The Discovery of Connectedness

When we see ourselves
as but a mere, yet mandatory, speck
traversing the conduit called time
we appreciate the necessity and beauty of destiny.
We begin to comprehend
the need for purpose and direction.
Uniquely created, we each somehow complete
the montage of the universe.
Such awareness can, ...perhaps, entice us
to dance more rhythmically,
whether to the symphonic melody of Opera,
the syncopated rhythm of Jazz
or the pulse-driven beat of Hip-hop
To dance is the thing!
Ever learning new steps--
ever bending, stretching, reaching
at once forward, but also embracing
the offerings of ancestors,
valuing each signature-driven step
dancing toward the discovery of connectedness
required to complete the masterpiece.

Sista Joy Matthews Alford, 2007

University of Alberta

Encountering the Other in Nurse-Patient Pedagogic Relationships: Becoming We

by

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in partial fulfillment of the requirements for the degree of

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Dedication

This thesis is dedicated to my parents, who taught me that the most challenging of tasks can be overcome if you have faith and believe in yourself,
and,
To my family, through whose love, patience and support, I completed this journey.

Abstract

The patient teaching relationship is entwined within the dialogue between nurse and patient. Using interpretive phenomenology, consistent with the philosophy of Martin Heidegger, this research study explores the meaning of the relationships that develop for patients with nurses during their learning experiences about gestational diabetes mellitus. It affords a better understanding of how patients engage with the *Other* in their mutual relationships and what influences their *Being-in-the-World.* The learning relationship occurs in the context of community, which, for this study is the acute care nursing units and ambulatory clinics that provide prenatal care for women experiencing gestational diabetes. Understanding, for this exploratory study, rests within the insight gained into the everyday experience of patient education, within the relational pedagogical space where patient and nurse connect as learner and teacher. A hermeneutical spiral of interpretation was used to identify four major themes: (1) Attuning to a New World Of *Being*: What is Happening to Me?; (2) Towards A Connectedness With The *Othe*r: Attuning To Possibilities; (3) Becoming *We*: Needing Creates Something Special and (4) Meeting Expectations And Reconciling Differences. The findings of this study have implications for patient education, nursing practice and education, health policy and research.

Key words: gestational diabetes mellitus, relational pedagogy, education, Heidegger, Buber, Gadamer, Macmurray, Noddings, phenomenology, hermeneutics, interpretive inquiry, nursing.

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Finally, a deep and sincere thank you must also go to the participants in this study who gave their time and interest to my research project. Your enthusiasm to make the world a little better by enhancing the understanding of what is it means to learn about and live with gestational diabetes reinforced the purpose behind my study and the importance of asking “why?” in my everyday life.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter One

Introducing the Thesis

I am learning the art of listening.
I wish to be an eternal student

I am learning the art of believing.
I wish to be an eternal believer.

I am learning the art of serving.
I wish to be an eternal servant.

I am learning the art of becoming.
(Chinmoy, 1973, p.51)

In this chapter, I outline my journey to the development of my research process and the nature of my thesis. This inquiry focuses on the meaning embedded in the pedagogic relationships that patients have with registered nurses during their learning experiences. The physical manifestations of gestational diabetes mellitus (GDM) and the social-political and psychological circumstances in which some pregnant women live and learn about gestational diabetes mellitus are incorporated to help set the context for exploring the lived relational pedagogic experiences that pregnant women can have with registered nurses.

The Dissertation Framework

The structure of this thesis consists of nine chapters:

- Chapter One: provides a comprehensive overview of the context of the research as well as my place, as researcher, in the research process.
- Chapter Two: draws upon the epistemological and ontological realms of knowledge and understanding to provide insight into the substantive aspects of this research inquiry concerning learning encounters occurring

between nurses and pregnant women experiencing a diagnosis of gestational diabetes.

- Chapter Three: overviews the philosophical foundations for the research methodology and the justification for interpretive phenomenology as the philosophical base for the research design.
- Chapter Four: presents the research methodology and method for the research process.
- Chapter Five to Eight: presents the results of my thematic analysis of the study conversations with the participants. Each chapter explores a theme that contributes to an overall understanding of the influences on their relational space with nurses as part of their learning encounters.
- Chapter Nine: presents my closing reflections pertaining to this research inquiry. The themes uncovered through my conversations with the participants are discussed from the perspectives of strengths and limitations of the research, the possibilities this dissertation thesis presents for patient education, nursing education and thoughts for future research.

For easy reference, I included in the appendices a glossary for thesis-specific word definitions. In addition, Heideggerian words are *italicized* throughout the text of the chapters to facilitate ease of reading and understanding. Excerpts from the participants' conversations are italicized and single spaced for easier differentiation within the text. Pauses in conversation are identified by (...) and points of exclamation or special emphasis are <u>underlined</u> within the excerpts.

Significance of this Research Inquiry

The themes arising from this research project provide insight on what influences mutuality and reciprocity in learning relationships, thereby enhancing understanding of the collaborative and holistic nature of patient teaching

relationships. Relationships characterized by mutuality and reciprocity have the potential to impact the certainty of achieving safe and effective outcomes for patient teaching by positively influencing learning experiences (Anderson, 2000; Bergum, 2003).

The outcomes of this study contribute to nursing knowledge in the following unique ways:

1. The findings illuminate how patients engage authentically in day-to-day learning experiences about GDM and the meaning of their encounters from a relational pedagogical perspective.
2. A relational pedagogy approach to patient learning is used with this study, supporting the need for nurses to incorporate an ontological way of being, thinking, and talking about patient teaching in acute care environments, with a focus on empowerment through relational dialogue.
3. A hermeneutic phenomenological research design is used for an area of study that has not received much exploration from this perspective. The themes that arise from this study provide insight into the meaning of the experience and the influences on nurse- patient relationships that occur as patients learn about gestational diabetes mellitus.

Background to the Study

Patient teaching is an important part of the healthcare role for registered nurses. Nurses facilitate independence or self-care by sharing knowledge needed to master complex technology and interventions. In addition, support is provided for patients who are coping with the physical and emotional suffering that is often

part of an illness experience and hospitalization (Friberg, Philhammar, Anderson & Bengtsoon, 2006; Gregor, 2001; Miller & Fain, 2006). This education role often has a formal, didactic approach to teaching and a more informal mentoring role that is characteristically imbedded within the concept of nursing care (Benner, 2000; Coster & Norman, 2009; Gregor, 2001). Proponents of relational pedagogy speak of the importance that the relational aspect of teaching and learning has for effective education. It is the reality of the relation occurring between the teacher and learner that is crucial to learning. It is within this complex relational space that information transference and knowledge is really affected. (Latta, 2005; Sidorkin, 2002).

Self-care or the self-management of health needs has a long tradition as a core concept for the maintenance of health and well-being, the prevention of illness and the promotion of health. In Canada, the Lalonde Report reconceptualized health as self-determining through lifestyle choices. The concept of self-care was eventually placed within the central framework of health promotion for Canadians. (Lalonde, 1974; McCormick, 2003). A major focus of the healthcare management of gestational diabetes is on effective learning strategies that promote a patient's independence in the self-management of their prescribed diabetic care routines (Canadian Diabetes Association, 2009). In addition to incorporating changes related to diet and exercise into their lives, pregnant women may also need to become competent in performing procedures such as blood glucose testing and injecting themselves with insulin (Canadian Diabetes Association, 2009; Miller & Fain, 2006; Reader & Sipe, 2001).

There are strong incentives for pregnant women who are facing the medical diagnosis of gestational diabetes mellitus to effectively integrate their healthcare needs into their day-to-day lives. Recommended interventions and lifestyle changes from health professionals offer an increased possibility of a healthy newborn, decreased morbidity for the mother at birth and may impact positively on the future health of mother and baby. However, it is the pregnant woman's knowledge, skill and desire to integrate the interventions into her life that determines success in relation to health outcomes when she leaves her prenatal appointment or is discharged home from the hospital. (Catrine Eldh, Ekman, & Ehnfors, 2008; Haidet, Kroll& Sharf, 2006)

Development of my Research Interest

In most circumstances, my patient teaching experiences have been positive. I share information with patients based on knowledge from my education and practical experiences. The patients, in turn, seem to apply their new knowledge to their daily lives in a grateful and competent manner. Our relationships appear almost instinctual in nature, with a sense of congruency with our goals and expectations. I usually come away from these experiences with a feeling that I had facilitated their success at maintaining and improving their health. Peers and managers often support these feelings, reinforcing that I have fulfilled my role and responsibilities as a registered nurse and patient teacher.

Not all patient teaching circumstances, however, have been so positive. Patients sometimes appear disengaged from what appears to me to be logical and positive information for health. There have been situations in which I left the

experience feeling unsettled, unhappy and even distressed. The circumstances of these encounters are often more complex. Patients are often experiencing significant life challenges and incredible pressure to accept unanticipated changes into their lives and to acquire skills to manage unfamiliar technology and daily routines. Often, despite my efforts at being a facilitative, caring and effective teacher, some patients do not accomplish the desired goals for learning or manage to achieve the required changes in their lives. Julia was such a patient who came into my world as a nurse on a high-risk pregnancy unit in the hospital where I worked.

> *Julia was a 19-year-old aboriginal woman expecting her first baby. She was in the thirtieth week of her pregnancy and admitted to our hospital because of unstable blood sugars related to her gestational diabetes mellitus. Three months earlier, she had moved from her reservation, where she grew up, to the city in order to distance herself from her boyfriend. Although he was the father of her baby, she did not want to have him involved with parenting her baby because of the personal struggles he was experiencing. As a result, Julia was currently living with her sister with the hope that she would eventually be able to obtain housing and work in the city.*
>
> *Julia's diabetes was out of control. This was apparent by her consistently high blood glucose levels (or hyperglycemia). Insulin therapy appeared to be a logical intervention to bring some stability to her elevated blood sugars. Her diabetic team hoped that an admission to the hospital could be a solution to facilitating Julia's learning about insulin administration and bring her blood sugars under control.*
>
> *When I entered her patient room, Julia was sitting on the edge of her bed, looking at her television with earplugs in her ears. Her body was moving rhythmically side to side. As I came closer, she looked sideways at me, acknowledging my presence with a furrowed brow. In a loud voice, she asked me if I wanted something. I nodded my head affirmatively and pointed to my ears, indicating my desire for her to unplug herself from the television. She complied with my request. I introduced myself, and shared my need to set up a time to help her learn to inject herself with insulin. She responded with a bit of a laugh, stating that she hated the thought of the*

needles and preferred not to take insulin. I shared that I understood the challenge of taking insulin and emphasized my concern of what might happen if she didn't follow through with the medication. After letting me talk, she confirmed that she had already been told everything that I had related to her. In an off-handed manner, she requested that I return the next day around breakfast time and we could discuss her diabetes issues further.

The following morning, Julia indicated she was open to my reviewing the theoretical principles of living with insulin-dependent diabetes with her. I demonstrated the procedure of drawing up and giving the insulin. Julia was a quick learner, easily catching onto the principles of the procedure. Her hands shook slightly as she attempted to draw up the medication and she closed her eyes tightly as she drove the needle into her thigh. I congratulated her on her successfully injecting herself and tried to encourage her by stating that it would get easier with time. She nodded back in response as she looked down at the empty syringe in her hand. I felt satisfied with the outcome of the session and confident she would manage her injections on her own. Based on Julia's success, her discharge from the hospital was planned for the next day and she was given an appointment for follow-up with her diabetes team the next week.

The next week Julia missed her appointment. I felt immediate concern. I anxiously contacted Julia by phone. In response to my query about why she hadn't followed up with her appointment, she related that she had run out of her supply of insulin and hadn't gone to the pharmacy to obtain another vial. She would get it as soon as she could.

I felt confused and frustrated. How could I have been so wrong in determining her level of understanding and compliance with her insulin therapy? I probed a little harder in an effort to understand her behaviour. Julia related that she didn't wish to come to her diabetic team appointment because she hadn't taken her insulin and felt everyone would be upset with her. She hadn't called me because she didn't have a problem giving herself the insulin. She reminded me that she didn't like the needles and strongly stated that she found her diabetic care routine burdensome and tedious. From her perspective, a few days off the regime were a blessing.

I tried to persist gently with the message that she should try to make the insulin injections a priority in her life and that we cared about her health and that of her baby. With a tinge of anger to her voice, Julia cut me off, stating that she wasn't sure what we cared about. Emotion built in her voice as she shared her thoughts. She felt she had no choice but to learn to give herself the injections. We made it all too clear how important the insulin was to her baby. With her voice now full of anger, she stated:

> *"I can tell you about diabetes and how to live. I know all about it. My grandmother had it. My mother had it with all of her kids and we are ok. She didn't use anything. She still has it and is ok. She says I will be ok. I just need to take care of myself and eat good. I know about diabetes. You guys know nothing about diabetes and me. I don't need you! You just make me feel bad!"*

I had no idea about all of the negative feelings Julia had towards her experience with diabetes and the subsequent learning encounter she had with me. I thought I had been caring and empathetic in my approaches to Julia. My motives and those of her other team members were caring and sincere, with a strong focus on the best health outcomes for Julia and her unborn baby. I had applied all the best theories and practices in helping Julia learn about her injections. She had learned to give herself the insulin so quickly, appearing to be compliant and embracing of the routines needed to manage her diabetic situation. Yet, it was obvious that Julia did not connect me, or her other care team providers as being knowledgeable, supportive and interested in her. The distinct disconnection in our relationship had been totally invisible during my interactions with her. Her embracement of our relationship was superficial and perhaps hindered by her perception of being negatively judged by me and the other members of her prenatal care team. She had shared so little with us about her life experience, the challenges that she may be facing and her understanding of gestational diabetes mellitus.

Perhaps it was my myopic focus on teaching the technical aspects of learning to manage her GDM that contributed to my missed understanding of the meaning of a diagnosis of gestational diabetes in reality of Julia's life experience

as a young, pregnant, aboriginal woman. Her understanding of the illness was strongly influenced by her past experiences with diabetes in her family. The intensity of our messages for the need for compliance with her diabetic regime appear to have overshadowed Julia's ability to express her own concerns and knowledge, thereby undermining her ability to feel in charge of her care routines and decisions. She appeared to have translated our lack of understanding about her life experience to a perception that we did not care about her. What were the barriers, from Julia's perspective, to our relating one to the other? What did my relationship with her as a patient teacher really mean to her? What hindered her ability to embrace the messages for health that we had for her?

Coming to the Research Question

It has been these very challenging pedagogical situations, such as I had with Julia, that created a strong desire for me to increase my understanding of the relational aspects of patient learning experiences. My curiosity has also been peaked by the more positive teaching experiences that I have had with pregnant women; women with whom I have felt a strong relational connection and who appeared have had more positive learning outcomes. I had come to appreciate the importance of understanding the influence that the meaning a diagnosis, such as gestational diabetes, has in the lives of patients as they learn to integrate interventions into their lives. A similar revelation occurred for an oncology nurse, Donalda MacDonald, through her personal experience of being diagnosed with cancer. In the article by Tosh-Kennedy (2007), Donalda describes how important it is for nurses to strive to understand the meaning of the illness experiences of

their patients and the impact the illness is having on their lives and learning. Through her own experience of cancer, she came to understand the complex nature of learning during periods of crisis and vulnerability:

> When I was diagnosed, I had been an oncology nurse for 20 years. But when you hear the word 'cancer' and your name in the same sentence, everything goes out of your head. No one can understand what it's like to be diagnosed. We think we do, as nurses. We don't (Tosh Kennedy, 2007, p. 18).

Coming to an Understanding the Relational Nature of Patient Learning.

As a doctoral student, I began the journey to understanding the nature of learning relationships and the significance of the meaning embedded in nurse-patient relationships within the ontological context of *Self* and *Other*. Having had few opportunities to study philosophy, I immersed myself in the work of philosophers such as Buber, (1922/1970), Heidegger (1927/1978), Gadamer (1960/2004), and Macmurray (1957; 1961) in order to come to an understanding of the philosophical underpinnings of relational theory and ethics. I also increased the breadth of my understanding of educational concepts, theories and philosophies, during which I was introduced to the notion of relational pedagogy as an approach to facilitating patient learning about gestational diabetes. Education proponents of a relational pedagogical approach to learning, such as Sidorkin (2000; 2004) and Bingham (2004), maintain that the relational nature between teachers and learners is foundational to the facilitation of positive learning outcomes.

The need for understanding the relational aspects of patient teaching is particularly supported by the goals in healthcare for patients' learning about gestational diabetes mellitus (Anderson & Funnell, 2005, 2008). A relational pedagogic approach to patient teaching has the goals of promoting self-efficacy and empowerment. Patients are in control of the learning; positive, power-neutral relationships are emphasized. With a relational focus to teaching and learning, a nurse would reach out and connect with a patient in search of understanding, instead of merely imparting information. The healthcare focus would be on the promotion of actions that foster empowerment (Anderson, 2008; Anderson & Funnell, 2005; Kettunen, Poskiparta & Gerlander, 2002). Learners become partners in their own education for life.

Active participation by patients in the learning experience is important to successful outcomes related to independence (Anderson & Funnell, 2005, 2008; Catrine Eldh, Ekman & Ehnfors, 2008). Research studies support that an empowering discourse between a patient and a nurse can positively influence self-efficacy and can facilitate effective health decisions by patients (Anderson & Funnell, 2005; Latta, 2005; Pibernik-Okanovi, Prasek, Poljicanin-Filipovic, Pavlic-Renar, Metelko, 2004; Virtanen, Leino-Kilpi & Salantera, 2007). Mutuality in a relationship may be disturbed if measures of success for patient teaching are directly related to the concepts of compliance and adherence. While teaching has the potential for enhancing and promoting health and well being, it also has the ability to do harm through "biased and incorrect educational messages delivered by methods aimed at changing behaviour" (Redman, 2002,

p.774). Historical social-political influences on the profession of nursing, the dynamic nature of the current healthcare system, and the diversity of patient populations may create challenges for nurses in their facilitation of patient learning within the context of their caring role. Perceptions of support and acknowledgement for their role as patient teachers may also influence the synergy in the teaching-learning relationships between nurses and patients. (Anderson & Funnell, 2005; Hrycak & Jakubec, 2006; Turner, Wellard, & Bethune, 1999). In any of these circumstances, ethical concerns, such as paternalism and coercion, may arise, and active patient participation and relational engagement may be lost (Anderson, 2000; Anderson & Funnell, 2005, 2008).

Knowledge transference and translation occurs within the mutual space between the nurse-teacher and the patient-learner. It is the embodied nature of this relationship that enables learners to become partners in their own education (Bergum, 2003; Sidorkin, 2000). The relational space between the nurse-teacher and the patient-learner needs to be positive and mutual in nature in order for learning to occur (Linscott, Spree, Flint, & Fisher, 1999; Nisker, 2004; Vander Henst, 1997; Sidorkin, 2000). Educator and philosopher, John Dewey (1916), wrote of the need for a learning environment to be democratic in nature. He described the goal of education as:

> the reconstruction or reorganization of experience which adds to the meaning of experience, and which increases ability to direct the course of subsequent experience. The increment of meaning corresponds to the

> increased perception of connections and continuities of the activities in which we are engaged (p. 77).

Patient teaching experiences, such as I had with Julia, helped to demonstrate the limitations of a strictly behavioural approach to understanding learning outcomes. Julia showed strong attributes of self-efficacy in relation to her being able to administer her insulin to herself at home. My approach to her learning, however, was not helpful in understanding the reality of what it meant for her to give herself injections every day; influences in her life may have been helping and hindering her integration of her diabetic routine into her daily life.

The following metaphor, which describes the nature of the interaction between two people dancing, helps to portray the complex nature of the pedagogical relationship as nurse and patient come together in a learning encounter:

> Sometimes dancers will immediately connect with the music and a beautiful synchrony occurs. It appears almost effortless and the two appear as one. Some couples take a while being out of step with each other, but gradually come together – sometimes in step with the music, sometimes not, sometimes each to their own rhythm. If out of step, even though the couple may be synchronized, disharmony occurs with the music and observers may become uncomfortable with the outcome. And sadly, sometimes the two never come into step – each interpreting the nature of the dance and the music perhaps differently, or perhaps not engaging with the music at all.

> When this occurs, not only is disharmony evident to observers, but the dancing may stop altogether (Dance in Time, 2006, para.1).

Determining Methodology

Relational pedagogy is best understood through its manifestation in behaviour (Sidorkin, 2004). Understanding the issues of relational power, democracy and co-constructed learning is foundational to the facilitation of positive learning experiences for pregnant women facing a medical diagnosis of gestational diabetes mellitus (GDM) (Anderson, 2005; Anderson & Funnell, 2005). Appreciation of the characteristics of the learning environment and human emotion are also central to relational pedagogy (Sidorkin, 2004).

A qualitative methodological approach appeared a logical choice to aid in the understanding of the meaning and nature of patient teaching relationships: to see what normally remains unseen through quantitative methods of research (Benner, 1994; Munhall, 2007). While the inquiry focuses on the relational learning stories of the participants, the context of these stories involves an array of relationships that occur in the same time and space. I considered critical social theory as a potential philosophical perspective to the research inquiry. It would aid in the understanding of the social-political pressures experienced by the pregnant women in their learning experiences. The nurse-patient teaching relationship happens in the context of community, which for this study is the acute care nursing unit or ambulatory clinic in which the learning relationship happens. It is an environment in which concepts such as compliance and adherence to prescribed regime may foster situations of vulnerability for both

patients and nurses (Anderson, 2000). Therefore, it is important to consider the social, political and group influences on the moral context of patient teaching relationships (Austin, Lemermeyer, Goldberg, Bergum & Johnson, 2005). Concepts such as vulnerability, empowerment, and autonomy can be explored through this theoretical approach, within the context of the human relationship. However, critical theory views understanding social structure as more important than the understanding of "personal meanings" (Campbell & Bunting, 1991, p. 141). Insight, therefore, is limited in relation to revealing the meaning of these relationship experiences from the perspective of the participant (Campbell & Bunting, 1991; Munhall, 2007; Sellman, 2005).

With my attention focused on the ontological aspects of learning relationships, I came to embrace the hermeneutic phenomenology of Martin Heidegger as the philosophical foundation for my research methodology. This approach allowed insight into the relational space where nurse and patient connect as teacher and learner. (Buber, 1970; Conroy, 2003; Gadamer, 2004; Heidegger, 1978)

Research Questions, Strategy and Focus

The question guiding this research inquiry grew out of my curiosity about the nature and meaning of a pregnant woman's pedagogic experience with registered nurses as they learn about the self-management of their gestational diabetes mellitus. Specifically, my question is: How do pregnant women, who are learning about self-managing their gestational diabetes mellitus, respond to *Self*

and *Other* in their pedagogic relationships with registered nurses? The following comprise the sub-questions for this research inquiry:

- What is significant or meaningful about patient teaching and learning relationships for patients?
- What is the meaning of teaching and learning for *Self* and *Other* in the nurse-patient relationship?
- How do patients come to understand their role relationships in patient teaching experiences with registered nurses?
- How does the relational space between nurses and patients facilitate or challenge learning?

The intent or purpose of this study is to enhance understanding of the meaning that pedagogic relationships hold for pregnant patients as they learn about managing their gestational diabetes mellitus from registered nurses. A major emphasis is to facilitate opening the moral and relational spaces where the participants can speak for themselves. It moves understanding from a prescriptive, formal world-view of relations to a more exploratory engagement of *Self* and *Other* in the world of obstetrical nursing units and clinics (Buber, 1970; Conroy, 2003; Heidegger, 1978). This is a social, political, historical environment in which perceptions often arise related to the concepts of compliance and adherence, affecting ethical space and relationships. Conversations of patients will be interpreted, according to Conroy's Pathways (2003) for interpretive inquiry, giving an understanding of mutuality and engagement within their relationships.

The patient participants will be the main focus of attention for understanding for the study. However, my encounters with the participants, their texts, their interpretations and past experiences will inform the interpretative stage of the research project. As researcher, I will be entwined in the conversational encounters, bringing my own preconceptions and pre-understanding of relationships to the study (Conroy, 2003; Wojnar & Swanson, 2007).

Definitions and Descriptions of Patient Teaching and Pedagogy

The term, patient rather than client is, used for this dissertation. Patient teaching for registered nurses practicing in acute care settings is usually viewed as being contextually different from health teaching and health promotion (Coutts & Hardy, 1985; Redman, 2004). The Oxford dictionary description of the root of the word patient means to suffer and traditionally carries with it a connotation of vulnerability, with the terms illness and suffering often used synonymously. Patient teaching implies a one-on-one relationship with an individual and/or family. The nursing relationship has the goal of engaging the patient in a change towards health, be it restoration from an illness or maintenance of health in an illness experience (Coutts& Hardy, 1985; Mitchie, Miles & Weinman, 2003; Redman, 2004). This relationship occurs in the context of community where nurse and patient come together in a relationship characterized by action towards the "Other" where *Self* and *Other* are capitalized and italicized to indicate the importance of each (Buber, 1970; Macmurray, 1957, 1961).

Pedagogy, for the purposes of this research, is defined as the art, science and practice of teaching, consistent with the online Oxford dictionary definition.

Originating within the profession of education, the term pedagogy encompasses the theoretical and practical aspects of teaching experiences (Sidorkin, 2002; van Manen, 1991). Applied to the situation of patient learning in an acute care setting, the definition of pedagogy incorporates both methods and theories of teaching, the understanding of how adults learn and the relational aspects of teaching (Caraher, 1998).

In summary, this study is a hermeneutic phenomenological exploration of the significance and meaning of nurse-patient pedagogic relationships within the context of a woman's prenatal diagnosis of gestational diabetes mellitus. A Heideggarian philosophical foundation for the research methodology affords the opportunity to enhance understanding of the meaning of the pedagogic relationships that occur for the patient participants as they learn to self-manage their gestational diabetes mellitus.

In the next chapter, I explore in greater depth the literature that encompasses the nature of gestational diabetes mellitus and the life and learning experiences of pregnant women facing this diagnosis. The attributes of a relational approach to learning are explored from the perspective of facilitating and empowering dialogues between patient-learners and nurse-teachers, thereby enhancing the possibility of positive patient learning experiences.

Chapter Two

A Review of the Literature

In this chapter, I explore what is written in the literature about patient teaching and learning from the context of nursing practice. Although my focus for inquiry is a better understanding of what occurs within the relational space that arises between a nurse and patient in learning encounters, it is important to understand the experience of having a diagnosis of and learning about gestational diabetes mellitus (GDM), as it possibly pertains to the participants in this study. An overview of philosophical foundations of relational pedagogy is presented from the context of incorporating an ontological relational way of teaching patients about gestational diabetes into their practice, with a focus on empowerment through relational dialogue. The overview does not discuss in depth the foundational philosophical thoughts underlying ontological relational pedagogy. Rather, it brings to the forefront the important aspects that aid in the understanding of how an ontological relational pedagogy would facilitate the learning experiences of pregnant women encountering a medical diagnosis of gestational diabetes mellitus.

Understanding the Lived Experience of Gestational Diabetes Mellitus (GDM)

As I started to think about my research question, I turned to what was written in the professional literature about GDM in order to increase my knowledge on what is already known about this prenatal health concern. I found a large volume of current empirical evidence that supports my understanding that uncontrolled gestational diabetes mellitus represents important health risks to

women and their children. There is an almost overwhelming amount of literature related to the risk and diagnosis of GDM and the health concerns of this population. However, far less attention has been paid to understanding the experience of living with GDM and the meaning of the learning relationships encountered by the patients as they work towards independence in their diabetic self-care needs. The physiological effects of gestational diabetes mellitus can have a significant impact on the bodily symptoms a pregnant woman might experience, but it also has an important influence on their learning experiences. Its effects on health are often strong motivating forces for nurses to facilitate positive learning experiences and guides the interventions used to control the high blood sugars experienced in diabetes. However, the degree to which a woman successfully comprehends and accepts the principles of this complex health issue may greatly influence her ability to manage and integrate, into her daily life, the recommended interventions needed to maintain a healthy pregnancy. I have grown in my appreciation of the significance of the challenges faced by pregnant women in trying to meet the mandate for health imposed upon them by their prenatal diabetic care teams and the healthcare system.

The physiological nature of gestational diabetes mellitus. For all human beings, the body depends on a continuous supply of glucose for proper cellular function. The regulation of blood glucose is done through the secretion of insulin from the pancreas. The beta cells in the pancreas release insulin when blood sugar levels rise in response to a person eating carbohydrates (Galerneau, Silvio & Inzucchi, 2004).

Observations from clinical studies have shown that, during pregnancy, there are changes in a woman's glucose metabolism, mainly in the form of insulin resistance. By the third trimester of pregnancy, it is thought that there is a reduction as great as 50% in insulin sensitivity (Galerneau et al., 2004; Metzger et al., 2007). This change probably occurs because of maternal increases in cortisol as well as placental lactogen and growth hormone variant, both of which are insulin antagonists. Human placental lactogen secretion is produced by the liver and affects fatty acids and glucose metabolism, promoting a breakdown in fat stores for energy called lipolysis. This decreases glucose uptake and insulinase secretion, which is produced by the placenta and facilitates the metabolism of insulin. It is proposed that the elevated estrogen, progesterone and prolactin levels of pregnancy may also affect the glucose-insulin relationship. A pregnant woman's body naturally compensates for the increased circulating glucose by producing increased amounts of insulin, thereby maintaining glucose levels that would be near that before pregnancy. (Galerneau et al., 2004). It is thought that this unique aspect of pregnant physiology is protective towards the fetus. After eating, a pregnant woman's glucose and insulin levels rise, promoting the storage of fat. During fasting states, such as when she is sleeping, her glucose levels drops and lipolysis occurs. This approach to glucose metabolism during pregnancy ensures consistent adequate nutrition for the pregnant woman and her fetus. Within a year after pregnancy, these changes in insulin and glucose regulation have dissipated in women with normal glucose tolerance (Metzger et al., 2007).

Gestation diabetes mellitus is defined as “glucose intolerance that was not present or recognized prior to pregnancy” and occurs if the pregnant woman cannot compensate for the increased circulating glucose in her bloodstream (Hoffert Gilmartin, Ural & Repke, 2008, p. 129). It is physically manifested in a pregnant woman by increased blood sugars due to carbohydrate intolerance, which is usually diagnosed during the second trimester of pregnancy (Coustan, 1997; Elnours, El Mugammar, Jaber, Revel & McElnay; 2008; Canadian Diabetes Association, 2009). Increased maternal adipose tissue, decreased exercise and increased caloric intake appear to add to the already elevated glucose levels and insulin resistance consistent with her pregnancy state (Coustan, 1997; Elnours et al., 2008; Galerneau et al., 2004; Hoffert Gilmartin et al., 2008). The degree of glucose intolerance for GDM is along a continuum of severity that includes blood sugar levels high enough for the woman to feel significantly unwell to mild glucose elevations that present no symptoms for the pregnant woman. However, even mild elevations of glucose may still carry increased risk for newborn and maternal health (Metzgeret al., 2007).

The health effects of gestational diabetes mellitus. Heinrich Gottleib Bennewitz is credited with having the first notion of a diabetic state in pregnancy (Hadden, 1998). In 1824, as part of his medical dissertation, Bennewitz described his experience with a 22-year-old woman, Frederica Pape, who had been admitted to the Berlin Infirmary during her fifth pregnancy. She had an “unquenchable thirst, consuming more than six Berlin measures of beer or spring water” (Hadden, 1998, p. B3). Bennewitz went on to describe her amount of urine as

greatly exceeding what she drank, high in sugar content and having an odour of stale beer. She had a weak voice, dry skin, cold face and a nagging pain in her back. He believed these "little fires which had hidden beneath the smouldering deceiving ashes broke forth and devoured again the woman's condition in the most wretched manner" were symptoms of a unique or rare pregnancy experience (Hadden, 1998, p. B3). Sometime around her thirty-second to thirty-sixth week of gestation, Fredericka's pregnant abdomen had distended to such a degree that it was thought she was carrying twins. Sadly, her baby died during labour due to arrested childbirth. Bennewitz observed the baby to be of "such robust and healthy character whom you would have thought Hercules had begotten" (Hadden 1998, p. B3). The baby was recorded as weighing 12 pounds. Fredericka gradually improved in strength and health during her postpartum period and the large amount of sugar in her urine eventually disappeared.

Matthews Duncan truly highlighted the significant negative effects a hyperglycemic (high glucose) state in pregnancy can have on the life and health of a mother and her unborn baby. He compiled observations of the pregnancies of fifteen women who developed high sugar concentrations in their urine. Out of the 19 pregnancies that he recorded, the fetus died in at least 13 of these pregnancies. Nine of these mothers died within a year (Hadden, 1998). Over the next century, the effects of a hyperglycemic state in pregnancy continued to be documented in the medical literature, with authors and researchers using descriptive terms and concepts such as "prediabetes in pregnancy", "latent" or "temporary diabetes" (Hadden, 1998, p. B4). While Jorgen Pederson has been credited with coining the

term gestational diabetes in 1967, it is Norbert Freinkel who developed the definition (Freinkel, 1980; Hadden, 1998). In 1984, at the Second International Workshop-Conference on Gestational Diabetes Mellitus, a consensus was reached about the "definitions, prognoses, and strategies for screening, diagnosis and intervention" (American Diabetes Association, 1985, p. 1351). Presentations at the workshop-conference supported that there is increased obstetrical and perinatal risk when women experience high blood sugar levels during pregnancy and that there is a tendency for these women to develop diabetes later in life. An emphasis was placed on the importance of understanding gestational diabetes as a "distinct entity deserving of increased recognition, treatment, long-range follow-up and research" (American Diabetes Association, 1985). Current research continues to support that it is the metabolic inter-relationship between the pregnant woman and her fetus that determines the health outcomes for each. .

During pregnancy, the fetus is dependent on the mother for nutrition, with the placenta being the passageway for most of the nutrients the fetus needs. While maternal glucose passes easily through the placenta, the hormones that control glucose levels in the mother are blocked. The fetus regulates its own glucose levels through its own production of insulin. Hence, if the pregnant woman's glucose states are high, more glucose passes through to the fetus (Galerneau et al., 2004). Termed macrosomia, these newborns are born with a birth weight often in excess of 4000 grams. Resulting complications from the birth of these large newborns include birth trauma such as fractures and perinatal asphyxia as a result of shoulder dystocia (Galerneau et al., 2004).

Newborns exposed to a hyperglycaemic uterine environment may also have difficulty breathing at birth, commonly termed respiratory distress syndrome or RDS (Galerneau et al., 2004). It is thought that the higher levels of insulin in the fetus inhibit its normal lung maturity throughout the last trimester of pregnancy. Following birth, these babies are also prone to significant metabolic problems such as hypoglycaemia, hyperbilirubenemia, and hypocalcemia, which present an increased risk for morbidity if not treated. The hypoglycaemia results from the high levels of insulin that the baby developed from high maternal glucose transfer during pregnancy. The insulin levels remain temporarily in the baby's bloodstream after birth when the supply of maternal glucose is no longer available (Galerneau et al., 2004). Early miscarriage and stillbirth are also associated with maternal hyperglycemias, although the risk is not as high with GDM as it is with women who have Type 1 and Type 2 diabetes pre-conceptually (Galerneau et al., 2004).

Manoeuvres to deliver a large baby may be physically traumatizing both to the mother and to the baby. If macrosomia is detected prenatally by ultrasound, perceived difficulties in delivering the baby may result in an induction of labour or elective caesarean section (Farrell, 2003). While these procedures are performed to decrease the morbidity and mortality risks for the mother and newborn, both of these interventions carry their own surgical risks to health and well-being of the mother, such as infection (Conway, 2007). Other health risks from GDM may include acute illness such as preeclampsia, a condition unique to pregnancy that is characterized by high blood pressure, compromised

cardiovascular circulation and a predisposition for seizures. (Carpenter, 2007; Farrell, 2003; Kim, 2010).

The long-term consequences of GDM are also significant for both the mother and child. A macrosomic newborn has an increased risk of developing childhood obesity and glucose intolerance (American Diabetes Association, 1985; Kim, 2010; Vohr & Boney, 2008; Yogev & Visser, 2009). For mothers, a significant association has been shown between women who experience GDM during pregnancy and the development of Type 2 diabetes after pregnancy, often within 10 to 20 years after their experience with GDM (Farrell, 2003; Metzger et al., 2007). Associated factors related to the development of Type 2 diabetes for these women include the severity of the gestational diabetes as defined by the need for insulin, the presence of newborn hypoglycaemia and recurrent GDM in a subsequent pregnancy (Russell, Dodds, Armson, Kephart & Joseph, 2007). The illness sequelae for these women are consistent with the general population of people who develop Type 2 diabetes, especially as it relates to cardiovascular health concerns associated with stroke and myocardial infarction. (Carpenter, 2007; Ohinmaa, Jacobs, Simpson, & Johnson, 2004).

Controlling the health effects of GDM. The primary goal for the medical management of the pregnant woman's health condition is the stabilization of the pregnant woman's blood sugar (Langer et al., 2005; Ghandi, Brown, Simm, Page & Idris, 2008; Kim, 2010). Much of the focus of care for diabetes is surveillance of symptoms for hyperglycemia and hypoglycaemia, or low blood sugar. Home glucose monitoring and evaluation of the woman's hemoglobin A1C

monitoring help to determine if there are short and long variations in glycaemia control between prenatal appointments. Hemoglobin A1C is the name given to hemoglobin that has been modified by glucose attaching to it. Hemoglobin is a protein found in red blood cells that transports oxygen from the lungs to other parts of the body. Hemoglobin A1C is expressed as a percentage and indicates the general trend of blood sugar levels over a past period of time (Ghandi et al., 2008). Comparisons are made of daily diaries of food intake kept by the woman and blood sugar testing in order to assist in problem solving control issues. The hemoglobin A1C laboratory blood tests are compared with the woman's own information to help the team members determine how well the diabetes is being self-managed at home (Kim, 2010; Scollan-Kolinpoulos et al. 2006).

Reader and Sipe (2001) state that the best interventions for GDM are lifestyle changes that include diet and activity designed to maintain stable blood sugars. Women who have been newly diagnosed with GDM are counselled in relation to their menu planning and encouraged to incorporate changes, such as carbohydrate restriction, into their normal diet. Women who are obese have their diets carefully monitored in an attempt to minimize further increases in weight (Langer, Yogev, Xenakis, & Brustman, 2005). Incorporating at least 30 minutes of moderate exercise a day into daily life has been associated with reducing the effects GDM in pregnancy and slows a woman's progress to Type 2 diabetes mellitus. If diet and exercise fail to regulate blood sugars in the woman, insulin therapy may be started (Couston, 2007; Kim, 2010).

Insulin has been the major pharmaceutical treatment of diabetes since its discovery in 1921. It is considered for use in the plan of care for GDM when lifestyle interventions, such as diet and exercise, do not maintain a normal glucose level in the pregnant woman. Originally, insulin was derived from the pancreas of cows and pigs. While animal insulin aided in carbohydrate metabolism, patients would experience issues related to unpredictable absorption and action, reduced efficacy and allergic reactions. After the 1980's, synthetic human insulin was developed. This form of insulin is almost identical to the insulin produced by the human pancreas. However, it also has limitations, especially around delayed action and variability in absorption (Crastro, Jarvis, Khunti & Davis, 2009). Research efforts continue to develop more effective and safer means of regulating maternal hyperglycemic states (Nicholson, Bolen, Witkop, Neale, Wilson, & Bass, 2009). Insulin analogues, which are biochemical modifications of the insulin molecule, have a faster absorption and a longer duration of action than traditional insulin (Crastro et al., 2009; Trujillo, 2007). In addition, the prenatal use of oral hypoglycemic agents, such as Metformin, may offer the hope of safely preventing the development of gestational diabetes in some women by reducing insulin resistance (Coustan, 2007; Nicholson et al., 2009).

While it is not possible to predict who will develop gestational diabetes mellitus, there are certain populations of pregnant women who appear predisposed to the condition. The Canadian incidence of GDM varies from 3.7% of the population of pregnant, non-Aboriginal women to around 8% in Aboriginal women. There are other ethnic groups, such as Asian and Pacific Island women

who are also considered at higher risk for developing GDM. Some underlying medical conditions, such as Polycystic Ovarian Syndrome (PCOS) or women requiring the use of corticosteroids, also appear to predispose pregnant women to the condition. As well, women having a multiple birth, or women who are older and when having their first baby all favour the development of GDM during their pregnancies (Scollan-Kolinpoulos, Silva, Kaholokula, Ratner & Mau, 2006). Risk for developing the condition in subsequent pregnancies is also elevated for women who have been diagnosed in a prior pregnancy with GDM, especially with birth of large baby,

Living as a pregnant woman with gestational diabetes mellitus. The experience of pregnancy, without any health complication, is usually described as a time of transition, introspection and reflection for women (Bergum, 1997). There is growing emotional engagement with their unborn babies, evident by the personal attributes they often attach to their unborn babies. The bodily changes, unfamiliar moods and unaccustomed worries related to health of pregnant women may create an "an altered mode of being" for pregnant women" (Bondas & Eriksson, 2001, p.824). They have both positive dreams and fears in relation to becoming a mother. This is a time of major life transition for themselves, their partner in life, their families and friends. The nature of pregnancy brings with it the wish for the perfect child. Pregnancy at its best, and at its most tragic, is a time of experience, reflection and interpretation (Bondas & Eriksson, 2001; Bergum, 1997).

While I have struggled to understand the experience of having gestational diabetes mellitus, I can relate to the descriptions of a woman's pregnancy journey. I remember being in awe of the changes occurring in my body while struggling, at the same time, with the uncomfortable and unfamiliar physique created by my pregnancy. As the vulnerable life within me grew in size and presence, my identity as a mother and that of my child also grew and developed. On the following page is a poem by Lori Romero (2005) that is a metaphorical representation of the embodied nature of pregnancy. She visually and linguistically depicts the somatic, physical experience of pregnancy as it entwines with the sentient, emotive world of a woman.

Pregnancy

mood
swings
piqued
 euphoric
morose
pooped
blue
pink
pale
anxiety
keenness
breasts blossom
small ring of color
caresses the areola
hypersensitivity
nausea
heartburn and indigestion
shortness of breath and backaches
frequent urination, abdominal cramps
tiny amounts of HCG enter blood stream
food cravings, fatigue, bloating, back pain
  incessant urination, constipation, irritability
   triple fudge sundae and pickles, navel pushes out
   ohwowsomethingismovinginsideyesicnafeel
   youmoveand nowyourarekickingandpunching
owwtherewewillbothshifttoamorecomfortable
position I wonder if you'll have my mother's
eyes or the soft curl of my sister's upper lip
should I name you Elizabeth or Samantha
Samuel or Caleb or wait until I see you
spider veins
fluid
edema
ankles
swelling
feet feel
tight and shoes don't fit quite right

(Romero, 2005)

Unanticipated complications presented by gestational diabetes mellitus may force the woman to adjust her expectations for her pregnancy experience and may create an aura of uncertainty around her upcoming childbirth experience. The pregnant woman is now considered to be a high-risk pregnancy, requiring more medical management and intervention than would normally be anticipated in pregnancy (Conway, 2007; Heaman, Beaton, Gupton & Sloan, 1992). In addition to the usual psychological stressors and strains on personal relationships, the status of a high-risk pregnancy brings its own increased sense of uncertainty and anxiety. Their lives and those of their families may be disrupted by the need to adhere to the new diabetic routine (Conway, 2007; Daniells et al., 2003; Evans & O'Brien, 2005; Lawson and Rajaram, 1994). Lawson and Rajaram (1994) describe the diagnosis of GDM as having a profound psychological effect on pregnant women, including feelings of fear, depression and anxiety.

A diagnosis of gestational diabetes mellitus will often require pregnant women to move from a personal relationship with their primary prenatal care provider to the potentially more impersonal nature of care within an ambulatory clinic. As well, women who have uncontrolled blood sugar levels while on insulin may be encouraged to be admitted to the hospital to have nurses aid in their daily surveillance and maintenance of their diabetes needs. Hospitalization may incur its own stigma and stress through feelings of loss of control, isolation and anonymity as a person (Clauson, 1996; Markovic, Manderson, Schaper & Brennecke, 2006; Sheffer, 2000; Richter, Parkes & Chaw, 2007). From a feminist perspective, Goldberg (2008) describes the medical management of pregnancy

and birth and the economic focus of health care as having an intrusive, oppressive and objectifying nature. It often lacks support for interaction and dialogue, which works in contradiction to the needs of pregnant women for embodiment that comes through the interpretation of their experiences. With a higher risk pregnancy, autonomy may be compromised and the woman may be objectified even more as a medical problem in the context of illness care. Women become vulnerable to the prescriptive, objective methods of care designed for ensuring safe passage for mother and baby (Goldberg, 2008). Hatrick (1998) also describes the relational world of a person facing a diagnosis of diabetes as conflicted with a struggle for control occurring between "the person with diabetes and the disease, the person and the regimen and/or the person and the medical/healthcare establishment" (p. 85). Dissonance between nurses and patients may arise if each has goals of care that are incongruent. Women may feel unheard or misunderstood in their needs and nurses may perceive patients to be denying the significance of their health situations. Nurses on the other hand may be perceived as "intrusively worrying and worrisome" (Sheffer, 2000; Stainton, 1992, p. 46). Being in control versus being controlled appears to be an important aspect in the lives of pregnant women experiencing GDM that nurses need to understand better (Evans & O'Brien, 2005). A pregnant woman may come to the gestational diabetes experience with attributes such as ethnicity, physique and mental health issues that traditionally may marginalize people within society. A woman's life experience, from the context of marginalization, either may help to facilitate or may hinder her reaching the goals of diabetes management. Resilience may have

become a part of her character as a result of learning to survive in her community and society. Alternatively, she may bring challenges such as negative emotions, poor self-esteem, or a decreased desire to engage with others because of experiencing oppression, which could affect her willingness to attend prenatal care (Hall, 1994). In their exploration of the meaning of GDM in the lives of pregnant women, Evans & O'Brien (2005) speak to the need for "unconditional respect for the lived realities of these women" in order to facilitate their ability to cope with both pregnancy and gestational diabetes mellitus (p.78).

Learning Self-Management of GDM

With the discovery of insulin in 1921, registered nurses assumed a patient teaching role related to the self-administration of insulin. Initially, this teaching was often done in the homes of patients (Allen, 2003). Throughout the 1930s and 1940s, as medicine learned more about the physiological mechanisms of diabetes and insulin, patients were kept in hospitals until their diabetic situation stabilized. This involved hospital nurses in the initiation of teaching the self- management of diabetes at home. By 1950, the Canadian Diabetes Association was established, giving strength to a specialized community and outpatient focus for diabetes education. Because of the complexity of managing diabetes, the long-term support and education for people with diabetes developed within a specialized group of healthcare professionals, which includes registered nurses (Nettles, 2005).

A pregnant woman's health care team may be expert in the knowledge of diabetes physiology and competent in the techniques of diabetes management. It

is, however, the knowledge, skill and desire that the pregnant woman has to integrate the information and interventions into her life that will determine success in respect to health outcomes (Anderson, 2000; Anderson & Funnell, 2005). The greater the competency the woman attains in relation to her self-regulation of blood sugars, the more successful the treatment plan and the less need for intervention by her healthcare team (Anderson, 2000; Anderson et al., 2005; Coustan, 1997). As well, to prevent the long-term consequences of GDM for mother and baby, it appears important that the woman continue to incorporate the life changes required during pregnancy throughout her life. However, studies indicate that many women tend to revert back to pre-pregnancy lifestyles after the birth of their babies. Effective approaches to learning that facilitate a woman's embracement of measures that will prevent GDM from progressing further to Type 2 diabetes mellitus appear an important component of health promotion for nurses providing care for this population (Evans & O'Brien, 2005).

A major factor to achieving successful health outcomes for a diagnosis of gestational diabetes mellitus is the degree to which the pregnant woman integrates the information she has on diabetes management into her life. The woman must often acquire new knowledge related to managing dietary restrictions, performing procedures such as blood glucose testing and giving herself insulin. The greater the competency the woman attains in relation to her self-regulation of blood sugars, the more successful the treatment plan is to counter the negative health effects of her gestational diabetes (Coustan, 1997). It is the active participation of patients in reaching the goal of independence that is most influential for

maintaining and improving health and preventing future illness. Successful teaching and learning outcomes are measured in physiological parameters which reflect how well the woman maintains precise glycaemia control and adheres to diet and exercise (Barber-Parker, 2002; Friberg et al., 2007; Linscott, 1999; Redman, 2004; Vander Henst, 1997).

Self-efficacy is a concept related to understanding behavioural change related to learning. It helps to delineate what it is that patients need to know to be independent in their care needs. It is defined as an individual's belief in one's ability to organize and perform the behaviours needed to achieve one's goals or perform certain tasks (Bandura, 1977; Clark, 1999). Drawing upon social-cognitive theory, it is thought that self-efficacy results from the interaction of personal, behavioural and environmental factors that influence a person's ability to perform required behaviours. The construct of self-efficacy has proven helpful in predicting behaviour in relation to specific tasks and addresses problem solving barriers to persons' successful performance of such tasks. It is, however, less useful in anticipating change in lifestyle issues which have a more futuristic, health-promoting context, as it is not considered indicative of any internal or motivational change on behalf of the patient (Catrine Eldh et al., 2008). Instead, some of the factors shown to have a more significant impact on the success of a person's integration of needed behaviours into their lives include: perceived significance of the illness; the hope held that the interventions can positively impact the illness; the degree of illness-related activity that must be changed in a person's life; and the nature and quality of relationship the person has with their

care providers (Catrine Eldh et al., 2008; Catrine Eldh, Ekman & Ehnfors, 2006; Haidet, Kroll & Sharf, 2006).

The Ontological Nature of Learning Relationships

The interest in relational learning represents a shift from an educational pedagogy of behaviour towards"pedagogy of relation" (Sidorkin, 2002, p.2). Relational pedagogy arises from the ontological philosophical traditions that include Martin Heidegger (1977) and Martin Buber (1970) and which embrace the concepts of teaching and learning as "a function of specific human relations" (Bingham & Sidorkin, 2004, p. 9). Bergum (2003) describes the pedagogical relation as the "relation of teacher and student, nurse and patient, self and the world" (p. 122). Relational pedagogy occurs in the context of reciprocity in the relationship, with the teacher and learner engaged as relating "interdependent" partners in the learning (Bergum, 2003, p. 126; Gadow, 1999). Respect, 'being-present to-the-other', trust, and mutuality are considered important features of a positive relational connection between nurse and patient (Bergum, 2003; Hatrick Doane, & Varcoe, 2007; Hatrick Doane, 2002; Hatrick, 1997).

The philosophy of Martin Heidegger affords a foundational way of coming to an understanding of "the centrality of human relationships to human beings" that is consistent with the notion of relational pedagogy (Bingham & Sidorkin, 2004, p. 45). Heidegger considers relationship an intrinsic part of the human reality of *Being*. To understand *Being*, one needs to first understand the human situation of *Being* or *Dasein*. Heidegger (1977) uses the term, *Dasein*, to refer to how we, as humans, "make sense of the world, our place in it and how we

become aware of this place" (Conroy, 2003, p. 6). One does not exist in isolation from the world. Rather, it is a person's self-interpretation of their relation with the world and others within the world that defines who they are in the world (Bingham & Sidorkin, 2004; Conroy, 2003; Conroy & Dobson, 2005; Heidegger, 1977, 1978).

From Heidegger's perspective, we do not choose our world of existence. Rather, we experience "thrownness" into a world not of our making, but where we nevertheless are caught. Existence entails dwelling alongside others, sharing meanings and understandings of our common world (Conroy, 2003). World is *a priori*, in that it is a given in relation to the shared meanings of culture and language. It is through a person's non-reflective "taking up of the meanings, linguistic skills, cultural practices and family tradition that shape a person's sense of Self or by which we become persons" (Wynn Leonard, 1999, p. 317). In other words, *Self* is constituted by *world* and also constitutes *world*.

Heidegger viewed three different ways of existence in the world for a person. The term, *authentic*, is used to describe a *mode of existence* in which one is truly one's Self; living up to what is *significant* to Being for a person. *Authentic* existence involves not being defined by norms and routines. *Authentic* individuals come to relationship with a genuine nature underlying their thoughts and action. Actions of people living an *authentic existence* are more clearly linked to purpose and are in accord with their world understanding of what is morally good (Conroy, 2003; Conroy & Dobson, 2005).

Heidegger contrasts an *authentic* mode of existing with that of an *inauthentic* mode of existing. The *inauthentic* person is characterized by a disengaged relational nature with others. They take on actions because they are perceived as the best - not from their *Self*, but from the social norms of their world or because it is a comfortable thing to do. This may be even though their actions bring them into conflict with their *authentic* selves. There is no "internal consistency between thinking and acting" (Conroy, 2003, p. 8). *Inauthentic* persons demonstrate a non-commitment to *care* (Heidegger, 1978).

The third *mode of existing* is an *undifferentiated* way of being. In this mode, a person goes about their day with little attention paid to the world or relationships about them. Actions are not self-directed, and there is a tendency to have a superficial regard to life experiences. Heidegger states that most people prefer to live in this *everydayness* state where we do and accept most of what everyone else does. Existing in an *undifferentiated* way, one forgets to care (Conroy, 2003; Conroy & Dobson, 2005). There may also be combinations of *authentic* and *undifferentiated* modes of engagement in which a person's actions are habitual in manner, but for whom their existence is *authentic*. Another mix could be that of *inauthentic-undifferentiated modes of engagement* in which the person demonstrates an *undifferentiated* approach to existence while "disburdening him- or herself of all responsibility of his or her actions" (Conroy & Dobson, 2005, p. 981).

Mood, or *affectedness*, is a Heideggerian term that helps us to understand "how a person is faring from an existential standpoint" in their shared world with

others (Conroy & Dobson, 2005, p. 977). It refers to a person's sense of how they find themselves to be in their world in relation to the encounter between *Self* and *Other*. *Mood* reveals what is valued from the perspective of the person and can be regarded as either harmonious or discordant depending on how "the mood and narrative match existentially" (Conroy & Dobson, p. 981). The resulting actions are not necessarily the result of self- reflection but, consistent with the nature of *Das*ein, retain the possibility of self-reflection.

For Heidegger, to *Be-in-the-World* is to always *Be-With Others*. Heidegger emphasizes that any separation between Self and Others is not as important as the fact that the *Others* are "here beside us" (Heidegger, 1978, p. 154; Olesh, 2008). While Heidegger acknowledged that the world of Dasein is shared, the concepts of relationship and relation, from a relational pedagogy perspective, are rooted within the philosophy of Martin Buber (Olesh, 2008; Sidorkin, 2000; Sidorkin, 2002). Buber (1954) criticized Heidegger's work on several accounts, including his understanding of the "essential relationality of human 'being'"(p. 164) Buber (1979) viewed Heidegger's concept of *Other* as an "object of consciousness" reflecting a "relation of solitude" (p. 169). From the perspective of Buber (1979), a solitude relation cannot to be considered a foundational relation since it does not "set a man's life in direct relation with the life of another ... Such a relation can share in life only when it derives its significance from being the effect of a relation which is essential in itself" (p. 169).

Buber (1972) viewed humans as relational beings, born with the desire and capacity to connect relationally with others. Buber called this relationship I-Thou. This relationship exists beyond social and political boundaries and has the quality of mutuality. Buber also described I-It relationships that characteristically lack mutuality. With I-It relations, individuals are objectified and alienated and there is only a mutual construction of relationship, lacking any form of shared meaning (Blenkinsop, 2005; Buber, 1970; Sidorkin, 2002).

Buber uses the notion of the 'Between' to differentiate between the nature of relationships, relations and relating. Relationship can exist in the absence of any form of relation or relating. To relate is to enact or do something with an *Other*; the focus is on the act, to discover unity between persons. The basic meaning of 'relate' for Buber is to step into the between. It is here in the between that a person goes beyond that of being an individual to that of becoming a person in-relationship (Macmurray, 1961). The participation is "so essentially other, so essentially not mine or ego-reducible, such as even a feeling might be, that it loses all reality unless it is shared, unless it is communed" (Tallon, p. 67). It is when a person enters the between that the fullness of personhood is realized (Buber, 1972; Tallon, 1973). Personalization is the notion of "becoming through relation" (Tallon, 1973, p.66). Becoming is the enactment of potential. One becomes a person through relation and it is through relation that the person has the potential for becoming a person (Buber, 1972; Tallon, 1973).

Buber considers community as the between. Not only is "relation the enactment of person" but "relation is the enactment of community" (Tallon, 1972,

p. 67). Buber (1972), as cited in Tallon, (1973) views true community arising "through relation, the living mutual relation of persons to one another, and their relating to a living center, an effective centre, without which there would be no community" (p. 67). To commune means to come together and share; communion is the act of coming together, stepping into the between. Communion has the characteristic of being fleeting and sporadic, lacking constancy. Community on the other hand is the "will to make the relation stay" (Tallon, 1973, p. 67). Community is the "extension of communion into space and time, community defines the 'between' of persons" (Tallon, 1973, p. 68). Occasional relations are not enough to make relations last. The human therefore only comes to self-actualization through a transcending journey of self-discovery toward the establishing of genuine community (Tallon, 1973). It is within I-Thou relationships that it is possible to be in relation with another person without any pretences, to have understanding and be there with another person. There are no preconditions to the relationship; each person responds to the other by trying to enhance the other person. This bond results in true dialogue. Any attempt to construct I-Thou relationships objectifies the relationship, resulting in only an I-It encounter, losing the notion of dialogue (Buber,1972; Tallon, 1973).

Dialogic conversations occur when each partner listens to the other as in I-Thou relations, rather than I-It objective relationships. Each person is vulnerable to the other in terms of their expression of Self as well as in their openness to encountering new understanding and ideas. Dialogue cannot occur if the relationship is such that one cannot or does not wish to speak. The dialogue must

have the characteristics of a love for the Other that is genuine. It cannot be dominating or used as a means to manipulate the other. Dialogue is more than communication; it is relation. Caring is being present for the Other as the person is and who the person will become. The ontological concept of dialogue treats all meaning as shared (Heidegger, 1978). It cannot be dominating or used as a means to manipulate the other (Buber, 1972; Sidorkin, 2000; 2002; van Manen & Li, 2002).

An understanding of the dialogical or intersubjective nature of communication in relationships comes from the philosophical hermeneutics of Hans-Georg Gadamer. For Gadamer, the conversation must focus on the matter of conversation; the subject leads it. Intersubjectivity reformulates the understanding of communication as dialogue. Meaning emerges from the interpretation and reflection located within a hermeneutical dialogue, rather than from the subjectivity of the partners. Prejudice or preconception is an inevitable occurrence as each person brings their own history and ideals to the conversation. However, each person brings new understandings that inform the Other, creating potential for new understandings of the experience (Gadamer, 2004; 2000).

From an Epistemological to an Ontological Understanding of Patient Learning

Registered nurses enact teaching through the assessment of individual education needs, as well as determining the patient's goals for health interventions. Both scientific and personal knowledge is used, consistent with the terms 'techne' and 'phronesis' (Benner, 2000; Benner, Tanner & Chesla, 2009; Schultz & Carnevale, 1996). Techne is the component of knowledge that nurses

use in patient teaching that is scientifically and theoretically based. Through experiences of patient teaching, or phronesis, they gain knowledge and wisdom of how to relate abstract concepts of health and illness within their relationships with others. Phronesis implies care giving that is engaged in the experience of the patient, is interpretive in nature and bound within a moral context:

> Technique and narrow rational-technicality alone cannot address interpersonal and relational responsibilities, discernment and situated possibilities required by caring for persons made vulnerable by illness and injury. Phronesis is required. Means and ends are inextricably related in caring for the ill. The clinician and patient bend and respond to the other so that horizons and world are opened and reconstituted, allowing new possibilities to emerge (Benner, Tanner & Chesla, 2009, p. xvi).

Registered nurses traditionally have based their patient teaching approaches on adult education theories and models, in which human learning is embraced within the concept of transformation (Baumgartner, 2003; Flecha, 1996; Redman, 2004). Professional teaching actions are directed towards the learner with the aim of helping the other achieve self-identified goals related to illness intervention, health maintenance and illness prevention (American Association of Diabetes Educators, 1999; Coutts& Hardy, 1985; Redman, 2004). As patient teachers, nurses embrace the educational methods and theories that, from their knowledge and experience, will best facilitate patient learning about GDM. Social, cognitive and behavioural theories of adult learning are often used to guide their teaching,

usually with an emphasis on instrumental approaches to learning (Anderson & Funnell, 2008; Bastable, 2003; Garcia-Patterson et al., Redman 2004, 2001).

However, there are inherent challenges in meeting the complex learning requisite related to self care if only an epistemological approach to patient education is embraced. Adult learning theories tend towards individualization, dichotomizing the teaching and learning roles of nurse and patient (Amstutz, 1999; Bingham & Sidorkin, 2004; Sidorkin, 2000). With cognitive and behavioural approaches to learning there is a tendency for a generalized prescriptive approach to learning that is "often based on the notion of prescriptive cultural knowledge" which is controlled by the teacher (Amstutz, 1999, p. 22). There is also a partiality to standardization, competency and outcomes-based education minimizing the diverse nature, life experience and learning needs of the learners. It is the teacher who often determines what competencies are needed and how they are measured (Amstutz, 1999; Merriam, 1996; Redman, 2004). This generalized approach to teaching and learning restricts the opportunities to adapt to meet individual learning needs of the pregnant women (Amstutz, 1999).

Andragogy is a term that originated from Alexander Kapp, a German educator, in 1833 and expanded by Knowles to describe principles of adult learning that is more learner-centered. These principles are based on humanistic assumptions that the adult learner is a self-directed human being who: (1) possesses rich prior experiences; (2) has a readiness and orientation to learn related to the roles and responsibilities of adult life; and (3) is internally motivated to acquire knowledge (Knowles, 1980; Pearson & Podeschi, 1999). However,

because andragogy is based on the theory and philosophy of Carl Rogers and Maslow, the influence of an individual's environment and society in the construction of "meaning and knowledge" is not acknowledged (Amstutz, 1999, p. 23). With the notion of self-directed learning, a concept related to andragogy, adults are viewed as independent individuals, who need to plan and take control of their learning (Amstutz, 1999; Merrium, 1996).

Only a minority of pregnant women come to the experience of gestational diabetes mellitus with the background knowledge, competencies and attitude needed to manage the unique complex medical management of their medical condition. In order for patients to participate fully in their healthcare, they require access to accurate and pertinent information based on their individual needs (Anderson & Funnell, 2008). It is also important, for her health and safety and that of her unborn baby, that the pregnant woman has access to information pertinent to her health condition (McCormack, 2003; Redman, 2004). Women may come into their learning experiences with different goals and perspectives from that that of a nurse. Stainton (1992) found that pregnant women admitted to hospital with high risk pregnancies often focused more on obtaining information. On the other hand, we, as nurses, often prioritize the identification of risk factors to which the women should attend. With adult learning approaches, the focus on individualization limits the opportunity for relationship to occur. Teacher and learner come to the experience from their own perspective of learning and knowledge. With opportunities limited by time, place, and space to co-create a mutual understanding of *Self* and *Other*, opportunities are lost to discover, from a

holistic perspective, what it is the that woman really needs or wants to learn for independence.

An ontological relational pedagogical approach views learning as a social intervention. Reflecting back to the previous discussion of Buber's view of 'becoming' a person, self-actualization occurs through relation. Buber uses the word humility to describe how the teacher must be attuned to oneself as well as to the learner. While it is recognized that people exhibit individual thinking in relation to learning, proponents of relational pedagogy state that there must be a balance between an over-focus on Self and the recognition of the issues of power and community, without losing the sense of *Self* (Sidorkin, 2002; 2004). Through dialogue, that emphasizes relationship characterized by mutuality in the nurse-patient relationship, the nurse-teacher would develop a deeper sensitivity to the individual strengths and challenges faced by the pregnant woman in her understanding of the nature and care requisites of her illness (Hatrick, 1997).

Coming to the Understanding of *Self* and *Other*

Much of the past focus with diabetes education has been on trying to affect behavioural patterns in patients to improve their compliance or adherence to recommended strategies for health (Anderson, 2000). For pregnant women with GDM, the outcome for not managing the self-care plan carries significant personal and economic costs in relation to their health and the health of the baby (Coustan, 1997; Elnours, et al., 2008). Definitions of adherence found in the nursing literature range from the extent to which patients follow instructions to the degree that a person's actions or behaviour has changed in relation to the

advice or instruction received from the healthcare team (Anderson, 2000; Bissonnette, 2008). There is little distinct difference found in the literature between the definitions of adherence and compliance. However, adherence implies conformation to an expected standard set by the educators. Compliance is viewed to have "an under tone of paternalism" (Bissonnette, 2008, p. 637) and suggests blame towards patients when their behaviours do not conform to the nurses' or other health team members' expectations for learning. Both concepts are teacher-focused and place the patient in a powerless, vulnerable status within the teaching-learning experience (Bissonnette, 2008).

Adherence to the plan of care, such as in the situation of a woman experiencing GDM, refers to how well the pregnant woman is self-managing the prescribed medical care plan at home or during her daily routine in hospital. Successful adherence is measured though comparisons of a woman's daily diaries of her food intake and blood sugar testing with laboratory blood tests, such as hemoglobin A1C. The woman may perceive this surveillance as judgmental and/or the team may misread her problem as one of low intelligence or a lack of responsibility (Anderson, 2000; Kim, 2008; Stainton, 1992).

The underlying challenge with an adherence or compliance approach to learning is that the team motivation for the patient to integrate their information and advice infers a coercive effect and demands acquiescence. Changes on behalf of the patient are externally motivated and controlled by others (Anderson, 2000; Kim, 2008). With the motive of promoting adherence or compliance, the educator's perspective of the 'successful patient' may be that of a passive

participant, readily following instructions and incorporating interventions into their lives. Often, non-compliance for patients is an attempt to regain or maintain control over their own lives. The care situation may become strained if the woman's behaviour fails to meet the needs of her diabetic state. The efforts of educators to persuade patients to follow the recommendations of care providers may result in conflict and tension. As well, nurses and other care team members may feel frustrated and weary from the strain of feeling responsible for motivating and attempting to change the behaviour of others. Patients may express perceptions of being negatively judged by those they depend upon for care and treatment. Health outcomes could be further compromised if the woman stops coming for prenatal care because she feels isolated from her prenatal care team and their motivations for care (Anderson, 2000; Anderson & Funnell, 2005; McCormack, 2003).

Heidegger's concept of *mood* is helpful in understanding the context of the relational issues that may arise with an adherence/compliance approach to patient teaching. If both nurse and patient come to the experience with a mutual understanding of their roles in teaching and learning and have a common acceptance of learning outcomes, it would be reasonable to expect a harmonious engagement of both teacher and learning in the relationship. Conroy & Dobson (2005) provide examples of how discordant *modes of engagement* may occur, depending on mood. As described in the previous paragraph, anger and frustration can occur when competition arises between those people with authentic moods and those people with *inauthentic moods*. Conroy & Dobson

(2005) also speak to the impact *inauthentic/undifferentiated* modes of existence could have on the learning experience if this mode became a normative way of Being for team members. If adherence or compliance is viewed as a valued outcome or norm for teaching, the result could be learning experiences that are nurse-centered and prescriptive. The resulting relationships would be characterized by detachment and prone to coercion.

From a relational pedagogy perspective, there is less focus on how well a person has learned or adhered to the teaching and more attention on understanding the experience and meaning of learning. It is within relation that teachers respond to the diverse and individual human responses to learning. The teacher must be attuned to oneself as well as to the student. The teacher must reach out to the student, be always present and available, affirming and encouraging the inner best in others (Sidorkin, 2002). Relational pedagogy values the concept of *authentic* teachers who care about teaching and have a capacity to connect with students and about what it is, they are teaching (Bingham & Sidorkin, 2004). Nurses, who are *authentic* teachers are guided more by caring for the education of their patients than their own self-interest and hence are able to do what is described. *Authenticity* in teaching means being genuine, becoming more self-aware, being defined by one's self rather than other's expectations, bringing oneself into interactions and critically reflecting on self, others, relationships and context (Conroy & Dobson, 2005; Hatrick, 1997; Kroeber, Klampfleitner, McCune, Bayne, & Knottenbelt, 2007).

Co-creating Knowledge and Revealing Inner Competencies

Heidegger (1977) viewed teaching as more difficult than learning because the nature of teaching is to "let learn" (p. 379). Proper learning occurs, according to Heidegger, if "the relation between the teacher and the learners is genuine, therefore, there is never a place in it for the authority of the know-it-all or the authoritative sway of the official" (p. 380).

Heidegger's (1977) ideal of teaching connects strongly with the concept of empowerment. The word, empowerment, builds upon the Latin root *posse*, from which the words power and freedom are derived (Rodwell, 1996). By the Oxford Online Dictionary definition, empowerment means the transfer of power from one person to another," to impart or bestow power to an end or for a purpose; to enable, permit; to bestow power upon, make powerful; to gain or assume power over. Appreciating the concept of power is significant to understanding the dynamics and meaning of empowering relationships between teachers and learners. Power is involved in all human interactions, and is interconnected with the transference of knowledge. It is generated through personal action with an increase in personal power (empowerment) arising from someone else surrendering power. In patient teaching relationships, nurses are powerful by expertise and position within the health care team (Anderson & Funnell, 2005; Funnell & Anderson, 2003; Rodwell, 1996).

For a woman experiencing GDM, empowerment would be a patient teaching focus, by the nurse, on understanding the meaning gestational diabetes has for the woman in her life. Barriers to integrating the care needs into her life

would be approached from solutions that would be individualized to the woman's life, with a focus on her strengths. This would be of particular significance for women who have been given a diagnosis of GDM because of their increased vulnerability to experience coercion and social marginalization. Pressure for compliance could arise from a woman's healthcare team because of the need for a woman to maintain her blood sugars within a range that decreases health risks to her and her baby. Failure on her part to achieve this goal can result in negative judgments by her care providers in relation to her capacity to integrate the diabetes care regime into her life and a relational divide could occur.

The empowerment philosophy of patient care is based on several tenets. First, it assumes that patients are responsible for making important and often complex decisions about their medical care. Second, it assumes that because patients themselves, experience the consequences of both having and treating their medical condition, they have the right to be the primary decision-makers in this regard. Therefore, according to this philosophy, the primary function of the health professional is to prepare patients to make informed decisions about their own medical care (Anderson & Funnell, 2005; Funnell & Anderson, 2003).

Empowerment is a concept from philosopher Paulo Freire, whose social ontological pedagogical approach stresses quality and mutual respect between students and teachers (Freire, 1993; Sidorkin, 2000). It is considered a holistic process encompassing cognitive, psychological, economic and political dimensions to achieve emancipation (Freire, 1993; Kim, 2008). Freireian pedagogical perspectives reject the idea that teachers know more than the learners

about how the learners think and feel or how they should think and feel. Students are not passive and ignorant recipients of information. Freire (1993) states that for teaching to be effective, the educational content must be meaningful to the students with information as an organized, systemized and developed re-presentation to individuals of the things about which they want to know more. Re-presentation gives learners the opportunity to reflect on conflicts or contradictions in their lives that the learning represents. The learners pose problems and then enter a dialogue with the teacher and others about suitable or desired solutions. The learner develops their power to perceive, critically, the way in which they exist in their changed world. It is through dialogue that any duality of the teacher and student roles is cancelled (Freire, 1993).

Empowerment, therefore, can be considered in the positive context of a dynamic, interactional process in which the nurse and patient collaborate to carry out mutually negotiated goals. The focus is on fostering relationship through dialogue, collaboration and integration. Dialogue evolves from the mutual respect for the meaning each person brings to the particular discussion at hand. It is associated with personal growth and development rather than only skill acquirement. It requires critical reflections and flexibility in response to individual situations (Kim, 2008; Kuokanen, 2000).

The term, power, does have a negative connotation, being associated with hierarchy and authoritative relationships. If connected with the concepts of efficacy and goal orientation, however, the creation of opportunities and the effective sharing of information and experience makes power not so much about

"action, domination or control as the manipulation of thoughts, attitudes and social relationships" (Kuokanen, p. 236). Buber (as cited in Sidorkin, 2000) stated that it is impossible for professionals to experience client relations characterized by freely open dialogue and mutuality because of the power imbalances inherent in their relationships. The act of empowering, therefore, requires reflection on what may be within one's Self, and the community to which one belongs, that may support or hinder the Other's full participation in learning (Sidorkin, 2000; Vander Henst, 1997).

For a true understanding of the nature and meaning of a person's learning experience, one must reach beyond the boundaries of relationship to that of understanding the relations between teacher and learner, between *Self* and *Other*. Teaching and learning cannot be entertained without consideration of the relational space between teacher and learner. It is the reality of the relation that occurs between the teacher and learner that is considered crucial to learning. It is within this complex relational space that knowledge is really affected. Within this context, it is recognized that nurse-teachers and patient-learners *co-constitute* the learning experience. Learners become partners in their own education (Bingham & Sidorkin, 2004; Latta, 2005; Sidorkin, 2000, 2002). It is the dialogical way to knowing, through shared conversation, that changes power relations. The nature of the conversation is such that the learner becomes an agent in the hermeneutic or interpretive community of teacher and learner. The patient's role changes from that of being passive to that of *co-creator*. The teacher and learner co-create a

shared world in which difference is expressed and respected (Bergum, 2003; Gadamer, 2000; Sidorkin, 2000, 2002).

Pedagogy has to do with the understanding by the teacher of what is appropriate or less appropriate in relation to action. It is characterized by reflection evoking an understanding, through conversation, of what is significant to the learner. Significant to the pedagogical relationship and dialogue is the nature of reflective questioning. Reflection is part of the act of interpretation (Doane, 2002; Hatrick Doane, 2002; van Manen, 1991). Self-reflective questions are rooted in the practical knowledge the teacher has obtained from other life experiences and from others who have been in similar situations. For nurse-teachers, self-reflection may be best done through conversations that are a form of relational and pedagogical thinking, allowing for insight that extends into the experience of the learner (Hatrick Doane, 2002; Sidorkin, 2004; van Manen, 1991). Teaching methods and practices would, therefore, not be superimposed on the learning experience and would not "override the human-relating process" (Hatrick Doane, 2002, p. 403).

In summary, learning about GDM presents a complex, multidimensional, relational experience for nurse-teachers and patient- learners. The outcomes for patient teaching are usually measured by the degree of a patient's independence, or ability to provide self-care. The need for understanding the relational aspects of patient teaching is strongly supported by these goals in healthcare for patient learning. Ethical concerns for nurses, such as paternalism and coercion, may arise when teaching methods foster disengaged relationships. A relational pedagogical

approach equips learners to become partners in their own education for life by embracing a relational approach to patient teaching where a nurse, as teacher, reaches out. It engages in the experience of learning in search of understanding the Other, as learner. Active participation is facilitated as nurses and patients co-determine and *co-constitute* the knowledge and information needed to facilitate independence. I recognize that the acquisition of knowledge includes other aspects, such as an individual's capacity to learn and is, therefore, not completely determined by relationship. However, knowledge transference and translation does occur within the mutual space between teacher and student. It is the embodied nature of this relationship that enables learners to become partners in their own education. Through the emphasis on caring and mutual respect, boundaries are broken down and the path for growth and independence for both patient and nurse is forged.

In the next chapter, I describe and explore the philosophical nature of Heidegger's hermeneutic ontological phenomenology from the perspective of research methodology. This foundational exploration supports my choice of an interpretive phenomenological inquiry as appropriate for this study. Heidegger argued against the traditional Cartesian notion that the human understanding of being arises only through the conscious nature of perception. Heidegger's hermeneutic phenomenology embraces human understanding as evolving through the revelation and interpretation of the meaning imbedded in the lived experiences of human beings (Benner, 1994; Conroy, 2001, 2003). It is Heidegger's concepts that will guide the participant conversations and thematic analysis of this research

inquiry, revealing the meaning embedded within the mutual space of the pedagogic relationships that arise from the learning encounters between patients and nurses.

Chapter Three

Philosophical and Methodological Foundations to the Research Study

In this chapter, I explore the hermeneutic ontological phenomenology concepts that guide the research design and method for this study. The differences between epistemological and ontological approaches to discerning how humans come to know and understand their world are discussed, with a focus on the philosophical writings of Edmund Husserl (1970), Martin Heidegger (1962) and Hans-Georg Gadamer (2004). I conclude this chapter with a description of Conroy's (2001; 2003) approach to interpretive inquiry methodology, which facilitates this ontological exploration and interpretation of the meaning of the experiences imbedded in the participants' worlds.

Just as the journey to my research question for this research inquiry was very personal and reflective, the path to understanding the philosophical nature of my methodology was equally reflective, personally challenging and all encompassing. Understanding the philosophical foundations and metaphysical arguments underlying a research methodology is important to sound research (Koch, 1996). However, I have had no formal philosophical learning opportunities prior to my entering the PhD program. Therefore, I entered this project as a novice to the world of philosophy and philosophers. My foray into the philosophical literature proved to be the "potential minefield" for misunderstanding experienced by many in trying to decipher the thoughts of philosophers (Koch, 1996, p. 175). Heidegger's (1978) foundational book, Being and Time, became a constant companion in my life, as I read and re-read the dense and often confusing text in an effort to understand his phenomenological

approach to interpreting human understanding. As an aid to understanding his philosophical language and often obscure concepts, I heavily relied on texts written by philosophers following in the Heideggerian tradition, such as Hubert Dreyfus (1991), and William Blattner (2006). As my knowledge and insight grew, I found myself turning back to Heidegger's writing, appreciating that his words, once familiar, usually presented the clearest view of human *Being* and *understanding*.

What is Phenomenology?

Phenomenology is a modern, 20th-Century European philosophical tradition and a guide for research methodologies that are designed to explore questions related to human understanding and perceptions of life experiences. Edmund Husserl is credited with phenomenology's origin as a philosophical method. He challenged those that believed that "objects in the external world exist independently and that the information about objects is reliable" (Husserl, 1970; Groenewald, 2004, p. 4). He hoped to "free philosophy" from the notion that certainty only exists in the way people perceive the world in their consciousness and from the distracting metaphysical questions about the "true nature of the world" (Blattner, 2006, p. 2; Groenewald, 2004; Husserl, 1970). The notion of certainty of human perception is reflected in the Cartesian view of person, in which the self is viewed as subject or "an uninvolved entity passively contemplating the external world of things via representations that are held in the mind" (Wynn Leonard, 1989, p. 316). This self consists of a body and an "assemblage of traits or variables such as anxiety, control and self-esteem" (Wynn

Leonard, 1989, p.316). This view of person presented questions as to whether knowledge was real and an accurate description of reality, or rather a subjective notion, thereby being an "idiosyncratic, private view of the world that can never be completely communicated" (Leonard, 1989, p. 316).

Through his transcendental phenomenology approach, Husserl aimed at providing a way of studying intentionality, or the "mind's capacity to represent the world" (Blattner, 2006, p.2; Husserl, 1970). He was concerned with the meaning of human experience. However, he stayed close to the Cartesian tradition of duality between subject and object, with his view that the subject always directed towards the object rather than in reciprocal action. He introduced the term life world (Lebenswelt*)*, as the world of immediate, lived experiences; the world of the "natural attitude of everyday life" (Husserl, 1970; Van Manen, 1990, p. 7). Dreyfus (1991) describes Husserl's view of human beings as "a consciousness with self-contained meanings" (p. 46) and that mental activity was always a part of human perception and action. Referred to as intentional content, Husserl explains how, through receiving and mentally synthesizing "a succession of visual experiences" he perceives objects, such as a die as carrying the meaning of something he can throw. (Dreyfus, p. 46; Husserl, 1970).

Husserl (1970) also introduced the notion of phenomenological reduction or epoché. He believed that it is possible for human beings to bracket or put aside life experiences in their understanding of phenomena, allowing for an objective description of the experience. Researchers using a Husserlian phenomenological approach to their methodologies would therefore focus on freeing themselves

from their own presuppositions and prejudices, thereby producing a descriptive, detached analysis of consciousness in which objects and its correlates are constituted (Dreyfus, 1991).

Heidegger's Ontological Turn in Phenomenology

Martin Heidegger, who studied under Husserl, led the phenomenological philosophical movement in a direction away from phenomenological reductionism (Blattner, 2006; Dreyfus, 1991; Groenewald, 2004). He believed that humans are interpretive beings who are "capable of finding significance and meaning in their lives" (Wojnar & Swanson, 2007, p.174). Human beings are mainly concerned with the ways of being in a world that is shared between *Self* and *Other*, with meaning and experience entwined with each other. Relationships, practices and language come into use by way of community culture (Conroy, 2003; Conroy & Dobson, 2005; Dreyfus, 1991; Heidegger, 1977). In contrast to Husserl's assertion that "mental content gives intelligibility to everything people encounter", Heidegger's phenomenological approach was that of "mindless everyday coping skills as the basis of all intelligibility" (Dreyfus, 1991, p.3). Dreyfus continues to describe Heidegger 's definition of phenomenology as opposite that of Husserl: "In Heidegger's hands, phenomenology becomes a way of letting something be shared that can never be totally articulated and for which there can be no indubitable evidence to show itself" (p. 30). Heidegger (1962), in seeking the answer to the question of what it means to be, rejected the Cartesian approach to understanding human behaviour and the tradition of naming a way of being, with the intent on making being a substance with a universal nature:

> If the question of Being is to have its own history made transparent, then this hardened tradition must be loosened up, and the concealments which it has brought about dissolved. We understand this task as one in which by taking *the question of Being as our clue* we are to *destroy* the traditional content of ancient ontology until we arrive at those primordial experiences in which we achieved our first ways of determining the nature of Being-the ways which have guided us ever since. (Heidegger, 1962, p. 44)

Traditional ontology has its beginning with Aristotle, who focused on developing a theory of the basic categories of substances, which Blattner (2006) refers to as "inventory of the furniture of the universe" (p.3). Heidegger was drawn by Franz Brentano, a neo-Scholastic scholar, towards the "hard metaphysical questions about the nature of the world as it is in itself – what else could be, be?" (Blattner, 2006, p. 3). For Heidegger, "ontology became the science of the meaning of being; the analytic of pure understanding. Phenomenology, as the study of intentionality, became the method of Heidegger's inquiries" (Blattner, 2005, p.3).

Heidegger (1978) uses the word, ontic, to describe the characteristics of a particular substance and the specifics of its existence. For example, he refers to the substances or entities that are studied through physics or chemistry as ontic. Their study does not necessarily raise ontological questions about their being. Ontological, from Heidegger's perspective, is concerned with understanding and investigating the concept of *being*, itself. Heidegger uses the word existence as a noun denoting that something is. Existentiell and existentiale are two related

words used as descriptive characteristics of *being*. An existentiell is an ontic characteristic, while and existentiale is an ontological characteristic (Blattner, 2006; Dreyfus, 1991; Heidegger, 1978).

Plato is usually credited with giving theoretical understanding its start, using a detached approach to discovering universal principles underlying the phenomenon in question. Aristotle's influence led to the view of the human as a rational, problem solving being whose action was usually directed by beliefs. While acknowledging that this approach might lead to a theory of mind and human decision-making, Heidegger criticized the resulting superficial description of human reality as not helpful to human understanding. Heidegger viewed theory as potentially "powerful and important – but limited", especially in the area of human science (Dreyfus, 1991, p.1). Heidegger was critical of the concept of subjectivity and the theoretical attempts to equate the basic, structural differences between our understandings of ourselves with the understanding we have of others. From the perspective of critical reflection, as proposed by Socrates, Kant and Habermas, Heidegger believed that this approach is only necessary when our own way of coping is insufficient. Decisions are required when we are dealing with something in our life that requires uncovering or clarification in order to understand (Dreyfus, 1991). Heidegger proposes that the most meaningful is not accessible to critical reflection. Instead, it is his hermeneutic way to understanding that seeks to point out and describe our *understanding* of *Being* from within the experience, rather than framing it around theory. It is through

encounters with objects and people that background practices develop, which are only understood by the "people who dwell in them" (Dreyfus, 1991, p.4).

Hermeneutic Foundations

Hermeneutics was traditionally concerned with interpretation of biblical texts, which by the 19th century was designated as a principle mode of historical inquiry. Blattner (2006) refers to Wilhelm Dilthey as introducing the notion of hermeneutics as a principle methodology for human sciences. Dilthey viewed the concern of human science as focusing on the phenomenon of lived experience. From his perspective, an attempt to understand lived experience through direct investigation would not be effective. It would be too overwhelming for the rigour usually expected of natural science. Instead the phenomenological focus of study should be the expressions of life, such as art, literature, cultural and social groups and norms, through which an understanding of lived experience could be gained (Blattner, 2006). Heidegger extended Dilthey's vision of hermeneutics from a method into ontology, proposing that understanding is a fundamental form of human existence. The "hermeneutic circle" as described by Heidegger and elaborated upon by his student, Gadamer (2000), represents "understanding as the interplay of the movement of tradition and the movement of the interpreter" (p. 293):

> Tradition is a belief system which lives through discourse while text is something written, read, and is a form of discourse. The image of a circle illustrates the tension in the interplay between the text's strangeness and

familiarity to us. The true locus of hermeneutics is this "in-between– the process of movement of understanding" (Gadamer, 2000, p. 295).

Gadamer and Heidegger both propose that this movement is best characterized not as a circle, but a spiral, called the hermeneutic spiral (Heidegger, 1997; Gadamer, 2000; Conroy 2003, 2005). Gadamer (2000) describes philosophical hermeneutics as being concerned with the fundamental conditions of understanding human existence in all its modes. All human existence unfolds in a context of meaning. Whenever we encounter the unfamiliar, a different experience surfaces as a possibility, a potential horizon. Understanding is the realization of that potential, with interpretation being a mediated union between an interpreter's own language and the language of the text. (Gadamer, 2000).

The following table contains a summary of the contrast between Heidegger's (1977) thoughts and five major traditional philosophical assumptions about human understanding and being: explicitness, mental representation, theoretical holism, detachment and objectivity and methodological individualism (Dreyfus, 1991).

Table 3.1 **Summary of Traditional Philosophical Assumptions of Human Understanding and Being as Critiqued by Heidegger**

Assumption	Philosophical Tradition	Heidegger's Criticism
Explicitness	**Socrates, Kant & Habermas**: Principles guide our knowing and action. By understanding principles we have enlightened control over our lives	Culture and community socializes us to be able to obtain necessary skills to pick out objects, understand them as subjects and be able to make sense of the world and who they are. Enlightened reflection is only needed when our own way of coping is inefficient.

Mental Representation	**Descartes**: in order for us to perceive, act and relate to objects, there must be content in our minds; internal representation that enables us to direct our minds toward an object. **Husserl & Searle**: Intentional content – experience is basically a relation between a self-contained subject with a mental inner content and an independent, outer object.	Agrees that humans can experience themselves as conscious subjects relating to objects as intentional states such as desires, beliefs, perceptions, and intention. This, however, is a derivative and intermittent condition that presupposes a more fundamental way of being-in-the world that cannot be understood in subject/object terms
Theoretical Holism	**Plato**: everything humans do is based on an implicit theory. **Descartes/Husserl**: humans perceive perspectives, then synthesize the perspectives into objects and finally assign these objects a function based on physical properties. Theory is represented in our minds as intentional states and rules for relating them.	There is no orderliness to human acting in the world. Humans manipulate tools that already have a meaning in the world that is organized in terms of purpose.
Detachment and Objectivity	**Greeks Plato, Descartes**: reality is understood only through detached contemplation. **Husserl:** Bracketing defends the validity or objectivity of the interpretation against self-interest.	Understanding comes through an embodied, meaning-giving, doing subject. Validity occurs through interpretation from within a hermeneutic circle (background, co-constitution, pre-understanding)
Methodological Individualism	**Descartes, Husserl:** All sociological explanations can be reduced to psychological characteristics of individuals who make up the society.	The social context is the ultimate foundation of intelligibility. Most philosophical problems can be "(dis)solved" by a description of everyday social activity.

Adapted from Koch, 1995 (as cited in Conroy, 2001, p. 88) & Dreyfus, 1991, p 4-7.

Heideggerian Concepts Fundamental to this Research Inquiry

In an effort to avoid the misleading interpretations that ordinary language can bring, Heidegger (1978) made up his own terms to describe his phenomenological concepts of human understanding. In this section, I describe and define the basic Heideggerian concepts that are pertinent to understanding the thematic analysis in this research inquiry. Some aspects of Heidegger's concepts

have already been mentioned in Chapter Two, in which I discussed the ontological nature of pedagogical relationships. The focus of this section, however, is to relate Heidegger's concepts of human *Being* and *understanding* to my attempt to bring about a greater understanding of the relational world of pregnant women who are learning about gestational diabetes, and the meaning these relationships hold for them. The Heideggerian phenomenological concepts that underlie the research question and sub-questions for this inquiry have been explored and are italicized throughout this text and included in the glossary for quick reference:

- What is significant or meaningful about learning relationships for pregnant patients who have a medical diagnosis of gestational diabetes mellitus? *(Significance)*
- What is the meaning of learning for Self and Other within the nurse-patient relationship? *(Mood, senses, embodiment, affectivity)*
- How do patients come to understand the teaching-learning role relationships with registered nurses? *(Historicity, co-constituency)*
- How does the relational space between registered nurses and patients facilitate or challenge learning? *(Space)*

Being. Heidegger views human *Being* as basically indefinable. He uses the word, *Dasein*, to describe the "place of the understanding of being" (Heidegger, 1978, p. 8). Heidegger proposes that being has a universal nature, but it is not like the generally accepted notion of universality to which being would be "conceptually articulated according to genus and species" (Heidegger, 1977, p.

43). Instead, Heidegger follows the writings of Aristotle and Thomas Aquinas in his understanding of the universality of being as contained in everything we come to understand in being (Dreyfus, 1991; Heidegger, 1977). *Being* for Heidegger, is a self-evident concept used in all "knowing and predicting, in every relation to beings and in every relation to oneself, and the expression is understandable" (Heidegger, 1977, p. 44). He writes:

> Everybody understands, "The sky *is* blue," "I *am* happy," and similar statements. But this average comprehensibility only demonstrates the incomprehensibility. It shows that an enigma lies a priori in every relation and being toward beings as beings. The fact that we live already in an understanding of Being and that the meaning of Being is at the same time shrouded in darkness proves the fundamental necessity of recovering the question of the meaning of "Being" (p. 44).

World. A phenomenological view of the *world* of a human being is very different from the traditional understanding of environment, which often is "the sum total of "things" in our world" (Wynn Leonard, 1989, p. 317). World, from Heidegger's perspective, is the "meaningful set of relationships, practices and language that we have by virtue of being born into a culture" (Wynn Leonard, 1989, p. 317).

The *world* of pregnant women in the experience of learning about gestational diabetes mellitus includes a milieu of relationships within *worlds* comprised of familiar people, such as their family and friends who daily *dwell* beside them and the less familiar clinical world of registered nurses and other

prenatal care team providers. The women come to their learning experiences with values, thoughts and understandings from their familiar *world*s, influenced by their daily life experiences. The pregnant women observe and then take in the values, traditions and beliefs of this new and unfamiliar *world* of their nurse-teachers where their learning largely occurs. The familiar and unfamiliar worlds in which the women dwell may be in harmony with each other, or they may be diverse and conflicting in nature. The women's *understanding* that arises from being in this complex world influences the meaning their pedagogic relationships hold for them.

Being-in-the-World. *Being-in-the-world* is a state for Dasein that is a priori but does not, by itself, determine *Bein*g. Dasein has a distinctive way of *Being-in*, which is not the same as the way in which one object can be in another (Dreyfus 1991). Heidegger writes:

> What is meant by "Being-in"? Our proximal reaction is to round out this expression to "Being-in" 'in the world'", and we are inclined to understand this Being-in as 'Being in something' ….as the water is 'in' the glass, or the garment is 'in' the cupboard. By this 'in' we mean the relationship of Being which two entities extended 'in' space have to each other with regard to their location in that space…Being-present-at-hand-along-with in the sense of a definite location-relationship with something else which has the same kind of Being, are ontological characteristics, called categorical (Heidegger, 1978, p. 79).

A person does not just exist or live in their world but rather, becomes fundamentally familiar with it by dwelling there. Familiarity makes the *world* "mine"; it matters to "me" (Blattner, 2006, p.43). All of our daily activities are specific ways of *being-in-the-world*. The *world* in which Dasein dwells is a "concrete experiential context or milieu" with a distinctive structure, which Heidegger calls, *significance* (Blattner, 2006, p.43).

> Dasein's *facticity* is such that its Being-in-the-world has always dispersed itself or even split itself up into definite ways of Being-in. The multiplicity of these is indicated by the following examples: having to do with something, producing something, attending to something and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing, evincing, interrogating, considering, discussing, determining. . . All these ways of *Being-in* have *concern (Fürsorge, care*) as their kind of *Bein*g (Heidegger, 1978, p.83).

Care or concern, which Heidegger calls *Sorge*, is a fundamental basis of our *being-in-the-world.* This is not matter or spirit, but care. It is the matter in which we relate to the objects and interact with the general "state of affairs" in our lives (Blattner, p. 44). Everything that one does is imbued by this care, even if a person neglects to do something or leaves something undone.

Facticity is a term used to describe our understanding of who we are in relation to each other and objects in our world. Heidegger (1978), as cited in Blattner (2006), describes the important ontological differentiation between fact and facticity: "Whenever Dasein is, it is as a Fact; and the factuality of such a Fact

is what we shall call Dasein's 'facticity'" (p. 82). Blattner goes on to define the difference between these two notions by comparing the fact that his computer weighs six pounds and the Fact that he is a father. Being a father is a way of *Being-in-the-world*, whereas weighing six pounds is just a fact, a description of his computer. Description disregards one's existentiality relegating the person to that of a physical object. The result of this disregard is our "missing what makes his or her life the *life* it is" (Blattner, 2006, p. 45). It is important, therefore, to acknowledge that we may take one of two attitudes when regarding a person: "a scientific-descriptive attitude, which focuses on the person's indifferent properties, such as weight and height, and an existential attitude, which focuses on the person's ways of *being-in-the-world*" (Blattner, 2006, p. 45).

Heidegger (1978) describes three distinct ways of interacting with the world, which he refers to as everyday intelligent "dealings" (p. 95). Intelligence, from this aspect, means practical attributes rather than cognitive. He writes,

> The kind of dealing with is closest to us is as we have shown, not a bare perceptual cognition, but rather that kind of concern which manipulates things and puts them to use (Heidegger, 1978, p. 95).

When one is in a familiar environment, little notice is taken of the immediate environment and the things in it. It is only when things are unfamiliar that one would pay attention, visually and cognitively, to the objects and nature of the environment, "in order to be able to make my way about this strange *world* effectively" (Blattner, 2006, p. 50). Familiarity with the objects in my environment may not allow for a description of them but one would be able to

articulate their role in the activity of daily life. Referring to these everyday entities as equipment, Heidegger (1978) writes, "That with which our everyday dealings proximally dwell is not the tools themselves. On the contrary, that with which we concern ourselves primarily is the work that with is to be produced at the time" (p. 96).

The term, *ready-to-hand*, describes this encounter of equipment during our common state of immersion in our everyday activity. Our immersion results in our paying little or no attention to the equipment itself. Heidegger uses the term, *present-at-hand*, to describe an observational attitude that is initiated through refection and which may affect or alter a person's actions. *Present-at-hand* is not the way things in the world are usually encountered. It emerges from an attitude in which we care about what is happening with the equipment and the equipment is seen in the context of a world of equipment that is near or remote, and that is there as a means to do something with the equipment (Blattner, 2006; Dreyfus, 1991; Heidegger, 1978).

When equipment doesn't function as we anticipate it should, a "phenomenon of breakdown" occurs, which Heidegger refers to as unreadiness-to-hand (Blattner, 2006, p. 57). There are three ways of *unreadiness-to-hand*: (1) conspicuous, in which there is obvious damage or change; (2) obtrusive, in which something is missing that is required for functioning and (3) obstinate, in which the equipment is actually a barrier to our desired action (Blattner, 2006). *Unreadiness-to-hand* brings the equipment back to our attention until the situation returns to its familiar state.

> Pure *presence-at-hand* announces itself in such malfunctioning equipment, but only to withdraw to the readiness-at-hand of something with which one concerns oneself – that is to say, of the sort of thing we find when we put it back into repair. (Heidegger, 1978, p. 73)

Primordial is a term that compares the state of *ready-to-hand* to *present-at-hand*. Primordial, in this context, refers to the idea that being can only be understood through what is everyday and close in proximity. The everyday understanding of one's world is not necessarily a part of any kind of scientific or theoretical study of what is occurring. However, a person's *present-at-hand* relationship with their world may have such a nature. Only by studying a person's usual, everyday *understanding* of the world, as it is expressed in their relationships to the ready-to-hand entities of their world, can there be a foundation for understanding specific entities within the world (Wynn Leonard, 1989; Dreyfus, 1991).

Affectedness. Heidegger (1978) uses this term in his attempt to describe how one finds things are going on in their *world*. The challenge faced with this concept is related to Heidegger's view that our *understanding* of how things are going is not a private matter. Dreyfus (1991) relates that common words such as "state-of-mind" or "disposition" reflect states that are too inward or outward in relation to self and others.

> To be affected by the unserviceable, resistant, or threatening character of that which is available, becomes ontologically possible only in so far as being-in as such has been determined existentially beforehand in such a

> manner that what it encounters within-the-world can "*matter"* to it in this way. The fact that this sort of thing can "matter" to it is grounded in one's affectedness; and as affectedness it has already disclosed the world – as something by which it can be threatened, for instance…Dasein's openness to the world is constituted existentially by the attunement of affectedness (Heidegger, 1978, p. 176).

Heidegger uses the word *mood* to reflect the ways of finding things matter. Dreyfus (1991) describes the definition of mood as including many different aspects of a person and their world:

> As Heidegger uses the term, mood can refer to the *sensibility* of an age (such as romantic), the *culture* of a company (such as aggressive), the *temper* of the times (such as revolutionary), as well as the *mood* in a current situation (such as the eager mood in the classroom) and of course, the mood of an individual. (p.169)

From a phenomenological stance, Blattner (2006) refers to the concept of *mood* as "atmospheres in which we are steeped" (p. 77). Mood can set the tone for our environment and influences our environment. Our *being* is disclosed in *mood*. Connected closely to *moo*d is Heidegger's concept of *thrownness*. We cannot stop caring about our life. We are always "attuned and disposed in the world" (Blattner, 2006, p. 78). Even indifference or a negative *mood* is a way of caring about the world. Blattner (2002) summarizes *thrownness* and *mood* as

> being thrown into existence, subject to the world, delivered over to life.

> This is to say that we are entities who encounter the world in terms of how it matters to us. We are tuned in to the way things matter, and our tuning or temper is our mood (p. 79).

Understanding and interpretation. Like *affectedness, understanding* is a state of mind. Heidegger's notion of *understanding* is the ability to do or master something. Understanding is not related to cognitive phenomenon:

> When we are talking ontically we sometimes use the expression "understanding something" with the signification of "being able to manage something," being a match for it," "being competent to do something." In understanding, as an existentiale, that of which we are capable is not a What, but being as existing. The kind of being which Dasein has, as ability-to-be, lies existentially in understanding (Heidegger, 1978, p.85).

Dasein interprets and *understands* the world in terms of *possibilities*, projecting itself onto the *possibilities*:

> Not only is the world, qua world, disclosed as possible significance, but when that which is within-the world is itself freed, this entity is freed for *its own possibilities*. That which is ready-to-hand is uncovered as such in its serviceab*ility*, its usab*ility*, and its detrimenta*lity*. (Heidegger, 1978, p. 144)

Possibilities, therefore are *understood* by the way the characteristics of the entities that we encounter in our world are entwined with how we will use them as well as who will be using them, as well as possible ways to be *Dasein* (Blattner, 2006). Projecting is not considered, by Heidegger, as having the nature of planning or being thought out from a cognitive sense, but what "we are able to be

or do; what we are capable of" (Blattner, 2006; Dreyfus, 1991). Heidegger (1928/1978) applies the term, "meaning", to something that is understood (p. 193). Blattner (2006) elaborates:

> Thinking metaphorically, when I drink out of this coffee mug, I am throwing it forth onto or into its possibility of being a coffee mug, its usability in the business of drinking. In this act of projection, we can identify what is understood, the role of being a coffee mug. (p. 87)

Understanding gives us "sight" which Heidegger uses as a metaphor for intelligence. This again is not a cognitive characteristic, but rather one of experience (Blattner, 2006; Heidegger, 1928/1978). Sight, from this perspective, allows us to draw on "the peculiar feature of seeing, that it lets entities which are accessible to it be encountered unconcealedly in themselves" (Heidegger, 1928/1978, p. 187).

Heidegger also addresses the concept of self-understanding. One's being matters to one's self, which Heidegger (1978) captures as "pressing forward onto possibilities" (p. 182). Self-understandings, which Heidegger uses the term, *for-the-sakes-of-which*, make up our identities. They are "those "aspects" of human life that engage us existentially and make sense of who we are" (Blattner, 2006, p. 89). Being existentially engaged means doing the things that one must do to be existentially engaged. Conflict or tension may occur when "who we are existentially engaged in being stands in tension with who we think of ourselves as being" (Blattner, 2006, p. 89).

Space and spatiality. *Spatiality* is a term Heidegger uses to describe the grounding of the person in a location, which he calls, "*the-there*" (1978, p. 171). Dreyfus (1991) describes Heidegger's perspective of space as not that of distance or a physical, objective point, but rather it ought to be thought of as concern. A person either experiences space and spaciality as close or remote. Dasein has a tendency to closeness. Dreyfus (1991) quotes Heidegger (1978),

> If Dasein, in its concern, brings something nearby, this does not signify that it fixes something at a spatial position with a minimal distance from some point of the body...Bringing-near is not oriented towards the I-thing encumbered with a body, but towards concernful being-in-the-world. When something is nearby, this means that it is within the range of what is primarily available for circumspection (p. 142).

Therefore, for Heidegger (1978), the definition of near is that something with which a person is coping and with which they have concern. It is part of being-in-the-world. "Space is not to be found in the subject, nor does the subject observe the world, "as if" that world were in a space: but the "subject" Dasein, if well understood ontologically, is spatial" (Heidegger, 1978, p. 146).

Human beings, however, can ignore the nearness of entities or substances, including their context and direction. Heidegger uses the example of equipment, with which *Dasein* is engaged, to describe the ontological nature of space. The *spatiality* of equipment is affected by *Dasein's mode of being*, its *readiness-to-hand*. Equipment can be encountered from the sense of close-by or closeness. Closeness is not determined by measuring distance, but rather by circumspection,

which also determines direction in which equipment may be accessed and thereby determining its place. (Blattner, 2006; Dreyfus, 1998) Place is where the equipment belongs, its place as the entity as equipment.

> The "world," as a whole of available equipment becomes spatialized to a nexus of extended things which are just occurrent and no more. The homogenous space of nature shows itself only when the entities we encounter are discovered in such a way that the worldly character of the available gets specifically deprived of its worldliness (Heidegger, 1978, p. 147).

Time and temporality. Heidegger (1978) distinguished ways of being for human being, relating them to a concept of *temporality* where the notion of *past*, *present* and *future* are perceived, not as being linear or successive, but rather entwined. Time, the present and the notion of the eternal, are *modes of temporality*. *Temporality* is the way we see time. Heidegger has a very different view of time from the more traditional view of time as being a linear series of past, present and future:

> The future into which the resolute self presses forward is not tomorrow, and the past from out of which it emerges is not yesterday. As Heidegger formulates the point, the future is not yet-to-come, the past is not gone by. Rather, the primordial past…is the past of I am as having been…His point is that who I already am, in Heidegger's preferred sense, is not the phases of my life that have gone by. Rather, who I have-been is disclosed by my

> disposedness, my mood. Who I have-been is who I find myself to be in so far as I press forward into my life (Blattner, 2006, p.165).

Therefore, Heidegger sees *time* in the context of futural projections and *possibilities*, and one's place in history. Possibilities, then, are integral to our understanding of time. (Blattner, 2006; Dreyfus, 1991) *Futurity*, as a direction toward the future always contains the past, the has-been, which is a primary mode of Dasein's *temporality*. A person is called to go forward with the person one finds as one's self , which may not be the person one has been "heretofore" (Blattner, 2006, p. 165). To not go forth in such a manner is to be lost in what Heidegger refers to as the Anyone. This is a superficial and limited life, characterized by little imagination and lived by the general prescriptions of the Anyone:

> For the most part, the self is lost in the Anyone. It understands itself in terms of those possibilities of existence which "circulate" in the "average" public way of interpreting Dasein today. These possibilities have mostly been made unrecognizable by ambiguity; yet they are well known to us. (Heidegger, (1978, p. 435)

Pregnant women who are diagnosed as having gestational diabetes find themselves *thrown* into a new or changed *world* that now encompasses being a pregnant woman with a diagnosis of gestational diabetes mellitus. This presents new *possibilities*, as described by Heidegger (1978). To choose to follow the new *possibilities* means that they are no longer the same as when they were a person who was not pregnant and who did not have gestational diabetes mellitus.

Being-with. For Heidegger, *being-in-the world* has aspects of embodiment, self-interpreting, situated in *time* and *space*. While all entities are encountered in the modes of *present-at-hand* and *ready-to-hand*, the mode of *being-with* and all the emotion, loneliness and togetherness that it implies, is a unifying mode of being for Dasein and its world (Blattner, 2006; Dreyfus, 1991). *Being-with* is a fundamental way of understanding *Dasein's* character. It is a descriptive characteristic of *Dasein*.

Dasein distinguishes between equipment and "objects of consciousness in the world" which Heidegger terms "Others" (Heidegger, 1978, p. 154; Olesh, 2008). Others are not just everyone else, but rather "those from whom, for the most part, one does not distinguish oneself…those among whom one is too" (Heidegger, 1927/1978, p.154). Therefore, for *Dasein* to be-in the world is for *Dasein* to always be-with Others. *The being-in-the-world of Dasein* is a *"with-world"* (Heidegger, 1978, p. 154).

Authenticity. As discussed in chapter two, *Dasein* may exist as *authentic* or *inauthentic modes of being* or in an *undifferentiated mode of being*. *Dasein's* understanding of itself differs profoundly from what would be understood through observational attitudes such as perception or intuition (Blattner, 2006; Dreyfus, 1998; Heidegger, 1978).

When Heidegger (1978) discusses *authentic* selfhood, *Dasein* cannot be understood in terms of subjectivity. To understand human beings as subjects in a technical sense is not simply to construe selves as things, but encounter the person

in an attitude of observation instead of interpretation, thereby missing the *meaning of being*.

Interpretive Phenomenology

Interpretive phenomenology is concerned with the interpretation of the substances and structures of experience, as understood by people who live through these experiences and by those who study them" (Conroy, 2003; Wojnar & Swanson, 2007). As described in the previous section, Heidegger's phenomenology is ontological in nature, focusing on the *meaning of being*. It is the way through which the *understanding of being* is obtained (Dreyfus, 1991). The key point then, for a researcher, who is following a Heideggerian phenomenological tradition, is to return to the phenomena to *understand the meaning* shared in the everyday activities in which humans dwell (Conroy, 2003; Dreyfus, 1991).

Wojar & Swanson (2007) view interpretive phenomenology as how the revelation of the structure of experience is *understood* by those who live through the experience and by those who study them. Gadamer (2000) refers to the hermeneutic research experience as more than a gathering or accumulation of experiences; it is a "learning experience" which allows for a shift in understanding or consciousness (as cited in Holroyd, 2007, p. 8).

Benner (1994) describes the circular interpretive action as moving back and forth between "part and whole" (p. 57) and "portions of the text and portions of the analysis" (p. 115). Consistent with the hermeneutic phenomenological philosophy of Heidegger (1978) and Gadamer (2004), Conroy (2003)

conceptualizes interpretive inquiry as a fluid and reflective approach best represented as a hermeneutic spiral. As a spiral, the phases of interpretation move "beyond the immediate concerns of the researched towards interpretation of a greater pattern of participant engagement with the world" (Conroy, 2003, p. 17). This approach opens the traditional Heideggerian concept of a closed circle to that of a spiral of interpretation and *understanding* among persons in relationship with each other (Conroy, 2003; Gadamer, 2004; Heidegger, 1978, Macmurray, 1961). With the hermeneutic spiral, interpretations are built on the understandings of a group of people over time. "The true locus of hermeneutics is the "in-between: the process or movement of understanding" (Gadamer, 2004, p. 297). Thus the movement is best characterized by a spiral and not a circle (Conroy, 2003; Gadamer, 2004). This allows the research process to grow in new ways of *understanding* by "including interpretation by others rather than just the primary researcher and study participants" (Conroy, 2003, p .10). Conroy's design uses a synthesis approach to interpretation, rather than analysis. Therefore, it "unifies or builds upon components through induction rather than reducing concepts into units for study then deducing outcomes" (Conroy, 2003, p. 34).

By way of the metaphors of "footprints and pathways", Conroy (2003) describes the complexity and flexibility required of interpretive inquiry research on the journey to understanding. "Footprints are unique, but they blend with the earth's contours or with other's tracks and fade or stray from a pathway in the woods. The responsive and reflective nature of interpretive inquiry is represented

by the many turns and twists characteristic of pathways, with an emphasis that they are “not paved in concrete” (Conroy, 2003, p.5).

Wojnar and Swanson (2007) describe *forestructure* as being closely linked with how “one understands the *world* and that such *understanding* is linked with how one interprets reality.” (p. 174). In order to achieve an *understanding* of the reality of what patients experience during teaching and learning about gestational diabetes, it is important to consider the broader aspects of existence for the participants as influenced by the social, psychological, spiritual and physical aspects of their day-to-day lives as well as myself as researcher (Conroy, 2003; Heidegger, 1978; Wojnar & Swanson, 2007). As I engaged in this research, I brought my own history of relationship experiences that have influenced my curiosity and perspective on relational learning. These experiences range from the most basic and personal as mother to the more professional role of a clinical teacher and mentor for nurses. As well, patient teaching is a core component of my role as a clinical nurse specialist attending to women experiencing complex, high risk pregnancies. All of this information and understanding contributes to or comprises my “*preunderstanding*” or *preconception* about the experience of gestational diabetes mellitus that I bring to the research study (Conroy, 2003; Heidegger, 1978; Holroyd, 2007; Wojnar & Swanson, 2007).

Conroy’s hermeneutical principles for research guided the design and method of this research project. Her hermeneutical principles for research (HPR) embrace the need to focus on the underlying goal of engaging participants in the research process and embedding a concerned, engaged standpoint that transforms

the hermeneutical circle into an interpretive phenomenological spiral. They represent Conroy's very comprehensive review of the literature related to Heideggerian philosophy and the concept of embodied intelligence. The following table lists Conroy's (2001; 2003) hermeneutic principles that guided my study design and the development of my research method.

Table 3.2 **Hermeneutical Principles for Research (HPR)**
1. Seek understandings of the participants' world of *significance* through immersion in their world 2. Make explicit the shared world of understanding between the researcher and the researched. 3. Immerse oneself in the hermeneutic circle throughout the research spiral. 4. Make explicit the immersion of the researcher in the hermeneutic spiral. 5. Draw out what is hidden within the narrative accounts and interpret them based on *background* understandings of the participants and the researcher. 6. Enter into an active dialogue with the participants, the second readers, the narrative itself as spoken and written. 7. Maintain a constantly questioning attitude in the search for misunderstandings, incomplete understandings, and deeper understandings. 8. Move in a circular progress between parts and the whole, what is disclosed and hidden, the *world* of the participant and the *world* of the researcher. 9. Engage the active participation of the participants in the research process: the implementation and the interpretation. 10. Encourage self-reflective practice by the participants through participation in the research and through offering a narrative account of the researchers' understandings and interpretation. 11. View every account as having an interpretation based on a person's *Background*. 12. View any topic narrated by the participant as significant at some level to the participant. 13. Deem every account as having its own internal logic; whatever is brought to an interview is *significant* to its bearer, consciously or not. 14. Access and make explicit participant understandings through their own modes of existence, mode of engagement while being sensitive to one's own modes of existence and of engagement and foregrounding. 15. Be aware of one's own use of coping tools in any of the modes of existing. 16. Engage in the spiral task of hermeneutical interpretation along with the participants. 17. Keep track of movements in understanding. 18. Work with participants to see which points are salient. 19. View interpretive phenomenology as an interpretation of participant's interpretation. 20. Look beyond the participant's actions, events and behaviour to a larger *Background* context and its relationship to individual events.

In summary, Heidegger's hermeneutic phenomenology affords a way to deepen one's understanding of what it means for something or someone to be. Through his departure from the phenomenological tradition of Husserl and the Cartesian influences on the philosophical determination of human understanding and being, Heidegger distinguished several ways of understanding (human) *Being* and relating it to *temporality* (Dreyfus, 1991). The "disclosure of things takes place through *Dasein'*s concernful dealing with things in the environment. Relating to things, disclosing them, always relates to our concerns in advance, our relation is primarily interpretive or *hermeneutical"* (Moran, 2000, p. 234). Use of the concept of a hermeneutic spiral, as developed by Conroy (2003), affords an opportunity for *co-creating understanding* of the meaning of the pedagogic relationships between patients and nurses to others beyond the circle of researcher and participant. This may afford a better understanding of how nurses and patients engage with the *Other* in their mutual relationships and what influences their *Being-in-the-World*. In the next chapter I describe my research design and method, which was guided by Conroy's (2003) hemeneutical principles for research.

Chapter Four

Research Design and Method

In the previous chapter I explored the philosophical foundations to my research methodology. I described how Conroy's (2003) hermeneutic principles for research have guided the design and method of this research project. These principles support the need to focus on the goal of engaging participants in the research process and embedding a concerned, engaged standpoint that transforms the hermeneutical circle into an interpretive phenomenological spiral.

Embarking on such a journey of interpretive inquiry is a challenging endeavour. There is no traditional method to guide a researcher towards understanding. Interpretive hermeneutic research designs do not have a "procedure for understanding", but instead "clarify the conditions that can lead to understanding" (Holroyd, 2007, p. 1). Data is not gathered through structured questionnaires and interviews; measuring and analysis are not the components of interpretive research inquiries. Rather *understanding* arises from an exploration of the participants' experiences occurs through conversations between the researcher and participants that reflect reciprocity and are approached from a position of a flexible and open inquiry guided by the participant. The researcher adopts a stance that is curious and facilitative rather than impersonal and probing (Holroyd, 2007; Conroy, 2001; 2003).

However, the study design does need to have a form of structure to it. For example, there needs to be a way of collecting the conversations and recounting the experiences, as they are told to the researcher. It is also imperative from an ethical perspective that there is transparency to the process for eliciting people to

participate in the study (Eide & Kahn, 2008). Following are descriptions of such aspects of my research design.

Participants

Congruent with qualitative research methodology, purposeful sampling was used in this research inquiry. There were no specific numbers of participants required for recruitment to this study. Significance for this study is not about power in numbers, but rather the understanding of individual experiences (Munhall, 2007). The decision to participate was through self-selection by patients; no one solicited potential participants in person about participating.

Inclusion criteria. Pregnant women who were, at the time of the study,

- diagnosed with diet and insulin controlled gestational diabetes mellitus at the time of the study
- inpatients or ambulatory patients in the prenatal clinics at the IWK Health Centre, Halifax, Nova Scotia
- over 18 years of age
- able to read, speak and understand English

Exclusion criteria. Pregnant women who were diagnosed with Type 1 or Type 2 diabetes mellitus

Recruitment of Participants

A letter of introduction to the study was handed out to all pregnant women attending the prenatal clinic, which specializes in caring for women with gestational diabetes mellitus (GDM). Potential participants receiving the letter reflected independently on their desire to participate the study (Appendix D).

Fifty-four letters were handed out to pregnant women who potentially met the criteria for the study. Of these, 12 returned the letter of interest and 5 proceeded to next steps of consent and participation in the study. Seven of the women were unable to proceed to the consent and participation phases of the study because of unanticipated health issues related to high blood pressure in pregnancy (preeclampsia). Two of the women had both inpatient and ambulatory learning encounters with nurses concerning GDM. The learning experiences for the other three participants occurred only in an ambulatory care setting.

Study Environment

The research study took place at the IWK Health Centre, Halifax, Nova Scotia. This acute care tertiary hospital provides inpatient and ambulatory care to pregnant women experiencing GDM. It is the main referral centre in the Maritimes for complex, high-risk women and children, with approximately 5000 births occurring annually. The diabetes-in-pregnancy clinic at the IWK Health Centre provides ambulatory care to approximately 300 pregnant women annually. Its high risk pregnancy unit cares for 15- 20 pregnant women annually who are experiencing complications with their diabetes management.

Data Collection

Data collection comprised three methods:

1. One-on-one conversations with pregnant women regarding the meaning of their experiences of learning about GDM. It is through the conversations that access to the participant's world is realized, with "minimal overlay of the researcher's language, pre-understandings and directive actions, while

promoting immersion in the other person's world" (Conroy, 2003, p, 16) see Appendix B).

2. Conversations were digitally recorded and transcribed directly to a word processor computer program verbatim. The recording offered an opportunity to re-listen to the conversations as needed to facilitate interpretation (Conroy, 2003).
3. Reflective journaling: I maintained a reflective journal throughout the research experience in which I recorded observations, thoughts about data, challenges and other significant points to remember. This aided in my reflection upon my potential *locatedness*, or perspective based on my knowledge and *understanding*. The reflective journaling provided me with an opportunity to link theoretical and personal knowledge with the data (Conroy, 2003; Munhall, 2007; van Manen, 1990).

Thematic Analysis

The interpretations of the individual interviews were guided by Heidegger's (1978) phenomenological perspectives of lived experience, including: *significance, authenticity, mood, senses, embodiment, affectivity, historicity* and *co-constituency*. It was during the interpretation of the dialogue between participant and researcher that the understanding and knowledge from the lived experiences of myself as researcher and participants merged, "re-interpretation" occurred and where meaning and understanding of these individual worlds were "co-constituted" (p.3).

Maintaining integrity. Researchers have a responsibility to be true to the stories of the participants throughout the interpretation of the conversations (Jacobson, Gewurtz & Haydon, 2007; Munhall, 2007). Central to the aim of this study is how well the stories of the participants are reflected by my interpretation of the conversations and writing, and how well it reflects the meaning embedded in their experiences.

In contrast to more standardized research methods, with interpretive inquiry methodology the researcher remains present and available to the participant (Conroy, 2003; Munhall, 2007). As a researcher I engaged in conversations with the participants that were intensely personal and emotional (Conroy, 2003; van Manen, 1990). I focused on recognizing and understanding my own perceptions, attitudes and emotions towards the women coming into the research study. Self-reflection, through ongoing review of the field notes and recordings, as part of the process of the thematic analysis, assisted in identifying and responding to any such behaviour on my part. (Conroy, 2003; Benner, 1994; van Manen, 1990).

Another vulnerability to maintaining study integrity is the potential during synthesis to slip to the descriptive modes, rather than interpretive, and therefore not staying true to the aims of the study and the expectations of the participants (Conroy, 2003; Wojnar & Swanson, 2007). The data was interpreted in collaboration with two second readers who read a maximum of 2-3 written texts for confirmation. One of the second readers was my thesis supervisor, Dr. Sherrill Conroy. Considered an integral part of the outward interpretive spiral, second

readers come as another eye to the experience, reflecting on the randomly selected narratives and my interpretations (Conroy, 2003).

It is a truism that in interpretive research, and with Heidegger's *Being-in-the-world* that interpretation is carried out as the conversations are occurring (Conroy, 2001, 2003). As the women were speaking, my mind constantly juggled between what they were saying at the moment with what they had said earlier, and making connections. Interpretation was already starting in the spiraling fashion that characterizes this type of research (Conroy, 2001, 2003). Although no formulated questions were asked as is done in structured or semi-structured interviews, I did respond in non-verbal fashion through nodding, showing interest, asking for clarification as necessary to let the women know that I was interested in what they had to say as per Conroy's Hermeneutical Principles of Research (2001, 2003). Given that the focus of the interviews was to develop trust and openness in the conversations, the participants may have disclosed information that, upon reflection, they did not wish to include in their transcripts or in the final dissertation. The women were offered an opportunity to review their recorded conversations and my thoughts about the conversations before synthesis began.

The strong focus on reciprocity between researcher and participant with Interpretive Inquiry methodology brings forth the question of how to truly to evaluate the collaborative and facilitative quality of the qualitative research process. Guba and Lincoln (1989) identified "authenticity criteria" or guidelines to aid in such evaluation from an ethical perspective (p.238). Their criteria for truly authentic research include having characteristics of fairness, being educative,

and ontological, catalytic and tactical authenticity (Guba & Lincoln, 1989, p. 245; Holkup, Tripp-Reimer, Matt & Weinert, 2004; Olitsky & Weathers, 2005). Following is a critique of this study in relation to Guba and Lincoln's (1989) criteria concerning the authentic nature of qualitative research inquiry.

Fairness refers to the ways in which the participant's worldview is sought and respected by the researcher through the research process (Geelan, 2004). Throughout my contact with the participants in this study, I retained a focus on the participant's perspectives, keeping them central to our research conversations and the thematic analysis. I clarified my understanding of what they were sharing. All of this was done in an effort to ensure my stance as interpreter of the conversations held as true as possible to reflecting the meaning of their learning encounters and not my thoughts on what should be explored.

Educative authenticity refers to the development and enhancement of the mutual understanding of the worldviews of the participant and researcher throughout the implementation of the research (Greelan, 2004; Guba & Lincoln, 1989; Holkup, Tripp-Reimer,Matt & Weinert, 2004; Olistsky & Weathers,2005)). Although my research question focused more directly on the relationship between nurse and patient, it became clear to me very early into the first conversation that the *worlds* of the participants included many persons that influenced their learning encounters with nurses. As well, I came to appreciate how important caring behaviours on behalf of their nurse-teachers were to their learning outcomes. From the participant's perspectives, I often clarified some aspects of their experiences with nurses and physicians when they expressed uncertainty about

what was actually occurring in their prenatal care or why a certain focus was important in learning. My experience as a nurse in the *world* of prenatal care providers concerning GDM afforded them opportunities to come to understand the *worlds* of their care providers and their motivations and actions better in some circumstances.

Ontological authenticity is the extent to which the worldviews of participants change with new understanding (Guba & Lincoln, 1989; Holkup, Tripp-Reimer, Matt & Weinert, 2004; Olistsky & Weathers, 2005). Some of the participants shared, throughout our experience together, that they had an opportunity to reflect on some of their actions and beliefs. In this case, they changed their perspective of what they should view as important in relation to priorities for their health as well as reflective understanding of why they responded as they did in certain situations.

Catalytic authenticity is the extent to the participant is inspired and facilitated to engage in action (Greelan, 2004; Guba & Lincoln, 1989; Holkup, Tripp-Reimer, Matt & Weinert, 2004; Olistsky & Weathers, 2005). For some of the women, their reflections on what might be occurring to them and/or their unborn babies, because of our exploration of their current approach to managing diabetes, caused them to consider engaging in different actions that would lead them to better control of their GDM in their daily lives.

Tactical authenticity focuses on empowering of the participant to act. (Greelan, 2004; Guba & Lincoln, 1989; Holkup, Tripp-Reimer, Matt & Weinert, 2004; Olistsky & Weathers, 2005). Through self-reflection, some of the

participants considered some aspects of their worlds that presented challenges on a personal or health system perspective. They were able to explore these concerns within the safety of our relationship as researcher and participant. Ours was not an evaluative relationship focused on how well they carried out the actions needed to manage their diabetes in their lives. Rather, our time together was concerned with what was important and meaningful to them. With strength of purpose and character, some of the pregnant women developed strategies that would help overcome barriers to health outcomes related to GDM. Some also benefited from insight as to how well they were actually managing their health issues and were an advocate for their unborn babies.

Ethical Considerations

Ethical principles guiding human research are based on respect for persons. These fundamental principles include the right to be treated with dignity, the right to be autonomous in their decisions, the right to be treated with sensitivity to unique needs based on vulnerability, and the right to have the expectation of privacy and confidentiality for personal information (Canadian Institutes of Health Research, 2010). The nature of this research project involved women experiencing high-risk pregnancies. Pregnant women, as a population, are classified as vulnerable by ethical review boards, based on Canadian Tri-Council Statement on the Ethical Conduct for Research Involving Humans (Canadian Institute of Health Research, 2010). As discussed previously, the risk factors for developing gestational diabetes brought women who are traditionally marginalized in our society to the research project, including Aboriginal women,

and women who are obese or suffer mental health issues. Despite the vulnerabilities presented by the proposed research population, they were still supported by offering them the opportunity to participate in research of pertinence to their health and wellbeing. It is considered ethically wrong to exclude them from research. Excluding them from the research study would prevent them and others like them, from benefitting from positive research findings (Canadian Institute of Health Research, 2010).

Potential harms. There were no expected harms associated with participating in this study. Some of the participants found the course of the conversation did trigger sad or angry emotions that brought tears. I offered empathetic emotional support and an opportunity to discontinue the interview. But none found the sessions too difficult to endure. No participant revealed a need for professional or therapeutic support that went beyond my role as a researcher.

There was a possibility that some participants may be have been living in abusive situations or suffer from mental health issues, such as depression, which they have not disclosed to anyone. One participant did disclose that she suffered depression earlier in her pregnancy during our conversation. With this revelation, I changed the focus of our conversation to explore if she had any present issues that would create concerns with her continuing with the interview and to determine if she needed assistance. She did not indicate a need to stop the interview nor did she believe that she needed any support at that time. Should she or any other participant have shared a situation that presented a real threat of harm to themselves or to another person, I would have stopped the conversation to

determine a strategy for support, as appropriate, with the participant. If needed, I would have provided them with names and contact numbers for support from other appropriate professionals (Eide & Kahn, 2008). If required, I would have informed the appropriate authorities about the information disclosed after informing that participant of my intention.

Potential benefits. There were no known direct benefits to a participant in this study. Patients may have benefitted from having the opportunity to discuss their experiences of teaching and learning about gestational diabetes. As well, they expressed that they were pleased to know that the knowledge gained from this research project would aid in understanding the relationships that develop between nurses and patients during learning experiences about GDM. This may have a positive impact on future nurse-patient teaching relationships and may help to foster further research in this area.

Informed consent. Formal consent was sought and provided to participate in the study (Appendix C). Pregnant women coming to their prenatal appointments were given an information sheet about the study by a receptionist or clerk and independently determined whether they wished to participate. The introduction to the study informed the women that their decision to participate would not affect their prenatal care. I also ensured that the person understood the nature of free and informed consent both at the time of recruitment and before conversations took place. The consent form was written at a Grade 8 level according to the Fleischman-Kincaid Reading Scale. Prior to the interviews, I read out the study aims and the nature of the interview with the woman. I ensured that

she understood that she could withdraw at any time and that participation did not impact the nature of her prenatal care. Any concerns that I would have had regarding a woman's decision to participate would have been a reason to pause before enrolling her.

Privacy and confidentiality. The agency where the study took place is small and the nature of the long timeline for prenatal appointments creates a familiarity between teams and patients. I informed the patients expressing interest in the study that there have been small risks related to other health team members recognizing them as participants in the study.

Because of the public nature of the reception area where pregnant women were required to wait until called for their appointments, they were provided with an envelope in which they could seal their form if they were interested in learning more about the research study. A box was available in which the women placed their sealed envelopes. I checked for any envelopes at the conclusion of the prenatal clinic when the patient appointments were finished for the morning or afternoon.

All participants who indicated an interest in participating were contacted by me on my private office phone. They were given options for interviews to occur at home or at a location separate from the clinic in order to protect their privacy as known participants in the study. All of the participants indicated that they were comfortable being interviewed in the hospital. As a result, the conversations took place in a room in a setting not associated with the prenatal clinics setting and the high risk pregnancy unit. Prior to starting the interview, I checked to ensure all of

the participants were comfortable to use this room from a confidentiality perspective, which they indicated they were.

Qualitative conversations are focused on understanding personal details. All field notes, the files of the data recordings and consents are presently being kept in separate cabinets with keys secured in an area not generally accessible to anyone but myself as the principle investigator. There is one contact person at the IWK Health Centre who also has access to these keys as part of a requirement of IWK Health Centre Research Ethics Board. All field notes and recordings will be destroyed 7 years after the research project was completed; consents will be retained for 7 years according to the University of Alberta's Health Research Ethics Board (HREB) Panel B regulations. Pseudonyms are used in my dissertation and will be part of any published research reports in order to protect the identity of the participants.

In summary, this proposed research design and methodology remains true to the hermeneutic phenomenology of Martin Heidegger (1978) and Conroy's (2003) hermeneutical principles for research. This research design affords the opportunity to enhance understanding of the meaning of the pedagogic relationships that occur for the patient participants as they learn to self-manage their gestational diabetes mellitus.

Chapter Five

Attuning to a New World of Being: What is Happening to Me?

> ... the meaning of life differs from man to man, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life in a given moment.
>
> (Frankl, 2006, p. 108)

The study participants' conversations in this chapter give insight into their understanding of their *worlds* as they came to their learning encounters regarding gestational diabetes mellitus (GDM). Because of their pregnancies and co-existing health issues, their *worlds* changed and took on different meanings. This moved them into unfamiliar ways of coping, into an *unready to hand mode of engagement* with the *world*. This is the *background* underlying their determination of whom and what would be important to them in their managing of their diabetes in everyday life. It is this *pre-understanding* or *background* that aids in their disclosure of their feelings or sense of *embodiment* as they engage in the everyday living of their changed worlds within which they encountered the nurse-teacher as *Other* (Buber, 1970; Heidegger, 1978; Taylor, 2006). Each woman brings to the encounter their own unique experience and understanding, heralding a possible need for a diverse relational approach for and with their nurse-teachers during learning encounters.

Suzanne: Here We Go Again.

This was Suzanne's third pregnancy with gestational diabetes. The diagnosis was not a surprise for her. Nor were the feelings of *anxiety* and concern unusual. *Anxiety* and concern marked all of her second and third experiences with

pregnancy due to her health problems. I still remember the deep breath Suzanne took as she started to recall what it was like to again have gestational diabetes in this pregnancy. The diagnosis triggered recollections of her past pregnancies, flooding her mind with memories of past hypertension issues, miscarriages and stillbirths, reflecting Heidegger's *forestructure of understanding* – what she knew, saw, and understood head of time (Conroy, 2001, 2003). Pregnancy had never been an easy journey for her. While tempered somewhat by a feeling of familiarity, the diagnosis of having gestational diabetes brought a more intense *mood* of fear this time:

> *Scary! I found it scary just because of all the problems I had before. Just one more thing added to it. It was, like, here we go again (laughs softly). And then, I don't know, you worry because you don't know what that means. My first question was how will that affect the baby? So that was the biggest thing. Even though I kind of knew from the first time. But the second time, I don't know. It was almost like maybe I was worse. Because this time, I was a little more overweight. A little more close to diabetic than I would have been at a lesser weight. Because I weigh now more than I did then when I had my first baby four years ago, right. And then there were other thoughts, too. Like, is the baby going to be overweight and have diabetes afterwards?*

However, it was remembering the feelings of stigma, negative judgments and non-acceptance as a person and mother in the relationships that she had in her last pregnancy that provided the greatest consternation as Suzanne anticipated negative encounters with nurses in this pregnancy. When she mentioned her fears about engaging with nurses, her affect changed noticeably. Her words were punctuated with ongoing, heavy sighs accompanied by a quick, sharp rising of her chest and shoulders. Tears welled up in her eyes as she spoke.

> *When you're overweight, people just assume. They just look at me [and think] "like you are overweight. How did you get that big?" It's like I just woke up one day and decided I just wanted to be fat today* (cynically laughs

through her tears). *Like, it is not a choice in that nobody wants to be overweight. You know, it is just something that just kind of happens.*

When asked how her perceptions from the past affected her anticipation of the learning relationships with her nurses this time, she stated,

> *I don't know. My biggest fear was that somebody would judge you. Somebody just assumes you are overweight for some reason. "Of course she is going to be a gestational diabetic." It is somehow your fault. "How could you do this to your kid? Why would you think about having a kid and being overweight?" You know what I mean? [I was] a little nervous about it at first.*

Note her awareness of and assumption by Suzanne of the healthcare professionals' *present at hand mode* or categorizing of Suzanne as a gestational diabetic because of her weight and history. Heidegger's (1978) concept of historicity is helpful to our understanding of the importance Suzanne's past played in her current relational experiences for *Dasein* is shaped by its past. Her past relationships with other nurses influenced her perception of how others viewed her as a person becoming a mother. Her current diagnosis of gestational diabetes meant being vulnerable again to stigma and biased judgment by the nurses upon whom she needed to rely upon to help her manage her condition. She was very aware of the medical risks in this pregnancy and how the past tragedies of the losses of her other babies influenced her emotions. But it was her perceived vulnerability to being judged again, to experiencing feelings of non-acceptance and being misunderstood as a good mother that held *significance* for her learning relationships, especially in respect to the degree with which she could relationally engage with her nurse-teachers. Heidegger's view of a person's *world* is that it is very interactive with *Others*. *Being-with* other persons influences who we are by

significantly impacting on our understanding of ourselves as persons - our *possibilities* – and by what we can choose to do or not do.

> In determining itself as an entity, personhood always does so in the light of a possibility which is itself and which, in its very Being, it somehow understands (Heidegger, 1978, p.62).

Heather: I knew I Would Have It.

Heather deftly grabbed the elastic waistband of her youngest son as he scooted towards the exam table in the small clinic room. Simultaneously, she retrieved a Game Boy from her purse to appease the pleas for a relief from boredom from her eldest son. In order to manage to participate in the study, she had to bring her two young boys with her to our session. Time was always at a premium for her. She had requested that we sandwich our interview between her prenatal check up and her ultrasound appointment. I soon learned that this very pragmatic approach to problem solving life issues and conflicts was characteristic of how Heather faced the diagnosis of gestational diabetes and its subsequent demands on her life in this, her third pregnancy. Placing her hand on her very distended abdomen, she shared her experience of learning about her pregnancy and having gestational diabetes.

> *This one wasn't [planned]. These two were* (points to her two sons), *but this one wasn't. I was shocked – but it is what it is* (laughs softly). *I never had morning sickness or anything like that – none of my pregnancies. I love being pregnant. The only thing is my sugars. I caught them this time on my own. It would have been really early in pregnancy. I knew I would have it. I had it with him* (points to her oldest child). *I had high sugars with him – I didn't come here because they said I was borderline with him. And he was 10[pounds]-7[ounces]. And I had it with him* (points to her youngest child).

When asked what it was like having a diagnosis of gestational diabetes again, she stated,

> *Normal, I guess. I just knew. I went to my family doctor and I told him to send me for the Trutol test and he said it was too early. And I said I know my sugars are up. So anyway, I went home and dug out my old monitor and started checking my own sugars. And I brought it to him and I was, like here you go. Do you believe me now? So he was like," yeah, we'll send you for the test".*

Heather takes charge in her life. She tries to manage her situations efficiently and prides herself in approaching challenges logically and practically. The diagnosis of gestational diabetes did not significantly disrupt her world. There was a familiar *average everydayness* about her experience. Her *past* and *present* experiences gave her confidence that the *future* would not be an unfamiliar journey.

Paula: Part of the Full Meal Deal.

Paula's pregnancy was a complicated and difficult journey from the very start.

> *My husband and I planned to have a baby. I first found out I was pregnant at the emergency department because I thought I was having a miscarriage. And I bled for 3 ½ months. I was sick for the first 5 months and then I gave birth by 6 ½ months. I had diet [controlled] gestational diabetes. I think I was diagnosed towards the end of September and I started insulin on the 1st of October when I was hospitalized the first time with high blood pressure and gestational diabetes. I was sent home on modified bed rest, came back on the 21st of October for an ultrasound, and had a high blood pressure of 180 over 110 and was admitted. And 5 days later I had my son.* (Softly laughs) *I ended up with toxemia and preeclampsia and I hemorrhaged. I had a small hemorrhage when they did the c-section. I don't think it has hit me yet, it was a pretty big shock. Because you go your whole life protecting yourself from getting pregnant. Then you have always been told its nine months of pregnancy. Then you have this baby and go home and you enjoy that first moment you bring that baby home after you've just carried the baby for nine months. And I didn't get to experience any of that which is kind of - it's hard.*

Paula's experience of gestational diabetes was intricately entwined with her other pregnancy complications, such as pre-term delivery, taking a very different trajectory than she anticipated.

> *Everything hit me at once. I wasn't diagnosed with high blood pressure and sent home on medication until the first time I was hospitalized. I had taken my Trutol test and had to call for my results. That was one part of my pregnancy that I wasn't impressed with. And they scheduled an appointment with the diabetic specialist – or the dietitian, sorry. And she cancelled my appointment due to sickness, which is understandable. And then I was hospitalized. So the beginning part of finding out I was diabetic was not very good. And I partly believe that that was part of the reason I ended up in hospital with my first hospitalization because I wasn't regulated with insulin. And they started me on insulin right away. But they didn't start me on high blood pressure medication right away [which] was what I was admitted for. So, I feel I probably could have gone a couple more weeks. Like, I wanted to go to 32 weeks. But I think that if I had had blood pressure medication when I first came in, when I first had insulin and all that stuff. I learned how to do my insulin and all about diabetes while I was in the hospital*

Paula came into her learning experiences about gestational diabetes feeling unrecognized and not cared for properly. The stress and tension displayed through her hunched body posture with arms tucked closely together during this part of our conversation indicated the heightened emotion Paula had in relation to managing her health concerns. Because of this, in Paula's engagement with nurses as she learned to work with insulin, she was vulnerable and dependent on her perception of being heard and understood – of being cared for.

Laura: Just One More Friggin' Thing.

This was Laura's first pregnancy.

> *We were really excited to get pregnant. It was a really wonderful thing when it happened. Scary, always a little scary cause you're never really ready. But we were trying. Some people have always wanted to be a mom. I was really, really excited to experience being pregnant. It was something*

I was waiting to do along the way. I was always really excited for pregnant women, the idea of actually having a little life form inside of you that you created. Unbelievable thing! I've always been someone who's been around kids a lot, has liked kids. I've babysat. We sat small babies a lot. And my husband too. I met him and that was one of the things I've always loved about him. He was a coach and I saw him with the kids and was this immediate, oh my gosh! He was going to be the best dad ever. It's been good.

However, towards the end of her first trimester, Laura's pregnancy took a sudden and tragic turn. Laura had cancer.

I didn't find out I was pregnant for a month or five weeks. For two months I was really quite sick. Quite nauseous. Then starting to feel better. That's when I found the lump. And the only reason I went to the doctor was because I was having problems with my lower back. I was having pregnancy-related issues with my lower back and I was in so much pain I couldn't move. So I called my doctor and said I was coming in. So while I was there I said to her: 'could she just take a look at this?'. And she immediately said I don't think this is pregnancy-related and we really need to move. So, within a week, I had the ultrasound, within another week I had the biopsy and a response within a day. Then right before Easter – surgery – a week later.

I asked her what it was like discovering that she had gestational diabetes in the midst of adjusting to the thoughts of having cancer. In an attempt to recollect her feelings at the time, Laura leafed through her appointment book, trying to determine the timing of the news of her diabetes in her pregnancy. Having difficulty locating the date in the thick, dog-eared journal, she finally gave up, closed the book and with a soft, little laugh, said,

Oh, honestly, it was just one more friggin' thing. Honestly, that was my reaction. I started to cry. Not because it was such an overwhelming diagnosis, you know. To me, it's not that big a thing in the scope of things. It just feels like I keep getting pounded [by challenges]. Like this is wrong! This is wrong! You know, now you need to do this and now you need to do this. It was one more appointment I had to go to and one more thing I had to deal with every day.

It was difficult for Laura to differentiate aspects of her experience. Timelines were vague, emotions were blurred and somatic or bodily feelings were confusing to interpret.

> *We were only 3 ½ months when we found out - when we kind of moved to the next phase. It is kind of hard for me to separate. I've said this a million times. It's really tough for me because it's hard to separate what's pregnancy related and what's related to everything else that's gone on with me. I don't know if I'm nauseous because of the pregnancy or because of this. So it's a little difficult to tell*

For Laura, the diagnoses of gestational diabetes and of cancer was but one more burden and a huge injustice in her life. How much more did she have to bear? The significance of the gestational diabetes in her life weighed lightly against the demands of needing to deal with her cancer. While she talked about the scariness of being pregnant and had tears with her diagnosis of gestational diabetes, she was very matter-of -in describing her experience with cancer. This may have been an important means of maintain self-control, hope and/or coping for her. Perhaps she could only allow herself superficial access to her true feelings around the meaning of her cancer diagnosis. I sensed there was something deeper in her experience with cancer that I could not touch with her. While struggling for my own understanding of an experience with a diagnosis of cancer, I came upon the following poem:

> I sat in shock as the surgeon
> Uttered the dreaded word
> Cancer
>
> He said other things – like "highly treatable"
> All I could hear for the time was
> Cancer

I sat there trying to take it in
Or block it out
Cancer

The word echoes in my head
Over and over and over
Cancer

I know my world will change
Never be exactly the same again
Cancer

(Privileged Presence, 2006)

While Laura's *disclosure* of the meaning of cancer in her life remained largely unspoken throughout our discourse, it appears highly probable that the *significance* of learning about GDM would not be a priority in Laura's world when balanced against the possibilities presented by her diagnosis of cancer.

Tricia: No Way to Win.

Tricia was struggling to survive in life with: a marginally supportive partner who was the father of her baby; a tumultuous relationship with her father and brother; a very limited income; and no place of her own to live. The demands she faced in readying herself to parent her baby were overwhelming. She described her life while being pregnant,

> *I'm ups-and-downs. I had a period of time in the beginning I was kind of excited. I mean at first, the initial reaction was kind of, oh my God, I did not want to be pregnant this quick. We talked about having kids some day and it happened so soon. Like, for me to be pregnant right away, it's crazy. I did have a little while where I was kind of excited that we would have a family like we talked about. But then his reaction wasn't very nice. And there was a little while where I thought, well I can do this without him. It could be a good thing. Could be nice to have a child, you know. Tried to think about fun things to do – you know, try to think about positive things for a while. But then with all the physical problems, too, all the heartburn, all the nausea, all the tiredness. All these things that, over time, just get worse and worse. That was stressing me out and the having to deal with*

all the problems with the house and the [bed] bugs. All the running around, trying to get everything done. I have been spending all this time running around and then the attitude I get from people. I have had times of being really overwhelmed.

Tricia went on to describe the troubled relationships she was having with her family.

All the expectation I get from family - people telling me like what I've done and what I should have done. Everybody likes to tell you what you should have done. Like, when I called my dad one time to give me help with something, he gave me a harsh attitude - you got yourself into this, you have to deal with this. Like, so there's a baby coming that's going to need a place to sleep. What I called him about was the mattress. Social assistance gave me enough money for the crib. I realized that the mattress wasn't included and I don't get any more money for that. So where am I going to get that. I couldn't reach the [baby's] father. I couldn't get hold of him to help. So I was desperate and I thought 'who do I know that could help me?' I thought maybe he could just think of me as his daughter and help me in some friggin' fashion. But he was just really nasty.

Tricia's brother had cut himself off, emotionally, from her as well. He felt stressed out just thinking about her because her life story "is like watching a train wreck". Tricia spent her days encompassed by negative emotions:

All this kind of stuff was really hurtful. And I already had moments of being overwhelmed enough to be, like, dying. There's been a few times when there was too much, like maybe I would be better off dead. I used to think like that when I was younger. I used to think about killing myself quite a bit. But I hadn't thought about it for a long time.

Tricia's diagnosis of gestational diabetes brought new fears and stressors into her already complex life. Like Laura, it was another bad event heaped on what seemed an already terrible life. Tricia's words reflected a world of aloneness, fear, helplessness and frustration. Her tone of voice intensified as she described the impact of embracing the demands of her diagnosis. This aspect of her conversation revealed her *mood* or her *affective* state of *Self* and gave insight

into how she was faring with everything (Conroy & Dobson, 2005; Heidegger, 1978). Mood, from Heidegger's perspective, is a way of being attuned or "tuned into the world" (Moran, 2000, p. 242).

> *I feel kind of like, frigged in a way (laughs). I feel like I can't do everything. Like, I am so... like I have a to-do list every day. I have to go running around. And the only way I can see anybody, eat every two hours, you know, meals and snack, and meals like that, is if you are home all day. And I did have a couple of days just after they told me I had diabetes that I was home for the day and I actually managed to eat pretty much at the times they said. But you know normal days are not like that. Normal days I am out of the house. And if I leave the house, it takes so long to take the bus. I'm not home all day long. I can't afford to buy food while I'm out and there is no way to come home every two hours to eat. I just can't fit in everything that I need to do and take care of myself.*

When I asked what her greatest worries were, in relation to her diagnosis, she responded,

> *Scared to end up on insulin! That was a big thing. My sister got diabetes while she was pregnant and she ended up on insulin. And she is still on it and her kid is three years old. So I was like...I really do not want to be on insulin. I don't really like to have to test my blood sugar. It's not fun* (laughs in a short, abrupt manner). *But I am mostly just scared that it will continue. My mom's been diabetic for a number of years and she's doing the monitoring. But she doesn't have to do insulin. And my sister, she's quite overweight and I think that contributes to it. But, she got the diabetes during pregnancy. So I know. And I've seen her have to do her insulin and I've seen her overdose by accident and have to be rushed to the hospital.*

Tricia faced her world as a pregnant woman with gestational diabetes alone and overwhelmed. She felt hurt and abandoned by the people she felt she should go to for help in trying to meet the demands of her life. She questioned the purpose of living and the meaning of her life. What effect would these relational experiences have for nurses providing her learning experiences about gestational diabetes? How could one surmount these negative barriers to a successful

learning relationship? How could she ever come to trust another, to feel that she was important and that they had vested interest in her as a person?

By virtue of being pregnant with a diagnosis of GDM, the women taking part in this study found themselves in a changed *world*. For some, the need to manage the diabetes in their lives started an emotional journey of discovery of what is now a priority in their changed worlds. For others, the diagnosis of diabetes brought an emotional reconnection with past experiences and relationships. Still, for others, it forced a redefining of what they knew. And for some, it was just one more burden to bear. The requisites of their changed *worlds* moved them into a relationship with others; others whose only commonality in their interactions would be needs created by their diabetes and pregnancy. The meaning of their lived experiences as pregnant women facing a diagnosis of gestational diabetes foreshadows the nature of their learning experiences and interpersonal connectedness with nurses as *Other*.

Time has been spent in this chapter with women who had received more than one blow to their world with multiple traumatic issues and concerns that could easily 'tip the balance' in their coping skills. They were facing a world of unknowns for which they needed to develop, with little help, skills to manage what life had *thrown* to them. In the next chapter I continue onto their movement towards coping with adversity.

What is Happening to Me?

Just beyond my reach
Is something I should know.
The quiet whispering of new senses
Murmur in the back of my head.

There is something important out there.
Comprehended only in fragments,
It speaks of profound mystery,
And suggests resolutions.

Like a blind man learning to see,
I am presented with random patterns
That convey new knowledge
When put together properly.

Stumbling about in the dark,
I should be able to find my way.
The information is all there,
But I do not yet know how to use it.

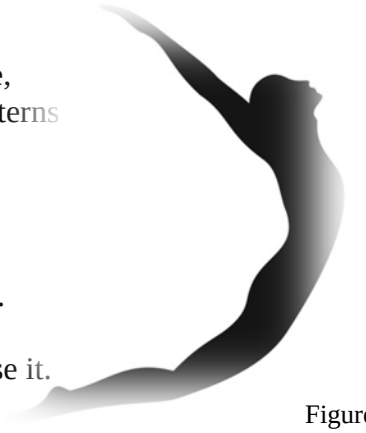

Figure 1

Across an abyss of unknown,
I feel a new bridge under construction.
When will it be finished?
How soon may I cross?

When that time comes
I will plainly understand
Things that existed outside of
Things that I could only guess about before.

(Cattey, 1979)

Chapter Six

Towards a Connectedness with the *Other*: Attuning to *Possibilities*

Anxiety is the philosophical mood par excellence,
the experience of detachment from which I can begin to think freely for myself
(Critchley, 2009)

As revealed in the prior Chapter, all of the women in this study found themselves in a changed *existence* when they became pregnant and eventually were diagnosed with gestational diabetes mellitus (GDM). They were confronted with new experiences that moved them from their *average everydayness* mode of existence to a changed or new understanding of *Being*. The *ontological mood* of *anxiety* arises in their struggle for meaning in their now strange worlds. The women experienced new *possibilities* that they could choose to act upon. They were *thrown* into a world of new relationships with *Others* who they might never have encountered if they were not pregnant and experiencing gestational diabetes. Consideration of possible outcomes, or consequences, influenced their decisions and the context and quality of their connectedness with *Others* in their learning relationships encounter.

Setting Priorities

For Laura, her physicians and nurses were concerned that the effect of taking steroids for her cancer treatment would cause a rise in her blood sugar, thereby giving her gestational diabetes. Laura embraced this concern and learned to test her blood sugar and manage her diet as requested. However, her perception of the need to adhere to the daily management routines was tempered by the actual outcomes she saw through her testing results.

For the first three weeks, start to finish with my chemo, I tested every day. You know, kept my little charts and menus and I was fine. Every reading was fine, basically. So I think after that it was - I'm going to keep doing what I am doing, keep having the meals and snacks I'm supposed to as best I can. But I am not going to keep testing. I think initially I was concerned that it might be a serious issue and that when I did the steroids, I was really going to have to deal with something. And then once I kind of got though the whole session and everything was fine, you know, I really can just manage this with foods.

Laura went on to explain how she came to decide what was most important in her life in relation to her health issues and what she needed to view as a priority in the daily routines.

You mentally go down a checklist and figure what is the most important thing to you. And you deal with those things. So, you have to just physically learn how to use the little tools and things. It was more the food that I had to learn than the testing. The testing was pretty straight forward. You know, I got my teaching - she told me how. I did have to pull out the little instruction book the first time I used it (laughs lightly). Just to make sure. But no, the teaching was good. It was really the food thing that I had to work at. And, it was remembering too. I would still probably be testing every day, all the time but for the fact that I would always do it before a meal. But it needs to be done an hour from when you finish a meal and I would forget to look at the clock when I finished the meal. Like `chemo brain`, pregnant brain`, whatever. It was just forgetting. That was the worst thing for me. So what's the point of testing before if I'm not going to test after?

The significant threat and demands in her life presented by her cancer had to be weighed by Laura against the pregnancy health issues stemming from her gestational diabetes. Her initial perception of the *significance* of her diabetes to her health changed with experience over *time*. Testing her sugars became less and less meaningful as her levels failed to meet the anticipated high blood sugar results about which she had been forewarned. She embraced the need to manage her diet and her cancer still continued to be a significant threat in her life.

What Can I do to Fix It?

Heather took pride in how she embraced challenges in life. She reflected on how she considered consequences and made decisions during new learning experiences.

> *I do a lot of research on my own. A lot of times I'm a doer, I'm a thinker. I can't leave things unknown. If I don't know things, I have to find it out from someone else - like the nurses here. I guess this is what it is. It's time to deal with it. I didn't get into – oh, poor me, what am I going to do? I didn't really get like that. It's just, well ok, what can I do to fix it?*

Despite her common sense and accepting attitude towards her diagnosis of gestational diabetes, Heather disclosed that she had experienced a time of *fear* and perceived vulnerability during this pregnancy. She had controlled her diabetes with diet in the past, but this time she needed insulin to keep her blood sugars within a normal range. She described, in a very emphatic manner, how strong her reaction was to taking insulin:

> *I didn't want to take that at all. Because I was scared my body would get dependent on the insulin and then it wouldn't go away. But they say that it doesn't. [But] I really didn't want to do that. I just don't take medication. I don't take Tylenol. My headache has to be really bad and I have to have it for a few days before I take a Tylenol. And, I hardly remember to take my vitamins. I don't like to take pills or anything like that. So I really didn't want to take the insulin. There was no way I was going to do it. There was no way! I'm not to poke myself. I'm not going to do it. It's not going to happen!"*

Heather came into her GDM experience full of confidence that all would be straight forward and predictable. After all, she had dealt with GDM in two other pregnancies. The diagnosis had a sense of familiarity and ordinariness to her in her *world*. The need to consider using insulin changed all this. Despite her strong

independence and knowledge from her past experience with diabetes, Heather now felt vulnerable and fearful as a pregnant woman requiring insulin to manage her dependent diabetes. Had she been able to control her diabetes by diet, she would have stayed in a familiar *everydayness*, managing her diabetes with assistance and mentoring from nurses as needed. It would have been a familiar learning experience and she would have been able to draw on her *past* to understand what was happening to her in the *present*. However, the need for insulin found her *thrown* into a strange and unfamiliar world. She was uncertain about the long term effects of taking the insulin and the needles were an unpleasant barrier for her. *Fear* challenged her ability to embrace the recommendations from her nurses and other care providers.

Heather did learn to give herself insulin with the help of a nurse who "calmed me down, mellowed me and kept the stress down". Her success at independently managing her insulin was so successful that she, like Laura, reached a point of modifying her prescribed diabetes management requisites. It was her understanding of risk from past pregnancy experiences and the knowledge of how to modify her blood sugar levels that led to her take liberties in the day-to-day control of her diabetes.

> *"I was more worried with him (pointing to her youngest son). But I actually lost weight with him. I did everything exactly like I was supposed to do. I don't know, It was just different. And with him, I didn't have the insulin. We bought ice cream cake for Valentine's Day and I had some with them. And I had a big piece. The insulin is not as good for me 'cause I know if my sugars go up too high, I can bring them down. [With diet] there was no play. No play there. I had to be very accurate. So last time with the diet, I had to be sure to follow it. This time, knowing I have the insulin on hand [and] especially knowing I can figure it out on my own (laughs lightly). But you only live once."*

Her confidence gained by learning to use insulin changed Heather's perception of the importance of strictly adhering to the diet recommendations. Sharing intimate moments with her children, such as the ice cream cake on Valentine's Day, became a *possibility* for her because of her mastery of control through insulin. This reduced her perceived threat to her health from the diabetes and the call to fulfill her maternal obligations to her children and family could now be a priority.

It Has to Make Sense.

Suzanne had significant past experiences with pregnancy and diabetes upon which to make decisions regarding who and what to embrace in her current experience. Her history with diabetes management at a different hospital was in stark contrast to the strategies recommended by her current team. She weighed the information from both sources.

> *I found a big difference between the two hospitals. The information [at the other hospital] was completely different than the information I got here. The [current] advice was that the last snack of the day is supposed to be my biggest snack. Four years ago, I wasn't even allowed a snack after a meal. You were cut back in everything. Cut back in quality and quantities.* <u>*Eat less, eat less*</u> (said with great emphasis in her voice and clenched fists). *Eat more, like, lettuce and tomatoes and things like salad. And, you know, berries and greens*.

She went on to explain how she evaluated what she would embrace in learning to control the effect of gestational diabetes. In a similar manner to Laura, she weighed outcomes of recommended interventions to determine their *significance* in her life.

> *I knew what made sense and what didn't. Like, I referred it to my life. It just didn't make sense to cut back my meals and I didn't get any results*

from that. You know what I mean? Like, I've done that, been there and that didn't make any difference. And it makes sense when they [current care team] were explaining to me not to eat through the day and eat my biggest meal at the night so your body doesn't think you are starving through the night. And being pregnant on top of that. So all that made sense. It fit. It made perfect sense - oh, so that is why that is happening. It goes with your life. 'Cause what I already knew from before didn't make sense. Like when someone is telling you something, you are thinking I've done that and it doesn't work. I don't want to sound mean, but then it just goes in one ear and out the other. It would be like I told you that the sky is really green and you know it is blue. It just doesn't make sense.

In contrast to her past experiences, Suzanne's current team of nurses and dietitians gave her something new and logical to try in controlling her diabetes. Their theories underlying the interventions spoke positively to Suzanne in relation to what seemed feasible to her. Whenever the nurses' approaches to her diabetes coincided with her understanding of what should be effective, she felt positive and encouraged to engage in the intervention. There was congruence between Suzanne's expectations and understanding of her experience as her *authentic mode of Being*. .

This is just not life honey

Tricia was given information by her nurses and dietitians that forewarned her about the effect that high blood sugars might have on her and her baby. Her past observations of the experiences of her mother and sister also informed her about possible risks. As she considered the consequences of diabetes on her overall health, her *world* was tainted her with feelings of *fear* that this too would be her destiny. However, these *possibilities* could not move Tricia to *care* enough to incorporate the needed actions into her life. Her other, *present* demands that

she was facing from her poverty and lack of social support were too overwhelming and *significant* in her daily life.

> *You have to be available to do nothing but worry about what you are eating. Well, I've expressed that this is just not life, honey. I have too much to do. I can't manage this. I tried, but the days that I have things to do – most days- I just can't do it. There is no way.*

As Tricia's pregnancy progressed other influences surfaced that caused her to reflect on how she was determining priorities in her life. Her somatic sensations of her growing unborn baby's presence increased her sensitivity to the possible effect that high blood sugars might be having on the size of her baby. She now used the information she had been given earlier by her nurses to understand risks being presented by her diabetes. She understood that large babies created the possibility of a difficult birth.

> *It just sort of came today that I thought about it. When they told me that I had the gestational diabetes and that I could regulate it with diet and exercise and there is a good chance I won't have diabetes after birth. That was an important thing for me. Like I don't want to have it, and I definitely don't want to end up on insulin if I can avoid that. But, you know, the business of life comes back in again. But now, I really should put all this busy stuff as a secondary priority. Like, no matter what anybody expects of me. This is what I need to do. I need to figure it out first. I'm getting scared now that the baby seems quite large to me.*

Tricia's bodily interaction with her baby brought the risk of gestational diabetes from a theoretical, future problem into a real *presence* in Tricia's *world.* She understood the information given to her by the nurses and weighed the many signs and symptoms presented by her body. But, because her body veiled her ability to visualize how big her baby actually was, Tricia reached out to technology to try to determine the true size of her baby and validate her concern.

> *"It's just the feeling of the baby stretching out and getting kicked up here (points to her breasts) at the same time as being punched in the bladder. And I'm thinking - <u>you must be huge.</u> You're over here and you're over there. And it doesn't help that he [the baby's father] is telling me that all the babies in his family are big. He was ten or eleven pounds or something ridiculous like that. And, I'm like, don't tell me that. I do wish they would do the ultrasound today. I am feeling big again today. This child is massive. I feel massive. Like, I am dilating. Lots of weird sensations. It's on my mind. More stress... (her voice drifts away)"*

It's not just about me.

Other participants also expressed a concern about the negative effect their illnesses may be having on the health of their unborn babies. Like Tricia, their babies had a real *embodied presence* for them and had become a focus of their *care* and concern. Unlike Tricia, however, they were less focused on the potential challenge of giving birth caused by the size of their babies. Instead, it was the *possible* effect of their pregnancy health concerns on their babies' health and wellbeing that became their point of consideration. Their maternal altruism was reflected in their safeguarding and prioritizing the health of their unborn babies. There was distinct movement through their journey of expectant motherhood from a focus on *self* to a new relationship with their unborn babies as *Other.*

Laura describes her fear for the wellbeing of her baby that started early in her pregnancy at the time of her cancer surgery.

> *It's a scary thing because it's not just me. Because at this point, mentally, I am having a child. It's the fear of what's going to happen to him, you know. [For] the surgery, I was scared that something was going to happen to the baby. I kept pushing, wanting someone to come and check the baby. Because, dear goodness...(looking down, she holds her rounded pregnant abdomen, shaking her head back and forth as her voice dies away).*

Laura's fears were quelled as the weeks progressed and there was no indication of ill health in her baby due to her cancer surgery. However, she was

not free from challenges and worry. Overtones of *fear* and guilt permeated our conversation as she described her ongoing struggles during her pregnancy.

> *It's also hard because I don't always feel like eating. Like I don't want to eat, ever, right now. And that's a problem with the chemo and everything. I get such bad heartburn two weeks after treatment. I just don't even want to eat. I am hungry but I don't want to eat. So I have to force myself.*

I was curious as to how Laura overcame this challenge. What motivated her to eat? She responded,

> *I feel bad. I've felt guilty a couple of times because when I come in, I've lost weight. And then, I lost four pounds here and then I gain back two. Then I lose three more. I feel really guilty. I feel bad for the baby. But the doctors keep saying, "we are checking the baby. The baby's weight is fine. Yours might not be." Really the only motivation I feel like I have is to make sure he is healthy. There's way too many things that he's having to battle through right now. I'm certainly not eating because I'm enjoying it right now. (She gives a short, brisk laugh) I just feel like I have to. That's what you do.*

Laura has come to terms with her feelings of responsibility for her unborn baby in her recognition that there are "too many things that having to battle through right now." Feelings of guilt are often equated with a moral sense of right and wrong. However, the ontological nature of guilt, from Heidegger's perspective, is related to a struggle with overcoming *inauthentic ways of being*. For Laura and Paula, to be authentically present to their unborn babies, they had to overcome aversions to eating from side effects to medication and a need for independence and self-control. Weight loss represented Laura's inability to fulfill the meaning of being a good mother while the reassurances from her prenatal care team help to calm her fear of possible negative outcomes for her baby's health.

Paula also struggled with maintaining nutrition during her pregnancy. However, her challenge arose more from her restricted diabetic diet and the

hospital's system for requesting food during her inpatient stay. She felt constrained in her need for independence and self-control. However, her focus on the health needs of her baby became the point of concern when she determined how best to respond to the situation.

> *I love food. I love eating. I didn't like being told I couldn't eat certain things because I like to eat certain things and I'm stubborn. I just didn't like having to call ahead [to the kitchen] and make my meals and wait and talk to somebody different. Half the time the people screwed up my order, so I got more food as it was. But after a while you sort of realize it wasn't about me; it was about my son. About my son's safety and healthiness. So when there's that extra food there, I never tended to eat it because it wasn't about me at that point; it was about him. [My goal was] my health and my son's health. And just trying to make sure I could keep him in there long enough.*

For all of the women, the presence of gestational diabetes and their other medical conditions created feelings of *fear* for them and were an important part of their considering action to manage the threat to themselves and their babies. For some, *fear* motivated actions also included determining whether to engage in learning encounters with nurses. For example, in our conversation, Tricia reflected on her *fear* of having to give birth to a large baby and Heather *feared* giving herself insulin. Suzanne *feared* she would be judged negatively by her nurse-teachers and other prenatal care team members.

Heidegger (1962) describes *fear* as a *mood* that discloses a person's *thrownness* and attunement to *possibilities* of harm or something frightening that may become alarm, horror, or terror:

> Fearing, as a slumbering possibility of Being-in-the-world is a state-of-mind (we call this possibility 'fearfulness' which has already disclosed the world, in that out of it something like the fearsome may come close. The

> potentiality for coming close is itself freed by the essential existential spatiality of Being-in-the-world (Heidegger, 1962, p. 180).

Heather's response to the need to use insulin is a strong example of how fear towards something "bewilders us and makes us 'lose our heads' (Heidegger, 1962, p. 181). She had so embraced the teaching she had received regarding the nutritional requisites that would help control the level of her blood sugars. But, the thought of giving herself insulin resulted, initially, in a very negative and reactive, "*no way am I doing that"*, response. Heather, however, is also a very good example of how *fear towards something* can be overcome through the fearful person's acquisition of knowledge and understanding of how to manage the threat. The calming effect of a nurse and coming to an understanding that insulin actually afforded more flexibility in her life in relation to managing her blood sugars changed Heather's very negative and fearful view. Rather than something to be feared, it became a positive tool in her life. Heather's response reflects her new *understanding* of insulin as it pertains to future *possibilities* of positively managing her gestational diabetes. When Suzanne realized that her nurses' understanding of how to manage her diabetes was logical or similar to her own understanding, her fear of repeating past sufferings were allayed. Suzanne felt connected with them in their approach to the management of her diabetes. As with Tricia's fear of giving birth to a large baby, *fearing-about-something* can be equated with being-afraid-for-oneself. While her bodily interactions with her fetus indicated that her baby may be large, she sought to understand the true threat through objective knowledge gained through an ultrasound examination.

Heidegger (1962) also differentiates “fear about something” from “fear about *Others”* (p.181). Fear about *Others* may not necessarily be frightening, but rather may be represented by concern or caring for the welfare or loss of an *Other*. Heidegger (1978) refers to this as *fearing for them* as described in the following quote:

> Here what one is apprehensive about is one Being-with with the Other, who might be torn away from one. That which is fearsome is not aimed directly at him who fears with someone else. Fearing-about is therefore not a weaker form of being-afraid. Here the issue is one of existential modes, not of degrees of ‘feeling-tones. Fearing-about does not lose its specific genuineness even if it is not ‘really afraid' (p.181).

Laura and Paula represent *fear about Others* through their concern regarding the possible negative effects their health issues would have on their unborn babies. Laura worried about the potential negative physical effects of her cancer interventions on her unborn baby while, for Paula, it was safeguarding her baby's health from a premature birth. Fear for these two expectant mothers did not arise from any specific threat to their *Self*, but rather the possibilities that their babies would perhaps encounter. A large part of their adherence to their diabetes care routines and their embracement of learning about diabetes was prompted by the concern they had regarding their perceived threat to health of their unborn babies.

In summary, the women participating in this study experienced different influences that governed how they would embrace the information given them

about GDM by nurses and other care providers. Emotions such as fear and guilt permeated their experiences, influenced by the *possibilities* presented by their new worlds. Decisions were directed by the participants' determinations of the consequences or *possibilities* of adhering or not adhering to the information and recommendations given to them. This affected their ability or willingness to embrace the routines and procedures taught to them by their nurses and other care providers. All of this became the lens through which they determined their connectedness with *Others* in relation to learning to manage their diabetes.

The Discovery of Connectedness

When we see ourselves
as but a mere, yet mandatory, speck
traversing the conduit called time
we appreciate the necessity and beauty of destiny.
We begin to comprehend
the need for purpose and direction.
Uniquely created, we each somehow complete
the montage of the universe.
Such awareness can, ...perhaps, entice us
to dance more rhythmically,
whether to the symphonic melody of Opera,
the syncopated rhythm of Jazz
or the pulse-driven beat of Hip-hop
To dance is the thing!
Ever learning new steps--
ever bending, stretching, reaching
at once forward, but also embracing
the offerings of ancestors,
valuing each signature-driven step
dancing toward the discovery of connectedness
required to complete the masterpiece.

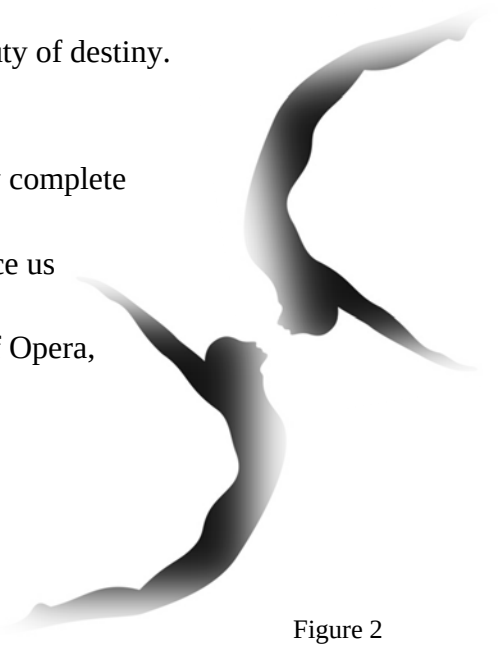

Figure 2

(Matthews Alford, 2007)

Chapter Six

Becoming We*:* Needing Creates Something Special

> When a human being turns to another as another, as a particular and specific person to be addressed, and tries to communicate with him through language or silence, something takes place between them which is not found elsewhere in nature. Buber called this meeting between men the sphere of the between.
>
> (Martin Buber, 1970, p. 72)

In the previous two chapters, the experiences of the participants in this study were explored from the perspective of how the diagnosis of gestational diabetes mellitus (GDM) changed their *worlds* and how they determined what was *significant* for them to learn about gestational diabetes. They shared the meaning that a diagnosis of gestational diabetes held for them in their lives and how they came to make some of the decisions related to gathering the information they needed to manage their health issues. Their understanding of what they needed to learn to manage their gestational diabetes mellitus appeared to influence their consideration of next steps in their lives, reflecting their *authentic selves.* They identified that they were concerned about the *possibilities* that the diagnosis of GDM held for them and their unborn babies and would take actions consistent with their *understanding* of what was *significant* to them. This included the consideration of engaging in learning relationships with nurses and other prenatal care team members. In this chapter, I explore the relational space that developed between the participants and nurses during these learning encounters in an attempt to gain a better understanding about the relational connectedness between them as well as what occurred within their encounters that influenced the participants connectedness with the nurse as *Other*.

Heidegger (1978) views *being-in-the-world* as indistinguishable from *being-with-others*. The world in which *Dasein* is *thrown* also has *Others* in it. The existence of *Others* is imperative to *Dasein's facticity of Being-there.* He stipulates that the difference between the *Self* and the *Other* is not nearly as important as the fact that they are *here (Da) with us in* what seems to be the sense of *here besides us* (Olesh, 2008).

Learning encounters, for the participants in this study, occurred in a variety of environments and contexts for the participants in this study. The women recounted formal teaching moments in which the nurses had a direct role in facilitating their competencies in managing the tools and methods for controlling the effect of GDM in their pregnancy. They also shared mentoring moments with their nurses, informal conversations at their prenatal appointments and sessions on the phone when nurses were assisting with problem solving and facilitating the decisions the women were trying to make regarding their diabetes care and interventions.

Buber (1993) emphasizes that relationship exists in the form of dialogue. With true dialogue, persons are present to each other as attentive and aware. Sidorkin (1992) describes the concept of an open ontological dialogue as placing "dialogical relation in the centre of human existence" (p.10). Sidorkin contrasts this with the non-ontological concept of dialogue for which dialogue is really communication with a "means towards some other goal" (p.12). Throughout our conversations, participants had the most difficulty describing this relational aspect of true dialogue and often referred to this aspect of *being- with* as being *cared-for*

by the nurse. An ontological intimacy appeared to occur in these circumstances in which the nurse-teacher moved from the *They* within the participant's world to that of a close communal consort, which I refer to as being *We.* In the following sections, the relational aspects of the learning encounters of the participants are explored from the perspective of influencing the journey to *Becoming We.*

Meaningful Presence

> *I know if my sugars were seventeen today, I would likely call a nurse. That she'll help me or if she can't she knows someone who can for me. So I guess you develop relationships with someone when they're needed and when they're available. You know, if you need them then that creates something special.* (Laura, participant)

From Heidegger's (1978) perspective, a relationship between two or more people is based on something that all within the relationship *care* about or share a perception of its significance. Some of the participants in this study revealed that connectedness with the *Other* was indeed influenced by the perceived *significance* of the role nurses and other care providers played in their lives in relation to the health issues they were facing.

When compared to her life-threatening diagnosis of cancer, GDM was not as significant to Laura in relation to the degree of risk or threat it presented to her. She expressed ambivalence towards engaging or maintaining a relationship with the nurses who were involved in her gestational diabetes teaching and care. Had GDM been more of an overriding concern or uncertainty, she would have engaged with the team differently. Complexity of the learning need, particularly if it required more frequent contact with the nurse, would have intensified the nature of the relational connection for Laura.

> *I think that the whole thing for me is that the diabetes became a back seat issue because it was almost a non-issue as long as I was eating the right things and I was ok. But I was a little bit nervous if it did [become more of an issue]. Like what was that next step going to be? And I would have needed somebody to help me with that. I hate needles, first of all. So there would have had to be some things that I would have needed to overcome. So I would have needed somebody to help me with that. The relationship would have more significant. If it was somebody that I was going to have to see for a second time or third time, then it becomes more of a priority for me too, right?*

Like Laura, Tricia also weighed the meaning of the presence of nurses by her perceived needs for learning. She needed to control her high blood sugars through her diet. This brought her into contact with a dietitian who filled her in "on some things" she didn't know. Her need for engaging in a relationship with nurses and other care team members, however, appeared to be limited. She used them as she thought she needed them, but any relational connection with any care provider appeared to remain minimal, reflecting the isolated independence from others that she appeared to experience in her life as a whole.

> *I don't think there is a lot of contribution from nurses. I only saw the dietitian once so far and then left to manage things myself for most of the things. Like, the doctors sometimes ask [me to do]. [But] my little chart is what they look at. I feel like the little yellow book was really helpful and her [the dietitian] talking to me [about taking] the sips of juice during the day, pick at things through the day. But most of the things are reading for me. The little yellow book they gave me was good.*

Relational connectedness for some of the participants was also influenced by opportunities for personal encounters with their nurse teachers. Heather described how the personal interaction with one nurse fostered a special closeness that she did not seem to experience with others. This divided the nurses, from a relational perspective, into those who became part of Heather's circle of *We* and those that remained in the realm of *They* in her *world*.

I like talking with the nurse...I have been dealing with one nurse though most of it. And when she is not here, I get someone else. But I don't really know the other. I've not really met them. So it is not the same. Like they are really good when I phone and talk to them. They listen, but, I don't know. I feel more comfortable with the nurse I always talk with. But I have never met the others. You know what I mean? Cause when I am here, the one nurse is here. There is definitely a comfort level. I've been with her from the beginning of it. Like the other nurses, I have never met them – spoke to them on the phone twice. But, I mean I call every week, so usually it is the same person."

Laura also experienced frequent, personal contact with nurses and other prenatal care team members. But her experience was quite different from that of Heather. Her combination of being pregnant, having cancer and gestational diabetes brought her into contact with many people. For Laura, however, some individuals that were part of her care could not be distinguished among a sea of faces:

For me it was a little bit different. For me, I have so many [people]*. I am lucky to have so many people around me at the hospital. I see so many people it's hard to even remember all the details of that conversation. I was in here, over month and a half,* [for] *two to three times a week. I think I have met nine different OB's* [obstetricians] *of the 10 or 12 that are here. So many different people that it is even hard to think back now. Did I have a connection? How did that conversation go? It's like a drop in the bucket. Honestly, that's what's hard. Every time I left here, I've always felt that everyone genuinely cares. Like everyone, the doctors, the nurses, you know, the technicians, like anybody I have ever seen. Everybody really does truly care about both of us. But specifically I can't really recall.*

When asked what seemed to influence her remembering some people over others, she reflected,

It's like there are people who I see over and over again. Certain people I see over and over again - like my obstetrician and the nurse in the ultrasound department. There's a real connection. You know, I get lots of hugs when I come here. With the other 25 people that I have met in the hospital, there are 10 that I know pretty well and there are 25 that I kind of know.

Prenatal care remained an important aspect of Laura's life, even when the threat of her gestational diabetes became minimal. Those care providers who remained relevant as part of this need in her life stood apart from the sea of faces that made up her care team. Getting to know individuals through physical presence appeared important to the strengthening of the relational connectedness between herself and these significant *Others.*

Learning experiences also occurred in-group sessions where several pregnant women with gestational diabetes were taught the basic principles and techniques for managing their illness. The presence of the other learners was helpful to both Suzanne and Paula in acquiring the necessary skills for independence. A peer learner helped Suzanne feel more normal and included in the world of diabetes and pregnancy. Her presence in the learning sessions helped to decrease the guilt and stigma that she felt because of her gestational diabetes.

> *This pregnancy, there was another girl with me and they did it [teaching] in two's. That was good. I didn't mind that. It made me feel like I wasn't the only person. To have somebody else kind of made me feel like it happens to more than just me.*

For Paula, learning with another person was also helpful because it beckoned to her natural competitiveness.

> *I was orientated with another lady that I had never met. It kind of helped me. I didn't wimp out giving myself that first needle, my practice needle because she was there. I'm a competitive person so she wasn't going to beat me giving herself a needle (laughs softly). She was a stranger. I had never met her before.*

When asked how important the presence of the nurse was in this learning experience, Paula stated,

It was a learning environment. It was a comfortable environment that the nurse allowed us to be in. She helped us.

Tricia also had opportunity for personal encounters with nurses and others during her prenatal appointments. During an early point in our interview, I attempted to explore the kind and quality of the relationships she had with nurses as a result of these encounters. It was a struggle for her to identify the people she encountered during her prenatal appointments. Her tone of voice was flat and her speech halting as she tried to recall the various care providers she came across during her appointments.

So far it seems like they have a lot of different people for different supports. Like they've got me talking to a dietitian and they got me talking to their social workers. Um, the nurses? (…5 secs…) *The people who come in to talk to you before the doctor comes in?*

I responded, straining to try to give her a clue that would help her identify the presence of a nurse, "they do your blood pressure".

Tricia continued,

Yeah, they seem to be [supportive]...(5 secs)... *I didn't know if they were students or what they were. At first, there was a guy. That was a student?*

I responded again by nodding, confirming that I thought that person could likely be a student. Tricia continued, looking more directly at me now,

And then the female – likely would have come in before the social worker. Yeah, I never know what they are. I think there was a guy who was a nurse, or a student. And then another student (Her voice drifts off as she drops her gaze towards the floor).

The sense of personal distance, of being alone and lacking distinctness in Tricia's relational world as a pregnant woman with gestational diabetes appears congruent with her experience of limited and unsatisfying relationships in her life generally. Although physically present and sharing space with Others, she refers to all her care providers in the third person, appearing distant and lacking concern for them. The experiences of Suzanne, Paula and Tricia can be understood through Heidegger's (1978) notion of space and his concepts of near and far being understood from the aspect of concern or significance of the other. As I reflect on Tricia's consistency in experiences, a question arises for me. Does the quality of past and current relationships in other aspects of the woman's world influence the ease with which nurses and other care providers take on a meaningful presence in a woman's world concerning learning relationships? How does one overcome a person's disposition to remain as a stranger and become as We in learning encounters?

Being Cared-for by the *Other*

All of the participants learned about the facts of their diabetes, how to detect the presence of high blood sugars, determine carbohydrates and sugars in their diet and how, in some circumstances, to give themselves insulin. Much of this learning or acquisition of knowledge occurred within relationships that did not always connect in the true sense of relational dialogue in which persons are truly present to each other (Buber, 1993). Relationships in which the patient-learner and nurse-teacher connected with a sense of reciprocity and mutuality were successful in enhancing confidence in and facilitated problem solving with

the participants' self-management of gestational diabetes into their lives. It was these learning relationships that all the participants described as *caring*.

Education philosopher Nel Noddings has explored caring encounters within an educational context. She views "receptive attention" as an essential characteristic of a caring learning encounter. The carer is open to what the cared-for is saying and might be experiencing and is able to reflect upon it. The carer is motivated towards the learner or cared-for in ways that are helpful. The final step in this interaction is that the cared-for perceives that caring has occurred. Therefore, according to Noddings, caring involves reciprocity between the carer and the cared-for. The "carer" or caring person "is one who fairly regularly establishes caring relations and, when appropriate maintains them over time" (Noddings, 2002, p. 11).

In this study, participants experienced actions on the part of nurses that relayed a message of being *cared about*. Characteristics of some of these relationships were friend-like and included relational qualities such as being understood from the context of their *worlds*, being accepted as an individual in relation to their experiences of learning, being trusted and being valued or *significant* to their nurse teachers. Relational connectedness also occurred in experiences in which their relationships were team-like and enlightening in terms of their ability to master the skills needed for independence. All of these characteristics served to build confidence and positively influence self-efficacy in the participants in relation gaining independence in the control and management of their gestational diabetes mellitus. Following are exemplars of what was

important to the participants in their learning encounters in order to feel *cared-for* by nurses and their other prenatal care team members.

Understanding the whole picture. For many of the participants, it was important that the nurse and other prenatal care providers were understanding of the meaning of being a pregnant woman diagnosed with gestational diabetes for them and empathetic towards their *significant* concerns and challenges. All actions perceived as understanding had empathetic characteristics with the nurse–teacher focused on understanding of the needs and experience of the patient-learner. Nussbaum (2001) describes true empathy as being closely connected to compassion in that the focus always is towards the *Other* and not towards only the *Self.* According to Nussbaum (2001), empathy, without its close alignment with compassion may result in a person perhaps understanding that the *Other* is in a bad predicament or in need of something but carries no particular feelings or emotion towards them.

As described in previous chapters, Suzanne was fearful of being judged as a bad mother because nurses would not see beyond her being obese and therefore would not understand the issues and challenges she was facing in her life. She yearned to be accepted like any other pregnant woman who had a health complication. While she had several examples of interactions with nurses in which she felt the pain of stigma and lack of empathy, she also was able to recount an experience in which she felt the nurse connected and understood her lived experience. The nurse had diabetes herself and seemed to relate to the

challenges faced by Suzanne. A small act of advocacy tinged with an aura of compassion immediately engaged Suzanne in the relationship.

> *The nurse that worked with me, she had diabetes, but it wasn't gestational diabetes. It was regular diabetes. Like Type 2, I think. Anyway, she knew all about it. So she was very helpful. Very understanding. There was one time I have trouble getting my strips. My medical plan covered it, but it was complicated. Anyways, I didn't end up getting my strips. But she gave enough to tide me over and took care of the problem right away.*

Heather shared that she also had a strong connection with her nurses. She felt they understood her world and the concerns and stresses she was experiencing with her gestational diabetes.

> *So if there is something - your diet. Might not be your diet, could be stress, could be anything. History, family history. So they really look at the big picture. Like when I was having trouble with work. I don't feel safe working [but] they were saying it is too early to go off. And she [the nurse] backed me up 100% with that.*

Paula's perception of understanding by her nurse was also positive. Like Heather and Suzanne, she felt a strong connection to her nurse while she was learning about managing her diabetes. In a similar manner to Suzanne and Tricia, however, it was the nonverbal as well as the verbal that relayed the message of understanding. She felt that a foundation to the nurse's understanding of what she was going through largely related to the fact that "she sees it on a daily basis with other people". But she also felt that the nurse's ability to connect positively through dialogue influenced her feelings of connectedness.

> *I think some people don't have the personality to carry on the conversations, to have the personal. Cause, you know you can read cues from people to have a personal conversation with them or not. And we just connected and she was able to help me through my diabetes, my high blood pressure, realizing I was going to deliver early. 'Cause I had in my head, I was going to lay in that bed and keep him there. And she reassured me*

everything was going to be ok and that goes a long way (laughs lightly*). That hope… (5 secs)…, gives you that resilience to get through stuff".*

It was a different experience for Suzanne when her nursing team in one hospital focused solely on her needs for a diabetic diet and controlled calories because of her obesity, leaving her hungry and unsatisfied. This contrasted with her current hospitalization where there was a variety of choice on the menu for patients with diabetes. Dietitians and nurses were also available to help with the selection of food, which assisted Suzanne in applying the principles for diabetes nutrition more successfully in her life.

I like how they give you choice. I never liked how at the one hospital, you eat what they give you or you starve. You are out of luck. Here you have this choice, this choice, [or] this choice. This is what you can have. Pick one of them. So if you didn't like one of them, then you had a choice.

She described the challenge she sometimes faced in her past when her food was rationed. The resulting anger and rebellion towards the nursing team created a disconnection that interfered with her reaching out for assistance when she didn't have the knowledge to make choices in her diet.

Then, I'm thinking, I'm pregnant. I'm eating for two. I would beg people to bring me snacks. Then my mom brought me a low fat blueberry muffin thinking that was great. But the carbohydrates in it are high. But we didn't know. We thought it was low fat and that was good.

I asked if there were any repercussions from her nursing team as a result of her eating the muffin. She responded with an angry edge to the tone of her voice,

No because I didn't tell anybody. It was there. I just didn't [tell them]. I just found it hard in [that hospital]. Just because of the fact, going that long with your stomach growling. And if you didn't like what they sent you, then you ate nothing for supper and you still had to go the whole night without food.

Tricia also often felt less of a connection with her nurses and healthcare team. She struggled, generally, in her relationships with others and often perceived herself as being devalued as a person and alone in the world with her life problems. While some of her encounters with individual nurses and other care team members were characterized by understanding of her issues in life, she also had times where she felt the nurse was not understanding of her concerns. She shared an experience that she had during her prenatal appointment on the day of our interview.

> *Today I felt a little bit of a less understanding when I talked to her [the nurse]. Like, other people seem to understand how busy I am. Like, it's the people's facial expression or tone of voice or something. Like, it wasn't anything she said that was any different than someone else has said. She seemed a little bit less of a woman to accept your busyness. More of "I don't care what's going on; you have to do this. You know, you really have to care about this more*.

For some of the participants, like Tricia, perceptions of being cared-for about by the *Other* arose from verbal interactions with their nurses as well as their observations of the nurses' actions, facial expressions and episodes of silence. This embodied understanding of the *Other* perhaps best reflects the thought that "our basic understanding of things depends on a relational grasp of the world that is not simply reducible to our possession of language" (Owens, 2011, p.4). Merleau-Ponty expands on this thought, by stating that "existence realizes itself in the body" (Merleau-Ponty, 2005, p. 192). Owens (2011) elaborates,

> Language becomes but a *species* of gesture rooted in our bodily comportment and perception of the world. Language is a fundamental possibility opened up by our bodily mode of understanding the world (p.6).

Learning about what works for me. Much of the work related to integrating what they learned about gestational diabetes into their lives involved problem solving on the part of the participants or moving into a through an unready-to-hand mode of engagement towards a more comfortable, less anxiety-provoking state of existence. . They needed to learn new techniques and strategies to maintaining blood sugar control across the hours of every day of their lives. This was often complicated by other health issues they were experiencing. Periods of discouragement and fear appeared as they embarked on the journey to competence and confidence. Nurses who stopped to reflect and learn about what was *significant* to the learners fostered successful individualized approaches to their teaching endeavours. This empowering dialogue encouraged the participants in appreciating their ability to attain independence. Empowering dialogue is responsive to the learner and considered foundational to successful adult education. The main task of adult education goes beyond merely having knowledge to that of having learners become enlightened to believe in themselves as well as having knowledge (Friere, 1993).

Paula had struggled to maintain control and independence in her life during her health challenges in pregnancy. She appreciated the nurses who fostered her learning in a style conducive to her maintaining independence while she was learning to give herself insulin.

> *Well they didn't really beat around the bush about anything. They just kind of said, "you got to get your sugars down because that would make a big baby. And we don't want big babies because, for one, it's harder to do it naturally and it's harder on them". They were just really informative. They were just upfront. And it was helpful because they would ask how my sugars were and if they were a little higher they would help me know if I*

should maybe adjust different in the morning, at lunch or at supper. Or, you know, encourage [me] because I was doing well, keep doing what I was doing. Just kept reassuring me that it was going to be gone, a high percentage of it is gone once you give birth.

When asked why this approach was so helpful, she responded,

I didn't know how to do it. I needed them to be matter-of-fact in order to learn how to do it. I had no idea what to do. They did it in a proper manner. They weren't overbearing. They taught along the way. Said this is how you have to do it and this is for the benefit of your baby's health and your health. I felt like it was teamwork. I didn't feel like I had options because I didn't really know what I was doing. Options were to give myself the needle. They were my coach and I was the player. They coached me with how to give myself the needles. Made it suitable towards me and still keeping it in the guidelines of the diet and knowing when to up and to lower my insulin with the sugars were too high or too low. Not do it, <u>try it</u>. <u>Try it this way</u> and if it doesn't work see if you can figure out something that works for you. I never felt like was told this is how it is and this is step one, two and three and if you don't do it that way, it's not going to work. I never felt that way.

Suzanne also appreciated the teaching style of nurses that was more collegial, direct and consistent with what she knew about GDM.

The more they told me about, the more I found out. That was the important part. Finding out the information. I am a very talkative person and like to ask questions. Any question was answered. And, I knew what they were talking about. And you didn't get four different stories from four different people. It was all the same. And it was stuff that made sense.

I asked Suzanne what made a nurse stand out during her learning to manage gestational diabetes mellitus. She related the following experience with a nurse-teacher who also had diabetes:

I was having trouble sometimes pricking my finger. I only had to do it once a day. She had to do it four times a day. And so she was telling me about her circumstances. Then she gave me some pointers, like keeping my [blood testing meter] in my purse and taking it with me on the go. And keeping snacks in my purse for situations. She always would question me whenever I would go in. She would ask how I was doing, what were my numbers. Very, very positive. I really liked her. She was sweet (laughs softly).

Heather also shared positive aspects of her learning encounters with nurses. For her it was their attention to all aspects of her health needs and experiences that were important to her, not just the need for her to become competent in treatment modalities.

> *The nurses here, if I have any questions, they are really good. They're good listeners. They really pay attention to the big picture. Not just your sugars. Everything that can go on with your sugars, stress, like you're outside life. They're more about the whole. They want you to understand. The whole, the sugar, the diabetes. They don't just treat you and you don't know what you are getting treated for. They do explain everything for you so you know exactly. If you look confused, they will ask you, they are good at reading you.*

Laura initially had concerns about becoming independent in the management of her gestational diabetes. The nurse was able to put her at ease, reassuring her and making her comfortable with the plan they had put in place.

> *I had some teaching as far as testing things. And I obviously never used those tools before. And she [the nurse] came in and had a good chat with me. Just about, don't be overwhelmed with it. You know, the main thing is just to keep yourself balanced with it. I actually talked over some of my concerns with it. Like, you know you have it and you read a little bit about it. And one of the things said is that babies can be quite large. And I was quite concerned about that. And she* [the nurse] *was good. Very reassuring about it. It's not always the case. It's usually when it's out of control. That causes that. So if you can control it with your diet, that's not going to be an issue. So that was reassuring. So she was good, she taught me, made me feel comfortable. Gave me everything I needed to go home with.*

When asked if it why it is important for a nurse to personally facilitate the learning situations as opposed to other media for learning, Paula spoke to the importance of opportunities for dialogue with her nurse-teachers.

> *It is different when a nurse tells you. Because when a nurse sits down and tells you about it, you have a conversation. I don't know. I just found easier to talk to someone that it is to read about it. When you read you might miss something or read over it quick, you know. And that would be the end of it. I found when we were having a discussion about it, it was different*

Being trusted. All of the women participating in the study faced some challenges in attaining independence and the necessary competence to manage their new lifestyles around their diabetes care needs. Like Paula, some women appreciated having some structure and information as they learned to manage their diabetic routines. However, the more positive, connected relationships were those in which the pregnant woman also felt some degree of trust the learner and felt that their nurses granted them autonomy when managing their life skills related to GDM.

While Suzanne did feel that she had positive relational experiences in her current pregnancy, she described past learning experiences that were laden with paternalistic, disempowering interactions with nurses. She was in the hospital and at home during her current and past pregnancy experiences with gestational diabetes mellitus. She found the two environments and nursing teams presented different challenges and opportunities for emancipation in managing her gestational diabetes. She described the difference between the three environments in which she experienced the care and management of GDM.

> *"At home you can get away with skipping a snack here and there but here [hospital] you can't. They are always asking - did you have your snack, what do you want for your snack? Therefore, I found that was a big difference. When you are in the hospital, you have to do it. When you're sent home, you still have to do it, because you want is best for your baby. It is still different to be in the hospital, even without the nurses asking you. But it is easy to slip up [at home]. It's easy and there is nobody telling you."*

Being a patient in the prenatal outpatient clinics meant that Suzanne would still have nurses checking by telephone on her blood sugar levels. I asked her if this relationship was as constraining as being in hospital.

"It is still different being in the hospital than it is, even with the [prenatal clinic] nurses asking you. In the hospital you don't have any choice. Well, you either follow what they say or you don't eat (laughs heartily). No, because [in the hospital] you call up on the phone. And if I want to go over my carbs, then they will say, "You can't have that. It has too many carbs". Whereas, at home, you can get away with eating pizza. The difference is at home, you <u>can</u> go over your carbs a little bit."

Suzanne went on to share some of her past encounters with nurses in learning to manage her diabetes and how they differed with her present experiences. During her current experience, the nurses would just check on what her sugars were. In her previous learning relationships, the nurses would physically do her finger prick for her to determine what her blood sugars were. She shared that this act of doing for her was most disconcerting and relayed feelings of mistrust that she could to the procedure on her own. Inherent in the discordance in the relationships was the sense of weighted power and control on behalf of the nurses. Despite the stress and negative emotions she was experiencing, Suzanne kept her feelings of needing independence quelled in response to her stronger need to comply because of her pregnancy and the needs of her unborn baby.

When you're pregnant, you just tell yourself it is for the baby. If I wasn't pregnant that would make me feel that was something that I could do myself [testing her blood sugars]. *That they didn't believe me, you know. Like a mother and child instead of a grown adult. That's a big one. Because, I don't know, it just makes you feel... (5 secs) … She looked down at the floor and then back into my eyes). Why would you lie about things?*

I asked her to describe how her present experience was different.

While if a nurse was in the room and she asked if I had gotten my sugars yet and I would say 'no I didn't. Then she may say something like, "why don't you do it now and I will go do [my] urine sample or something". They would come back and it would beep and I would show them what it was and we would go from there. But there was times when the nurse wasn't in my

room and I would just do it myself. Then they would just ask me what my number was and that was fine too. It didn't take - this may sound strange- but it didn't take all your independence away. Made you feel like you could still do something. They didn't have to do everything for you.

Feeling valued. The importance of availability on the part of the nurse, as a physical presence, was described earlier in the section, 'Meaningful Presence'. Availability, from the context of nurses being inclusive and open to the participants from a relational aspect, was also an important characteristic influencing the degree of intimacy or connectedness. Suzanne described the difference between nurses that were open, warm and connected with her and those that remained more aloof and disengaged.

Well, they were nice. It's not that they were ignorant or mean. It's just they just weren't as welcoming.

For Laura it meant having "people that I know I can talk to" and who offered accessibility through offers like "call me or e-mail me any time". When asked what was special about the nurses in her experience that led her to feel they were helpful to her learning to manage her very complex life, she softly explained,

They are there beside you, taking care of you, making sure you are comfortable and you understand. I've always had an image of nurses as the ones who are actually there with you, going through it. Whereas, doctors are kind of the ones who come in and give you the diagnosis and the nurses are sort of there beside you, helping you through. So I think for me it's kind of hard where I have dealt with a lot of different nurses at this point. I feel like, not so much for diabetes, but when it comes to you know, just being prepared for the baby. Like knowing you can pick up the phone and say is it ok if I have this drug or is it ok if I have that. That's like a huge thing for me. Like a huge support ... (10 secs. She starts to cry). Sorry. It's been like a big support for [my husband] and I. Just knowing that when we had questions we had a number. So that, I think, you know it's hard to separate all these different things (wipes tears from her face and laughs lightly). Sorry.

Taking time to compose herself, Laura continued,

> *And when you worried and when you've got so many things going on knowing that you can just pick up the phone and know that someone will be at the other end with probably an answer. That is a huge thing - emotionally and mentally. It's like just knowing that you're there. Just knowing that I don't have to call and leave messages and [wonder] - will somebody call me back and will it be tomorrow and do I just sit around and wait for someone to call me back? Sit around all day, and worrying. You know, I've had lots to think about and lots of questions that I need to ask. Just be able to ask somebody willing to answer.*

Paula described characteristics of one nurse who was with her during her hospital experience who she thought of as caring. To Paula, this nurse was "awesome" in relation to teaching her about giving herself insulin and managing her diabetes at home. The nurse's attitude towards her gave her hope that all would be okay. Paula was quite engaged in this relationship with her nurse who was helping her manage unstable diabetes. She shared what was special about their connectedness to her learning. When asked how this characteristic influenced her learning experience, Paula stated with great energy in her voice,

> *Every time she came to the room, she would ask how I was doing and she would stay there and talk. Just give me more information if I had questions. She never turned her back and said I don't have time for you, I've got to go look at somebody else. She always would do what she could.*

I asked Paula if that translated into the nurse caring about her. She answered,

> *Yeah, and the baby. She made me understand it [GDM] and understand that there was a light at the end of the tunnel.*

Suzanne also supported that positively connected relations between nurses and patients helped the nurses develop a better understanding of the *world* of the patient. This, in turn, aids the nurse in providing positive, individualized

mentoring and educational support. Suzanne's diverse *past* and *present* prenatal experiences provided her with this insight.

> *Not all nurses like to share – some don't even want to be talked to. Caring nurses want you to understand. The whole – the sugar, the diabetes. Don't just treat but explain. [They] pick up cues if you look confused.*

I asked Suzanne about the effect of different types of encounters she had during her learning relationships - the relationships where she felt judged and unaccepted and those in which she felt heard and understood. She remarked, with a strong emphasis in her voice on some words.

> *I think it is very <u>significant</u> - relationships, I mean, if you are not gonna <u>trust</u> your nurse, you're not going to tell her anything. And if you <u>trust her</u>, you will <u>tell her stuff</u>. And the more that you tell her the more they're helpful in finding solutions to problems and that kind of thing.*

Nel Nodding (2005) writes that in truly caring relations or encounters, there is a reciprocal action on behalf of the *cared-for:*

> The cared-for recognizes the caring and responds in some detectable manner. An infant smiles and wriggles in response to it mother's care giving. A student may acknowledge her teacher's caring directly, with verbal gratitude, or simply pursue her own project more confidently. The receptive teacher can see that her caring has been received by monitoring her students' responses. Without an affirmative response from the cared-for, we cannot call an encounter or relation caring (para, 6).

In summary, positive learning experiences were entwined with caring actions on behalf of the nurses. The giving of information was not necessarily an essential part of the nurse-teaching role for the women in this study. It appeared more important that the nurse put together "the whole picture" of what the woman was experiencing - how she came to understand the individual experience of the learner. This facilitated the exploration and incorporation of needed actions to

control diabetes in the women's lives. In positive, empowering encounters, the women perceived the nurse, as *Other*, as displaying caring behaviours. Perceptions of being cared-for arose from an embodied understanding of the *Other's* actions. It was not only what the nurse said in the learning conversations or dialogue but also how she acted and appeared.

Some experiences reflected these positive attributes of being *cared-for* in their relational experiences. Others were unfortunate representations of what can happen when attributes foundational to relational connectedness were missing. In the following chapter, I extend this search for understanding the relational nature of these learning experiences by exploring the women's expectations for caring and facilitative pedagogic relationships.

Tape for the Turn of the Year

don’t establish the
boundaries
first
the squares, triangles
boxes
of preconceived
possibility
and then pour
life into them, trimming
off left-over edges,
ending potential;
let centers proliferate
from self-justifying motions!
the box can’t bend
without breaking:
but the centre-arising
form
adapts, tests the
peripheries, draws in.
finds a new factor,
utilizes a new method,
gains a new foothold.
responds to an inner & outer
change:

(Ammons,1965, p. 116)

Figure 3

Meeting Expectations and Reconciling Differences

"Truth is not born nor is it to be found inside the head of an individual person. It is born *between people* collectively searching for truth, in the process of their dialogic interaction"

(Bakhtin, 1984, p. 10)

In the last chapter, I explored the influences on the quality of the relational connectedness between the participants and their nurses during their learning encounters . Participants often related experiences in which the caring actions of their nurse-teachers set the foundation for a close relational connectedness or ontological intimacy that facilitated their learning experiences. In addition, they revealed that not all of their experiences with nurses and other care providers met their expectations caring and facilitative behaviour. As a result, strong negative emotions carried forward into their new learning relationships. Despite this, some of the participants did appear to move beyond the negativity and mistrust that they harboured from the past to a place of acceptance and trust within their current new relationships. In this chapter, the women's experiences of having their expectations met and the resulting influence on their learning relationships will be explored through Heideggerian lenses - the concepts of *authenticity, mood* and *modes of existing.*

From Heidegger's perspective, a person's *understanding* of the *authentic* way of *being* is set within the context of *past* experiences and relationships with the *They* (Braman, 2008; Conroy & Dobson, 2005; Heidegger, 1962). While the focus of this study was to explore the relational interactions between the participants and nurses during their learning encounters, it became very apparent

during the conversations that there were other voices involved in the learning interactions involving gestational diabetes. These voices included family, other care team members, other patients who were learning to manage their diabetes as well as members of their community and society. Some were *present* and *significant* and some were voices from the *past.* For some of the participants, the influence of the *Other* was positive and the relational learning experiences with the nurses and other care providers were harmonious. In other experiences, discord arose within their relational experiences when the *Other* failed to enact the expected behaviour or response. There were also experiences in which there appeared to be a mix of harmony and discord. This often arose in experiences where the present learning relationship was harmonious but there were unresolved negative emotions arising from past unmet expectations or current discordant relationships with *Others.*

Expectations, according to Macmurray (1961), constitute that which is imagined and therefore demanded of the *Other*. If what occurs is different from what is expected, the result is a contrast between what is imagined and what is occurring in reality. This is perceived as a "contradiction of his own [Self] will and the will of the Other; between what he intends that the Other should do and what the Other intends and does" (Macmurray, 1961, p.97).

To move forward in relationships, it is necessary for the *Self* to overcome the negative emotion that occurs from unmet expectations. From Macmurray's perspective, *forbearance* and *forgiveness* are necessary for positive personal relationships:

> Since the You and I relation constitutes both the You and I persons, the relation to the You is necessary for my personal existence. If, through fear of the You, I reject this relation, I frustrate my own being. It follows that hatred cannot, as a motive of action, be universalized. It presupposes both love and fear, and if it could be total, it would destroy the possibility of personal existence (p. 75).

Derrida (2001) views forgiveness as given in response to a significant transgression or wrong. One moves to forgiveness when an *Other* has caused *significant* suffering or pain. From Derrida's (2001) perspective, "genuine forgiveness must engage two singularities: the guilty and the victim" (Derrida, 2001, p. 42). When expectations for authentic responses on behalf of nurses and other care providers were not met for the participants in this study, their voices changed in tone and were often tinged with angry overtones. Their bodies often became tenser. Their conversation became focused and distinct in an apparent effort to relay the *significance* of their message that a perceived wrong was done on behalf of or to the *Other*. There were also conversations in which participants appeared to minimize or rationalize any shortcomings in meeting expectations by their nurses and caregivers. They would justify actions with logic, maintaining that the other person was naïve or innocent in relation to perceived transgressions.

Reconciliation is defined as a "state of acquiescence with or acceptance of a situation" (Oxford English Dictionary, 2011). For some participants, their abilities to reconcile differences and transgressions in expectations led to relational outcomes that appeared harmonious and or barriers to entering the

space of *We* were lessened for the *Oth*er. For others, there always remained an underlying current of discord that carried potential for becoming a significant presence given the right milieu of persons and events. And still for others, reconciliation reflected an acceptance of a situation that did not fulfill their *authentic* understanding of action or behaviour on the part of an *Other* but they settled for a lowered bar of acceptance.

Conroy and Dobson's (2005) exploration of the relationship of *mood* and *narrative* with *authenticity* is helpful in understanding the interrelationships between the *mood* and *modes of existing* of the pregnant women as they encounter *Others* in learning experiences. They describe the interrelationship between *mood*, *moods of existing* and *narrative* as an entwinement in which "moods and modes of existing are never obvious but, rather, found in a subtle entwinement of narrative and mood" (p. 975). Narrative is the "verbal, written or enacted account about events and/or thoughts as perceived by the narrator" (p. 976). The harmony and discord uncovered in the participant's relational experiences in this study reflects Conroy and Dobson's (2005) understanding of the interrelationship between a person's present *mode of existing* and their *mood*:

> If the narrative and the mood match existentially, then the message sent is harmonious or attuned. If there is conflict between the narrative and mood, then the message sent is discordant. Similarly, if there is a correspondence between the message sent and recipient's modes of existing, the reception of the message is either harmonious or not attuned (p. 982).

Conroy and Dobson (2005) also address the presence of counter narratives in which voices in the narrative are polyphonic and indistinctive. When counter narratives become dominant or emerge, they upset the master narrative. The notion of polyphonic voices is helpful to the understanding of counter narratives. Voices are independent but yet have a voice among and with others. Nikulin (2006) further describes the characteristics of polyphony in the context of dialogue- “every voice is unique and is precisely what it is; that is every voice already has its own theme and melodic structure and is thus independent” (p. 48).

The follow sections contain examples of how *mood* and narrative are connected with the different combinations of the *authentic, inauthentic* and *undifferentiated* ways of existing in the world for the study participants and *Others* in their *Worlds*. As described in previous chapters, the concept of authenticity is not an evaluation or an assertion of a quality of moral behaviour from the context of being a good or bad person. Rather, it is coming to an understanding of how a person, "in struggling to find a place in the world, exists in these interdependent modes in their attempt to make sense of the world" (Conroy & Dobson, 2005, p. 979).

From Heidegger’s perspective, the undifferentiated mode is a person’s usual state of being – one in which we exist unreflectively in our everyday world. This mode of existence can be either authentic/undifferentiated or inauthentic/undifferentiated. In the combination of authentic/undifferentiated, one acts authentically in a habitual manner. For example, a person may be lost within everyday routines but still acts in what they determine to be an honest or right and

proper way of being. They may have skills of a graceful, competent practice so well honed that it is only when some situation calls for extra energy and attention that the person becomes aware of any deliberations or intentions needed to address the situation. In the inauthentic/undifferentiated mode, one is lost in a world in which one passively assumes a stance picked up from the public collective or normative way of acting. Conroy & Dobson (2005) refer to the inauthentic/undifferentiated mode as a state of unmindful oblivion or lived meaninglessness. Such a person is not focused on what causes him or her to feel unsettled but tends to 'go with the flow'. A person in this mode of existence settles into everyday routines, content to live with the rules and norms, thereby disburdening oneself of all responsibility for personal action. They are “oblivious to what is significant in their lives and are, therefore, at a standstill in their moral agency” (Conroy & Dobson, 2005, p. 981).

The resulting influence of met or unmet expectations on the integrity of present learning relationships for the participants is explored from the concepts of forgiveness and reconciliation. Within the context of this study, the understanding of *narrative* complies with the article by Conroy and Dobson (2005) and focuses on the predominantly verbal and enacted events that occurred between the participants and those persons *significant* to them in their *worlds*. I, as researcher, exist in the stance of listener, observer, recorder and interpreter of their narratives of their relational dialogue during learning encounters.

Met Expectations as Attuned Priorities

Laura came into her experience of a diagnosis of gestational diabetes mellitus almost at the same time she was diagnosed with cancer. She took the concern about the need to control her high blood sugars seriously until the results from her testing failed to reach the level of risk to her health that her nurses and care team members thought might happen. At the same time, the effect of the chemotherapy medication had also affected her unborn baby's blood cells. As a result, she stopped testing her blood sugars on a regular basis and returned her attention to managing the health concerns arising from her cancer. When asked how her nurses and other care team members responded to her not testing her blood sugar at home, she responded,

> *I've not had an issue at all. Then I think for everybody, it has taken a bit of a back burner too. Like, since we had the scare with the baby being anemic. That became far more important than this. So, for everybody, it's taken a bit of a back seat – being under control*.

Laura's changed perception of what should be the point of attention in her life was congruent with the understanding of what should be *significant* in her learning and care by her nurses and other care providers. This created a "harmonious attunement" of *mood* for both Laura and those engaged in her care and teaching (Conroy and Dobson, 2005, pg. 985).

Heather also came into her present pregnancy having some knowledge and understanding about GDM gained from past prenatal experiences. She understood the risk of having it occur in this pregnancy and took measures to detect it early.

> *I went to my family doctor and I told him to send me for the Trutol test and he said it was too early. And I said I know my sugars are up. So anyway, I went home and dug out my old monitor and started checking my own*

sugars. And I brought it to him and I was like 'here you go, do you believe me now'?

When presented with the evidence that Heather may be experiencing high blood sugars, her doctor did send her for a blood test. The high results brought Heather to the diabetes team for care who expressed that her diabetes was more severe than in past pregnancies.

They got me on insulin this time. They actually think I might be Type 2 where it came out so early. They wouldn't have found it if I didn't find it. So they wouldn't have known how early it was until they did the random test. But they said my doctor should have sent me early anyway because I've had a previous history. But he didn't. So... (…5 sec… Heather's voice trails away)

When I asked what her reaction was in response to her physician's initial lack of action and the subsequent concern on behalf of her diabetes care team, she rationalized his behaviour in a frank, unemotional manner,

I just told him. He's pretty good. Once I told him. I guess [the reason is] he didn't handle my last pregnancy. An obstetrician did. So I guess that was why. It just didn't register with him to think of that. Once I brought it to him and told him [what my sugars were], he sent me for the test.

I remember my response as I listened to Heather related her experience with her physician. I was somewhat appalled at the way he dismissed her initial concern regarding the likely return of her gestational diabetes. To me, it rang of disrespect and uncaring on his part, reflective, perhaps, of an *inauthentic* or *undifferentiated* response. However, it was Heather's expectation that he would follow through with a blood test when she presented actual evidence that her blood sugars were high. By her physician following through as he did, there was *attunement* between Heather's mood and the *narrative* between them. The potential for disharmony in their experience was reconciled through her

justification that he would have had to be involved in her last pregnancy in order to appreciate the risk. This difference in perception between Heather and me of her physician's responses underlines the importance of understanding master narratives from the authentic ways- of-being and *understanding* of the key players. Heather shared with me that he was "pretty good" in relation to being attentive to her. This perhaps reflects the influence of their past experiences together as patient and family physician outside of the experiences of her past pregnancies – experiences unknown to me. As a nurse-teacher it would appear important for me to understand this relationship from Heather's perspective if I was to truly understand the meaning of her experience as a pregnant woman with gestational diabetes, especially from the perspective of understanding *significant Others* in her world.

Discordant Voices in Caring– a Collision of the *Authentic* and *Inauthentic*

Thoughts haunted Paula throughout her pregnancy that her baby's health was put in jeopardy by the possibility that his premature birth was brought about inaction on the part of her healthcare team members. Their lack of response to her blood test results and symptoms of illness failed to meet her expectations of what she should have experienced in this situation. Recalling these past events were emotional moments for Paula. While she described their actions merely as "frustrating' her words and tone of voice reflected significant anger towards the team members. A slight quiver in her voice surfaced occasionally during this part of our conversation, making audible and visible how close to tears she was as she related the meaning of the experience to her.

> *I feel I could have maybe gotten a couple of extra weeks out of my pregnancy that if they would have realized that when I rang in a 10.8 somebody needed to call me. And I understand there is a lot of people and stuff like that, but everybody else's reports come through the same place and results are, you know* (deep sigh). *So, it should have been flagged and it was flagged. But it was put in my file. So* (another deep sigh) *it took me to call them, to figure it out* (…5 secs…) Her voice quivers slightly as she continues). *And* [then they] *say "well just watch your sugars for the weekend . That was <u>their first reaction to it</u>, <u>their answer, their response</u> was* (…5 secs…). *So then, I called my dad, where he's the diabetic. And he has no idea. He thought he knew, but he didn't.*

In another part of my conversation with her, Paula indicated that she did not deal well with uncertainty and feelings of a lack of control over events in her life. When encountering her prenatal care team, Paula found herself with unmet expectations when her nurses did not display *concern* towards her high blood sugars from her ideas of an appropriate response from them. The resulting feelings of vulnerability were compounded by her test reports not being efficiently and effectively dealt with. Underlying anger towards these team members remained throughout her pregnancy, overshadowing future learning encounters with nurses. Paula's experience reflects what Derrida (2001) calls a "permanent rupture or a wound that refuses to heal (p. 42). Underlying the act of forgiveness appears a need for understanding of the *Other*, which Heidegger (1978) views as happening only within the context of dialogue. It may only be through another encounter, another dialogue with the *Others* who failed to meet her expectations that the understanding needed for forgiveness would be found.

Despite the distress of past memories of unmet expectations, Paula did express that she had a very positive relationship with her nurse-teachers, especially the nurse that helped her become competent in managing her diabetes.

One of Paula's nurses, in particular, communicated that she understood Paula's perception of risk to herself and her baby. Paula shared that she felt this nurse had understood the meaning of her experience and what was *significant* to her. From Paula's perspective the nurse met her expectation for having an interest in the safety and best health outcomes for her and her baby – something she perceived as lacking with her past team of care providers. The master narrative between the caring nurse and Paula remained harmonious with a congruency of *mood* between them. Paula gained the necessary knowledge, competencies and confidence to be able to manage her healthcare needs independently.

If one went merely from outward appearances, you could conclude that Tricia had little expectation of *Others* and that her relational distance and disengagement was reflective of ambivalence and an *undifferentiated mode of existence*. However, reflecting closely on our conversation, there were significant expectations on behalf of *Others* to act in a caring manner towards her. After hearing her share the disharmony in her life in her relationships with her family, I asked if she had experienced similar discord in her learning and prenatal care relationships. Tricia mused for a moment and then responded,

> *Well, to an extent. Like, I've have some really crappy doctors. It seems to be like it should be pretty warm, easygoing doctors. But some doctors in the clinics are just indifferent. I felt like they just really couldn't be bothered about your life at all.* (Her tone of voice hardens and she speaks louder with more determination). *And that they <u>don't really want to hear what your problems are</u> and they <u>don't want to take the time to understand</u> you. And, I don't know, it's kind of more frequent that obstetricians would more likely to be people who are caring than regular doctors.*

Tricia translated the apparent indifference of some of the physicians that she encountered into their being uncaring and dismissive of her. These interactions

reminded her of similar experiences with some of her family members. Their *undifferentiated mode of being* clashed with Tricia's understanding that a caring manner was an *authentic* mode-of-existence for obstetricians. The master narrative between them was, from Tricia's account, discordant. Tricia's normally quiet and submissive demeanor of Others could very well conceal the underlying anger that she shared towards some of her physicians.

Tenuous Harmony in *Worlds* of Mixed Expectations

Some of the participants came into their experience of learning about GDM with an expectation that a nurse would seek to understand the meaning of their experience as a *significant* to them. As described in the previous chapter, understanding by the nurse of the women's experiences influenced the dialogue that occurred in a learning relationship perceptions of connectedness in the learning relationships or, in other words, the presence or absence of a harmony between the *authentic modes of existence* of the patient and nurse. Mutual understanding of what was important to the participant fostered a harmonious attunement of mood and mode of existence for the participants. The narrative, in these circumstances, appeared to be characterized by relational engagement that was open to dialogue and mutual understanding

Suzanne had a strong need to being accepted and valued as a person and a good mother. She shared, though out our conversation, feelings of being judged negatively from some nurses because of her obesity and related GDM. She sensed that she was perceived as not competent in managing her diabetes because she was obese and somehow less able to manage her life. She also felt that they

viewed her as a poor mother for not controlling her weight and for subjecting her unborn baby to the consequences of having gestational diabetes. These experiences, therefore, influenced her expectations of how *Others* might come to encounters with her. Suzanne did acknowledge that not all people judge obese persons in the same light. However, she did expect to encounter mostly people who would come to a relationship with her in a negative or non-accepting stance because of their *inauthentic* or perhaps *undifferentiated* manners of understanding obese, pregnant women. This may be based on their own life experiences and/or cultural and societal influences. She described how she discerned an accepting, *authentic* manner in the nurses she met during her present learning encounters.

> *As soon as she [the nurse] said she had diabetes, I just connected right there. You [the nurse] know what I am going through. That's the way you feel. Instead of you walk in there and have some young, thin pretty person - not that there is anything wrong with that - but then they don't understand it. If they understood it, you're automatically connected. I just mean, I would feel judged if I walked in there and somebody has never been overweight. Has never had to go through it. You feel like they are judging you. Not that they are. It's kind of my own thing- it's nothing to do with them. It's my own insecurities.*

Suzanne paused at this point for a minute, looking pensively down toward the floor. With a heavy sigh she continued,

> *Like, if they have never been overweight and you come in and you have flab here and flab there and they have to look at it because they're a nurse. And you feel gross. I don't know. It's weird. Some of the ones [nurses] - when they come in and look at my belly, the first thing I would say is 'I am sorry for my ugly belly'. <u>The first thing.</u> It's kind of their reaction. If they would say, "Oh no, don't worry about that. I've seen this a million times". Then you feel alright. But if they say, "Don't worry about it" and just keep doing their thing and don't say anything, then you kind of feel, "I know what they are thinking. They're thinking this is disgusting. <u>You know what I mean</u>?*

Suzanne went on to explain how she came to make her own judgment about the thoughts and feelings the nurse was having.

It's something I do to myself, because I don't know what they're thinking. But I just assume it because you are used to people looking at you like that. I've never really thought about this - and it's going to sound kind of mean. But it is kind of like a test. You know what I mean? It is kind of like a test. I would say something to them and by their reaction I would automatically know whether to trust them or I don't. Or whether I feel comfortable or I don't.

I was curious whether this happened in most learning encounters. She replied,

I think so. Yeah, but [on] a more of a subconscious level. Because I didn't even realize that [I did this] until now. I think a lot of overweight people feel that way. And if you are overweight and diabetic I feel that people probably assume that you are going to be diabetic. Just because it goes hand-in-hand most of the time (sighs heavily).

For some of the participants, the diagnosis of GDM brought them into the focus of caring family and friends whose aim was to be helpful. But, sometimes their advice was contrary to what the women were learning from their nurses and other care team members. In these circumstances, the polyphonic voices in the learning experience became frustrating and sometimes discordant in contrast to the relationship that had developed with the healthcare providers. Paula had such an experience.

Paula came into her pregnancy with limited knowledge about the normal characteristics of pregnancy. While her friends were helpful in counselling her about possible health issues that she might be facing when she began to feel unwell, the diagnosis of GDM brought her into conflict with loved ones. Shortly after her admission to the hospital, Paula's GDM was diagnosed and she was started on insulin. She struggled with the well-intentioned support and information from family members that was often incongruent with what her

nurses were telling her. Contrary to her initial experience with her friends, this information was not helpful.

> *The most frustrating part about being gestational diabetic was making my family understand it. I didn't know anything about it. They were telling me one thing and the nurses and my diabetic specialists would be telling me different things. The diabetic specialists are telling me that it was gestational [diabetes], so it's different from the other - the normal diabetes - Type 1 and Type 2. So, where my father's a diabetic, he had his own ideas and my aunt's a diabetic and she is insulin dependent. So I had a lot of frustration with that because I was feeling overwhelmed with their opinions. And then throw the high blood pressure in there. My aunt and uncle has high blood pressure and we are close to them. I am trying to explain it to family members as a pregnant lady and I am trying to make them understand that they are not pregnant. They're like 30 years older than I am and completely different. That was a really frustrating part of that.*

As described previously, the interaction that Paula had with one of her nurse-teachers was perceived as caring and the information gained from her was important to the self-management of her diabetes and high blood pressure. As a result, Paula's *mood* was attuned with the narrative in an *authentic* manner. Unfortunately, the conflicting information given her by her family to that of her nurse-teacher created discord in her relationship with them. Paula cared about her family, but could not engage positively with them because their understanding of her experience did not meet what she determined as *significant* in her *world* at the time. This experience is reflective of what Conroy and Dobson (2005) refer to as mixed moods in which there are "various narratives being played out". In Paula's experience, there is attunement in her narrative with the nurse but the inability of her father and aunt to appreciate the difference in her experience with diabetes creates discord in their narrative. As a result, Paula limits her relational connectedness with them in the context of her experience pertaining to diabetes.

Heather occasionally strayed from the guidelines for diet, especially when participating in family celebrations, finding it difficult not to partake of the treats such as ice cream. She was, however, very aware that there was a limit to her bending the rules. The nurses who were helping her manage her diabetes did not share the same philosophy of flexibility in relation to diet and blood sugar control. While some women might have had resisted the amount of surveillance Heather received from nurses in relation to their need for or ideas of independence, she appeared to expect their vigilance and use it to her advantage. With a very positive and bright demeanor, she shared some of her experiences with me.

> *I call them [the nurses] every week. Usually talk to a nurse every week. And she's really good. Helps me keep in check. Makes it so that I am more aware. I am thinking, you know, I better not eat this ice cream 'cause that will put my sugars up and then she'll ask me why it is so high. What did I do to make it so high?* (laughs softly with a nervous tone). *Then I know I am going to have to explain it* (laughs harder with the same nervous tone).

Heather's call to fulfill her maternal obligations to her children with family celebrations was strong but she did also look to her nurse-teachers as a measure for understanding her risks or boundaries of control for her diabetes. Her perception of risk and her required actions varied according to what she perceived was most *significant* at the time. Her laughter during this part of our conversation and the variation in the tone of her laughter should not be construed as Heather finding the task of managing diabetes mirthful or funny. Rather, it appears to reflect that that she does heed the nurses' expectations for compliance on her part seriously and that she is accountable for her behaviour. Although her relationships with her nurses appear harmonious, the nervous edge to the tone of her laughter perhaps suggests that there is some concealed or underlying

discomfort such as guilt intermingled in her relationships. Viewing this part of Heather's response through Heidegger's notion of conscience and the mood of guilt puts a slightly different understanding of Heather's mode of existence . Heidegger views conscience as something that calls one from an *inauthentic* mode of existence through immersion in *everydayness*. Braman (2008) writes, "As call, conscience discloses to Dasein its they-self and the subsequent need to break away from this mode of being-in-the-world, this inauthentic form of existence" (p.20).

The call of conscience comes from the person but yet is beyond the person in the "context of the world" (Braham, 2008, p. 20). Reflecting on the scenarios played out with her nurse-teachers, and from their perspective, Heather's behaviour could be viewed as normally *inauthentic* and *undifferentiated* for the larger part of her daily life. It is the interactions, or narratives that occur between Heather and her nurses that draw her towards an *authentic way- of- being* in relation to caring for her health by stirring her conscience as to the right thing to do. It becomes clearer to me that determining *authentic* manners may be complex. Therefore one must be attuned not only to actions reflecting a person's *mode of existence* within the current narrative, but also how *authenticity* plays out in narratives with *Others* in different times and contexts.

Seeking Harmony for Unmet Expectations in an Uncaring *World*

Pregnancy is often a time for special recognition and attention by society in general. For some of the women, however, the attention given them because of health complications left them feeling bittersweet in relation to a sense of being

important to others in their *world*. Laura questioned whether her cancer might have been picked up and acted upon so quickly if she had not been pregnant. However, the harmonious relationships that she had with her family countered any concerns that she held regarding her holding place of *significance* in their lives.

Tricia perceived an ongoing general lack of caring towards her as an adult person by society. While Tricia spoke in a flat monotone for most of our conversation, her voice changed in strength and intensity as she shared her understanding of what it meant to her to be a person in her *world*. Her voice resonated with tones that reflected her feelings of being marginalized and ignored in life.

> *The impression I've gotten is that people are more concerned about your wellbeing because you are pregnant. As long as you are carrying the baby, they'll ask you how you're doing, about how you're feeling. I've seen enough services, supports that are available at different stages of life. I get the feeling that children are valued more than adults. Even just in looking at the way we talk to other human beings. Like when people talk to babies, everyone is happy to see them. Everyone smiles when they see them. People are kind and patient with them most of the time. But as children get older and talk and move around, their actions and talking becomes inconvenient and annoying to people. And they get less patience and encouragement. Your first steps are such a big deal, but then as you get older it gets harder to get the same reaction from your parents. You know? And by the time you are an adult, nothing really impresses anyone. You know (laughs softly)? You know, no one really gives a damn (laughs harder with a tone of cynicism to her voice).*

She continued, relating a long standing concern that she had regarding the possibility of her having diabetes and the continual experiences of having her expectations for care going unheeded. Her experience with being diagnosed with

gestational diabetes reinforced that her perceptions were valid of not being valued and being ignored and not valued.

> *I feel like, for my sugars and stuff, my mom told me when I was young, that me and my brother were both glucose intolerant and could become diabetic. And there's been times when I have asked them to test me and I've gotten tests. But I felt like they probably weren't letting me know. They kept telling me you're fine, you're fine. And it's like, I'm pretty sure I wasn't fine. Like I have times when I'm not eating that I've felt how the sugars go off – like go up and down. <u>You know</u> symptoms that are on those charts. The dry mouth, the weakness, the symptoms, <u>you know</u>? It's like people have told me "I'm fine, I'm fine". And now that I am pregnant, because it might affect the child (...3 secs... She sighs). I don't know, I guess just them telling me about my sugars being high just made me think they've probably been high. Like if I wasn't pregnant, with the sugars as high as they were, they wouldn't be concerned.*

I asked her if her learning experiences during her prenatal care in the clinics left her with a similar sense of being unimportant and unheard in her *world*.

> *Not really the specific people I see. I feel like there is sort of a difference between individuals that you deal with and the mass-like faceless kind of society. As individuals we might have moments of caring about each other, have compassion. We might do good things some of the times as individuals. But as a whole, sort of, silently conspiring with one another, we don't act in the best of our own well-being. So yeah, I'm kind of cynical of the larger, uncontrolled machine. The individual people sometimes can be helpful and caring and warm towards you. There's a coldness there, kind of an undercurrent or background. A force that we are all kind of under.*

Tricia's experience of everydayness and the overall *undifferentiated modes of existence* of the *Theyness* of her *world* results in her feeling lonely and insignificant to *Others* in her world. However, there appears to be a counter narrative that rises in the face of caring individuals. She responds to compassionate persons within her encounters and has an expectation that it should be found within the dialogue she has with individuals. But she has come to understand from experience that most times her expectations will be unmet. I asked about her overall expectations from *Others* in her learning encounters.

> *I don't know. I just try to just follow the information I've been given. It is just enough with them telling me the sugar levels, and the book. Other than that I write my list of questions when I come in.*

If a nurse did not have an understanding of Tricia's diminished expectations and *mood* it would be easy for her to misunderstand the appearance of Tricia's taking on responsibility as a mark of independence and confidence in her ability to manage the care requirements of her gestational diabetes. Instead, Tricia's response is that of disengagement and, in some circumstances, concealed anger and disappointment arising from her perception that her life story is of little consequence. Being closed to dialogue with those who could help her, created more challenges in Tricia's ability to manage her diabetes successfully in relation to the many other issues stemming from her poverty and limited social support.

As part of her attempt at reconciling her relationships in which she experienced negative judgment and lack of caring from nurses, Suzanne shared the importance attunement of *mood* and narrative for nurses and learners was to the development of a ontological intimacy between them – becoming *We* - and the effectiveness of the teaching and learning occurring within the experience. When asked about the importance of her quality of relational connectedness, she replied,

> *It is very, very important. But it depends on the people too. The way you go into it and the way you go out of it. Because if you're going to go into it and not care what they are going to say (sighs). I don't know. If you go into it like "yeah, yeah, yeah, I have been here before" Then you're not going to learn anything anyway. Hear anything they have to say. You're going to do your own thing anyway. But if you go into it with an open mind, then it makes a difference.*

I asked if this understanding made a difference in relation to her expectations of how nurses might approach her learning encounters.

Of course it would. Because I mean, who would want to tell you something if they knew you weren't even going to listen. I just mean, you need to be open about it. Like I said, it makes a difference for the nurse. Like, if I was to teach somebody to play the piano and they're not following anything I say. And I'm telling them to touch this note and this note. And they are not listening and they touch different notes. Then you are wasting your time.

I asked if this could cause a disconnection or discord in the relationship. Nodding her head in the affirmative, she replied,

Yeah it would. It would make a difference for nurses to help someone learn about gestational diabetes, or any diabetes. Like I am not a nurse, but I deal with patients myself. You know and dealing with families. So I kind of understand both aspects in some sort of sense that way. Like, if you walk into a resident's room and you are trying to help them get dressed. And they pick out a grey shirt, so you get the grey shirt. Then they say, not that one. Then you get compromised. There are times when a nurse can't help them. Like, they just don't take it to heart.

Consistent with Macmurray's (1961) premise that humans seek forgiveness and reconciliation with each other, Suzanne strives to put *inauthentic* behaviour of the nurses that created discord in their relationships into a different, less personalized perspective. During part of our conversation she shared how she reasoned that nurses' inconsistent teaching could be because they just did not know any different. She also modified expectations for caring and reciprocity through her identification of the difficult learning situations nurses also face. While the expectation of patients needing to take responsibility for integrating diabetes interventions into their world is important to overall success. Reciprocity in a learning relationship benefits from empathetic understanding on the part of both players in the dialogue. However, heightened sensitivity to the needs of the nurse might result in the patient putting more energy into taking care of the nurse's struggles than she puts towards her own needs and expectations for learning and problem solving. For Suzanne, the contrast of her strong negative

emotions that she expressed throughout our conversation when recalling experiences of feeling stigmatized and unvalued as a woman and mother, and her acceptance of their *undifferentiated, inauthentic* ways of *being* reflected a lowering of expectations or a modification of her own *authentic* stance of right action.

Both Tricia and Suzanne strived to reconcile their differences in expectations related to the failure of *Others* to meet their basic human need for care and compassion. They reasoned that people would respond in a certain manner and a way to reconcile differences was to move responsibility for action and accountability to themselves. Their striving for harmony within the entwinement of their narratives with Others and their *mood* may reflect what Taylor (1991) refers to as the instrumental aspect of reason. Braman (2008) further describes this concept:

> reason functions as a means to an end relationship, rather than a normative activity of the person that allows us to raise and answer questions concerning what it truly means to be authentic. In other words, instrumental reasoning restricts the horizon of questions that we can ask to the point that decisions and choices are already circumscribed by predetermined decisions (p.44).

The presence of instrumental reasoning carries a potential barrier to true dialogical learning relationships. For example, a nurse immersed in an *inauthentic mode of existence* in the *everydayness* of her *world* may come together with a patient who has minimized her expectations for *authentic* relational encounters.

In such a situation, the needs of the patient, who should be the focus of the relationship, may go unmet and unheeded. Lowered expectations for *authentic* actions on the part of their nurse-teachers could limit the questions and choices necessary to successfully integrate measures that would effectively manage their gestational diabetes. Similar instrumental reasoning on behalf of the patient would further limit access through lowered expectations of the *Other*.

In summary, participants in this study came to their learning encounters with nurses with expectations of behaviours and actions based on past experiences and relationships with *Others*. For some, these past encounters included experiences in which *Others* failed to meet their expectations for caring and concern. Despite this, they were able to transcend feelings of hurt, alienation and marginalization in their current pedagogic encounters if the nurses' actions were perceived as *authentic*. Counter narratives existed in some experiences that presented a potential for anger or guilt to rise and disrupt the master narrative between the nurse and the learner. Other participants rationalized the transgressions of the *Other* through an understanding of their actions as that of naivety or ignorance. In some of these circumstances the participants merely moved responsibility in the relationship to themselves. Despite an apparent harmonious attunement of *mood* and narrative in these circumstances, there was never a true relational connectedness in the encounter – a coming together as *We*. Instead, the patient and nurse remained in divided worlds thereby limiting opportunities mutual sharing and understanding about what is important in the woman's *world* concerning learning about GDM.

Reconciliation

Living is experiencing
both paths of life—
Peace and turmoil,
right and wrong,
together and alone.

Wisdom is knowing why—
so we can see the difference
and finally find
the hidden path between,
where things rejoin.

We get our share of bruises
searching for this simple truth;
as it is revealed to us
when we don't understand,
loitering and lost,
deaf and blind.

When we do wake up
to knowing who we are,
we start our real journey —
putting back together
all the things we took apart.

(Cottringer, 2003)

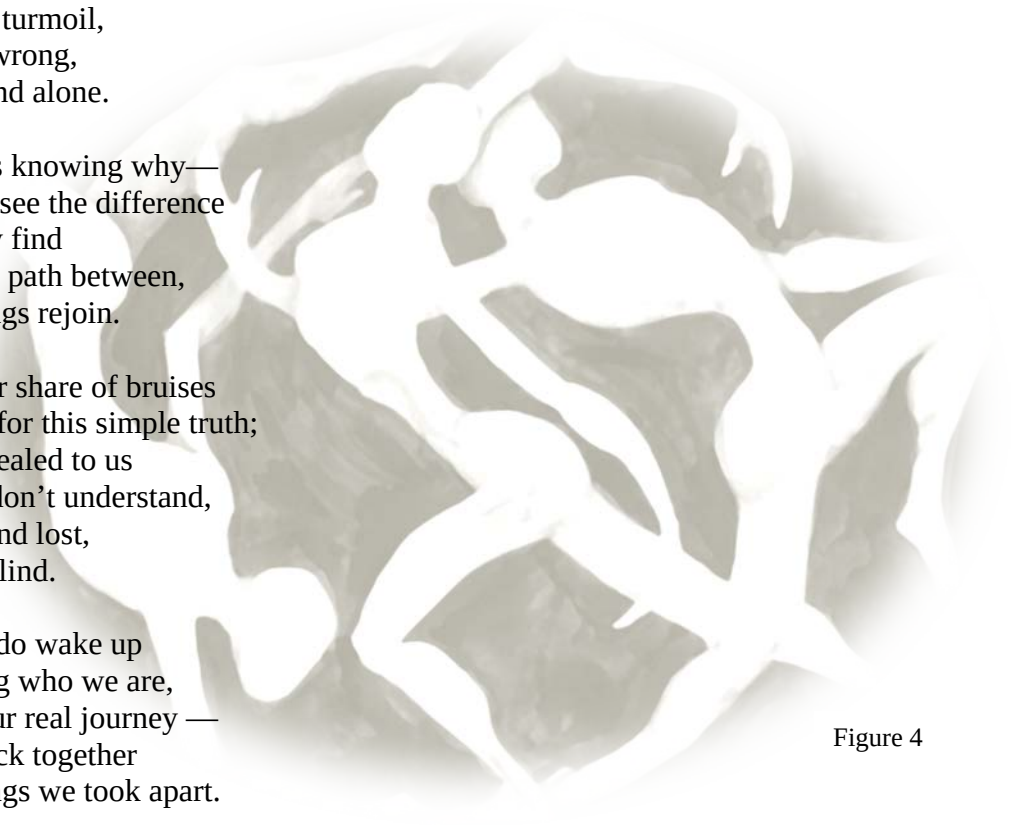

Figure 4

Chapter 9

Closing Reflections

> The most beautiful experience we can have is the mysterious.
> It is the fundamental emotion, which stands at the cradle
> of true art and true science.
> Whoever does not know it and can no longer wonder, no longer marvel,
> is as good as dead, and his eyes are dimmed.
>
> Albert Einstein, 1931, p. 193.

I came to this research project with a desire to understand the meaning imbedded in the pedagogic relationships that patients have with registered nurses through the exploration of learning experiences of pregnant women diagnosed with gestation diabetes. Since my desire was to gain insight into the relational space between nurse-teacher and patient-learner, I embraced the hermeneutic phenomenology of Martin Heidegger as the philosophical lens through which to understand the ontological aspects of the participants' learning encounters with nurses.

In the first three chapters of this dissertation, I describe my journey to final determination of the research question for study and provide insight into the knowledge and philosophy underlying the study. My journey included reflecting on personal points of curiosity that arose through my interactions with patients encountered in my nursing practice environment. I was introduced, as a PhD student, to the philosophical theories and perspectives foundational to this study, including those of Buber, Gadamer, Heidegger, Macmurray and Merleau-Ponty. The literature pertaining to the substantive aspect of the thesis was reviewed in Chapter Two. This in-depth review provides a special focus on the meaning that gestational diabetes may have in the lives of pregnant women as well as what is understood about the relational aspects of learning encounters between nurses and patients. Along the way to determining my question for research, I was

introduced to the notion of relational pedagogy as an alternative to the traditional, epistemological means of approaching adult learning and education within nursing and health care in general. Its philosophical traditions arise from the thoughts of those philosophers that emphasize the relational aspects of human *being-in-the-world*, thereby resting comfortably within the philosophical heart of my inquiry.

Chapter Four outlines the methodology and method of my research project in detail. It is written with a more perfunctory style with the aim to clearly delineate the study process and procedure for the reader.

In chapters five to eight I share the results of my thematic analysis of the conversations with the participants in this study. Each chapter explores a theme that contributes to an overall understanding of the influences on their relational space with nurses as part of their learning encounters:

1. The first theme in Chapter Five, explores the meaning embedded in finding oneself in a changed world of being a pregnant woman diagnosed with gestational diabetes mellitus (GDM).
2. Chapter Six provides insight into how the participants determined what was important for them to learn about gestational diabetes from the perspective of their understanding of their changed world that now encompasses gestational diabetes.
3. Chapter Seven explores the influences on the relational space within the context of the learning and prenatal care experiences of the participants. Each participant presents a unique perspective of that which is needed on behalf of nurses and other care providers to

complete the journey to ontological intimacy with their nurse teachers, which I call *becoming We*.

4. In Chapter Eight, the participants' met and unmet expectations for caring actions from the context of their learning encounters and their reconciling of differences is explored through Heidegger's concepts of *authenticity, mood* and *modes of existing.*

In this chapter, I reflect upon the themes uncovered through my conversations with the participants from the perspectives of strengths and limitations of the research, my thoughts regarding the possibilities this dissertation presents for influencing patient education, nursing education, and my thoughts for directions for future research.

Study Strengths

This research has opened the relational space between nurses and patients thereby affording an opportunity to enhance understanding of mutuality and reciprocity that may occur between a nurse-teacher and a patient-learner. Interpretive inquiry methodology has aided in a more holistic understanding of the context of the relational experiences of the women by integrating the theoretical and philosophical with lived experience.

Heidegger's notion of *understanding* situated the conversations and analysis in the roles, culture and relationships consistent with a person's stance or perspective in life (Longerhan & Taylor, 2008). The query into the meaning of the learning encounter also opened a self-reflection on the part of the participants,

helping both the researcher and participant to engage in meaningful reflection on their *being-in-the-world* (Orbanic, 1999).

This study provides reflection on how caring and learning are entwined in the nurse-patient relationship. It gives more light into the strength caring brings to a learning relationship, empowering the participants to be successful in their incorporation of the diabetic care requisites into their lives. It demonstrates that successful implementation of diabetic care concepts go beyond pure acquisition and application of knowledge to positive and effective learner-teacher relationships. It also gives insight into some aspects of the resilience of people to overcome disappointment in past relationships and to trust engaging in new relationships that could potentially result in similar experiences of emotional hurt and trauma.

Embracement of relational pedagogy, as an alternative lens through which to understand adult learning relationships, has added to the understanding of how some women come to understand what is important for them to learn and ultimately, what aids in their connectedness to their nurse-teachers as *We.* Over time, as my proposal was being developed, the research enacted and the thesis written, I shared my research area of interest with nurse colleagues. It has been very encouraging to experience their curiosity and enthusiasm for the study outcomes. Many share similar practical and philosophical questions related to learning encounters as well as my passion for understanding relational pedagogic relationships, thereby adding to the credibility and importance of this topic for study.

The research design and method were guided by Conroy's (2003) hermeneutic principles for research. Strategies for evaluating the study outcomes were consistent with standards expected of a qualitative research project and included critiquing the research project for integrity consistent with qualitative research projects. Ethical considerations included ethical reviews by the University of Alberta and the IWK Health Centre as well as being critiqued against Guba and Lincoln's (1984) criteria for authenticity.

Study Limitations

The study population was small and does not include participants from unique cultures or ethnic groups who may be at risk for experiencing diabetes in pregnancy, such as Aboriginal women. However, interpretive research designs do not carry an expectation for the generalization of findings to a broader, more generalized study population. Instead, they "clarify the conditions that can lead to understanding" (Holroyd, 2007, p. 1). The participants in the research all had very different life experiences in relation to their GDM. The thematic analysis brought forth the unique perspectives of their experiences, disclosing what was *significant* to them in their learning encounters with nurses.

Considering possibilities for patient education

The experiences of the participants in this study supported the importance of nurses embracing a relational pedagogic approach to patient education. This appeared to facilitate their successful integration of required actions into the daily lives. Engagement in learning was facilitated when the nurses and participants *co-determined* and *co-constituted* the knowledge and information needed to facilitate

independence. Knowledge transference and translation occurred within the mutual *space* between nurse-teacher and patient- learner. The embodied nature of this relationship enabled learners to become partners in their own education.

Aspects of the learning relationships that appeared important to the participants in this study were sensitivity to the meaning the diagnosis held for the woman and an empathetic message of caring and respect. A nurse's introductory engagement as "welcoming" often set the tone for the relationship and influenced whether a truly relational dialogue would transpire. Cameron (1992) describes the importance which a sincere introductory engagement plays within interactions between nurses and patients. When patients are extended an invitation for engagement from a nurse, the possibility of a harmonious relational encounter is enhanced (Cameron, 1992; Conroy & Dobson, 2005).

In some of the learning experiences in this study, nurses were highly visible and valued for their role as patient teachers. However, there were also encounters where the nurse's role not was recognized or appreciated. For some participants, the nurse remained invisible in the 'sea of faces' that made up the care and education experiences for the participants and was viewed as carrying little pertinence to the participants learning experience. Nurses who met the participants' expectations for being knowledgeable, and compassionate, who understood and accepted them as persons and who were able to respond to their individual needs for learning were embraced as significant and meaningful in their *worlds*. When participants' expectations were not met, the ensuing relationship was fraught with negativity, discord or ambivalence.

The learning and prenatal care experiences of the participants in this study reinforced the importance for nurses to have the time and ability to embrace learning from the perspective of engaging in the aspects of true dialogue (Anderson, 2008). The acute care and community worlds of nursing practice may need to explore ways of developing, maintaining, and supporting a relational pedagogic approach to patient teaching. In today's situation of lean healthcare resources, this may be challenging to fulfill. The possible consequence, however, to not addressing these learning needs of patients and nurses is the ongoing challenges of hospital readmissions for inadequately educated patients who are poorly prepared for independence at home

Philosophical challenges also exist in today's health care system that works against enacting a relational pedagogical approach to patient education. As a nurse, I encounter a healthcare system under tremendous economic pressure. Stress experienced from practicing in a fast-paced acute care environment is augmented by systemic pressure for clinicians to comply with ever decreasing lengths of stay that are based on quantifiable indicators for readiness for discharge. This affords less and less time for nurses to interact with patients and to foster positive learning encounters. Situations appear on daily bases that challenge a nurse's ability to facilitate patient knowledge and independent problem solving of their health care issues.

All of this is coupled with a system of care that favours the technical, objective and pathological dimensions of patient care. This competes as a priority for a nurse's time, and undermines the softer touch of relational pedagogic

approaches to learning. The efficiency of teaching strategies which focus on information-giving as an approach for learning find a much more comfortable fit in today's world of health care. Concepts such as patient autonomy, accountability and empowerment become translated into outcomes measures that focus on the needs of the system, thereby losing the true sense of the concepts related to true emancipation and independence on the part of the patient. Governmental healthcare policies continue to view patient care as a budgetary liability with short-term resolutions that often fail to promote the philosophical tenets that protect and promote an approach to patient education that is individualized and focused on empowerment.

This may sound very dire indeed for the hope of enhancing patient education strategies in today's health care system. However, by nature of our work, nurses are positioned to participate in healthcare decisions on an individual, local and global scale with wisdom and pertinence. The Canadian Nurses Association (2009) calls for registered nurses to work toward healthcare policy and models of care that promote a high quality system of care that keeps best practices for patient care and education in the forefront. Their vision embraces nursing education strategies that prepare registered nurses for the challenges in care environments that they will face in hospitals and the community and enables them to engage effectively within the political arena that influences health policy. Based on this vision, it appears important that programs for nursing education develop and maintain aspects of their curricula that would foster confidence and competence in enacting the philosophical and dialogical tenets of a relational

pedagogy approach to adult learning. Cameron (1992) echoes this *possibility* for the future. Hope resides within the profession of nursing and within each nurse, which, despite challenges, always strive to keep what is *significant* to the patient or client as a priority for nursing care and patient education: .

> The heart of nursing is not lost...not lost, just mislaid. It's mislaid somewhere between the enormous demands of nursing and the infinite resource of the person in the nurse. However, that heart can be found again (p. 184).

Considering possibilities for future areas of research

The outcomes of this study have given insight into how patients engage in day-to-day learning about gestational diabetes mellitus and what influences their relational learning experiences. The themes from this study have helped to expand understanding of patient teaching in the world of obstetrical nursing units and clinics from a prescriptive, epistemological approach to that of relational learning. There is potential for future studies to expand on the *k*nowledge gained from this research by exploring in greater depth and across a broader population the positive influences on the learning experiences for pregnant women, including those with gestational diabetes mellitus. This may result in better health outcomes for this population of pregnant women and their newborns. Approaches to such inquiries could entail both qualitative and quantitative approaches to research methods and methodologies.

While understanding of the relational space between teacher and learner has been enhanced, questions remain that could be explored in future studies. For

example, there is a need to learn more about the influences of a person's *past* or *present* learning encounters, especially in relation to understanding barriers and advantages to relational engagement with nurses and other care providers. The participants in this study revealed aspects how they may come to a point of reconciliation for unmet expectations for actions and behaviour held by their nurses and other care providers. Benefits may also be realized through further exploration that would deepen understanding of the complex interrelationships between *authentic modes-of-being*, *mood* and the narratives that occur between teachers and learners. Knowledge gained from such inquiry may aid in a better *understanding* of the harmonic and discordant aspects relational dialogues. Conroy and Dobson (2005) speak to the importance of educators understanding *authenticity* from the perspective of *mood* and narrative,

> This entwinement of mood, narrative and modes of existing dominates social interaction and is a social issue. If educators and learners are unable to recognize the twist and turns of this intertwining, the possibilities of learning how to be and act as authentically in practice will be limited (p. 976).

While reflecting on the conversations of the participants I wondered and worried why some nurses and care providers did not display the caring attributes, such as empathy and respect that appear so foundational to positive learning experiences. What was underlying their apparent *inauthentic modes of existence*? Was it something missing from their basic education or a subtle acculturation to an indifferent *everydayness* through their immersion in a culture that fails to

demonstrate value for such merits of character? Were they just too busy and life too stressful to be able to care? The voices of the nurse as *Other* are silent in this study because of its focus only on the learning experiences of patients. Future studies that include opportunities for nurses and other care providers to share their experiences in patient teaching experiences may enhance current insight into the relational space they share with the patient as *Other*.

Preparing nurses for learning and integrating concepts important to the enactment of a relational pedagogic approach to patient learning can be challenging. Studies exploring the strategies that enhance environments for nurses and other healthcare providers to enact a relational pedagogy approach to the formal and informal aspects of patient teaching could potentially enhance success with which nurses engage in relational dialogues concerning learning. Moreover, for pregnant women with gestational diabetes, understanding gained from such studies may assist in attaining the goal of healthier mothers and babies across the perinatal continuum and beyond to childhood and adulthood.

> Let the sky
> Become
> Your teacher.
> You will learn how to serve.
>
> Let the moon
> Become
> Your teacher.
> You will learn how to love.
>
> Let the sun
> Become
> Your teacher.
> You will learn how to become.
>
> (Chinmoy, 2007).

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APPENDIX A

[1] Glossary

Affectivity as complement to cognitive knowing, allows emotional engrossment with the Other through the use of humour, genuine cheerfulness, sensitivity, and joy in being with the cared-for; creativity, emotion and imagination are components of affectivity in the quest for particularity

Anxiety that which gives cause to pause, that which causes a disturbance to everyday existence. It is caused by what is of significance to a human, who is startled, being challenged, threatened, puzzled or confused resulting in what is significant to be more accessible in the background. Anxiety is a special form of disturbance which faces us with a demand to own up to our lives (authenticity) or to get lost in inauthenticity or to remain in an undifferentiated existence. It can show up primordially the everyday state of mind of a person (modes of existence). It points to what is significant to a person; it provokes movement within the mode of engagement with the world

Attune/Attunement a fundamental constituent of *care* (Sorge), attunement is basic to our grasp of the world and our place in it. Heidegger uses attunement to convey the way in which "emotion or mood (Stimmung) constitutes the sense of Dasein's inextricable entanglement with the contexts of worldly significance" (Ratcliffe, 2002, p. 289).

Authenticity one lives up to what one feels to be significant even if it is at odds with what is socially acceptable.

Authentic genuineness; lives up to what one believes

Authentic/undifferentiated habitual genuineness

Background the 'place' where mindless everyday coping skills, discriminations and practices, into which we are socialized, are situated; we use our everyday coping skills or 'tools' without mental representations; a web of relations of the tools with purposes assigned to them by persons; "practices are an aspect of an aspect of our everyday transparent ways of coping" (Dreyfus, p. 75); in the Background we engage in 'silent thought'. What is most significant in our lives is not easily accessible to reflection - it is not visible to intentionality

Background Meaning a web of relations in which something becomes intelligible through interpretation; discovered through the hermeneutic task of interpretation or the fore-structure

1. *Note*. From. Moral inclinations of medical, nursing and physiotherapy students by S. Conroy, 2001, Unpublished doctoral dissertation, University of Oxford, Oxford, United Kingdom. Reprinted with permission.

Belief a mental acceptance of a proposition or statement, under or beyond observation, as true, although not necessarily factually correct.

Being 'Human being'; refers fundamentally to intelligibility; a human is self-interpreting; necessarily involved in and dependent upon the world; amid a world of shared meanings and understandings in the social context; mode of being human which must exist factically. A person is never settled in the 'world', never clear about the 'world' in which one finds oneself.

Being-in-the-world a specific form of existence which emerges into presence in reciprocal interdependence with other Beings

Care engrossment with the Other; the moral agent is in concert with the Other, with intention 'Other-directed'.

Care-for necessitates a level of reciprocity between the one-caring and the one-care- for. (Noddings, 2003)

Co-constitution persons form an integral part of a communal world, not as separate entities; the world and the individual co-constitute meanings or understandings;

Concern a way in which one is available or engaged in dealings with others. This concern manipulates things and puts them to use when trying to understand the other people around us and move into some decisive involvement. It reflects onto our own way of being as well being of others. The world is experienced directly in terms of meaning for the self. It is transparent coping with equipment (concern) versus coping with people (solicitude)

Connectedness a basic bond in a relationship that has a holistic quality, influencing the whole person. ((Bennett, 1997, 2003; Giles, 2008) .

Dasein how we, as humans, "make sense of the world, our place in it and how we become aware of this place" (Conroy, 2003, p. 6).

Equipment things at hand to get something done; always thought of in terms of what it will accomplish. It is always thought as part of whole set of equipment, as part of a relational whole; instrumental objects

Empathy true empathy is closely connected to compassion in that the focus always is towards the *Other* and not towards only the *Self*. Empathy, without its

close alignment with compassion may result in a person perhaps understanding that the *Other* is in a bad predicament or in need of something but carries no particular feelings or emotion towards them (Nussbaum, 2001)

Encounter is what happens when two *I*'s come into relation at the same time. It is within encounter 'that the creative, redemptive, and revelatory processes take place which is associated with relational dialogue. (Buber, 1970).

Epistemology 'Knowing that' something is true; constructed way of knowing; consistent with Cartesion duality or mind/body split; abstract theoretical calculation.

Facticity the idea that we are able to understand ourselves as bound up in our own as well as others' destiny. We 'dwell alongside other persons.

Fore-structure involves temporality; an explicit understanding of the *Background*; involves fore-conception, fore-having, and foresight

Hermeneutical circle the circular form of interpretation shared between persons in their interactions

Hermeneutical spiral spiralling interpretation where the interpretations of a group of people build on each others' understandings over a period of time

Historicity Heidegger's notion that we have a past which forms our background (culture) which affects our present (and in many ways our future).

Inauthentic mode assumed by someone who actively adopts a way of doing something, even though the person does not necessarily value that way of being on the surface; covers one's genuine way of *being*; discord (distress) between what one says and what one does; we have lost ourselves in things and other persons while existing in the everyday world; although it is necessary to regard scientific things in this objective way in healthcare, inauthentic in a moral sense refers to regard of people as things to be used for one's own purposes.

Inauthentic/undifferentiated habitual way of being inauthentic

Intentionality a system of coping for ongoing purposes, as the 'toward-which', the 'for-sake-of', the 'in-order-to'. There is recognition of alternatives for action and the possibility of choice between them.

Lived experience antonym to observed or vicarious experience; experience in which we are actively engaged with our whole Being

Modes of engagement ready-to-hand; unready-to-hand; present-at-hand

Mutuality reciprocal and fundamental recognition of partnership in the caring relationship. It requires recognition by the one-cared-for that the practitioner has an expertise in providing competent care within his discipline and a recognition that the One-cared-for knows himself best. In deference to the Other and involved 'significant others', the one-caring allows room and time for sharing knowledge and for choice in solutions, rather than encouraging dependent behaviours. Empathy is a necessity in understanding. Comforting or compassion is a practical outcome of mutuality.

Ontology 'Knowing how'; understandings of ways of being; embodied knowing

Paternalism behaviour by one which assumes guidance for another.

Pedagogy: the art, science and practice of teaching, It encompasses the theoretical and practical aspects of teaching experiences (Sidorkin, 2002). Applied to the acute care setting, pedagogy incorporates both methods and theories of teaching, the understanding of how adults learn and the relational aspects of teaching (Caraher, 1998).

Person Incorporates in moral agency the concept of culture (*historicity*), *significance,* present and future *(temporality* and *intentionality*), and lived experience (*embodiment*).

Phronesis practical wisdom; body and mind are synergistic in making sense of the world; embodied intelligence; "presupposes a direction of the will (i.e., moral) and a moral attitude" (Gadamer, 1989, p.22); engaged agency; experience only *makes sense* against a background of one's understanding of one's physical relation to the world.

Possibilities the characteristics of the entities that we encounter in our world are entwined with how we will use them as well as who will be using them, as well as possible ways to be *Dasein* (Blattner, 2006).

Present-at-hand mode of non-engagement with people, where entities are context-free; Cartesian duality of body/mind is the norm; context free engagement with the world; ahistorical understanding; mental representations; skilled scientific activity

Ready-to-hand seamless, transparent coping in the 'background' of the world. Can move gracefully in a relationship characterised by mutuality, reciprocity, particularity; characteristic of an engaged agent functioning with embodied intelligence

Reciprocity a receptive exchange between *Self* and *Other.*

Significance things which show up as mattering or counting in relation to our practical affairs. The for-the-sake-of which. Significance is "the background upon which entities can make sense and activities can have a point" (Dreyfus, p. 97) .Of significance is what matters to a human. It directs our activity in a taken-for-granted, non-mental way towards the future, towards the 'for-the-sake-of which'. Things which show up as mattering or counting in relation to our practical affairs.

Temporality Heidegger's notion that our past and future projections or desires affect our present situation and choices

Undifferentiated a mode where one is lost in a world where one passively assumes a stance picked up from the public collective way of not taking charge of oneself; person goes uncritically 'with the flow'; people exist in this mode most of the time; many of life's activities happen while we are in this mode

Unready-to hand mode of engagement with the world which can be entered into *conspicuously*. Conspicuousness occurs when a person pauses, hesitates because unusual tools are needed - the old tools are not appropriate for the context. Obstinancy occurs when the distressing 'object' becomes manifest. Obtrusiveness occurs when there is a total breakdown in our usual coping methods. nothing 'works' the way it normally does for us. Activity is very apparent to us, and we trun to more theoretical reflection about how to cope

World the entire constellation of beliefs, values, assumptions, background meanings, possibilities, and cultural organization shared by the members of a given community. Heidegger deems the world of society to be always prior to one's own world (Dreyfus, 1993; Hall, 1993). The world of the student is the set of meaningful relationships, practices and language to which students are introduced upon entering the health sciences field of study (the present). It incorporates the world they have inhabited in the past. It is directed towards the future; a person can exist in three interdependent modes - authentic, inauthentic, undifferentiated; organised equipment and practices in which *Being* is involved

Appendix B

Guiding Questions for Participant Narratives

Introduction to the conversations with participants

I am interested in understanding the relationships that develop during patient teaching experiences about gestational diabetes mellitus. Please tell me about your experiences of learning about gestational diabetes mellitus with nurses as your teachers.

Areas of focus for conversations with participants

1. What are the patients' understandings of the role components in patient education that facilitate health behaviours?
2. What is their understanding of their role in learning and change?
3. What is their understanding of the nurses' role in learning and change?
4. What are the patients' understandings of the elements essential for effective learning and change?
5. What is significant in their learning experiences?
6. How did it feel to engage in the teaching-learning process?
7. How do they make sense of what they experienced and felt in the relationship?
8. How did they manage anxiety (angst) from the relationship?

Appendix C

Information and Consent Form for Individual Interviews with Patients

Title of Research Study: Learning About Gestational Diabetes Mellitus: Encountering the Other in Nurse-Patient Pedagogic Relationships

Principle Investigator: Glenda Carson, PhD student (nursing), RN
University of Alberta, Edmonton, AB

Thesis Supervisor: Sherrill Conroy, D Phil, RN
Assistant Professor, Faculty of Nursing
University of Alberta, Edmonton, AB

Background: Gestational diabetes mellitus (GDM) is a common health problem for pregnant women. Nurses help pregnant women learn how to take care of their GDM. This research study explores the relationships that develop between patients and nurses when learning about GDM. You have been invited to take part in this study because you have GDM.

Purpose: This study will show what learning about GDM means to patients and nurses. It will also help us know what is important in the patient teaching relationships between nurses and patients.

Procedures: You will take part in an interview with Glenda Carson. The time needed for the interview will be about 60 –90 minutes. A voice recorder will be used. The data will be put directly on to a computer that only Glenda Carson can use.

Possible Benefits: There are no benefits to you for taking part in this study. You may benefit from having the chance to talk about what it is like to learn about GDM. This research may be helpful to future patients learning about GDM. It may also help to foster further research in this area.

Possible risks: There is no expected harm for you while taking part in this study. You may find some topics upsetting to you.

Confidentiality: No one but Glenda Carson will know that you are taking part in this study. There may be a small risk of others see you when you take part in the study. Your name will not be on any personal information you give to this study. You will be known only by your initials and a coded number. Any report put out about this study will not have your name. Anything that is learned about you will be kept private. Any direct quotes from you that are used in reports will be have a false name. Your doctor and and other team members will not be told that you are

taking part in this study. Data will be kept on a computer, but will not have your information with it. Recordings will be erased as soon as the study is complete. Dr. Sherrill Conroy, University of Alberta, Edmonton, Alberta, will help with the analysis of the data. All data given to her will not have any personal information. The study records will be kept in a locked area for 7 years following the report of the results

Voluntary Participation: You don't have to take part in this study. Your care will not be affected if you do not take part in the study. You will be notified right away is anything becomes known that may make you not want to stay in the study. You can let Glenda Carson know if you decide not to take part in the study.

Repayment of Expenses: You will not be paid if you take part in this study. There will be no costs to you if you because you take part in this study. You will be paid for parking and bridge tolls that occur because you are taking part in this study.

Possible conflicts of interest: There is no known conflict of interest.

Participant research rights: By taking part in the study, you agree to have your information used for the study. It does not mean that you have lost any legal rights. Glenda Carson, the University of Alberta and the IWK Health Centre still have their legal and professional duties.

Contact Names and Telephone Numbers: If you have questions or concerns at any time about the study, you may contact:

1. Dr. Christine Newborn-Cook, Nursing Research Office of the Faculty of Nursing, University of Alberta, Edmonton, Alberta at 780-492-5929

2. The Research Office of the IWK Health Centre, Halifax, Nova Scotia at 902-470-8765, Monday to Friday between 9am and 5pm.

3. Dr. Sherrill Conroy, University of Alberta, Edmonton, Alberta. Phone: 780-492-9043

Please contact Glenda Carson at any time of day if you have any questions or concerns:
Phone: 902-470-6648

Consent Form

Title of Project: Learning About Gestational Diabetes Mellitus: Encountering the other in Nurse-Patient Pedagogic Relationships.

Principal Investigator(s): Glenda Carson, PhD student RN. Phone Number: 902-470-6648
Thesis Supervisor: Sherrill Conroy, D. Phil, RN.

Contact Names:	Phone Number(s):
Dr. Christine Newborn-Cook	780-492-5929
Research Office, IWK Health Centre	902-470-8765

To be completed by the participant:

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your employment status?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your personally identifiable information?	☐	☐

Who explained this study to you?
_____

I agree to take part in this study: YES ☐ NO ☐

Signature of Participant _____

(Printed Name)
_____

Date: _____

Signature of Witness
_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator _____
Date _____

Would you like to receive a copy of the study results? Yes □ No □
Would you like to receive a copy of your transcribed interview? Yes □ No □

If yes, please provide your contact information or mailing address below:

Appendix D

Consent for Disclosure of Health Information

I consent to Glenda Carson sharing the data from my interviews with the following people who are acting as second readers for the analysis phase of this research study:

Names: _____

_____

- I understand that there will be no personal information accompanying any of the interview information forwarded to the second reader.
- I understand that this information will be used only to aid in the analysis part of this research project.
- I understand that I may withdraw this consent for release of health information at any time.

Signature of Participant:

_____

Printed Name:

_____

Signature of Investigator:

_____

Date _____

Appendix E

Letter of Introduction to the Research Study: *Encountering the Other in Nurse-Patient Pedagogic Relationships Concerning Gestational Diabetes Mellitus*

(Ambulatory Patients)

You are invited to participate in a research study that is exploring the relationships that patients have with registered nurses (RN's) while they learn about gestational diabetes mellitus (GDM). If you have gestation diabetes mellitus (GDM) in your pregnancy, you are invited to take part in a one-on-one interview with me, Glenda Carson, to explore and discuss your thoughts and feelings related to learning about gestational diabetes. I am the main researcher for the study. The interview should take about 60-90 minutes. The information gained from this research will be used to help nurses and other health professionals understand more about the relationships that occur with patient teaching and gestational diabetes mellitus.

Taking part in this study is entirely your choice. Should you wish to stop taking part in this study, you may do so at any time. There is no payment for being part of the study but there will be no costs to you. All information that you share in the interview will be kept confidential and your identity will be protected. Your information will be joined together with other interviews and put together into themes for the study. If your direct quotes are used, a false name will be used to protect your identity. The results of the study will be made available to you upon its completion and at your request. There is a written consent with more information about the study. If you would like more information about this study, or would like to take part, please put your name on the bottom of this form. Put the form in the box marked "Gestational Diabetes Study" by the desk where you checked in for your appointment. I may also be contacted at a private phone number: (902) 470-6648.

Thank you,

Glenda Carson, PhD (C)

Name: _____

You may contact me at phone # _____

Appendix E

Letter of Introduction to the Research Study: *Encountering the Other in Nurse-Patient Pedagogic Relationships Concerning Gestational Diabetes Mellitus*
(Inpatients)

You are invited to participate in a research study that is exploring the relationships that patients have with registered nurses (RN's) while they learn about gestational diabetes mellitus (GDM). If you have gestation diabetes mellitus (GDM) in your pregnancy, you are invited to take part in a one-on-one interview with me, Glenda Carson, to explore and discuss your thoughts and feelings related to learning about gestational diabetes. I am the main researcher for the study. The interview should take about 60-90 minutes. The information gained from this research will be used to help nurses and other health professionals understand more about the relationships that occur with patient teaching and gestational diabetes mellitus.

Taking part in this study is entirely your choice. Should you wish to stop taking part in this study, you may do so at any time. There is no payment for being part of the study but there will be no costs to you. All information that you share in the interview will be kept confidential and your identity will be protected. Your information will be joined together with other interviews and put together into themes for the study. If your direct quotes are used, a false name will be used to protect your identity. The results of the study will be made available to you upon its completion and at your request. There is a written consent with more information about the study. If you would like more information about this study, or would like to take part, please put your name on the bottom of this form. Put this form in the envelope and box marked "Gestational Diabetes Study" by the desk where you checked in for your appointment. I may also be contacted at a private phone number: (902) 470-6648.

Thank you,

Glenda Carson, PhD (C)

Name: _____

You may contact me at phone # _____

Appendix F

Budget

(1)	Sony ICD-PX720 Digital Voice Recorder	$90.36
	Paper and Computer Supplies	$180.00
	Bridge tokens and parking for participants	Nil
Total		$270.36