

The experience of fertility nursing within the New Zealand context

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma at a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements."

Signed:

Amy Williams

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Abstract

Personal experience of working as a fertility nurse has brought an awareness that the complexity of this work brings challenges that are significantly different from those experienced by nurses in other clinical settings. While much has been documented in the literature on the advances in reproductive technologies, little has been published internationally on the nature of nursing in the fertility field. The purpose of this qualitative study was to investigate nurses' experiences of working in fertility clinics in New Zealand. Phenomenology, a descriptive research methodology which focuses on people's experiences, was selected. Purposeful sampling was used to recruit four nurses working in fertility clinics in the North Island of New Zealand. Data comprised taped in-depth conversational interviews. The data analysis, which was undertaken following van Manen's (1990) methodological steps, revealed that the experience of being a fertility nurse is one of: realizing that *fertility nursing is a different kind of nursing, living care as worry and living with one's own emotions*. There are a number of individuals or groups who may benefit from the study findings. Registered nurses who aspire to be fertility nurses will benefit from the insights shared by nurses currently working in fertility clinics. Fertility nurses themselves may also gain new understandings of practices they take-for-granted.

Key to Transcriptions

The following transcriptions have been used throughout this dissertation:

Italics: have been used to represent the participants' voices

Names: all study participants are identified by the use of pseudonyms

p. page reference within the report

() are used in author/date quotations

... represents material edited out of the interview

Chapter One

Introduction

This dissertation is a report on a small qualitative study that was carried out to gain an understanding of what it is like to be a fertility nurse. It addresses the question: “What is the experience of working as a nurse in a New Zealand fertility clinic?” I have used the title fertility nurse throughout this study as this is what the participants are referred to in their role within the New Zealand context. The terms infertility nurse specialist and assisted conception nurse are also used in the literature to describe similar roles in the United Kingdom (UK), and United States of America (USA). These titles are therefore used interchangeably throughout the study. This chapter focuses on the purpose of the study, the background to the study, the context of the study and the significance of the study for nursing.

Purpose of the study

This project was undertaken to describe the experience of being a nurse in a New Zealand fertility clinic. It seeks to raise awareness of the fertility nurse’s role so that it is better understood by nurses,

other professionals and the public. A phenomenological approach informed by the work of van Manen (1997) was used to analyze, interpret and present the study findings.

Background

The world's first baby to be conceived through in vitro fertilization (fertilization of an egg with a sperm in the laboratory) was Louise Brown, born in Oldham, England on July 28, 1978. Live births following in vitro fertilization (IVF) were then recorded in Australia in 1980, the United States of America in 1981, and Sweden and France in 1982. New Zealand followed this world wide trend towards interventionist obstetric care with the introduction of New Zealand's first assisted conception unit at National Woman's hospital in Auckland in 1983. The following year New Zealand's first baby conceived through IVF was born at National Women's Hospital in Auckland. Over the next decade the increased demand for assisted conception provided impetus for further fertility clinics to open. These clinics were; Fertility Associates Auckland (1987), Christchurch/North Shore (1990), Fertility Associates Wellington (1993), Dunedin (1998), and Fertility Associates Hamilton (1999).

Traditionally, nursing care within these clinics was carried out only under the instruction of the doctor with nurses having little or no autonomy (Muirhead, 1999). However, over the past 25 years expectations of the fertility nurse have changed, with a demand for greater “responsibility, accountability and keenness to extend previous roles” (Muirhead, 1999, p.400). The area of fertility nursing has subsequently undergone a rapid role expansion. According to Muirhead (1999) fertility nurses have moved away from providing nursing care under the instruction of doctors. They are now trained to carry out many procedures previously undertaken by medical staff. For example, patient/client education, planning of the treatment cycle, support, teaching drug self administration, venepuncture, ultra sound scans, intracervical inseminations, assistance with oocyte collection, embryo transfer and pregnancy testing (Denton, 1998). The sensitive nature of fertility treatment frequently means that “a natural extension of the nurse’s role is also to provide counseling” (Muirhead, 1998, p. 391). Consequently, the most visible health professional in the care of an infertile couple during an IVF cycle is the nurse (Denton, 1998; Breidahl, 2005).

The contribution made by fertility nurses to assessment, planning, implementation and evaluation is well recognized (Muirhead, 1999); yet little research has been published on the nature of nursing in this

field (Payne & Goedeke, 2007). The lack of published research on fertility nursing, coupled with the fact that fertility nursing is undergoing rapid role expansion, means that research such as this is timely. The stories of the fertility nurses in this study provide an opportunity to explore and describe the experience of fertility nursing in New Zealand.

Context of the study

Until recently in New Zealand, assisted conception units and hence fertility nurses have been small in number. IVF is a relatively new and controversial field of medicine primarily available through the private sector. The competition between clinics meant that communication between fertility nurses was minimal and usually social in nature (Pollock, 2005). Nurses entering the field learned their role via an apprenticeship system. There was little or no formal education and most of their training occurred 'on the job' (Pollock, 2005). However the 21st century is bringing rapid changes (Muirhead, 1999). At present there are more than one hundred nurses working in both private and public assisted conception units throughout the North and South Island of New Zealand. National and international conferences are providing educational opportunities for fertility nurses and assisting their role expansion. The introduction of named nurse programmes, in which one nurse

has overall responsibility for the care of selected patients (Steven, 1999; Wright, 1992), is also changing the nursing care within New Zealand clinics. There is a greater focus on individualized patient care. Muirhead (1999) argues that “infertility nursing will continue to evolve and change as nurses, motivated by the potential develop new skills, strive to be at the forefront in the pioneering sphere of assisted conception care” (p. 400). Thus, research such as this is necessary if fertility nurses are to continue to develop their role in ways that benefit their clients.

Significance of the study

This study gives voice to fertility nurses by describing the lived experience of a phenomenon that can be controversial and is little understood. There are a number of individuals or groups who may benefit from the study findings. Registered nurses who aspire to be fertility nurses will benefit from the insights shared by nurses currently working in fertility clinics. Practitioners working in related fields and disciplines may gain greater understanding of their nursing colleagues. Fertility nurses themselves may also gain new understandings of practices they take-for-granted in the every-day world of their practice.

Structure of dissertation

The dissertation is presented in five chapters. Chapter One has provided an introduction to the study topic including the purpose of the study, the background, context and the significance of the study. Chapter Two reviews the literature relating to the evolving role of the fertility nurse from historical and professional perspectives. Chapter Three will outline the research methodology, ethical considerations, method of data collection, and analysis. Chapter Four presents the interpreted findings gained from the stories of four fertility nurses. Finally, Chapter Five will discuss the findings and offer recommendations for nursing practice, research and education.

Conclusion

The role of the fertility nurse within the context of New Zealand has been evolving since the conception of New Zealand's first fertility clinic twenty-five years ago. Since this time, the roles and responsibilities of fertility nurses have developed considerably. Fertility nurses are increasingly demonstrating their capacity for providing holistic care, yet research in this field of nursing is sparse. The next chapter will review literature relating to fertility nursing.

Chapter Two

Literature Review

Introduction

This chapter reviews the literature relating to being a fertility or assisted conception nurse. The purpose of a literature review in phenomenological research is to assist the reader to understand what is already known on the research topic so that they can better understand the phenomenon under investigation (Smythe, 2000). Drawing from non research-based literature, I will begin by providing background information of the medical and technical developments related to in vitro fertilization. I will then outline the role of the nurse in assisting couples through all the various treatments that currently comprise an in vitro fertilization cycle. Research literature relating more specifically to the study topic will then be reviewed.

Definition of in vitro fertilization

In vitro fertilization (IVF) refers to fertilization of an oocyte with a sperm in the laboratory (Fertility Associates, 2007). After fertilization, early embryo development is monitored. Three to five days later one or more embryos are transferred into the uterus in the hope that they will give rise to pregnancy (Fertility Associates, 2007). IVF was

originally developed as a way of giving woman with damaged fallopian tubes a chance of becoming pregnant (Porth, 1998). More recently, however, it has been shown to be useful for people with other causes of infertility such as poor sperm quality, endometriosis, antibodies to sperm, and/or 'unexplained' infertility (Birdsall, 2000). Recent advances with sperm microinjection (injection of a single sperm into the middle of a single oocyte) means IVF can now be used even when sperm quality is poor (Birdsall, 2000).

Conception via in vitro fertilization in humans

Based on Min Cheuh Chang's (1909-1991) application of in vitro fertilization to animals, the technique was first developed for use in humans in the United Kingdom by Robert Edwards and Patrick Steptoe (R. G. Edwards, 2001). Together with a nurse named Jean Purdy, Edwards and Steptoe started doing the first embryo transfers in 1972 (Pollock, 2005). This did not achieve a pregnancy until 1976, and unfortunately the pregnancy was ectopic, "a fertilized ovum implanting outside the uterine cavity" (Porth, 1998, p. 1200). Two years later, Louise Brown, the world's first baby conceived through the treatment of in vitro fertilization was born in Oldham, Great Manchester, England on July 25th 1978 (R. G. Edwards, 2001). As previously mentioned, New Zealand followed this world-wide trend towards interventionist obstetric care with the introduction

of New Zealand's first assisted conception unit at National Women's hospital in Auckland in 1983.

Current process of treatment in New Zealand

At its conception, in vitro fertilization was undertaken in a theatre using a laparoscope (Barber, 2000). However, advances in technology have meant that in vitro fertilization is now performed with ultrasound under light narcotic analgesia (Barber, 2000). Depending on clinic protocol, treatment cycles usually commence between the first and third day of menstrual bleeding (Barber, 2000). Most patients start with the combined oral contraceptive pill which stops the pituitary gland from releasing hormones (Marieb, 2004). Between 14-28 days after starting the contraceptive pill patients begin daily sub cutaneous injections of a GnRH – agonist named Buserelin (Fertility Associates, 2007). This is used to prevent ovulation by suppressing production of luteinizing hormone (Lh) (Fertility Associates, 2007). Several days after starting the GnRH - agonist the OCP is discontinued. One week later a blood test confirms that the ovaries are quiescent.

Under close monitoring, an injectable gonadotrophin is then used daily to stimulate the development of oocyte production (Birdsall, 2000). Once ovarian stimulation has been achieved both the

injectable GnRH – agonist and gonadotrophin are stopped and an injection of human chorionic gonadotrophin (hCG) is given (Birdsall, 2000). This injection results in the release of the oocytes from the ovary after approximately 36-38 hours. The collection of oocytes takes place just prior to ovulation (Birdsall, 2000).

The oocytes are removed from the ovary using an ultrasound guided technique (Brinsden, 1999). A needle is passed along the side of the ultrasound probe piercing the top of the vagina entering the ovaries to aspirate the follicular fluid within the ovarian follicles (Brinsden, 1999). An embryologist identifies the ova under a microscope and places them in a fluid culture medium (Fertility Associates, 2007). Sperm are added to the oocyte and these are checked the next day to see if fertilization has occurred. Between two and five days following oocyte collection one to three of these embryos will be transferred into the uterus (Birdsall, 2000). Two weeks after oocyte collection a blood test assesses whether or not conception has been achieved (Birdsall, 2000).

Non research based literature

In searching the literature relating more specifically to this research project I used the following key words: fertility nursing, assisted conception nurse, assisted reproductive technology, infertility nurse

specialist. The following data bases: CINAHL, MEDLINE, ProQuest Nursing Journal, Blackwell Synergy, Google Scholar, InformaWorld and National Bibliographic Database yielded a number of non-research based articles describing the roles and responsibilities of a fertility nurse. These range from clerical through to technical and interpersonal nursing skills (Barber, 1994; Traveledyan, 1994; Denton, 1998; Muirhead, 1999; Boon, Oliphant, & Fleming, 2004). I will begin by outlining the role of the fertility nurse and then discuss the findings of these authors under sub-headings which describe the range of responsibilities and requisite skills.

The role of the fertility nurse

The complexity of IVF treatment requires close collaboration between the different professional groups (nurses, doctors, embryologists and counselors) within the assisted conception unit. While all of these professionals have specific roles and responsibilities, the fertility nurse is usually the only one involved in a patient's treatment and care throughout the whole IVF cycle (Breidahi, 2005; Denton, 1998). The nurse-patient relationship begins with conversations in which the nurse explains the practical aspects of treatment to couples. Once the nurse has provided the necessary information and the couple has chosen IVF treatment, the nurse explains their plan for their cycle. He or she then sees couples

on numerous occasions to teach them about drug self-administration, organize blood testing and vaginal ultrasound scanning, assist with oocyte collection, embryo transfer and pregnancy testing (Barber, 1994). Each of these stages brings different challenges for the nurse and the couple. The precision required of fertility treatment frequently means that it is a natural extension of the nurse's role to provide emotional support (Muirhead, 1999). The role of the fertility nurse is therefore recognized as being "pivotal in providing information and facilitating couples through all the varied steps of in vitro fertilization" (Muirhead, 1999, p.392).

According to McTavish (2003), the diverse roles performed by fertility nurses are congruent with the roles undertaken by clinical nurse specialists, "a nurse who gives direct and expert nursing care, models expert behavior for other nurses, and serves as a consultant or coordinator for persons needing nursing care in the area of specialty" (Lindberg, Hunter & Kruszewski, 1994, p.81). This level of specialization has been argued by Ashcroft (2000) to have come about through fertility nurses taking a proactive and multidimensional approach to their practice.

Clerical responsibilities

Specialist nursing care of fertility patients relies on “detailed planning and accurate documentation” (Muirhead 1999 p. 392).

According to Muirhead (1999) the administrative skill required of a fertility nurse includes:

- Sending initial information to couples who have enquired about treatment.
- Witnessing consent forms for treatment and completing patient health questionnaires
- Reviewing the client’s medical records to plan treatment cycle dates in accordance with clinic protocol
- Once the cycle plan has been confirmed, ensuring that the patient is telephoned and the treatment plan is sent to couples to confirm treatment dates
- Making appointments in accordance with the treatment plans and clinic procedures
- Arranging for necessary prescriptions and medications to be distributed to couples
- Following blood tests and ultrasound scans, telephoning couples with the results and advising them of the next actions which are to be taken
- Answering phone calls and acting as a liaison between the patient, clinic and doctor

- Maintaining accurate written documentation

Technical responsibilities

Travelyan (1990) has suggested that prospective health care employers often believe that fertility nurses do not practice fully comprehensive nursing. Yet technical skills required of a specialist fertility nurse are very diverse (Travelyan, 1990). The literature reveals that they include the following:

- Venepuncture
- Administration of hormone injections
- Pregnancy testing
- Performing abdominal ultrasound scanning
- Intrauterine insemination and post coital testing
- Assisting with oocyte collection, embryo transfer and testicular biopsies
- Administering intra venous sedation and narcotic analgesia
- Maintaining asepsis during surgical procedures
- Undertaking pre-operative and post-operative care of patients following surgical procedures

(Denton, 1996; Muirhead, 1998; Boon, Oliphant, & Fleming, 2004).

Interpersonal skills

Couples' needs for emotional support during in vitro fertilization mean that the interpersonal communication skill levels required by fertility nurses have been recognized in the literature (Barber, 1994; Denton, 1996; Muirhead, 1999; Boon, Oliphant, & Fleming, 2004). Effective interpersonal communication are considered to be the most important attribute of a fertility nurse. These skills include:

- Offering support and counseling
- Assessing for any signs of anxiety and depression
- Providing extra counsel to those couples considering donor gametes or surrogacy and;
- Being able to give bad news sensitively

Research of nursing in fertility settings

Apart from the non-research based contributions of Barber, (1994), Traveyan, (1994), Denton, (1996) Muirhead, (1999) and Boon, Oliphant, & Fleming, (2004) that articulate the roles and responsibilities of fertility nurses, few authors have reported research relating to this relatively new specialist role. My search of the literature revealed only five studies. Four of these were undertaken in the United Kingdom and lead by the same researcher (Allan 2001; Allan, 2002; Allan & Barber, 2005; Allan, 2006). The 5th and latest study was undertaken by Payne and Goedeke (2007).

In the first of the four studies, an ethnographic research approach was used to examine how fertility nurses managed their emotions in response to client situations (Allan, 2001). Over a period of two years data collection comprised participant observation and interviews with 15 patients and 23 members of staff (six doctors, two counselors, three receptionists, two specialist nurses and ten gynecological nurses). A thematic analysis generated findings suggesting that infertility treatment evokes a range of powerful emotions for patients and staff members alike. Patients managed their emotions privately but nurses were found to have used non-caring (emotional distance) as a means of coping with the painful feelings they experienced. It was suggested that the nurses, in maintaining this defense mechanism, attended to the needs of the clinic and doctor ahead of the needs of the patient (Allan, 2001).

Based on the findings of this study, Allan (2002) proceeded with further research, again using an ethnographic approach. This time the focus of the study was exploration of the meaning of caring in a fertility clinic. Data was collected through participant observation, a field research diary, and semi-structured interviews with 20 staff members and 15 patients. Using modified thematic analysis, the findings suggested that a caring role is strongly associated with

fertility nursing; however patients' expectations of fertility nurses were more practically than emotionally focused. Allan (2002) argued that the practical approach to care was facilitated by the organization of nursing work which again put the needs of the clinic and doctor ahead of the needs of the patient. Similar to the previously reported findings Allan, (2002) argued that limiting one's emotional involvement in the nurse-patient relationship was a defense mechanism against the powerful emotions inherent in fertility nursing practice.

Three years later Allan continued, with Barber, to examine the nature of the nurse – patient relationship in the context of fertility nursing (Allan & Barber, 2005). An ethnographic approach using participant observation over a period of four weeks was undertaken by one of the researchers. Both researchers then analyzed the findings to identify interview questions for semi – structured interviews which were carried out with five nurses, a health care assistant, a doctor and three infertile couples. Thematic analysis revealed that fertility nurses working in advanced roles facilitate greater continuity of care and a shared sense of 'managed closeness'. However none of the nurses described the relationships they had with patients as having increased intimacy. Again it was argued that emotional distance was maintained as a defense

against the emotions recognized as being present in interactions with patients (Allan & Barber, 2005).

A further study by Allan (2006) has argued that ethnography is an appropriate research approach for illuminating the roles in nursing. Feminist psychoanalytic analysis of the findings of this study suggest that because the experience of infertility is so emotionally powerful, caring and non-caring strategies are used by staff to manage their emotions. The second significant finding of this study is that the traditional relationship between nursing and medicine results in nurses taking care of the doctor rather than nursing the patient (Allan, 2006). This view implies that the patient is not the focus in fertility nursing care (Ashcroft, 2000).

In contrast to this UK-based research, Payne & Goedeke (2007) undertook a qualitative study in New Zealand to investigate the roles and experiences of nurses caring for clients undergoing assisted reproductive technologies. A convenience sample of 15 nurses was interviewed. Data was then analyzed using interpretive description. The findings of the study identified that the role of the nurse was to 'hold together' several key components of the assisted reproductive technology (ART) treatment. This included "holding together the clients' emotional and physical experiences of ART; holding together

the roles of the different specialist team members; and holding together her own emotions” (p.4). The finding that fertility nurses provide support to “woman and their partners by helping them to ‘hold together’ their emotions and their plans, and to reduce the feelings of being alone and vulnerable” resonates more closely with my own experience of fertility nursing. Unlike the nurses in Allan’s (2001, 2002, 2005, 2006) studies I endeavor to practice from a holistic philosophy centered on the unique needs of couples.

Allan (2006) argues forcefully that ethnography provides insights that are not generated by other research approaches because it involves immersion in the field over a sustained period of time. However I wonder whether the reason I have difficulty fully accepting these findings over those of Payne & Goedeke (2007) relates to the use of a methodology which yields generalized descriptions of groups of people, rather than illuminating context-related meanings of lived experience. In particular, length of time in the field does not necessarily equate to depth and adequacy of understanding. I therefore chose to undertake research informed by hermeneutic phenomenology because it focuses more specifically on uncovering the meanings of every day experience that are often invisible to observers and even to practitioners themselves.

Conclusion

Literature derived mainly from the United Kingdom, United States of America and New Zealand has provided useful information about the processes of in vitro fertilization, the role and responsibilities of fertility nurses and the culture of nursing in fertility units. In the absence of research that focuses on the experiential meanings inherent in fertility nursing, I have chosen a methodology that will enable deeper understanding of fertility nurses' experiences. The next chapter describes the methodology and methods used to better understand the meaning of being a fertility nurse in New Zealand.

Chapter Three

Methodology and Methods

Introduction

This chapter describes the research design used in this study. It provides an overview of qualitative methodology, rationale for the selection of phenomenology, ethical considerations, methods of data collection, analysis and issues pertaining to rigor. I have used a phenomenological approach informed by the work of van Manen (1997) to analyze, interpret and present the study findings. This has enabled a deepening consideration of the meaning of being a fertility nurse in New Zealand.

Qualitative Research

In the past decade qualitative research methods have become more popular as health care researchers move away from the traditionally focused quantitative research models (Mays & Pope, 2000). Unlike quantitative approaches, the goal of qualitative research is to enhance understanding of complex phenomena (Bryne, 2001). For the most part this is achieved through interviews and observational processes which involve the analysis of information not amenable to measurement. For the reason that phenomenological descriptions

seek to elucidate meaning of the lived experience which is usually hidden; a phenomenological approach is particularly appropriate, because in describing the experience of being a fertility nurse, this study focuses on a phenomenon about which little is known, and which much is taken-for-granted by those who practice in this field.

Phenomenology

Developed through the work of the German philosopher Husserl, phenomenology is set in philosophical tradition. It is a research approach which focuses on illuminating people's experience (Sadala & Adorno, 2002). This methodology fits within the interpretive paradigm. According to Crotty (1998), interpretivism is linked to the work of Max Weber (1864-1920) who suggested that human sciences are concerned with understanding. Crotty (1998) explains that interpretivism takes the epistemological view point of constructionism which suggests that "meanings are constructed by human beings as they engage in the world they are interpreting" (p.43). Constructivism therefore suggests meaning is not discovered but created through experience. Different people will construct different meanings about the same phenomenon. Therefore this paradigm takes an ontological position that reality is multiple and subjective (Crotty, 1998).

The focus within phenomenology of describing existential meanings “to a certain degree of depth or richness” (van Manen 1990, p.11) is what differentiates phenomenology from other social sciences. It does not seek to describe human behaviors in a different culture (ethnography), explain certain social groups (sociology), or document historical periods (history). Phenomenology “attempts to explicate the meanings as we live them in our everyday existence, in our life world” (van Manen, 1997, p.11). The data analysis methods used to discover essential meaning of being a fertility nurse in New Zealand followed van Manen’s (1997) method. The methodological steps involved in this process are as follows:

Turning to the nature of the lived experience

Phenomenological researchers must have an interest in the aspect of human experience from which they seek to gain meaning (van Manen, 1997). My interest of uncovering the essence of fertility nursing derives from personal experience of being a fertility nurse for three years.

Investigating the experience as lived rather than as we conceptualize it

According to van Manen (1990), our past experiences and pre-understandings predispose us to analyze and interpret the nature of

the phenomenon before we have even comprehended the meaning of what the phenomenological research question is seeking to discover. Because one cannot simply forget or ignore these past experiences van Manen (1997) believes that it is important for researchers to uncover their pre-understandings, suppositions and assumptions. A 'pre-understandings interview' with my supervisor helped to reveal the understandings I held in relation to fertility nursing generally and, more specifically, to my research question. In this way I was able to identify the preconceived assumptions I was bringing to this research study. These assumptions will be discussed on page 29.

Reflecting on essential themes

According to van Manen (1997), a true reflection on the lived experience of a phenomenon requires the researchers to thoughtfully reflect on "what it is that gives a particular experience its significance" (p.32). As the researcher, this methodical step began with me transcribing the tape-recorded interview data provided by the participants. Through listening, writing and checking the words that the participants used I became immersed in their stories. Then, through reflecting on the stories collectively and thinking carefully about what seemed to be essential to the phenomenon, I began to identify initial or tentative themes which were further developed into

a description of the essential meaning of being a fertility nurse. These findings will be presented in chapter four.

The art of writing and re-writing

According to van Manen (1997) the act of writing and re-writing is an essential part of reflecting on essential themes. van Manen (1990) suggests this most commonly this occurs through a writing activity which involves the “complex process of re-writing re-thinking, reflecting and re-cognizing” (p.131). Within this type of research such writing and re-writing is not accomplished quickly. It required that I go back and forth to the transcripts many times, writing, checking and reflecting upon my choice of words, and re-writing to ensure that I had captured the essential meanings provided by the study participants. The repetitive nature of this process created multiple layers through which I was able to uncover the taken-for-granted meanings inherent in being a fertility nurse. For example, as I became aware of words repeatedly used to describe their practice, I came to understand the significance of the sub theme: *being not doing*. The words ‘comfort’, ‘support’ and ‘empathy’ used by the participants described actions focused on consoling couples. These words emphasized the how of the nurses’ practice, rather than the ‘what’ or the type of tasks they undertook.

Maintaining a strong and orientated relation

According to van Manen (1990), unless the researcher remains focused, it is easy to get side tracked and stray from the phenomenon of interest. I avoided this when analyzing the data by continually referring back to the guiding research question: 'Tell me about your experience of fertility nursing?' Reminding myself about the fundamental question prevented me from getting side-tracked and settling for what van Manen (1990) describes as "superficialities and falsities" (p.33). For example, *cognitive complexity* was a phrase initially used to describe the experience of felt concern for others. But what did this say about the experience as lived? On deeper reflection and through discussion with my supervisor, in the final analysis; this idea was described thematically as 'living *'care as worry'*.

Considering parts and wholes

An important component of van Manen's (1990) methodological structure involves balancing the research context by considering parts and the wholes. van Manen (1990) believes this action to be necessary because without taking this methodical step, researchers can get so caught up in the data that they fail to arrive at new insights. Consequently in this phenomenological study, it became necessary to regularly examine "how each of the parts contributed

to the whole” (van Manen, 1990, p.34). The movement from the parts (transcripts, interpretations, self experience, and literature), then back to the whole allowed me to articulate the experience of fertility nursing, to show in detail, particular meanings for fertility nurses in the New Zealand context. This will become evident in the themes and summaries in Chapter Four.

Ethical considerations

In November 2006 ethical approval was sought from the Auckland University of Technology ethics committee (AUTEC). Following minor amendments approval was granted in December 2006 (see Appendix A). The ethical issues pertaining to this study have been outlined using the most recent revision (2000) of the Declaration of Helsinki, originally adopted in 1964.

Do no harm

Research processes should not harm or inconvenience participants. The interviews in this study took place in a venue that was safe for the participants, either in their own home or a venue of their choice. Because the study explored potentially sensitive human experiences it was possible that the participants may have experienced strong emotions. To limit the risk of distress relating to being interviewed all

participants were offered counseling services, although none required this service.

Voluntary participation

Participation in the study was voluntary. To avoid the risk of coercion, I did not approach potential participants directly. Advertisements and an intermediary person disseminated information about the proposed study. Those who volunteered were informed of their right to withdraw from the study at any time with the assurance that the information that they provided in the course of the research study would be destroyed in accordance with their wishes.

Informed consent

All of the study participants were provided with sufficient information about the purpose of the study to make informed consent (see Appendix B). Written consent (see Appendix C) was obtained prior to commencement of data collection.

No deceitful practice

Involvement in a research study should not exploit or disadvantage study participants (Polit, Beck & Hungler, 2001). Participants were

assured that the information provided during interviews would not be used against them in any way.

Confidentiality and anonymity

Anonymity cannot be maintained in studies where the researcher interviews participants' face-to-face. It was therefore essential that I ensure privacy and confidentiality. This was maintained through the use of pseudonyms. Names and other unique identifying information were removed from the interview transcripts prior to analysis. Following completion of the research study, the original data will be stored securely by Auckland University of Technology for six years, after which time it will be destroyed.

Pre-understandings and assumptions

Because I am a fertility nurse, I have already formed my own understandings of this phenomenon. In order to become more fully aware of the ways my assumptions would influence the research process, my supervisor interviewed me prior to commencing data collection. The following pre-understandings were identified from this process:

- That fertility nursing is a different type of nursing from the traditional surgical nurse, in terms of range, types of tasks and nature of patient care.
- Like other forms of nursing, there are highs and lows associated with the role.
- Some people do not believe that fertility nursing is 'proper nursing'.
- The role of the fertility nurse is challenging, exciting and often challenges ethical boundaries.
- Fertility nurses need to be caring, empathetic, and be able to advocate and have sensitivity to people's cultural and spiritual beliefs and values.
- That the role of a fertility nurse is not well understood

Sampling methods

Having identified the above pre-understandings and assumptions I began recruiting participants using non-probability sampling. The participants needed to be registered nurses with experience in fertility nursing. They also needed to be willing and have the ability to articulate their experiences in English. Nurses excluded from the study were those not fluent in English and nurses who had been employed as a fertility nurse for one year or less because I believed

that they would not be able to draw from a sufficient range of experiences in the field of interest.

Data collection

Information about the study, inclusion criteria and an invitation to participate (Appendix D), were posted on notice boards in three out of the four Fertility Associate clinics in New Zealand. Then, due to an initially slow response, an intermediary was used to further assist in recruitment. The four nurses who responded were sent an information sheet (see Appendix B). They were then contacted by telephone and a time convenient for interviewing was scheduled. Consent issues were explained and forms were signed by the study participants prior to commencing interviewing (see Appendix C).

Interviews

The principal method of data collection was in-depth conversational interviews with four study participants. Open ended questions were used because “this questioning method helps the study participants describe their lived experience in full, without the researcher influencing what the participants say” (Knaack cited in Forrest 1989, p.817). I began by asking the guiding question for the study: ‘Tell me about your experience of working as a fertility nurse?’ Some of the following questions included:

- 'What keeps you coming to work each day?'
- 'Tell me about how you feel about your job?'
- 'What makes your job special?'

Participants were encouraged to describe their experiences as fully as possible drawing on specific examples from their practice. Each interview was audio-taped and transcribed verbatim. I was interested in hearing about their thoughts and reactions and encouraged them to describe their feelings, concerns and priorities relating to the experience of being a fertility nurse.

Data analysis

The goal of data analysis in phenomenology is to provide a thick description that captures the "lived experience or what the experience meant to those who lived it" (Sadala & Adorno, 2002, p.289). Phenomenological research does not produce theories. Its goal is to accurately describe the experience which is being studied from the participant's perspectives (Morse & Field, 1995). As previously mentioned, the method of data analysis outlined by van Manen (1990), combines characteristics of both descriptive and interpretive phenomenology. The methodological processes used to analyze, interpret and present the study findings, informed by the

work of van Manen (1997) have been addressed earlier in this chapter.

Maintaining rigour

Qualitative research has often been criticized for lacking the scientific rigour which characterizes quantitative research approaches (Mays & Pope, 1995). It is generally accepted however by many researchers that the positivist criteria used to establish rigor in quantitative research (internal and external validity, reliability and validity) are inappropriate for determining the rigour of qualitative research studies. According to Polit, Beck and Hungler (2001), using different criteria does not mean that qualitative researchers are not concerned with data quality. Therefore, I have selected the following criteria as appropriate for judging the rigor of this study; trustworthiness, researcher credibility and transferability (Polit, Beck and Hungler, 2001).

Trustworthiness

As outlined by Lincoln and Guba (cited in Polit, Beck and Hungler 2001, p.313) the first step involved in establishing trustworthiness involves prolonged engagement. Polit, Beck and Hungler (2001), explain that this requires the researcher to invest sufficient time in the collection of data in order to have a deep understanding of the

phenomenon under investigation. This was achieved by taking time in the interviewing process to allow the study participants to tell their experience in their own way; but also, and more importantly, a large amount of time was also given to the analysis to achieve the deeper thinking required for phenomenological description.

Researcher credibility

Another important aspect of trustworthiness is researcher credibility (Patton, 1990). I recognize that being a fertility nurse working in the Auckland branch of Fertility Associates could potentially create bias. To limit this risk I completed a pre-understandings interview prior to commencing the research study. I also decided to only interview nurses from other clinics so that my role as a researcher was not confused with that of practitioner. There were many occasions when my supervisor questioned me about the origins of personal biases that became evident during the processes of data collection and analysis.

Transferability

The final criterion used to judge qualitative research is transferability. According to Polit, Beck and Hungler (2001) transferability refers to the extent to which the findings from the research can be transferred to other settings. Polit et al. (2001)

argues that in order to establish transferability, the researcher must provide “a thorough description of the research setting, the transaction, and processes observed during the inquiry” (p.36). In order to achieve transferability, I have included thick and rich descriptions of the research so that others can decide for themselves whether the interpretations resonate with their own experiences

Summary

This chapter has outlined the research design used in this study including methodology, rationale, ethical considerations, pre-understandings, method of data collection, data analysis and issues of rigour. The following chapter presents a description and analysis of the research findings.

Chapter Four

Findings

Introduction

This chapter presents the findings of the study. It describes the lived experience of fertility nursing within the New Zealand context. The data findings are presented in themes which are interrelated. There are three essential themes within each of these themes are several sub-themes. I have used the words of the study participants to give voice to the themes and to provide illustration. The three essential themes are: *becoming a different kind of nurse*, *living care as worry* and *living with one's own emotions*.

Becoming a different kind of nurse

The theme of becoming a different kind of nurse describes the experience of realizing that compared with traditional health care settings, fertility nursing is a different kind of nursing. There are two parts to the theme of *becoming a different kind of nurse*: *beginning as a fertility nurse* and *being not doing*.

Beginning as a fertility nurse

Each of the study participants began by describing their initial expectations of what they thought the role would encompass. Beth talked about looking forward to *'taking it easy'* after working in the specialized area of a coronary care unit for so many years.

"I was working in a coronary care unit and I was doing full time shift work and deep down inside of me I had decided I had done so many years of shift work and I didn't want to do it anymore, I wanted to take it easy for a while. I saw this job advertised and applied and well here I am today"

Beth recalls the experience of working in the highly stressed environment of a coronary care unit, in particular the long hours, the *'shift work'*. She remembers deciding that she did not want to *'do it anymore'*. She had enough of shift work. She recalls seeing the job advertised and *'applying'*, apparently with little thought about the nature of the job. Her expression of *'taking it easy'* reveals that she thought the regular hours of working in a clinic environment would be less stressful. However she appears not to really know what the role and expectations of being a fertility nurse would encompass, going on to explain that she came to a realization that the role was much bigger than she had originally anticipated.

"There was so much more to it...there is theatre work in the mornings, you have to process day ones, answer phone calls, run doctors clinics, give out drug packs, you are doing the

blood meetings, there is education, but a big component is also dealing with emotional issues”

Beth’s description of learning her new role suggests that becoming a fertility nurse was not ‘easy’. She talks of the role encompassing a wide spectrum of care ranging from clerical, pre-operative, and laboratory related participation through to the more interpersonal skills required when dealing with emotional issues.

Kate similarly recalls her initial experience of becoming a fertility nurse:

“When I started, my experience of fertility nursing is that it was a whole new field to something that I had never done before, it was like starting nursing right from the beginning, it was a different sort of care, there was theatre work, a lot of patient education which I enjoy, but also a lot of people contact”

Kate reveals that, despite being an experienced and clinically competent staff nurse in other areas of nursing, becoming a fertility nurse was like ‘starting nursing from the beginning’. Skills from previous settings were not easily transferable because nursing in an assisted conception unit is a ‘different sort of care’.

Both Rose and Kate began by describing the technical nursing tasks involved with the ‘different sort of care’: ‘processing day ones’, going

to '*blood meetings*', and providing '*patient drug education*'. Perhaps this was because identifying different tasks is more tangible than describing the caring components of practice which are more difficult to articulate. However, as their stories unfolded, the significance of '*emotional issues*' and '*people contact*' became increasingly apparent. These are described further in the following sub theme: *being not doing*.

Being not doing

Originating from the work of Heidegger (1962), two nursing theorists; Benner and Wrubel (1989, p.xi), describe "caring as a basic way of being in the world". They contrasted, intentional care ("voluntary deliberate nursing actions") with ontological care (being there) (S. Edwards, 2001, p.167). Benner and Wrubel (1989) suggest that 'true' caring within the realms of nursing involves more than just carrying out procedures. True nursing care is based on an approach of 'being there' by nurturing and supporting another person. This holistic manifestation of caring appears to be central to being a fertility nurse. The participants found it hard to describe discrete nursing activities that exemplified the experience of fertility nursing. Instead their words and stories revealed that the experience of fertility nursing practice as rooted in the how or being, rather than the what or doing of practice. Rose asserts that 'being

there' with patients by *'providing comfort'* is a primary focus of caring in fertility nursing.

"If you only had one word to describe it fertility nursing is about comfort, and that's at every level, comfort about having babies if patients want them, dealing with it if they can't and providing comfort during the process"

Nurses, in all settings, regularly use the word *'comfort'* when referring to their practice with clients. Comfort seems to involve more than just carrying out nursing procedures such as fixing a pillow or smoothing a wrinkled sheet. For Rose, *'comfort'* seems to mean nurturing. She focuses on couples' needs for emotional comfort. She knows that nurses must support couples' hopes as well as their disappointments. But being with couples in terms of supporting their emotional needs is challenging. It means providing *'comfort'* on-goingly in a physical as well as an emotional sense. For Rose, *'providing comfort'* means more than bringing something to the situation like a bandage for a cut, or a morphine injection for pain. In the context of fertility nursing, *'providing comfort'* means using highly developed interpersonal skills to reduce feelings of 'dis-ease' by 'being with' couples throughout the lengthy and demanding process of assisted conception. This may begin by being near physically or sitting beside, but the presence with other becomes close, intimate and sensitive in a way which fosters 'deep care' (Van

Hooft 1995, p.25). This humanistic view of care exemplifies holistic nursing philosophies.

Jessica suggests that *'empathy'* lies at the heart of fertility nursing.

'Although fertility nurses need to be clinically good, if this is your main focus you are missing the ex-factor, you have to be able to touch base with people and have empathy for it'.

Her use of the term *'ex-factor'* suggests something special or extraordinary is required. Being a fertility nurse seems to mean contributing sympathy, compassion and understanding beyond that required of registered nurses in general settings. She explains:

"It's the intimate nature of what we are doing. You are right there in peoples most personal and private life. You are kind of sitting on the end of the bed with them...I have one couple who told me that they tell their friends there's me, him and Jessica making a baby.... It's a privilege to be with couples like this one at that stage and it's not something that you take lightly"

Although Jessica describes *'being with'* couples, her description reveals that this is multifaceted. This exemplifies what Heidegger (1927) (cited in S. Edwards, 2001) describes as *'dasein'*, *'being there'*, close enough to be seeing and sharing others' feelings. Jessica is providing comfort in a way that reveals how much the outcomes for patients matter in this setting. She understands and

works from a deep concern for the well being of all of the couples with whom she is working.

van Manen (1990) refers to the lived relation that human beings maintain with others in the shared interpersonal space as 'lived other' (p. 104). He suggests that when we first meet a person we gain an impression of them by what we physically see in front of us, such as the way they dress. However, though time, the relationship allows us to move beyond a corporeal or physical way of knowing to a more existential awareness of the person. I believe that this interpretation is congruent with the strong affinity for other that the study participants develop with couples. It seems to derive from the intensity and length of the relationship. Thus, unlike nurses who are involved with patients for brief periods of time only, the nature of fertility treatment means fertility nurses live a shared interpersonal space with couples before, during and after completion of one or more treatment cycles. The experience is one of being present, 'being there', nurturing and supporting couples at all of the stages, always with hope, but with variable outcomes.

The theme, *becoming a different kind of nurse*, reveals that fertility nursing is different from conventional nursing. Being a fertility nurse means providing a special kind of holistic care which emphasizes

the 'how' of practice through support, comfort and empathy. The closeness of their relationship with couples means fertility nurses work from a deep concern for other. Reflected in the following theme, this is also often experienced as worry.

Living care as worry

van Manen (2002) writes about 'care-as-worry', suggesting that caring concern or worry is borne out of our responsibility for the other. "The more we care for a person, the more we worry, and the more we worry, the stronger our desire to care. Why? Because care is worry" (van Manen, 2002, p. 270). This view suggests that worrying is a manifestation of caring. van Manen's (2002) definition of 'care-as-worry' is supported by the Oxford dictionary (Thompson, 1995), which states the first equivalent of the non *care* as being *worry*. The stories of the participants in this study revealed that '*living care as worry*' comprised *feeling responsible* and *confronting personal and professional tensions*.

Feeling responsible

Each of the participants in the study described an overwhelming sense of worry for patients and staff within their clinic. Kate talks about the worry associated with feeling responsible and accountable

for patient care decisions. The concern is ongoing and exists both within and outside the clinic setting.

“I do try to leave as much of the worry as possible at work, the fact that I woke up at two o'clock this morning and thought did I put that patient on the blood list goes to show I haven't really left it there at all....Even if you are not here your mind is here twenty-four-seven”

Although Kate tries to forget work when she goes home she finds herself waking at night worrying about patients. She worries about the ‘what-ifs’ – what if something goes wrong? What if she did not put a patient on the blood list? The term ‘*twenty-four-seven*’ reveals a concern or worrying kind of mindfulness that she lives 24 hours a day, seven days a week and cannot switch off.

Rose similarly talks of thoughts which return and exemplify her worry and concern:

“It's the nature of the job to go home recounting the day, thinking oh did I phone that patient back?”

The words ‘*recounting*’, ‘*thinking*’ and ‘*part of the job*’ show the extent to which fertility nurses can feel responsible for patients’ outcomes. Rose also describes the constant fear associated with making an error in patient care.

“You just don’t want to mess anything up, not that I have ever wanted to in any other area of nursing, but with this, its day by day, you don’t have a week, you can’t miss it and say oh we’ll pick it up next week.... Not wanting to make a mistake or let anyone down is sort of paramount to wanting to help them”

Rose knows the importance of the role she plays in the patient’s achievement of a successful cycle. She worries about letting the couples and colleagues down and recognizes that unlike other types of nursing, these responsibilities cannot be deferred or deflected.

Confronting personal and professional tensions

The burden of making decisions and taking appropriate actions when so much remains unknown was another significant revelation. The participants described constantly finding themselves grappling with tensions between personal and professional values, beliefs and principles. Kate speaks from a personal perspective.

“Personally I don’t think that I could be an egg donor. Well, their part of your genetic make up and I don’t know that I could be that magnanimous to give away something that’s part of me. I think too it’s because I have got children of my own, so it would be like giving one of them away”

Although Kate works to assist others, she worries about the future and the unknown consequences associated with being an oocyte donor. Because she has children of her own, she knows how impossible it would be to give one of them away. She feels

uncomfortable about the thought that a child carrying some of her genes would exist completely separate from her in the world. Yet, at the same time, her use of the word '*magnanimous*' suggests she admires and is grateful for those who generously contribute to oocyte donation, believing it to be a gift to people who cannot have children of their own.

Rose also worries about the unknown consequences of treatment and, in doing so, alludes to the moral implications of scientific advances.

"I do feel that just because we can do something it doesn't mean that its actually absolutely right to do it; you know, just because it can be done doesn't mean it should be done"..

Rose knows that nothing is black or white, right or wrong, but rather that there are various shades of grey. She also worries about having to make decisions and take appropriate actions when so much remains unknown. She lives the tension of knowing the processes and some possibilities, yet not knowing other possible outcomes, and thus lives with the burden of these questions.

Terms such as '*twenty-four-seven*', and '*recounting*' suggest that care-as-worry is an integral part of being a fertility nurse. The participants in this study have described being drawn beyond the

‘normal’ expectations of professional practice. The experience can be draining and sap the nurse emotionally. Learning how to live with these feelings is reflected in the following theme: *living with one’s own emotions*.

Living with one’s own emotions

The stories revealed the considerable energy invested by the nurses in living with one’s own emotions. This theme also has two parts: *emotional claim* and *emotional drain*

Emotional claim

All of the participants talked about the powerful feelings they experienced as they supported couples throughout infertility treatment. They described becoming co-passengers on the roller coaster ride of highs and lows over which they have little control. Rose’s words reveal the extreme and variable nature of *emotional claim*:

“When someone has a positive pregnancy test I am always thrilled to bits for them. I just about fall on the floor with excitement over positive results, just as I am disappointed, really disappointed for those who do not get pregnant”.

The phrases ‘*thrilled to bits*’ and almost ‘*falling on the floor*’ alongside ‘*really disappointed*’ suggest the sudden and dramatic

way in which emotional states can change. When everything is going as expected the joy is overwhelming, but just as suddenly things can go very wrong. Her words reveal that being a fertility nurse means being claimed, almost simultaneously by feelings of delight, triumph and despair.

The experience of feeling such paradoxical emotions was similarly expressed by Jessica:

“I was looking after a couple during their second IVF cycle. Again they had no eggs at egg collection...to have been propping them up all the way through the second cycle saying this is a different cycle and it won't necessarily be the same outcome...you know it was just such a low spot...it was gutting actually for them and for me”.

Jessica knows that the chances of success are usually lower than those of failure. This inevitably means that part of being a fertility nurse means being the bearer of bad news. Jessica remains hopeful, trying to be positive, trying to provide support. However, the words *‘it was gutting for them and for me’*, suggests that the feelings of despair are not easy to diminish or dismiss. The *‘gutting’* is shared. It is devastating. It hurts suddenly, is hard and the pain does not go away easily.

Emotional drain

The ongoing nature of working in this emotionally demanding environment is recognized as potentially draining. This was best described by Kate who said:

"Sometimes I feel like crying along with patients...because it can be emotionally draining...you feel really tired, not from doing hard physical work, but just that emotional drain".

Kate's reference to crying illustrates the emotional demands of being a fertility nurse. It is '*draining*'. She feels '*tired*' and worn out. The word '*sometimes*' suggests that the level of tiredness is accentuated by the unpredictable and interrelated nature of the emotional claim and its capacity to drain. This means fertility nurses cannot easily prepare or protect themselves from what they will experience.

Beth and Rose explain:

"It can be tiring emotionally working in this sort of environment because you are dealing with the highs and lows for your patients and clients, that can be probably a bit more tiring than we actually appreciate really". (Rose)

"It can be really emotionally draining" (Beth)

When talking about their experiences of being a fertility nurse, Rose, Beth and Kate seem to underplay the intensity of their emotions by

using words such as *'probably'*, *'a bit more'*, and *'can be'*. This seems to be a coping strategy but it begs the question: How do fertility nurses live with these emotions? Rose talked about the importance of acknowledging her feelings.

"Its important to recognize that because it can be challenging, emotionally working in this sort of an environment its important in this job to have a bit of regular time away from it".

Rose knows that, in order to recover and regain emotional stability, she needs to have *'regular time away'*. This seems to enable her to continue being a fertility nurse.

Kate and Jessica similarly describe living with their emotions through acknowledging their feelings. They achieve this through getting support from the other health care professionals with whom they work.

"There is really great support here; there is always somebody to talk to if you are feeling a bit down". (Kate)

"We have got a counselor, she is a great support when you need it...it's at a level where you can just sit down and talk". (Jessica)

Both Kate and Jessica live with their emotions by talking with their colleagues; perhaps because they know that emotions are best understood by people who have had similar experiences.

The way of living *with one's own emotions* has been experienced differently by the participants; yet in many ways there are similarities. Being a fertility nurse means being claimed on an emotional level. The ongoing nature of working in the field of infertility treatment is '*emotionally draining*'. Fertility nurses live with their emotions by having '*regular time away*' and/or though talking to those who understand the nature of this work because they have similar experiences.

Summary

The purpose of this chapter has been to describe the lived experience of fertility nursing within the New Zealand context. Analysis of the data has revealed that the experience of being a fertility nurse is one of realizing that this is a *different kind of nursing, living care as worry and living with one's own emotions*.

The following chapter discusses these findings and makes recommendations for the future of fertility nursing within the New Zealand context.

Chapter Five

Discussion

Introduction

In the previous chapter the experience of being a fertility nurse in New Zealand has been presented descriptively in themes that portray the essential parts of this phenomenon. This chapter discusses these findings and makes recommendations for practice, education and further research.

Becoming a different kind of nurse

This important thematic finding describes how the participants felt when they were new in the role of a fertility nurse. Despite previous experience this felt like 'starting nursing from the beginning' because it was a 'different sort of care'. Becoming a fertility nurse means taking on new roles, new tasks and new responsibilities. Chapter two reviewed the non-research based work which supports the diverse range of roles and expectations inherent in fertility nursing practice (Barber, 1994; Traveyan, 1994; Denton 1996; Muirhead, 1999; Boon, Oliphant, & Fleming, 2004).

While earlier studies reported by Allan (2001; 2002; 2006) and Allan & Barber (2005) described the nature of the nurse patient relationship as being rooted these technical nursing skills, the findings of this study suggest that being a fertility nurse means providing a special kind of care which emphasizes the 'how' or being, rather than the 'what' or doing of practice. This exemplifies what van Manen (1999) describes as 'pathic' care, the 'felt' knowing gained through being with, being alongside, and learning and experiencing together. According to van Manen (1999) pathic knowing is different from gnostic knowing which emphasizes knowledge and science deriving from the scientific realm as is evident in the word dia(gnostic).

Within this study fertility nurses found the experience of being-with-another difficult to articulate. van Manen (1999) suggests that this is because 'pathic' care becomes "so much a part of to and fro of living that it is difficult to unname it" (p.19). Smythe (1998) contends that this represents "the paradox of knowing something is there because we feel it, experience it, live with it, and yet at the same time we struggle to show what 'it' is" (p.82). Thus, I argue that in choosing to undertake research informed by phenomenology I have been able to unlock meanings concerning the lived experience of being-with-another that would not have been generated by other research

approaches. In particular, the ethnographic studies undertaken by Allan (2001, 2002) and Allan and Barber (2005)

Living care as worry

Living care-as-worry was revealed as being one of the central parts of being a fertility nurse. Feeling responsible illustrated the extent to which fertility nurses often feel accountable for patients' outcomes. van Manen (2002) suggests that this caring responsibility manifests itself as concern. The fertility nurses in this study also talked about what van Manen (2002) referred to as "ethical pain" as being part of the concern of the "care-as-worry" (p. 276). Thus one of the strengths of this study, unlike the work of Allan (2001; 2002; 2005; 2006) is that it has explored experiences in a way that has also begun examination of the paradoxical tensions of straddling the boundary between professional and personal worlds.

Although the fertility nurse found the on-going nature of this as being worrying and troubling, van Manen suggests that living 'care-as-worry' is necessary "because in this care-as-worry I experience the other who calls on me" (p.276). This view suggests that without working from a deep concern for the other the fertility nurse would lose touch with her ability to 'be with' the couple in a deep intimate

and sensitive way. Learning how to live with these feelings is reflected in the theme living with one's own emotions.

Living with one's own emotions

In the theme 'living with ones own emotions', I talked about nurses as co-passengers with couples on a roller coaster ride. This finding is in keeping with studies which have revealed that infertility treatment is an emotional experience for both nurses and patients (Allan, 2001; Allan, 2002; Allan & Barber, 2005, Allan, 2006). However, in exploring the unpredictable nature of these emotions I have suggested that fertility nurses are 'claimed' and cannot distance themselves as Allan suggests. In the moment of being with a couple they cannot easily prepare or protect themselves for what they will experience. The on-going lived responsibility of this becomes 'emotionally draining'.

The psychological term for the experience of long-term 'drain' is 'burnout'. Cordes and Dougherty (1996), in their study of health care workers, found that those employees within the health industry who have frequent and emotionally laden interactions with others are more susceptible to experiencing 'burnout'. As previously discussed, Allan's studies (2001, 2002, 2005 and 2006), suggest that one way of managing this is to maintain 'emotional distance'.

However the findings of this study suggest that a philosophy of care centered on the needs of patients by 'being with', encourages and requires emotional closeness. Thus it is possible that fertility nurses also work from a deep concern for the other. The study by Payne & Goedeke (2007) suggests that in response to the intimacy of the nurse-fertility patient relationship, fertility nurses need to be able to hold their emotional reactions together. The findings of this study suggest that those who are close to the experience 'hold together' and find comfort in talking to others who have had similar experiences for they understand the multi-faceted and changing personal nature of the experience of being a fertility nurse.

In summary then, I have argued that becoming a different kind of nurse, living care as worry and living with one's own emotions, collectively provide a different and deeper insight of the experience of fertility nursing than was previously articulated in the literature.

Limitations of the study

This research was carried out for a dissertation as part of a Master of Health Science; consequently all parts of the project were subject to time constraints. The number of participants was small and congruent with phenomenological research. The findings cannot be generalized to other settings. A further limitation of the study relates

to the participants' lack of cultural, geographic and gender diversity. All of the nurses were female of European ethnicity and similar in age.

According to Spence (2004), "prejudices originating from past experiences enable us to make sense of the situations we find ourselves, yet they can also constrain our understanding and limit the capacity to come to new and different ways of understanding" (p. 163). This view suggests that, in being a fertility nurse, I have views that will have influenced the findings. The strategies used to acknowledge and work with these influences were outlined and discussed in chapter three. The presuppositions that I brought to this study have both enabled and limited the findings. By way of illustration; when my supervisor thought my own experience of being a fertility nurse was influencing the findings she advised me to go back to the nurses' stories. Doing this enabled me to check the similarities and differences between my own pre suppositions or pre-understandings and the data provided by the participants.

Recommendations for practice

The findings of this study have important implications for practice, especially in the areas of on-going education and clinical supervision.

On-going education

The findings of this study have begun to reveal the complex and demanding nature of fertility nursing. Nurses who undertake this work need to be supported and assisted to develop the advanced practice expertise expected of them not only by couples, but also by medical and laboratory staff. The United Kingdom and United States of America have recognized certification processes in fertility nursing. I would like to see nationally recognized programmes in New Zealand that focus on advancing nursing practice in this field. The findings of this study suggest such a programme should include the following:

- Emphasis on interpersonal communication
- Learning how to recognize and accept one's emotional responses
- How to give and receive support
- Understanding the implications of technological advancements and;
- Developing an ability to think deeply about ethical issues in the present and towards the future

Education of this type also needs to be supported by structures in practice such as clinical supervision.

Clinical supervision

I believe that nurses need regular, tangible support to enable them to keep practicing in ways that benefit couples. To support those beginning as a fertility nurse, clinical supervision should commence with the orientation programme. According to Bernard and Goodyear (1998)

“Clinical supervision can be defined as an intervention provided by more senior member to a more junior member of that same profession. The relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the more junior person” (p.6).

Clinical supervision provides the new nurse with an experienced and competent role model, a one to one teaching and learning experience and assistance to transition from learning to being an accountable practitioner (Johnston, 1999). Positive benefits for senior staff members include professional satisfaction and personal growth from aiding and abetting another's development (Zey, 1984, Cooper, 1990, & Freeman, 1998). My belief is that clinical supervision would enhance the performance of nurses at all levels. Experienced nurses would remain stimulated educationally and professionally by the experience, while those beginning as a fertility nurse would display enhanced performance. Other forms of support such as Employee Assisted Programmes (EAP) as outlined by

Berridge and Cooper (1993) could also provide opportunities for nurses to talk through the burdens they encounter in practice.

Recommendations for the undergraduate preparation of nurses

Nursing schools have traditionally structured curricula following the classical divisions of medicine, surgery and public health. Thus, most nursing students are taught according to traditional conventional approaches to schooling, learning and teaching, where the emphasis is on nursing theory, nursing science and cognitive gain (Diekelmann, 2001). While this approach has served nursing well by bringing nursing education from hospital based programmes to university level qualification, it has limitations. For example, such content driven approaches ensure that many nursing programmes “teach to test” (Swenson & Simms, 2003, p.109). This results in courses that encourage rote learning and reinforce an element of teacher-centeredness, in which the teacher pre-specifies the learning outcomes (Ironsides, 2004). As a result specialty areas of nursing practice are not included in the curriculum. One way of overcoming this would be to offer elective modules so that undergraduate students interested in infertility could gain insight into this specialty area of practice. Opportunities for facilitated reflection

on practice would need to be an integral part of this elective experience.

Recommendations for research

This study has provided a small glimpse of the meaning of being a fertility nurse in New Zealand. There is huge scope for further qualitative research. Specifically, a larger, more comprehensive New Zealand study needs to be undertaken so that meaningful comparisons can be made internationally. Moreover, the participants in this study were all Caucasian. Further research using ethnographic and indigenous methodologies would help to extend understanding of the influence of different cultural values and expectations relating to infertility. It could also be interesting and valuable to replicate the ethnographic studies by Allan (2001, 2002, 2005; 2006) within the New Zealand context.

Concluding statement

This study has brought meaning to the experience of fertility nursing within the New Zealand context. The stories of the participants in this study have revealed that being a fertility nurse differs from other forms of nursing. Nurses work continually to provide a special kind of comfort and empathy to those undergoing assisted conception. The closeness that develops between nurses and couples suggests

that fertility nurses practice from a deep concern for other. They experience a range of strong emotions personally and professionally. Muirhead (1999) suggests that “the opportunity to give a patient good news, an unequivocal positive pregnancy test, is a wonderful panacea for the stresses of the role” (p.393). Yet Allan has argued that nurses use both caring and non caring strategies to manage their emotions. The findings of this study have revealed that the ongoing nature of working in an environment that claims and drains their emotions means that fertility nurses must understand and care for each other. They must also ensure that they receive support and assistance to work through their emotional challenges. This will enable fertility nurses to continue practice in ways that benefit themselves and their clients.

Appendix A



MEMORANDUM

To: Deb Spence
 From: **Madeline Banda** Executive Secretary, AUTECH
 Date: 14 December 2006
 Subject: Ethics Application Number 06/217 Nurses' experiences of working in a fertility clinic.

Dear Deb

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH) at their meeting on 13 November 2006 and that as the Executive Secretary of AUTECH I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 22 January 2007.

Your ethics application is approved for a period of three years until 14 December 2009.

I advise that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/research/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 14 December 2009;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/ethics>. This report is to be submitted either when the approval expires on 14 December 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTECH is notified of any adverse events or if the research does not commence and that AUTECH approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented. Please note that AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

A handwritten signature in dark ink, appearing to read 'Madeline Banda'.

Madeline Banda
 Executive Secretary
 Auckland University of Technology Ethics Committee

Cc: Amy Williams nurseamykins@yahoo.co.nz

Appendix B

Participant Information Sheet



Date Information Sheet Produced:

29 October, 2006

Project Title

Nurses' experiences of working in a fertility clinic

An Invitation

I am interested in hearing about your experience of working as a nurse in a fertility clinic. Participation in this research is voluntary and you may withdraw at any time without penalty.

What is the purpose of this research?

Little research has been published about nurses working in the fertility field. This study will explore and describe the experience of working in a fertility clinic from the perspective of New Zealand nurses. It will provide insight into an area of practice which is not widely understood by others in the community. The study is being carried out by the investigator towards completion of a Master of Health Science degree at Auckland University of Technology. In addition to the publication of a dissertation, an article will be submitted to the Fertility and Sterility Journal. Study findings will also be presented at the Australasian Fertility Nurses Association (FNA) conference in 2008.

How was I chosen for this invitation?

You will be one of three to five registered nurses with a current practicing certificate who have volunteered to talk about their experiences of working in a fertility clinic. All study participants will be selected on the basis that they have a least one year's experience with fertility nursing and are currently employed as nurses in the fertility field. If you consider you fit this description then you are most welcome to join the study.

What will happen in this research?

You will be interviewed for between 60 and 90 minutes. The interviews will occur at a time and place convenient to you. With your consent, the interviews will be audio taped. The researcher will then transcribe the interviews and discuss their analysis with her supervisor. She will focus on identifying common themes and describing the essential

meaning of fertility nursing. The researcher may wish to contact you again by telephone to clarify any points raised in the interview.

What are the discomforts and risks?

It is possible that you may communicate information that evokes strong emotions. The researcher will be sensitive to your feelings and stop taping the interview should you ask for this to be done.

How will these discomforts and risks be alleviated?

Should any emotional distress occur as a direct result of the interview a counsellor from the AUT Counselling Service will be made available at no financial cost to you.

What are the benefits?

Being involved in this study will give you an opportunity to share your experience of being a fertility nurse. People sometimes find this an empowering and rewarding experience.

How will my privacy be protected?

The researcher will take the following steps to ensure that confidentiality is maintained:

1. The researcher will not divulge your participation in the study to anyone other than the supervisor
2. Names will be substituted with pseudonyms in all reporting of the study findings.
3. All identifying information will be locked in a cabinet only accessible by the researcher
4. Upon the completion of the study, data and consent forms will be stored securely on AUT premises for six years. You will be offered your taped interview upon completion of the study.

What are the costs of participating in this research?

The main cost of participating in the study is your personal time (60-90 minutes). Should you choose a venue away from your home the researcher will reimburse you for your travel costs to that venue.

What opportunity do I have to consider this invitation?

If possible, the researcher would appreciate hearing from you before 20th March 2007.

How do I agree to participate in this research?

If you would like to participate in the study please contact the researcher (see details below). You will be sent an information sheet and be asked to sign a consent form prior to being interviewed.

Will I receive feedback on the results of this research?

You will have the opportunity to view and approve your interview transcript prior to analysis. The dissertation will be available in the AUT library and a copy of the research article will be made available to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Deb Spence, deb.spence@aut.ac.nz, (09) 921 9999 ext 7844. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Amy Williams

Registered Nurse

Tel. Work (09) 5209520 ext 68136

Project Supervisor Contact Details:

Dr. Deb Spence, Principal Lecturer, School of Nursing, Faculty of Health, AUT, Private Bag, 92006, Auckland. Telephone (09) 921 9999 ext 7884.

Approved by the Auckland University of Technology Ethics Committee on 14 December 2006, AUTECH Reference number 06/216

Appendix C

Consent Form

For use when interviews are involved.



Project title: **Nurses' experiences of working in a fertility clinic**

Project Supervisor: **Dr. Deb Spence**

Researcher: **Amy Williams**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 29th of October, 2006.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that the interviews will be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 14 December, 2006 AUTEK Reference number 06/217

Note: The Participant should retain a copy of this form.

Appendix D



FERTILITY NURSES

**I am undertaking a Masters
dissertation on:
Nurses' experiences of working
in a fertility clinic**

If you are interested in participating in this
study or would like more information,
please contact
Amy Williams

Phone (09) 5209520 ext 68136
Or e-mail nurseamykins@yahoo.co.nz

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