University of Alberta

The Perinatal Nursing Relation:

In Search of a Woman-Centered Experience

by

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IN LOVING MEMORY OF HIRSHAL
(1913-2003)

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Chapter One

Understanding the Meaning of the Perinatal Nursing Relation

> *My experience as a woman demonstrates, as does my analysis of language of women and men, that women almost always privilege the relationship between subjects...the relationship between two.*
>
> *(Irigaray, 2001, p. 17)*

Coming to the Question: Researching Experience

In this study I explore the nature of the perinatal nursing relation [1] as it is lived out in current nursing practice. My curiosity has led me to inquire into an understanding of the unique capacities and abilities that enable the perinatal nurse to facilitate women's positive birth experiences in the current Canadian climate of highly technologized health care. Although there is concern that such a climate removes women's bodies from their experiences of birth, this research asks: What are the practices that transpire between perinatal nurses and birthing women that enhance and empower their relationships in spite of hierarchical health care environments and highly technologized perinatal settings?

The question, *what is the nature of the perinatal nursing relation?* is the question that guided the research inquiry, and reflects my own commitment to understanding perinatal nursing practice and its potential within nursing to support *a woman-centered experience,* in which the birthing woman is central to her own experience of birth. In so doing, the birthing woman is able to choose her own positions for birthing and her "own birthing imagery" (Goldberg, 2002, p. 450). As nursing is a practice discipline committed to understanding human beings in all their uniqueness and individuality (Pascoe, 1996), a

[1] Although the perinatal nursing relation refers to the relational practices that occur between labour nurses and birthing women, references to postpartum and antepartum relations are occasionally mentioned throughout the study. Postpartum refers to a woman's experience after childbirth. Antepartum refers to a woman's experience prior to birth.

goal of perinatal nursing practice is to understand individual women in all their uniqueness. Thus my curiosity led me to ask: Is the relation that perinatal nurses foster with birthing women one that supports each individual woman?

By relation, I am referring here to that essential connection that exists between at least two people. Although a verbal exchange is not necessary, some form of interaction is required if two persons are said to be in relation (James, 1997). Gadow (1994) speaks of relation as a way of opposing the disappearance of either the caregiver or the woman within their health care encounter. She claims that it is only in relation that both (woman and caregiver) can be truly present as moral agents, "confirming or declining the meaning of health that each offers the other..." (p. 305).

Bergum (1994) defines relation as an essential engagement that occurs between the patient and professional: together they strive to comprehend the meaning and interpretation of the illness experience for the patient. According to Benner (2000), relation is found in those nursing practices that "meet, comfort, empower, and advocate for vulnerable others" (p. 11). Such practices are considered "embodied" practices and take us—as nurses—directly to the place of the body. It is here in the place of the body that my work begins, as the nursing relation enacted in labour and childbirth is one that invites us to engage with birthing women and their bodies.

The intent of the question then, *what is the nature of the perinatal nursing relation?* was explored to gain in-depth understanding into how perinatal nursing practice is lived *in relation* with birthing women. This question is therefore congruent with a phenomenological question, as it embraces the notion of "understanding the meaning of our life though interpretation of human experience" (Bergum, 1989, p. 44). A

phenomenological question asks, "What is this or that kind of experience like?" (Van Manen, 1998, p. 9).

My experiences as a perinatal nurse both in Canada and the United States working intimately with birthing and postpartum women have been some of the most memorable experiences that I have known. Being privileged to engage with birthing women as a perinatal nurse inspired me as a novice researcher to reflect more deeply on the ontology of the perinatal nursing relation and its potential for re-examining current perinatal nursing practice. What, for example, does it mean to be a perinatal nurse and engage in relation with birthing women? When is a positive and meaningful relation present, and are there occasions when it is not?

A return to the birthing room

The birthing room is a familiar place for me that evokes many images of the women whom I have come to know and the relations that we have shared. A place where women can be found in various positions—sitting, standing, squatting, immersed in water—birthing their babies, and I have been privileged to be part of their births. Krysl (1989), in her poem, *The birthing room*, captures an understanding of the bodily experience of birth, and the atmosphere that evokes the birthing room:

> It's like stepping into a slow
>
> elevator. You feel the pressure beginning to climb,
> lifting the scale, the scissors, the basins, the clamps,
> the light, the air and the white mound
> of the mother, that muscle pulsing at the center

of the room. You have come into a room

that is rising, and you are round and lifting

off the round earth, flying a little, as you were

meant to, hovering over this sphere—labor—

You seem one with the nurse measuring the opening

with the mother's sister whispering in her ear,

with the midwife waiting, calm in her blue gown—

and as you rise in the air with these women

the mother bears down. She bears down and the room

rises—oh but she feels she's about to fly off—

as though these three laid their hands on her flesh,

this clay—and said *ascend*. Now they kneel, they stand,

they lean over the mother, they lift their arms

like wings, they say soon. *Soon*

they croon, turning, looping over and around

the mother, and as they gather, as they turn

and wind and attend, as they bend to her

they touch her hand, her thigh, her hair,

talking to her the way you talk to a woman

in a room that is rising into the air.

Rising now like the sweep of an updraft,

rising now like the shouts of a crowd,

inevitable as bread in which the yeast is good.

The midwife says *I can see the crown*

and together now they lift the last distance,

and the room rises the last distance,

and the midwife says *now, here, bear down*

and the mother cries out a great cry

and rises up amazed, like a flag suddenly unfurled,

rises, and pushes the child

down,

down and out

Into the world. (p. 39)

This evocative poem returns us to the place of the birthing room. As I sit here writing this piece, I remember my experiences as a labour and childbirth nurse. My body also remembers: the kink in my neck from having a birthing woman's leg find a resting place on my shoulder during "the pushing" stage of labour. The dryness in my throat from breathing in unison with the birthing woman in a chant-like hum that becomes equated with a holy mantra. And if I am quiet for a moment I can still hear the breathing,

the moaning, the laughter, the tears, and the questions directed specifically to me, the woman's nurse for that short period of time in which together we come to know each other in a unique way. In fact, I can still remember the first birthing woman and her partner that I was assigned to as a novice student nurse so many years ago. Although the situation ended in an emergency Caesarean section, the relation that evolved over the two days prior was remarkable. I recall it being so much more than a verbal exchange. Rather, I experienced an embodied relation like no other I had known. To speak of that relation as embodied was to experience the body of another so completely that I could imagine myself as being that body. In other words, I didn't distance myself from the pain or the joy the woman was feeling (Goldberg, 2003). I was present with her pain and her joy, or as Leder (1990) would suggest, I entered into compassion: I experienced with the woman in some general sense through a process of "empathic identification" (p. 161).

To be empathic suggests an ability to share in another's emotions and feelings, as if they are one's own. This is not to suggest that as the perinatal nurse I can know the experience of the birthing woman—what it is like, for example, to live in her body as she births (Goldberg, 2003). Nevertheless, as the perinatal nurse I can "experience-with" (Leder, 1990, p. 161) the birthing woman, and partake in a relation that fosters her experience, recognizing her bodily presence and complete existence. Perhaps Gadow (1989) says it best by suggesting that caregivers can only be empathic when they experience the body of the Other (patient) in a way that situates themselves first in a place of vulnerability:

> Only through that reinhabiting of the body does it become possible to experience the patient's body as a subjective being, rather than a mere thing. This of course,

> revives the [caregivers] vulnerability; it means [caregivers] are unprotected from patient's pain. If that is so, however, it also means they are able to experience the patient's well-being in a way that is impossible without the resonance of their own embodiment (p. 38).

My nursing practice has not been reserved only for strangers. I have found it to be particularly rewarding that so many of my friends and colleagues have continued to request my presence or advice during their births. I regularly receive requests and updates about their pregnancies and births, as if I am continually present in their lives. Thus I begin to question how the perinatal relation may be present in a place of familiarity. How does it evolve with strangers? And how does it evolve with friends? Does it look different or does it look the same? Although much of my practice has been committed to working with women in relation, I also recognize that it is not without problems. From the onset I have been aware of the power differential, between me (the health care professional) and the birthing woman (a "patient") and how badly women can sometimes be treated—often silenced or ignored by health care professionals. Within the hierarchical structure of health care environments, women's access to their own experience is often denied (Gadow, 1999). In so doing, women are positioned as epistemologically absent and therefore incapable of fully enacting their own agency (Goldberg, 2003).

Nevertheless I have continued to work collaboratively with birthing women. In other words, I have recognized the pervasiveness of power relations within institutionalized health care, however, I have found alternative ways of working together with women, creating an environment in which both our voices are recognized as epistemologically relevant and legitimate sources of knowledge (Goldberg, 2003). There

exists mutuality, respect, and a sharing of ideas around how we co-construct a plan of care. We engage as partners and collaborators, reflective of my commitment to my feminist orientation; a way of being and doing that is enacted in my perinatal nursing practice. Power thus becomes understood as "power-with" women, actualizing an understanding of empowerment and intersubjectivity within my relations fostered with birthing women.

The question, then, *what is the nature of the perinatal nursing relation?* is a multi-layered question. It is an ontological question (Merleau-Ponty, 1962) regarding the nature of the relation perinatal nurses foster with birthing women. Exploring this question provides dialogue, in-depth understanding, and knowledge development grounded in current and experiential practices enacted within health care between and among perinatal nurses and birthing women. From a feminist perspective, this study provides epistemological insight and potential for corrective policy development (Benner, 1994), insofar as it gives both voice and visibility to the concerns and practices of those often exempt from contributing to perinatal policy. By attending to the pervasive power dynamics found in institutionalized health care, and their influence on the experiences of female subjects, this research potentiates the development of perinatal policy reflective of marginalized concerns and practices that have historically been absent from policy development.

Situating and Contextualizing the Perinatal Nursing Relation

To inquire into the nature of the perinatal nursing relation and its importance to nursing practice, I looked to the theoretical literature to sketch an understanding of how birthing women are situated within the highly technologized health care environment in

North America. To further evince the ways in which women's experiences of their births have become disembodied, thus resulting in their objectification within the current health care landscape, I turn to the works of various feminist, cultural, and nursing scholars (Bergum, 1997; Duden, 1993; Gadow, 1994; Jordan, 1987; Martin, 1992; Rothman, 1996; Sandelowski, 1998).

Birthing, women, and technology: A cultural and feminist perspective

In Jordan's (1987) anthropological research study, *The hut and the hospital: Information, power, and symbolism in the artifacts of birth*, an evocative comparison is made between the birthing artifacts and rituals of the Maya Indian women in Yucatan, birthing women in Holland, and women birthing in highly technologized health care facilities in North America. As the artifacts of birth evolve over time from simplistic household objects—like the hammock—to highly technologized objects—like the birthing table or the fetal monitor—the experiential knowledge of the birthing woman becomes increasingly less valued. What is most striking in this cultural comparison of birthing environments is the positioning of the birthing woman in the Mayan culture when compared with the birthing woman in North America.

When, for example, a Mayan woman gives birth, her hut becomes a place for her partner, family, and midwife to gather and communicate a system of strength in a web of relations to empower her birth. The hammock upon which she births is used in ways "that allow her to exploit its properties for maximum comfort. She can lie on it on her back, on her side, even on her stomach. She can hold onto the strands of the hammock as she pushes" (Jordan, 1987, p. 37). Equally important is the value of those around her:

Her attendants—most likely her husband, her mother, experienced women of the

> family, and the midwife—are equally familiar with the potential of hammocks. They may give advice about appropriate positions, and they know how to arrange their own bodies around it so as to give her physical and emotional support. Thus their cumulative experiential knowledge becomes available to the woman in labor and provides a valuable resource for solving problems of comfort, lack of progress, or pain as they may arise (p. 37).

In addition to the above support, when a Mayan woman is in labour, one of the birthing attendants positions her or him self in a strategic location for the birthing woman to sling her arms around the attendant's neck. Therefore, as Jordan (1987) suggests:

> [The] overwhelming impression one gets from participating in such births is that there is a close-knit group of people, bringing all their resources to bear on getting the baby born. Within the collaborative group, the woman is always central as the object of attention as well as the source of crucial information (p. 37).

In contrast to the above birthing experience is the highly technologized birthing environment that permeates North American hospitals. Unlike the Mayan woman birthing in her hut on her hammock, the North American woman is often positioned in stirrups, covered in sterile drapes. The positioning of the table, writes Jordan (1987) often negates the ability of a partner, friend, or nurse to support the weight of the birthing woman, as is done for the Mayan woman. Moreover, the lack of space in the room precludes a relational gathering of supporters to fully empower the birthing woman, as is done in the hut in Mexico. Although birthing environments in North America have changed since the writing of Jordan's 1987 article, birthing women are rarely central to their own birthing experiences. In other words, the birthing woman's embodied

knowledge regarding her own pregnancy is rarely counted as epistemologically relevant when she encounters the health care system (Goldberg, 2003).

Concerned with a similar problem approximately ten years later, Rothman (1996) in *Women, providers, and control* discusses the pervasive ways in which the North American "management" of childbirth has negated women's power and control. In her elegant words she contrasts the ordinariness of home births with Dutch women with its rarity among American women. Thus she asks "[h]ow is it that in one country birth is so easy, so ordinary, so well done, and in another, such a problem, such a project? Is it that Dutch women are different? Some deep cultural thing?" (Rothman, 1996, p.253). For the Dutch, claims Rothman (1996), birth is not only about babies. Rather, birth is about making "mothers—strong, competent, capable mothers, who trust themselves and know their inner strength" (p.253) Birth in America is not about fostering such strength in mothers. Rothman (1996) further writes:

> But birth in America is not organized around mothering, around teaching, around midwifery, or women's strength. Birth in America is about the efficient removal of a fetus; it is about getting a rather unwieldy object through a small space. Obstetrics, one must always remember, is a surgery specialty, and birth in an American hospital is, more than anything else, a kind of surgical experience (p. 254)

Nevertheless, it becomes clear that Rothman (1996) is not attempting to blame health care professionals, for the medical model of childbirth management is most often enacted by individuals who are well meaning professionals: "caring, nurturing, and protecting" (p. 256). However, what we must continue to ask ourselves as health care professionals,

and perinatal nurses in particular, is what we are providing in our practices with birthing women. As Rothman (1996) makes clear: "We can not *give* a woman a baby. Birth management does not produce babies; mothers do that" (p. 256) At best, she suggests, we can enable and empower.

The highly technologized health care environment found within North America is further discussed by nurse-philosopher Gadow (1994), when she claims that objectification within the medical narrative is "intrinsic, not episodic, to women's experience. The resulting impossibility of living the body as fully her own means that a woman's embodiment, not merely occasional illness, is laid bare for medical definition" (p. 298). Gadow's (1994) work explores the ways in which women's embodiment is negated within the medical establishment, which reduces the female body to the literal metaphor of a machine. Gadow (1994) states:

> The body on this view is pure object, without interiority; every recess can be examined, in effect externalised. There is no intrinsic relation between a pump and its owner, a scientific object and the person as subject. The relation between body and person is a contingent one. The person thus has no inherent authority over her body. Logically it belongs to the expert; the brain to the neurologist, breasts to the gynecologist (p. 298).

Martin's (1992) work on the female body and metaphors surrounding reproduction foregrounds Gadow's (1994) work on metaphor and embodiment. Martin discusses how birthing and pregnancy are a "natural" event for medicine to control, as she provides a cultural analysis of metaphor surrounding the female body in medical literature. Martin (1992) claims, "medical imagery juxtaposes two pictures: the uterus as

a machine that produces the baby and the woman as laborer who produces the baby. Perhaps at times the two come together in a consistent form as the woman-laborer whose uterus-machine produces the baby" (p.63). Thus Martin (1992) asks what role the physician is given within this model. It is clear, she states, that he is predominantly the "foreman" and "manages" the conditions that require "active management" (p.63).

That women's experiences of birth have become "managed" by professionals and disembodied within a technologized environment is discussed by Duden (1993) in *Disembodying women: Perspectives on pregnancy and the unborn.* In this provocative work, she illustrates the ways in which the interiority of women's bodies has become externally available to the public gaze. Duden (1993) claims:

> Step by step, the physician's finger, then his stethoscope, later X rays, tests and sonar have invaded woman's gendered interior and opened it to nongendered public gaze. Pregnancy has become operationally verifiable. Women of my generation look at their insides with medical optics that create scientific facts. Now, quickening is at best a feeble reminder of what a woman already "knows." This characteristic experience, which leaves neither bloody nor slimy traces, has lost its former social relevance (p. 81).

Historian Duden (1993) is looking at the history of quickening—when a woman first feels the movement of her unborn baby—as a reminder to us of how a woman's embodied knowledge of her pregnancy is erased within the medicalization of obstetrical care. Hence she tells us, "consciousness of pregnancy [now] starts in a very different way. Women are informed by mail, when the test results come from the lab...A scientific technological test rather than a kick urges the woman to change her self-image" (p. 80).

Both the woman and the fetus have become objects of medical assessment and monitoring in ways that have never existed prior to the new "visualist technologies" (Sandelowski, 1998). Yet, with such technologized obstetrical care, "women are technologically erased as the beings in whom fetuses reside" (Sandelowski, 1998, p.7). However, pregnant and birthing women—being responsible for fetal well-being—are forced to re-appear, never being fully erased indefinitely (Sandelowski, 1998).

The knowledge lost from quickening is not replaceable with technologized optics. Bergum (1997) claims, " knowledge of quickening is the foundation from which to build a lifelong relationship between mother and baby" (p. 22). Quickening allows the mother to experience her child in a new way, or as Bergum (1997) suggests: "Through the experience of quickening, she begins to touch her child, to know her child— to be quickened and enlivened by the new life of her child, the new life for herself. Such knowledge, which can be seen as a moral move toward the Other, is not found in technological measures" (p. 22).

Health care practices, perinatal nurses, and the Cartesian legacy

Perinatal nurses working in labour and childbirth have an opportunity to contribute to women's experiences of their births by virtue of their epistemic positioning—social, moral, and political. Nurses working in relation with birthing women are both health care professionals and women: They have an understanding of the current technologies and how women are positioned within the technological landscape. Understanding the perinatal nursing relation enacted in labour and childbirth—between perinatal nurses and birthing women—offers a way of bringing us closer to actualising birth experiences central to women's needs, in which women are the central focus of their

own birth.

Although perinatal nurses are uniquely positioned within the health care landscape, it is of import to recognize that they are not exempt from the influences of the hierarchical power structures in which they work. The historical context of health care practices, like those previously discussed, are grounded in a Cartesian metaphysics (Descartes, 1641/1993; Leder, 1990; 1998) that permeate the foundations of perinatal health—so much so, that nurses are subject to constraints that profoundly impact the tenets of their practice (Goldberg, 2002). Because the foundations of health care are founded on a Cartesian metaphysics, in which the human body is relegated to nothing more than a physical object, perinatal nurses are often reduced to working in health care environments that further position birthing women as mechanistic objects (Leder, 1990). Descartes (1993) states,

> ...there is a great difference between mind and body, in as much as body is by nature always divisible, and the mind is entirely indivisible. For, as a matter of fact, when I consider the mind, that is to say, myself inasmuch as I am only a thinking thing I cannot distinguish in myself any parts, but apprehend myself to be clearly one and entire; and although the whole mind seems to be united to the whole body, yet if a foot, or an arm, or some other part, is separated from my body, I am aware that thing has been taken away from my mind (p. 97).

According to Descartes (1641/1993), the mind is distinct from the body, insofar as the body is divided into physical substance—the empty vessel—and immaterial matter—the mind or soul. This separation of mind from body gave rise to a branch of Cartesian medicine that objectified the body, reducing it to the status of a machine.

Although Descartes' intent was to develop a science capable of prolonging life to combat the perils of disease, the results of his labour reduced the living, breathing body to an automaton. The origins of Descartes' science can be traced back to his methodology of investigation. This entailed the extensive use of animal dissection that further influenced his "*metaphysics* of embodiment" (Leder, 1998, p. 118). Descartes' understanding of the living body became modelled on the dead, and his fascination with automatons of the day resulted in the objectification of the human body. Descartes (1664/1972) claims, "the fire which burns continually in its heart...is of no other nature than all those fires that occur in inanimate bodies" (p. 113). For Descartes, the human body is thus reduced to a mechanical object, no different than a corpse.

Reducing the living body to a Cartesian corpse continues to permeate the practices of modern medicine (Leder, 1990; 1998). Technologies like the X-ray, the stethoscope and the blood test allow for a type of dissection of the experiential, living body: compartmentalizing it, revealing what is typically concealed on the inside (Leder, 1998). The corpse itself has shaped health care and clinical practice. Leder states (1998),

> Medical education still begins with dissection of a cadaver, just as the clinical case ends in the pathologist's lab. In between, the living patient is often treated in a cadaverous or machine-like fashion. We see this, for example, in the traditional physical examination. The patient is asked to assume a corpse-like pose, flat, passive, naked, mute... Then too, the patient's voice is, for long stretches, silenced. After all, a heartbeat cannot be heard above a patient's query. (p. 121)

Leder's (1998) description of the patient as a corpse is not far removed from the image of the birthing woman. Obstetrical practices, co-opted from midwives in the

seventeenth and eighteenth centuries have appropriated the metaphor of the uterus as a machine, using forceps and other technical instruments derived from male physicians to replace the hands of female midwives (Wertz & Wertz, 1977). Women's inferior status and arrested moral development can be traced back to medical theories inferring these conclusions from women's reproductive organs (Tuana, 1993). The uterus itself was considered the cause of many physical and mental diseases (Erenreich & English, 1978; Tuana, 1993). Cartesian medicine, which permeates the foundations of perinatal health, prescribes health care practices contrary to the philosophical tenets of perinatal nursing: Those that promote concepts of holism and wellness encapsulated in a unified woman, denying her objectification, thus reducing her to a birthing body (Goldberg, 2002).

In recognizing the ways in which birthing women have become disembodied, and thus objectified in their experiences of birth (Duden, 1993; Gadow, 1994; Goldberg, 2002; Rothman, 1982), it is equally relevant to attend to the ways in which nurses themselves have become disembodied from their own practices within institutionalised health care. Schroeder (2003) suggests that the "conscious act of a nurse trying to remain embodied and awake during clinical situations could reduce many of the horrors of hospitalization" (p. 159). Regrettably, nurses are precariously positioned between the constraints of a health care system that reduces women to nothing more than their bodies, and a practice discipline committed to the tenets of holism, healing and wellness (Benner, 2000; Bishop & Scudder, 1997). Although perinatal nurses offer us a unique perspective to bring to the experiences of birthing women, we must be cognizant of the ways in which they are positioned within the health care system and embedded within its Cartesian legacy.

Where is the Perinatal Relation?: The Perinatal Research Literature

In my attempt to understand the relational practices of perinatal nurses within the context of clinical practice, I perused the research literature in perinatal nursing. Although nursing scholars have done groundbreaking research in relational approaches to ethics (Austin, 2001; Bergum, 2004; Bergum & Dossetor, in press; Gadow, 1994; 1996; 1999), no such research was found within the perinatal literature. In what follows, I offer an overview of how the perinatal research literature interpreted the relational practices of nurses. In short, they were defined in terms of supportive nursing care (McNiven, Hodnett, & O'Brien-Pallas, 1992; Gagnon & Waghorn, 1996; Gagnon, Waghorn, & Covell, 1997; Sleutel, 2000), maternal perceptions of labour support (Callister, 1993; Bryanton, Fraser-Davey, & Sullivan, 1994; Mackay & Stepans, 1994; Brown & Lumley, 1994) and dimensions of the nurse-patient role in labour (Beaton, 1990; Bergstrom, Roberts, Skillman, & Speidel's, 1992; Bergstrom, Seidel, Skillman-Hull, & Roberts, 1997).

Labour support

In their 1992 work sampling study of labour and childbirth nurses, McNiven, Hodnett, & O'Brien-Pallas operationalized supportive nursing care into the categories of "emotional support, physical comfort measures, instruction/information, and advocacy" (p. 3). The purpose of the study was to obtain the amount of time nurses spent with birthing women in supportive care. To determine this outcome, the researchers employed a work sampling method of measurement in which "workers [were] observed and their activities [were] observed using an activity list to estimate the amount of time encompassed by categories of work " (p. 4). It is curious, however, that no time was spent

in conversation with nurses regarding the work activities that they did. The nature of the study reduced the complexity of nursing support enacted with birthing women into four categories. However, the research findings did not address whether such categories could appropriately reflect the complex nature of such intimate work, nor did they point to the importance of relation as a significant measure of support.

In a similar work sampling study to McNiven et al, Gagnon & Waghorn (1996) conducted random, four-hour observation periods of the supportive activities intrapartum nurses did during their regular scheduled work. Within each period, "eight 15 minute observation times were randomly selected. Observers located each nurse assigned to the unit at the time and recorded her activity. Supportive activities [also] included physical comfort, emotional support, instruction, and advocacy" (p. 1). The research indicated that nurses spent a small amount of time in supportive care with birthing women.

Although the study was specifically designed to measure only supportive outcomes, the researchers suggested possible reasons for their findings. The majority of time nurses spent away from the women was actually spent either "giving or receiving reports of patient status and care or charting, and more than one-fourth (28.6%) in preparing equipment or drugs" (Gagnon & Waghorn, 1996, p. 5). The researchers asked why these activities were given priority over supportive care. Ultimately, they suggested that current obstetrical environments—with the increased use of epidural anaesthesia, continuous fetal monitoring, intravenous infusions, and oxytocin inductions—have required nursing expertise of a technical rather than a supportive nature. Although both are necessary, the demands of current perinatal practices require more emphasis on technical proficiency, leaving little time for supportive care. If both the emotional and

physical needs of childbearing women are to be met, Gagnon & Waghorn (1996) claim that current caregivers and administrators have to re-examine their current "philosophy and practice of providing good perinatal care" (p. 6). Their research is nevertheless deficient in addressing how this would be accomplished.

In research that explored one-one nurse support of women in labour, Gagnon, Waghorn, & Covell, (1997) conducted a randomised, controlled trial with 413 nulliparous women, at more than 37 weeks gestation with singleton pregnancies, to compare the risks and benefits of one-to-one nursing labour support with regular intrapartum nursing care. The one-to-one support consisted of a nurse "during labor and birth who provided emotional support, physical comfort, and instruction for relaxation and coping techniques" (Gagnon et al, 1997, p. 71). The usual support consisted of a nurse caring for two or three labouring women doing a variety of supportive activities. The results of the study showed a beneficial trend from the one-to-one nursing support group, with a 17% reduction in oxytocin induction rates. No significant difference, however, was found in rates of epidural anaesthesia, caesarean section, perineal trauma, instrumental vaginal delivery, or admissions to the neonatal intensive care nursery. Although the randomised trial provided insight into what happened, it didn't tell us why it happened. In other words, future research is warranted to explain why the one-to-one nursing intervention entailed a reduction in the rates of oxytocin induction but not in the other technological procedures.

In Sleutel's (2000) pilot study of supportive labour techniques and strategies, observation and audiotaped interviews with an "expert" intrapartum nurse were used to document how supportive techniques were used to enhance the progress of labour and

prevent caesarean sections. The results of the study concluded that intrapartum nurses worked within a "medical model of controlling and hastening birth, as well as a supportive, nurturing, and empowering model of practice that used independent clinical judgments and advocacy" (Sleutel, 2000, p. 38). In short, "...[t]he nurse used various strategies to promote the wishes and welfare of the labouring woman" (Sleutel, 2000, p. 38). This pilot study identified labour support practices utilized by one nurse to "enhance labour and prevent cesarean births. It also identified barriers in the form of ethical dilemmas and conflicts that prevented her from implementing supportive interventions" (p. 44).

Maternal perceptions of their labour support

Acknowledging the value of qualitative research, Callister (1993) in *The role of the nurse in childbirth: Perceptions of the childbearing woman,* documented the perceptions of twenty-six married, primiparous women, in a descriptive qualitative study of the nurse's role during childbirth. The participants expressed their satisfaction with care and were previously unaware of how much nurses actually did. The "domains of support identified by these women included: emotional support, informational support, and tangible support" (p. 288). Callister (1993) suggested that qualitative research was instrumental in facilitating "sensitive caregiving...thus promoting positive childbirth outcomes" (p. 288).

In their 1994 research study with fifty-six women following delivery, Bryanton, Fraser-Davey, and Sullivan documented twenty-five helpful behaviours performed by labour and childbirth nurses that made women feel cared about as individuals during their birth experiences. This retrospective study used both quantitative and qualitative

approaches, including a ranking of the means and a content analysis of the data. Via analysis of questionnaires given to the fifty-six women, the researchers concluded that emotional support provided during labour was deemed most helpful of all behaviours. In addition, labour and childbirth nurses needed both a "high degree of interpersonal skills in the care of labouring women in addition to being technically competent" (p. 638). Nowhere in the discussion, however, was there mention of the unique nature of the perinatal nursing relation. Might one conclude that such a relation was simply reducible to interpersonal skills and a degree of technical proficiency?

In *Women's evaluations of their labor and delivery nurses,* Mackay & Stepans (1994) documented postpartum women's experiences of their labour and childbirth nurses via an exploratory, qualitative study. This study used open-ended tape-recorded interviews with sixty-one Lamaze-prepared, married, multigravidae women between the ages of twenty-one and thirty-seven. The study concluded that "although technical competence [was] important, manner, provision of supportive care, and acceptance of each woman as a unique human being may be a nurse's most important characteristic" (p. 413). Of the participants involved in the research, 90% viewed the nurses favourably because of their acceptance, encouragement, presence, positive participation, and competence. Nurses who received unfavourable evaluations failed to meet the aforementioned needs.

In an Australian study with 790 women regarding their satisfaction with care during labour and childbirth, Brown & Lumley (1994) conducted a study via questionnaires distributed to a representative sample of women living in Victoria, eight to nine months after giving birth. All hospitals and home-birth practitioners in the area

were involved in mailing out the questionnaires, although one country hospital declined to participate. The results of the survey provided evidence of dissatisfaction with intrapartum care and "demonstrated the importance of information, participation in decision making, and relationships with caregivers to women's overall satisfaction with intrapartum care" (p.4). These findings, however, did not provide concreteness or meaning into the nature of what these relationships with caregivers would entail. Future studies are warranted to understand these relations.

Dimensions of the nurse-patient role in labour

In *Dimensions of nurse and patient roles in labor* (1990), Beaton explored the social context of childbirth by analysing the records of nurse-patient interactions during labour using Stiles Taxonomy of Verbal Response Modes. Within this taxonomy, nurse and patient interactions were scored "on three dimensions of interpersonal roles, attentiveness, acquiescence, and presumptuousness, were determined" (p. 393). The research findings indicated that nurses controlled the experience of childbirth and the viewpoint of the birthing woman was rarely acknowledged. Recommendations for future research entailed studies designed to more fully understand the interaction of the nurse-patient relationship, as Beaton (1990) concluded that "nurses, through their interactions with women in labor, are one of the major determinants of the quality of each woman's birth experience" (p. 407).

Bergstrom, Roberts, Skillman, & Speidel's (1992) research with perinatal caregivers examined the ritualistic ways in which sterile vaginal examinations were performed with birthing women. By videotaping women during the second stage of labour, Bergstrom et al (1992) analysed how caregivers repeatedly performed these

examinations. The results of the study showed that examinations were performed in a ritualistic fashion that demonstrated the "power of the caregiver over the woman" (p. 10). The researchers, building on the work of Gadow (1989), recommended that caregivers re-examine their practices with birthing women and become "re-embodied." That is, "experience their bodies as part of their own subjectivity rather than as unfeeling instruments" (p. 18). Although research on embodiment is found in the nursing literature (Benner, 1994, 2000; Bergum, 2004; in press; Gadow, 1989, 1994, Wilde, 1999), little exists within the language of perinatal health (Goldberg, 2002). Future research studies are warranted.

In *"I gotta push. Please let me push!" Social interactions during the change from first to second stage labor*, Bergstrom, Seidel, Skillman-Hull, & Roberts (1997) examined the communication and social events that occurred when a birthing woman progressed from the first to the second stage of labour. The researchers analysed three videotapes of women in the second stage of labour interacting with their caregivers, usually a nurse. The research findings showed a discrepancy between the birthing woman's sensations and involuntary urge to push and the caregivers' understanding of how labour should be conducted (Bergstrom et al, 1997). Implications for clinical practice included ways of working with women that fostered women's accomplishments rather than directing ritualistic deliveries. No recommendations for future research was suggested.

Phenomenological research and perinatal nursing: A unique perspective

Understanding the need for qualitative research of an interpretive and phenomenological nature to explore the depth of women's experiences, Bergum (1989)

explored the meaning of "the mothering" experience, and how it was lived out in women's lives. This phenomenological study centred around conversations (five to eight) with six women regarding their experiences of pregnancy, birth, and mothering. This research attempted to capture the life experiences of these women and identify themes "in which to pursue a hermeneutic analysis that [pointed] back to *that* life in a deeper way" (Bergum, 1991, p.60). This research elicited knowledge via stories that were "contextualized, personal, [and] never replicable..." (Bergum, 1991, p. 62). Thematic reflections and moments came forth from the women's stories which "characterized a particular theme" (Bergum, 1991, p. 63). The themes gave rise to commonalities of the experience of mothering and were then represented phenomenologically in a written text.

Phenomenological research is reflective research that illuminates experience via thematic analysis. This methodological framework brings forth questions that are continually lived that foster dialogue and action within our practices—particularly within our practices with women. Bergum's (1989) experiential findings regarding women's transformation to motherhood further encouraged health care professionals to explore forms of knowledge appropriate for each context and each woman, "while trying to avoid attachments to knowledge for technical, marketplace, sexist, or economic reasons" (Bergum, 1991, p. 69). Bergum's (1989) *Woman to mother. A transformation* was one of the first phenomenological research studies documented within the perinatal nursing literature.

Continuing her phenomenological work in *A child on her mind*, Bergum (1997) further explored the mothering relation through the process of birth and adoption. This

phenomenological text constructed a multi-layered understanding of women's experiences of mothering: the pain, the joy, the choice, and the responsibility inherent in the transformative relation of mothering. Bergum's (1997) research entailed numerous one to two hour conversations with women about mothering, in which various women shared their stories. Throughout the research further themes emerged to capture the commonalities shared by the women which revealed "what makes mothering what it is" (Bergum, 1997, p. 10). The intent of the research was to "discover what women as mothers can be" (Bergum, 1997, p. 12). The phenomenological text crafted by Bergum revealed a way of understanding the in-depth meaning and concreteness of mothering

With woman: The midwifery relation by James (1997), is an unpublished doctoral dissertation which explored the meaning of the midwifery relation as it was experienced between midwives and women receiving midwifery care. This hermeneutic phenomenological study analysed the meaning of being "with woman" as a midwife. Data were collected through conversational interviews and observations of women engaged with their midwives. The data was analysed and themes revealed five interpretations of the whole of the experience (James, 1997). The themes included: (1) Setting the tone. (2) Trust as primacy within the relation. (3) The birth as a way of uniting the woman and midwife in the experience together. (4) Sisters, mothers, and friends as ways in which women and midwives experienced birth together. (5) "[A]wakening to our women-selves reveal[ed] the nature of women's work as experienced in the midwifery relation" (James, 1997, abstract). Although the findings of this study were not to generate theory, the results of the study brought us closer to

understanding how current midwifery practices empower a woman's experience of birth. Moreover, this study provided insight into alternative models of health care services available to women.

Callister, Semenic, & Foster (1999) in *Cultural and spiritual meanings of childbirth: Orthodox Jewish and Mormon women,* investigated the spiritual and cultural meanings of childbirth with 30 Canadian Orthodox Jewish women and 30 American Mormon women. In this descriptive phenomenological study, the participants expressed an inherent importance to bearing children in accordance with religious law. "Birth was articulated as a bittersweet paradox, often accompanied by a sense of empowerment" (Callister et al, 1999, p. 280). Religious beliefs assisted the women in defining meaning within their experiences of birth, and provided coping techniques during birth. This study identified the spiritual and cultural meanings of the birth experience "in religiously motivated women. Interviews provided personal contact with culturally sensitive nurse researchers. The women were provided with the opportunity to integrate a significant experience into the framework of their lives" (Callister et al, 1999, p. 288). Findings from this study provided a foundation for continued research on spiritual and cultural meanings of childbirth. The researchers recommended similar data be gathered from other cultural and religious groups and that data also be collected on how nurses can "more effectively care for culturally and religiously diverse women during pregnancy and childbirth to better address the spiritual needs of childbearing women" (Callister et al, 1999, p. 289).

In *The lived experience of women accompanied by husbands in labor ward*, Fu, Lee, & Yeh (2001) explored the lived experiences of women accompanied by their

partners (husbands) in Taipei, via a phenomenological methodology. Data were collected using questionnaires and tape-recorded interviews. Giorgi's phenomenological framework was used to analyze the data. Three themes emerged from the research findings: (1) The effect on the labour process by having the husband present during the birth. (2) The emotional impact of the husband's presence during the birth. (3) The impact on the family relations by having the husband present. These research findings were used to assist nurses and health care professionals understand the importance of having husbands accompany their wives during their entire delivery experience in Taipei, as existing practices prevented this experience (Fu et al, 2001).

Building on their previous research with Mormon and Jewish Orthodox women, Seminic, Callister & Feldman (2004) described the meaning of the childbirth experience from the perspective of Orthodox Jewish women living in Montreal. In *Giving birth: The voices of Orthodox Jewish women living in Canada*, the researchers appropriated a descriptive phenomenology that elicited four themes that reflected the experiences of the 30 participants within two weeks of giving birth. The themes documented were: (1) Birth is understood as a significant event. (2) Birth is defined or construed as a bittersweet paradox. (3) Spirituality is a significant aspect of the birth experience. (4) The importance of support and affirmation during the birth experience. The researchers concluded that their findings contribute to the growing body of knowledge capable of providing insight and understanding into the spiritual and cultural perspectives of birthing women. Further, "[c]hildbirth narratives from women representing other distinct cultural/religious groups will contribute to an enhanced understanding of how perinatal and women's health nurses

can optimize their care and support for all families across the childbearing continuum" (Semenic et al, 2004, p. 85).

In summary, the existing perinatal nursing literature fails to address the in-depth and complex nature of the relation labour and childbirth nurses foster in their daily practices with birthing women. Although James' (1997) study revealed this relation in her work with midwives, no such study exists with perinatal nurses in current practice. A phenomenological study is thus warranted to understand this relation and reveal its meaning and concreteness.

This chapter has explored the research question, its significance in my own life, how it influences my perinatal practice, and the ways in which it affects my experiences with birthing women and their families. To fully understand the relevance of the question, I have situated it within the greater context of the perinatal nursing literature. In so doing, I have highlighted the ways in which my interpretation of the question is distinct from other researchers in perinatal health.

In chapter two, *a corporeal methodology for living practice,* I legitimize my choice of interpretive and feminist phenomenology as the methodological framework to guide the research study. Because phenomenological research focuses on understanding about, perceptions of and attitudes toward lived experience (Benner, 1994; Bergum, 1989; Merleau-Ponty, 1962), such a framework is appropriate for this study as it focuses on nurses engaged with birthing women during their bodily experiences of birth. Moreover, such a methodology is justified when attempting to elicit the meaning of a phenomenon from the participants themselves (Morse & Field, 1995).

A feminist orientation is also pertinent to the study, as this research is concerned with hierarchical health care practices and how they have positioned birthing women and their nurses against a Cartesian backdrop of disembodiment and power relations. How these practices are lived within the embodied consciousness of the female subject is thus relevant to the research project (Beauvoir, 1952/1989; Young, 1990).

The next four chapters, *introductory engagement*, *embodied trust*, *woman-centered birthing*, and *power*, reflect the storied text embedded in the themes used to explore the meaning of the perinatal nursing relation. The heart of the research findings is found in chapters three through six. Chapter seven, *final reflections*, provides a brief summary of the overall project and its relevance to current practice and suggestions for future research.

Chapter Two

A Corporeal Methodology for Living Practice

> *Philosophy is indeed, and always, a break with objectivism and a return from constructa to lived experience, from the world to ourselves. It is just that this indispensable and characteristic step no longer transports it into the rarified atmosphere of introspection or into a realm numerically distinct from science. It no longer makes philosophy the rival of scientific knowledge, now that we recognize that the "interior" it brings us back to is not a "private life" but an intersubjectivity that gradually connects us ever closer to the whole of history.*
>
> *(Merleau-Ponty, 1964, p, 112)*

In reflecting on an appropriate methodology to ground my research inquiry, I turned to phenomenology, which was not surprising considering my background in philosophy. As I required a research tradition conducive to understanding the in-depth nature of perinatal nurses' experience of being in relation with birthing women, phenomenology provided living knowledge for experiential research (Allen & Young, 1989; Benner, 1994; Leder, 1990; Merleau-Ponty, 1962, 1964; Van Manen, 1998; Young, 1990). Because much of the aforementioned perinatal research focused on supportive care (including categories of support and maternal perceptions of support), but ignored the relational practices of nurses, I was curious to understand these practices in an in-depth and experiential way—incongruent with methodologies that reduced nursing relations to categories, variables and/or behaviours.

As "[h]uman experience is incarnated...[and our] relations with others are based upon our mutuality of gaze and touch, our speech, our resonances of feeling and perspective" (Leder, 1990, p. 1), a phenomenological exploration of relation provides a way of understanding perinatal nursing practices as they are lived out with women during their bodily experiences of birth. Phenomenology is derived from the Greek

word *phenomenon,* meaning "to show itself," and such a form of inquiry elicits a methodology for revealing the unique nature of nurses' work. Phenomenological accounts of embodiment, specifically those of Merleau-Ponty (1962) have primarily focused on the modalities of motility and perception, and how we experience such modalities in our interactions with the world (Leder, 1990). According to Merleau-Ponty (1962),

> [L]iving (*leben*) is a primary process from which, as a starting point, it becomes possible to 'live' (*erleben*) this or that world, and we must eat and breathe before perceiving and awakening to relational living, belonging to colours and lights through sexuality, before arriving at the life of human relations. Thus sight, hearing, sexuality, the body are not only the routes, instruments or manifestations of personal existence: the latter takes up and absorbs into itself their existence as it is anonymously given. (p. 160)

Unlike the majority of perinatal research that has ignored the relational practices of nurses, negating the contextual nuances of lived experience, phenomenological (interpretive) research constructs a view of reality in which the situated experiences of perinatal nurses and birthing women are understood as existing in a human world—historically constructed, multifaceted, and grasped only under certain finite situations (Benner, 1994). Rejecting the Cartesian model of healthcare that has permeated the natural sciences, decontextualizing research environments and generating models of abstraction and generalization (Plager, 1994), phenomenological inquiry allows us to research experience as it is lived in the world of everyday life (Merleau-Ponty, 1962).

In other words, interpretive (hermeneutic) phenomenology as a research tradition lends itself to an in-depth description of and understanding about the meanings embedded in the phenomena to be studied. Such a tradition challenges us as practitioners to become "more effectively, skilfully, or humanely engaged in practice" (Benner, 1994, p. xv). This view of science provides a discipline like nursing with a framework for embracing the contextual situatedness of our complex lives (Clandinin & Connelly, 2000). Benner (1994) suggests that, "Interpretive phenomenology holds promise for making practical knowledge visible, making the knack, tact, craft, and clinical knowledge inherent in expert human practices more accessible" (p. 124). Through stories, exemplars, and thematic analysis, this research tradition offers in-depth understanding. "Because nursing is primarily a practice discipline, it seeks to understand individuals in all their uniqueness and particularity" (Pascoe, 1996, p. 1311). We cannot hope to capture this uniqueness by remaining detached, uninvolved, or disinterested (Pascoe, 1996). Rather, such a research tradition demands of us an immediacy, a sense of meaning within our encounters, and a uniqueness in how we view the lifeworld (Dahlberg & Drew, 1997).

However, "[a] concrete philosophy is not a happy philosophy. It must hold close to experience, and yet not limit itself to the empirical but restore in each experience the ontological cipher that marks it internally" (Merleau-Ponty, 1964, p. 157). In other words, a concrete philosophy is a messy philosophy because it is committed to capturing an understanding of experience. Although there are facts to guide our inquiry, phenomenological research is bound by the incalculable nature of experience itself. Phenomenological (interpretive) research therefore becomes both the source and object

of the research (Van Manen, 1998), situating experience within a dialectic between self and the world. A dialectic suggests a relationship of increasing complexity, in which we advance from partial knowledge to a more comprehensive state of understanding (Gadow, 1982). Merleau-Ponty (1962) claims:

> All my knowledge of the world, even scientific knowledge, is gained from my particular point of view, or from some experience of the world without which the symbols of science would be meaningless. The whole universe of science is built upon the world as directly experienced, and if we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by awakening the basic experience of the world of which science is the second-order expression. (p. viii)

Phenomenological inquiry thus "recasts the question of the empirical, and hence all the questions of subjectivity and objectivity with regard to it, on a fundamentally different plane, tracing these back to the intersubjective origins of meaning" (Burch, 1989, p. 206). Therefore interpretive phenomenology rejects a Cartesian metaphysics in which the body is divisible into material matter—the empty vessel—and immaterial substance: the mind or soul. An interpretive phenomenology is thus committed to an inter-subjective understanding of the body: historically situated, relational, and defined in Heideggerian terms as a "being-in-the-world." Such a term suggests human knowledge is relational, temporal, and present in the world, as opposed to being objective, static, and independent of the questioner. Stewart & Mickunas (1990) write,

> [O]ne discovers his own authentic humanity only by recognizing the humanity of others. Authentically existing individuals who recognize each other's

humanity constitute a community. This dimension of concrete human existence cannot be ignored any more than body or freedom, for the social context in which one finds himself is also part of one's being-in-the-world. (p. 67)

Although the origins of phenomenological inquiry (method) can be traced back to the philosophy of Husserl (1936/1970) and the study of consciousness, the phenomenological tradition has been hermeneutically shaped by the historical interpretations of Dilthey (1987), the Heideggerian (1927/1962) concept of being (*Dasein*) and the Gadamerian (1982) "fusion of horizons," in which an historical perspective influenced the hermeneutic (interpretive) process. However, unlike the transcendental phenomenology of Husserl (1936/1970), committed to uncovering the essential structure of "things-in-themselves," suspending from consciousness all presuppositions, Heidegger (1927/1962) introduces the notion of "being-in-the-world". For Heidegger (1927/1962), presuppositions give legitimacy and intelligibility to the possibility of being. It is with Merleau-Ponty (1962), however, that a research tradition capable of eliciting knowledge for the body is revealed: a tradition particularly compelling and relevant to this project because it provides a methodological framework capable of reconceptualising the body outside dualism.

Although Merleau-Ponty's work has been appropriately criticized by feminist scholars for generalizing all experience to male experience, he makes an important contribution to the mind-body relation outside dualism. Grosz (1994) suggests, "Merleau-Ponty's work provides a set of powerful insights and a broad methodological framework in which to rethink the body outside dualism [although] his work remains inadequate for understanding the differences between the sexes" (p. 109). Merleau-

Ponty (1962) claims,

> Bodily experience forces us to acknowledge an imposition of meaning which is not the work of a universal constituting consciousness, a meaning which clings to certain contents. My body is the meaningful core which behaves like a general function, and which [therefore] exists... (p. 147)

For Merleau-Ponty (1962), the phenomenological project is revealed in the relation of the body as it is lived and experienced in the world. The body is therefore interpreted as both immanent and transcendent. "Insofar as I live the body, it is a phenomenon experienced by me and thus provides the very horizon and perspectival point which places me in the world and makes relations between me, other objects, and other subjects possible" (Grosz, 1994, p. 86). As Irigaray (2001) reminds us,

> We perceive, think, remember the encounter between living bodies though different types of particularity: colour, height, age, facial features, etc. We have not considered this encounter within the horizon of what is, at the same time, interior and exterior, to us. Of what unites the in-us with the outside-of-us: gender. Intersubjectivity, in order to succeed in interiorising the exteriority of the human, must take into account the dimension of gender as a means capable of protecting alterity. (p.53)

Irigaray's (2001) words suggest that gender is relevant when engaging with living bodies. As perinatal nurses engage with birthing women within the context of relation, the gendered body becomes relevant to their practices, particularly when such practices are situated within the hierarchy of health care institutions, and the power dynamics that permeate these environments. In what follows I situate my understanding of

phenomenology within a feminist perspective by building on Merleau-Ponty's (1962) notion of the lived body. In so doing, I briefly explore my interpretation of feminism and its relevance to the research project.

Feminist Phenomenology: A Blending of Traditions

My understanding of feminism is situated within a tradition of feminist theory that is neither monolithic or simplistic. Although feminism began as a way of naming patriarchy, revealing the systemic oppression and victimization women routinely confronted, the feminist concerns of today are more complex. Because of challenges put forth by women of colour, women from the Third World, women with (dis)abilities, and lesbian women, essentialist claims about women's nature and women's shared identity have been critiqued and theories of difference have been developed (Allen & Young, 1989). Allen and Young (1989) suggest,

> Claims, frequently French inspired, that to define a common woman's oppression is inappropriately essentialist, have motivated many American feminists to withdraw from the categorical claim that there is a single system of patriarchal expression. Reflection on the positive values of female experience of the body, female friendship, motherhood, and women's culture as expressed in feminist art, music, and poetry has brought feminists... to develop varied understanding of women's liberation. (p. 12).

I concur with Allen and Young (1989), insofar as there is no common experience of women's oppression. Further, to foster an understanding of women's liberation requires us to value a variety of diverse female experiences. Although many feminists turn to phenomenology, particularly the work of Merleau-Ponty (1962; 1968)

to legitimise their projects on female experience, these writers are dubious of the ways in which phenomenologists take men's experience to be synonymous with human experience (Grosz, 1994). Because a feminist project takes seriously the ways in which power shapes women's experience within patriarchy, generalizing all experience to male experience is inappropriate for a feminist undertaking, particularly a project based on the relational practices of nurses and women during the embodied experience of birth.

Being critical of a feminist project, some traditional phenomenologists (Van Manen, 1998) claim that it is inappropriate to conduct research from a particular standpoint. If one is to research experience phenomenologically, it can only be done through the experience, not by imposing a theoretical lens. Because phenomenological research is not politically motivated or aimed at social change—as is feminist research—certain phenomenologists reject the possibility of a "feminist phenomenology".

Although I understand the concerns of these scholars, I disagree. Many of the methodological and epistemic assumptions of a phenomenological inquiry are compatible with a feminist perspective. Beauvoir (1952/1989), for example, in her revolutionary text, *The second sex*, provides a feminist phenomenology of exceptional depth exploring women's experience and the "becoming" of a woman. Although Beauvoir's (1952/1989) claims are often controversial on topics such as mothering and marriage, she nevertheless provides a phenomenological project similar to Merleau-Ponty's (1962) work on the "lived body". Beauvoir (1948) states, "The body is not a brute fact, it expresses our relationship to the world" (p. 41). It is within this bodily

relation that Beauvoir attempts to provide a phenomenology of female experience, not as "a theory of changeless essences but to study the feminine variation of human experience" (Heinamaa, 2003, p. 79). A further trait of Beauvoir's work is her ability to affirm "women's recovery of lived experience" (Allen, 1989, p. 79), insofar as she provides ways of understanding women's lives that are unlike those traditionally represented by men.

The recovery of women's lived experience found in Beauvoir (1952/1989) is echoed in the phenomenological writings of Young (1990). In her accounts of breasted experience, pregnancy and female bodily comportment, Young turns to women's embodied consciousness as a vital component of women's existence. Recognizing that women's experiences in the world are uniquely embodied by virtue of gender, Young challenges us to see how these embodied experiences position women in the world of patriarchy, and how these experiences could be otherwise.

Recognizing the value of women's lived experience and the primacy of the embodied female subject, Beauvoir (1952/1989) and Young (1990) provide phenomenological traditions that reflect my interpretation of feminist phenomenology. Understanding that there is no one female experience that reflects the complexity of women's lives, my research explores the variation of experiential practices nurses foster within their relations with birthing women. These experiential practices have often been marginalized and made invisible, largely based on the fact that women have traditionally carried out caring practices, like those embedded in nursing. Because nursing has historically been deemed women's work, the practices associated with it have been

devalued, further reducing the ethical possibilities for women within the gendered institutions and social structures in which they work (Bowden, 1997).

Caring practices have been difficult to specify, unless made visible by task-oriented functions that negate the inherent value and complexity found in caring itself (Bowden, 1997). Hence caring practices, like many of those found in this research study, are often lost when translated into tasks, skills, and functional duties. Policy makers have difficulty understanding practices that can't be quantified or made visible through techniques other than those embedded in functional nursing: inserting a catheter, initiating an IV, or administering medication. Although these skills are both necessary and important to nursing and the health and well being of birthing women, they don't reflect the ways in which nurses comfort women prior to and during the administration of medication (i.e. epidural anesthesia) or the care and time it takes in relating to a birthing woman prior to administering a catheterization or a vaginal exam.

The nurses and women in this study reveal the ways in which vulnerability is situated at the center of the birth experience so much so, that functional nursing is not sufficient to embody the practices necessary to sustain a woman during her bodily experience of birth. Neysmith (1991) reminds us, "Caring is pivotal to keeping the human enterprise going, yet its function is invisible in the organization of our daily lives" (p. 281). Feminist phenomenology, then, offers us a methodological framework capable of making the invisibility of the female gender visible, by bringing the relational practices of perinatal nurses engaged with birthing women, within the confines of institutionalized health care and power relations to the forefront. In so doing, this research provides an

initial way for policy makers to understand that "good" and ethical practice requires more than what is merely functional or task-oriented.

Method: Collecting the Data

As phenomenological research is a "human science that strives to 'interpret' and 'understand' rather than observe and explain" (Bergum, 1989, p. 46), its ultimate goal is not generalization to like populations. Rather, phenomenological research "is a science whose purpose is to describe particular phenomena, or the appearance of things, as lived experience" (Streubert & Carpenter, 1999, p. 43). For the purpose of this study, data were collected via conversational interviews, participant observation, and reflective journaling. In addition, I explored philosophical, feminist, and literary sources of information to further deepen my understanding of the perinatal nursing relation.

Getting started

Following approval from the University of Alberta Ethics Committee, I recruited participants from a low-risk hospital in Edmonton. After meeting with the nurse manager and explaining the purpose and intent of the study to gain her support, the next step in the process was twofold: First, I provided numerous informal talks to the perinatal nurses on the labour unit during shift changes to explain the background, purpose, and intent of the study, and to recruit interested nurse participants. This was a stressful experience, as I had little time to explain the full extent of the study, and as a nurse myself, I knew first hand how tired the nurses were after a 12 hour shift. Therefore, I often came to the unit with doughnuts and a good sense of humour. This seemed to work well, as 8 of the nurses agreed to participate in the study.

Letters of invitation (see Appendix A) with the relevant information pertaining to the study and a contact number that indicated where I could be reached were also left on the unit for interested nurse participants. I was pleasantly surprised upon my return to the unit one morning to see that one of the nurses had actually made a space for my letters of invitation, and put them on the bulletin board in the report room for everyone to see. This inspired me further as it suggested an interest in my work.

The second step in the recruitment process was also facilitated by the support of the current nurse manager. As with the brief talks I gave to the nurses introducing the background and purpose of the study, I did the same in prenatal classes in order to recruit women participants postpartum. Letters of invitation (see Appendix B) were made available for the women interested in participating in the study. A contact number was included where I could be reached if the women wanted to participate in the study. I also included a voluntary sign-up sheet that enabled me to contact the women to talk further about the study and answer any of their questions, as the time I was given to discuss the study was minimal. All arrangements with the 8 women who participated in the study were made in the antepartum period.

Throughout the study, perinatal nurse participants were selected based on the following: 1) Participants involved had clinical practice in labour and childbirth for a minimum of one year. 2) Participants had the reflective capacity to recall their storied experiences of working in relation with birthing women, and a willingness to share their experiences with the researcher. 3) Participants involved in the study were registered nurses working in labour and childbirth, although varied educational backgrounds were encouraged (diploma, baccalaureate, and/or midwifery education).

4) Participants were able to speak and read the English language. As the research study was concerned with the relation between and among perinatal nurses and birthing women, participants within the study also included postpartum women approximately 2 weeks following their birth experience. Hence, postpartum participants targeted for this study were selected based on the following criteria: 1) Participants gave birth in the targeted low-risk obstetrical facility (hospital) and laboured for no less than 2 hours. 2) Participants had the reflective capacity to recall the ways in which their nurses enacted relation within their practices during their birth experiences. In addition, the participants had a willingness to share the data via stories and conversations with the researcher—independent of the outcome. 3) The postpartum women participants had the ability to speak and read the English language.

In keeping with the tenets of phenomenological research, purposeful sampling was employed throughout the study as it involved the selection of the best participants, those who had lived the experience to be studied (Morse & Field, 1995). Both perinatal nurses and women were selected as participants for the study, as relation involves an interaction between persons. More importantly, institutional hierarchies influence and shape perspectives in diverse ways. It was therefore of import to have the various perspectives represented in the study.

The nurses in the study include: Jessica, Marcia, Phoebe, Melanie, Joan, Amy, Michaela, and Karla. These nurses represent a range of educational backgrounds: some have degrees in nursing or are working on their degrees, while others have diplomas in midwifery and come from countries other than Canada. There are nurses in the study who have a diploma in nursing, and have spent their career working in Canada,

although some of the nurses have also worked in other countries prior to returning home to Alberta. The women involved in the study are Susan, Madison, Rachel, Anne, Mary, Jen, Meagan, and Abbey. They reflect a variety of first time mothers living in Alberta who have birthed their babies in a hospital environment. Like the nurses, some have university educations, while others do not. All the women in the study have received care from nurses who work on the unit where I recruited the nurse participants, although they may not have received their care from one of the nurses in the study.

In chapters three through six, there are other women who contributed to the research study. During my research experiences as a participant observer, I obtained data by participating in care with the nurses, and the women they attended on the days I joined them in practice. Although I have not identified all the women who signed consent forms (see Appendix C) permitting me to participate in their care, their generosity in allowing me to be in their presence while they birthed contributed greatly to my understanding of the perinatal nursing relation.

Conversational interviews

The participants involved in the research were one of the primary sources of data used to develop the study. Data collection involved the use of conversational interviews which lasted 45-90 minutes in duration prior to any observational data, and were used for the purpose of obtaining an understanding of the perinatal nursing relation. Although most of the women participants were interviewed in their own homes, often in the presence of their babies, the majority of the nurse participants were interviewed in a small conference room at the John Dossetor Health Ethics Centre, University of Alberta. Conducting conversational interviews as a novice researcher was

both interesting and exciting.

Because I am verbose by nature, it was important for me to arrive at the interviews prepared to listen, not to talk. Surprisingly, that is what I did. Sometimes I would compose a little song in my head that would instruct me not to talk. I am not sure what the melody was, but the words seemed to take effect, for a number of the participants frequently commented on my quiet nature. I often thought, "If only my friends and family could by privy to this information, they would never believe it!" There were times, however, when the conversations needed occasional guiding or prompting. As the conversational interviews occurred with both perinatal nurse and postpartum women participants, different questions were selected to keep the conversations open and encourage reflective dialogue with each group of participants. The first three questions were therefore selected to prompt the conversations (Bergum, 1997) with the nurse participants. The fourth question was used to encourage similar conversations with the women participants:

(1) Describe an experience of being in relation with a birthing woman as a labour and childbirth nurse.

(2) Are there things that either enhance or diminish your ability as the nurse to work in relation with birthing women? Are there barriers that prevent you from doing your work in ways that you would like?

(3) How do you as the nurse experience birth with women in terms of their bodies, birthing time, and birthing space? In other words, how do you interact with birthing women in ways that consider their bodily needs, the space required for birth (the atmosphere, spatial positioning) and the birthing trajectory?

(4) Describe your relationship with your labour and childbirth nurse.

All conversational interviews were audiotaped and transcribed verbatim by a transciptionist for data analysis. Although only one formal interview was done per participant, I engaged in many informal interviews, particularly with the nurses during my time spent in participant observation on the labour unit. Further, I did follow-up phone calls with all participants, which often evolved into informal conversations regarding the research study, birthing, relationships, and the practices of perinatal nurses and birthing women.

Participant observation

Other data sources used to further elicit the perinatal nursing relation included participant observation within the labour and childbirth area, in which I shadowed a nurse assigned to work with a birthing woman for a portion of her shift. Depending on the status of the birthing woman and/or the activities on the labour unit, my observational shifts ranged anywhere from 4-6 hours in duration. As the researcher, I remained as either a quiet observer, or an active participant engaging in nursing care with the labour nurses in the birthing environment—depending on the situation involved. As birth is an unpredictable experience, as the researcher I employed a variety of observation techniques, taking my cues from the nurses providing care, and the birthing women they attended in their practice. During my observational shifts, no time was spent taking notes or writing accounts of the activities I observed. In fact, I was often so involved in the birth experiences I was researching, I was occasionally mistaken for one of the nurses on the unit. However, I did write accounts of all my observations as soon as I had time to commit them to paper shortly after they occurred.

Additional sources

Philosophical, feminist, and literary sources as they were uncovered throughout the research inquiry further provided sources of data for the research study. Poems such as *The womb* (Spade, 1994) and *The birthing room* (Krysl, 1989) helped to evoke a deeper understanding of the perinatal nursing relation. *To be two* (Irigaray, 2001), *Phenomenology of perception* (Merleau-Ponty, 1962), and *Whose body? Whose story? The question about narrative in women's health care* (Gadow, 1994) laid further claim to the ways in which the perinatal nursing relation was understood philosophically. Feminist scholars including Beauvoir (1952), Bowden, (1997), LeGuin (1989), Mairs (1994), Taylor (1993) and Young (1997) nuanced the relational practices of the nurses within a feminist understanding and interpretation.

Throughout the research I maintained a reflective journal describing my thoughts, feelings, and beliefs associated with each interview and observational experience. The reflective journal reinforced rigor within the study, insofar as it kept me—the researcher—aware of my personal biases and the unique perspective I brought to the research project. For example, after conducting a conversational interview with one of the nurses, I would often reflect on how that nurse made me feel. Did she reflect aspects of my practice? If so, in what ways were we alike, and in what ways were we different? If we were different, how did this make me feel, and did it reflect aspects of my practice as a nurse? These were the types of questions I pondered in my reflective journal.

Written narratives (see Appendix F) were also requested from the nurses and postpartum women in an attempt to provide additional stories to understand the

relationship that exists between and among perinatal nurses and birthing women. No such narratives were written by the participants. The research was undertaken during the summer months in which the labour unit was very busy, and many of the nurses had vacation time. The women participants were also busy, spending their time caring for their newborn babies. Thus the narratives and stories throughout the research were written solely by me and derived from the transcripts and observational data only. All citations documented throughout the research without an accompanying reference are taken directly from the transcripts provided by the perinatal nurse and postpartum women participants.

The use of story and narrative

The use of narrative was prominent throughout the research inquiry, as each participant shared her unique story during our conversational interviews. Gadow (1996) suggests that stories about particular lives are not isolated stories, but rather they exist within a web of impersonal narratives embedded in gendered, politicised, and cultural interpretations of the self. Sandelowski (1991) claims that stories are typically presented and understood within an archetypal narrative framework. Thus stories have a shape and structure with a subject matter: a beginning, middle and an end (Scholes, 1981). More importantly, stories provide a method of elucidating experience that cannot be expressed in abstract propositions or mathematical calculations. Carter (1993) says,

> At one level, story is a mode of knowing that captures in a special fashion the richness and the nuances of meaning in human affairs. We come to understand sorrow or love or joy or indecision in particularly rich ways through the

characters and incidents we become familiar with in novels or plays. This richness and nuance cannot be expressed in definitions, statements of fact, or abstract propositions. It can only be demonstrated or evoked through story. (p. 6)

Carter's words remind us of the unique knowledge gained through storytelling. It is richly layered and experiential, unlike knowledge gained through abstract reasoning or mathematical formulations. Fairbairn and Mead (1993) concur with Carter's (1993) understanding of storied knowledge, and employ the art of storytelling as a tool in their educational workshops with nurses, and other health care professionals. Fairbairn and Mead (1993) suggest,

> In this development, the emphasis is on understanding people by listening to the stories they tell about their lives rather than treating them as if they are passive subjects (or even objects). It is about helping them to make sense of their lives by listening to the stories they tell and of making sense of our own lives by listening to the stories that we tell. (p. 38)

For Fairbairn and Mead (1993), the use of storytelling becomes a form of active knowledge, insofar as it requires the nurse to participate in the process of making her experience visible through the telling of her stories. "Nurses tell stories about their practice in different ways, depending on the way in which they construe nursing and the contexts in which they work" (Fairbairn & Mead, 1993, p. 38). Within the context of the research study, stories provided an experiential framework for exploring the perinatal nursing relation.

Thematic analysis

As phenomenological inquiry is interpretive inquiry, data analysis within this

tradition "requires that researchers dwell with or become immersed in the data" (Streubert & Carpenter, 1999, p. 60). Such immersion fosters the researcher's ability to acquaint herself with the uniqueness of each participant's story while facilitating a unique interpretation of the phenomenon under investigation (Streubert & Carpenter, 1999). Data analysis throughout the study entailed careful listening to the verbal descriptions provided by the participants, followed by a reading and re-reading of the transcribed text. Text was analysed in a reflective and questioning manner, yielding a process of thematic analysis—in which themes evolved within the text.

Van Manen (1998) suggests that a *theme* in phenomenological work is a tool for understanding the meaning of experience. It provides focus, insight, and a point of entry into the work. Unlike a category that may be fixed and unchanging, a theme is never complete, although it attempts to "touch the core of a notion we are trying to understand" (Van Manen, 1998, p. 88). A theme is often a simplification of an experience, as we often fall short of capturing an adequate interpretation; words may not fully capture the depth of an experience. Bergum (1989) suggests that we must not make too much of themes, as they could be otherwise. Thus themes are not things we encounter within a text; but rather, they are structured ways of attempting to shape a text to elucidate a deep interpretation of experience (Van Manen, 1998).

Thematic analysis refers to "the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work" (Van Manen, 1990, p. 78). For example, Van Manen (1998) suggests the use of temporal, spatial, relational, and bodily existentials to guide the analysis of phenomenological work. The result of such an analysis yields a richly textured understanding of lived

experience. The conversational interviews, observations, and reflective journaling conducted throughout this research study revealed storied (narrative) accounts of the perinatal nursing relation. Thematic analysis aided me—as the researcher—in eliciting the themes within the stories that reflected the embodied meanings of such a relation.

Throughout the period of data analysis, I continued to return to the transcribed text with new questions and new insights to further explore the depth of analysis inherent in the phenomenological inquiry to understand the perinatal nursing relation. I was therefore engaged in a conversation and relation with the text, as well as with the participants. My phenomenological analysis began with text, but coalesced into the collection of data, analysis, and phenomenological writing, as there was no separation from the comprehensiveness of the whole by compartmentalizing each event into discrete stages (Van der Zalm, 1999).

Evaluating a Phenomenological Inquiry

The credibility and authenticity of a phenomenological and interpretive inquiry is not validated by the objective measures of reliability and validity. Within a phenomenological inquiry, the researcher is concerned with the meaning of experience, rather than the nature of truth (Sandelowski, 1991). Smith (1994) suggests "that the mark of good interpretive research is not in the degree to which it follows a specified methodological agenda, but in the degree to which it can show understanding of what it is that is being investigated" (p. 125). A credible and good interpretation is one that Jardine (1992) describes as non-definitive, yet "keeps open the possibility and the responsibility of *returning, for the very next instance* might demand of us that we understand anew" (p. 57). Scholars of such work suggest that one evaluate

phenomenological and interpretive work on its ability to open up questions and adhere to the philosophical traditions in which they are derived (Benner, 1994; Van Manen, 1998). The validity of qualitative and interpretive research findings exist in their offerings, and "...how they look to your mind's eye, whether they satisfy your sense of style and craftsmanship, whether you believe them, and whether they appeal to your heart" (Sandelowski, 1994, p. 61).

An approach of the study

This inquiry was approached from my experiences as both a feminist researcher and practicing nurse, thus offering certain political, historical, social, and gendered interpretations of the work. Scott (1992) suggests, "Experience is at once always already an interpretation *and* in need of interpretation. What counts as experience is neither self-evident nor straightforward; it is always contested, always therefore political" (p. 37). Scott's words articulate the view that experience is not removed from political, social and historical influences. We cannot therefore construct a "vantage point from which to judge them" (Grosz, 1994, p. 94). Although this inquiry was situated within an interpretive tradition, previous studies in perinatal health have also been situated in certain traditions, often those that excluded experiential and interpretive work. My aim in this research was to incorporate experiential methodologies to provide both voice to and visibility for the relational work of perinatal practices, while recognizing that such methodologies, like all methodologies, were not exempt from certain perspectives.

Ethical Considerations

Ethical approval to conduct this inquiry was sought through the Health Review

Ethics Board. The ethical considerations of the study as they related to the participants included informed consent, confidentiality, anonymity, and ethical sensitivity—as the nature of phenomenological work is highly personal, intersubjective, and capable of eliciting emotional responses.

Nurse and postpartum women participants were invited to participate in the study via a letter of invitation (see Appendix A and B). Those who expressed an interest in the study were able to meet with me (the researcher) at a time and place of their convenience. At this time the study was explained and questions were answered. If interested in participating in the study, the consent (Appendix C) was explained and signed, my number was given, and the participants were informed that they could withdraw from the study at any time without adverse consequences. Each participant was given a copy of both the information letter and the consent form.

Confidentiality protects the vulnerability of participants who have shared their lived experiences with the researcher. Participants were informed that only the researcher, research committee, and transcriptionist had access to the raw interview data (audiotape/transcribed text). These individuals were aware that all research data and information was confidential. Pseudonyms were selected by participants for the purpose of anonymity and used throughout the research process. The true identities of the participants involved in the research study were known only to the researcher. The nursing community within a hospital, however, is very small, and although I made every effort to keep the nurses' involvement in the study confidential, many of the nurse participants were excited about contributing to the study, and often shared information amongst themselves.

As the nature of the study related to the intimate experience of birth, I was constantly aware of how the experience situated a woman in a place of vulnerability. As the nature of the research was not limited to the time of the birth experience for the postpartum woman or perinatal nurse, interpretations and reflections may be altered over time. As the researcher, my ethical commitment to the participants—both the nurses and the postpartum women—extends beyond the research, and beyond that particular point in time (Bergum, 1991; James, 1997). I therefore remained sensitive to the needs of the participants, and understood that I—as the researcher—was also transformed in the telling of the stories, as phenomenological research potentiates a powerful emotional response for both the participants and the researcher.

This chapter has provided an overview of the methodological framework used to conduct this research inquiry. The next chapter, *introductory engagement*, explores an understanding of the initial moments of care that occur between and among perinatal nurses and the birthing women within the context of institutionalized health care.

Chapter Three

Introductory Engagement

> *First of all, I want to say that it's an honour to work with women who are giving birth. I think, 25 years ago I sort of promised myself that if I ever lost the wonder I would leave and I never have lost the wonder and I think that's really important. I think it's probably the most empowering thing a woman can do. There's this old Helen Reddy song, you know, "I am woman, hear me roar."*
>
> *(Nurse Jessica)*

The relation that forms between a labour nurse and a birthing woman is unique. In a short period of time an engagement occurs that unites the two together in an embodied experience that ends with a remarkable journey: the birth of a baby. When we first think of engagement, lovers approaching marriage often come to mind. To engage with another is derived from Old French, meaning to secure, pledge, attract or charm (Oxford Concise Dictionary of English Etymology, 1996; Bergum & Dossetor, in press). Gadow (1999) speaks of engagement as intrinsic to relation, but incapable of being defined by principles. Building on Dillon's (1992) concept of "care respect", an integration of respect for persons with the compassion of care ethics, Gadow (1999) states,

> The engagement of care respect is the opposite of ethical objectivity; it is personal responsiveness to the particular other, a relation between individuals that is grounded in the ambiguity of their being at once encumbered and free, situated and transcendent. (p. 63)

For Gadow (1999), rules and codes have no command on engagement. The moral worth of engagement is embedded in the very nature of engagement itself. Drew and Dahlberg (1995) claim that engagement rests on how the caregiver is perceived:

"The caregiver is more likely to be productive if the caregiver is perceived as nonjudgmental, sensitive, ethical, someone who creates a sense of comfort in the collaborative relationship involved in the healing process."(p. 337). Only then, can the caregiver engage and be in the immediacy of the relationship. That engagement can be interpreted within a moral realm is the view described by Bergum and Dossetor (in press). In this context engagement is defined as a response to the Other, a possibility of attaining full personhood by discovering one's full capacity in relationship. Within this relationship, the self is not challenged to hold altruism in opposition to egoism. Rather, the self attends to the Other while simultaneously attending to the self. For Bergum and Dossetor, this entails that the "You and I" in the relationship are fully present and thus engaged.

The engagement that evolves between a labour nurse and a birthing woman is often predicated on the importance of their initial encounter. Although engagement is necessary to sustain relationships over time, the initial moments of care leave lasting impressions on both birthing women and their nurses. Marcia, one of the nurses in the study, suggests that engagement begins with "a smile or a sense of reverence" for the Other. Jessica, another nurse participant, claims that relationships with birthing women begin with "a sense of wonder." "Reading your audience and understanding what they will need from you" is how Nurse Michaela understands the initial moments of care with the birthing women in her practice.

Whether the birthing woman arrives in labour with the baby crowning, where little dialogue is possible and birth is imminent, or for a scheduled induction, where a leisurely conversation can occur, the introductory engagement that evolves between a

birthing woman and her nurse is the initial theme that foregrounds this phenomenological research and evokes the perinatal nursing relation enacted in labour and childbirth. In what follows, the ways in which the introductory moments between birthing women and their nurses ground their future relationships and "set the tone" (James, 1997; Nurse Marcia) for their engagements will be the focus of this chapter. The first moments of an engagement reflect the importance of the gaze, the touch, and the listening qualities a nurse reveals in her care. If these qualities are forgotten or dismissed, a relationship may be disrupted, resulting in an uncomfortable and/or disrespectful experience for both the birthing woman and her nurse. If, however, the nurse is both attentive and supportive in the initial moments of care, a foundation is established that potentially promotes an engaged and respectful experience of birth.

To Revere the Other

> Part of building a relationship is working with the family, with the people in the room that are the support for the mum because if the family is upset, the mother's upset. So the most important thing when a woman walks in is to smile at her. There is nothing worse than the initial meeting of a woman coming to our unit to meet someone who says, "yes, what do you want?" and no smile. I think it is extremely important because that sets the tone. So when I go in I usually smile and explain exactly what's going to happen, and I explain that I am aware that they're nervous and it's exciting all at the same time. I usually ask them about why they are here and I try and make a joke, especially if I know them, because I teach Prenatal Classes, and I have worked in the same area a long time.

When you first lay your hands on a patient she must know you're treating her with respect, with reverence. You just don't pull the covers back, you try to make sure that she's covered and she's warm and she's comfortable. You talk to her and make eye contact with her, and you smile at the same time. Then, when you are taking her personal details, even though you have to do the history and confirm the information, you make it more about the questions that she has, not about what you are asking. For the most part you can obtain the information you need. How many pregnancies you have had is an easy question. At the end of the history, though, I say, "What did you like about last time? What do you want this time? Do you want to hang from the ceiling by a rope singing a song? Or, do you want to go upside down and show the world your bottom?" Then, I incorporate the dad and ask if he is going to be part of the experience or if he is going to faint?

Marcia's words reflect the reverence she enacts with the women in her care. To revere another human being is to elicit deep respect. Marcia enacts her respect for women from the very moment she introduces herself: Her touch, her smile, and her exuberant humour encapsulate an intrinsic respect for women. Within her practice, Marcia values women as particular selves, attending to their individual differences, concerns, and needs, thus "cherishing a form of respect that involves profoundness of feeling, treasuring, warm regard, [and] solicitous concern" (Dillon, 1992, p. 120). By incorporating individual questions specific to each woman's experience, and directing questions to partners and family members, Marcia is able to individualize her care to the unique needs and requests of each birthing woman, while simultaneously

understanding how each woman is situated within a network of relationships. Marcia's interpretation of respect reflects aspects of Dillon's (1992) care respect. Dillon (1992) states,

> Care respect also recognizes us simultaneously as separate and self-synthesizing and as embedded in innumerable networks of personal, social, and institutional relationships with others in ways that mark our very being as relational and interdependent. Thus, care respect values persons not only in our distinctness but also in our commonality, which is seen to reside as much in the profuse details of our individual selves and in our mutuality as in the congruence of abstract 'me-ness.' (p. 122)

Dillon's (1992) words suggest that care respect values persons not only as individual selves, but also as relational selves that exist in a social network of relationships and communities. Marcia also recognizes that birthing women must be valued both as individual selves, and within the context of their families, friendships, and social relationships. Respect, for Marcia, is encapsulated in the details of her care: from the way she uses touch to how she positions a blanket over a birthing woman's body. Marcia's attention to detail is inherent in her interpretation of respectful nursing practice. Recognition of this respect is revealed in her practices with women, and in her understanding of how a woman is uniquely situated within the full context of her life.

Engagement: Creating the Space

For many women, arriving on a labour unit is their first encounter with labour and childbirth nurses. Many feel a sense of vulnerability, recognizing that their experience of birth may not be fully their own. To give birth in a hospital often negates

the familiarity of home, that place where many feel a sense of ownership, comfort and trust. Bachelard (1958) states, "Our home is our corner of the world. As has often been said, it is our first universe, a real cosmos in every sense of the world. If we look at it intimately, the humblest dwelling has beauty" (p. 4). Bachelard (1958) suggests that our home is our refuge, a place where we can feel safe and secure. Recognizing the value in Bachalard's (1958) description of home, modern perinatal practices have attempted to emulate women's homes by converting birthing rooms into LDRPs (allowing women to labour, deliver, recover and have their postpartum stays in the same room) providing consistent nursing care, and greater ease for birthing women and their families in attractive surroundings. Yet, is it possible to feel at home in an institutionalized environment where fetal monitors, stethoscopes, and sterile gloves abound?

For many of the women I interviewed in the study, and spent time with as a participatory observer, the birthing room became a vital space where relation could nourish all those involved. Madison, one of the mothers interviewed in the study, describes the labour unit as "a happy place" where everyone wanted to be working. When she arrived, the nurses were smiling and joking with her, as if she were a long lost friend returning from afar. To create this relational space within the walls of institutionalized healthcare, Mary, another mother, recalls that the initial calmness exuded by her nurse was essential for her own well being. Although Mary now recognizes how busy the labour unit was during her initial induction of labour, her nurse was able to leave the busyness behind, as if closing the door made it all disappear. Whether a nurse exhibits calmness, humour, reverence, or wonder, the introductory engagement that unfolds in the beginning moments of an interaction is

crucial to establishing a relation with birthing women. The gazing, touching, and listening qualities of a perinatal nurse are not forgotten by the women who have been in their presence, if even for a moment.

The Averted Gaze

To gaze into the eyes of another human being and authentically recognize the face of the Other (Olthuis, 1997) creates a moment for engagement to occur. If the gaze is averted, the opportunity for engagement can be lost . Within the study, however, it was noted that gazing directly into the eyes of certain culturally sensitive groups of women was not appropriate. Some of the nurses talked of these cultural differences and adjusted their practices accordingly.

Jen, a twenty-five year old mother interviewed in the study, describes the experience of having a nurse come into her birthing room, not introduce herself, and negate Jen's breathing efforts to cope with her birthing pain. After a long night of induced contractions with minimal cervical change, Jen was exhausted and attempted to deal with her pain by incorporating various breathing techniques. This nurse, covering on break for Jen's primary nurse, invaded Jen's room and accused her of utilizing coping techniques inappropriate for her stage of labour. The nurse said, "Do you really think that you're in enough pain to use these breathing techniques"? In this situation, Jen's nurse did not invite engagement or "practice those modes of speaking which respect the breath: The word[s] of praise...are preferred to words uttered without any concern for the breath" (Irigaray, 2001, p. 64). Irigaray (2001) suggests,

> In Western culture...we—the wise—[sometimes] practice a mode of speaking which is logical, abstract, conceptual and a bit suffocating, which implies an

> almost insurmountable master-discipline relationship. The culture of the breath and of the world, which respects the breath, on the other hand, procures life and autonomy. But this culture has been, for the most part, lost in our tradition. (p. 64)

Iragaray's (2001) words remind us of a culture that has relied on abstract and logical thinking, rather than a culture that reduces hierarchical thinking and attempts to see the Other as an equal. In Jen's situation, she is positioned as Other, and is negated in her experience because she does not practice the appropriate breathing techniques indicated by her nurse. Jen recalls the aforementioned experience, remembering that the nurse averted her gaze, denied her breath (breathing techniques), which reduced her to tears. She states,

> That really bothered me; she would not look in my eyes, she wouldn't look in my husband's eyes. She came in and she would check my vitals and she just wouldn't really look at me. And, that to me just seems like people are either being sneaky or they just don't care when they won't look into your eyes.

Jen's experience shows us that the introductory moments of an engagement between a birthing woman and her nurse are not soon forgotten. They "set the tone" (James, 1997; Nurse Marcia) for the future relation, and potentiate what will or will not occur. The gaze, the touch, and the breath are essential components of creating an introductory engagement. When they are lost, as Cameron (1992) suggests, "The heart of nursing is lost...not really lost, just mislaid. It's mislaid somewhere between the enormous demands of nursing and the infinite resources of the person in the nurse. But that heart can be found again" (p. 184).

The Attentive Gaze

Melanie, a nurse in her mid twenties with less than a year of labour and childbirth experience, is one of the eight nurses I interviewed in the study and accompanied in a research capacity on the labour and childbirth unit. Melanie has a baccalaureate education in nursing, and a six-month obstetrical course that is offered locally in the city. On the day I joined her in practice, we entered the room of Rose and John. Rose was having her first baby, and about to receive an epidural. The anesthetist was waiting impatiently for the nurse of the day, as the shift was just beginning. Melanie went directly to Rose, and quietly introduced herself: saying her name, while simultaneously touching Rose's arm and softly moving her loose blonde hair away from her eyes. Watching Melanie engage with Rose, I saw Rose respond to Melanie's gentle touch and affirming gaze. Melanie did not negate Rose's pain, she spent time attending to it, recognizing that the anesthetist would have to wait until Rose's contraction was finished. Melanie offered Rose encouraging words while orchestrating what needed to be done from where she stood: directly next to Rose. By the time the epidural administration was completed, vital signs done, the fetal monitor re-applied, Rose repositioned, and made comfortable, the relation was established. Rose and Melanie were now joined in a vital relation that would progress over a twelve-hour day, and the initial moments of the engagement were predicated on the introduction that Melanie established with Rose.

In *The nursing "how are you?"* Cameron (1992) eloquently reveals that the essence of nursing practice is ensconced in the authenticity of the nursing "How are you?" In this simple, yet vital question, Cameron (1992) reminds us that such a

question evokes the embodiment of nursing practice: "That relationship, that grace of being totally present, is waiting, just waiting to be actualized. Call it forth, nourish it, live it, let it be" (p. 185). Melanie embodied the nursing "how are you?" by being fully present with Rose. She heard Rose's pain, and responded. She waited patiently for Rose's contractions to finish prior to repositioning her, only then appeasing the anesthetist and facilitating the administration of the epidural. Melanie looked into Rose's eyes and did not avert her gaze, as did the nurse caring for Jen. Rose's pain was thus acknowledged, and with a gentle touch, Melanie said "hello".

Engagement: Building Relation

To initiate engagement with birthing women, the exchanging of names often begins the journey. Mary suggests, in remembering her second nurse during her birth experience, there is something in the power of a name. Knowing who we are begins the relation and "makes us more than simply strangers". To call the Other by name reveals an intimacy, and conjoins the two as one in the experience. Karla echoes Mary's words regarding the power of a name. Karla says,

> First names make a difference to the level of the relationship. This way you are not just the nurse you are their nurse. I also call women by their first names. If I don't know how to pronounce it, I will ask them. I think it is about trust and intimacy. I am practically a stranger when they come in, but when they know my first name and I know their first name, there is some comfort in that, there is respect.

Mary and Karla's words resonate with my own perinatal practice, as I have made a commitment to knowing the names of those in my care. Referring to a birthing

or postpartum woman and her family by their first name is essential to initiating relation. First names are not always used in practice, as elderly patients may, although not always, prefer a more formal designation. However, working with birthing women entails a young population, and calling a birthing woman by her first name is respectful and standard practice. I recall affirming comments from women when I referred to their babies by their first names. There was no mistaking the smile on the mothers' faces, as if they heard for the first time their babies' names spoken aloud by someone other than themselves.

On one occasion I accompanied a mother and her baby to the Special Care Nursery, and had the experience of hearing another nurse refer to the baby by his first name. I brought the mother and her baby over to the nursery from postpartum, as the baby was profoundly pale, presenting with tachypnea, nasal flaring and grunting upon initial assessment. I gave a brief report to the Nursery nurse and helped the mother and her baby get settled. Prior to leaving, I witnessed a nursing moment that has stayed with me for some time: a nurse referring to the baby by his first name. As I watched in the background, I could see the mother's body almost relax: her shoulders became soft, and her face more open. It was as if she recognized that her baby was now in a conversation or a narrative with the nurse, and the two were joined together as one. Although the nurse stood over the baby as she began her assessment, the gentleness of her touch, the inclusiveness of her care, and her recognition of the baby's complete presence revealed a way of engaging that positioned the nurse in a narrative that was relational with the baby.

Gadow (1994) reminds us that there are a variety of narratives (social, medical,

ethical, and relational) that permeate healthcare, but only the relational narrative can decipher the storied experiences of the patient and the healthcare professional together. In the relational narrative each person—nurse and patient—is ascribed moral agency, but such agency is not detached or void of relation. Rather, "[t]he relational narrative they compose is an interpretation of their situation together and an imagining of alternatives to which they could both be committed" (Gadow, 1994, p. 306). The nurse who referred to the baby by his first name, like the nurse who introduced herself to Mary during her birth experience, both invited an opportunity to engage. During these introductory moments, the beginning of a relational narrative was fostered, as the two came together potentiating a shared meaning of experience. Within this experience, "[t]heir narrative transcend[ed] the particular subjectivity of each of them as individuals; ...But it [did] not transcend their relationship" (Gadow, 1994, p. 305).

The Disengaged Other

Mary's words describing the power of a name and its ability to "make us more than strangers" reflects her initial description of her second nurse during her birth experience. During her stay on the labour and childbirth unit she met a number of nurses, three of whom were her primary nurses, which she describes with great fondness. There were, however, a few occasions with other nurses that resulted in "abrupt and dismissive" relations, so much so, that Mary was made to feel afraid to even ask a question. On one such occasion, Mary's IV bag was empty, and her mother volunteered to find one of the nurses to replace the bag. Her mother went to the nurse's desk, and the nurse at the desk said she would be in when she had time. Mary's mother pleasantly persisted, as she knew that a nurse needed to come into their room and

change the IV solution, as the bag was empty. She soon returned to the room with the nurse following shortly behind. When the nurse entered the room, she stated, "Oh, the bag is empty," and in a hurried state replaced the bag. She then proceeded to say, "So, we are changing an IV bag for an epidural that you are NOT going to get for an hour or an hour and a half." The nurse then left the room, saying nothing as she closed the door. Mary recalls the encounter and states, "That nurse was pretty rude and unprofessional. It just seemed unnecessary for her to say something like that". Mary goes on to discuss the interaction and remembers another nurse who had a similar disposition: "It's not just a busy demeanor, [Mary says], they bring it with them and you can read it off them. It is as if you are a chart they need to get through. Or, they want to finish so they can get to what they need to do. There is no warmth and no relationship".

Mary's description of her nurse is reminiscent of Jen's situation, as both women are diminished in their experiences of birth. Rather than being understood as distinct and unique individuals, Mary and Jen are reduced to generalities. In so doing, their nurses disengage from relation, entailing the disruption of the birth experiences for both women. The nurses who participated in the study, however, fostered relation, working tirelessly to understand the unique situation, context and histories of the women they cared for. Nevertheless, some of the nurses in the study also discussed situations that occasionally positioned them in ways that resulted in treating women as disengaged others, diminishing their relations with the women in their care, although they desired to do otherwise. Language, circumstances, and barriers to practice have all interfered with introductory moments of an engagement, positioning both nurses and women in situations that prevented them from appreciating women within the

particulars and context of their lives.

The Conversation

Joan, a nurse in the study with twenty-seven years experience, eighteen in labour and childbirth, and a midwifery background, talks about the necessity of having private time with the birthing woman and her partner or coach, as soon as they are admitted to the birthing unit to prevent future misunderstandings. Joan states, "During labour, you have to get those two people at the very beginning and say, 'what do you see happening today and where do I [the nurse] fit into this picture'?" Joan further discusses the fact that birthing women and their partners often arrive on the labour unit with twenty other supportive relatives and/or friends. It is thus important to negotiate with the birthing woman and her primary coach what their expectations are, prior to engaging with the extended support system.

For Joan, introductory engagement is encapsulated in "mutual trust and respect," both of which are elicited through negotiation, discussion, and open communication. Joan says, "I ask them about their expectations so I think initially I'm trying to show that I'm respecting their wishes, their desires, their wants. I want to know where they're coming from and where their anxieties are." Joan is invested in the relation, and "works on the relationship right from the very beginning." In her provision of care, she says, "I try to look at the holistic patient and not just the machines or the fact that she's here to have a baby and I don't know what happened before or what's going to happen in the future."

However, there are moments when a birthing woman can negate an engagement for a nurse, in the same ways that a nurse can negate an engagement for a birthing

woman. Joan recalls one such situation, when a birthing woman she was working with requested she be replaced with another nurse, for the sole reason that Joan didn't have children of her own. Although Joan can find humour in the situation now, she remembers how traumatic it was at the time. Joan says,

> I can kind of laugh about it now, but for a while it was very traumatic for me because I have had some infertility problems so it was very difficult. That patient has no idea about my life and she's assuming because I don't have children I'm not caring or I'm not loving or not understanding about the labour process. Anyway, there was a time when this was very distressing and I would have to walk out and go cry somewhere.

Hearing Joan's words reinforce the recognition that the introductory engagement between a perinatal nurse and birthing woman is relational. Both the nurse and the woman are invested in the engagement; it is not one-dimensional. It occurs between and among those vital moments when the nurse and the woman are in conversation. Brody (1987) suggests that "a conversation is the sort of thing that occurs over time, and although it may occur as a discrete event, it can also be laid aside for now and picked up again later" (p. 177). Brody further claims that a conversation allows for the meaningful sharing of responsibility between the patient (woman) and her health care provider (nurse).

Bergum and Dossetor (in press) suggest that engagement, by its very nature, entails conversation, and it accords a primacy to persons and the nuances of their lives. Relational engagement created through conversation is not grounded in reason, but is based on interpretation and trust within the context of concrete experience (Bergum &

Dossetor, in press). Although conversations between perinatal nurses and birthing women are often of a verbal nature, there are non-verbal conversations that are of equal import. Spending time with Jessica, a nurse with twenty-five years experience, illustrates the power of non-verbal communication, and the quieter moments that can occur between a birthing woman and her nurse.

Quiet Time

My day with Jessica began with a report on Linda, a birthing woman at 8cm requesting an epidural, who had spent the last few hours of the early morning in the shower. The night nurse gave us the report that she was coping "beautifully," but had been waiting for some time for an epidural. Jessica read the chart, called the anesthetist, and then quietly entered the room for introductions. At that time, Linda's partner (husband) was sitting on the opposite side of the bed, and Jessica found me a stool to sit on, as she liked to stand quietly beside the bed. Jessica began by gently complimenting Linda on her breathing, only then did she begin to discuss the epidural. It was not that Jessica wanted to discourage or dissuade Linda from having the epidural—as she had already called the anesthetist requesting his presence in the room. Rather, she wanted to ensure that Linda was fully informed of all the requirements involved with the epidural, particularly because she was doing so "beautifully" with her birthing pain. Jessica explained to Linda that an epidural often requires a lot of equipment: continuous fetal monitoring, IV hydration, and a foley catheter. Jessica presented this information in an open and quiet dialogue. She did not negate or judge Linda's choice, but quietly encouraged her breathing, and presented information. Shortly thereafter, the anesthetist came into the room to administer the epidural, but Linda had decided to wait, holding

off on the epidural. Jessica explained Linda's decision to the anesthetist and he soon left the room. Having the anesthetist actually appear in the room may have been affirming for Linda, as it assured her that Jessica did actually notify him regarding her request.

As the morning progressed, I experienced Jessica's quiet engagement with Linda. Often people imagine that a labour room is loud; this room was quiet. The only sound I heard was Linda's breath. Yet, I was very aware of Jessica's presence, the whisper of her voice as she offered encouragement, and the gentleness of her expressive hands as she adjusted the fetal monitor. Watching her, I felt reminded of a Zen presence, as there was something meditative and mindful about the way she gently applied the fetal monitor. There was no urgency in her movements and no concern regarding time. Watson (1999) suggests that nursing should reclaim the act of bedmaking as nursing art, by re-examining it as a Zen act, in which one reconsiders the bed as a sacred place. "The bed,... or nursing art stands alone in this example as a single statement, symbolizing beauty, simplicity, elegance, wholeness; it is an invitation to comfort, safety, privacy, rest, recovery and a place for healing to occur" (p. 238).

Watson's (1999) comparison of bedmaking to a Zen act is reminiscent of Jessica's engagement, and the way in which she applied the fetal monitor. There was elegance in both Jessica's presence, and the way in which she positioned the monitor—a technical procedure that I saw again in a new light. In doing so, nursing (applying the fetal monitor) can be reinterpreted as a Zen act returning nursing to the place of the body, where embodied acts are carried out with intentionality and an awareness of

integrated holism (Watson, 1999). Rather than seeing the monitor only as a technical apparatus to assess the adequacy of fetal oxygenation during labour (Gilbert & Harmon, 1993; Pillitteri, 2003), Jessica's mindful application of the monitor reinterpreted it as something more: her attention to Linda's comfort entailed frequent, yet gentle, repositioning to ensure that the belts of the monitor attached to Linda were not too tight. Jessica often removed the belts altogether holding the cardio manually to auscultate the fetal heart rate to increase Linda's comfort. Jessica's engagement, from the moment she entered the room, entailed that the primacy of her acts were directed to Linda, not the machines. Jessica's presence seemed to create an atmosphere in which time almost stood still.

"Why Such Haste"?

Unlike Jessica's ability to create an atmosphere where birthing occurred on Linda's (the woman's) timetable, Rachel, a young mother interviewed in the study, describes the "haste" of her birth experience. She says, "I wasn't a fan of her [the physician] wanting to hurry everything up so much. But, maybe I was scared to have it [the birth] progress." Although Rachel asked the nurses why there was such a "big hurry," to expedite her birth, she recalls only that the "doctor [was] at home just telling them [the nurses] what to do." Rachel states that because the nurse didn't want the "doctor to show up and hurry the birth along anymore," as she was already on a pitocin augmentation and had an epidural, the nurse was able to slow things down.

In reflecting on my own practice as a labour nurse in the past, I recall similar situations in which "slowing things down" often meant refraining from calling the physician until absolutely necessary. This was done to give women an opportunity to

birth on their body's own schedules, as opposed to the schedules of others. This was the situation with Rachel's birth, as her nurse did not phone Rachel's physician until the birth was imminent. Rachel laughs remembering her experience and says, "Yeah, I swear the doctor was there for like fourteen minutes. That's all the doctor was there for, and the nurses did everything else, they were caring, reassuring, and capable, the nurses didn't ever have that feeling of haste".

Will I be "Woman Delivering Baby 517"?

Rachel's comments regarding the "haste" of her birth are echoed in the words of Susan, as she recalls her experience of "feeling like an object" during her weekly ultrasound visits to another hospital in the city for her diabetes. Although she went to the same facility each week, the technicians doing the ultrasound would often talk over Susan as if she wasn't there. They rarely, if ever spoke directly to her, they didn't acknowledge her name, and they treated her as a body, not "an individualized person." Heidegger (1977) reminds us that technology is both a human endeavor and a means to an end. He states, " That is why the instrumental conception of technology conditions every attempt to bring man into the right relation with technology. Everything depends on our manipulating technology in the proper manner as a means" (p. 5). In Susan's situation, the technology is given primacy. Rather than manipulate technology to accommodate Susan, which is the recommendation made by Heidegger (1977), Susan is the one being manipulated. She says,

> For eight weeks I went to the same place and got an ultrasound. It wasn't always the same tech, obviously they rotated, but they would always talk over me, and they didn't talk to me. I had that experience, and then coming into the hospital, I

> wondered if I was going to get individualized care. If they [health care professionals] were going to recognize me as a human being, as a woman, you know, with this name, with my name or were they just going to treat me as woman delivering baby 517.

Susan's fears were put to rest, as she describes most of her perinatal care during her birth as "excellent." Although her birth entailed an insulin infusion to manage her diabetes, and she was induced with pitocin, and had an epidural, she never felt as if the nurses were only treating her as a body or "woman delivering baby 517." "Love," is actually the word Susan used to describe her favourite nurse, the night nurse, as she felt this connection from the very beginning. "Her humour, openness, and genuine warmth" were evident from the moment this nurse entered the room. She was inclusive of Susan's partner (husband) and her family, and although Susan felt like "Frankenstein's monster" with all her technical equipment, IV solutions, fetal monitor, and catheter, this nurse was able to keep the room laughing and Susan cognizant of the fact that she was not "Frankenstein's monster", but a woman giving birth. When this nurse came to take blood from Susan's finger for a glucose reading, she would not only be apologetic for causing more discomfort, she also asked Susan which finger she would like to use. Although this is a small gesture, it has stayed with Susan as a further example of being treated as a person, not an object. Susan states,

> I think it's helpful insofar as it shows me that she sees me as a person, she recognized that I was in pain. Or she recognized that I was going through whatever I was going through. And that she recognized she was potentially going to cause me more pain. I appreciated it because it showed me she cared

about me as a human being and as a person, rather than another finger to prick.

Susan's ability to distinguish between when she was treated as an object or as a subject is reminiscent of a phenomenological view of health care. Unlike much of Western culture that has been built on a Cartesian metaphysics that objectifies the body and reduces it to a mechanistic object (Goldberg, 2002; Leder, 1990; 1998), Susan's nurse subscribed to a phenomenological view of the self, in which all parts of the body are unified and not objectified (Leder, 1990; Merleau-Ponty, 1962; Wilde, 1999). A phenomenological view of the self is "[t]he very intertwining of self and Other, of body subject and object" (Leder, 1990, p. 6).

Although much of health care has been built on a Cartesian metaphysics that positions women as objects, similar to machines (Leder, 1998; Goldberg, 2002), a phenomenological view of health care is more in keeping with the tenets of nursing as a practice discipline (Bishop & Scudder, 1997), committed to the principles of holism and embodied care. An embodied view of the self, which integrates the body-subject as lived, views that all parts of the body are necessary to being human.

The origins of embodiment, in which the subject-body can be interpreted outside of a Cartesian metaphysics can be attributed to Merleau-Ponty (1962). He states that the body "expresses total existence, not because it is an external accompaniment to that existence, but because existence realizes itself in the body. This incarnate significance is the central phenomenon of which body and mind, sign and significance are abstract moments" (p. 166). When, for example, Susan experienced her weekly ultrasound, it is clear that she wasn't treated as an embodied subject. The health care professionals administering the procedure negated her subjective experience. She was a body on a

table, an object to be molded, or as Susan would say, "woman delivering baby 517."

Contrasting this experience was Susan's night nurse, who engaged with Susan by treating her as an embodied woman: This nurse acknowledged Susan's pain and fear, offering humour, warmth, and choice. Susan was not made to feel like a body attached to machines, although there were many. This nurse was someone Susan "loved" in part because she brought laughter and openness to a vital experience that could have been otherwise. Susan says she will not forget this nurse, or what she brought to her birth experience by treating her as a complete and "individual person."

Throughout this chapter, I have shown introductory moments of engagements between perinatal nurses and birthing women. In so doing, I have attempted to reveal the necessity of this vital time during the perinatal nursing relation. In the next chapter, Embodied Trust, I build on the notion of embodiment introduced in this chapter, and elicit various ways in which nurses can and do enact trusting relations with the birthing women in their care.

Chapter Four

Embodied Trust

> *I think a lot of the relationship in labour and delivery is based on trust. That would be one thing, and it works both ways. They have to trust that we're educated and professional enough to care for them, and we have to trust that they're educated enough in their own childbirth process to make the right decisions.*
>
> *(Nurse Joan)*

In this chapter, the notion of embodied trust is developed through the conversational interviews and participatory observations I explored with labour and childbirth nurses and birthing women. Working through the concept of embodied trust not only reveals the ways in which vital relations are both established and maintained between nurses and birthing women, but also elucidates the ways in which the relation of trust becomes embedded within the woman's own bodily experience of birth. In building a trusting relation with the nurse, the birthing woman simultaneously begins to explore self-trust, thus enabling her to develop her own birthing abilities and birth her baby into the world.

Within labour and childbirth settings, trust is foundational to establishing a nurse-patient relation. To trust another may take the form of a parent trusting a child, a student trusting a teacher, or a patient trusting a health care professional. The word *trust* is derived from the Old Norse, *traust,* meaning to support, help or elicit confidence (Oxford Concise Dictionary of English Etymology, 1996; James, 1997). A trusting relationship is valued in friendship; it is shared among respected colleagues and is cherished in those we love. Baier (1994) suggests that trust is dependent on another's goodwill. Although it need not be acknowledged, as there can be unwanted or unconscious trust, appropriate trust is always agreed upon by both parties and provides an opportunity to "signify

acceptance or rejection" (p. 99) of that trust. Because trust entails a dependence on another's goodwill, "one is necessarily vulnerable to the limits of that goodwill" (Baier, 1994, p. 99). When one trusts, one is vulnerable to the harms of others, but one does not expect such harm to be enacted. Reasonable trust requires "good grounds for such confidence in another's goodwill, or at least the absence of good grounds for expecting another's ill will or indifference (Baier, 1994, p. 99).

Amy suggests that trust is established in the very beginning of a relationship. She says, "It's where you start to make your connection with the patient and establish your relationship. It's kind of where the trust starts to happen because they are walking into a totally foreign place that I [as the nurse] am totally comfortable with." Karla says that trust comes from "mutual respect" and must move beyond the medicalization of birth. "Being kind, creating a relaxed atmosphere, and offering reassurance" are part of Karla's ways of establishing trust with the women in her care.

Michaela believes that "bonding" with women and their partners will facilitate a trusting relationship. She says, "My ultimate goal is to bond with the woman and her husband because then they will trust what I do." "Trusting the body" is Jessica's interpretation of embodied trust, as she suggests that North American women have "intellectualized" their bodily abilities, forgetting to trust the power of their own bodies. In so doing, many women have negated their own bodily power in their distrust of their "natural" bodily capacities, failing to recognize their power and strength in birthing their babies.

The trusting relation that is established between the perinatal nurse and birthing woman is embodied. Through incarnate experience, rotund abdomens, pendulous breasts,

bleeding vaginas, and amniotic fluid nurses and women establish and maintain trusting relations that are uniquely situated against the landscape of the birthing body. Recognition of this trust is visceral and can promote a woman's trust not only in her nurse, but also within her own corporeal and experiential reality. By building a trusting relation with her nurse, a birthing woman potentiates the possibility of discovering the birthing powers embedded within her own body. In what follows, I examine embodied trust by way of the words and narratives of the birthing women and perinatal nurses who participated in the study.

Trust in Relation: The State of Being Whole

For many women, trust is revealed in the honesty and the integrity of the nurses' conversations and interactions while engaged with the women themselves. Abbey, a first time mother interviewed in the study, describes the frightening experience of her initial arrival on the labour and childbirth unit. Although she was expecting a "normal" vaginal delivery, she arrived to discover a diagnosis of HELLP syndrome resulting in a C-section by the end of that evening. HELLP syndrome is a condition of pregnancy named for its resulting symptoms of hemolysis (the destruction of red blood cells), elevated liver enzymes, and low platelets. It is a variation on pregnancy induced hypertension (PIH), and occurs in both primagravidas and multigravidas. Women often present with malaise, epigastric pain, nausea, and right upper quadrant pain (London, Ladewig, Ball, & Bindler, 2003; Pillitteri, 2003). HELLP syndrome is a serious illness for women in pregnancy.

Upon Abbey's arrival to the labour unit, the day nurse was going off shift, leaving Abbey alone to get situated in her room, as her partner (husband) had to go home to give

insulin to their diabetic cats. At that time Abbey's contractions were mild, in spite of being 2-5 minutes apart. The physician arrived and abruptly stated that her liver enzymes were "very high" and she was "very sick." She was told that she needed a C-section that evening, but the physician gave no further information or clarification. This came as a frightening shock to Abbey, who was now hearing the "scary" news for the first time. Abbey had little understanding of the illness, what it meant, or how it might affect the health of her unborn baby. It was Abbey's evening nurse who came into the room and explained everything to her and her partner once he arrived. Abbey says,

> She was amazing, and the only one who told me why the surgical team would be there. Because there was a chance they would have to take out my uterus if I didn't stop bleeding, it was the nurse who gave me that scary information. But it was done very delicately. I could ask her anything. She was very caring, and she always touched me, which I found very comforting. Even when they were getting me set up for the C-section, she blew my vein, but she brought in another nurse right away and it was quite funny. We had a good giggle over that. It wasn't too bad because she was so comforting and relaxing. I'll always remember her name, and that she made it all so bearable for me. We left her a card after the birth.

Abbey's words used to describe her nurse suggest a relation built on trust, caring, and integrity. The word integrity has many meanings, often associated with wholeness and sturdiness. Integrity can be used to describe the structural hardiness of a building, or refer to the structures dependability of holding up under great stress or weight (Walker, 1997). Walker (1997) suggests that integrity is reliability in the moral sense: "dependable responsiveness to the ongoing fit among our accounts, the ways we have acted, and the

consequences and costs our actions have in fact incurred" (p.72). In Abbey's situation, the relation enacted by her evening nurse made the integrity and wholeness of her experience possible. Unlike the physician who abruptly cited facts about Abbey's condition, the nurse situated the facts about her HELLP syndrome in the context of Abbey's life: her history, her pregnancy, and her own experience. Abbey suggests that in doing so, the nurse made her situation "more real" by entailing that she was not jettisoned from her own bodily knowledge. Because HELLP syndrome was both an unexpected and foreign experience for Abbey, her nurse took the time to acquaint her with the meanings associated with her illness. Understanding the lab values associated with HELLP syndrome, the epigastric pain potentiated from an enlarged liver, and the physiological risks to both the baby and the mother were fully explained to Abbey and her partner in a "relaxed and calm environment." Abbey says, "The nurse actually filled us in far better than the doctor. She calmed me down and gave me more information on HELLP syndrome."

"Her Voice Is All I Heard"

Abbey's confidence and trust in her nurse are echoed in the words of Anne, another mother interviewed in the study. Anne's experience of birth contrasts with Abbey's, insofar as Anne came into the hospital in active labour and had her baby vaginally within two hours of the time of her arrival. Although Anne and her partner (husband) were unprepared for how quickly the birth occurred, she speaks of her night nurse as "fantastic right from the start to the finish." In fact, this nurse was able to provide things for Anne prior to her even asking for them: ice chips, blankets, answers to questions, and assistance with breathing techniques and position changes. Anne claims

that it was the nurse's voice that she remembers, and heard throughout her entire birth experience. She says,

> I found that through the whole delivery it was her voice and her instructions that I was listening to even when the doctor was there. I didn't really pay much attention to the doctor until we got to the point where the baby's head was out. It was the nurse there beside me the whole time. And once we got to the pushing stage, because it happened so quickly, I found she was so encouraging even when she wasn't beside me. She would be holding my leg for a while, and then moving around doing other things in the room. But she was still talking to me no matter where she was in the room. She talked the whole time. And anytime I had a contraction, she would be right back over beside me, and making sure I was pushing properly, encouraging me, and encouraging my husband because he felt kind of useless since everything went so fast.

The mother tongue: speaking the voice with the Other

Anne's description of the nurse's voice is reminiscent of LeGuin's (1989) mother tongue. Unlike the father tongue that embraces the objectified and the rational, the mother tongue is often embedded in the embodied language that many have come to know, positioned in a place of vulnerability, yet capable of empowering those who speak it. LeGuin (1989) states,

> But none of us lives there alone. Being human isn't something people can bring off alone; we need other people in order to be people. We need one another. If a woman sees other women as Medusa, fears them, turns a stone ear to them, these days, all her hair may begin to stand up on end hissing, *Listen, listen, listen!*

> Listen to other women, your sisters, your mothers, your grandmothers—if you don't hear them how will you ever understand what your daughter says to you? (pp. 158-159)

LeGuin's (1989) talk of the mother tongue refers to the language that often brings women together: it is relational, it is vulnerable, and it is of the body. Although we speak of the mother tongue as the language that many women come to know, it is not reserved for the female nurse. My past experience has provided me with a rare and unique opportunity of working with a male labour nurse, Frederic Largin, (personal communication, December 10, 2003) whose empathic, relational, and intelligent practices with birthing women were also reminiscent of the mother tongue, similar to those ascribed to Anne's nurse. Thus gender becomes erroneous when using the mother tongue, when the nurses using it understand both its power and purpose when applying it with the women in their care. Regrettably, not all nurses use the mother tongue in their practices with birthing women: however, Anne's nurse provides us with a rich example.

Although the mother tongue has been defiled by the father tongue for being primitive and irrational, it is reinscribed by those who use it:

> Using the father tongue, I can speak of the mother tongue only, inevitably, to distance it—to exclude it. It is the other, inferior. It is primitive: inaccurate, unclear, course, limited, trivial, banal. It's repetitive, the same over and over like the work called women's work, earthbound, housebound...The mother tongue is language not as mere communication but as relation, relationship. It connects. It goes two ways, an exchange, a network. Its power is not in dividing but binding, not in distancing but in uniting. It is written, but not by scribes and secretaries for

> posterity; it flies from the mouth on the breath that is our life and is gone, like the outbreath, utterly gone and yet returning, repeating the breath the same again always, everywhere, and we all know it by heart. (LeGuin, 1989, p. 149)

Anne's experience resulted in trusting the language of the mother tongue communicated to her through her nurse. The use of LeGuin's (1989) mother tongue in Anne's example offers us a way to recognize the potential power of the nursing voice when it is embedded in the language offered by the mother tongue: encouragement, intelligence, and relational strength for the sole purpose of fostering Anne's self-trust in her body to birth her baby. Anne says,

> Once I started feeling like I had to push, her instructions to me were just super. She explained to me right away to put all my energy and effort into the pushing and it made the force of my push so much better and stronger. I wasn't using all of my energy. And that wasn't something anyone had really showed me or explained to me before. Her instruction made a huge difference for me in terms of how easy it was for me to push. She showed me not to arch my back, but rather to curl my back like this and push down through my bum. Her voice and her words made all the difference.

Vulnerability

Hearing Anne speak of her labour nurse, and the constant presence of her voice throughout Anne's birth, suggests that the language of the mother tongue is brought to fruition. That the nursing voice was the only voice Anne heard throughout her birth experience, suggests that this voice was a trusted voice, although Anne was positioned in a place of vulnerability. Vulnerability is inherent in the experience of birth, as women are

completely exposed. The birthing body undergoes position changes that entail exposing all parts of the body, particularly the perineum. During the pushing stage of labour it is not uncommon for a woman to push for a few hours with a nurse or other health care professionals frequently staring at her perineum, to see the progress of the baby. The vaginal area is frequently cleaned, sterile vaginal examinations are done, and a catheterization to empty the bladder is performed prior to birth, unless a foley catheter is already in place because of an epidural. During the birthing process, a woman's legs are often held open to facilitate pushing, entailing that a woman's body is fully exposed and open, although nurses attempt to keep as much of the woman's body covered as possible. This exposed state situates women in a place of vulnerability.

Throughout the study, the topic of vaginal exams was discussed as one of the most invasive procedures performed during a nursing assessment. Jessica reminds us that she is "entering a woman's body" when she performs a vaginal exam. She says, "I don't think there is a need for all those examinations." Jessica suggests that in developing other skills, nurses can just as easily assess a woman's labour status, thus reducing the added invasiveness and stress induced by unnecessary exams. Phoebe shares Jessica's thinking and also views vaginal exams as unnecessary most of the time.

Hearing Jessica and Phoebe's perspectives on vaginal exams, I am reminded of my own practice as a labour nurse. Similar to their practices, I also became aware of the invasive nature of vaginal exams, and how easily they position women in a place of vulnerability. In so doing, I began to perform as few exams as possible in my own practice. In performing very few exams, I realized that it was not because I was not permitted to do so. Working in the US for four years as a night nurse in labour and

childbirth gave me ample opportunity to perform as many exams as I desired, needed or deemed necessary. Not performing many exams with birthing women was based on the fact that I, perhaps like Jessica and Phoebe, often thought of the birthing woman's body as my own. I didn't distance myself from the discomfort, the pain or the vulnerability the woman would feel in having another invade her body (Goldberg, 2003), specifically her vagina. Perhaps for a moment I felt like Ensler (1998) in *The vagina monologues* when she says, "I was worried...I was worried about vaginas. I was worried about what we think about vaginas, and even more worried that we don't think about them. I was worried about my own vagina" (p. 3).

Although Ensler's (1998) powerful work had not been written during my days as a labour and childbirth nurse in the US, it nevertheless resonates with my experiences as a woman and a perinatal nurse. It is embodied, and it captures a sense of how easy it is to turn away from and ignore the place of the body, specifically the vagina, even in the landscape of birthing. To be embodied as a perinatal nurse entails that I, as the nurse, am aware of the subjectivity of the birthing woman. Schroeder (2003), building on her doctoral work stimulated by her classes with Gadow, suggests that if nurses were embodied, they "would be forced to recognize (and hopefully, work to change) the systemic objectification of patients" (p. 159), as their bodies contain the same subjectivity as the patients in their care. Embodiment thus requires us—as nurses—to exist in a place of vulnerability. Gadow (1989) suggests that it is only through vulnerability that caregivers can experience their own embodiment and understand a patient's pain. Within the context of the study, Marcia speaks of being vulnerable both "professionally and emotionally" every time she meets a new couple at work. She says,

> I meet a new couple that is going to critique me and I know that I use language that is different than theirs. I had one patient say, " I'm sorry, but I don't want her back in the room." In 22 years I think, "Okay, maybe I misjudged what I said and I shouldn't have said it."

Marcia found this experience difficult, insofar as she felt vulnerable to the critique of the Other when she was dismissed by the birthing woman. Whether it is was due to a personality conflict or a cultural difference, as Marcia is from the UK, her experience positioned her in a place of vulnerability, open for others to see and judge, poke and prod. Marcia echoes the words of Joan (chapter 3), who also spoke of vulnerability when a birthing woman dismissed her as a nurse because she did not have children of her own. Thus vulnerability becomes a shared experience between birthing women and their nurses, and although it is experienced in different ways, it nevertheless resonates with both the women and the nurses in the study.

Lost Trust: Not Hearing the Voice of the Other

Although all of the nurses who participated in the research can recall situations where circumstances resulted in negative birth experiences for both the women and themselves, Karla, a perinatal nurse in the study with 8 years of labour experience, discusses one of the rare occasions where trust was lost in the relationship she attempted to establish with a birthing woman in her care. Karla says,

> I had a patient before that was 8 cm. And it was her second baby, and I thought, oh, I thought it was her third baby. I'll never forget it. Her doctor wanted me to "hold her off and see what happened," and so I stayed with her the whole time

> and she didn't look at me after she delivered because she didn't get the epidural she requested. She couldn't even, wouldn't even talk to me.

Karla remembers how "horrible" she felt after the experience of denying a woman's request for an epidural, even when there was no medical reason for denying the woman's request. This has stayed with Karla for so long that she now works diligently to ensure that any woman who comes in to give birth and is "firm" that she wants an epidural receives one, unless circumstances are beyond Karla's control. This is not to suggest that Karla does not explain the risks of an epidural and/or encourage other options when necessary. However, Karla is truly listening to what women are requesting, particularly because of the situation she experienced in the past. Karla remembers the silence of a relationship void of trust, and a space lacking engagement.

Taylor (1993) reminds us that in recognizing our own dominance, we are forced to renegotiate our habitual ways of relating to others. She states,

> A dominant subject-narrator may name Others different from herself and have a desire to resist her own forms of dominance. Yet her own narration cannot pull itself up by her own hair; those Others' narrations, however, may force her to confront how her subjectivity has objectified their experience. Now she must negotiate the tensions between all the habitual ways of differentiating herself from objects—and objects from each other—and a new subjectivity's dislocations of those habits (p. 69).

Taylor's (1993) words reinforce the discomfort in recognizing our own dominance, particularly when the recognition occurs at the expense of objectifying the less dominant. Similar to Taylor's (1993) subject- narrator, who attempts to reject her own dominance,

but nevertheless comes full circle in the objectification of the Other, Karla is confronted with the recognition of her subjective dominance and the truth about herself in the situation. For Karla, feeling "horrible" comes only after she recognizes what she has done to the birthing woman—the less dominant. Yet, is Karla positioned in such a way that she can do otherwise?

In reflecting on Taylor's (1993) use of the subject-narrator, and her understanding of dominant relations, is Karla only positioned as the dominant subject-narrator, or is she also positioned in a place of less dominance, at least in reference to the physician and her or his request? Is Taylor's offering of the dominant subject-narrator potentially too narrow to fully reflect the complex ways in which Karla is positioned between the birthing woman and the physician? If so, Taylor's (1993) work may not offer us the most useful way to understand Karla's situation, particularly in relation to the birthing woman in her care.[2]

Independent of how Karla is positioned, she nevertheless understands why trust was lost in the relation with the woman in her care. Rather than hearing the request of the woman—which was her usual practice—she prioritized the physician's request to that of the woman's. However, Karla did not do this uncritically. Because the birthing woman progressed quickly from early labour to 8 cm, it seemed likely that an epidural would be unnecessary, as she would be at the pushing stage of labour imminently. Karla says,

> She went really fast but then got stuck there at 8cm for about an hour and a half. So at that point she could have had an epidural but the anesthetist was busy. She was at 8 cm and feeling a lot of pressure and couldn't sit still; she wouldn't talk to

[2] The complex ways in which Karla is positioned in relation to both the physician and the birthing woman are discussed in greater detail in chapter 6.

me, and was really uptight with me. So I think now she probably thought we were hopeless because we did not do for her what she wanted or needed.

Karla's example of lost trust with the birthing woman in her care is shared by Madison, a first time mother interviewed in the study. Although Madison's baby was born via a C-section, she spent a lot of time in labour prior to the surgical birth of her baby. Madison describes most of her experience on the labour unit as affirming. She states, "Apart from being professional, the nurses were friendly, funny, really good, and made the days so much easier for me. I feel blessed they were there." Madison arrived at the hospital only to discover that she was not in active labour, the nurses checked her cervix, did a monitor strip of the baby, and with Madison's convincing, finally sent her home. Madison returned a number of hours later and was then admitted to the labour unit.

Madison painfully recalls her initial arrival to the labour unit. Because she was not in active labour with regular contractions actively changing her cervix, the resident on call wanted to medicate Madison to sleep on the unit for the evening and induce her in the morning. Rather than spend the night sleeping on the labour unit aided by medication, Madison wanted to return to her own home and rest until her contractions were more regular. Often, this is standard perinatal practice, as long as the fetus in not at risk, the monitor strip is reactive, membranes are intact, and the woman is low risk. However, this was not the plan of the health care professionals involved in the care of Madison that evening. Madison says she felt "pushed" to stay for the night to be induced early in the morning, rather than rest at home as per her request. In this situation, Madison felt her own decision making about her body was mistrusted, and she was reduced to tears. She states,

"I'm going to give you morphine." She didn't ask me and I said, "Wait, wait, wait, what are you saying? Why are you going to give me morphine?" And, she says to me, " Because you need to rest" and I say, "No I don't." She was kind of pushy you know. She was good and worried about me I think, that is why she was pushing the morphine. Then she talked so much about the morphine I didn't know if it was good anymore. So she went away to talk to my doctor and I started crying because I said to my husband, "I don't know anymore what is going to be good for the baby."

Epistemic absence

Madison's situation is not unique. Within perinatal health, a birthing woman's choices regarding her own bodily knowledge are often constructed within a framework that limits choice to those considered legitimate by the institution itself (Sherwin, 1998; Goldberg, 2003). Within these institutions, women are often positioned as epistemologically absent, reducing them to situations that make them feel incapable of enacting their own birthing trajectories (Goldberg, 2003). Health care institutions, being hierarchical in nature, consider expert knowledge to be legitimized only when provided by health care professionals, not by the women themselves (Goldberg, 2003). Madison, in her request to avoid medication (morphine) and sleep at home, attempted to enact her own knowledge regarding her birthing body. Understanding that she did not need medication to sleep, and uncertain of the consequences of the medication to her baby, Madison's epistemic position was distinct from that of the health care professionals. Madison's request to return home was finally granted, but it came only after Madison argued for her position to the point of exhaustion and tears.

Madison's interaction with the health care professionals that evening is reminiscent of "paternalism." Within health care relationships, the health care professional, analogous to the father, is the caring parent with expert knowledge and education to oversee the lives of scared, uneducated and often needy children or patients (Beauchamp & Childress, 2001). Health care professionals subscribing to this model make decisions for patients, assuming that they are unable to make these decisions for themselves. Although the health care professionals are not making these decisions out of malice, for they assume that they are protecting the good of the patient, such decisions can reduce the patient's dignity and epistemic worth (Gadow, 1980; Goldberg, 2003). In other words, making decisions for patients denies them the ability to contribute to their own care. In so doing, health care professionals disrespect the decision-making capacities of patients and disregard their experiential knowledge. In the case of Madison, and the situation with Karla, decisions were being made that didn't respect the choices of the birthing women. Recall that Karla, in her relationship with the birthing woman, ended up with a negative outcome because decisions were made that didn't respect what the birthing woman requested until it was too late. In the end, both Nurse Karla and the woman were left with a negative experience. In Madison's situation, getting to go home was finally an option, but the events leading up to the decision took their toll. Madison was left wondering why "pushing" the medication was so important, particularly because she did not want to be medicated, nor was it a requirement of perinatal policy.

Trust in the Body: "The Uterus Births the Baby"

Throughout the study, examples of trust were not only embedded within the relationship established between the nurse and the birthing woman; but rather, trust was

further explored when the birthing woman discovered ways, through the relationship she established with her nurse, of relying on the power of her own body to birth her baby (self-trust). Recall Anne, the birthing woman previously discussed in this chapter, who explained the ways in which her nurse helped her to trust her own bodily abilities. In so doing, she was empowered to birth her baby into the world. By way of instruction and encouragement through her nurse's voice, she discovered ways of using her body to birth her baby that were previously undiscovered. Jessica, first introduced in Chapter three, defined trust, in part, as something embedded within the woman's own body. Working from this philosophy, Jessica perceives her nursing role as one that assists women in learning to trust the power of their own "amazing" bodies.

Having worked in Los Angeles with a number of paraplegic and quadriplegic birthing women, Jessica learned a great deal about trusting the power of the birthing body. Working with this unique population of women taught Jessica about the power of the uterus and the importance of trusting its abilities during birth.

> This experience taught me that the woman doesn't deliver the baby. Once it gets started the uterus delivers the baby. The whole idea behind prenatal classes and what I used to teach is how to stay out of the way of the uterus. I never use the 'R' word because in 25 years I have never seen a woman relax in labour, but to stay out of the way of the uterus so it can do its work. And it even pushes the baby out and so you push with your uterus. You push with your baby; you work with your body. This body's an incredible machine. I have even noticed that other nurses are saying similar things on the unit, so I think people are coming around to this way of thinking. (Nurse Jessica)

Trusting the power of the uterus to birth a baby grounds the birthing process in the body. This negates the intellectualizing of birth and encourages women to return to their inner voice and listen to their bodily abilities. Spade's (1994) poetic offering of the uterus in her poem, *The womb,* provides a further illustration of the visceral knowledge embedded within the power of the body. Spade (1994) writes,

> Hidden deep and layered safely
> lies the visceral knowledge
> of our mind's eye
> Where all life begins and
> Where all life must exist
>
> Surrender to the womb
> soulless nights of despair
> restlessness and
> fallow there
> powerless, timeless, awaiting
>
> Be soft and gentle with
> the wait
> The womb conceives, embeds and aches
> Out of reach
> comes hope

Hope before clarity

And in the void of desire

the spirit quickens

and is reborn. (p. 8)

Spade's (1994) words provide visual imagery, as we imagine a surrendering to "the womb" similar to Jessica's surrendering to "the power of the uterus." Jessica suggests that women sometimes work against themselves, negating the power of their own bodies. Working with women for many years as a labour and childbirth nurse, Jessica has experienced the many ways in which women deny, forget, or negate the power and strength of their own bodies when birthing their babies. She thus considers part of her role as working with women to reclaim these bodily abilities. Jessica says,

> I think a lot of good things have come out about education around childbirth and mothering and breastfeeding, but I think what's happened is a lot of women have intellectualized childbirth. They've intellectualized parenting, they don't listen to their inner voice, they don't listen to their body and what I do by telling them to let their uterus do the work, is it takes a lot of the pressure off because a lot of women come in saying, "I can't do this". So, what I try to do is let them know that they don't have to know how to do it. Their body will just do it for them. Just trust your body. We have intellectualized things, made it a knowledge thing, rather than a trusting of your body.

Jessica is not alone in her trusting of the body, as Phoebe shares many of Jessica's ideas. Phoebe says,

> You know, you really can trust in your body, and the amazing thing is that when we do trust in our bodies, the most beautiful deliveries happen. It is those deliveries when we listen to our bodies that everything is wonderful.

Phoebe is not suggesting that all births are "wonderful" in a superficial way, denying the pain, the work, and the difficulties encountered by many woman during their birth experiences. However, she does believe that when women trust in their bodies, and learn to work with their bodies, not against them, birth experiences are more successful for women. In other words, women learn to "push" with their bodies, not against them. In doing so, women don't "tear their cervix" or " turn purple from not breathing." As Irigaray (2001) aptly claims, "Trust, it is true, restores the body to its integrity" (p. 13).

Embodiment

Phoebe and Jessica's trust in the body, allowing the uterus to do the work of birth suggests a notion of trust that is embodied. This description of trust applies to the lived body; an experiential being that integrates a deeper understanding of corporeality as a general principle of being (Leder, 1990; 1998). Embodiment, derived from the philosophical writings of Merleau-Ponty (1962), suggests a unified view of the body, in which one lives in one's body, not somehow separated from it (Goldberg, 2002). "An assumption of embodiment is that all parts of the body are integral to the human being; no part can be separated from the rest or objectified" (Wilde, 1999, p. 26). Recall Susan from the previous chapter, she was treated like an embodied woman by her night nurse because she engaged with Susan as a lived body, thus acknowledging Susan as an "individualized person" recognizing her complete presence, never reducing her to only a pregnant or birthing body. Unlike the technicians administering Susan's weekly

ultrasounds, who reduced her to nothing more than her body, Susan's nurse recognized her experientially, understanding that Susan was more than the body in which she birthed.

Within Western culture, and the medical paradigm in particular, the notion of embodiment described in the writings of Merleau-Ponty (1962), (and found in the practices of Jessica and Phoebe), is rarely implemented. Rather than embracing an understanding of the body as lived, in which each bodily being is comprehended within the full context of her experiential life, we have relegated the body to an object status and subordinate moral category. Mairs (1994) claims, "we treat our bodies as subordinates, inferior in moral status. Open association with them shames us. In fact, we treat our bodies with very much the same distance and ambivalence women have traditionally received in our culture" (p. 270). Mairs (1994) further discusses the suspicion with which the female body is viewed, particularly because everything is surreptitiously concealed on the inside. She states,

> And a woman's body is particularly suspect since so much of it is in fact hidden, dark, secret, carried about on the inside where, even with the aid of a speculum, one can never perceive all of it in the plain light of day, a graspable whole. (p. 271)

Mairs' (1994) interpretation of the subordinate body reveals the standard paradigm that permeates healthcare. Yet, in spite of this, Jessica, like the other nurses introduced in the study, works diligently to embrace an alternative paradigm that views birthing women as embodied and whole. Jessica says, " I have tried to learn from women and they have

taught me many things. Like they amaze me, women are wonderful creatures, just the fact that we can give birth and that the human body is simply amazing."

Misplaced Trust

Because of negative or hurtful experiences with health care professionals, women can sometimes have misplaced trust, even of their own body. In so doing, a woman is left with no option but to trust in her body, even when such trust is misguided. Although Jessica reminds us that the intellectualization of birth has negated women's ability to trust in their bodies, there are actual times when doing so is misplaced. One quiet Saturday morning on the labour unit, I spent time with Phoebe, a full time labour nurse, originally from the Netherlands, with 28 years experience. On this particular morning, we were assigned to a 43-year-old mother coming in for a non-stress test as part of her biophysical profile. Erica was 42 weeks gestation with her fourth baby, having had two previous C-sections and a home birth with her third child at 44 weeks gestation. This data was concerning to all, as this mother, Erica, also wanted to have her fourth baby at home with a midwife. Given the gestational age of the baby, Erica's maternal age, and her two previous C-sections, this was not a decision that would be deemed safe or ethical from a perinatal health care perspective.

Prior to Erica's arrival, Phoebe and I looked through the chart. Although there were a lot of concerns voiced about this woman, and some very negative comments made by health care professionals, Phoebe seemed to have an understanding of why this woman might have done what she did. It was not that Phoebe agreed with Erica's decision-making, because ultimately she didn't, but she was open to Erica's situation, and she didn't judge her for the decisions she made. Phoebe began to question why this

woman would have wanted a home birth after two C-sections. The chart told some of the story, but it left us wondering: Was her cervix ripe for an induction of labour at the time of her first C-section, was an appropriate scoring done on the Bishop's score, and were all options exhausted prior to her previous C-sections? In our conversation, we both discussed how often women were induced when their cervix was not overly favorable, and the assigned Bishop's score was sometimes exaggerated. In doing so, women often ended up with a C-section, when the situation could have been otherwise, if we—the health care professionals—would have the patience to wait until women's bodies were actually ready to birth. Phoebe and I began to question if this had been the situation with Erica. Had the health care professionals been impatient during her first birth experience, thus reducing her to situations where she misplaced trust in her own body?

Intersubjectivity

To be patient asks us to hold back or refrain from imposing our expectations on another. Patience demands tolerance, empathy, and care. It forces us to see the Other as ourselves. Irigaray (2001) says, "If I become the other—through love, for example—I abolish the two poles I—you, she—he. Thus, the relationship between two disappears and, with it, a possible dialogue and a possible intersubjective dialectic" (p. 49). Phoebe, in her desire to understand Erica's situation, attempted to abolish the polarity of the two, and see Erica's situation as perhaps no different from her own, if circumstances had been reversed. Irigaray's (2001) talk of an "intersubjective dialectic" is phenomenological in its conception, often found in the writings of Merleau-Ponty (1962), Beauvoir (1989), and Sartre (1973). Intersubjectivity, although not a theory or set of theories, refers to the

ways in which subjects are ensconced in the world together, how one is both effected by and effects the self and others in relations. Sartre (1973) says,

> I cannot obtain any truth whatsoever about myself, except through the mediation of another. The other is indispensable in my existence, and equally so in any knowledge I can have of myself. Under these conditions, the intimate discovery of myself is at the same time the revelation of the other as a freedom which confronts mine, which cannot think or will without doing so either for or against me. Thus, we find ourselves in a world which is, let us say that of "inter-subjectivity." (p. 45)

Sartre's words reflect his profound awareness of the ways in which the truth about himself is only known through the mediation of another. Hence truth becomes a form of interpretation, based on how the Other both perceives and engages with the subject. Like the situation of Erica entering the hospital for a non-stress test as part of her biophysical profile, the truth (interpretation) of her experience is determined by her encounter with her health care professionals. Her interpretation of her experience, and thus the interpretation of herself, is only known through intersubjectivity.

Reclaiming trust

Erica arrived for her non-stress test accompanied by her partner (husband). She used her partner's walker, as she found it difficult to get around. She was in good spirits and was happy to have me working with Phoebe that morning in my research capacity. Our interaction was brief, but meaningful. As I accompanied Phoebe, I continued to experience the ways in which she remained open with Erica, and trust was revealed within the engagement. Although Erica knew Phoebe very briefly from the community, it

was her open dialogue, her non-judgmental approach, and her authenticity that convinced Erica that this was the nurse she wanted.

Phoebe applied the fetal monitor for the non-stress test and asked Erica a number of questions. There was nothing but openness and empathy in her approach: No judgments, no scathing remarks, and no guilty comments were directed to Erica for the medical decisions she made in the past, or for those she might make in the future. Erica responded to Phoebe and said, "Will you be sure and be here with me when the doctor comes. I really want your support." This comment came after Erica shared with us the scare tactics used by physicians and nurses previously to convince her to have her baby in the hospital, rather than at home. Although I understand why health care professionals were concerned, as both Phoebe and I were equally concerned, scare tactics are ethically objectionable approaches to use in health care, aside from having little effect on outcomes.

Erica's non-stress test was reactive and her biophysical profile was scored high enough to send her home. The plan was for her to return the following week on Monday for another non-stress test. As Erica left, and my morning with Phoebe came to a close, I was left with the following thought: As a nurse, it is easy to work with those women who are mirror images of ourselves, who embody those virtues that we hold dear, and reflect that which we love, but the real challenge is to work in relation with women who are not like ourselves. Those women who challenge our principles and values, who make us question our very being. However, working with these women teaches us the most about ourselves, and more deeply about what it is to nurse and be nursed.

Phoebe, in her encounter with Erica, authentically enacted a trusting relation, in which she recognized her dominant position, yet did not attempt to negate or change Erica's subjectivity. Erica was heard and fully present, although every opportunity was there for Phoebe to enact her dominance and negate the trust she established with this mother. Phoebe, being both aware of and a practitioner of perinatal health standards, recognized that Erica was rebelling against these standards, but nevertheless valued Erica as a woman and respected her epistemic worth.

The notion of embodied trust was explored throughout this chapter by examining the ways in which trust was revealed within the relational practices of nurses engaged with birthing women. Trust was revealed not only in the relationship between a birthing woman and her nurse; but rather, trust was further elucidated in the relation a birthing woman explored within her own body (self-trust) and its potential to facilitate the birth of her baby. In chapter five I build on the notion of embodied trust by incorporating the ways in which such trust promotes a woman-centered approach to birthing, in which the primary ways of learning are woman-centered. In so doing, I explore the notion of woman-centeredness through the words and stories of the perinatal nurses and the birthing women who have participated in the study.

Chapter Five

Woman-Centered Birthing

> *Some people have never seen the miracle of birth, and we get to see it everyday, sometimes several times a day. Sometimes we take it for granted, that it is part of our job, but it really does make a big difference to the women and their families. There are days when it's a job—usually when there's a lot of politics going on, extra stresses of being a nurse that don't relate to the patient, time constraints. I thought about going elsewhere, but I really don't want to leave. It is an amazing place to work.*
>
> *(Nurse Amy)*

Throughout perinatal health care the term woman-centered has been used to describe a number of birthing environments, yet few of these environments have enacted practices resembling woman-centered care. Increased patient acuity and a reliance on technological intervention have removed women from the nexus of their own control (Goldberg, 2002). In so doing, women's experiential knowledge regarding their birthing bodies is often denied in their health care encounters. Within the research study and in other contexts, women have stories that tell of their birth experiences, and how they have either been nurtured in the presence of their nurses (physicians and other health care providers), or co-opted by their "expert" knowledge, giving rise to an experience of birth that was not their own.

Within the context of the research study, a woman-centered approach to birth is defined as one in which a birthing woman is central to her own birth, not only because it is her physical body that births, but because it is the woman herself who is an active participant in her birth. In this chapter, woman-centered birthing is understood as a lived, experiential, and embodied practice. It is embedded within the moments of care that I experienced with the nurses as a participant observer, and understood from the conversational interviews that I had with the women and nurses who participated in the

study. Woman-centered birthing is thus actualized when there exists a relational engagement that is directed from nurse to woman, woman to nurse, and between and among the nurses providing care. The focus of this chapter is to illuminate these relational engagements. By attending to the learning, collaborative knowledge, and epistemological value that the nurses reveal within their practices, a woman-centered approach to birth with the women in their care is fostered.

Woman-Centered Understanding

Woman-centered birthing situates a woman at the center of her birthing experience. To be centered suggests a state of balance or stability. A dancer's work, for example, is often predicated on her ability to find her center. A pirouette is rarely possible without first learning to be centered: finding that inner core where bodily alignment is seen as an imaginary line from the tip of the skull to the edge of one's metatarsal. The term woman-centered is best captured in the phenomenological writings of Young (1990), who conceptualizes her understanding of woman-centered as a construction: one in which women's breasted experience is imagined as moving from the masculine gaze (which objectifies and positions the woman as Other) to the female point of view, in which "the breasted body becomes blurry, mushy, indefinite, multiple, and without clear identity" (p. 192). Young imagines a feminine epistemology that uniquely privileges touch, rather than sight:

> With touch as the model of experience of the world, moreover, dividing the world into objects with definite borders makes much less sense. Touch differentiates—indeed, takes pleasure in—the subtlest difference of texture or softness, but inasmuch as the things touched also touch each other, the borders

are not firm. Without a place outside the world to stand, touching also steps down from the clouds of universalism; and not merely as the instances of general laws imagined by a mathematical mind. (p.194)

Young's construction of a woman-centered space (grounded in an epistemology of touch) consists of bare-breasted women walking freely, in which breasts become similar to faces. A woman's breasts, like her nose or mouth, become a further expression of who she is and how she is both recognized and expressed within her body (Young, 1990). Young's construction, although imaginary, is not far removed from the actual labour rooms of the women and nurses who participated in the study. Coming to know aspects of a woman's body, her abdomen, her breasts, and her cervix, is not foreign to a perinatal nurse, especially during the birthing process. Jessica, for example, is both gentle and directive in her approach to breastfeeding, particularly when touching a woman's breast in assisting a baby to feed. Marcia too, reminds women to "breathe through their vaginas." Marcia's familiarity and ease with the female body, including her own, allows her to encourage women to birth in the nude, if they are comfortable and choose to do so. Meagan, a birthing woman interviewed in the study, describes the gentleness of her nurse's touch. She says, "My partner was rubbing my back really hard. But, my nurse sat in front of me and she held my hand and rubbed my hand softly while I whined and complained."

The perinatal nurses and birthing women related those experiences that both fostered the woman's ability to actively engage in her birth, and those experiences that denied or negated her active involvement. Woman-centered birthing was actualized not only when nurses and women were able to collaboratively learn from each other, but

further when nurses were capable of collaboratively learning from themselves, and able to share their collaborative knowledge for the benefit of the birthing woman.

Being for the Other: Non-Interference

During our second shift together, Nurse Marcia and I had the experience of working with Becky: a woman in active labour, 7 cm dilated, using occasional entonox (gas) to cope with her birthing pain. When we entered the room she was breathing through her contractions with the encouragement and support of her partner and her mother. Becky was in a semi-fowler position with a pillow wedged under her right side with the fetal monitor attached to her abdomen to auscultate the fetal heart rate and the frequency and duration of her contractions. Her brow was slightly moist; her lips pursed and dry. There was a quiet intensity about this woman. Because my experience of birth is not first hand (I have not birthed my own baby, only assisted as a nurse with the birth of others), I could only imagine that bodily place where Becky resided. Her body revealed that place: the commitment in her eyes, the tautness of her abdomen, and the secretions from her vagina. The baby would soon arrive.

Marcia introduced herself and I offered a brief explanation of why I was there. At 7cm with no medication, I kept it brief. Becky understood that I was a perinatal nurse but was working in a research capacity with Marcia for the evening. She stated that she was comfortable with my presence. To be in the presence of another suggests more than being physically present. One can have a strong presence in a situation and I wanted to be a calm presence, allowing Becky to be the focus of the experience. Parse (1992) speaks of true presence, in which the nurse invites the Other to relate the meaning of their experience to themselves, the nurse and others in the situation. Parse says,

> The process of sharing thoughts and feelings in itself sheds a new light on the situation. Often the thoughts and feelings discussed have been lying dormant beneath the surface for some time. Articulation of such thoughts connected with the moment and in the presence of the nurse may lead to an "ah-ha," a way of viewing the familiar from a different perspective. (p. 39)

My presence as a nurse has always been that of a clinician, working at the bedside with birthing and postpartum women. Tonight was different. My presence was that of a researcher. Although I was in green scrubs, the same as Marcia, and the labour room was a familiar place to me, I felt out of sorts, almost like a new graduate not quite knowing what to do. I had a little notebook in my back pocket, and forms in a pink folder that I placed on a shelf in the corner of the room. I needed to remind myself to take the forms when I was done. But the labour room was for birthing, not for note-taking.

Once our introductions were established, Marcia suggested that Becky have some time in the shower, giving her a rest from the monitor and the bed. The monitor was then removed and we assisted Becky to the shower. Because Becky's partner and mother were doing so well supporting Becky, Marcia did little to intervene. She said that she didn't like "to interfere when couples and families were working so well together." Once Becky finished in the shower, Marcia and I went back to the room and assisted her into bed. Because Becky didn't have an epidural, and the tracing of the baby was reactive, there was no need for continuous fetal monitoring. Thus Marcia opted for intermittent monitoring. Marcia talked with Becky about the importance of position changes during birthing, and how each position helped physiologically to rotate the baby. Remaining in a supine position was discouraged by Marcia, as she often demonstrated position changes

with her own body, and did so with great ease. Independent of where Becky was in her contraction pattern, Marcia could elicit a smile from her, however slight. Marcia's humour was contagious, and her knowledge of the birthing body was exceptional. Being an avid reader in perinatal health and feminist literature, Marcia was able to provide Becky with substantial knowledge throughout her birth. Citing physiological reasons for pain, contextual nuances specific to Becky's situation, and providing empowering information particular to birthing women, Marcia collaborated with Becky to provide knowledge to facilitate her birth.

Becky changed her position to her hands and knees, rocking back and forth, continuing with her breathing. Marcia and I remained as encouragement, participating with her family members to support Becky's progress. Marcia introduced the importance of firm massage. She began with a demonstration, and then gave the activity to Becky's partner to continue, ensuring that he remained as active now as he had been prior to our arrival. We were a positive force working with Becky, surrounding her, encouraging her, and supporting her.

Andrist (1997) suggests that there are essential practices grounded within a feminist model that are necessary for the health care of women. By exploring relationships between and among female surgeons and their patients undergoing treatment for breast cancer, Andrist (1997) was interested in understanding the practices of these surgeons, who were believed to challenge the standard medical model of health care. Symmetry in relation, access to information, shared decision-making, and social change evolved from Andrist's (1997) research model. She concluded that these features of her model had the potential to change the ways in which health care

was currently delivered to women. Andrist (1997) states,

> Symmetry is the attempt on the part of the clinician to reduce the inequities that have existed in the healthcare environment...By recognizing that the provider-patient relationship is one of mutual reciprocity, the clinician is able to decrease traditional physical, social and personal barriers.(p. 269)

Knowledge in relation: epistemic presence

Marcia, in her relation with Becky, understood that her practices were also based on symmetry in relation and shared decision-making. Their encounter was constructed on the premise that both Becky (the birthing woman) and Marcia (the nurse) were counted as epistemologically present. In other words, although Becky was not a health care professional, she was nevertheless recognized as a legitimate source of knowledge about her own body (Goldberg, 2003). Because the decisions about Becky's birth were collaborative, based on a process of symmetry, Marcia was not considered the only authority in the decision-making process (Goldberg, 2003). In her relationship with Becky, Marcia co-constructed new knowledge that potentiated the experiential knowledge of Becky, the birthing woman, as symmetry suggests that one (birthing woman) cannot be available without the other (perinatal nurse). Marcia and Becky co-constructed new knowledge within the context of Becky's birth. Becky is counted as epistemologically present because she is both an active participant in her care, and legitimised as a knower in the contribution to her own birthing trajectory.

Marcia's nursing knowledge of birthing women provided her with a context in which to hear Becky's experiential knowledge. Becky's desire to birth "naturally," with minimal to no pharmacological intervention was respected. Although Marcia suggested

various position changes to facilitate the birth of Becky's baby, Becky contributed to how she felt with each position change, and if the position were uncomfortable or inappropriate, she would opt for another. There was a constant back and forth in the knowledge that unfolded. It was actively engaged and constantly in flux, reminiscent of birth itself. Recall the situation of Madison (chapter four), who unlike Becky, in her relation with Marcia, was not in a symmetrical and collaborative relation with the health care professionals she encountered on the labour unit. She was reduced to a position of epistemic absence, in which she was denied consideration in the plan of her own birthing care. When she arrived in early labour, her request to return home and rest differed from the request of the health care professionals. They wanted her to be medicated and sleep on the unit in preparation for an induction the following morning. Although Madison was later granted her request to return home, it came after a tearful and exhausting evening, not indicative of an environment that positioned her at the center of her own experience or valued her epistemic worth. Madison's initial encounter was one in which the decisions that were made were co-opted by the resident, and little time was afforded to Madison to discover what she imagined or anticipated for her own birth.

It should not be presumed, however, that an environment is only woman-centered when it values the individual woman's knowledge over and above the knowledge of health care professionals. Rather, a woman-centered environment is one in which both the woman and health care professionals relationally foster a woman's birth experience in an ongoing and open dialogue. "By combining contingencies through engagement, persons are able to coauthor an interpretation that may be more

inhabitable than either of their individual narratives as they seek a new form of the good" (Gadow, 1999, p.66). Marcia, in her relation with Becky, was clearly working from this perspective. As I participated with Marcia in Becky's care, the practices that evolved were not only focused on Becky, but included Becky as a full participant. The position changes for birthing, the decisions regarding medication (only entonox), and the persons to be present at birth, were decisions that included Becky's full participation. Woman-centered birthing entailed nursing practices that positioned Becky at the center of her own birth, thus providing a positive and safe outcome that evening. Becky birthed her baby in the company of her partner and mother, and the joy that she experienced was evident upon the birth of her baby.

Woman at the Center

Phoebe, like Marcia, also embodies practices that promote woman-centered birthing. Having spent the first few years of her nursing career doing home births in the Netherlands with physicians and midwives, Phoebe's perspective on nursing and the ways in which she views women reflect these experiences. Growing up in a small community where birth and death occurred in one's home, Phoebe reveals a comfort with the normalcy of these experiences that many North Americans may not share. She says,

> Where I grew up, we were comfortable with both life and death, but I think in Canada people are comfortable with neither. It's true! Part of that is the way our houses were. If somebody passed away, they would be in your house for five or six days. I was raised in a little village and actually lived this experience and the entire neighbourhood came and saw the person who died, and it was a get

together and a way to support the family. It was a wonderful thing. And for birth it was the same. If you had a birth in your street, the houses weren't exactly sound-proof. If it was the middle of the night, it was not abnormal that quite a few people were out on the street saying, "How close is it now?" The women would be together and the men would be trying to sleep. All the houses were in a row, and there was not much room. So, when you heard the baby cry, everyone would go into the house and say congratulations and probably have a drink and a good time. It was completely different, and a completely different way of living.

Phoebe believes that some of her practices are very different from those of her colleagues. Whether it is because she is less confined by the rigours of policy from doing home births in the Netherlands, or is indebted to the holism of her cultural past, Phoebe envisions birthing as a process that should be directed by the woman herself, not by a machine, or by the medical establishment. Within her philosophy, Phoebe is committed to including the mother's wishes, but not at the expense of her safety. Phoebe views a woman in labour as "just such a beautiful thing, and that you cannot help but be in awe of women...of the strength they have". She says, "I feel privileged to be part of that". Phoebe suggests that facilitating "good" nursing that is directed to the woman and her experience of birth is not about sitting at the desk charting nurses notes. She says,

> If you sit at the desk or if you're busy charting all the time, some people think it's good nursing, but I think that it's almost impossible to chart at the same time while you're giving care. And so I'm known to be a very bad charter. But I do

everything after the fact. If the mum is on the monitor then I get a lot of times from the monitor and if she's not on the monitor, and most of my people are not on monitors unless they really have to, then I just scribble it on any piece of paper, scrap of paper that I can find like a towel or whatever. Sometimes even on my uniform so I know when I checked the baby's heart rate. I examine the mum very little. I believe you don't need to examine somebody at all. I don't really care if she is 4cm or 8 or 10. If she feels like pushing, then she should push. I believe our body doesn't make mistakes. I've noticed if the mum isn't ready she won't push. If I tell her not to push, and she needs to push, it does something to our relationship...I encourage her when she wants to push, and I try to go with what she wants to do because I find that everybody does it in her own way.

Phoebe suggests that although the body doesn't make a mistake, that doesn't entail that nothing ever goes wrong. Although she is not against fetal monitoring, and says, "nature is wonderful," she also believes, "it sometimes messes up". She provides the example of appendicitis to illustrate her point. A lack of progress is also known to warrant intervention, and to be an illustration of the body going awry. If a woman is having contractions over an extended period of time that are not increasing in intensity, frequency or duration, it is likely that she is not progressing with her labour. Phoebe says that without examining a woman internally, this lack of progress would be evident, although a physician would likely require a vaginal examination before intervening. Phoebe often recommends the shower or a rest before notifying the physician, as the woman may be tense or exhausted and need time for herself. In this situation, Phoebe is

speaking of a lack of progress in a full-term woman, who is labouring "naturally" on her own, and given time to progress with her labour, not a woman induced prematurely. Phoebe says,

> Only if she wants to and if she agrees to lie in bed for a while, I'll just help and massage her back and whatever to get her sometime to rest, often the labour will actually pick up on its own. If not, I would try that probably for about an hour and if I think it is not changing at all, then I would examine and contact the doctor. Now I don't do any of this without explaining everything to the woman and why I am doing what I am doing. I ask if it's okay, if that is what she feels should be done. I find, though, that sometimes they are so overwhelmed and scared.

"A Motherly Sort of Way": The Mothering Metaphor

Phoebe's approach to working with the women in her care is indicative of various relational models proposed for re-conceptualising women's autonomy within the feminist and bioethics literature. Because Phoebe works from a perspective that respects the agency of the birthing woman, but continues to value the knowledge that evolves from working in a relationship, examples of relational models would be relevant to Phoebe's practice. Held (1993) and Raymond (1986), for example, have proposed feminist models based on mothering and friendship. Within the study, women participants have also used the mothering metaphor when describing their nurse. Recall Rachel (Chapter 3), who discussed the "haste" with which her birth took place. During our interview she refers to one of her nurses as being helpful in a "mothering sort of way". Rachel says,

She would be like, we are going to do this, and she would always come and check back with me, she always touched my shoulder, she was very kind and so competent. She was right in there with me, and making sure I was doing well. She didn't remind me of my mother. My mother was good at the delivery, but she was more held back than that. My nurse was very good, in a mothering sort of way.

Abbey, who discussed her experience of HELLP syndrome in the previous chapter, shares Rachel's use of the mothering metaphor. Abbey says, when referring to one of her nurses involved with her care,

She was quite experienced. Motherly. Not like that young bright thing like my doctor. Part of being motherly for me is age dependent, at least a little bit. She was comforting, caring; she looked me in the eyes. She was very reassuring; she would touch me on the arm, or the hand, even when she would be looking at the monitor. It was very appropriate, but I would touch her too. I related to her, I related to that touch. Even though I had HELLP syndrome, she found a way to make it okay. She found a way to make it not the end of the world. She said, "You'll have a baby today Abbey. Isn't that great? You will get to see your baby."

The mothering metaphor used by Rachel and Abbey to describe their nurses is a generous offering: one of caring, support, and reassurance. Their descriptions reveal their nurses' investment in both their birth experiences. Through touch, affirmation, and authentic care, these "motherly" nurses fostered a safe and comfortable environment, in spite of Abbey's HELLP syndrome. For both Rachel and Abbey, the "motherly"

reference was one of relationship and mutuality. Their knowledge and experience were valued in the relation; in the same way, they valued the knowledge and experience shared with them by their nurses.

Held (1993) uses the mothering metaphor as a possible example of other human relations (recognizing its limitations). Because the intent of mothering is to give of the self without the expectation of returned self-interest, the internal joy of mothering comes from the well being of the other (child), and the relation itself (Held, 1993). In the mothering relation, a new concept of power comes to fruition. Although power is often understood as something that can be held by one person over another, or wielded by one over another, mothering power, according to Held (1993), is redefined when applied to the bringing up of her child. She states,

> The mothering person seeks to *empower* the child to act responsibly; she neither wants to "wield" power nor to defend herself against the power "wielded" by the child...When the child is physically weakest, as in infancy and illness, the child can "command" the greatest amount of attention and care from the mothering person because of the urgency of the child's needs. (p. 209)

The mothering relation is a caring relation, often dynamic with the wants and expectations of the child, concerned that the child will leave before she or he is ready for independence and self-reliance. This relation in its functional forms is not characteristic of dominance (Held, 1993). The child, in search of her or his own projects, attempts to develop as a person and gain self-control over her or his life events. This is done while relying on the mothering person, while not submitting to a superior or dominant power (Held, 1993).

Held's (1993) view of mothering, although of import for providing an ethical framework based on mothering, portrays an idealized view of mothering. Ruddick (1989) suggests that although many mothers begin from a place of love for their child, it can be negated by the very anger that love entails. Regardless of the degree of maternal competence mothers provide, not all children thrive: "Even the luckiest children are often ill, lonely, mean, dispirited, or afraid. The emotional and physical pains of their children are anguishing for mothers, inducing a sense of helplessness and guilt" (Ruddick, 1989, p. 30). Ruddick (1989) suggests that mothers succumb to temptations intrinsic to their work: fearfulness, self-righteousness, possessiveness, and denial (among others). "Mothers infuriate their children and disappoint themselves" (Ruddick, 1989, p. 30). Thus to appropriate the mothering metaphor uncritically is concerning, for like Ruddick's possessive or self-righteous mother, there exists the potential for such qualities in nursing. Nevertheless, Rachel and Abbey offer the mothering metaphor as an affirmation of their nurses.

The use of the mothering metaphor in nursing is not surprising, particularly in the area of perinatal health where women are birthing their babies. Rachel and Abbey refer to their nurses as "motherly," in both a positive and complimentary way. Their use of the metaphor is to give praise to their nurses: to describe them as trustworthy, experienced, and warm. As I think of my own mother, I am reminded of her kindness, her wisdom, her unique humour, and her touch. There is no mistaking the mother's touch with that of another's. Bergum (1997) suggests,

> The relational commitment learned through mothering—the being with and for the Other and the being with and for the self—needs to be cherished. So while

wisdom learned by mothering is primarily for the mother and child (a particular mother and child), it is also for all of us—creating the possibility of a full life, a morally lived life—and thus for life itself. (p. 137)

Bergum's description of mothering, derived from her phenomenological account of women's experiences of mothering, offers us the possibility of loving both the self and others in the mothering relation, opening the possibility of extending the relation to more than the particular mother and child. The mothering relation, for Bergum (1997), becomes foundational in offering a moral impulse, a "turn toward the Other—to be with and for the Other" (p. 163). Understanding mothering as the primordial relation of commitment and caring (Bergum, 1997) further reflects Abbey and Rachel's descriptions of the mothering metaphor within the research study. Bergum's (1997) work on mothering is a potential way of understanding the perinatal nursing relation: an embodied relation that is committed to the needs of the Other (patient), but not at the expense of losing the self (nurse). The context of the relationship thus becomes bound by the embodied experiences of concrete persons engaged together (Gadow, 1994), with the nurse fostering the needs, concerns and experiences of the birthing woman. Like the mother responding to the Other (child, adolescent, or adult), fostering an attentive and dependable love (Bergum, 1997), the perinatal nurses described by Rachel and Abbey embody a similar relation in their account of the mothering metaphor.

Although there is no denying the richness of the mothering metaphor and its potential use within perinatal nursing, caution must be taken in its appropriation. Ruddick (1989) reminds us that it is easy to idealize mothering, but mothers like everybody else have their struggles. "Mothers can dominate, humiliate, hate, and hit"

(Ruddick, 1989, p. 30). Humiliation and domination are not behaviours appropriate for perinatal nurses to embody in their practices with birthing women. Further, that the mothering metaphor may normalize an inequitable relationship resulting in women's oppression (Donchin, 2001), suggests that appropriation of the mothering metaphor will require further revisioning before its potential consideration for nursing practice.

"I Try and be Their Friend in Labour": The Friendship Metaphor

Models based on mothering are not the only accounts provided within the feminist and bioethics literature. Alternative models based on friendship have been developed (Friedman, 1993; Raymond, 1986). Raymond's vision of friendship, for example, promotes a mindfulness that includes both rationality and caring, and a quality of passion that embodies a complete sense of self (Donchin, 2001; Raymond, 1986). Raymond (1986) suggests, " Female friendship is characterized by thoughtfulness, it is also marked by passion. Friendship is a passion but, in my vision, it is a thoughtful passion. It manifests in a thinking heart" (p. 223). Karla referred to the friendship metaphor when describing some of the ways in which she engaged with the women in her care. Karla says,

> I try and be their friend when they're in labour, so maybe that is why we're kind of equal. Maybe I know more about how to deliver a baby, but I don't ever put that across...I had a patient the other day; I shook her hand when she came in and we had a great chat the whole time. Well, she got into active labour and I was pulled to do a C-section. I felt horrible because I'm the one who started the relationship with her and I came back and she had her epidural and everything else. I said, "I'm sorry I abandoned you." I could joke around with her like that.

> And, I think you can do that with friends. You don't talk to a friend for four months, and you can call them up and be the same way with them as when you last left off.

Marcia, also used the friendship metaphor when talking about the ways in which she enacts care with the birthing women in her practice. She says,

> When I meet somebody I treat them just like I would treat my friends and I think that relationships are very important. And over the years it's got easier because I now have the confidence of 20 years of experiences as well. So, whatever I do, I'd like to think that I continue the same kind of relationships that I have with my friends.

Engaging in a nursing relation based on a model of friendship is one I recognize as a clinician, as it reflects my own practice: mutuality in the engagement, a desire to be with the person in the event, and a genuine affection or concern for the Other. Nurses in the study demonstrated various qualities of friendship when engaging in practice. Ease, humour, and interpersonal caring were evident from the moment they entered the labour rooms. Madison says,

> You don't want to go to a place where everything is like an office, and it's robotic, especially when you're in pain. The nurses were fun, and they are the ones who are with you for your entire birth. My nurse was professional, she knew what she was doing, and she was very friendly.

Susan also comments on the humour and friendly disposition of her nurse. She says, "My nurse was very funny, solicitous, and genuinely cared about me. Her humour was important and her joking kept me calm." Joan, however, cautions against the overuse of

humour, although recognizing it has its place. Experience as a nurse has taught her that birthing situations can quickly go from "normal" to emergent, insofar as "low-risk" births can quickly result in complications requiring emergency interventions. Therefore, humorous comments previously thought entertaining can later be misconstrued as inappropriate if circumstances result in a negative outcome for the birthing woman and her baby.

Bowden (1997) suggests that friendship as a model of care may offer liberating potential because it is not constrained by administrative roles and social structures, she nevertheless recognizes its limitations. She states:

> The expansive promise of friendship, the possibility of freely choosing and being freely chosen, is conditioned by vulnerability to the vicissitudes of its participants and the exigencies of the more structured relations in which they are involved. The friendship that is given freedom can also be withdrawn with impunity. (p. 60)

Bowden's (1997) concern is worth consideration, particularly in light of the women participants who spoke of the guilt they felt when their birth decisions differed from those of their nurses. Whether it was in relation to pharmacological options or breathing techniques, there were occasions when women participants felt guilty or remorseful for choosing an option that differed from their nurses. However, the women were not alone in their feelings of remorse, as nurses occasionally voiced their feelings of guilt when they persuaded women to make decisions that were based more on their choices rather than the women's. Thus the freedom to choose within a friendship model doesn't eliminate the potential problems elucidated within the very act of choosing. Yet, as

Friedman (1993) suggests,

> One friend's superiority in one area, for example, in breadth of life experience, need not give that friend a privileged place in the relationship if it is balanced by the other friend's superiority in some other area, for example, in vitality of imagination. (p. 189)

Friedman's (1993) words aptly reflect many of the practices of the nurses in the study. Rarely did the nurses discount the experiential knowledge of birthing women as being less valuable than their knowledge derived from perinatal nursing, health care or midwifery. Further, revealing an interest in the Other, mutuality in relation, and benevolence (Friedman, 1993) were friendship qualities frequently demonstrated by the nurses. Yet, Donchin (2001), unlike Bowden (1997), suggests that the lack of structure in friendship is not liberating for health care, insofar as it is not indicative of the goal-directed activities and institutionalised constraints reflective of health care practices. That Donchin's (2001) claim is warranted there is no doubt, yet the nurses and women in the research study experienced nursing moments grounded in qualities of friendship, even within the constraints of institutionalised health care. In so doing, the nurses and women reveal future possibilities for practice that move us beyond the standard health care model.

Regardless of the situation, Karla and Marcia, in engaging with birthing women as friends, reveal a way of enacting practice that jettisons the standard medical model of hierarchical relations. Mutuality in relation, concern for the Other, and a desire to be present are essential to Karla and Marcia's nursing practice. In working from the friendship metaphor, both Karla and Marcia not only recognize their clinical knowledge

as labour and childbirth nurses, but equally recognize the knowledge a woman brings to her own experience of birth. There exists collaborative practice within the relation to promote a woman-centered experience of birth.

Expanding the Center: Aesthetic Knowledge in Perinatal Nursing

Creating an environment that fosters woman-centered birthing is actualized not only when perinatal nurses and birthing women are collaboratively engaged and learning from each other. Learning is further actualized when perinatal nurses are learning from themselves, and sharing their knowledge for the benefits of their own practice and the birthing women in their care. Amy, a young nurse in the study with over four years experience in labour and childbirth, talks about her transformative growth as a nurse from working with the birthing women in her practice, and the experienced nursing colleagues on her unit. Like the other nurses in the study, Amy is "honoured" to be working in the area of labour and childbirth, and says that she "enjoy[s] working with women and their families and being part of a life-altering experience that is often the most important part of people's lives."

Amy says that when she first graduated from nursing, she took the view that pain during birth needed to be avoided. The pharmacological options and technological advances in perinatal health have made birthing without pain an option. She concluded that there was no need to birth with pain when women could do otherwise. Both the birthing women she attended in her practice and her experienced nursing colleagues, who shared their knowledge of working with women without pharmacological interventions with Amy, soon challenged Amy's thinking. She says,

When I first came to labour and delivery I thought that if you can have labour

without pain why wouldn't you? But experience with women has taught me that they have labour with pain all the time and have been doing it forever. And, the nurses on our unit who have a lot of experience from working in places that didn't have epidurals, or if they had them they came later in their careers, have experience of helping women from measures of support without medical intervention. Watching them has helped me learn about supporting women without morphine or epidurals and develop my bag of knowledge.

Amy's "bag of knowledge" has expanded with the aid of her experienced nursing colleagues, many of whom have participated in the study. Her learning and knowledge for assisting women in labour without medication now entails a variety of expanded techniques and practices: diverse position changes, grunting and breathing techniques, and bodily rocking that gently moves a woman back and forth, usually positioned on her hands and knees. Amy is also known to alter the height of a bed to change a woman's position in labour, suggest the use of a birthing ball, or utilize other strategies that were not the focus of her undergraduate nursing education. Amy's reference to her expanded "bag of knowledge" is reminiscent of aesthetic nursing knowledge (Carper, 1997), which moves Amy beyond the empirics of her practice. Understanding the various stages of labour, the anatomical and physiological changes of the birthing body, and the principles of fetal monitoring, provide Amy with an empirical foundation for understanding perinatal nursing.

However, aesthetic nursing results in the art of nursing practice (Carper, 1997), revealing creative, skilled and empathic qualities that foster Amy's ability to acquire knowledge that is beyond the world of empirics. "Esthetics requires engagement in the

moment and the 'all-at-once' interpretation of a situation to project an outcome and act in relation to what is envisioned" (Jacobs-Kramer & Chinn, 1988, p. 136). Lumby (1991) states,

> I see this art every time I walk into an environment where a nurse is busy "creating" the day for another person. They are busy using light, space, sound, words, movement, and touch to deliver the message of care. And like true artists they are willing, indeed they see it as essential, to share their performance with others. (p. 463)

Like the nurses Lumby (1991) describes, Amy is busy using labour rooms in new ways, creating birth experiences with women that move beyond the standard practices she learned in her education. Not to deny the importance of nursing education, and the learning that evolves within that environment, but the aesthetics of practice often occur in the company of experienced clinicians who share their experiential knowledge and "bedside scholarship" (Mauve, 1994) working side by side with new graduates and inexperienced nurses. Marcia, stating concern over what is occurring within health care education:

> Times are changing. We now have a new generation of students, both in nursing and in medicine. They come out of school and they know how to think. What did I learn in nursing school? I learned how to care. We have taught our youngsters, both in medicine and nursing to think. Can they critically think? Critically think all you like. Does it show you how to build a relationship? Does it show you how touching and talking to a woman can be part of empowering that relationship?

Marcia's words reflect her concern with nursing education; she is currently enrolled in a post RN degree program, and completing her baccalaureate in nursing after 20 years of practice and a background in both nursing and midwifery. Marcia's issues with nursing education reflect the lack of clinical hours devoted to bedside care, and how the current curriculum continues to devalue the experiential knowledge that is embedded in years of nursing practice. Yet, does critical thinking preclude the ability to engage in a meaningful relationship, as Marcia implies? My experience with young nurses teaching at the University of Alberta suggests quite the opposite, as do the findings of this research.

Nurse Joan, like Nurse Marcia, also calls attention to the lack of clinical teaching available to nurses in their undergraduate programs. Upon graduation, she sees young nurses coming to work in her area with minimal understanding of why they are doing what they are doing. Technology is often the focus of their learning, and not "the personal hands on clinical care of the patient." Joan says,

> Teaching, teaching, teaching is so important with these young nurses. You need to take some of them by the hand, although they get upset sometimes. It is an ongoing process. But if I'm doing it and nobody else is doing it that is not what we need. It needs to be shared. It's difficult because you expect them to work. You expect them to educate themselves. You expect them to be proactive and say, "I really don't understand this, or can you explain this to me, or is there something else I can be doing to do a better job of looking after this patient?" But, most of them don't ask, or do that.

Mauve (1994) reminds us that "Clinical education must occur within a community of

experienced bedside nurses who can competently demonstrate to student nurses how to nurse and how to develop an integrity of practice that will sustain them through their careers" (p. 21).

The knowledge gained from Amy's colleagues to expand her learning has fostered a positive working environment for Amy, enhancing her clinical learning and perinatal practice. In so doing, she is able to work with birthing women in new and aesthetic ways that move beyond the pharmacological and interventionist models of care. Amy says,

> I actually feel really privileged to work with the group of staff I do because they have so much experience. When those people retire, women will probably get more epidurals and more medical intervention because they don't have the techniques, the nurses won't be able to turn a baby without instruments or be able to make use of comfort measures without epidurals to get through labour.

Regrettably, not all nurses have benefited from their colleagues' experience, and the learning environment occasionally has made younger nurses feel uncomfortable, even in the presence of the birthing women in their care.

Conflict at the Center

Melanie describes some of the difficulties in being a young and inexperienced nurse when working with some of her colleagues. She says,

> One of the biggest barriers is probably my age and my experience. You see other more experienced nurses that just waltz into the room and because of their age and seniority, they think they know what is going on and they can just come in and call the shots. Whereas, I may have developed something totally different

with the patient, different atmosphere, and they come in and they're trying something that's totally different and they undo what's been done or they really get the patient to put up her guard. And, I'm not sure how to handle that as an inexperienced nurse. I don't want to be insubordinate or rude to my colleagues, but it is difficult to tell some of them, "I have things under control."

There was actually one evening I was working with a woman, and she requested that two of the four nurses I was working with not come into the room while she was in labour. I was actually able to tell the other nurse I was working with that the woman would really love her to come back for the delivery. She said she would come back but she had one thing to do first. In the meantime, one of the other nurses that the woman had requested not to come into the room came in and just took over. At that point it was really difficult to really stand up for what the patient wanted, although I knew what she wanted and I felt quite helpless.

I have seen this happen with other younger nurses as well, even when things are going just fine. I think it's a learning experience just to know how to deal with these particular colleagues. Sometimes it is best to let it go, and other times it is more appropriate to say something, because to mess that up, and for patients to have a bad taste in their mouth because of something that happened right near the end when you have done so much up to that point. They remember this for the rest of their lives, their deliveries, their nurses, and their experiences, and that is why it is such an honour and a privilege to be there.

Melanie is not alone in her feelings of discomfort when working with her colleagues where there is inability to share their learning experiences with her, thus creating an environment that is uncomfortable for both Melanie and the women in her care. Recall Mary, one of the women participants first introduced in chapter three. During our interview, she discussed the occasional "tensions" that existed between a few of the nurses who entered her room during her stay on the labour unit. She says,

> My labour nurse was in my room working with the baby or just finishing up, while a lot of my family were still in the hallway, laughing and joking, excited about the baby. Another nurse came into the room, it was probably about 10:30, and she said to my nurse, not looking at me, "Who are those loud people in the hall, they need to leave. I have mothers trying to sleep." My labour nurse said she wasn't sure, but she wouldn't look at the other nurse [realizing that they were Mary's family]. I mentioned that the other nurse wasn't very nice. My nurse tried to dismiss it, but it was obvious that there was no connection between them. It is obvious that there are different relationships among the nurses themselves.

Mary goes on to discuss a similar situation, in which one of her nurses suggests one course of action, while another negates the initial suggestion, while in the very presence of the first nurse. Mary states, "If you are going to be like that amongst yourselves that's one thing, but in front of a patient, I find that quite another thing altogether, but bringing that kind of tension into the room is not appropriate." Every nurse brings something different into the room, says Mary, and that is expected. We are all different. "Body language, eye contact, tone, facial expressions, these can all indicate sincerity to

me or not. They can all be sincere even if they are different," but to dismiss the work of one colleague in the presence of another, with the patient in the room is neither professional practice nor respectful conduct.

Returning to the situation of Jen (chapter 3), she was also rudely interrupted by a nurse covering on break for her primary nurse, who was "wonderful, supportive, knowledgeable, and loved what she was doing." After a long night of induced contractions with minimal changes to her cervix, Jen was using breathing techniques to cope with her birthing pain. The nurse covering on break came into her room, reduced her to tears, and accused her of using breathing techniques inappropriate for her stage of labour, thus undoing the previous work Jen and her primary nurse had done. Jen's situation echoes the words of young Melanie, who reminds us of her experienced colleagues who "waltz" into her room and take over the work that she had done, assuming their experience and years of practice entitles them to do so. Hearing the words of young Melanie and her struggles, I am reminded of my own experience years ago as a new labour nurse, and what it felt like to be in the tenuous position of having to prove my worth as a nurse every time I embarked on a new nursing venture, resulting in a move to another state or province. With every job change came the initial discomfort of having to validate my abilities as a nurse in the company of other nurses, who often worked in the same institution since graduation. It took time, patience, understanding, and humour, but I often succeeded in my endeavors. Working with Melanie, I have no doubt that she will also find her way.

Listening to Joan and Marcia, I also recognize the position of the senior nurse, and her desire to feel a comfort with the younger nurses, and know that they are safe

and competent in their rooms, working with the women in their care, capable of enacting relationships that move beyond technological understanding. Recognizing how technology can be used within nursing practice to enhance, rather than diminish the experience of birth is embedded within the aesthetics of nursing knowledge and further demonstrated in years of practice exemplified by Marcia and Joan. Learning to value the abilities of the younger nurses, Marcia and Joan can thus begin to collaboratively share their senior knowledge, if they are not doing so already, and further enhance the abilities and aesthetic knowledge of the junior nurses, like Amy, who views her colleagues experiential scholarship as invaluable and transformative to her practice.

Returning to Mary and Jen, the birthing women, they further remind us of the importance of working together as nurses, and how our differences, although evident and important, must not undo the previous work that has been done before us, particularly by our nursing colleagues. Every moment that nurses are in the company of women, they (the women) are attentive to our presence, and aware of our actions and inactions. If woman-centered birthing is to be fully actualized, the practices that have been explored in this chapter must to be enacted, not only between and among the nurses and the birthing women, but also between and among the nurses themselves. Woman-centered birthing is a lived practice; it therefore entails a commitment to active learning, collaborative knowledge, and valuing the epistemic presence of the birthing women in the context of the nurses' care.

This chapter has illuminated perinatal practices that promote woman-centered birthing within the context of nursing care. In chapter six, I conclude the findings section of the text by focusing on the pervasiveness of power positioned against the

backdrop of oppressive and hierarchical health care institutions. The focus of attention is directed to the power relations that exist between and among perinatal nurses and the birthing women they attend in their practice.

Chapter Six

Power

> *Sometimes the "feminine world" is contrasted with the masculine universe, but we must insist again that women have never constituted a closed and independent society; they form an integral part of the group, which is governed by males and in which they have a subordinate place. They are united only in a mechanical solidarity from the mere fact of their similarity, but they lack that organic solidarity on which every unified community is based; they are always compelled...to band together in order to establish a counter universe, but they always set it up within the frame of the masculine universe. Hence the paradox of their situation: they belong at one and the same time to the male world and to a sphere in which that world is challenged; shut up in their world, surrounded by the other, they can settle down nowhere in peace. Their docility must always be matched by their refusal, their refusal by an acceptance. In this respect their attitude approaches that of the young girl, but it is more difficult to maintain, because for the adult woman it is not merely a matter of dreaming her life away through symbols, but of living it out in actuality.*
>
> *(Beauvoir, 1952/1989, p. 597)*

> *Rules are made to hide behind, so you don't have to give of yourself. Maybe they work for a lot of people, but someone is going to go outside the rules. If, for example, a mum comes in and says that she hates being examined vaginally and she just cannot have you do it, you must believe her. Perhaps there was a trauma of some kind. There are rules that you have to examine her, but to me, the woman is more important than those rules, and I will listen to her. In the end, I can't really think of a good reason for examining her anyway.*
>
> *(Nurse Phoebe)*

Power within institutionalized health care is pervasive. The concrete or steel walls that form the foundation of most health care facilities create a barrier between the outside world and the facility itself. Inside, a birthing woman is positioned within the interiority of the health care facility, and the fate of her birth is determined, in part, by the relation she establishes with her labour and childbirth nurse: birthing positions, the choice of pharmacological options, persons present at birth, and the decision or not to breastfeed her baby are decisions a birthing woman makes in conversation with her nurse. How these decisions are made, the spirit in which they are received, and the expediency with

which they are delivered are dependent upon the nurse's understanding of her own power, and the way(s) in which this power is enacted with the women in her care. Within the context of the research, Susan discusses the concept of power when she describes an encounter with one of her nurses. She says,

> There was a point when another nurse came in and covered for my regular nurse. She had something of an agenda. She seemed to disapprove of me wanting the epidural. I think for a health care professional in her position to pass judgment is not at all productive. It's not good or bad. It's just not productive, and I didn't feel she was there at all to help me. At that point I felt she was there to apply her values and her agenda.

Karla, although a nurse herself, shares Susan's understanding of the health care professional who enacts her own agenda and set of values, over and above the agenda of the woman. Karla describes the ways in which different nurses on her unit enact their care according to different agendas, particularly with respect to pharmacological intervention and epidural anesthesia. Nevertheless Karla says, "I can't put my beliefs on a woman, but I can give her the facts and offer an explanation." Melanie speaks of power as a struggle between her and one of her more senior colleagues. She says, "There is one nurse that I am in a power struggle with the most." Uncertain as to whether this is the result of the senior nurse's own insecurity or need to "be in control," Melanie feels this nurse has created a difficult working environment for everyone involved.

Whether power is conceptualized as a struggle between persons, as in the case of Melanie, or an enactment of one person's agenda over another, as discussed by Susan and Karla, this chapter is concerned with institutionalized power, both who has authority over

whom and how that authority constructs docile bodies within the context of perinatal health. Modern practices found in education, prisons, factories and health care produce ways of coercing and directing the human body that conform to the constraints prescribed by disciplinary institutions (Foucault, 1999). In so doing the body becomes disciplined, restricted, and coerced. Foucault (1999) states,

> What was then being formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A "political anatomy," which was also a "mechanics of power," was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, "docile" bodies. (p. 264)

Foucault (1999) articulates the view that disciplinary power functions by placing a hold on the body defining it, sculpting it, and re-aligning it to the very practices and procedures deemed desirable by the disciplinary institution itself. In what follows the stories and words of the perinatal nurses and birthing women are woven into the larger fabric of institutionalized health care. The focus of attention is directed to the ways in which the nurses attempt to challenge the power dynamics that permeate these environments. In so doing, the nurses' conceptualization of power became based on a concept of empowerment, thus creating a way of engaging with the Other as neither identical with nor radically different from oneself. The following stories and narratives provided by the nurses and women participants reveal their strategies of resistance and

caring practices used to enact their script to counter the pernicious effects of institutionalized power embedded within the confines of perinatal health.

Power, Objectification, and Docile Bodies

Throughout the research study, occasional examples provided by the nurses and the women participants revealed situations in which their relationships broke down, resulting in disengagement and feelings of regret and disrespect. Whether these situations were caused by a lack of resources, insufficient staffing ratios, demoralized or impatient practitioners, the underlying culprit was not far removed from power, or how each person involved in the situation either perceived or enacted her own power. Recall how Karla (Chapter four), in listening to the physician's request to "hold off on the epidural," negated the request of the birthing woman. In so doing, Karla felt "horrible" because the birthing woman did not get the epidural she requested. Susan, in Chapter three, described how she was treated during her weekly ultrasound visits to the hospital: nobody spoke directly to her, she was not acknowledged by name, and there was nothing "individualized" about her care. She was treated like a body, and reduced to an object. Melanie, in chapter five, spoke of her experienced colleagues, and how they "waltzed" into her room and took over her care when it was already in progress. These diverse situations have in common disrespect for the wishes or very existence of a subordinate person that an authority figure is powerful enough to override or ignore. In so doing, the subordinate person is further reduced to a docile body.

In the situation of Karla, her practice was influenced by the primary physician or obstetrician who was also attending to the care of the birthing woman. Although labour nurses have independence and autonomy in their practice (Goldberg, 2003), and the

nurses in the study rarely talked about physicians being significant barriers to their practice, it is clear that certain physician-directed decisions can't be overturned or disregarded. In Karla's situation, when the physician asked staff to "hold off on the epidural," although there was no medical reason to do so, it was not likely that she would disregard the request. The power in this situation was with the physician, not with Karla.

Karla's situation is positioned within a long history of nurse-physician relationships. Traditionally, nurses were required to accept authority and were denied participation in patient decision-making and treatment (Hameric, 2000). A gender stereotype perpetuated power imbalances with earlier divisions between male physicians and female nurses. This imbalance continues to instill contemporary confusion regarding moral responsibility, and although the gender gap is closing with more female physicians and male nurses, the hierarchical institutions persist, and nurses continue to work with powerful physicians guiding their care. The powerful structures that created these conditions help to sustain the profession in a somewhat diminished state of power, whether nurses deny, acknowledge, or actively resist (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2004; Erlen, 2001; Tiedje, 2000).

Karla's lack of authority, however, is further exemplified by the disciplinary practices that pervade health care institutions and thus perpetuate normalizing behaviors that maintain its precision and oppressive structures. Although there is no denying Karla's inability to disregard the physician's request to "hold off on the epidural," she is nevertheless situated in other ways that may further explain her inability to override or counter the physician's request. Nurses, unlike many physicians, are subject to normalizing constraints regarding their behavior, dress code, and general conduct. The

standards of behaviour to which a nurse is accountable are not the same for a physician, although many nurses, like the nurses in the study, are now recognizing this is unacceptable and act accordingly. Nevertheless, these differences aid in perpetuating a disciplinary form of power that makes possible the reduction of nurses—at times—to docile bodies. For example, nurses are expected to be polite, respectful, and accommodating to physicians, even when they are being belittled or treated with disrespect. My years of clinical practice have unfortunately allowed me to experience situations where physicians were actually yelling at nurses. To be in the presence of this, particularly in front of a birthing woman, is difficult, insulting, and demeaning. During the research study I witnessed a physician (anesthetist) being disrespectful to a nurse; however, it seemed more the exception than the norm.

Nurses are also required to wear uniforms, keep jewelry to a minimum, and generally conform to a standardized look. This is not to suggest that nurses want to come to work wearing the crown jewels, but there are disciplinary constraints imposed on nurses when they are forced to standardize their appearance. Conformity is a further disciplinary practice imposed on nurses, and it is highly encouraged. Failure to conform can result in isolated working environments, moral distress, and great difficulty navigating one's way through the profession (Austin, Lemermeyer, & Goldberg et al, 2004). In light of these disciplinary constraints, it is possible to further understand why Karla was unable to negate the request of the physician in order to accommodate the situation of the birthing woman in her care.

In Susan's situation, the power resided with the health care professionals, not with Susan herself. Embedded within the hierarchy of healthcare is the view that

epistemological worth resides with the healthcare professionals, not with the patients themselves (Goldberg, 2003). Susan's status as a woman patient makes her even less epistemologically powerful and more likely to be objectified. Gadow (1994) states,

> The narrative about women's bodies is a different story, without heroes. There is no plot; nothing happens. The question is answered before it is asked. The question, the body's call for meaning, the "What am I?" of swelling, smelling, bleeding, birthing, is answered once and for all: You are object. For others you are object, but immeasurably more important, for yourself you are object. (p. 296)

The objectification of Susan is further perpetuated when her situation is understood against the backdrop of health care practices that reduce women to docile bodies. To discipline a woman to the practices of health care institutions, particularly in Susan's situation of weekly ultrasounds, conforming and normalizing behaviours were prescribed: no talking, no interaction, and nothing beyond the business at hand. There were prescribed methods for lying down, removing one's clothes, and positioning oneself on the bed. Susan says,

> Things were being done by rote; they had a checklist of what to do. They were like a telemarketer. It is like they had a script to read from, and you could even tell they were reading from it. It is awkward and uncomfortable when I am just lying on the table with my abdomen sticking out.

Susan's words suggest that her experience is synonymous with a script, one that is done by rote, checked off, and read. The end result of the script entails docility in Susan's experience, resulting in further objectification. Yet the script in Susan's story has no leaders, only players (the technicians), and like all disciplinary power its directions are

invasive, dispersed and anonymous (Bartky, 1990). Regrettably, this anonymity diminishes the extent to which women, like Susan, recognize the constraints of disciplinary power on their experiences. Unlike situations where an individual in authority can be held accountable for their misuse of power, the invasive and anonymous nature of disciplinary power makes such accountability relatively impossible.

Melanie, like Karla and Susan, also finds herself in a diminished state of power, but, unlike her counterparts, she is positioned there by virtue of her inexperience and youth. Independent of the competence, skill and ethical sensitivity she brings to her practice, many of her colleagues will disregard her worth until she is a more seasoned clinician. Melanie says,

> I want them to think I am approachable and that I am willing to ask for help so that they don't have to second-guess my judgment. I want them to be thinking that "she will ask for help if she needs it." And not, "Okay, do we need to go and check on her?" There are definitely some very approachable, experienced colleagues, but there are others that I can ask a question that make me feel about two inches tall for asking.

Melanie's situation, although similar to Karla's varies slightly because of her inexperience and youth. Normalizing behaviours result in what has been termed, "eating their young," as older nurses have been known to diminish the worth of their younger colleagues. Melanie says,

> I might as well be two years old the way I get treated. You feel like a kid obeying your parent when we should all be colleagues. I recognize that everybody has more experience and I'm not going to try and talk back and be rude and yet I

shouldn't be talked to that way in the first place. Those are the days you think, "Okay, nursing politics—what did I get myself into?"

Although Melanie's words suggest that some of her senior colleagues are at times the culprits, the invasive nature of these behaviours is self-sustaining, existing far and beyond the actual nurses where they may reside.

The Wall: Power, Authority and the Birthing Agenda

Michaela, a nurse with 35 years experience, 14 in labour and childbirth, referred to her understanding of power in relation to her authority. She says,

> I find a bit of a wall goes up when I have a couple that says, " I want my epidural now" before we even get started. Before I've even admitted them or assessed them. And I find there's a little bit of a wall and I have a really difficult time getting across that wall as it goes on because they, in my opinion, have not given anything of themselves to attempt to do this without giving in. That probably comes from an era of having children of my own where epidurals were not available. It is a personal thing I have to bypass. I love to work with couples that want to do the best they can without an epidural. I think they are great to work with, because I can find all kinds of things to help them cope and I can give more of myself.

Michaela's wall suggests that her commitment to the Other is interrupted when faced with birthing women whose requests differ from her own. Whether it is the result of Michaela's ability to birth her own children without medication, or her definition of an "empowering" birth experience as one without epidural anesthesia, Michaela views epidurals as unnecessary for many birth experiences.

Other nurses in the study also discussed the differences of working with women having epidurals, as opposed to those who didn't. Amy suggests that you develop a different kind of relationship with women who don't have epidurals: "It is not necessarily better or worse, but it is more intimate because it requires that you must be more constantly available to her because she relies on you more." Without an epidural women require more assistance with position changes, greater encouragement, support and individualized care. With an epidural Amy says, "the same level of reassurance is not needed and comfort is basically taken care of." Although women with an epidural still need attention and support, it is on a much smaller scale than women "struggling with labour and birth naturally" (Nurse Amy).

Jessica says that one of her nursing colleagues actually feels "like a failure," when a women she is working with decides to have an epidural, rather than birth "naturally." A "natural" birth is defined here as a non-epiduralized birth, and occurs when a woman births without medication, or with entonox (gas) and/or morphine analgesia. Jessica's comments prompted me to reflect on what it means to feel like a failure as a nurse. I recall experiences in my own practice when I left a shift feeling defeated, as if I had failed a woman, unable to do what she needed, or expected. Perhaps, like Michaela, I constructed a wall, and could not move beyond it. Was this what Jessica's colleague was feeling when she felt like a failure? Or, was there something more in what her colleague said? Was her sense of failure more about the self, as opposed to her commitment to the Other?

Michaela's wall, although figurative, exists in some real sense. A wall separates one space from another; it blocks, occludes, and hides what exists on the other side. It

prevents us from seeing what is over, under or in between. A wall is a restrictive or protective barrier. We speak of a wall of silence. Michaela's wall represents her authority when it is questioned; it reinscribes power *over* the birthing woman. Authority legitimizes that power; it both sustains it and perpetuates it. Nevertheless, authority, like Michaela's wall can be questioned, broken down or redirected.

Breaking down a wall facilitates a larger space; a home, for example, becomes more open when there are no walls to hide behind. Breaking down "the wall" is essential to the success of Michaela's practice. She now regrets having talked various women out of decisions they had previously made. Michaela says,

> I have a lot of regrets with patients that I've talked out of epidurals if they're multips and they're moving along quickly and they said, "I want it" and I've talked them out of it. And then at the end of the labour, even if they've done well, something happens that they have a whole slew of stitches and we have to end up in the OR and giving them general anesthetic. Then I'm the one who feels badly because I have talked them out of the epidural. Or, the ones that end up with a retained placenta. It seems a lot of women will have retained placentas when I've talked them out of an epidural. I don't really talk them out of an epidural; I try to lead them away from an epidural if they are progressing quickly because, in my opinion, it slows them down. I think the empowerment a woman feels afterwards from delivering her baby without an epidural is awesome. They think they have been brave and wonderful. I think it's wonderful. If I can get them there, that's where I am coming from, and the ones that want an epidural from the beginning, I just don't connect with as well.

Michaela's regrets suggest that she is aware of her authority and the power that is associated with it. Michaela, like the other nurses in the study, is in a unique position to affect the decisions a birthing woman makes, particularly in relation to pharmacological intervention. She often speaks of the empowerment a woman feels when she births a baby without epidural anesthesia. Recent conversations with female colleagues and friends suggest Michaela is not alone in her view that epidural anesthesia potentially disempowers a woman during her birth. This raises interesting questions for women in light of the recent media coverage highlighting the availability of elective C-sections, thus allowing women to schedule the surgical birth of their babies. That women must have choices available to them regarding their birth experiences is not in question. However, what underlies the context in which these decisions are made, and the future implications for the birthing experiences of women remains to be seen.

Power With and for the Other

Throughout this chapter the narratives and stories of the perinatal nurses and birthing women have provided examples of the ways in which institutionalized power dynamics have negatively effected their relationships and constructed docile bodies: Michaela's struggle to deal with her wall and why it arises, Susan's nurse enacting her own agenda, Melanie's power struggle with her senior colleagues, and Karla's inability to override or redirect the physician's request. Although there is no denying that power exists in complex and invasive ways, both the nurses and birthing women in the study often exemplified alternatives when working within these power relations and disciplinary structures. The nurses in the study constantly worked against a landscape that positioned women in situations of less power and epistemic absence, embedded in

disciplinary practices that further objectify women and potentially reduce nurses themselves to docile bodies. Yet, in spite of this, the nurses often enacted their practice differently, re-interpreting the perinatal script. In so doing the environment was redefined, and the nurses re-aligned themselves *with* the birthing women, employing an empowering view of perinatal nursing practice, thus rejecting the opportunity to enact their power in a more traditional model of power *over* the birthing woman.

Empowerment

How then do we understand the notion of empowerment, particularly within the context of perinatal nursing practice? Although it has become woven into the fabric of our lives, few of us define it in the same way. Michaela views empowerment as something she can support in a woman by dissuading her from having epidural anesthesia. Yet, empowerment like birth itself, is not something a perinatal nurse can give to a birthing woman, nor can she define it for a birthing woman; it is not reducible to one pharmacological option, birthing position, or birthing plan; rather, it is embedded in the dialogue, reflection, and narratives the women and nurses construct, positioned against the politicized landscape of institutionalized health care.

Young (1997) suggests that empowerment is best understood as "the development of a sense of collective influence over the social conditions of one's life" (p. 89). Therefore, empowerment is not defined as an individual concept promoting "autonomy, self-control, and confidence" (Young, 1997, p. 89); but rather, it is a politicized term requiring collective action. By employing this interpretation of empowerment, relatively disempowered individuals engage in dialogical activities in order to comprehend the etiology of their powerlessness, and discover the collective ways of changing their social

environment (Young, 1997). Throughout the interviews and participatory observations, the perinatal nurses revealed ways of empowering both themselves and the birthing women in their care. By employing strategies of resistance that counteract the demands of those in power, nurses often subverted the perinatal script, eliciting birthing moments that belonged not to the health care "experts;" but rather, to the birthing women themselves.

Meagan, one of the mothers interviewed in the study, talks about one of her nurses and the ways in which she empowers her birth. After spending three hours in a shared room with five other women waiting for her induction of labour, Meagan was finally admitted to a single labour room later that morning. Her labour progressed slowly over the day, and by early evening she was exhausted, having regular contractions, but with minimal changes to her cervix. The nurses from the previous shift suggested that she ambulate to facilitate the progress of her labour, but her exhausted state entailed a refusal to do so. Prepared for a negative reaction, she was delighted when her new nurse listened to her request, took a chair, sat by her bedside, and suggested that Meagan rest for a while, affirming her original request. Meagan says,

> She really listened to me, even when I complained. She was very nice, she didn't ever force me to do anything I didn't want to do, and she was even really helpful to my husband, and how to deal with everything. It was our first baby, so he didn't really have any idea about what he was doing.

Meagan goes on to explain the conclusion of her night: the delay in the administration of her epidural because the anesthetist was in surgery, the fetal distress that soon followed after the administration of her epidural, and the concluding chaos that resulted in

Meagan's C-section by the end of the evening. Before she knew what was happening, she says,

> There were people everywhere, and the nurse took my husband out of the room, dressed him and let him know exactly what to do. This was so good because I was heading off to surgery and he needed to know what to do. She led him down to surgery; let him know where he could sit. They were doing monitors, and there was trouble with the baby, I was panicking, but she was right there with me, she stood beside me and even held my hand and told me what was going on. Then the surgery started, but she talked to me. When the baby came out, he wasn't crying, but she let me know what was happening, and that he was okay. She was so reassuring. She seemed to really care about what I was feeling not just kind of brushing it off. She had a sense of humour as well, but she was very sympathetic and was actually concerned when something didn't seem right for me. That can be a good thing and a bad thing, because if I see my nurse concerned, then I tend to worry. But, that made me really listen to her. Like when she told me to take deep breaths, or put on the oxygen. I listened, instead of doing other things.

Meagan, in her interpretation of her nurse's care, describes practices that are not divorced from the politicized landscape of perinatal health, or lacking in concern for her pain, individual fear, or family needs (Goldberg, 2002). In addition to engaging in nursing practices that attend to Meagan holistically: emotionally, physically, and psychologically, Meagan's nurse understands that the anesthetist has ownership of the OR. In so doing, she empowers Meagan's partner (husband) by ensuring that he is ready for the OR (i.e. that he is appropriately dressed, has directions to the OR, and knows

where to sit). This entails that he has no difficulty attending the birth of his baby. My past experience has revealed situations where an anesthetist actually precluded a partner from attending the birth of her or his own child. Therefore, Meagan's nurse was working to ensure that her partner would be well versed in OR protocol, and appropriately attired to attend the birth of his baby. Meagan's nurse, like the nurses in the study, provides a first glimpse at practices that begin to reveal an alteration in the traditional script, by elucidating power *with* the Other, particularly at a time of profound stress and difficulty for Meagan and her partner.

Forms of resistance

That the nurses employed strategies of resistance to subvert the perinatal script were evident in the days I spent participating in care with the actual nurses in the study. Although there are numerous examples also found in the transcripts provided by the nurses and the birthing women, there is something exhilarating in witnessing these strategies first-hand and being part of the actual experience. To partake in the resistance, even as a researcher, is to return to a secret society and re-discover the ways in which nurses subtly thwart institutionalized power. For example, working with the nurses one busy afternoon on the unit, numerous physicians were requesting pitocin inductions and augmentations to be administered to the birthing women. Although the nurses said they were starting the inductions and augmentations, the rate and expediency with which they were done were less than what the physicians expected.

Like the example of Rachel (Chapter 3) who talked about the "haste" of her birth and how the nurses worked to" slow things down", the nurses in the study employed similar strategies and forms of resistance. Practices by the nurses included, but were not

limited to, holding off on calling the physicians until birth was imminent, using a variety of techniques to facilitate birth in ways that would not require intervention by physicians until absolutely necessary, and reporting cervical dilatations to be slightly less than they actually were. By doing so, they gave a woman more time to birth: once a woman is fully dilated, she is expected to begin the pushing stage of her birth. However, if it is charted or recorded that she is only an anterior rim, a woman has more time to birth her baby, even if she is occasionally pushing. Phoebe says,

> The doctor's are never in the patient's rooms. They don't see it. I think every labour nurse knows but a lot don't want to rock the boat because it is us fighting against the doctor. Who needs it? But, we can have it so women have an amazing long period where they have an anterior rim. They are really fully dilated, but we chart it as a rim. Then they have all the time in the world. An anterior rim is okay, and a lot of us are doing it, until the doctors come of course. Then they say, "Oh she is fully dilated and can begin pushing."

Phoebe's words give further recognition to the strategies employed by the nurses to subvert the perinatal script to empower both themselves in their practices and the birthing women in their care. Scott (1990) suggests that such forms of resistance by the less dominant require an "experimental spirit and capacity to test and exploit all the loopholes, ambiguities, silences and lapses available to them (p. 138). Scott (1990) further claims that such forms of resistance are sustained by adopting some of the dominant practices, forming dissonant groups, creating a politic of disguise, and engaging in occasional explosive outbursts, whereby the less dominant confront the dominant in open confrontation. The nurses in the study didn't display open confrontation with

physicians, administrators or other dominant individuals, at least in my presence. Nevertheless, my time with them was limited, and that many of the nurses had independent and passionate personalities suggests that such confrontations were plausible. Open confrontation is one way for nurses to resist those in authority, but other ways of resisting, albeit less visible, are more frequently employed by nurses in their practice to subvert the perinatal script. Adopting some of the dominant practices is necessary if a nurse is to thrive in institutionalized health care. Cognizance of perinatal policy regarding standards of practice is necessary for nurses to maintain knowledge of the requisite requirements for practice. Yet, there are subtle ways of working within these standards and requirements that maintain safe practice, but resist complete adherence to the traditional script.

Marcia, when working with women with epidurals, utilizes diverse and unique positions to facilitate the birth of a baby, even in the presence of epidural anesthesia. Although a woman's legs are often numb from the anesthesia and capable of minimal to no movement, Marcia finds ways of working with family members and various instruments (i.e. birthing bars, bedpans for sitting) to help support a woman and alter her position from lying down, which is the standard practice, to sitting and squatting with the assistance of her family. Although Marcia remains within the standards of practice, she nevertheless pushes the envelope by adopting alternative position changes, and ways of working with women that subvert the traditional script. It should be further noted that the traditional script also negates the effects of gravity, working against a birthing woman with an epidural by positioning her in a lying position.

A culture of dissonance (Scott, 1990) is a further strategy that nurses use to enact their forms of resistance. Scott (1990) suggests that "here offstage, where subordinates may gather outside the intimidating gaze of power, a sharply dissonant political culture is possible" (p. 18). Look no further than the report room before a shift begins or the nurses' station during a late evening shift, when nobody else is around. It is here where nurses speak words of disagreement, confusion, and concern, free from the gaze of the intimidating Other, who is both powerful and privileged (physician and/or administrators). In the safety of their own company, the nurses speak openly of their experiences and do not hold anything back: there is anger, humour, sarcasm, empathy and wit. It is here that I heard the nurse's stories: unabridged and unapologetic. These forms of quiet resistance reveal some of the collective strategies the nurses in the study endorsed to empower both themselves and the birthing women in their care. A further way to reveal these strategies is to return again to the area of epidural anesthesia, and the alternative ways in which the nurses subvert the traditional script to focus their collective strategies on empowering the birthing women in their experiences of birth.

The Alternative Script

The issues surrounding epidural anesthesia raise many questions regarding how we, as nurses, relate to women in pain, how we address our own biases and agendas, and how they influence us, particularly when they differ from the women in our care. The topic of epidural anesthesia was an ongoing discussion during the research project. One experienced nurse suggested that younger nurses don't know how to "be with" women without epidurals. Therefore they are more likely to influence women to have an epidural. Another nurse in the study remarked that nurses who don't have children

advocate for epidurals more than those who do. Does having children really make nurses more likely to advocate for one type of pain medication over another? Or, does experience, culture, education, and individual difference also account for how nurses relate to women and their requests for epidural anesthesia?

Other nurses in the study actually suggested that there are colleagues who are anti-epidural, and often dissuade women regardless of what women desire or want. I have heard many affirming accounts of nurses described by the women participants in the study, and yet there were occasional narratives that described feelings of guilt and remorse when women choose options at odds with their nurses' suggestions. Women in the study have also shared different accounts of their experiences. Some have birthed "naturally," while others have chosen the option of an epidural. To birth "naturally" raises interesting questions regarding our interpretation of "natural" because there are so many differences in how the term "natural" is perceived. Joan, for example, suggests that many women come to their birth experience requesting that it be "natural." Yet, these same women also want an epidural. She says,

> The women come in and say they want their birth to be "natural" with no inductions and no intervention and then they say they want an epidural. My understanding is that an epidural is not at all "natural". It is about the most invasive, traumatic, and dangerous thing we can do to women, except a C-section. I guess I do try and understand where the woman might be coming from, no episiotomy, and no induction, but she wants an epidural. I just don't think they comprehend how invasive the procedure is.

Joan claims that once she explains to women that having an epidural requires them to basically remain in bed with IV hydration, a foley catheter, and continuous fetal monitoring, many change their minds recognizing the epidural was not what they had imagined it to be. Perhaps the women come to believe that technology, catheters and IV hydration are not "natural" because they are "invasive and traumatic." Is there a view that equates being "natural" with being "good," safe or healthy?

Unlike Joan, Phoebe considers a "natural" birth to be possible, even in the presence of epidural anesthesia. Recognizing her own cultural background in the Netherlands, which entailed the experience of doing home births without medication, and her personal journey of birthing four children without an epidural or analgesia, Phoebe nevertheless realizes the importance of differentiating between her own experiences from the experiences of the women in her care. She says,

> Who am I to say a woman can't have an epidural? I think that is again putting a woman down. Give her informed consent. Now, it is easy when they are in pain to scare women half to death about being paralyzed or dying, as I hear some people do. That is unfair. That is not informed consent. I don't go on and on about side effects. I say, "It has some side effects that can be counter acted, and you are in the hospital and we have everything to attend to that." If they are upset that they are not doing it "naturally," I let them know that it is still "natural," because their body is still doing the work; you are just not having all the pain. I think that even though I would stay away from the epidural, I know I affect this woman's life, and I am not going to make her feel guilty for taking an epidural. And if anything goes wrong, not even related to the epidural, there would be a chance that the

> mum thinks it's because I took the epidural. I sure hope I never lay anything like that on any person.

Phoebe's recognition of her position of power and capacity to affect a woman's life, is part of her awareness of the politicized landscape in which she is working. Nevertheless, Phoebe's recognition of her power does not necessitate an enactment of that power, at least within a traditional sense. Phoebe's practice allows for a redirection of her power by "drawing on the resources that are available in every woman." This is one of her strategies for working *with* women, as opposed to working *over* women, or further reducing women to docile bodies.

Unlike the situation of Susan who experienced docility in her situation of weekly ultrasounds, insofar as she was directed by an invasive script that was rote, checked off and read, Phoebe attends to the context in which women are situated and respects the individual woman within the landscape of her history and personal situation. Phoebe states,

> I don't think you should even say that this would never be my choice because it's not about you as a nurse. It's about the mum and dad or whoever is having the baby. So, you have to be able to take that step back, and I think it is always hard to hear nurses talk about their own experiences, as part of the coaching.

It is not that Phoebe avoids sharing her own experiences with the women in her care, for she enjoys the mutuality of engaging with women, the relationality of her work, and the dialogue that unfolds. However, Phoebe assures the woman birthing that her experience is just that: her own experience. Birth belongs to the woman birthing, not the nurse attending the birth. Spending time with Phoebe, it became clear that she also finds ways

of redirecting the disciplinary functions of the perinatal script to work *with* birthing women. Whether it is by reducing or eliminating fetal monitoring time when it is unnecessary, or by encouraging alternative and less traditional birthing options, Phoebe is aware of the script and working tirelessly to alter its text.

Jessica views her nursing role as facilitating what women want in their birth experience, and not what she prescribes, or considers important. Like Phoebe, Jessica says,

> There are women, just in the last 5 years asking for epidurals, and it's a very invasive thing that we do, but for some women it is their fantasy of their birth, and that's my job: to make sure she gets that epidural and feels okay about taking it and having it. People were funny around me at first with epidurals, because I have this philosophy. Often if mums would have a failed home birth and they'd come into the hospital, then I would look after them, because I don't care. I don't care what they want to do. It is their birth experience. I see our role in labour and delivery as so important because if they don't have a positive experience, it can affect how they feel as a woman, how they feel as a mother, how they feel as a wife. Even with breastfeeding, some women are so apologetic when they say they're not going to breastfeed their baby, and it's so important to make sure they feel all right about the decision they have made.

Jessica's philosophy speaks to her openness and way of being with birthing women. However, Jessica's words suggest that her colleagues were actually surprised when she was so accepting of epidural anesthesia because she was also a nurse who was open and understanding of women who chose home birthing—a birth experience quite different

from an epiduralized birth. This speaks to the commitment Jessica has to birthing women. Independent of the birthing situation, according to Jessica, it is the woman's choice to decide how she should approach her birth.

During the early days of Jessica's career, she remembers how important it was for her to be an essential voice in the birthing room, and for women and their partners to recognize the significance of her voice. Often her work was rewarded with a multitude of gifts and cards. These days, however, it is vital that Jessica become peripheral to the birth experience, and that women and their partners do the work together; recognizing that it is their experience, their efforts, and the woman's power that birth the baby, not Jessica's. Jessica considers herself a gentle presence in their experience, not the focus. Jessica says that her approach is successful when the gifts and the cards are few and far between. It is not that she doesn't enjoy the gifts, but if they are in abundance, it suggests to her that she is doing too much, negating the potential abilities of each woman and her partner.

Reflecting on Jessica's practice, I begin to wonder if she redirects her power like her colleague Phoebe, or does she refuse power altogether? Having the opportunity of being in her presence, I suggest that Jessica offers us an exemplar of quiet power. Analogous to the examples of quiet resistance, Jessica works on the sidelines, embodying subtleties and silences that promote ways for women to enact their own experiences of birth. Aware of the power dynamics in which she works, Jessica embodies mindful ways of thwarting such power to work *with* the women she attends in her practice. Unlike many of her colleagues, Jessica's ways of subverting the perinatal script are the most silent, but at times I found them to be the most compelling. Irigaray (2001) reminds us that cultivating the art of silence takes us to the nature of relationship itself: "Beyond the

fact that I must be quiet to be attentive to the difference of the other, so that the relationship can grow, silence itself must be cultivated... (p. 65). Jessica, in her practices with birthing women, exemplifies the cultivation of silence and its power within perinatal health.

Recall young Melanie; she shares many of the philosophical perspectives reflected in the practices of Phoebe and Jessica. Although both Phoebe and Jessica are highly experienced clinicians with many more years of practice to draw upon, Melanie engages in similar ways with the women in her care. She says,

> I think it is the patient's choice and we can't force them either way in terms of having or not having an epidural. Yes, there's probably far more women that could cope without if we could give complete one-on-one nursing care, and not leave the room all the time, but our unit doesn't allow for that. It is also not our prerogative to tell them what they can or cannot do. We are there to advocate for them what they would like and try to help. So, I think it's totally up to the patient and their husband or partner because she knows how she can cope. We do need to discuss, encourage, and support, but it is not about deciding for them.

Melanie's words echo those of Nurses Phoebe and Jessica. That she is a young clinician should not negate the value of the work she does to support the women in her care. My time spent with Melanie in a research capacity affirmed what young nurses have to offer birthing women in perinatal nursing practice. Although her ability to redirect power is lessened by her inexperience and youth, she is intelligently and empathically navigating her way through a powerful system. Her self-awareness, curiosity and

questioning nature suggest that she is attending to her own epistemic value, in addition to the epistemic value of the women in her care.

Although women's understanding of their childbirth experiences has become woven into the patterns of society, it fails to be afforded the status of knowledge (Dalmiya & Alcoff, 1993). "Epistemic discrimination" has resulted from providing knowledge requirements and definitions that women have traditionally been unable to meet (Dalmiya & Alcoff, 1993). Health care practices are no different, often negating women's experiential knowledge because they fail to meet the standard knowledge requirements. However, the examples provided within this chapter illustrate the ways in which the nurses promoted an environment that recognized women's epistemic presence. Understanding how women were positioned within the landscape of perinatal health, and the potential effect the nurses had on the experiences of the women, entailed that each of the nurses recognized what she could do to empower both themselves and the women in their experiences of birth. Bringing the women's voices to fruition, by allowing them to be supported, rather than co-opted, helped to position them in a place of value and epistemic worth. Although the nurses remained aware of the ways in which power infringed upon both themselves and their practices, they often worked to redirect, reinterpret, and redefine power *with* the women in their care. By employing a collective notion of empowerment resulting in subtle forms of resistance and caring practices, the perinatal nurses in the study subverted the traditional perinatal script. In so doing the perinatal script was redefined, and women's experiential knowledge was legitimized and their knowledge claims validated.

Chapter Seven

Final Reflections

> *Beginning from women's perspective, philosophy need no longer get straight to the point, but consists in thoughtful wandering through the shadows of experience, not in order to bring them into light, but to reveal the ambiguous edges of things.*
>
> *(Allen & Young, 1989, p. 1)*

The central aim of this project was to provide a phenomenological understanding of the unique relationships that perinatal nurses foster with birthing women in the current climate of hierarchical health care and technologized perinatal settings. In turning to a phenomenological framework, my intent was to show the ways in which phenomenology brings both voice and visibility to the relational practices of perinatal nurses engaged with birthing women.

In chapter one, I explored the ways in which the practices of perinatal health have disembodied women from their experiences of birth. Because the foundations of health care have been built on a Cartesian metaphysics, in which the body is relegated to nothing more than a physical object, perinatal nurses are frequently reduced to working in conditions that position both themselves and birthing women as objects, synonymous with a machine (Goldberg, 2002; Leder, 1990; 1998). Understanding the pervasive ways in which birthing women and their nurses have become disembodied within the current climate of health care is one of the main goals of chapter one.

In chapter two, I turned to interpretive and feminist phenomenology as the methodology to guide the research project. By incorporating Merleau-Ponty's (1962) notion of the lived body, I secured a foundation for reconceptualizing the body outside dualism. Because Merleau-Ponty's (1962) work has been appropriately criticized for

generalizing all experience to male experience (Grosz, 1994), it became relevant to provide further phenomenological sources to legitimize my project as a feminist undertaking. Recognizing that my work was reflective of women's experiences (perinatal nurses and birthing women) situated against a backdrop of hierarchy, disembodiment, and power relations, I turned next to the projects of Beauvoir (1952/1989) and Young (1990) to situate my work. Although Beauvoir's (1952/1989) claims in *The second sex* are controversial on topics such as mothering and marriage, she nevertheless provides a study that recovers women's lived experience in ways unlike those previously represented by men (Allen, 1989).

The recovery of women's lived experience in Beauvoir (1952/1989) is echoed in the writings of Young (1990). In her phenomenological accounts of pregnancy, bodily comportment and breasted experience, Young turns to the embodiment of the female subject, recognizing the ways in which this embodiment situates women in a world of patriarchy, and how these embodied situations might be otherwise. By incorporating Beauvoir's (1952/1989) recovery of women's lived experience, Merleau-Ponty's (1962) notion of the lived body, and Young's (1990) interpretation of the embodied female consciousness, I offered a new framework for interpreting relationships between women and perinatal nurses in a highly embodied experience—childbirth.

In the next four chapters, *introductory engagement*, *embodied trust, woman-centered birthing*, and *power*, I built on the aforementioned phenomenological concepts, and used them to guide my analysis, interpretations, and descriptions of the relational practices of perinatal nurses engaged with birthing women. I continually returned to an understanding of the lived body, the recovery of women's lived experience, and the

embodied consciousness of the female subject during the course of writing the project. These phenomenological concepts were woven throughout the body of the research project and grounded in the central themes and storied text of the work.

Introductory engagement, first introduced in chapter three, was a central theme of the work that explored an understanding of the importance of the gaze, the touch, and the listening qualities the nurse revealed in her initial moments of care. If these qualities were dismissed or forgotten, relationships were disrupted, often entailing a disrespectful experience for both the birthing woman and her nurse. If, however, the nurse was attentive and respectful in the first moments of care, a foundation was potentially created that promoted an engaged and supportive experience of birth. Although engagement is essential to sustain a relationship over time, the initial moments of care enacted between a birthing woman and her nurse are profound, thus influencing their future relationship.

The theme of *embodied trust* elucidated the ways in which the relation of trust established between a birthing woman and her nurse simultaneously promoted self-trust, thus empowering a birthing woman to explore her own bodily abilities and birth her baby into the world. Although some women arrived in labour convinced that they were unable to physically birth their babies, a trusting relation with a perinatal nurse fostered a woman's ability to explore self-trust and actualize her own birthing power.

Woman-centered birthing, the theme assigned to chapter five, revealed the relational engagements that were directed from nurse to woman, woman to nurse and between the nurses providing care. This chapter explored these relational engagements by illuminating the collaborative knowledge, learning, and epistemic value the nurses

exhibited in their practices that promoted a woman-centered approach to birth with the women they attended in their care.

Power, the final theme in the research project, examined the ways in which perinatal nurses and birthing women both perceived and understood the influence of power within the context of their relationships. By revealing the ways in which the nurses attempted to subvert power, and re-interpret the perinatal script, the status of birthing women was elevated from epistemic absence to epistemic presence. In so doing, the nurses' understanding of power became based on a concept of empowerment, thus enacting a form of power that promoted practices *with* birthing women, as opposed to those that wielded power *over* birthing women, or reinscribed disciplinary practices producing "docile" bodies.

The Relevance of the Research to Current Perinatal Nursing Practice

The narratives woven throughout the research project provide nurses with a beginning account of stories reflective of practices that support, empower, and foster women in their experiences of birth. Not only have nurses contributed to these accounts, but birthing women have also shared their interpretations of their nurses, including recounting the experiences when they felt supported in their choices, and those when they did not. These accounts provide nurses with powerful and compelling ways of reflecting on and thinking about their own practice.

The accounts of practice found in this research provide nurses with opportunities to engage in dialogue about their current practice, insofar as the nurses' and womens' experience provide the very tools for questioning, deepening, and changing their own practice. In referring to the storied accounts of perinatal nursing found in this project,

nurses can explore their own practice by using the current findings as a reference. Van Manen (1998) suggests,

> The research may have certain effects on the people with whom the research is concerned and who will be interested in phenomenological work. They may feel discomfort, anxiety, false hope, superficiality, guilt, self-doubt, irresponsibility—but also hope, increased awareness, moral stimulation, insight, and a sense of liberation, a certain thoughtfulness, and so on. (p. 162)

Van Manen (1998) suggests that phenomenological work may elicit diverse feelings in persons who become acquainted with the work. I concur, insofar as a nurse may feel guilt upon reading a perinatal account of practice, if that account resonates with demeaning practices that nurse occasionally enacts with the birthing women in her care. On the other hand, a nurse may feel a sense of hope and moral worth if she recognizes aspects of her practice in complimentary ways discussed by the birthing women in the research study. Hence, this research offers nurses both the opportunity to engage in conversation about their practice and alternative strategies and ways of altering their current practice.

Phenomenology, self-understanding, and other relations

Phenomenology, in its ability to heighten awareness and increase thoughtfulness, (Van Manen, 1998), provides opportunities for the researcher to engage in relationships in new and alternative ways. Within the context of the research study, I have deepened my awareness of introductory encounters with birthing women, and how a woman can interpret the smallest gesture as either a positive or negative response by the nurse attending to her care. Understanding these introductory encounters, and their importance

to birthing women and their nurses may also be relevant in other situations and contexts. For example, attending to my listening and gazing qualities as an educator with nursing students becomes equally as important as attending to such qualities with birthing women. That these qualities have significance and meaning in the context of the classroom and the clinical environment, in addition to the labour room becomes evident in light of the research findings.

Power is fundamental to the research study, and reflects the ways in which the nurses attempt to re-interpret the perinatal script in order to position themselves and the birthing women in a different alignment of power. In so doing they attempt to maneuver within the power dynamics found within institutionalized health care in order to promote practices based on power *with* the Other. Recognizing the ubiquity of power in relationships with nursing colleagues and other health care professionals has transformed my own understanding. Relationships with nursing students, nursing colleagues, and other health care professionals are also embedded in pervasive power relations, and my role as clinician, educator, learner, and researcher is re-interpreted and re-evaluated in the ongoing process of these relationships. Understanding how power plays a role in these relationships, what strategies are employed to counter the effects of power, and how I am positioned in relation to power are questions and concerns that emerge from the process of undertaking the research study.

Positioning the Research and Future Recommendations

By way of interpretive and feminist phenomenology, this research offers an alternative methodology to many of those currently utilized in perinatal health. Through engaged and embodied practices, perinatal nurses fostered woman-centered experiences

with birthing women against a Cartesian backdrop of disembodiment and power relations. Because feminist phenomenology takes seriously the embodied experiences of the female subject, this research attends to the practices of women and female nurses in ways that other non-feminist methods reject or dismiss. Future research is needed, however, to further explore these relationships in other situations, particularly in situations of difference. For example, how do the relationships of nurses and women play out when a birthing woman is in a lesbian relationship, has severe disabilities, or is struggling with substance abuse? Further, what happens in times of grief when a woman experiences a fetal demise? Understanding the ways in which these relations are enacted between birthing women and their nurses will further contribute to the knowledge required to work with birthing women in empowering and embodying ways.

Interdisciplinary research is also warranted to understand how diverse disciplines work in relation to each other to contribute to the experiences of women during their births. Nursing is not an isolated profession, and other disciplines—particularly medicine—influence its capacity to either enhance or diminish a woman's ability to enact her own birthing trajectory, particularly within the landscape of Cartesian health care. Although interdisciplinary research in relational ethics (Bergum & Dossetor, in press; Bergum, 2004) has been groundbreaking in nursing, and developed to foster a moral space for the intrinsic value of nurse-patient relationships, no such research has been developed in perinatal health. Further, the current research in relational ethics is not grounded in a feminist tradition, and is therefore unable to account for the ways in which power uniquely shapes women's experience within patriarchy. Future feminist research is thus warranted in phenomenology to understand how diverse disciplines enact their

relational practices in collaboration with nursing for the benefit of the birthing women in their care.

The perinatal relation enacted between and among perinatal nurses and birthing women is an embodied relation grounded in engaged practices that empower women in their experiences of birth. The perinatal relation is an intersubjective relation that promotes practices based on power *with* the Other, as opposed to power *over* the Other. The perinatal relation does not reduce, negate or dismiss the Other in the context of care. Although this relation is lived against a Cartesian backdrop of disembodiment, power relations, and patriarchy, the perinatal relation enhances, elevates, and celebrates the Other in Her experience of birth.

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Appendix A

Information Letter for Perinatal Nurse Participants: Research Conversations

Title: The Perinatal Nursing Relation: In Search of a Woman-Centered Experience

Investigator: Lisa Sara Goldberg, RN, PhD Candidate
Faculty of Nursing, University of Alberta
Phone: 434-1639

Supervisors: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492- 6677

Dr. Cressida Heyes, Associate Professor
Department of Philosophy, University of Alberta
Phone: 492-9031

Purpose of this Study: This purpose of this study is to describe and understand the relations between nurses in labour and childbirth and birthing women. I want to understand these relations through the eyes of nurses and birthing women.

Procedure: In this study, I am inviting you to share your experiences of working with birthing women as a labour nurse in conversational interviews. The conversations will last about 1-1 ½ hours. The conversations will be audio recorded and a written copy of the audiotape will be made. You have the freedom to refuse to answer any question. I will interview you at a time and place of your convenience. If I have additional questions, I may wish to interview you again.

Voluntary Participation: You do not have to be in this study if you do not wish to be. If you decide to withdraw from the study—which you can do at anytime—you just have to let me or one of my supervisors know (Dr. Vangie Bergum or Dr. Cressida Heyes).). If you have concerns regarding the study, you may contact the Caritas Health Group Research Office at 930-5274. This office has not affiliation with the study.

Risks/Benefits: There will be no harm or direct benefit to you if you participate in this study. Certain participants may find it helpful to share their experiences in conversation with the researcher. Findings from this research may help health care professionals (nurses, physicians, midwives), and the public at large, gain greater insight into the importance of the relationships perinatal nurses in labour and childbirth contribute to women's birth experiences. This may help improve the care that labour and childbirth nurses give women.

Confidentiality: Your name will not appear in this study. Only a code name will appear on forms and will be used during the conversational interviews. Your code name will appear in the audiotape and the transcribed text of the tape. Your real name and code name will be kept in a locked place. The only people with access to this information including myself will be my research committee and a transcriber who will type the audio taped interview. All information will be kept for five years and then destroyed.
The information and results of the study will be published and presented at conferences. I will not use your name or any information that would reveal your identity. If you have any concerns or questions about this study at anytime, you can contact me or one of my supervisors at the numbers given above.

If you are interested in participating in this study, or have any questions regarding the study, please call me (Lisa Goldberg) at the above number.

Appendix B

Information Letter for Women Participants: Research Conversations

Title: The Perinatal Nursing Relation: In Search of a Woman-Centered Experience

Investigator: Lisa Sara Goldberg, RN, PhD Candidate
Faculty of Nursing, University of Alberta
Phone: 434-1639

Supervisors: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492- 6677

Dr. Cressida Heyes, Associate Professor
Department of Philosophy, University of Alberta
Phone: 492-9031

Purpose of this Study: This purpose of this study is to learn about your relationship with your labour nurse during your birth experience. This project is part of my doctoral program in nursing.

Procedure: In this study, I am inviting you to participate by describing your experiences with your labour nurse during birth in a conversational interview. The conversations will last about 1-1 ½ hours. The conversations will be tape-recorded and a written copy of the tape will be made. You have the freedom to refuse to answer any question. I will interview you at a time and place of your convenience. If I have additional questions, I may wish to interview you again.

Voluntary Participation: You do not have to be in this study if you do not wish to be. If you leave the study—which you can do at anytime—you just have to let me or one of my supervisors know (Dr. Vangie Bergum or Dr. Cressida Heyes). If you have concerns regarding the study, you may contact the Caritas Health Group Research Office at 930-5274. This office has not affiliation with the study.

Risks/Benefits: There will be no health risk or direct benefit to you if you agree to be in the study. Some women may find it helpful to talk about their experiences with the researcher. Results from this research may help improve the care that labour and childbirth nurses give women.

Confidentiality: Your name will not appear in this study. Only your code name will appear on forms and will be used during the interviews. Your code name will appear in the tape and the transcribed text of the tape. Your real name and code name will be kept in a locked place. The only people with access to this information including myself will be my research committee and a transcriber who will type the taped interview. All information will be kept for five years and then destroyed.

The information and results from the study will be published and presented at conferences. I will not use your name or any information that would reveal your identity. If you have any concerns or questions about this study at anytime, you can contact me or one of my supervisors at the numbers given above.

If you are interested in participating in this study, or you have any questions regarding the study, please call me (Lisa Goldberg) at the above number.

Appendix C

Consent to Participate: Research Conversations

Title: The Perinatal Nursing Relation: In Search of a Woman-Centred Experience

Investigator: Lisa Sara Goldberg, RN, PhD Candidate
Faculty of Nursing, University of Alberta
Phone: 434-1639

Supervisors: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Dr. Cressida Heyes, Associate Professor
Department of Philosophy, University of Alberta
Phone: 492-9031

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Letter?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand that the interview data you provide for this study may be analyzed in future studies?	Yes	No
Do you understand that if any information about abuse of someone under 18 Years of age is disclosed by you during the study, the person conducing this Study is under legal obligation to report it to the proper authority	Yes	No

This study was explained to me by: _____ Date: _____

I agree to take part in this study.

Signature of Research Participant/Date

Witness (if available)

Printed Name

Printed Name

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

Signature of Investigator

Date

IF YOU WISH TO RECEIVE A SUMMARY OF THIS STUDY WHEN IT IS COMPLETED, PLEASE COMLETE THE FOLLOWING:

NAME:_____

ADDRESS:_____

Appendix D

Consent for Perinatal Nurse Observation

Title: The Perinatal Nursing Relation: In Search of a Woman-Centred Experience

Investigator: Lisa Sara Goldberg, RN, PhD Candidate
Faculty of Nursing, University of Alberta
Phone: 434-1639

Supervisors: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Dr. Cressida Heyes, Associate Professor
Department of Philosophy, University of Alberta
Phone: 492-9031

Purpose of the Study: This study is to describe and understand the relations between perinatal nurses in labour and childbirth and birthing women. I want to understand these relations through the eyes of perinatal nurses and birthing women.

Procedure: The researcher will collect data during observations of nurses in relation with birthing women in labour and childbirth. The observations will occur over a five-month period, with each observation lasting no more than 3-4 hours at a time, occurring 1-2 times weekly, for a maximum of 3 observational sessions per each nurse who has been previously interviewed in the study.

Included in this time, will be periods where you will be observed while working with birthing women. These observation times will be pre-arranged with you. The researcher will respect the privacy, confidentiality, and intimacy of the birthing experience at all times. In this study, the researcher will be both "observer" and "participant". Although the researcher can participate in certain aspects of care, under the nurse's supervision, the primary focus of my role will be that of observer. As the researcher, I am not evaluating the nurse's role. Rather, I am trying to understand the important relation that the nurse develops with birthing women to empower and foster her birth experience.

Voluntary Participation: You do not have to be in this study if you do not wish to be. If you decide to withdraw from the study—which you can do at anytime—you just have to let me or one of my supervisors know (Dr. Vangie Bergum or Dr. Cressida Heyes).

Risks/Benefits: There will be no harm or direct benefit to you if you participate in this study. Findings from this research may help health care professionals (nurses, physicians, midwives), and the public at large, gain greater insight into the importance of the relationships perinatal nurses in labour and childbirth contribute to women's birth

experiences. This may help improve the care that labour and childbirth nurses give women.

Confidentiality: Your name will not appear in this study. Only your code name will appear on forms and will be used during the interviews. Your code name will appear in the audiotape and the transcribed text of the tape. Your real name and code name will be kept in a locked place. The only people with access to this information including myself will be my research committee and a transcriber who will type the audio taped interview. If you are agreeable, I may use findings from this study for a future research inquiry. If so, appropriate approval will be sought from an ethical review committee prior to beginning with the study.

The information and results of the study will be published and presented at conferences. I will not use your name or any information that would reveal your identity. If you have any concerns or questions about this study at anytime, you can contact me or one of my supervisors at the numbers given above.

Participant's Signature	Date
Investigator's Signature	Date
Witness's Signature	Date

A copy of this consent form has been given to you to keep for your records.

Appendix E

Consent for Observation with Birthing Women Participants

Title: The Perinatal Nursing Relation: In Search of a Woman-Centred Experience

Investigator: Lisa Sara Goldberg, RN, PhD Candidate
Faculty of Nursing, University of Alberta
Phone: 434-1639

Supervisors: Dr. Vangie Bergum, Professor
Faculty of Nursing, University of Alberta
Phone: 492-6676

Dr. Cressida Heyes, Associate Professor
Department of Philosophy, University of Alberta
Phone: 492-9031

Purpose of this Study: The purpose of this study is to learn about your relationship with your labour nurse during your birth. This project is part of my doctoral program in nursing.

Procedure: If you would like to be in this study, you will allow the researcher to observe and participate in your care with your nurse. During this time, the researcher will assist with care, and quietly make notes that will become part of the research. The researcher is a registered nurse with a number of years of experience. The researcher will be present for no more than a 3-4 hour time period, and you can ask the researcher to leave at any time.

Voluntary Participation: You do not have to be in this study if you do not wish to be. If you leave—which you can do at anytime—you just have to let me or one of my supervisors know (Dr. Vangie Bergum or Dr. Cressida Heyes). If you have concerns regarding the study, you may contact the Caritas Health Group Research Office at 930-5274. This office has not affiliation with the study.

Risks/Benefits: There will be no health risk if you participate in this study. The only risk is that you may find it bothersome to have the researcher present while your nurse works with you during birth. The researcher will respect the nurse's/patient's request to leave if asked. Taking part in the study will have no direct benefit to you. However, results from this study may help health care professionals (nurses, physicians, midwives), and the public at large, gain greater understanding into the importance of the relationships nurses contribute to women's birth experiences. This may help improve the care that labour and childbirth nurses give women.

Confidentiality: Your name will not be in this study. Only your code name will appear on forms and will be used during the observations. Your real name and code name will be kept in a locked place. The only people with access to this information including myself will be my research committee. All information will be kept for five years and then destroyed.

The results from the study will be published and presented at conferences. I will not use your name or any information that would reveal your identity. If you have any concerns or questions about this study at anytime, you can contact me or one of my supervisors at the numbers given above.

Participant's Signature	Date
Investigator's Signature	Date
Witness's Signature	Date

A copy of this consent form has been given to you to keep for your records.

Appendix F

Letter to Perinatal Nurses and Postpartum Women Requesting Narratives

I am a graduate student at the University of Alberta and a perinatal nurse living in Edmonton. I am doing a research study for my doctoral program on the relations that exist between nurses and birthing women. I would like to learn more about how nurses and women experience these relationships.

I am asking you, as a nurse, or a woman who has given birth, to help me with my study by writing and/or audio taping a "story" about your experiences of birth. If you are a nurse working in labour and childbirth, can you describe an experience in your practice that illustrates what it is like to work in relationship with birthing women. I am inviting you to record in writing or by audio tape an account of a situation (or situations) that you have experienced in your practice as a nurse that illustrates what it is like to develop a relation with the birthing women you work with during your daily practice.

If you are a woman who has recently given birth, can you provide a description of your labour nurse and how she made you feel during your recent birth experience. In other words, by writing and/or audio taping a story, can you describe the relation you developed with your labour nurse during your birth experience. How did she make you feel? Was she present throughout your entire birth? If you had more than one nurse, were the various nurses different? If so, can you describe these differences and how they influenced your birth experience?

You do not need to put your real name or identifying information in your story. I may use parts of your story in my research findings or in presentations about my research results. If you have made yourself known to me, a code name will be selected to refer to you. If there are parts of your story that you do not want me to use, I will not. Please inform me of your instructions regarding the use of your story.

If you are interested in sending me a narrative of your experiences, please mail a copy to me at the following address, or contact me at the number listed below.

Thank-you for your time.

Lisa Goldberg
University of Alberta
FON, 6-126G CSB
Edmonton, AB
T6G 2C3
lsg@ualberta.ca

Appendix G

Biographical Data of Perinatal Nurse participants

To help me with my research, I would like to have some additional information about you and your background. If there are questions that you do not feel comfortable answering, just leave them blank. This information will be included in the final research findings, but it will be done so that you cannot be identified.

What year were you born? _____

How many years have you been a nurse? _____How many years have you worked in labour and childbirth? _____

What is the highest level of education you have obtained in nursing?
_____ Diploma in nursing
_____ Baccalaureate in nursing
_____ Masters in nursing
_____ PhD in nursing
_____ Midwifery education in nursing

Do you have an educational background that is not in nursing? _____
If so, what is it? _____

What is your current working status? (Please give in hours/week)
_____ Full-time
_____ Part-time
_____ Casual

Have you worked in other hospitals or birthing centres? _____
If so, where? _____

Appendix H

Biographical Data of Women Participants

To help me with my research, I would like to have some additional information about you and your background. If there are questions that you do not feel comfortable answering, just leave them blank. This information will be included in the final research findings, but it will be done so that you cannot be identified.

What year were you born? _____

What is your marital status? _____

Are you currently employed outside the home? _____

What is your current level of education?
_____ High School
_____ Postsecondary
_____ College
_____ University
_____ Other

Who was present at your birth?
_____ your partner?
_____ mother?
_____ sister/sisters?
_____ father?
_____ brother/brothers?
_____ your children?
_____ other family members?
_____ friends?
_____ doula or support person?

How many times have you been pregnant? _____

Did a midwife, general practitioner, or obstetrician attend your birth? _____

Were there complications that occurred during your birth experience? _____

If yes, what kind? _____