p. 208).

This is interesting, the reader might wonder how an online course with thousands of students that uses videos to deliver content could be experienced as intimate! We might be left wondering, what does this student *mean* by intimate? For the researcher, it could prove difficult to reflect on since this is a reflective comment by the student sharing some detail of the moment (it surprised him to feel an intimate connection) but is perhaps not specific or clear enough. However, he continues:

It was about three weeks in when I began to have this sense—while watching the videos—*like the instructor was speaking directly to me, almost as if he were just sitting across that table from me* [emphasis added]” (Adams et al, 2014, p. 208).

Now, through the student’s vivid description, the reader can sense the intimacy. Most of us have sat across the table from another and felt the intimacy of a close conversation, maybe while sharing food together. Understandings of intimacy are evoked through the expressiveness of description of experiences, generally more so than an individual’s perspectives, opinions, or judgements about experiences. We might note that the student was not actually sitting at the table with his instructor and question if this is lived experience or metaphor? If it was metaphor, we might try to guide the participant to more concrete and less abstract details. But pre-reflective experience includes our thoughts and feelings from the moment, rather than a retrospective, reflective, conceptual conclusion.

From M. A. van Manen’s phenomenology of parental decision making in the neonatal intensive care, a parent recounts:

The doctors kept on asking us about withdrawing care. We felt pressured to decide, almost hounded, to take Sam off life-support. It was as if they thought that we did not get it. But we knew that he could be severely disabled, that his chances were so poor. Yet, how could we kill him? How could we have a part in ending his life? We avoided the staff to avoid the discussion. *We avoided coming in to see our son* [emphasis added], just to avoid being confronted with the predicament of having to face some kind of impossible decision. We just wanted to let him have a chance. If he was to die, he would die on his own. We did not want to take his death away from him (2014, p. 283).

In this instance, the parent describes being made very uncomfortable by the healthcare professionals and questions about the care of their baby. Their language is particular and vivid, laying bare their experience of these requests in a recognizable way: *how could we kill him?* and *we avoided coming in to see our son*. Imagine, if the parent had instead said, “The doctors and nurses didn’t understand us, we wanted to continue treatment”. These words give some access to the experience, of course. But the lived immediacy of their response is characterized by a punctive, devastating admission: in the discussions with caregivers, the parents likened themselves to being the architects of their child’s death. From here, the researcher can ask the

basic phenomenological question: what is this particular moment of making a decision like? (see M. A. van Manen, 2014).

In these examples, I have emphasized the foundational importance of the addressive quality of lived experiential material to phenomenological reflection (see Adams & van Manen, 2017; M. van Manen, 1997; 2014; M. A. van Manen, 2020) before delving into how to practice the reduction during the interview to recognize and elicit concrete description.

### ***To Gather Lived Experience in Interview***

In previous research interviews (for different qualitative methodologies), I created a comfortable, safe space, listened attentively, followed up, probed, ensured the recorders were working, and used a light touch to keep the interview broadly on topic. From there, the participant's responses and stories were the "data" that would constitute the research. Sometimes concrete in detail, more often the participant's words would be more abstract, expressing their perspectives or opinions about the matter. This is not to suggest I took on an entirely passive posture, and I recognize that my choice of responses influenced and co-created the data.

However, those first phenomenological research interviews felt completely different. My experience of the interview was much more active, listening for accounts of concrete description of pre-reflective experience. Most often, the concrete detail of pre-reflective description that I was listening for did not come from the participant as a discrete gem of information. To remain phenomenologically oriented to the experience under study during the interview is a demanding task. It necessitates a self-consciousness, a split in awareness on the part of the interviewer – remaining attentive to the person in front of you, while also staying alert to the participant's responses: are they pre-reflective descriptions of experience using concrete detail? It can be hard to recognize concrete description while immersed in the interview. It may be helpful to consider how concrete description might be recounted, that is, what pre-reflective may 'sound' like, during an interview.

Here is an excerpt from an interview transcript from the nurse's touch study (edited slightly for clarity):

*Researcher:* Remembering back to when you first started touching babies in the NICU, is there a baby or a time that stands out?

*Participant:* I think the first baby I held on the unit was on level 2. And it was a smaller baby, like maybe 32 weeks [gestational age] and probably weighed about 2 kgs. So, smaller

than any baby I'd held in my life. The nurse with me said, "Just bottle this baby." And I had never even held a baby that small before. I didn't really know what to do. I was really scared. I think touching the baby for the first time was a bit scary because I thought they were so delicate. I try to remember that now going forward, when I see dads doing their first diaper change, and the moms doing, whatever for the first time. I try to think of how nervous I was and that wasn't even my child.

*Researcher:* Ok, let's stay there for a minute. "Just bottle the baby." There's a whole bunch of steps for someone that's new--to 'just' bottle the baby.

*Participant:* Oh yeah. I remember looking at her and saying, "I don't, I don't know how to do that."

*Researcher:* Right.

*Participant:* So, she walked over with me and she said, "Well just try picking her up." The baby was a girl, I remember. She said pick her up and I was nervous as to how much I needed to support her head. I definitely had one hand under her head and then I just picked her up and held her against my chest like I would hold a full-term newborn.

*Researcher:* And then what? Because you had to move to the chair to feed her?

*Participant:* She had cords attached because the leads are attached, so they're just dangling down. And then we sat in a big recliner chair and I held her there. Then the other nurse helped me to move her into more of a cradle position for bottle feeding, and then put the bottle in, and at first, I didn't put the bottle in the whole way because she's too small. And then she showed me, the other nurse was holding my hand. Well, holding the baby's head and holding my other hand to help me get in there.

In this instance, the nurse starts to describe the first time they held a premature baby. Their recollection is entwined within attitudes and reflections, as often happens when telling a story. I found it helpful to slow the story down, to let the participant finish and then ask them to go back. The initial response from the participant revealed how the experience of learning to pick up a small baby informed her practice with parents who were hesitant to hold their own baby. This is an interesting reflection on their part that leads into a more general account of her approach with parents. Going back to the beginning of their story helped to retrieve more pre-reflective and concrete details of the experience itself. Being able to "see", or picture the participant moving

through the experience in my mind was a good signal that they had shared concrete detail of an experience.

A straightforward practice that may help the researcher to both recognize concrete description of experience during the interview and help participants recall and describe moments of experience is to provide an example from one's own experience. During interviews for the *Embodied Ethics* study, if the nurse was having trouble recalling and sharing an experience where they felt affected by the touching contact between them and a baby, I would share a story from my own experience. My story is one of a very ordinary moment, of a very busy day on the unit when I caught myself rushing through a diaper change. I described to the nurses my recollection of slowing down and having a physical sensation of calm and connection. In some instances, this led the nurse to remember and share a poignant, detailed memory of their own. Other times, it did not seem to inspire or enlighten the nurse at all, reminding me that there is no surefire or guaranteed recipe for the phenomenological interview.

### **The Unique Intimacy of the Phenomenological Interview**

Many qualitative research methodologies require the researcher to confront and set aside their assumptions by practicing a form of reflexivity or bracketing; a form of the epoché. Phenomenologists alone follow this gesture with its complementary philosophical method: the reduction. There is a particular vulnerability and intimacy that may occur if a participant is able to recount through their words moments that speak soundly to the pre-reflective meaning of their experiences; that is, if they can invite the researcher into a moment of their life so the researcher too encounters semblances of this meaning. Such a gesture is not to be taken lightly and deserves a thoughtful response and awareness of risk. The intimacy that I am suggesting is unique to the phenomenological interview is not one of rapport, or empathy, or even the creation of a safe, disclosive space. Although all of these characteristics may benefit the success of a research interview, and are ethically necessary, the intimacy I refer to is more radical, more fundamental. The phenomenological researcher is attempting to garner an invitation into the lifeworld of the participant, to encounter meaning aspects of a moment, through their own subjective sensitivities.

For this to be possible, however, the participant needs to intimately reencounter their own experience. As established, it tends to be difficult for a participant to go back to a memory and then express it as closely as possible to what happened with concrete detail. It is the delicate task

of the interviewer to guide the participant to expand their attentive awareness, to unfold the telling of an experience when pre-reflective meaning has been sedimented over with opinion and reflection. Several nurse-participants teared up (as did I) at different points in the interview, recalling in detail instances of touching the tiny babies who are their patients. The personal meaning of the moment relived was evident in their response. It is in the moment of the experience, where the reduction may be experienced in the context of the interview. Merleau-Ponty (2012) is resolute when he says about the world that “[w]e must—precisely to see the world and to grasp it as a paradox—rupture our familiarity with it, and this rupture can teach us nothing except the unmotivated springing forth of the world” (p. xxvii). In the gesture of the epoché, the researcher is open and exposed to structures of the experience that were not their own. If able to somehow put their own strongly held structures of meaning of the topic at bay, the researcher may find themselves in the rich and intimate territory of contacting the world, through the words of the participant.

### **Concluding Thoughts**

The focus of this paper is deliberately narrow, recognizing that other authors have eloquently and comprehensively described other aspects of the phenomenological interview, important practical and methodological details such as the selection and number of participants, preparation of the space, and other pragmatic considerations (Bevan, 2014; Englander, 2012; Gubrium et al, 2012b; M. van Manen, 2014). All of these particulars of the research interview are important to consider and accommodate, but none are sufficient for phenomenology. I hope that the suggestions, ideas and examples in this essay may feel supportive and helpful to phenomenological researchers. Unfortunately, the techniques, strategies, and “tricks” are no guarantee that pre-reflective experiential detail will be given by the participant. Even the researcher’s dedicated commitment to adopting a phenomenological attitude and the questioning laying aside of their preconceptions, assumptions and presumptions about the phenomenon may not be enough.

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**Chapter 3: Paper 2. Embodied Ethics: Phenomenology of the NICU Nurse's Touch**

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### **Embodied Ethics: Phenomenology of the NICU Nurse's Touch**

Important and difficult discussions of health ethics often revolve around weighing the moral correctness of clinical actions around issues such as decision-making for medical interventions, truth-telling following medical error, and informed consent for experimental therapies. Yet, in the clinical day-to-day of practice, health ethics do not unfold from abstract moral discourse but instead arise from the everyday and extraordinary moments of contact between health providers, patients, and their families. These moments might better be described as revealing the felt sense of ethics that is experienced in an encounter with a vulnerable other. Many such encounters in healthcare are experienced in physical contact. The touch of the nurse is essential to perform routine and urgent tasks as well as to comfort and communicate with people in care. There are few patients that need a more delicate, sensitive, and skillful touch than premature or ill babies requiring care in a newborn intensive care unit (NICU).

Touch is deeply embedded into NICU nursing, sometimes so taken-for-granted as to seem invisible, although implicated in nearly every nursing gesture and pursuit. Inserting an intravenous line, bathing a baby, assessing vital signs, or holding and rocking a baby to sleep, and more; all of these activities are rich with the immediacy and intimacy of personal contact, and dependent on sensitive, capable touch. Understanding touch as physical contact alone may fail to capture what is encountered in the touch between nurse and child. The nurse's touch is probably one of the most simple, recognizable, and understandable gestures of NICU treatment. Indeed, the baby may not survive without it.

A phenomenological inquiry explores an experience in context, as it is lived in the world. Michel Serres (2016) suggests that the world is not a medium in which we live, rather, that things in the world mingle with each other. This includes us, intersecting and caressing the world, as it intersects with and caresses us. Over the last months, the world within which we mingle, intersect, and caress is fundamentally changing. With the onset of a global COVID-19 pandemic, our lives and the way we live them are radically transformed. Undertaking "social" or "physical" distancing has become an unvarying public health directive and the theme of daily life. We are being educated, and legislated, to stay apart from each other. The nature of the novel coronavirus' contagion makes our intersections, with those we know and those we do not, starkly clear; we breathe each other's breath and our touches linger on surfaces and packages long after

we are gone from them. Due to the risk of disease transmission, physical contact has become associated with a danger of becoming ill or transmitting disease.

Many healthcare practitioners, including NICU nurses, are not able to physically distance themselves from the babies that need their care. The interviews and observations in this study did not occur during the pandemic and do not address “the dangerous touch”, nor discuss the ways touching practices are currently being mediated by personal protective equipment or legislated behaviour changes. Still, the current global situation allows for a unique methodological possibility as we enter into this text, writer and reader. Missing the ordinary and extraordinary experiences of touch in our lives has given rise to a heightened awareness of human touch between people and what it can mean to us all. An increased sensitivity about human touch and its meanings in our lives in general unsettles our pre-understandings and preconceived biases about the nurse’s touch in the NICU. Phenomenologically, we have become shaken from our natural attitude, released in part from the state of moving through the world without questioning or even noticing those everyday practice experiences.

### **Related Literature**

Human touch, as a tool or technique of nursing practice, has been written about in adult patient settings for decades. Research studies are somewhat limited and sporadic. Early on, observational studies counted and categorized nursing touch as variations of necessary (or procedural) and non-necessary (or communicative and caring) (Barnett, 1972; Mitchell et al, 1985; Watson, 1975). An assumption in many of these studies is that the touches of nurses exist in one category or another, without making clear how different types of touches are identified in research or occur in practice (Estabrooks & Morse, 1992; O'Lynn & Krautscheid, 2011). The research results tend to offer information about who touches who, where, and how often, without uncovering any real sense of the possible meanings of touch in nursing practice (Estabrooks & Morse, 1992; Jones & Yarbrough, 1985).

This may in part be due to the notion of nursing touch not being clearly defined in the literature (Connor & Howett, 2009; Estabrooks, 1987; Gleeson et al., 2005; Warwick, 2017). Often a conventional definition of touch as observable skin-to-skin contact can limit studying other variations of touch (Estabrooks & Morse, 1992). Using grounded theory methods to consider the process of nursing touch, Estabrooks & Morse (1992) discuss touch as a tactile gestalt, involving other sensual components such as voice, movement and gaze.

As well as necessary to provide physical care, human touch is an important form of non-verbal communication (Chang, 2001; Gleeson, & Timmins, 2004; Kübler-Ross, 2014) and can be used to demonstrate empathy (Kelly et al., 2020), help patients to cope (Bottorff, 1993), and “may well be one of the most central aspects of healing that occurs between a nurse and a patient” (Connor & Howett, 2009, p. 127). Touching encounters reveal the ethics embodied between nurse and patient and make possible a relational space where openness and disclosure is made possible (Benner, 2004). Here, touch can be a transformative experience for both patient and nurse (Edvardsson et al., 2003). In a technical and busy healthcare environment, the nurse’s touch is a means of re-establishing mutuality between nurse and patient that is the moral foundation of care (Gadow, 1984).

Intimate touch of patients’ bodies is a routine part of accomplishing many of the tasks of nursing (Adomat & Killingworth, 1994; Chang, 2001; Connor & Howett, 2009; Estabrooks & Morse, 1992; Pedrazza et al., 2017). Patients expect to be touched intimately and that the nurse knows what to do (Edwards, 1998). On the other hand, nurses tend to be more comfortable initiating touch than being touched (Edwards, 1998), which is similar across health disciplines (Kelly et al., 2018). It is possible that nurses feel differently related to their care settings; Routasalo (1996), discovered that it was important for nurses to receive non-necessary touches, such as hugs, from residents in elder care. Ambivalence and uncertainty about physically touching patients can be related to several factors (O’Lynn & Krautscheid, 2014; Pedrazza et al., 2015; Picco et al., 2010). For example, gender is one barrier, with evidence to suggest male nurses feel more discomfort and worry about how their touch will be interpreted by patients (Pedrazza et al., 2017; Whiteside & Butcher, 2015).

Ambivalence and uncertainty around touching may be related to gaps in nursing undergraduate education. Little is known about how nursing students learn about touch during their education (O’Lynn & Krautscheid, 2014) and nurses have acknowledged a desire for more explicit education on touch (Estabrooks & Morse, 1992). Adult patients have indicated the belief that touching should be taught in basic nurse education (Mulaik et al., 1991). Nurses identify the workplace as the place they learn to touch, through trial and error (Estabrooks & Morse, 1992; Paterson et al., 1996). Beyond simply how to touch, a lack of education addressing the nurse’s own emotional responses to touch may potentially leave them unsure and ill-equipped to respond to patients’ needs (van Dongen & Elema, 2001). While the research and commentary focused on

nurse touching encounters with adult patients can offer opportunities to contemplate ethical moments and meaning, it is insufficient to simply “apply” it to the particularly vulnerable premature and ill newborn babies of the NICU.

### *The Nurse’s Touch in the NICU*

Human touch is widely considered critical in the development of infants and children and throughout the human life span (Barnard & Brazelton, 1990; Colton, 1983; Field, 2014; Montagu, 1986). Premature infants often lack tactile stimulation and comforting touch, beginning with their early birth (Abdallah et al., 2013; Field, 2014). Following admission to the NICU, and especially if unstable, the babies may be touched in ways that are unsupportive to their development and comfort (Álvarez et al., 2017; Benner, 2004).

Babies in the NICU undergo various more or less invasive procedures for diagnostic and therapeutic purposes, in an often brightly lit, loud, and otherwise inappropriately sensory overloaded environment (Abdallah et al., 2013; Im & Kim, 2009; Smith, 2012; Zeiner et al., 2016). Excessive noise and long-term exposure to pain can have detrimental effects on the physical and behavioural development of premature babies (Brown, 2009; Lidow, 2002). Policies of using minimal touch – limiting the touching of the baby in order to prevent infection and to minimize unpleasant or procedural touch may paradoxically contribute to both sensory deprivation (curtailing comforting and supportive touching) and overstimulation (procedural touching) (Álvarez et al., 2017; Leonard, 2008; Smith, 2012).

The NICU nurse’s experience of touching the baby and their families is a relatively unexplored subject, particularly the possible meanings of the ethical encounter of nurse and baby. This is despite the need for babies to be cared for through touch for even their most basic needs and the importance of touch to growth and development. This research project explores the relational ethics of healthcare practice by considering the phenomenology of a lived experience: the touching encounter of nurse and baby. To help realize its significance in NICU nursing care and to grasp an even deeper human meaning, I explore the lived experience of the nurse’s touch as an exemplar of embodied, originary ethics in nursing in the NICU.

### **Methodology**

Touch between people is a human event overflowing with complicated, contextual, contemporaneous meanings and it would be foolish and unhelpful not to acknowledge the many implications and associations that are lugged along with the word touch. Especially in an age

where the abuses of touch are (finally) coming more fully to light and heightened even more by a pandemic response requiring us to be physically distant from one another. These are not the experiences of touch I seek to understand here, but rather I am deliberately oriented to exploring the lived experience of touch by the NICU nurse.

I employed the qualitative research method phenomenology of practice, a context-sensitive form of interpretive inquiry (van Manen, 1997; 2014). It is an approach well-suited to cultivate rich and ethically sensitive understandings of human life as it is lived. The ethical meaning of touch between nurses and babies or their parents cannot be separated from the context within which it takes place. Different from theorizing or explaining touch, a phenomenological approach allows us to describe, regard, and grasp a deeper understanding of touch as it is lived through.

Phenomenology of practice is grounded in the phenomenological philosophy of Husserl, Heidegger, Merleau-Ponty and others, and the practical phenomenology of the Utrecht school (van Manen, 2014). The Utrecht scholars were practitioners, psychologists, physicians, and teachers who saw the possibility of an applied use of phenomenology that could lead to better, more reflective practice and practitioners. It draws together the philosophical concern of understanding life as lived with the orientation of practice, an understanding rooted in the ordinary and everyday. To understand experience, it is not enough to have it explained or summarized or analysed. Rather, coming to know another's experience requires a sympathy or resonance with the other that can help to foster an understanding of what their experience was like and what it might mean. Phenomenology makes possible this kind of pathic, tentative understanding, through reflection on pre-reflective experience, before we have had time to analyze and label the experience, or attach it to a theory or other preconception. Phenomenology of practice assists us to draw near to a human experience, in order to try to understand it better, and to "nurture a measure of thoughtfulness and tact in the practice of our professions" (van Manen, 2014, p. 31).

The underlying notion of this study is that the touching encounter between the nurse and patient is one of relational, embodied ethics. While acknowledging the utility of moral philosophy and rational approaches to ethics, relational ethics is founded on the premise that life is lived together with others. In their relational ethics project, Bergum and Dossetor (2005) phenomenologically explore thematic ideas such as complexity, vulnerability, uncertainty and

environment. They emphasize that relational ethics is an embodied ethics; we live ethics in our relationships with others. I hope to deepen and explore this idea here. Another influence is Maurice Merleau-Ponty's phenomenology of the body and perception (2012). The realization that we experience the world through and as our bodies helps us understand ethics as occurring not at a distance, or in a rational way, but enmeshed in the particular, "which locates the ethical moment within the beckoning of the body" (Mazis, 2006, p. 187). It is in this sense that I use the idea of "ethics" throughout this article, not as a cue for moral reasoning (although it may be a precursor), but instead as originating in our caring relationships with others.

### *Methods*

The primary philosophical method of phenomenology is the reduction. Although the notion of the reduction has been articulated in a variety of ways, broadly it may be understood as a gesture consisting of two opposing moves; the epoché and reduction proper (Taminiaux, 2004). The epoché, or pause, refers to an ongoing attempt made by the researcher to set aside assumptions, theories, preconceptions, ideas and judgements held about the phenomenon under study, in order to gain access to the experience as lived. For this study, I constantly asked myself to suspend what I know and think I know about the experience of the nurse's touch, ingrained during my own experience and learned through studying the texts of others. For example, I question if touch requires physical contact, and recognize that in my thinking about touch, I tend to emphasize healing and pleasurable touches versus hurtful or harmful touches. I recognize the need to intentionally check my research for the influence of this bias. The reduction proper follows the epoché, a positive movement toward the experience, to see its specific mode of appearing in the world (Taminiaux, 2004). Here, I consider what the moment of the nurse touching the baby might be like, as it is lived. Importantly, the phenomenological reduction is not reductionism, it does not make the phenomenon smaller or lesser than it was; it is not removed from context. Rather it suggests to lead back to, from the French root *reducere* (Reduction, OED 2021). As much as possible, we return back to the phenomenon as it gives itself to the world, before it was theorized, analyzed or explained.

Empirical phenomenological research relies on human science research methods, such as interview and observation, to explore an experience beyond that of the researcher (van Manen, 2014). I sought out nurse participants from four NICUs in Western Canada, using recruitment strategies of posters and emails. Interested participants contacted me directly and interviews

were arranged at their convenience. In total, ten currently practicing NICU nurses participated in the study. All were interviewed. The nurses shared experiences of nursing touch in the NICU during phenomenological interviews, oriented to gather pre-reflective experiential accounts of the nursing touches as they were lived. I paid particular attention to encouraging descriptions of specific moments, with as much detail as possible. Some participants were in their first few years of practice and others had practiced for decades. The nurses described varied experiences of touching babies and their families, providing a broad range of diverse examples of nurse-touch experiences. Interviews were audio recorded and transcribed verbatim.

In addition to interviews, one nurse submitted a written account of touch, and three nurses agreed to me observing their practice. For these observations, I joined each nurse at work on two occasions: each period of observation lasted between three and four hours, totaling approximately eighteen hours. Close phenomenological observation can generate different kinds of experiential material, including that which is hard to articulate for the participant. While watching I became privy to small gestures that had not been referred to in interviews, such as stroking the baby's cheek, gently bopping the nose, and light torso strokes while feeling the fontanelle. When I asked the nurses later about touches such as these, they often did not remember them. I wrote descriptive notes during and following the observation periods.

I worked with the gathered experiential material using thematic analysis. I read and re-read through anecdotes, interview transcripts and notes, wholistically and line-by-line attending to concrete descriptions of nursing touch. While reading, I identified lived experience descriptions of the nurse's touch. Lived experience descriptions are descriptive moments that recollect the nurse's experiences as pre-reflectively and concretely as possible, without personal opinions or generalizations about the experience (van Manen, 2014). Anecdotes were constructed by editing these descriptions in the direction of accessing the phenomenon by removing identifying and extraneous materials. From this material, I drew phenomenological themes. Phenomenological themes are not meant to summarize data, nor to generalize research outcomes, but to serve as heuristics meant to help uncover possible meanings that inhere in a particular moment of the nurse's touch in the NICU. Lifeworld existential themes such as lived space, lived body, lived time, lived things, and lived relation, were used to guide reflection on nurse experiences. I explored etymological and conceptual meanings to attend closely to the words and language used to describe the nurse's touches. I have written and re-written the text

many times, aiming for resonance with the reader, in an attempt to convey some sense of the experience itself (van Manen, 2014). In deference to the infinite number of possible meanings associated with any human experience, phenomenological texts, including this one, should be read tentatively and with a questioning attitude (van Manen, 2017).

### ***Ethical Issues***

Permission to conduct this study was received from the university health ethics review board and appropriate administrative and operational authorities. Consent was treated as an informed, ongoing and evolving process. Before the interviews, the participant and I reviewed information about the study and any questions were answered before the consent form was signed. The interviews were held at a time and place chosen by the participant.

### **Results**

I remember one mom whose baby would cry and cry, and I would go into the isolette and contain the baby with my hands and tuck in the soother and rest my hand on her head.

The mother said, “I feel like you have this magic touch, because every time I go in, she cries so hard. You go in, and she settles right away. What are you doing different than me?” I answer, “It's really not me, it's just what I'm doing”. Then I showed her how to try and soothe her baby with her touch.

A nurse may hardly be aware of the smooth movements of their own body while routinely involved in the NICU world, attending to a baby in daily care, only noticing if they are disrupted, for example, by dropping the soother or noticing a new rash on the baby. Until and unless the nurse-ly movements and actions are gently uncovered by the observations of the mother's parental gaze, nudging the nurse to attend to the ordinary moment afresh.

Parents who witness the skilled and soothing touches of a nurse likely do not believe the nurse is supernaturally conjuring comfort through their hands. To have a magic touch suggests that to someone else's eyes, what appears to be a difficult task is handled with ease. For the nurse, responding to an unsettled baby's cry is an ordinary and common part of daily practice in the NICU. The experienced nurse moves deftly: turning, re-positioning, containing, supporting, lifting, guiding the baby's little body to find a comfortable position. Without needing to think it through, make a plan, or use an algorithm or other prescription, it seems the know-how to soothe a babe is expressed as coming from the nurse's hands.

Often referred to as a phenomenological philosopher of the body, Merleau-Ponty asks if a routine movement (a habit) is “neither a form of knowledge nor an automatic reflex, then what is it? It is a question of a knowledge in our hands” (2012, p.145). Embedded in the muscles, tendons, skin, and flesh of the hands themselves, human touch seems to communicate in a vibrant and embodied complexity unrecoverable by words. It is difficult to express in spoken or written language what it is that touch does, or to describe how to touch the unsettled baby in a way that soothes and comforts, although some combination of words and demonstration might move someone closer to understanding. Without clearly spoken language, to an observer, these movements may look like magic, or at least effortless and natural. In this inquiry, however, we are continually asking what is the experience of touch like for the nurse? And we also recognize that this includes wondering what is the experience of touch like for the baby?

Even given a nurse’s tact and experience, there is no promise that any particular gesture or movement will “work” to settle the baby every time. For the nurse who returns to the baby to comfort and settle him over and over, the experience might be one of a practice, implying an ethical commitment. The nurse seems to act in response to an ethical appeal from the baby. As Langeveld (1983) reminds us, when we speak of encounters, it “does not mean we meet ‘others’, but it means that we meet ‘each other’” (p. 6). There are ethics in these moments, welling up in the hands of the nurse, embodied in relation between nurse and babe.

The study participants described a manifold of examples of the varied touching gestures of an NICU nurse. These descriptions of touching moments have been organized around interpretive themes: the learning touch, the mark of touch, the missing touch, the gnostic touch, and the call of touch.

### ***The Learning Touch: Finding a Way to Hold the Baby***

I am orienting to the unit and my preceptor says "just bottle that baby", referring to this little premature baby in our assignment. I don't know what to do, I have never even held a baby that small before, she seems so delicate. I say "I don't know how to do that." My preceptor walks over with me and says, "Well, just try picking her up." I'm thinking, "How much do I need to support her neck? What do I do with the wires?" I put one hand under her head, pick her up and bring her against my chest with her head to my shoulder, my other hand under her bum, the cords that attach her to the monitor dangling.

We can appreciate how the learning nurse is focused on the many details of the task. The nurse may be self-conscious and unsure - I have never even held a baby that small before, taking in the physicality of the baby - she seems so delicate. Simply being in the NICU may make a baby seem more delicate and fragile, even when relatively well (van Manen, 2011). When first learning to retrieve a tiny premature baby from their bed, some preliminary, general knowledge is helpful; for example, the baby may have decreased tone and needs physical support, particularly under the neck as with all newborns. It is also important to know which cords or other attachments may be undone and which are critical. Ultimately, however, the way to learn how to pick up and hold a very small baby, is by picking up and holding them. With practice, the skill becomes embodied and fades to the background for the nurse. Before, in between not knowing and knowing-how, is a rarefied interval of time and space where it is possible to catch a glimpse of what is happening for the nurse when lifting a tiny baby out of bed.

Openness, on the part of the nurse, seems necessary to allow for the possibility of moving toward and cradling such a small baby. The experience of holding the baby may seem constructed of separate, self-conscious gestures and physical maneuvering. The nurse may experience becoming newly aware of their own hands, where they are and how they move. We sense that the initial gesture is one of faith and requires courage - to reach for the baby and trust that they will figure out how to support, hold up and bear the little one.

A movement is learned when the body has understood it ... when it has incorporated it into its "world," and to move one's body is to aim at the things through it, or to allow one's body to respond to their solicitation, which is exerted on the body without any representation." (Merleau-Ponty, 2012, p. 140)

Learning to hold a premature baby tenderly and competently is not only a matter of developing clinical skill, but also cultivating an ethical receptivity to the comfort and needs of the baby. The gestures and movements of reaching toward and picking up the tiny premature baby inform and reform the nurse's body.

From the thoughtful, careful attention to the task, we may discern that an experiential realization of the relational ethics involved occurs. Ethics in this sense; a felt, embodied recognition that I (the nurse) cannot touch you (the baby) without being responsible for doing the touching, nor without being responsive to the baby (Manning, 2007). The experience of a novice nurse lifting a tiny baby up out of the plastic NICU cot for the first time, reveals the ethical

relation of the nurse and baby. In the nurse's arms, the baby may seem less unknowable; the first embrace, though awkward, discloses to the nurse the possibility of moving closer to this baby in their particularity, as the baby's nurse. The baby is wrapped up in the nurse's arms and body, enmeshed and entangled in the nurse's nursing world. Not simply fragile cargo, requiring careful handling, but a little human being fully implicated in the enfolding movement, weighing and pressing against the nurse, wiggling, moving, crying, sleeping, demanding the nurse's attentive response.

***The Marking Touch: When Touch Lingers Long After Physical Contact***

I scratch little Sam with my fingernail. Not just superficially. I draw blood. That's how fast I am going. I am rushing through my assessment because I have so much to do. I feel horrible! I am instantly sweaty, and hot. I can feel the heat in my cheeks. I am so ashamed. I think to myself, "This is not OK. How could I let my nails get so long?" I hurt this child.

Unlike most touching moments experienced by the NICU nurse, an accidental scratch is unusual and may catch the nurse off guard. In a distracted rush, the nurse's touch can injure the baby, blood signalling a wound in his tender, fragile skin. The appearance of bright red blood is experienced as an interruption, a rupture that jolts the nurse awake from the occupation of physical assessment, to see the baby as a child, as an other. In this moment of recognizing the injury, the baby may appear to the nurse differently than a second earlier, when he was the object of the assessment. The nurse encounters the wounded baby, perhaps in the same way she may encounter a hurt child she knows or any child who is not examined for their physiology. So delicate, the slip of a fingernail may break the skin and draw blood. To touch another always holds within it the possibility of harm. If an injury occurs, the nurse may viscerally resonate with the baby's pain in a bodily response, flushed and shaken. Causing the unintended damage disrupts the nurse from a clinical attitude and awakens them to the being of the baby in such an immediate and compelling way that there is no option but to respond.

I was overcome with guilt for the rest of the night whenever I looked at him because of what I had done. I was so conscientious for the rest of the night, trying to be extra careful, feeling like my touch had to make up for hurting him.

The sensations of touch may linger after the physical contact is over - a painful touch that continues to hurt. These impressions of contact may mark not only on the baby but also the

nurse. These may be fleshly vestiges felt in tired arms from holding and rocking a child to sleep, or a sore neck from bending over a lengthy dressing change. The lasting impressions of a touching encounter may also illuminate an experience of ethics, the touch that re-awakens the nurse to an ethical responsivity toward the baby. In these lingering reflections on an accidental, inadvertent touch, the nurse seems to experience a genuinely touching connection with the baby, one that persists after the physical contact is over. The nurse and baby remain connected, in touch while apart; the nurse now linked to the baby in attentive, apologetic, worrying, remorseful ways. Abruptly recognizing the baby as a child may be experienced by the nurse as being touched by the hurt baby, inviting the possibility of the nurse opening to sensations, perhaps of pain and anguish or sorrow. Although there is no way to heal the skin, or even explain and apologize, an ethical gesture is revealed in the impulse to make up for hurting the baby. We can imagine that the nurse may be forever marked, more attentive, more careful - yes, but also more aware of human frailty, of possibilities inherent in the intimate care of an other.

***The Missing Touch: Or Touching Without Physical Contact***

Sometimes, a baby who is very ill needs to be pharmacologically paralyzed with a neuromuscular blocking agent to prevent them 'fighting' the breathing machine.

Normally, if they're awake and alert, I hold their hands and kind of play with them and make eye contact. With him, because he is paralyzed, I don't. I resist running my hands through and combing his hair and even holding his hand because I don't know what's going to agitate him; he's a very sick baby. Any time I do touch him I wonder if he's tolerating my touch. When I reposition him, I wonder if my touch is bothering him. I hope the medications are keeping his mind quiet, but is he in there, upset?

Usually, the nurse draws near to the baby and reaches to touch and care for them. A wordless dialectic occurs as the baby feels the nurse's touch and grimaces or wiggles or cries; the nurse adapts and modifies their touch in the lived immediacy of the moment, trying to find the most fitting of touching gestures, sensitive to the contingencies of the moment. For the experienced nurse, these bodily gestures tend to happen in a smooth, spontaneous, unremarkable exchange.

Conversely, the paralyzed baby cannot respond to any touch, laying still and unresponsive. Unable to touch the baby in the usual ways, or experience the baby's physical response, makes the nurse feel somewhat uncertain about how to care for the baby. Even

knowing that the baby is receiving sedatives and analgesics, the nurse worries that the baby is suffering when turned or shifted. Without grimaces, or squirms, or crying, or arching; the nurse does not know if they are giving care in a tactful way. Tact (OED 2021) refers to both the sense of touch and a delicate sense of what is fitting in dealing with another. Mutual responsiveness helps to determine what is most fitting in any particular moment or situation. When the baby is unable to respond, the nurse may be left questioning what to do or how best to care for them.

In the absence of the baby's corresponding gestures back toward the nurse, we might notice more clearly the formative part the baby plays in the nurse's experience of touch, co-composing and co-constituting the physical connection between the two. Still, the potential of a touching moment may not be lost even when physical contact with the baby is compromised. Manning (2007) describes touch as a double genitive of two touches: "once in my gesture toward you and once in the experience of feeling your body, my skin against yours" (p.11). The gesture that is initiated toward another with directionality is also touch. Rather than in spite of, but due to, not being able to touch the baby, the nurse becomes keenly sensitive to the experience of the baby, absorbed in wondering about the possible effects of limited touch when paralyzed and unable to respond. Refining physical contact to prevent potential discomfort to the child is an ethically conscious movement, attending to this individual child in the moment. Even without physical contact, the nurse may experience the connection to the ill baby as a touching one that begins and exists in a gesture of reaching toward the baby.

***The Gnostic Touch: The Possibility of Knowing An Other and Ourselves***

I lightly lay my hand on his belly and wait a minute for it to soften, becoming used to the presence of the contact of my hand. As I feel him relax, I press gently with the pads of my fingers on one side and thumb on the other. I feel a soft firmness, like bread dough. I press a little more firmly and move gently and slowly back and forth, feeling for any masses, bowel loops. Then, I soften the pressure and move to feel for the margin of the liver with the side of my index finger on the right side; in the squishiness of the belly, the liver is firm, its inferior edge like a ridge pressing into my finger, just under the ribs.

The usual belly of a healthy newborn feels soft to palpation. The nurse's comparatively large fingers sink into one side and then the other, alert to feeling any masses, lumps, or dilated bowel "loops" (regions of intestine filled with air or feces). In the contact of touch, the nurse may realize that their hands are too cold or too firm, or become alert to pathology beneath the

skin. Palpating, assessing touches require a particular posture of hands, not digging in with fingertips, but pressing with the fingers' pads to best feel for any unusual findings. Dense with nerve endings and with a capacity for fine dexterity, the human hands are well-suited to perceiving a wide variation of sensations. The touches that compose the physical assessment are necessarily tuned in, sensing and perceiving the baby's body. To feel the texture of the abdominal organs and structures through the baby's skin, the nurse may have to ease into the deep, searching touch of palpation, allowing time for the baby to relax and soften.

The Greek root *gnostic* means "pertaining to knowledge" (Gnostic, OED 2021). The nurse assesses the baby to come to know the baby better, both physiologically and by their reaction to the probing, pressing, feeling touches of assessment. The generalized knowledge required to perform a physical assessment is transformed through precise, perceptive touch to particular knowledge about one specific baby. Where does this baby press back, how do they move, does their liver sit a bit lower in the abdomen, is the brachial pulse steady, is their fontanelle tenser than yesterday? The nurse seems to be feeling beneath what the eyes may see, and tactilely exploring for what they expect to be present and for what they may find.

Nurse-philosopher Gadow (1985) reminds us that caring has a distinct moral position of "attending to the 'objectness' of persons without reducing them to the moral status of objects" (pp. 33-34). It is possible to objectify patients in healthcare, for example, when reducing a new baby born to their diagnoses: "the 28-weeker with hydrocephalus." In the focus and concentration of assessing the baby, the nurse may experience the baby as an abdomen, a brachial artery, a skull. Perhaps it is less an experience of forgetting the body is a child and more that the child-ness of the baby fades into the background.

During a period of observation, I watched as the eyes of a nurse met the eyes of the baby whose heart she was auscultating. The baby was small enough that when the nurse noticed the baby's gaze, while still holding the stethoscope in place, she reached with her index finger to the baby's nose and gave it a soft, playful tap. The nurse did not remember the experience when I asked about it later. The moment invites a wondering pause – noticing the baby's gaze, the nurse effortlessly switches from auscultating the baby's heart sounds to another touching moment. It is as if the baby's gaze touches the nurse who responds with a tender, playful touch. Perhaps any distinctions between the *gnostic* touch and the more relational touch are mellowed and softened in the nurse's experience of them, not necessarily changing from one to the other, but merging

and blending. As the nurse assesses the baby by touching, feeling, listening and observing, they perceive corresponding sensations of pressing, grazing, squeezing, tickling in return. The nurse does not need to think about or give cognitive consideration to these touches to experience being in contact with the baby; rather, they are felt. Coming to know another through the touches of assessment may be experienced as embodied intersubjectivity.

### ***The Call of Touch: Drawn to Hold***

A nurse recalls a baby arriving with the transport team. The baby had a significant heart defect and was profoundly unstable and unwell. His parents are still en route from a remote community. His blood pressure just keeps tanking, just dropping. We push fluid, transfuse blood, infuse epinephrine boluses, only to be followed by more medications. There is a lot of intense activity ... but nothing is helping. We arrive at consensus that nothing is going to work, the resuscitation ends. As the rest of the team left, my first instinct is to pick him up and I hold him close in my arms. I don't think about whether or not I should, just that this baby is dying alone.

The moments of trying to stabilize and resuscitate a critically ill newborn can be congested, hectic, and demanding. Healthcare practitioners, IV poles, and equipment crowded around the small bed, trying to save the baby's life. These urgent touches require their own expertise; they are not the gentle or tender or comforting touches that we might expect in newborn care. These touches, the touches of revival and survival - pressing and compressing the chest, straightening and stretching limbs, poking and pulling skin- happen at a pace of disciplined efficiency, constantly calibrating with physiological feedback: How's the blood pressure? What's the oxygen saturation? In such moments of striving to save the life of the baby, the team of healthcare practitioners do not seem to reflect on whether or not they should touch this child. Instead, these touches are given in response to the demand of the moment - saving the small baby.

As the end of the code is realized, the practitioners slowly draw away from the baby. Chest compressions cease; stethoscope hung up; IV pumps stopped; remaining syringes of medications lie still full on the counter, ungiven. The float nurse who had been helping goes to assist others; the physician, respiratory therapist, nurse practitioner all similarly leave to assess another child or to speak to families, or to write notes, or do other work. Without parents, eventually, the nurse is left with the baby at the now quiet bedside, the urgency seemingly over.

And yet, a different kind of ethical necessity occurs. In that moment the nurse realizes the child is dying alone and is struck by their alone-ness, with no parent present to hold them. It is as if the nurse recognizes the child needs to know the presence of another, and is spontaneously, compellingly drawn to hold the child. To hold, from the Old English *healdan*, is to keep watch over (Hold, OED 2021). The NICU nurse is always already “watching over” the baby in their care. But when parents are not present, they may also stand in a relation of *in loco parentis* to the baby, their nurse-responsibility augmented by the temporary responsibility of filling in the place of a parent, assuming for a moment the sense of caring for this child as one’s own. The baby dying alone utters a call of need and the nurse experiences being claimed by this child who is dying, called to foster and watch over him, revealing the close-up, temporal, situational and spontaneous nature of ethics embodied.

### **Discussion**

It may seem odd to have embarked on a phenomenology of the NICU nurse’s touch and the relational ethics wherein, without any mention of the right or wrong touch. In a Levinasian sense, the purpose of this research was to attempt to make contact with the ethics of touch even before we consider what a morally correct touch might be in a particular situation or context. It is not that a normative quality cannot be observed in the phenomenological examples shared here. Rather, this is an attempt to resist the development of a health ethics that exists primarily at a cognitive level, which sets the body aside, flattening the significance of our daily lives into representations (Fielding, 1998). An embodied ethics is a vibrant, corporeal, felt ethics, perhaps a result of the body’s amazing ability to adapt to our world, not merely through our rational abilities, but through our senses (Merleau-Ponty, 2012). Touch is the nurse’s primary connection to the textures, temperatures, and topographies of the baby and the NICU-world (adapted from Montagu, 1986).

Exploring the touching gestures of NICU nurses discloses the relational ethics at the heart of caring practices. Surely these gestures vary in purpose and character, each with its own particular pace and rhythm: the charged, acutely-focused, algorithmically-guided movements of resuscitation; the slow, awkward, self-conscious gesture when learning to pick up and hold a premature baby; the methodical, systematic techniques of physical assessment; the smooth, spontaneous swoop of gathering the dying baby into arms; even the rushed, distracted, accidental scratch. Yet fundamental to all of these gestures and movements is an embodied ethics expressed

in the mutuality of touch. To consider how touch brings us close to one another; we might read Merleau-Ponty as Stephen David Ross does, by: “recognizing bodies, touch, and proximity as the places where beings open to each other, interrupting the solidity of everyday life” (1998, p. 9).

When interrupting the solidity of life through touch, we become aware of being in constant relation with an other. The nurse is not only the one who touches the baby, but also the one being touched by the baby, in the inherently ethical experience of touch - making relational contact with another. Sally Gadow reminds us that “both sides [patient and nurse], as it turns out, have something of value to give the other - a fact overlooked” (1984, p. 69). Perhaps in the context of the NICU, what the baby offers the nurse is physical vulnerability that demands a response. The baby cannot verbally proclaim trust of the nurse, cannot convince the nurse to care for them, squeeze their hand in return, or make a bargain, or justify, or advocate. They can only make an embodied claim by their very existence.

The NICU nurse being claimed by a child may be likened to experiencing a spark of ethics, a felt impulse reaching toward the baby. Whether this impulse is to pick the dying baby up, or another gesture of touch, the nurse is not acknowledging ethical codes, nor ascribing to philosophical theories of ethics; instead, they are open to the baby’s appeal. Conceiving an embodied ethics implies that we are not bound only to rules and duties, but that an evolution of ethics is “the ongoing transformation of expressive bodies toward spontaneous right action.” (Mazis, 2006, p. 188). Nurses have long recognized that touch is more than skin-to-skin contact, involving a “multi-dimensional gestalt” along with voice, posture and affect (Estabrooks & Morse, 1992). Sometimes touching transcends physical contact and the nurse can both touch and be touched without physical contact (as with the paralyzed baby) or with “broken” touch (the scratch).

Living through the physical distancing required during the pandemic has uncovered a tension involved with being physically close. Many of us have discovered the possibility for meaningful encounters without touching, by keeping distances and connecting online, while simultaneously recognizing that nothing really takes the place of close, touching gestures in our relationships and lives with others. A question that remains may be whether or not there can be physical contact, the most basic understanding of the definition of touch, without a genuine touching encounter with an other. In particular, is the accidental scratch a nursing touch at all, as it lacks the characteristic care and attention we expect of a nurse?

By including the scratching touch as an example of the way nurse's experience touch, my purpose was to illuminate the genuine closeness between the NICU nurse and the baby; both are vulnerable to the risk that human touch poses and to its lingering influence potentially extending the sensation of touch beyond and after physical contact. "Sensations are not governed easily; they reach deeply into and around the body, creating space and altering the trajectories we thought we could delineate cleanly, legitimately, between sensing bodies in movement" (Manning, 2007, p. 66-67). Bodily skills and practices of nurses do not occur fully formed; nurses cannot hope to never harm a baby with their touch. Expertise in practical skills develop over time and through practice. I have attempted to show the inherent ethics of the nurse's touch and emphasize that it is more than a physical tool of task performance. Dreyfus, Dreyfus and Benner (2009) explore a phenomenology of expertise for ethical comportment in nurses in part through an analysis of Carol Gilligan's moral maturity scholarship. They suggest "the highest form of ethical comportment consists in being able to stay involved and to refine one's intuitions" (p. 328). By staying present, the sensations of harming the baby wrapped around and drew the sympathetic nurse back to the baby, close in a (nurse-) touching response of ethical attendance.

### **Concluding Thoughts**

In the nursing literature, as well as in practice and in society more generally, there is not enough attention to the risks of the lack or absence of touch. Too often, our collective response is to forbid touch--to restrict and condemn all touches--in order to prevent harmful touching. Poet David Whyte (2018) reminds us that

to forge an untouchable, invulnerable identity is actually a sign of retreat from this world; of weakness, a sign of fear rather than strength and betrays a strange misunderstanding of an abiding foundational and necessary reality: that untouched, we disappear. (p. 223).

The corollary of this, of course, is that touched, we appear. For the NICU nurse, might we think of the ethics of touch as one of appearing? Through touching gestures, the baby is revealed and appears to the nurse in their full subjectivity. We can only thoughtfully speculate about what the baby is experiencing, but the touching encounter strikes the nurse as a reminder to constantly be concerned for the way the baby might experience the nurse's appearance to them.

Attending to the experience of nurses' touch gives us more clues to understanding the experience of an embodied relational ethics implicit to the practice of nursing and other

healthcare practitioners. The effects of touch may go undocumented and unrecognized in many nursing situations. By attempting to articulate these practices, the hope is that the significance and contribution of touch and the embodied wisdom of the nurse might be recognized and brought forward to our individual and professional consciousness, conversations, and curricula.

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**Chapter 4: Paper 3. In Good Hands**

**The Phenomenological Significance of Human Touch for Nursing Practices**

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Submitted to Medical Humanities

### In Good Hands:

#### The Phenomenological Significance of Human Touch for Nursing Practices

“With hinged knees and steady hand to dress wounds,  
I am firm with each, the pangs are sharp yet unavoidable,  
One turns to me his appealing eyes - poor boy! I never knew you,  
Yet I think I could not refuse this moment to die for you, if that would save you ...

I am faithful, I do not give out,  
The fractur'd thigh, the knee, the wound in the abdomen,  
These and more I dress with impassive hand, (yet deep in my breast a fire, a burning flame.”

(Whitman, 1871, pp. 33-34)

During the American Civil War, soldiers' injuries were especially grisly and painful; tissue, skin, and bones shredded, shot, and severed due to the combat “innovations” developed for this war. American poet Walt Whitman worked as a volunteer nurse during this time, and he describes moving from soldier to soldier tending to their care in his poem *The Dresser* (also called *The Wound-Dresser*). It is the gift of a poet to saturate writing with imagery; Whitman recounts scenes of dressing the wounds of soldiers, without seeming to directly mention touch at all. Yet the nurse's touch inheres in every physically intimate gesture he describes. He removes the soiled cotton, sloughs and cleanses the harmed tissue; compresses and wraps the injury. Manipulating the raw, open wound exacerbates the pain felt by the soldier -- the nurse's touch is not always soothing. Whitman is focused on his occupation at hand, while at the same time the reader senses his anguish at the suffering of the one under his hands. Faced with the soldier's visceral suffering and vulnerability, he describes an overwhelming sense of becoming present, no longer to the procedural task, but to the soldier. Whitman draws close and cannot help but be moved by the other's vulnerability as revealed in flesh and bone. A fire in his chest ignites, not an intellectual calculation or professional observation, but a felt recognition of the patient as person. It is an ethical moment.

For the nurse, physical contact with others happens in the nursing world of hospitals, clinics, people's homes, remote outposts, schools and other places. Touching gestures and

movements often pass under the radar in practice, subsumed by whatever meaningful act they are the medium for, rather than experienced as meaningful acts in and of themselves (Classen, 2005). As a profession, nursing seems to revere the possibilities of touching gestures, citing touch variously as essential, inherent, integral, and central to the practice (for examples see Chang, 2001; Connor & Howett, 2009; Estabrooks & Morse, 1992; O'Lynn & Krautscheid, 2011; Pedrazza, Minuzzo, Berlanda & Trifiletti, 2015), implying that the nurse's touch has important and profound implications for both the nurse and people in their care (Green, 2013). Further illustrating nursing disciplinary attention to this topic, scholars from other disciplines observe that the bulk of touching research is in nursing, and many begin there as a starting point for their own studies (Bjorbækmo & Mengshoel, 2016; Kelly et al, 2018; Morris et al, 2014).

Yet, there is little attention to the possible meanings and ethical implications of everyday, ordinary moments of contact between a nurse and patient. The nuance and sensitivity of taking care of another person may be revealed in these moments. Individual nurses have reported being uncertain and ambivalent about touching patients (O'Lynn & Krautscheid, 2014; Pedrazza, Berlanda, Trifiletti & Minuzzo, 2018; Pedrazza, Minuzzo, Berlanda & Trifiletti, 2015), especially in ways that are private and intimate (Picco, Santoro & Garrino, 2010). Vortherms (1991) observed that for some reason it is assumed that nurses understand the impacts of their touch and know how to touch patients (but that they may not). Nursing students must learn task-oriented touch, for example when learning procedures, assessment techniques, and so on, but it is not clear whether or not nursing education includes teaching students about the manifold meanings of touch, its gestural diversity or ethical relationality (Gleeson & Higgins, 2009; Keogh & Gleeson, 2006; O'Lynn & Krautscheid, 2014). Indeed, nurses report learning very little or nothing explicitly about any kind of touching contact, gesture or movement during their nursing education (Estabrooks & Morse, 1992; O'Lynn & Krautscheid, 2011, 2014).

The purpose of this essay is to explore the lived experiences of the nurse's touch. I ask what it is like for a nurse to come into physical contact with another person in their care as a means to uncover the significance and ethical meaning of touch in ways that may provide insight to nurses and, ultimately, be of benefit to them and their patients. My intent is to broaden the conversation about the embodied nature of ethics in healthcare, and to vitalize a meaningful understanding of the nurse's touch by reflecting phenomenologically on experiential accounts of the nurse's touch.

## **Phenomenology of Practice**

Moments of touching physical contact, whether skin-on-skin or through mediators of clothing or gloves, are difficult to express in language, to talk and write about in a way that captures their rich, tactile fullness and wordless expressiveness. We often rely on the gestures of touch to communicate things that cannot otherwise be said, so it makes sense that the meanings of this non-verbal language resist being rendered in spoken expression or in written text. How to describe the visceral, embodied, intimate sensations of touch? How can a researcher draw near to the experience of touch in a way that is true to the evocative, yet unspoken, sensuality of this basic and familiar shared human phenomenon?

Studying the meaning of human touch; the gestures, movements, emotions, expressions and attachments that compose and constitute the contact between two people as lived through, requires a methodology that is sensitive to the subtleties and sensualities of contact between two people; the embodied and embedded nature of the nurse's touch. Phenomenology of practice (M. van Manen, 2014) is a strong methodological fit for such an investigation: applying phenomenological questioning and reflection to the practices of such disciplines as nursing (medicine, teaching are other examples) in an effort to cultivate more thoughtful, ethically sensitive practitioners. Eschewing a set of steps, rigid protocol or an over reliance on method, rigor in phenomenological research begins with a clear and sustained orientation to the phenomenon under study, and a radical openness to the world (M. van Manen, 2014). As a phenomenological researcher, I become intentionally attentive to details and other aspects of the phenomenon that have become overlooked or taken-for-granted.

A phenomenological inquiry will not result in a "how to touch" policy or protocol for nurses, nor even a conclusive description of the nurse's touch. Rather, I attempt to gain insights into the possible meanings of the nurse's touch in an effort to generate a questioning awareness in practitioners. I draw on multiple sources for detailed descriptions of concrete experience. Some accounts are drawn from research interviews with neonatal nurses. The interviews were recorded and transcribed. All participants were free to withdraw consent or take a break from the interview at any time. I interviewed ten nurses in total and observed the practice of three of them, joining them in the neonatal unit for portions of their regular working shifts. Other examples of the lived experience of touch were drawn from academic, poetic, memoir and personal accounts.

The outcome of this research is intended to be an evocative text, meant to stir within the reader a sense of the experience of the nurse's touch and its possible meanings.

The self-effacing nature of touch, the way it recedes into the task or gesture or movement at hand, makes it elusive to explore and difficult to render in description on the page. At the same time, there is an advantage to investigating an experience (the nurse's touch) with such ubiquitous experiential roots (human touch). We all navigate our way through life and the world by feeling our way, by touching and being touched. With this in mind, I start by investigating the sense of touch itself, including a brief overview of the sense of touch, the nature of the skin, and some implications of the sense of touch in our language and lives. A general glimpse of touch is meant to open and invite the reader to an eidetic consideration of the nurse's touch, how it may be constituted and composed. This exploration is continued through the balance of the article, through phenomenological reflection on diverse, descriptive accounts of touching contact between the nurse and the other being cared for.

This study was approved by the Health Research Ethics Board at the University of Alberta, Edmonton, Canada.

### **What is Touch?**

Touch is an aspect of almost every human experience. We meet the world in a feeling way, whether standing, sitting, walking, lying, there is a sense of being in contact. The depth and breadth of meanings of touch are hard to compass. A brief exploration of the sense of touch may help us to uncover the unique ways in which we perceive contact; both touching and being touched. Touch is primordial; the first sense to come into being in utero and has been observed around 7-8 weeks of embryonic development (Hooker, 1952; Manning, 2007), before eyes or ears are formed. The other senses are sometimes described as physical derivations of touch, developed from specializations of skin tissue (Montagu, 1986; Pallasma, 2008). The sweet taste of an orange becomes available through the contact of the fruit to one's tongue, favourite music is heard as sound waves vibrate one's eardrums, the scent of freshly baked bread wafts via airborne chemicals to olfactory receptor neurons in one's nose. Even the corneas of one's eyes are covered with a thin layer of skin cells, through which light enters, realized by us as simply seeing the world (Montagu, 1986).

We tend to use the verb "to touch" in two ways (Bremer, 2011). For one, if we notice a houseplant is too close to a cold window in winter, we say the two things are touching, meaning

they are in direct physical contact. This sense of the word refers to the materiality of our bodies, we are physical things that come into contact with other things. The other use refers to the way the touched surface feels, when we reach to touch the cool leaves, they feel soft and limp in our fingers. In this second sense, we are exercising “the sense of touch; to explore, examine, or interact through physical contact” (OED 2021). That is, we have an experience *of* physical contact, we perceive with and on our bodies through our sense of touch.

Touch itself is a word not especially evocative of these nuanced meanings or of the richly textured feel of things or each other; there is no tactile onomatopoeia to its spoken utterance or written appearance, such as in the word “smooth” that may elicit a feeling in one’s fingertips of a smooth texture. Yet “touch” refers to wildly diverse and multifaceted sensations, and endless gestures and meanings. The feeling of a cool breeze across our face, a motherly kiss goodnight on our lips, and the smooth, slightly tacky consistency of well-kneaded bread dough all belong to a categorical *touch*. A sense of relation is also missing from the word touch, but Ratcliffe emphasizes that touch is not a matter of humans or things colliding with one another, but rather “it is a sense of relatedness between the two” (2008, p 89). At the same time, sometimes just the mention of the word touch, especially in contexts where touch was unwanted can revive vivid and often painful memories. The word *touch* is somehow both bereft of and overflowing with meaning.

As touching, perceiving, sensing beings, we move through the world mostly without giving much thought to the way touch works. We tend to consider the sensations we feel on our skin as those of touch, and our skin as the sense organ of touch. Yet, philosophers and scientists are not so convinced. From Aristotle on, the sense of touch has been hard to define, not necessarily because less is known about the biology of touch but because what we mean by touch is not always clearly delineated (de Vignemont & Massin, 2015; Fulkerson, 2020). Aristotle submitted that the organ of touch was situated inward, near the heart, making flesh its medium (Aristotle, 2001; Bremer, 2011). Even though Montagu (1986), in his classic text *Touching: The Human Significance of the Skin*, claims the skin as the organ of touch, he acknowledges that unlike other sense organs, the skin has many concurrent and diverse purposes, such as protection and temperature regulation.

We feel things over our entire bodily surface, making the skin plausible as the organ of touch. However, human skin itself is not sensory (Fulkerson, 2020); rather, it contains many

sensory systems, divided into qualities such as pressure, warmth, cold, pain, stretch, itch; “at least 15 functionally and morphologically distinct” afferent units (Iggo, 1982). The many sensory systems of skin sponsor somewhat of a controversy as to the character of touch; philosopher Matthew Ratcliffe argues that the sense of touch “encompasses a wide range of perceptual achievements”, making it distinctive but problematic in terms of understanding its nature (2012, p. 413). Even more, touching gestures that include movement, also called *haptic* touch, such as reaching, exploring, caressing, involve sensory feedback from receptors in the muscles, joints and tendons as well as the skin (Fulkerson, 2020). Yet, no matter what distinct sensory mechanism is responsible for felt sensation, and even if the skin cannot be associated with the sense of touch in a simplistic way, we tend to consider the sensations that we perceive through the skin as touch (Nudds, 2004).

Being touched by the world and those around us, being carried and caressed and soothed and embraced, is essential to life and human development (Durkin, Jackson & Usher, 2021; Field, 2014; Linden, 2015; Montagu, 1986). Montagu (1986) centers his text on touching around the “human significance of the skin”, exploring and documenting the tactile needs and experiences of babies and children and the tangible effects on human growth and development. Preliminary results suggest that adolescents who received less affectionate touch in childhood have higher depression scores and are more aggressive (Field, 2002). Touch deprivation has been shown numerous times to be detrimental to human health, in some cases even attributed to the death of babies and small children (Field, 2014; Montagu, 1986). Life during the global COVID-19 pandemic has afforded nearly everyone to experience a decrease in or lack of normal human touching. The lack of hugs, handshakes and even companionable closeness has been experienced by many of us as a longing to feel and be near to another. So overwhelming at times, the experience of living without touching might be characterized as a modern, communal experience of touch-hunger (Durkin, Jackson & Usher, 2020).

Living without one’s sense of touch is exhausting and nearly impossible. When 19 years old, Ian Waterman lost his sense of touch and proprioception due to an immune response that destroyed some of the sensory nerves in his skin (he can still feel pain and temperature) (Cole, 2016). Described in *Losing Touch: A Man Without his Body*, he is unable to feel anything, including the positions of his limbs or body, lying on a bed feels like floating (Cole, 2016). Eventually and through extraordinary effort, he learns to stand and walk and move through life,

thinking about and visually guiding every moment. A friend asks him if he can make a gin and tonic after he gets home to relax. The answer is yes, but it is not relaxing. “sitting is a task I think about and the glass is fragile and I have to grip it so carefully to avoid it slipping or breaking” (Cole, 2016, p. 16). When moving takes such concentration and focus, then going for a walk, having a drink or even sitting down is never simple. He describes his life as a daily marathon -- a mental marathon of thinking touch.

Our own experience of touch and touching surely begins with feeling the tightening walls of our mother’s womb. Upon our birth we are embraced in the arms of our parents, skin-to-skin on the chest of our parent or swaddled tightly in blankets. Later, we hold hands, we stand arm to arm, we encircle the shoulders and waists of our parents, our friends, our lovers, our children; we kiss, we hug, we caress. In the context of social, family, cultural and other influences, we learn and come to perceive a normative sense of touch; there are good and bad touches. A baby recognizes the loving touch of their mother (Field, 2014), and yet, when used to report an unfamiliar adult ‘touching’ a child, a colloquial meaning of the word may be invoked: to grope or molest without consent (Touch, OED 2021). The meaningfulness of touch exists in wide variety, along many continuums with shades and nuances: touch comforts and violates, smooths and ruffles, holds and lets go, reveals and conceals. All the touches we feel, the touches we hardly notice, the touches that hurt us or pleasure us, soothe us or irritate us, intimately and elementally entangle us with the world and to those with whom we share it. The nurse, in each touching encounter, is intimately and elementally entangled with another person, often otherwise unknown to them, but nonetheless in their care.

### **What is the Nurse’s Touch?**

Distinctions are drawn in the nursing literature as to types of touching contact between the nurse and the other person, for example, necessary, non-necessary, task, comforting, procedural, spontaneous and more (see Barnett, 1972; Estabrooks, 1989; Gleeson & Timmins, 2004; Routasalo, 1996; Schoenhofer, 1989). It is tempting to categorize or name touches, in an attempt to make sense of the wide variety of touching encounters. Naming may risk limiting the richness and depth of meanings that a touch may hold and, especially when done prematurely, can result in a kind of dominance, or control over that which we name. To claim touch is comforting risks denying its gnostic utility, to call a touch instrumental may cover over its fundamentally connective nature; to say it is communicative may imply a transaction; and so on.

To concede that gestures of touch can be in multiple classifications at the same time seems to render the purpose of classification moot.

The classic image of a nurse's hand on a fevered brow is long outdated, and largely exchanged for one of the digital thermometer pointed at one's forehead, wrist, or temple for an instant and accurate body temperature. Technological progress is a critical part of health care. However, we might wonder what may be lost here without the nurse reaching toward the patient, sensing the heat through skin-to-skin contact, and simultaneously offering consolation and treatment to the patient, in the cool relief and thoughtful attention of their hand? Perhaps this moment no longer becomes one of pause on the patient; no longer a moment to witness suffering; no longer a gesture of offering comfort; no longer a moment of affirming, "I am with you". The old-fashioned gesture holds the possibilities of an ethical encounter.

This is not to dismiss the importance of accurate temperatures, nor to suggest there will not be many other moments to offer consolation and attention to a patient. Rather this short contemplation is meant to serve as a mindful observance of what else happens when we change a practice for obvious beneficial reasons. Phenomenologically we ask, how does the nurse's touch give itself? Is the nurse's touch simply physical contact between a nurse and another person? What is the ethical significance of the nurse's touch? A phenomenological investigation is concerned with the 'whatness' of the human experience under consideration; when does touch between humans become the nurse's touch?

While waiting to have facial moles removed, British law professor Stewart Manley (2018) describes lying on a cold table in a hospital in Malaysia, his vision obscured by a paper sheet over his face. The surgeon briefly pulls back the covering to say hello, allowing Manley to see a "whole gaggle" of students filing in before being covered again (he had previously given permission for them to attend). As the procedure begins, he describes feeling claustrophobic and alone, until a noise close by interrupts his thoughts. He is brought back to the moment as he realizes a nurse is reaching over him to hand something to the surgeon. In doing so, the nurse's body comes into contact with his:

Then I feel it. Her soft abdomen pushes against my arm. Its warmth flushes into my bones. She keeps it there. It eases slightly, then pushes again. *Is she comforting me?*

There are layers between our flesh, of clothing and sheets. But a touch need not be direct.

The scalpel, the bright light, even the white paper, disappear. *Will this be what it's like when I die? Thank you. Let the last thing I feel be a human touch* (p. 1822-1823).

As impactful as this moment of contact was for Manley, we can only speculate on the nurse's experience. Earlier in the piece, Manley recalls the nurse had gently placed a pillow under his head, seeing to him and his comfort. She stands close, her abdomen pressed against the patient's arm. She might (must?) feel the bulky, material presence of the patient's arm against her abdomen. It seems unlikely that this was a deliberate action to provide comfort to a person having day surgery, yet is it possible that the nurse had some sense of what she was doing? There is something in the interaction that causes Manley to wonder if there is intention to the nurse's posture - *is she comforting me?* Perhaps she perceives the pressure without acknowledging its cause, occupied with her role in the surgery, making this touch quite accidental. Not like the accidental bump into one's partner while cooking together in a small kitchen, when we might apologize - oh whoops, sorry - before letting the other pass. Not like coming too close to another on a crowded bus, instinctively pulling away to make space between our body and the other.

Even accidental, the effect of this touching moment on the patient invites our attention. This instance is missing some structural aspects that we may have assumed to be part of the nurse's touch, for example that it is a touch of competence and skill; a "knowing" touch. Another, that there is intention in the nurse's touch. The touch described here does not seem to be a particularly skillful or intentional touch, and we might wonder if this is a nurse's touch, after all? Perhaps the question that needs to be asked is does the nurse, in the course of nursing care, have to intend or realize the impact of the touching contact? On the other hand, is it possible to ever, even in an intentional and skillful touch, fully recognize and understand the impact that might be happening? Perhaps the nurse's touch is composed partly of the response of the person being touched.

Recalling Ratcliffe's (2008) observation that touch between humans is not merely a matter of bumping into one another, but one of relation, a seemingly "insignificant" touching gesture is revealed as existentially significant to the patient, providing solace in a moment when he is vulnerable and fearful. Perhaps another patient would hardly notice, another may feel annoyed by the pressure, yet another may feel self-conscious. The procedure itself is relatively minor surgery, with few risks of complications, however, the fear of cancer combined with being across the world from family and friends has left Manley feeling vulnerable and afraid. The

structure of nursing work, to be with patients, means that nurses are often present in vulnerable, intimate, meaningful moments of the lives of others. Rather than one of skill or intention, the nurse's touch may sometimes happen as a part of human coexistence, a way of being in the lifeworlds of the patient and nurse.

Speculating on the nurse's experience through the patient's eyes provides an opportunity to see an implied but integral aspect of the nurse's touch: the patient's response to touch. Touch is not simply a nursing strategy or tool. The nurse's touch can be these things, but the incidental, everyday, ordinary touching moments always and already constitute ethics in the nurse's practice.

### **In Good Hands**

Most often it is the hands of the nurse that are particularly occupied with touching, sensing, reaching for and perceiving the other's body. Human hands are implicated in touching gestures and movements; we most often make contact with others and things of the world with our hands. The anatomy of hands reflects this: they are well-suited to feel, explore and maneuver. Nineteen bones connected by tendons and cartilage create an articulated structure that affords a powerful grip, but also renders subtle finessing movements that deftly manipulate small objects. The number and size of bones and joints allow for nuanced pressures and gestures. A nurse may experience many capacities of their hands in just one shift. Inserting an intravenous catheter requires delicate and precise movement: the instant the needle punctures the vein, it is felt through the catheter by the sensitive pads of the fingertips. Delivering the blows of chest percussion requires a cupped posture of the nurse's hand and enough force to loosen thick lung mucus without causing pain. Holding hands or touching a shoulder may offer comfort and respite to patients who are afraid or lonely.

Human hands are intelligent and complex embodiments of the architecture and engineering of our bodies, and surely in this sense they are "good". The phrase "in good hands" (of the nurse), is a figure of speech that seems to bridge both the tangible, tactile genius of our physical hands with the normative or "good" quality of the nurse's touch. I recognize metaphor may easily cover over the meanings I seek, and with that in mind, I have attempted to maintain a "light touch" on the image, without spreading its analogic value too thinly (M. van Manen, 2014).

A parent leaving the neonatal intensive care unit (NICU) says “We’re going home early, we know she’s in good hands with you.” A nurse hears these words affirming the value of their nursing care. *In good hands* means to be in the care of a “reliable and trustworthy person” (Hand, OED, 2021), which seems an ideal way for a parent in the NICU to feel as they leave their baby for the night. Whether intentional or not, the parental farewell also refers to a physical reality of the flesh-to-flesh connection and the trust that comes with the competent, compassionate hands of the nurse who is palpating, turning, feeding, assessing and treating their baby. For those babies in the NICU that are small enough to fully nestle into two hands pressed together, the sentiment becomes quite literal. Whether the person is big or small, most people requiring health care will be touched by the hands of their nurse. The figure of speech incorporates the embodied relation between the nurse and patient.

But being in good hands can also refer to a relationship with one’s trusted lawyer or real estate agent. My house is in the good hands of my neighbour when I am on vacation; my child is in the good hands of their teacher. In these instances, the phrase has metaphorical value; it conveys meaning because it recalls the sensations of comfort and safety when being held securely or embraced with care by a trusted person. Of course, it is not only the nurse’s hands that make contact with people. The small NICU babes are carried in the nurse’s arms, unsteady adults are braced to walk against the nurse’s hip, people in labour are supported by the nurse’s shoulder, and so on. With the multitude of bodily connecting gestures of the nurse in mind, *in good hands* may be best interpreted as a synecdoche, where a part is meant to represent the whole (the nurse). The implication is that if one trusts the nurse who is touching them, they are in good hands, and conversely if the hands they are in are doing good (whatever this might mean in the moment), they can trust the nurse. This is necessarily different from saying comforting touches are good, or that skillful touches are good, and perhaps the meaning of “good hands” is inextricably linked with the one who is “in” them, the particular one addressing the nurse in their need.

What follows are further phenomenological reflections on some ordinary aspects and moments of the nurse’s touch, beginning with touch as embodied language. The word “moment” has multiple origins and comes from the Old French *moment* and the Latin *momentum*. Its French etymological roots concern time, holding within its oldest meaning a very short period of time, evolving to mean one of indeterminate length and most recently to refer to the present, e.g. at the

exact moment of time one is in. Its Latin roots also refer to a short period of time, but are more influenced by a sense of movement, impulse, and to influence, be of importance and decisive (Moment, OED 2021). Together, the etymology suggests that “moment” is only loosely connected to objective or clock time and may be more resonant as lived time. To be a moment, even if the moment is only an instant of clock time, there is a sense of something sustained, by its gesture or its meaning.

### **Tactile Fluency in the Language of Touch**

“In good hands” is only one metaphoric allusion to touch in the English language. Many various meanings of touch can be noticed in the way we speak to one another, through metaphors and idioms that invoke the sensations of touch. We say we need to get “in touch” with those we miss. We describe personal gestures as “touching” when they stir our senses. Some people seem “touchy”, when a topic is sensitive to them; others have “abrasive” personalities and need to be “handled” carefully. Sometimes a certain person just “rubs” us the wrong way. Excitement may be “palpable” in the air of an important event, or we might feel the “pressure” of a job interview or piano recital. When firmly convinced of something, we say that our belief is strongly “held”, and when interrupted, we might say “hold that thought”.

During the research interview, when asked to describe what a newborn’s femoral pulse felt like, a nurse-participant pauses and then says; “pulsating?” We both laugh, acknowledging again the difficulty to describe sensation with words. We explore adjectives: tapping? No, tapping misses the subtle, fleeting wave-like movement across one’s fingertip. Thumping, throbbing, thudding - these words might describe a heartbeat, but do not seem quite right for a pulse. Weak, strong, thready, bounding; all technical adjectives commonly used when documenting the quality of peripheral pulses in the health record. These qualities might be clinically significant, possibly providing evidence about hydration and heart function, and they are relative, a strong pulse may feel faint if not quite aligned with the searching tip of the nurse's finger. The way a nurse experiences the sensation of touch depends to some extent on practice, experience, and competency. Being able to name and describe sensations of touch may be helpful to communicate them to others, but likely do not affect the tactile fluency of the nurse at all.

Ioana Baiu (2019) describes learning the *language* of touch during her surgical residency. She remembers instructions to proceed “Gingerly. Feel it between your fingers. Let the tissue tell

you where the plane is.” (p. 720). Feeling at first “blinded by the textbook knowledge” in her brain, she began “awakening to the awareness of texture, architecture, weight, firmness, wetness, and temperature”, noticing that “with time, my fingertips exuded a near-magical power that allowed me to distinguish induration from an abscess, a lymph node from a fat lump, cancer from healthy tissues ... what once seemed a mush of tissue was now a fountain of information” (p. 720).

Similar to a surgeon, but different in context; skillful, competent contact with another’s body may reveal information to the nurse that would otherwise stay hidden. The information of flesh is given in a tactility that is difficult to translate in words. During my tenure in the NICU, I became proficient at inserting intravenous lines (IV), especially into preterm babies. Their veins were small and fragile, but visible through their skin, making them easy to aim for. Inserting IVs into the antecubital vein of a full term, chubby baby was different. A small shadow of blue may be visible at the inner elbow, but the direction and condition of the vein has to be felt. I always used the same finger, the index of my right hand, to become familiar with the feel of a vein suitable for an IV - this fingertip learned “the touch”. An undamaged vein feels full and bouncy, different from the sinewy texture of a tendon, the slippery nerve or other tissue. As Baiu describes, what at first felt soft and homogenous becomes differentiated and potentialized.

These skills could be described as simply the development of clinical competency, outlined in textbooks and then practiced like any fine motor skill. But phenomenologically we ask how are these moments of investigative palpation and manipulation experienced? There seems to be an ethics in getting to know the body of another intimately, and in some specific ways better than the person knows themselves, to cutaneously feel the differentiation in the texture of flesh that once felt amorphous and undifferentiated. Through practice and with care, the structures formerly hidden reveal themselves to one’s tactual explorations, revealing both physiologies and pathologies of another’s body.

There is more to touch than gathering empiric information. To study touch is to study gestures and movements that take on different meanings and significations depending on their context, environment, and setting, as well as the characteristics of the touch itself. The pressure, duration, placement, articulation, and persistence of one’s touching contact influences the way the touching is felt. Even very subtle differences may have distinctively different impacts. The pressure of touch may be a firm grip or feather-light graze, or anywhere in between. Carel and

Macnaughton (2012) note that the body of the one touched touches the practitioner in return. The nurse will feel the bracing of muscles in response to pain, before the baby can cry, or the adult can say a word. This transforms the nurse from the experience of the one touching to the one being touched.

The nurse's touch is in the gentle, precise two-finger pressure on the fontanelle of a baby born at 27 weeks gestation, both feeling and being felt the first day out of their mother's womb. If sunken, the baby may be dehydrated, if bulging and tense, perhaps caused by the baby crying, or it may mean hydrocephalus, an accumulation of fluid in the ventricles of the baby's brain. In these examples, the nurse's touch feels *for* something, for information, for tissue density and differentiation, becoming adept at a fleshy understanding of the patient's body. The nurse's tactile fluency is further revealed when something meaningful is conveyed through touch. Santos Salas and Cameron (2010) describe a palliative home care nurse cleaning diarrhea from a woman's body. Ruth, the patient, is in pain and unsteady; the nurses help her to the bathroom where she stands, leaning on the sink for support. The nurse, Sarah,

moves back and forth between Ruth's body and the sink. She washes Ruth's pubic area, her swollen labia, her thighs. She asks her to turn around and washes her buttocks. She washes again and again as traces of diarrhoea are all over. Sarah is entirely immersed in action, her sleeves rolled up, her hands gloved, her body close to Ruth's body ... The stench is everywhere. Ruth is silent, mortified. Yet there is something in Sarah's actions that makes this moment a little less unbearable, something in this nursing act that turns this horrific moment into a more liveable human experience (p. 660).

As difficult as it seems to articulate the sensations of touch, it seems practically impossible to describe in words what is happening in the room with Ruth. What is the 'something', present to the observers but inarticulable? The contact of Sarah's cleaning touch must be thorough, wiping in the folds and creases of Ruth's vulva and perineum, and also tender, to not worsen what is already a painful existence. The nurse's posture, gestures, and movements must somehow communicate equanimity and poise.

Fluent comes from the Latin *fluēre*, meaning "to flow", and the noun fluency means the state of flowing, to have a smooth and easy flow, a readiness (Fluent, OED 2021). Sarah is fluent in her response to Ruth's distress, in its gentle matter-of-factness. Her fluency reveals a moral demand and response that inheres in nursing practices and is enacted in touch. Put bluntly, to

comfort and reassure Ruth without cleaning her would be a neglectful response; to clean and wipe without regard for preserving Ruth's dignity, a transgressive one.

### **Radical touch: I am for you**

A young nurse describes an urge to connect with a little one who was born with their bowels outside their body, during a procedure to assess readiness for surgery.

*I see the surgeons enter the neonatal unit, coming to push the baby's intestines back into his body. They always rush in, between other surgeries and patient consults. I've talked to the surgeon who says it shouldn't hurt because the intestines don't have that sort of innervation. I think, okay, but the skin around the opening is innervated, and it must hurt when they press on the abdomen, when his little face grimaces into a cry, when he wriggles and kicks and punches the air. I give Tylenol as soon as I see them come through the door of the unit and initiate a pre-prescribed IV bolus of pain medication. The surgeons arrive at the bedside, and I think, 'somebody needs to get hands on this baby'. I squeeze in beside the small open bed, it's crowded because there are the surgeon and some residents, and I can't do much except cradle his head. My own stomach tightens as I watch them push the intestines in, I clench my teeth and try not to wince.*

Gastroschisis is a condition that develops in utero, when a structural defect in the front of the abdominal wall occurs, and intestines and other organs escape outside the body. They spill over and need to be reinserted so the opening can be surgically corrected after birth. If the hole is small and the intestines can be reduced (put back) into the belly, surgical repair can be done soon after birth. Other times, if placing the viscera back into the abdomen is difficult, a slower, staged approach is taken to accommodate all of the organs and tissue that had free reign to expand in utero. The reduction may take days, during which the abdominal contents outside the body are kept warm and moist in a "silo" attached to the margins of the opening itself, suspended or held up in some way to facilitate gravity easing the intestines back into the baby's abdomen. A baby with a silo is regularly visited by the surgical team to assess the progress of the intestines back into the abdomen and to prepare for surgical repair.

The baby with gastroschisis can present in a radical way; it is shocking to see the insides of a body, outside. Parents are exposed to seeing their baby with their intestines suspended above their body, unable to hold or feed them. And the process and procedure of reduction may seem more radical still. "Radical" is commonly used as a synonym of extreme, but the etymology of

radical is from the Latin *radicalus* (Radical, OED 2021), meaning relating to the root, original, fundamental, and vital. It is correct to say the abdominal opening is vitally affected, the process of reduction a fundamental treatment to heal the baby. In this sense, the nurse's touch seems radical as well, connected to recognizing the baby in their originary form, intact and as a little person.

In an effort to 'put hands on the baby', the nurse reaches for the child, to comfort, to be present to and with the child. The nurse surmises that the baby is in pain or discomfort, reading his movements and facial gestures as best as possible, and responds by administering pain medication. Through touch, the nurse is responding to the claim of the child, recognizing the baby in their vulnerability and then meeting the baby there. Free from the task of the surgeon, the nurse sees the baby, and is addressed by the baby's needs. The baby, in fact, has hands all over him when having his intestines reduced back into the abdominal space. The nurse is not advocating for the baby "against" the surgeons who are touching the baby in their own competent, knowing, feeling way. Yet this sense of advocating for the baby, being there not only with but *for* the baby is felt.

Cradling the baby's head may not stop the baby wriggling or crying, but it is a physical gesture that seeks to offer something when it is not clear what is needed, in the moment when the nurse senses something needs to be done. In an important way, the nurse is witnessing the baby's discomfort, but not by watching alone, which would not be enough. It seems that the nurse's touch is an active witnessing, an advocacy. The nurse is there with the baby in the tangible, tactile, undeniable way of touch. Michael A. van Manen reminds us that each baby newly born into the NICU developmentally accrues the experiences of the NICU, and we must continually ask "what beginning are we giving these children" (2019, p. 92). Although the vulnerability of children and babies calls for especially tender attention, we might extend this to better appreciate that encounters between the nurse and the one they look after have an ethical and developmental weight to them. The question may become "how am I affecting the life of this person?" Each moment of touch extends, beyond the instance of the gestural exchange, out into the life of the person.

### **Touch Makes Us Over**

This inquiry is an exploration of the nurse's experience of touch, its purpose to take notice of what happens in touching moments of the nurse and to consider the significance of

these moments of human-to-human contact. Interwoven to this is the intention to develop nursing practices through thoughtful attention to these touching encounters. A related purpose is to uncover the effects of moments of touching contact on the nurse, which has been difficult. It has stubbornly resisted unconcealment, even as it has peeked at me, eluded and slipped away from me. This final account of the nurse's touch is one of my own, wherein lives the impulse that inspired this whole project.

During a particularly hectic day shift, short of staff and over-capacity in a busy neonatal intensive care unit, I recall walking so fast that I was nearly running, and all the while grabbing supplies, answering parent phone calls, administering medications, feeding babies, monitoring intravenous drips, assessing babies and more. The alarm of a bedside heart monitor attached to a baby was ringing erratically, not the warning of a dipping heart rate. Upon a quick check of the red-faced, crying baby, I reach for a clean wipe and diaper and start to unfasten the wet one. My movements are nimble, lifting the baby's pelvis and legs up, whisking the old diaper out, sliding the new one under. Wiping, wrapping, fastening, like a well-rehearsed dance my hands perform almost of their own accord, my mind half-occupied with enumerating the tasks and duties to be done next. When suddenly, I caught myself, and slowed my hands that were moving this little one like bread dough, kneading, lifting, shifting, turning. Competent and gentle enough, but until that moment, distracted and generic. So committed to moving on to the next item on my list, it was as if my feet were already walking away. I stopped.

I took a deep breath, looked at the baby and cupped one hand around the little head, the other gently tucking legs and arms into flexion, simulating the embrace of the womb. Slowly the baby becomes quiet and still under my hands. Still feeling chagrined that I had been preoccupied with other tasks, rather than focused on the baby, I bargain with myself: move as quickly as necessary but not when my hands are connected to a tiny child. I did not expect what happened next, when my neck muscles relaxed and spread and some calm came to my body. I stopped rattling through the task list in my mind, became aware of the little one under my hands and felt different. That baby, in that moment, has lived with me in my mind and hands ever since.

Ordinary and automatic gestures and movements come easily when changing the baby's diaper; none are technically difficult or highly sophisticated. The meaningful connection that occurs after the diaper change seems at first to transcend physical contact. Or does it? Rather than *transcending* physical contact, touching the baby sponsors the direct connection of physical

contact itself. Instead of diminishing the meaning and effects of touch as *just* physical contact, it may be that physical contact itself is the embodiment of relation. Not *more than* touch, but instead, exactly, simply, the touching contact itself. The nurse touches the baby and experiences being touched back; encountering the now restful baby as a material presence in their hands.

Maclaren (2014) recalls Merleau-Ponty's embodied phenomenology and pursues his ideas to argue that touch is a transformational form of intimacy. It is in touching and being touched that we realize "both a coexistence or participation with other bodies, and an organization and differentiation of ourselves as embodied beings" (p. 95). This intimacy is not simply one of recognizing or coming to know one another, as if we were fully formed. Rather, we find an intimacy that consists in *becoming* oneself through the other. Through others' touch, we grow into ourselves, become more than we were by developing not only a new living affective sense of our own body, but also, more fundamentally, a new organization of that body .... One is born anew through the other's touch (p. 101).

Calming a baby through touch often slows their heart rate, regulates their breathing rhythm, and as much as we can speculate, calms them. Maclaren might say their body is reorganized. They are constituted partly of the nurse's touch. In turn, or rather, simultaneously, the body of the nurse is also reorganized by the passive touch of the baby under their hands. The nurse is affected in the moment, but also changed. Touching the baby is more than an act done to the baby, it is a reciprocal moment that serves to uncover the gestural communion possible between the nurse and newborn baby.

### **Concluding Thoughts**

In his biography of the Whitman brothers based in large part on letters written to their mother and each other, Roper (2008) notes that early into his hospital work, Walt Whitman had a profound idea. He wonders if it was not the battles of war that mattered after all, rather it was the suffering experienced by the soldiers following the war that was everything: the meanings of war unfolded in the suffering of war. He arrived at the hospital ready to champion the war but its reality was driven home to him by the terrible sacrifice of the soldiers; not only their physical suffering, but that of their psyche. Whitman writes of his change in purpose at the outset of his poem, *The Wounded Soldier*:

(Arous'd and angry, I'd thought to beat the alarum, and urge relentless war,  
But soon my fingers fail'd me, my face droop'd and I resign'd myself,

To sit by the wounded and soothe them, or silently watch the dead;) (Whitman, n.d.)

Can we say that it was through being in close physical contact with the soldiers that Whitman's change of heart was borne? It is likely a multitude of experiences that affected him, but he expresses through poetry that close contact with the soldiers - speaking to them, giving them gifts and caring for their physical afflictions - brought him close to their suffering. And that so close he could not remain unmoved, becoming transformed from who he was before.

To become open to the transformational possibilities of touch in our nursing practices may require that we ask different questions. Cameron (2006) observed that the fundamental nursing act of bathing a patient has been misconstrued to be seen as only an act of hygiene, while asking nothing about "what it is like to stand before a naked human being" (p. 25). Similarly, we benefit from setting aside (without dismissing) conceptualizations of the nurse's touch that seek to define and categorize touch, which cover over its complexities and nuances. As well, it is important to ask "what is it like to touch a human being?" or, better, "what is it like to touch *this* human being before me?", in an effort to make space for the full complexities of the ethics and meanings of the nurse's touch.

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## Chapter 5: Discussion

Touch comes before sight, before speech.  
It is the first language and the last, and it always tells the truth.  
(Atwood, 2000, p. 308)

“... we can, at least at first glance, flatter ourselves that we constitute the world, because it presents a spectacle spread out before us at a distance, and it gives us the illusion of being immediately present everywhere and of being situated nowhere. Tactile experience, however, adheres to the surface of our body; we cannot spread it out before ourselves and it does not fully become an object. Correlatively, as the subject of touch, I cannot flatter myself as being everywhere and nowhere, here I cannot forget that it is through my body that I go to the world. Tactile experience is accomplished “out in front” of me, and is not centred in me.  
(Merleau-Ponty, 2012, p. 330)

### **Touch as a Touchstone (the problem of embodiment)**

Rather than asking about a problem to be solved, the phenomenological research question opens an abiding concern for the researcher. The researcher wonders: how does this question live in me, how do I live this question (M. van Manen, 1997; 2014)? I came to the phenomenology of the nurse’s touch because I was interested in embodied knowledge as it shapes the experience of ethics in the NICU. I wrestled with how to identify and talk to nurses about experiences of embodiment, yet the more I tried to grasp embodiment in a definitive sense, the more it seemed to slip through my fingers. Philosopher, phenomenologist and dancer Sheets-Johnstone (2015) puts the treatment of embodiment “on trial”, arguing that simply designating an attribute as embodied (e.g. mind, self, language) “short-circuits veritable phenomenological accounts of experience” (p. 23). Sheets-Johnstone’s cautions against using the term *embodied* as “an all-purpose lexical band-aid” without providing the “bodily grounds for the integral nature of the feature or character they are embodying” (p. 26). It was only once I landed on a recognizable human nursing experience—the nurse’s touch—that I could see a way to come close to the originary nature and phenomenology of ethics. It was opposite to my initial assumption: rather

than coming to touch via embodiment, the way to understand embodiment was through the kinetic, postural, textural, tactile, animating, connecting, touching gestures of the lived body.

During the time frame of this study, my contemplation on the meanings of the nurse's touch was augmented by an unexpected global event: the COVID-19 global pandemic. Touch between humans emerged into the light of public discussion, highlighted by the disruptions in our desire and ability to touch each other. Although the interviews with neonatal nurses were completed before the pandemic, the effects of the illness itself as well as the restrictions to interpersonal contact provided the environmental context for much of my reflection and writing. I was living a paradox: as I sought to uncover and reveal the "hidden" effects of the nurse's touching contacts and movements, the whole world began talking about touch. As the hospitals began to fill with patients, and the death count mounted, nurses and other healthcare practitioners bore (and continue to bear) a heavy weight of the pandemic's effects and consequences. Inside and outside of hospitals, as everyone seemed to feel the effects of limited closeness and mediated touch with others, our intermingling with each other and the world was never more evident.

### **A Breach of Touch: Covid-19**

*I keep automatically wanting to hug my sister, we move toward each other and then catch ourselves, laughing nervously into our masks. When we say goodbye, we both pause and take time for a longer look. I try to convey with my gaze both my affection and my regret, for all of this, and I feel the same from her. We part without words.*

In late 2019, a crisis of public and individual health began when a novel coronavirus causing a primarily respiratory illness named COVID-19 emerged and began to spread around the world. In North America, it reached the public consciousness at the end of February. The initial response included public health advice to frequently wash hands, resist touching one's face and keep two meters of distance from those people outside of one's household. Replacements for handshakes such as bumping elbows or touching feet were suggested as people tried to navigate the requests to avoid touching each other. Individual countries chose different policy approaches but, for many, the response quickly escalated to shelter-at-home public health orders. The orders were intended to decrease the risk of contact with people outside of one's household to the very minimum, including going out for any non-essential reason and wearing masks to prevent spread. Many of us began to experience the jarring nature of avoiding behaviours that happened automatically and felt instinctive. Shaking hands, sitting together,

embracing started to feel dangerous. The easy hug that many of us once greeted our friends and family with is now fraught with concerns for each other's health, and with worry of causing transmission, in other words, concerns for everyone's health. In an attempt to restore the emotional connection usually made easy by touch, greetings and good-byes may be characterized by lingering moments of eye contact, "far away" hugs that reach toward each other, blowing kisses, even phone calls looking at each other through a window. We have developed a vocabulary for when we are together, but apart. Experiencing the disruptive absence of a warm embrace, a hand to hold or a kiss good-bye reveals something of the meaningfulness of touch: the habitual gestures of contact and connection leave a gap in our lives. We seek to fill in the space left in other ways: long video calls, porch drop-offs of gifts and other goods, screen sharing software to watch movies "together", and more. Perhaps none of these quite recover the closeness of a hug or of sitting shoulder to shoulder; but divorced from touch we have discovered diverse ways to connect using virtual, digital, and physically distanced means.

A fruitful method of phenomenological research is the study of variations of the phenomenon in order to focus on its uniqueness, called the eidetic reduction, (M. van Manen, 2014), or studying breakdowns (Adams & Thompson, 2016). Studying breakdowns is a way to catch some of the aspects of a phenomenon that otherwise become transparent to us, covered from our awareness by the habits of daily life. Used as a heuristic, studying breakdowns can be an effective way to make visible an experience that goes largely unnoticed, by paying attention when it is removed or breaks down (Adams & Thompson, 2016, Chapter 2). A breakdown can allow us to momentarily see not only structures of touch that are otherwise hidden from view, but also how touching one another fits into and connects with the world. We "wake up" to the effects and influences of a taken-for-granted experience when they are revealed by its removal (Adams & Lemermeyer, 2020). To a degree, I have reflected on breakdowns of touch earlier in the dissertation. In Chapter 3, the account of a nurse accidentally scratching the baby they were looking after helped me to consider the lived temporality of touch; it is possible that very brief encounters of physical closeness transform the nurse with long lasting effects. In Chapter 4, Cole's (2016) account of Ian Waterman's life after losing all sense of touch and proprioception, a powerful biological breakdown of touch, makes visible the complex, but mostly unnoticed experience of one's body maneuvering through the world.

More generally, research on the effects of touch deprivation has tended to focus on extreme situations such as the conditions in Romanian orphanages that came to light during the 1990's (Field, 2020; Harvey, 2011). The pandemic, its fallout and consequences, has proven to be broader in effect and longer in duration than most of us imagined at the beginning. The public health restrictions necessary to mitigate spread of the novel coronavirus have provided an opportunity to consider the effects revealed by the removal and breakdown of touch on a large scale, allowing us to further reflect on the meaningfulness of touch. The nature of a pandemic caused by a contagious illness alerts us to the way we share the world with each other. The word contagion is composed of stems from the Latin *con* meaning together and *tangere* to touch (Contagion, OED 2020). Diseases can be contagious, but so can joy, laughter, and sadness; to be contagious is to be near to each other, in touching contact.

While many nurses and other healthcare practitioners do not have a choice about touching their patients, they are inevitably affected by the efforts to mitigate and stop the infectious spread of the virus. These include practical requirements, such as using extra caution and preparation when taking care of patients who have or are suspected of having COVID-19. This includes all patients, to some degree, due to the risk of asymptomatic infection and exposure during hospitalization. The manifold effects of the pandemic on nurses and healthcare workers far outweigh the scope and space here to do them justice, but I will consider one of these effects more closely. With less visitors allowed into hospitals, nurses have had to “fill in” for family members and friends with sick and dying people. A family tells the story of saying good-bye to their husband and father dying of COVID-19 (Humphrey, 2020). Unable to visit, the nurse taking care of him stood by the bedside for three hours, rubbing his hand and holding an iPad so they could talk to him and “be with” him during his final breaths. His son recalls that it was the only way they could be there; through the nurse, the family touched their beloved by proxy.

Nurses have always attended to the ill and dying, but the nature of the contagious coronavirus restricting visitors has cast the nurse into the role of being a conduit for family members saying good-bye. Although the nurse held his hand, he heard the words of his wife and son; perhaps in that moment, he also felt their hands rubbing his head and providing comfort in his last moments. The connective, relational, ethical encounter of touch may transcend what we normally think of as a touching gesture. Just as we do not speak to a phone, but rather to the person on the other end, is this dying man feeling the touch of his own wife through the hands of

the nurse? What a weight and privilege this may be for the nurse; and we can further wonder at the nature of touch being composed wholly of direct contact.

In Chapter 3, the nurse who does not touch the medically paralyzed baby is no less attentive to the baby. The nurse engaged in “touching” behaviours of careful observation and tactful consideration of the possible experiences the baby may be having when unable to respond. In light of the pandemic, we have been tasked with looking for other opportunities to touch when we are distanced from our loved ones and colleagues. Even as we long for it, returning to our touching ways seems hard to imagine - in nursing practices or in the world of our families and friends and community. Perhaps the habits borne over months of avoiding strangers outside, talking to friends over FaceTime and colleagues over Zoom will all slip away as the memories fade. We all hope there will be healing from the loneliness and fatigue that the pandemic restrictions have wrought. But nonetheless, the experience of living through and with a “breakdown” in touch affords us the possibility to reflect on the taken-for-granted meaningfulness of touch. New ways to be in touch have opened—it is not only the pandemic visitor restrictions that keep families and their dying loved ones apart. Factors such as distance, timing and affordability are just a few other reasons that families and friends may not be able to gather. The removal of touch has helped not only to see new ways to connect people for a last touching moment from afar, but it has also affirmed and clarified that we need space for touch in clinical practice.

In chapter 4, I describe a moment of placing my hands in gentle containment on a baby after a diaper change. When a neonatal nurse rests their hands on the baby they are caring for in this way, they use a precise pressure that is tender but with enough weight to provide resistance and feedback to the baby. The nurse feels the responsive ripples and pokes of the baby’s squirmy, wiggly movement pressing up into and against their hands. In such a moment, it is unclear who is touching and who is being touched. Or, perhaps it is more helpful to notice that both people are touching and being touched at the same time, involving a “reciprocal insertion and intertwining of one in the other” (Merleau-Ponty, 1968, p. 138). The touched other is passively active in responding to the touch-*er*; when the nurse is actively touching, they are also passively following. Our bodies simultaneously sense and are sensed, although one experience is foregrounded while the other recedes (Maclaren, 2014).

Regardless of romantic or parental or friendly intentions, touch is an intimate connection to another. This is what makes the nurse's touch a privileged one - the nurse shares this intimate connection with someone they otherwise would not. Touch inherently involves "an encroachment upon the bodily intentionality of the others ... it is *essentially* transgressive" (Maclaren, 2014, p. 101). Transgressive, in this sense, is not to mean offensive or sinful, or that a touch is experienced as transgressive. To transgress, from the Latin *transgredi*, means to step across, climb over, go beyond. (Transgress, 2020, OED). When we touch we are always "stepping across and climbing over" into the other's space, into border territory where we experience the limits of ourselves. Passing through and over the threshold of the other is where connection happens and where we find the ethics of touch.

### **Limitations of the Research**

At the end of any research project, the researcher is obligated to reflect on its process and outcomes. There is no expectation that the findings in this study are generalizable or replicable. However, I hope that the insights uncovered about the neonatal nurse's touch may spark some contemplation for nurses who work in other contexts, and for other health practitioners. The biggest strength of this study lies in my intention to investigate the lived experience of the nurse's touch as an ethical encounter. One limitation that is inherent to a phenomenological study is Merleau-Ponty's reminder that the philosophical reduction, becoming aware of my own biases and preconceptions about touch, is impossible, though we continue to try. Perhaps the main limitation of this study is my ability as a phenomenological researcher to uncover the meanings of the nurse's touch and, further, to evoke them through written text in a rich and meaningful way.

### **Concluding Thoughts: Reflecting on the Babies**

Choosing the NICU for the setting of this study was founded partly on my clinical nursing history; I am eternally fascinated by and drawn to this patient population of babies and parents becoming families in difficult circumstances. I was also mindful of the opportunities for the nurse's touch in the NICU. Nurses work with relatively low patient ratios and their patients, by virtue of being babies, require a plethora of varied physical touching contacts: for basic care, for comfort, for treatment, for diagnosis, etc. Further, and importantly, it seemed that newborn babies, perhaps especially those that arrive at the NICU, deserve the most tender, thoughtful, befitting touches from the adults in their lives. The neonatal nurses bore this out in their stories

of touching moments. However, the babies of the NICU awakened me to an unanticipated opportunity for this investigation, and a way to deepen the account of the nurse's touch by revealing some of its intricacies and nuances.

I conclude the dissertation by recognizing the babies. On one hand, the newborns that made their way into this study by virtue of the words and stories of nurses allow us, researcher and reader, to contemplate the nurse's touch in a way less obscured by assumptions, expectations and concerns. The newborn baby presents to the world as a new beginning. There is a naked openness in their pre-verbal, pre-cultural, pre-political being. Every baby is situated within the traditional roots of their family, and every newly born human baby is needful of physical and emotional care. Whereas past experiences of touching and being touched shape and constitute adults in ways that influence and affect our perception of every new touch; the brand new baby is nearly ahistorical in this sense (I am careful not to discount their experience of touch in utero and birth, see M. A. van Manen, 2019). In their nascent capacity, each baby has offered a space for the nurse to be relieved of considering any learned experiential aspects of touch such as modesty, shame, embarrassment, or fear.

On the other hand, these same aspects of the baby's life and condition are not static. From the moment they are born, their touching experiences in the world begin to shape and inform them and their bodily memories. In the NICU, the obligation and privilege of the practitioners is to recognize we are responsible for the beginnings we are giving them, through our touch. The newborn baby cannot clearly express what they prefer or what hurts them except perhaps in general and reactive ways. The nurse cannot be guided by verbal cues from the baby-patient to lighten up, or be more firm, or be asked for a hug. At best, we speculate about the meaning of the baby's cries, facial expressions, etc., and respond improvisationally. So, we must pay close attention to this very originary touch of the nurse.

The outcome of a phenomenological research project, an evocative text, does not lend itself to the usual "recommendations" section at its conclusion. Instead, "the practical significance of phenomenological knowledge is *formative* [emphasis added] in nature" (van Manen, 2011). The root of recommendation is the verb to recommend, which comes from the Latin prefix *re* meaning again or anew, and *commendāre*, to give in trust, or commit to one's care (Recommend, 2020; OED). From this originary meaning, a phenomenological recommendation for nurses may be to commit again to care, in our practice. Or perhaps, better to

say that the commitment to care becomes a practice of renewal and renewing, shaping and reshaping both ourselves and those for whom we care.

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## Appendix A.

### **Relational Ethics of Mediated Touch: A Phenomenological Inquiry into the Nurse's Glove**

Preoccupied with concerns for an ill loved one, a visitor to an acute care unit in a hospital may not even notice the various boxes of gloves fastened to the hallway walls. Slightly larger than tissue boxes with oval-shaped openings, they are positioned in groups of sizes ranging from small to extra-large. A nurse walks down the hall, reaches to grab a pair without missing a beat, and puts them on while continuing into the room of a patient. The movement is so practiced it appears smooth and natural. Perhaps the nurse pauses only when the glove box is empty, and then smoothly alters course to a storage room for a new one. The gloves tend to be vivid in colour: blue, purple and green, or another other-worldly colour. When the nurse enters the patient's room to say good morning and begin their work, the patient's attention may be called to their hands by the bright and unexpected colour of the gloves.

For those who live in the world of the nurse, gloves are used so routinely we may fail to actually notice them anymore. As well as being attached to the walls, boxes of gloves sit on counters and shelves and bedside tables and are found discarded in every garbage bin. Gloves are a part of the scenery of the nurse's world. They exist quite unobtrusively, as part of the background of hospital equipment, ranging from expensive technical devices such as electronic heart monitors, programmable intravenous delivery pumps and adjustable electric beds to mundane and plentiful boxes of syringes and needles, plastic tubing and catheters. The rubbery, plastic smell of the glove may be hardly noticeable in the soiled yet sterile environment of a hospital ward, ripe with antiseptic and cafeteria food odours. The gesture of reaching for the glove is recurrent and automatic, one motion in a choreography of people and equipment moving through the halls.

Of course, the use of gloves is not privileged in some way by nurses alone. Most of us are familiar with gloves and experience their general utility, for example, during a northern winter, to protect our hands from the cold or while doing dishes, to protect our skin from the hot, soapy water. But neither the thick, puffy gloves of winter nor the clumsy over-sized rubber gloves of kitchen chores are the gloves of the nurse. The gloves of the nurse are intimately related to the work of nursing, to the technical and compassionate touching of the nurse's hand to the patient's body. We cannot look at the nurse's glove without wondering about touch between patient and nurse. Does wearing a glove matter to the experience of the nurse, to the experience of nursing?

Does wearing the glove reorient the experience of providing nursing care in some way? What is it like to wear a glove while touching a patient?

### **The Automaticity of the Glove: Donning the Glove Quickly to be Ready to Nurse**

*I grab a pair of gloves as I walk into the room to examine the wound of a patient. I slip them on while chatting with her about how she is feeling and then set up a dressing tray.*

The gesture of reaching for and then donning gloves seems automatic for a registered nurse in clinical practice. We might reach for them without really looking and we can speak to our patient as we put the gloves on, beginning the assessment without being sidetracked by the action of our hands. They are a part of the getting-ready routine almost entirely in the background, perhaps calling for attention for just a single moment; that moment when we reach for them. Only if they don't fit, or we drop one, do we turn our attention to the gloves. Once on, awareness of the gloves seems to give way, and the focus of the nurse is effortlessly and automatically oriented to the patient and to the procedure that needs to be done.

While reflecting on the painting *A Pair of Shoes* by Vincent van Gogh, Heidegger (2001) writes:

The peasant woman wears her shoes in the field. Only here are they what they are. They are all the more genuinely so, the less the peasant woman thinks about the shoes while she is at work, or looks at them at all, or is even aware of them. She stands and walks in them. That is how shoes actually serve. (p. 32)

The nurse puts the gloves on, they touch the patient with them and move their fingers and hands in them and that is how the gloves serve. The gloves are known in their usefulness. In turn, knowledge of the gloves affords the nurse the possibility to come to know their patient and to nurse.

Yet, the nurse's gloves are also different from the peasant's shoes. We can imagine that at the end of the day, the shoes are carefully placed on a shelf or by the door, to be ready for the next. The shoes might seem to prepare the peasant for work in the field and if they are 'genuinely' what they are – they fit well and are comfortable – they remain on her feet until the end of the work, quite unnoticed. The nurse needs the glove only for parts of the nursing work. The gestures of putting on and removing the glove might be thought of as book-ends to certain, specific tasks of nursing. Donning the gloves is a part of the movement toward the patient, part of the preparatory ritual to being ready to do what needs to be done. The gloves seem to bring to

the nurse a quality that they are yet without. Putting on the gloves augurs a shift in the nurse's way of being. Wearing the gloves inevitably changes the experience of the professional, nursing world even if this happens unawares. The nurse is now able to nurse; able to change the dressing, insert the intravenous catheter, clean the excrement, draw the blood. The gloves momentarily become part of the nurse, and simultaneously the gloves bring a nurse-ness to the hands that wear them.

### **The Possibility and Opportunity of the Glove: Protecting and Touching Clean and Messy Bodies While Being a Nurse**

It is easy to feel the soft plumpness of a newborn's arm through an exam glove, the tender yielding of muscles and flesh. With a refined and precise sensitivity, the fore finger and thumb of a well-fitted gloved hand can gently squeeze the baby's arm and retract the flesh just slightly, to create a tourniquet. The pressure is such that the underlying veins fill with blood, allowing the blood vessel to be more easily seen and felt, but not so snug as to cause pain or damage to the delicate flesh of a baby. The glove may make the procedure possible, keeping the nurse and the baby safe from exposure to bacteria of the other.

It is not really possible to feel the exquisitely smooth texture of a newborn's skin through the glove. And it might be hard at first to feel the bouncy resistance of the blood vessel with the tip of a gloved finger. With practice, however, feeling the vein can become quite easy, almost as if there is no glove at all. Wearing gloves might even make it easier to grasp the intracatheter device, a small plastic tube attached to a needle used to deliver fluids and medication directly into the vein. The plastic polymer-ized glove-finger provides extra friction for a secure grip while smoothly inserting it through the baby's skin and into the inside space of the vein. It has been said that inserting an IV into the vessel – moving the needle first through the skin, then through just the close wall of the vein, but not through the other side - requires a certain *touch*. The nurse *feels* their way - feels *through* the glove and the device to the end of the needle in the vein. The glove becomes nearly transparent to the nurse here; it is absorbed into the experience as an extension of the nurse's body (Ihde, 1979). However, Ihde notes that the things (or the machines, as he refers to even very nontechnical objects) in our world are never entirely absorbed into our experience. There is simultaneously an "echo focus", where one is aware of the glove pressing against one's hand at the same time as the inside of the vein is felt (p. 7). The echo of the well-fitting glove softly pushing back against the nurse is faint compared to, for

example, the grip on a pencil. The glove extends the skin and provides a special layer of softened sensation.

*I see the wound is still draining fluid and pus. As I slowly remove the length of gauze packing that fills the wound, I am glad I have the gloves.*

The glove here becomes present to the nurse when they recognize that the glove is allowing them access to a nursing obligation. The glove can *make possible* the care of a patient. The glove may reveal the patient's body to us as a body – contaminated and dirty or susceptible and vulnerable – that we cannot otherwise touch. The body that needs sterile touch, or clean touch, or the unabashed touch: a touch that is not withheld for any reason, not hesitating or cringing away from blood or tissue or pus, from excrement or urine or vomit. In these moments, the body of the patient becomes disclosed to the nurse through the donning of gloves. A nurse removing the soaked and soiled packing from deep in the infected wound of another is grateful for the gloves that protect them from the possible exposure to harmful microbes, but also from the full experience of handling the perhaps sticky, bloody, or slick, slimy gauze. Similarly, it becomes easier to clean a patient of vomit or excrement when the glove mitigates the burden for the nurse of the involuntary bodily response of cringing or recoiling. The glove allows the nurse's touch and attention to remain tender here (Benso, 2000). In this instance, the nurse is able to fully engage with the nursing task and the body of the patient because of the lessening or dulling of sensation made possible by the glove.

### **The Impediment of the Glove: Being Obstructed from Nursing by the Broken or the in-the-way Glove**

*I begin to remove the dressing but it is stuck so well I can't get an edge to lift off. I should have known better; I can never get these dressings off with gloves on. I pull off my gloves and throw them away, annoyed that I can't lift the dressing. With my fingernail I find a spot on the edge that has some give and slowly pull it off.*

Sometimes the dampened sensation may confront the nurse when the gloves interfere with caring for the patient: they are no longer useful but rather cumbersome. They are no longer experienced as being an extension of the nurse's hands rather they are *between* the nurse's hands and the patient, conspicuous as an obstacle. Here, perhaps even the thinnest gloves are still too thick, when removing the dressing requires the very fine dexterity of our hands and the delicacy of our fingernails. What a moment ago was quite incorporated into the nurse's being, might now

become foreign and again an object separate from the body of the nurse. The nurse may be abruptly reminded that after all the skin of the glove is not their own skin, they cannot do all of the nursing things with the gloves on their hands. What happens when this is the case - when the gloves do not become a part of the nurse, but rather make their hands somehow not their own? The practiced, familiar movements become clumsy and awkward. The nurse's hands become their 'real fingers', there is no longer a sense of transparency about the glove. Not only do their hands not work in the way they usually do, they also become conscious of their *self* as not working. No longer able to do what normally is taken for granted, the nurse may need to learn a new way to use now unfamiliar hands.

### **The Expendability of the Glove: Consuming the Disposable Glove and Throwing it Away**

*I discard the soiled and soaked gauze used to pack the wound and with it, my now soiled gloves.*

What is thrown away, with the soiled gloves? We tend to peel dirty gloves off carefully, making sure to touch only the outside of the first glove which, once off, is crumpled in the palm of the second. The second glove is then pulled off in a neat gesture of hooking a finger or two inside the edge at the wrist, inverting the glove as it is pulled off and capturing the first inside the second. Removing the glove happens with an inside-out gesture; we notice it is now the inside surface that protects the nurse from the soiled outside surface. When soiled gloves are thrown away, we may wonder if the nurse's part in the infected wound, or the clumsy intravenous line attachment, is also thrown away, forgotten? There may be a sense of conclusion, when the gloves are taken off and thrown away. As the glove is thrown away, so perhaps is the nurse's part in the procedure: the pain caused, the blood spilled, the inevitable discomfort of the patient in many procedures. Perhaps removing the glove reveals the nurse as not only a nurse, removing the gloves allows the nurse to remain clean, blameless, before returning home to their family. If Lady Macbeth had only worn gloves when covering up her husband's murder of the king, would she still have committed suicide, having gone mad with guilt? It is as though the blood has seeped into her, changed her: "Here's the smell of the blood still: all the perfumes of Arabia will not sweeten this little hand. Oh, oh, oh!" (Shakespeare, n.d., 5.1). If she had not felt the blood of the king on her hand, if gloves had protected her, could she have disposed of the gloves and felt her part complete?

### **The Inappropriate Glove: The Hand of the Nurse Making Contact with the Patient**

A nursing student recalls:

*We were taught to always wear gloves when bathing a patient, but I decide today that I am going to use my hands. I felt that the patient, a kind, elderly and very frail woman suffering from COPD and other ailments, and whom I had come to know and even grown quite attached to, might benefit from a kind touch without a cold, sterile layer of latex between my hand and her tired, old body. I wash my hands with warm soapy water from the sink in her single-bed hospital room. I prepare the water and washcloths and, chatting casually with her, I begin to bathe her in bed. After about 10 minutes, I am done. The patient looks up at me and smiles, says “thank-you so much, you’re so kind to me.” I felt my eyes grow hot with tears- sudden tears, I’m not sure why. I leave the room and think to myself, “this is what it’s like to be a nurse.”*

When we look at the gloves of a nurse, we cannot help but see the hands of a nurse and consider the touch of a nurse’s hand on the skin of a patient. In certain moments of nursing, the glove may become present to the nurse as being unnecessary, unhelpful or inappropriate. The nurse needs to remove their gloves.

The nurse might *just know* when not to wear gloves. The student nurse here felt that today, in this moment and with this person, they did not need the gloves. The glove might interrupt the relationship between the nurse and the patient. We have seen that the glove can be a sort of bridge to being a nurse, but here we are reminded that sometimes, wearing a glove may present a risk to the nursing relation. We might ask what this risk could be; surely, it is possible to wear gloves and bathe a patient with a careful and comforting hand in a way that the patient is not harmed. The risk does not have to do with physical safety, but rather is one of a missed opportunity to answer a call to be with a patient in a moment of genuine human connection. It is indeed hard to put to words what meaning occurs in such a moment of intimate skin-to-skin contact, but this student nurse expresses at least a part of it: this is what it’s like to be a nurse.

### **Concluding Thoughts**

A phenomenology of the nursing glove cannot be concerned with decreasing the rate of infectious disease transfer between patient and nurse. Nor can it prescribe a practice guideline that outlines when gloves should or should not be worn, although it may remind the nurse to consider the glove in a new way. A phenomenology of the nurse’s glove is, at its root, a rather humble study. To look at the ordinary and common exam glove lying on a bedside table in a soft

heap, is certainly to see nothing remarkable at all. And yet, by paying attention to the glove as it comes alive in the world of the nurse we are now pointed toward the ethical and inter-subjective nature of the nursing-patient relation. By gently raising the glove to our consciousness as nurses we may come to understand the work of nursing, or be reminded of the work of nursing and its nature. As I contemplate these concerns my attention cannot help but also consider the experience of those who are touched by the hands of the nurse, wearing gloves or not. I am also drawn to consider the shared experience of human skin-to-skin contact and the implications on human relations. Perhaps looking closely at the experience of the glove in the nurse's world has cast some light on how we come to understand each other, as humans in the world.

### References

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## Appendix B. Research Ethics Approval

<https://remo.ualberta.ca/REMO/Doc/0/3D7CI77D0DVK59JH1TH...>

### Approval Form

Date: April 10, 2018  
Study ID: Pro00079444  
Principal Investigator: [Wendy Austin](#)  
Study Title: Relational Ethics of Touch in the Neonatal Intensive Care Unit  
Approval Expiry Date: Tuesday, April 9, 2019

Approved  
Consent Form: Approval Date  
4/10/2018

Approved Document  
[Participant Consent Form](#)

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel. Your application, including the following, has been reviewed and approved on behalf of the committee;

- Social Media Message (4/2/2018)
- Recruitment Poster (4/2/2018)
- Participant Information Letter (4/2/2018)
- Information Letter for Families (4/2/2018)
- Proposal (3/13/2018)
- Guiding Interview Questions (4/2/2018)

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Alberta Health Services or other local health care institutions for the purposes of the research. Enquiries regarding Alberta Health Services approvals should be directed to (780) 407-6041. Enquiries regarding Covenant Health should be directed to (780) 735-2274.

Sincerely,

Anthony S. Joyce, PhD.  
Chair, Health Research Ethics Board - Health Panel

*Note: This correspondence includes an electronic signature (validation and approval via an online system).*