A Discursive Dance

A Foucauldian Discourse Analysis

of

Caring Touch in Health Practice

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Abstract

The act of one person touching another is an act discursively produced and, therefore, constructed as acceptable in some situations and not in others dependant on who, where, and when the touch is actioned. Challenges, therefore, have the potential to arise; particularly within the realms of health practice where acts of touch are commonplace. This study has a specific focus on caring touch. Caring touch is a form of non-verbal communication enacted between people to demonstrate compassion, support, and empathy; and is constructed by social, gender and cultural perspectives.

The aim of this inquiry was to analyse the discursive constructions of caring touch in health practice. The complexity of caring touch required a methodology that recognised the presence of multiple viewpoints, values, and practices. Therefore, this study employed post-structural discourse analysis, which drew on the work of Michel Foucault and his notions of discourse, the subject, technologies, and governmentality.

Semi-structured interviews with 20 practitioners recruited from nursing, paramedicine, midwifery, and medicine, provided the data for this inquiry. Analysis of the data demonstrated an interplay of multiple discourses that made caring touch, as an act incorporated into health practice, challenging.

Findings from this study showed constructions of caring touch were at times juxtaposed across, and within, the four health disciplines. Although scopes of practice meant participants were able to legitimately cross boundaries of interpersonal space to employ their specific acts of care, caring touch was made more complex as it was not a 'necessary' part of practice. At times, caring touch was constructed as part of professional identity where it was normalised as complementary to other tasks undertaken, and an important aspect of care. Conversely, caring touch was sometimes constructed as an 'extra', an unnecessary part of professional practice that restricted time for diagnosis and treatment. Evident for most participants were uncertainties pertaining to what acts of caring touch were doable and, what were not, in terms of their professional practice, situating these participants at a discursive impasse. Similarly, there was an underlying unknowingness that pointed to wider constructs of touching another person that dominated practice.

Contradictions in the constructions of caring touch co-existed for the participants. This created tensions and unease; particularly for the male practitioners, where an undercurrent that discourses of gender and the sexualisation of touch knowingly or otherwise, influenced their acts of caring touch. Irrespective of how the male practitioners experienced or understood

caring touch, there was a hesitation regarding how acts of caring touch would be interpreted. Acts of caring touch, therefore, became too complex to negotiate and touch interactions with patients were limited.

In summary, caring touch is a social construction that permeates the working lives of many health practitioners where acts of caring touch are both taken up or marginalised according to the discourses that dominate practice for the individual. The findings from this study contribute to the body of knowledge in a topic of significant complexity. This thesis opens up possibilities for the production and circulation of alternative discourses that may broaden the potential for patient wellbeing; and specifically, may create a space for health practitioners to navigate opportunities for caring touch.

Glossary

Wellbeing: Multiple definitions and interpretations of wellbeing exist depending on the context and perspective. However, in the context of this thesis, wellbeing is defined as a multidimensional state of health, encompassing physical, spiritual, psychological, and social factors all of which are influenced both internally and externally such as genetics and environment.

Māori: The indigenous Polynesian people of Aotearoa New Zealand

Aotearoa: The Māori translation of the name for New Zealand. As shown in this thesis, the two terms are often used together in recognition of the original term used by the indigenous people.

Marae: A Māori meeting ground. The place for communal, sacred, religious, and social purposes, where cultural traditions are reaffirmed.

Lead Maternity Carer (LMC): A midwife, obstetrician, or general practitioner (GP) who co-ordinates maternity care for a pregnant woman, throughout pregnancy, labour, birth, and for up to six weeks post-birth. They have a professional and legal responsibility to ensure mother and baby are given appropriate care.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the awards of any other degree or diploma of a university or other institution of higher learning.

Signed: Date: 12th November 2022

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Name: Nicola Power

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I dedicate this thesis to my father who, sadly, did not live to witness its completion. He was a guiding light throughout my life and a constant source of comfort and support. I know you were there travelling the entire journey with me, and I hope I have made you proud.

Chapter One – Introduction

The magic cot

I want to begin this thesis by telling a story. It is a true story told to me in 1991 when I attended a seminar in the United Kingdom (UK). It is the story of the magic cot and provided the initial inspiration for this research. The speaker at the seminar was a nurse who had recently returned to the UK after working for several months in a Romanian orphanage. She had volunteered her services as a nurse following 1989 media reports exposing the atrocities in the treatment of children in Romanian orphanages.

Before telling the story of the magic cot, I wish to set the scene of the plight of those living in Romania at that time. After coming to power in 1966, President Nicolae Ceaușescu made plans to raise the international standing of his country. He borrowed the 1930s Stalinist dogma that population growth would fuel economic growth (Beckett et al., 2006). In his first year as President, his government outlawed abortion and contraception for women under 40 with fewer than four children, stating anyone avoiding having children was a deserter to the country. All childless persons, regardless of sex or marital status, paid an additional monthly tax, enforced by a group of secret police (Glasper, 2020). As explained by Odobescu (2015), doctors found to be performing abortions were imprisoned and every few months women were examined in their workplaces for signs of pregnancy. Any woman found to be pregnant but who subsequently did not give birth, faced prosecution. According to Weir (2014), fertility was an instrument of state control. Consequently, the birth rate doubled and coupled with Romania's poverty, families found they could no longer care for their children. Countless numbers of unwanted children were abandoned to state care. Medical professionals were denied access to academic journals published outside of Romania, and many were poorly trained. In the orphanages, electricity and heat were often intermittent and food was limited. Physical and emotional needs were ignored, and developmental delays were routinely diagnosed as genetic mental disability.

Facing the revelation of these orphanages, the UK volunteer nurse went about her duties in the orphanage in an attempt to make the lives of these children more tolerable. During this time, she was told the story of the magic cots. Cots were placed end to end around the circumference of each room with a number of cots forming a central mass in the middle. There was one cot in each room squeezed in by the doorway. These were the magic cots. Staff told the nurse that babies placed in these cots were much healthier than other babies, despite there being no difference in nutrition and overall living conditions. Thinking there was no

reason for the babies in these cots to be any healthier; the nurse put the story down to either local myth or coincidence. Some weeks after her arrival, she was working late in an office near the infant rooms and was able to see the staff member responsible for cleaning coming and going from room to room. It was not until she had watched for some time that she realised the routine of the cleaner. The ageing village woman started cleaning the floors at the far end of the room and worked her way across, taking no notice of the children in the cots to avoid distraction from her duties. However, as she finished her floors and laid her mop and bucket at the entrance, she picked up the infant in the last cot by the door and spent several minutes cuddling and interacting with the infant. She did this in every room she visited. The nurse realised after several days of observing this routine, that it was a pattern of work repeated by the cleaner every day. Without fail, each day the cleaner gave a few minutes of her limited time to these particular infants. It came to light that this had been the case for nearly 20 years. The nurse realised the interaction between the cleaner and these infants was the only thing that differed in the lives of all the children in the room. She started to believe that rather than myth or magic cots, this caring action provided by the cleaner may be more important to the well-being of these babies than anyone had previously understood. With this new understanding igniting her, she began talking to the others; and thus, a new philosophy of practice began in the orphanage. After her time in Romania ended, the nurse returned to the UK and continued to extol the importance of caring touch to general health and wellbeing. For reasons I am unable to articulate, this story resonated with me so markedly that since that time I have been intrigued and captivated by this simple yet conversely complex, form of human interaction.

Why this research topic?

I was raised in England to loving parents who did not mirror the alleged stereotypical unemotional, stiff upper lip of the English. My siblings and I were hugged and kissed often. Touch was initiated when we were upset and again when a celebration was called for. Unsurprisingly, being raised in this environment I chose to train as a holistic therapist, a role that encompassed touch with people every day. This role focused on the wellbeing of people encompassing dimensions of physical and psychological health. Later, my work as a childbirth educator also provided the opportunity to see what I perceived as caring touch interactions at work. It was these environments that fostered my construction of a 'positive' caring type of touch. I grew up knowing some forms of touch had devastating physical and emotional effects on people, but it was rarely an aspect of my life. Consequently, I became more interested in exploring the potential for touch as a beneficial form of communication. In later years, as an

academic, I became increasingly interested in the ways touch was constructed by general society and how it was actioned. I was drawn to the discourses that dominated perceptions of touch not only throughout society but within health practices where the academic literature suggested touch to be of benefit to the patient. I was curious to know when, how, and why caring touch played a part in the work of health practitioners.

My interest in the area of human touch was demonstrated in my earlier research and in my academic teaching. For several years I developed and co-ordinated an undergraduate course entitled the 'Principles of Touch', and I remain an invited guest lecturer on the topic in a core undergraduate paper for students in the University's School of Clinical Sciences. Additionally, my master's thesis explored the experiences of male primary school teachers' acts of caring touch. Whilst the data from that study elicited interesting and poignant aspects of touch, I was mindful that the chosen methodology did not explore the wider meanings and complexities of touch. Consequently, when embarking on my PhD journey, I was drawn to a methodology that allowed me to explore and analyse social constructions that produce particular ways of thinking about this complex form of human interaction.

Having explained the background that inspired this thesis topic, I now introduce touch as it is generally constructed and defined in Western society and health practice.

Introducing touch

The complexity of touch is evident even in language where there is a myriad of ways in which the word touch is utilised on a day-to-day basis. Phrases such as "he's always been a soft touch"; "her words touched me"; "there was a touch of malice in his voice"; "she's a touchy-feely person", have been commonly used in the English language; yet rarely do we give thought to the complex nature of touch or the important place it is argued to have in human existence. When Takeuchi et al. (2010) suggested that caring touch can be defined as "putting hands on someone in order to show them kindness and affection" (p. 110), they posited that touch enacted to demonstrate care is not simply an action. Rather, it is a form of non-verbal communication that may promote wellbeing in interpersonal relationships.

As a means of communication, touch is explained in multiple ways. These understandings are contextual, dependent, and shaped by historical, social, and cultural perspectives. It is the complex constructions of touch that produce a type of communication that can be wanted or unwanted, beneficial or harmful. Thayer (1982) stated, "of all the communication channels, touch is the most carefully guarded and monitored, the most infrequently used, yet the most powerful and immediate" (p. 298). As articulated throughout this study, there is considerable

and persuasive evidence suggesting positive, caring acts of touch are an important aspect of human development from birth until death (Shamay-Tsoory & Eisenberger, 2021).

However, when studying the topic of human touch, there are alternative societal discourses that often place emphasis on the negative aspects of touch between people. Finnegan (2005) stated that touch is perhaps the most direct intrusion into the personal space and privacy people create around themselves. In Western societies, where there is a climate of suspicion often linked with touch, it comes as no surprise that its practice is often questioned, particularly touch between people without a close connection. Furthermore, unspoken rules about who a person can touch, where and when they can touch, prevail throughout daily life; this is particularly so for those working in health practice where the need to touch patients is commonplace. Cultural, gender, and relationship conventions all play their part in the acceptance of touch. It is these complex discursive constructions that health practitioners are required to negotiate on a daily basis.

Touch is described as a powerful vehicle enabling interactions between people and, as such, underpins many of our actions when we engage with the world around us (Davis et al., 2017; Ratcliffe, 2012). Classen (2020) suggested touch is laden with meanings and bound by rules, preceding, informing, and overwhelming language. It is with these understandings, and those from other prominent writers, that I present the first chapter of my thesis. This introductory chapter presents the research topic and, the context for embarking on this thesis. I introduce the chosen philosophical approach deployed to answer the research question and summarise the forthcoming chapters.

Defining touch in health practice

This study gathered data from four groups of health practitioners, these being nurses, doctors, paramedics, and midwives. The groups represented practitioners who, during their everyday practice, were required to engage in touching others through assessing or administering treatment. These practitioners were also more likely to encounter people in pain and/or distress, where acts of caring touch may be engaged in. Unlike many people in society, health practitioners are sanctioned to touch others. Morris (1997) referred to doctors as being in a minority of "professional touchers" (p. 67), meaning they are part of a particular group whom, by way of their profession, are able to legitimately cross the boundaries of personal space and touch people in the course of their practice. Indeed, Western societies have a limited number of people with what is referred to as 'license to touch' others (Brown & Seddon, 1996; Nicholls, 2012). Health professionals, including paramedics, doctors, nurses, and midwives, are part of

this legitimised group of people. Within health practice touch can take on many forms. Whilst the use of touch to undertake professional tasks has been studied in depth (Baker et al., 2021; Davin et al., 2019; Fleischer et al., 2009; Kronsberg et al., 2018; Wearn et al., 2020), there is a type of touch that is a more subtle and contested part of practice. Prior to outlining this specific type of touch, I next explore the numerous ways in which touch is categorised in the literature.

By outlining the categories and terms used to describe types of touch, I aim to provide insight into the multiple interpretations and complexity of touch, and clarify the terms I have chosen to apply throughout this thesis. Connor and Howett (2009) stated that reviewing literature on the terminology defining touch is challenging given the many concepts and terms used. Nevertheless, in health disciplines early literature classified touch into three main categories: directional, procedural, and comforting (Edwards, 1998; Estabrooks & Morse, 1992; McCann & McKenna, 1993; Picco et al., 2010). Whilst directional touch pertains to those attempting to provide physical guidance to a specific destination (e.g., assisting a person into an ambulance or onto a bed), procedural touch infers a type of touch enacted to achieve a specific task (e.g., taking a pulse or manipulating a limb) (Edwards, 1998). Later studies expanded upon terms for procedural touch such as instrumental touch (Playfair, 2010), task orientated touch, and necessary touch (Gleeson & Timmins, 2004). In this thesis, I apply the commonly used term procedural touch, as a type of touch utilised to assist a patient back to good health. Procedural touch is suggested to be the main form of touch used in the rehabilitation/health setting (McCann & McKenna, 1993).

It has been similarly challenging for studies focusing on the type of touch that provides emotional support to agree on a recognised term. Over time, many terms have been added to an ever-expanding list. For example, Porter et al. (1986) choose to use the term 'expressive touch'. Edwards (1998) suggested comforting touch, abridged to 'comfort touch' by Butts (2001), and Kruijver, Kerkstra, Francke, et al. (2000) employed the term 'patient-centred comfort touch'. Several writers embraced the word 'intention' when describing a type of touch consciously enacted. Edvardsson et al. (2003) used the term 'intentional touch', whilst Chang (2001) preferred 'touching with intention'. Similarly, Connor and Howett (2009) wrote of 'intentional comfort touch', proposing a type of touch that offered a level of safety and caring whereby a patient feels the environment provides the trust and reassurance required to ask about important health issues such as depression or alcohol use. Whilst these terms suggest a deliberate act of touch, it was important within this thesis to provide transparency and consolidate the vast array of contexts and variety of terms used. I have, therefore, chosen to

adopt the broad term 'caring touch' (Airosa et al., 2013; Ozolins et al., 2015). Caring touch, in this sense, is the conscious act of touching another to demonstrate care, comfort, reassurance, consolation, or praise, and is the term that forms the focus of this inquiry. The many terms and multiple complexities of touch actions have provided a rich array of academic literature as outlined in the following sections.

Touch as problematic

Commentary on acts of touch are often focused on any type of touch as being problematic. Classified as negative touch, whereby harm and injury to the recipient is caused, such acts are presented on a regular basis through media reports and a significant number of academic publications (Adams et al., 2018; Sachs-Ericsson et al., 2005; Thompson et al., 2004; Wiens et al., 2020). The various ways touch can be enacted are rarely differentiated in the media (e.g., to carry out a procedure or comfort someone in distress) and become constructed as one form of physical interaction with limited clarification. As such, touch is a social construction that may produce some people who consider it problematic.

In the 1980s and 1990s sociologist Frank Furedi (2006) suggested the repercussions of well-intentioned changes in educational policy created an era of moral panic where the ongoing concern of child safety pervaded society and the resulting discourse constructed adults touching children as problematic. Other commonly trusted professions, such as sports coaches and priests in the Catholic church, were similarly tainted with speculation. Accordingly, there have been changes to guidelines, specifically those relating to boundaries of touch (Catholic Church in Aotearoa New Zealand, 2017; High Performance Sport New Zealand, 2018). In the health professions, where acts of touch are commonplace, the suggested 'moral panic' may have also created a reticence to engage in any touch interactions other than those required to complete a task (Baker et al., 2021; Kelly et al., 2018). Consequently, caring touch may be constructed as difficult to manage, meaning some people may restrict its action.

Touch as a topic of scholarly and social interest

Throughout the 1980s and early 1990s there was an increase in the published scientific literature focusing on touch (e.g., deYoung, 1988; Estabrooks & Morse, 1992; Field et al., 1986; Hollinger & Buschmann, 1993; McCann & McKenna, 1993; Older, 1982; Thayer, 1982). During this time, there was also an increase of studies examining and problematising touch that coincided with a flurry of media attention related to 'problematic' touch (e.g., Battiata, 1990; Lattin, 1998; Perlex, 1996). Much of this media coverage focused on several television and film celebrities who were accused of inappropriate touching and there was a resurgence of

allegations of inappropriate touch made against members of the Catholic church (Burton, 2018; Park, 2017). Arguably, it was the widespread reporting of abuse that dominated concerns and created a climate of fear around any form of touching. Despite the renewed attention given to types of touch that caused abuse, there was little published on the potential problematic nature of touch in the health arena outside the professions of psychotherapy and nursing (Fleischer et al., 2009). Moreover, much of this literature was focused on patient experiences rather than that of health practitioners, making understanding of touch from the health practitioner's perspective limited (Elkiss & Jerome, 2012; Routasalo, 1999; Smith et al., 2001; Waters, 2010; Wolf et al., 2014). Given the focus on touch as having the possibility to be problematic. The following section explores this construct of touch particularly in the Aotearoa New Zealand context.

Contexts of touch as a problematic in Aotearoa New Zealand

The suggested tensions and moral panic construct discourses around touch and produce actions whereby withholding caring touch is one way to manage the possibilities of harm and/or misinterpretation. This is pertinent within the health sector in Aotearoa New Zealand where touch from male health practitioners in particular, has resulted in a breakdown in trust of hitherto trusted professions.

The following legal cases are influential because they position touch from a male in a particular way, perpetuating a discourse through mainstream society that touch from a male is problematic. When a culture of fear dominates acts of touch, it can initiate a change of behaviour in a group whereby a fracture to existing practices can occur (Evans, 2002). Such a shift in behaviour was noted in the years following the conviction of Peter Ellis in the Christchurch Civic Childcare centre case in 1993, where accusations of child abuse in an educational childcare facility held public attention for years (Hood, 2001). Evidence against Ellis suggested his acts of touch, both in terms of caring touch and the touch required to assist children in tasks, were inappropriate and therefore abusive. While charges against four of his female colleagues were dropped after an 11-week preliminary hearing, Peter Ellis, an openly homosexual childcare worker with five years' experience, was later sentenced to 10 years' imprisonment after being found guilty on numerous charges of abusing children in his care[1].

[1] Ellis, who always maintained his innocence was the subject of extensive legal battles, including two appeals, an inquiry, and a 2003 petition to Parliament (Farquhar, 2001; Hood, 2001). In 2015, Ellis appealed once more to the Privy Council to clear his name after a request for a Commission of Inquiry into his case was rejected by the Justice Minister. However, on October 7th, 2022, the final appeal to the Supreme Court found there had been a significant miscarriage of justice and he had indeed been innocent of all charges. Sadly, he did not live to hear his name cleared of charges having died from cancer in 2020.

The high-profile trial of Peter Ellis in Aotearoa New Zealand, as well as the reporting cases of child abuse overseas, appears to have heightened the level of anxiety in communities regarding physical contact between adults and young children, suggesting a rise in the visibility and legitimacy of touch as problematic.

However, following the publication of studies that suggested the importance of caring touch in education (Jones, 2004), the New Zealand Education Institute (2006) revised its guidelines of physical touch acknowledging the need to be more flexible around touch practices. Nevertheless, as the discourse that constructed touch as problematic continued to dominate, the ongoing public anxiety relating to actions of touch prevailed. As cases in education resulted in a shift in the discursive constructions of touch, similar cases were highlighted in health practice.

In 2000, Morgan Fahey, an Aotearoa New Zealand general practitioner (GP), was convicted of rape, sexual violation, and indecent assault on his female patients (Horwood & Corbett, 2000). Fahey was an international authority on trauma medicine, had served as Deputy Mayor and, as such, was perceived as a highly respected member of the community. His conviction determined that he had been exploiting his power as a doctor for over 34-years (Sainsbury, 2015). The case of Fahey, and other cases internationally (e.g., Campbell, 2017; Rabin, 2021), caused a shift in policies pertaining to touch interactions between the health practitioner and patient, and the Medical Council of New Zealand set out to reappraise its policies and procedures. Since these cases were brought to public attention, stated appropriate boundaries in the doctor-patient relationship have been continually amended (Medical Council of New Zealand, 2018). The visibility of power imbalances in the health practitioner/patient relationship is driving change in a way that produces health practitioners who are more aware of their professional boundaries.

Despite the on-going concern and speculation in Western society regarding acts of touch, there is considerable academic study that supports the potential for caring touch to provide benefit to people and enhance wellbeing.

Caring touch as essential to human survival

Acts of caring touch are complex and appear to be inextricably related to values and attitudes within a community or culture. Moreover, a strong body of evidence concludes that being devoid of caring touch during lifespan is problematic to many of those experiencing its absence, particularly in terms of diminishing psychological wellbeing, increasing the potential

for anxiety, insecurity, and aggression (Davis et al., 2017; Nelson, 2007; Ratcliffe, 2012). This absence or limited access to caring touch is most often called touch deprivation or skin hunger (Davis et al., 2017; Field, 2014; Lemermeyer, 2022; Montagu, 1986).

Although the effects of touch deprivation are experienced across the lifespan, empirical research on touch deprivation has tended to focus on the young (Beckett et al., 2006; Field, 2010; Herrera et al., 2004; Moszkowski et al., 2009), as what happens early in life is seen to influence later experiences (Cekaite & Bergnehr, 2018; Swade, 2020; Takeuchi et al., 2010). One of the reasons caring touch is constructed as necessary to wellbeing is the potential for its absence to have multiple adverse effects across the age spectrum. Hertenstein (2002) stated that the earlier in life a child experiences touch deprivation, the higher the likelihood of more serious physiological and psychological outcomes. Infants suffering from touch deprivation can suffer more illness from a suppressed immune system, poor sleeping patterns, reduced mental capacity, increased hyperactivity, and an increase in aggressive behaviour (Field, 2014). Being deprived of touch is also reported to have the potential to cause serious and long-term problems in many areas of society including adults who may become uncommunicative as they live a life with limited physical human contact (Davis et al., 2017).

At the other end of life, many elderly adults in Aotearoa New Zealand live alone or in retirement homes (Boyd et al., 2021; Jamieson et al., 2018). Living without a partner or being geographically distanced from other members of their family, often means living a life without caring touch. Elderly adults in residential nursing homes are generally touched every day, but this touch is almost always procedural and related to being bathed, dressed, and/or examined (Aung et al., 2017; Gleeson & Timmins, 2004). Absent for many of these elderly adults is touch that communicates caring and ensures they feel valued and important (Rinnan et al., 2018; Sansone & Schmitt, 2000). Furthermore, in the current climate of a worldwide pandemic and the necessary isolation that has occurred, many elderly people have experienced a decline in receiving caring touch reporting negative effects on both physical and psychological wellbeing (Armitage & Nellums, 2020; Berg-Weger & Morley, 2020). In summary, there is an abundance of published evidence suggesting people across the age spectrum are adversely affected when acts of caring touch are absent or withdrawn. Furthermore, there are possibilities that caring touch has an effect on both parties involved in a touch interaction.

Reciprocity of touch

The act of touching a person is generally not a solitary communication moving in one direction only. In terms of health practice, both the patient and the practitioner are part of this

exchange. Although professional guidelines attempt to articulate standards of touching practices, few raise the important notion of reciprocity between the toucher and the touched. Touch is a reciprocal action, a gesture of exchange that occurs in multiple daily activities, but is the essence of many forms of health practice (Donovan, 2015). It is an action that carries with it an expectation that the person touched (the patient) is required to accept and comply. Caring touch offers a form of communication that may signal alternative messages such as empathy. When the health practitioner touches a patient to indicate empathy or comfort, both parties experience something that remains challenging to explain. This undetermined 'something' can be interpreted in multiple ways by the individuals participating in the touch, reinforcing touch as a complex interaction (Wood, 2015). The reciprocal and mutual nuances that are experienced between the health practitioners and the patient are dynamic and fluid and require deeper understanding. This form of interaction involving patient and practitioner is often guided by professional registration and licencing bodies that serve to safeguard those working in professions where touch is possible and open to scrutiny, as articulated in the following section.

Professional guidelines

The health practitioners that are the focus of this study are nurses, midwives, doctors, and paramedics. All have professional guidelines offered by the overarching registration body, council, or association, these being the Nursing Council of New Zealand, the New Zealand College of Midwives, the Medical Council of New Zealand, and Te Kaunihera Manapou Paramedic Council of New Zealand. The guiding principles of these individual councils/colleges suggest they can influence the varied practices and subjectivities adopted by health practitioners, including physical contact with a patient and, consequently, serve to legitimise what is done and not done. All of these health practitioner groups also have legal implications under the directives articulated through the Health Practitioners Competence Assurance Act 2003.

Although the need to engage in physical contact with a patient varies considerably from one health profession to another, the organisations guiding the practices of doctors have, in recent decades, recommended the protocol of having chaperones available on a consistent basis when examination or treatment of the patient is required (American Medical Association, 2020; General Medical Council U.K., 2013; Medical Board of Australia, 2020). For example, "It is recommended best practice to offer a chaperone for all intimate examinations" (Medical Council of New Zealand, 2018). This is particularly suggested for examination or treatment of particular intimate areas of the body, such as the genitalia and breasts.

The Nursing Council of New Zealand (2012) guidelines offer one statement referring to the act of touch between the nurse and patient suggesting boundaries of a professional relationship may have been crossed when "the nurse touches the health consumer more than is appropriate" (p. 9). As with other guidelines, the boundaries are loosely alluded to and do not offer any detail as to what type of touch is "appropriate" and what is not. Furthermore, there is no mention of adopting a chaperone for nurses as there is for doctors, perhaps suggesting the exclusion of the chaperone means a nurse and potentially other health practitioners pose less risk. The Paramedic Council offers no specific guide on touch practices but, interestingly, recognises the significance and problematic nature of touch and that gaining the patient's trust is important in order to allow touch. "Paramedics need to establish trusting relationships with health consumers to effectively provide care that involves touch" (p.3). The New Zealand College of Midwives does not highlight acts of touch as being problematic in either the scope of practice or code of ethics.

Acknowledging the perspectives of these different professional practicing bodies highlights the margin of tolerance for caring touch that guides practice. Although such differences are largely understandable, the ambiguity pertaining to touching practices potentially leaves health practitioners having to make their own decisions about utilising acts of caring touch. Given the complexity of touch as a topic of interest and the arguable difficulties in conducting research, locating a suitable methodology was an important aspect in the early phases of this project.

Philosophical approach and aims of this study - Why Foucault?

The complexity of touch, specifically caring touch, required an epistemological approach that would account for diverse constructions and the possibility of multiple subjectivities. I needed to be able to recognise how different subject positions were produced and how these played out to produce complex power relationships in the context of caring touch in health practice. As someone who sought alternative views on topics, I was drawn to the work of French philosopher Michel Foucault who sought to undermine and disrupt certainties that dominate ways of thinking (Cole et al., 2004). It was his encouragement to break free from established understandings and question differently that called me to draw on his work. Using an approach that would acknowledge multiple perspectives, I also wanted to employ a methodology that explored the way power operates to open up or close down certain ways of thinking or being at particular times. Thus, a Foucauldian poststructuralist approach was used to explore what was taken for granted and how health professionals conceptualised caring touch in practice.

While reading Foucault, I began to see in his writing a way of analysing multi-layered common daily practices that have become generally accepted in society. His philosophy resonated with me in that it embraced complexity and thus provided a lens through which I could investigate the discourses involved in the practice of human caring touch.

The research question

Despite the body of research on the topic of human touch (see Chapter Three), I considered there was a gap in the current literature that needed addressing and had the potential to be significant for those working in and experiencing health practice. To my knowledge, no studies to date have specifically investigated the discursive constructs of caring touch in health practice, and none have explored health practitioners' constructs of caring touch across various professions. If the majority of academic literature supports acts of caring touch as being beneficial to health, discovering the 'why' and 'how' caring touch is integrated or otherwise in the practice of health practitioners warranted investigation.

This study does not aim to reveal the truths about the use of caring touch as offered by a health practitioner. Looking for truths would be inconsistent with Foucault's position that knowledge is historically and culturally situated. Rather, the aim of this thesis was to explore the assumptions and understandings that are taken for granted and shape acts of caring touch in health practice. I will make transparent why some aspects of caring touch are constructed as part of practice whilst others may be absent or suppressed. As such, this study sought to ask:

> *What are the dominant discourses that enable or constrain acts of caring touch in health practice?*

The forces at play when exploring the ways in which caring touch is spoken of exhibit a fluidity that is multiple and complex. Therefore, attempting to define acts as right or wrong is not congruent and possibly naïve. In making visible the sequence of knowledge that forms the space occupied by health practitioners, Foucauldian discourse analysis provides an effective methodology for inquiry and deep reflection on the normalising power of discourse (Springer & Clinton, 2015).

Thesis outline

In Chapter Two I introduce philosopher Michel Foucault whose concepts underpin this study. I describe poststructuralism and its value as an epistemology to locate Foucault, and I offer a rationale for choosing particular Foucauldian concepts which shape the analysis of this study.

Chapter Three is a review of the literature with a focus on the multiple and overlapping discourses that make visible the complexity of caring touch. This literature review offers insight into the conflicting discursive constructions and practices of caring touch that place particular focus on caring touch as essential to wellbeing, and caring touch as problematic.

Chapter Four provides an explanation of how my chosen methodology shaped my method. I explain recruitment, data collection, and analytical processes.

Chapters Five, Six, and Seven present an analysis of statements from the interviews with participants. I explore and analyse the interview texts, the discourses articulated, and the subject positions taken up. The first of these, 'Professionalism and Caring Touch' (Chapter Five), explores the constructions of professionalism that reflect what acts of caring touch may or may not be possible or appropriate. Chapter Six I have called 'Constructions of the Role and Purpose of Caring Touch in Health Practices'. Constructions were diverse and contradictory presenting caring touch as both important and unnecessary across the four groups of practitioners. The last of the three analysis chapters, Chapter Seven, entitled 'Male Touch as Sexualised', highlights the ongoing negotiation and possibilities of caring touch for male health practitioners, and the underlying tensions present when touch was actioned.

These three analysis chapters provide the foundation from which to develop the arguments presented in Chapter Eight which concludes the thesis through the discussion of the insights, implications that arose from my findings, and limitations to the overall study.

Chapter Two – Philosophical Underpinnings

Introduction

Philosophical approaches to research vary considerably, each having the potential to provide different insights on a given topic. It is therefore, pertinent to highlight the theoretical approach that guides this study. This chapter extends the initial introduction to Michel Foucault from Chapter One and provides a more in-depth rationale as to why his concepts of discourse have shaped the methodology and research methods used in this study. I offer an overview of Foucault's key notions: the object, the subject, discursive practice, and technologies, to provide justification for their place in this study. Additionally, the work of Foucault is often linked within the traditions of poststructuralism; therefore, I begin this chapter by outlining the theoretical epistemology of poststructuralism and the relevant concepts important to this study. The epistemological position I adopt in this thesis enables the identification of the variety of ways that caring human touch is constructed, recognising how this knowledge is used to produce particular subject positions and technologies of power.

Poststructuralist approach to understanding

The act of one human touching another is constructed in multiple ways and as shown in following chapters, its interpretation is contextually dependant. Furthermore, the complexity of understanding how touch is constructed by health professionals requires the employment of a methodology that recognises the presence of multiple values, viewpoints, practices, and acknowledges that meanings are unstable and open to interpretation (Cheek, 2000). It is this multiplicity that lends this study to poststructuralism. Poststructuralism offers a distinctive way of analysing the production of knowledge and attempts to explore and analyse how 'truth' may be played out (Crilley & Chatterje-Doody, 2019). Simplistically, poststructuralism invites questions that reach beyond the general common sense understandings of the world in which humans live (Gavey, 2011). It presents numerous ways to uncover conditions of possibility which makes it difficult to make a claim for a unified approach (Crilley & Chatterje-Doody, 2019; Niesche & Gowlett, 2015). Additionally, poststructuralism is useful as a way to open up new lines of analysis not offered by other approaches (Niesche & Gowlett, 2015). Foucault, and other philosophers of his time, such as Gilles Deleuze and Jacques Derrida, questioned the objective investigation of cultural, social, and political structures (Peters & Burbules, 2004). Foucault (1975-76/2003) argued that because understandings are historically and socially contextual, constantly shifting and therefore unstable, there can be no facts; rather, varied constructions. As such, poststructural discourse analysis has become

a popular choice of methodology when conducting research in aspects of health (Cheek, 2004; Crowe, 2005). In 1992, Lupton promoted the use of poststructural discourse analysis to address what she perceived as the failings of other research methods, particularly when exploring attitudes towards the subject of health. Lupton believed the strength of poststructuralism lay in comprehending the underlying assumptions that health professionals had towards patients in addition to "the messages and meanings about health issues disseminated by the popular media" (p. 149). Poststructural discourse analysis is a method that can offer valuable insight into social and emotional phenomena in the healthcare setting (Candlin & Candlin, 2002) and is a suitable method to use when exploring the discourses prevailing in the construction of caring touch in health practice. Poststructural studies identify why aspects of health care practice are taken for granted and represented as a 'normal' part of practice when others are absent or suppressed. A poststructural discourse analysis is, therefore, committed to a critique of dominant modes of thinking, speaking and writing (Peters & Burbules, 2004). Poststructural discourse analysis is the chosen methodology for my study as it highlights the complexity of situations and can bring to light discourses that are marginalised, taken for granted, lost, or hidden in relation to caring touch (Khan & MacEachen, 2021; Peters & Burbules, 2004).

A Foucauldian philosophical positioning

Through my understanding of poststructuralism, I was drawn to the work of Michel Foucault, published in texts dating from the 1970s. Foucault positioned his understanding of the history of thought through a lens of social constructivism (Kröner & Beedholm, 2019). Social constructivism is a philosophical ontology that suggests the way we perceive reality is due to shared social constructions that shape experience (Agius, 2013). Willig (2013) stated, the same event can be perceived by two people in different ways, demonstrating different societal constructions in play at the same moment in time, with neither being particularly right or wrong. Foucault's work examined and problematised various social conditions that may have produced certain ways of thinking about something and was able to analyse how these concepts were socially constructed and maintained. A growing number of authors in the field of health practice suggest Foucauldian discourse analysis is a useful tool when seeking a deeper method for reflection on the discursive and ethical practices of health practitioners (Ceci, 2006; Ceci & Purkis, 2009; Patton, 2010; Rudge & Morse, 2001; Springer & Clinton, 2015). Foucault's extensive work in this field makes Foucauldian discourse analysis an appropriate choice for exploring the different ways in which caring touch is constructed.

Historically, the development of well-formed ideas that demonstrated clarity was sought from intellectuals. Rarely was much thought given to the insights and experiences of the everyday person (Whisnant, 2012). Foucault (1970/2002) suggested that philosophy should look outside the perceptions of intellectuals' and look at what was/is happening for people at that moment in time. He suggested that by placing emphasis on the continuity of ideas showing flexibility and acceptance of continual change and reformation, there was a lessened risk of overlooking the discontinuities or ruptures that had occurred previously. Foucault, therefore, regarded 'theory' as a toolbox of potential useful instruments (Hope, 2015; Kendall & Wickham, 2003) and suggested readers may want "to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including eventually those from which my books have emerged ... so much the better!" (Foucault, 1975 cited in Paton, 1979, p. 115).

Foucault's metaphorical toolbox has facilitated users of theory to choose a conceptual tool from the 'tool box' and apply it to a specific problem, furthering inquiries rather than reaching an "intellectual end" (Garland, 2014, p. 366). Throughout his life, Foucault's work encompassed a variety of ideas and topics, but several broad concepts underpin his writings: those of discourse, the subject, and power/knowledge. The remaining parts of this chapter present an overview of each of these concepts. I also introduce the two methodological tools located through much of Foucault's oeuvre: archaeology and genealogy.

Discourse

Those embarking on discourse analysis in social sciences can be perplexed by the variety of definitions and perceptions available (Alvesson & Karreman, 2000). Defining discourse is challenging as it appears contradictory, having many diverse and intersecting meanings (Fairclough, 2003). Discourse is more than merely the use and implication of words in language. In this study, discourse produced certain practices that denoted how a health practitioner 'should' behave and perform. Discourse is reflected in the different constructions of a health practitioner: what it means to be professional and/or what it is to be cared for by a health professional. Whilst there are multiple diverse constructions of discourse available, here I articulate definitions drawn from authors who focus on meanings originating from a Foucauldian perspective.

Defining discourse

Discourse is defined in different ways depending on the theoretical stance of the researcher (Jansen, 2008). The term discourse is not a homogenous concept. It is used by disciplines in

differing ways, sometimes in linguistic analysis, and at other times to analyse social practices (Garrity, 2010). Powers (2001, p. 18) defines discourse as a "group of ideas or patterned way of thinking that can be identified in textual and verbal communications and can also be located in wider social structures". Likewise, Jørgensen and Phillips (2002) suggested discourse is a set of common assumptions that are often not recognised on a conscious level but, nevertheless, form the basis of conscious knowledge. Language and knowledge together form a dyad through which discourses have the ability to influence thoughts and actions to regulate people and populations and condone or legitimise certain practices (Holmes & Gagnon, 2018).

Frequently, discourse is a term not defined but assumed (Cheek, 2004). Mills (2003) likened this to the use of discipline specific 'common currency', whereby discourse:

> is frequently left undefined, as if its usage were to imply common knowledge…It has perhaps the widest range of possible significations of any term in literary and cultural theory, and yet is often the term within theoretical text which is least defined. (p. 1)

Several theorists have suggested that how people as individuals or groups understand both themselves and others is largely constructed by a series of discourses or systems of thinking (Alejandro, 2020; Berger & Luckmann, 1991; Burr, 2003; Keller, 2005), marking discourse as a "complex, conceptual, minefield" (Garrity, 2010, p. 194). Despite the myriad interpretations of discourse, it is Foucault's definition of discourse that I take up in this study.

Foucault's meaning of discourse

Discourses are diverse representations of social life, reflecting on and generating power, while serving as a mirror of particular ideologies and socially constructed norms (Foucault, 1978/2000e). Discourses are bound up in institutional practices. An example is shown by an individual being positioned as a patient within a medical discourse. This means their body is an object of legitimate interest to health practitioners and is able to be observed, assessed, and touched in the process of being diagnosed and treated.

Although discourse is central to much of Foucault's work, academics have long struggled with the vagueness and contradiction he attributed to the definition (Mills, 2003). Foucault (1970/2002) argued that when people use thoughts and language to communicate their experiences, it should be remembered that any experience is located in a specific historical context. Rather than the concept of a discourse as being related primarily to language and speech, Foucault held to the notion that it was something broader, using the term in its rudimentary form as a reference to the material verbal traces left by history, or a way of speaking (Devisch & Vanheule, 2015; O'Farrell, 2005). As human beings who live, work, and

act within these discourses, it is often difficult to see the way we are affected or constrained by them. Foucault (1981) held to the notion that all human beings are constituted by discourse. This is significant when analysing how health practitioners make decisions about the use of caring touch in their professional practice. The discourses we constantly participate in are always multiple and never fixed, and therein lies the potential for us to be constituted in several ways. This in itself provides flexibility and openness to the different ways in which people speak about caring touch, when embarking on research using this methodological approach.

In *Archaeology of Knowledge,* Foucault (1969/2002) referred to discourse as "the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a number of statements" (p. 90). However, Foucault's most commonly quoted summary of discourse is identified as "practices that systematically form the objects of which they speak" (Foucault, 1969/2002, p. 54), suggesting the role of discourse and material reality cannot be separated (Mills, 2003). Engaging in discourse analysis through a Foucauldian lens constructs discourse as including actions, thoughts, and beliefs with discursive arrangements. Discourses are not a coherent whole; rather, they are discontinuous and do not always agree with each other (Kendall & Wickham, 2003). They compete for dominance and power as they work in conjunction with each other. This power, in a Foucauldian sense, is a power that is diffuse and interacts on multiple levels (Gordon, 1972/1980).

Reading the plethora of available texts on the subject of discourse leads one to believe that discourse seems to be all encompassing with no sign of a non-discursive realm (Mills, 2003). However, despite accusations to the contrary, Foucault has never suggested there is no non-discursive realm; rather, he alluded to the fact that we can only think about and experience the material world through the imposition of discourse (Foucault, 1981). To explain, I draw on an analogy proffered by Laclau and Mouffe (1985/2001) but written here using the concept of touch. In the course of our lives, we think, categorise, and interpret what we experience using the structures around us. In the process of this happening, we give these structures the status of normality. This normalisation thus becomes challenging to question. For example, when a person observes someone touching the leg of another person, the action can be witnessed and constructed as a comforting act of compassion or, conversely, an expression of something sexually motivated, depending on the discursive field of the person viewing. Although there are two possibilities when observing the touch to a leg, we may be unlikely or unable to 'see' outside the discourse that dominates thinking.

Foucault is consistent in his proposal that an individual is subject to the influences of several discourses at one time (Markula & Pringle, 2006). Generally speaking, discourse is governed by rules that lead to statements which circulate throughout society and are closely associated with Foucault's notion of exclusion (Mills, 2003). Certain discourses dominate and others are marginalised, as explored throughout this thesis. In *The Order of Discourse,* Foucault (1981) describes the procedures that constrain discourse and lead to the production of other discourses. The first set of procedures are made up of three external exclusions: 1) prohibition or the taboo, 2) the distinction between madness and sanity, and 3) the distinction between true and false.

As stated above, one aspect of discourse is that of the object (Foucault, 1969/2002). In this thesis, the action of caring touch is considered to be the object of knowledge in that it is constituted and transformed by discourse. Foucault (1969/2002, p. 49) described objects as being formed through the relationship established "between institutions, economic and social processes, behavioural patterns, systems of norm, techniques, types of classifications, modes of characterization". The manner in which we perceive discourse relates to the way in which objects become seen as being thinkable and knowable, and constantly emerge as a re-worked version. In this study, I aimed to show that caring touch, as an object of knowledge, is constituted "by all the statements that named it, divided it up, explained it" (Foucault, 1969/2002, p. 35).

In summary, Foucault defined discourse as systems of ideas, attitudes, beliefs, practices, and courses of action that shape who, what, and why (Foucault, 1972/1980). He proposed that discourse constitutes reality by forming the objects of knowledge and power. Consequently, "discourses are covert agents of power, constructing 'valid' knowledge, effecting behaviour and other discourses" (Phelan, 2011, p. 894). Discourse should "not be considered as a simple translation between reality and language but as practices that shape perceptions of reality" (Markula & Pringle, 2006, p. 31). Throughout this thesis the discourses that constitute the practice of health practitioners are analysed. This analysis is articulated in three chapters and underpins the premise of this thesis.

Discursive practices

Discursive practices are the actions of subjects brought about by the relationship with the discursive object (Foucault, 1969/2002). The processes by which cultural meanings are produced and understood are forms of discursive practice. Such practices operate according to the rules pertaining to a specific time, space and environment (O'Farrell, 2005). In reference to

examining discourse, Foucault (1969/2002) explained the process as: "show[ing] with precise examples that in analysing discourses themselves, one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice". (p. 54)

Foucault was also interested in how discursive practices are used to produce truth (Cooper & Blair, 2002). The main purpose of a discursive practice approach is the development of thought, skills, and concepts that form relevant behaviours in a given situation. Discursive practices are overt in many healthcare settings where the rules that define practice may conflict between practitioners. These practices may not always align and may well collide. Gubrium and Holstein (2001) stated that discursive practice, "provides the footing for answering why recognisable constellations of social order take on locally distinctive shapes" (p.502). If discourse is the result of human thought and practice (Allen & Hardin, 2001), then discursive practices are an inevitable expression of those discourses: deemed to be discursive events. Foucault (1969/2002) summarised his notion of the complexities of discursive practice by stating they "show that to speak is to do something" (p. 230). The various discursive practices of the health practitioners in this study are unpacked and evidenced throughout chapters five, six and seven.

Statements

In *Archaeology of Knowledge* Foucault (1969/2002) stated:

> The analysis of the discursive field is orientated in quite a different way; we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it and show what other forms of statements it excludes. (p.28)

Foucault's concept of a statement describes it as the most basic element of discourse and may comprise other than written text. A statement may also be particular practices, pictures, or the environment/spaces under exploration. Foucault described a statement as 'basic' because any interpretation of the statement relies on understanding the relationship and context in which they are made. However, exactly what Foucault described a statement to be appears to be complex and he admitted to struggling with providing a unitary definition. He does, however, suggest "a statement belongs to a discursive formation as a sentence belongs to a text" (Foucault, 1969/2002, p. 130). A statement therefore can be seen as the most elementary component of a discourse and provides a logical point to commence analysis (Fadyl et al., 2012).

Inherent in a Foucauldian approach is the requirement to consider the types of statements found within discourses and describe aspects of "sameness" that are "peculiar to the historical discursive formation in which the statements are formed" (Clifford, 2001, p. 30). Such statements should then be sensitively considered to enable understanding of the meaning, context, and historical implications, in addition to the assertions to knowledge and truth (Springer & Clinton, 2015). Foucault (1969) suggested statements cannot be made that do not in some way reactivate or recycle others. Similarly, Sawyer (2002) indicated that statements are always lacking, in some way, as they are always dependent on what is made available at a particular place and time. Central to describing a statement is the need to define the conditions of its specific existence. It is the precise description of what is exactly said at a particular time in a particular place and not an interpretation. It is the description of how meaning is produced in texts. Statements made by the participants in this study were integral to developing understanding, exploring, and unmasking the discourses constructing caring touch.

Discursive formations

There are multiple social structures and practices that have the potential to generate knowledge, operate to shift meaning, and reflect systems of thinking and knowledge throughout health care practice. It was these systems of thought that Foucault termed discursive formations. Foucault (1969/2002) stated:

> Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, typesof statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functionings, transformations), we will say, for the sake of convenience, that we are dealing with a discursive formation. (p. 41)

Sawyer (2002) suggested that a discursive formation is a group of statements gathered together due to similarity or institutional pressure. Additionally, discursive formations are the rules and systems in use that operate without the conscious knowledge of individuals. They serve to establish what is possible to be said, and what is not; but, specifically, determine in a given context or time, what can be thought (Foucault, 1969/2002). In *Archaeology of Knowledge*, Foucault (1969/2002) described what he believed were the four components that comprised discursive formations - objects, enunciative modalities, concepts, and strategies. Through discourse, objects are formed and become evident so that we are able to think, speak, and act on them. For this study, the object of focus is caring touch. Objects of caring touch differ depending on the discourses that construct them. The response of a health practitioner to caring touch links to enunciative modalities, whereby the author of a

statement 'holds' certain rights by way of their qualifications that construct what they say as considered rational, reliable, and true (Fadyl et al., 2012).

Foucault suggested that when statements are produced through discourse and organised in a particular manner, they become concepts. Concepts are then able to be modified by a variety of interventions such as when that statement is applied to an alternative area of thought or work (Foucault, 1981). The final element of discursive formations is something Foucault termed strategies. Strategies refers to the organisation of information into themes or theoretical structures for the purpose of inducing analysis regarding the compatibility of the object, subject, subject position, and concepts within the one discourse (Foucault, 1969/2002). My analysis in this study used Foucault's discursive formations to ascertain possible inconsistences in the statements.

Discontinuity of discourse

Discourses may persist over time, continually circulating and competing with each other (Foucault, 1969/2002). Discontinuity refers to the notion that a discourse does not function by itself. Discourses often conflict with each other, and certain discourses are able to subvert others. This discontinuity does not represent the dissolution of one discourse and the emergence of another; rather, one discourse may prevail over another (Foucault, 1969/2002). As Mills (1995) suggested "discourses tend to lumber on through time, being activated when their use is anachronistic" (p. 73). The fractures and shifts pertaining to the acceptance or rejection of caring touch can be observed throughout history where dominant discourses have disrupted particular constructions of caring touch. Within health practice, acts of human touch are constructed by more than one discourse. The subversion of a discourse that suggests caring touch is risky with a discourse that proposes caring touch is therapeutic and of benefit to the patient, demonstrates discontinuity that emerges and transforms according to discursive formations (Foucault, 1969/2002).

The Subject

Foucault (1978/2000d) maintained the power that permeates individuals in everyday life as categorising:

> …the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him. It is a form of power that makes individuals subjects. (1978/, p. 331)

Subjects are active in producing themselves as subjects because they are subjected to forms of power. The action of subjects occur within discourse and the subject themself is produced

through discourse (Kendall & Wickham, 2003). Foucault's theory of the subject includes many meanings and occupies a key position in his work. In a Foucauldian sense, the subject can mean a person that is governed, a disciplinary domain such as history, a topic under investigation (Fendler, 2010). It is this ambiguity that makes a simple definition somewhat elusive. These meanings do not suggest a picking and choosing of whichever meaning suits at the time; rather, the meanings are entangled with each other. Nevertheless, Foucault (1978/2000d) did suggest two meanings of the subject as being:

> subject to someone else by control and dependence, and, tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to. (1978/, p. 331)

Subjectivity refers to the ways in which sense of self is produced through discourses that are multiple and unstable indicating the type/s of subject/s that a person may comprehend or embody or, alternatively, choose to resist (Willig, 2013). Throughout the 1970s, Foucault wrote widely on the discursive organisation of subjectivity (Gubrium & Holstein, 2002). He commented on the historical shift in the way people formed their subjectivity and stated:

> in the course of their history, men have never ceased to construct themselves, that is, to continually displace their subjectivity, to constitute themselves in an infinite, multiple series of subjectivities that will never have an end. (Foucault, 1978/2000b, p. 276)

Foucault wanted to emphasise the subject as constantly in a state of flux, along with other forms of understandings and social practices (O'Farrell, 2005).

Taking up subject positions

Foucault's interpretation of discourse suggests it plays a major role in the way we perceive those around us and the subject positions we adopt. A subject position is produced when people use language in various forms of interaction to negotiate positions for themselves (Davies & Harre, 1990; Foucault, 1969/2002). More simply, subject positions can be defined as "locations" within a conversation (Wetherell et al., 2001, p. 210). An individual creates an identity by the manner in which they might act, engage, and talk. Moreover, the ways in which people engage in conversations can alter, both during a conversation and between conversations. Burr (1995) explained:

> Discourses provide us with conceptual repertoires with which we can represent ourselves and others. They provide us with ways of describing a person … Each discourse provides a limited number of 'slots' for people … These are the subject positions that are available for people to occupy when they draw on this discourse. Every discourse has within it a number of subject positions … . (p.141)

Individuals, often subconsciously, negotiate different and shifting subject positions from one minute to the next, dependant on where they are and whom they are with at that moment in time. Subject positions constantly emerge and thus people are both products of discourse and producers of discourse (Jarden, 2004). In a social constructionist sense, they are products in that their identities have been produced by a socially and culturally available discourse (Davies & Harre, 1990). Similarly, the cultural discourses experienced and witnessed by health practitioners have the ability to produce subject positions. These subject positions provide both a sense of who we are and, open up the possibilities for, and limitations on action within a discourse (Burr, 2003). Foucault (1977/1995) suggested the subject position of a health practitioner as a legitimised holder of knowledge and speaker of a medical discourse; and the patient has the subject position of a docile subject.

Foucault's thinking about discourse did not remain static but developed over time, as seen in his concepts of archaeology and genealogy.

Archaeology and genealogy

Archaeology and genealogy were Foucault's approaches to analysing texts (Fadyl & Nicholls, 2013). He stated they were his "dimensions of analysis" (Foucault, 1984/2006, p. 14). Although I have outlined these two approaches as separate entities, genealogy adds to and refines Foucault's earlier aspects of archaeology (Tamboukou, 1999). Both approaches are associated with uncovering discursive formations and practices found within various historical periods. However, these differ in that genealogy places a greater focus on the analysis of power (Danaher et al., 2000). Archaeology was a term Foucault used to distinguish his historical work from traditional history (Fendler, 2010) and is present in Foucault's earlier texts such as *The History of Madness* (1961), *The Order of Things* (1966), *The Archaeology of Knowledge* (1969), and *The Birth of the Clinic* (1973). Historical investigations are often longitudinal, looking at the shifts over a designated period. In contrast, archaeology refers to the study of ideas that occurred at the same time, and is thus a more cross-sectional analysis of history (Gutting & Oksala, 2021). It is a method of historical analysis that focuses on discourse or, more accurately, the analysis of the unconscious "rules of formation" (Foucault, 1969/2002, p. 42) that play a role in the emergence of discourse (Kendall & Wickham, 2003). Archaeology enabled the clarification and articulation of singular threads of discourse through time, capturing Foucault's (1969/2002) approach to the history of science, and the production of scientific knowledge. At that time, the focus of interest was to explore the networks of what is said and what can be seen in a set of social arrangements (Kendall & Wickham, 2003). Foucault wanted to explore the strata of problems, reflecting the more general understanding of

archaeology. Archaeology reviews phenomena through critical investigation, delving deep into the ordinary ways of thinking that are behind the diverse actions and opinions of individuals with focus on the historical conditions that made it possible to think and act in particular ways (Calvert-Minor, 2010; Kendall & Wickham, 2003; Oksala, 2007; Phelan, 2011). In this sense, it was an ideal approach to integrate into the exploration of caring touch, in that it allowed me to investigate the ways in which caring touch was constructed and enacted in health practice.

During his work on archaeology, Foucault probed into the history of normalised concepts such as madness and questioned how these concepts came to be. He demonstrated that such concepts were a product of socially and ethically dubious practices (Springer & Clinton, 2015). Archaeological research is non-interpretive, focusing on an alternative but important examination of a topic by concentrating on statements (Kendall & Wickham, 2003; Phelan, 2011). It allows insight into discursive suppressions and inconsistencies (Foucault, 1969/2002) and asks 'how' and 'why' such knowledge emerged (Mills, 2003; Phelan, 2011). It is in this context that this study aims to identify the significant discourses and practices that are privileged or obscured and analyse the statements within these discourses.

Expanding on his notion of archaeology, Foucault's texts shifted towards genealogy. Genealogy is an analytical tool that Foucault developed from the ideas of German philosopher Nietzsche (Markula & Pringle, 2006). Foucault never provided a succinct definition of genealogy; thus, the key features of his genealogy need to be collected from different texts (Oksala, 2007). It is, therefore, best understood as a multi-layered critical practice rather than a strict method. The move to genealogy at the beginning of the 1970's was a shift in Foucault's questioning (Mills, 2003). Texts such as *Discipline and Punish* (1977/1995) and *The History of Sexuality Volume 1* (1978/1998) showed Foucault's move towards exploring the connection between power relations and the formation and maintenance of knowledge. The main assertion in Foucault's genealogy is that the "rules regulating practices are always tied to the power relations of society" (Oksala, 2007, p. 55). Foucault believed that by turning to history we are more able to clarify the development of thinking, leading to better understanding of why we act and think in the way we do (Kendall & Wickham, 2003). Foucault referred to this as a 'history of the present' (Dreyfus & Rabinow, 1983; Willig, 2013). Although his focus remained on history, having already used an archaeological approach to identify and tease apart the threads of discourse found in institutions and practices, his genealogical approach aimed to describe the intricate discursive threads.

Genealogical studies encourage exploration of areas that may otherwise remain unrecognised as being influential and unchallenged (Springer & Clinton, 2015). Thus, it brings forth mechanisms of power that "would rather remain hidden", (Kendall & Wickham, 2003, p. 29), so the discourse can be named and spoken to. It does not judge, rather it flushes out any perceived assumptions. Foucault's writing on the subject suggests that history could help us see that "the present is just as strange as the past" (Kendall & Wickham, 2003, p. 4). Genealogy is, therefore, a historical analysis that describes events from the past without making specific causal connections (Danaher et al., 2000; Oksala, 2007; Smart, 2002). Furthermore, Foucault's work is used in many aspects of studying society examining how current ways of thinking and understanding make things possible (or not), along with opening possibilities to expand our thinking about a current issue. Thus, a genealogical approach to the topic of caring touch is a useful tool for this study. Bishop (2009) supported this notion of genealogy, stating:

> We are concerned with what is present – near to us in space; after all, that is the task of the scientist to look at things present in front of us. We are concerned with what is present – near to us in time; after all that is the task of the social scientist to look at the behaviours of this object called society and to describe what is happening in real time. (p. 334)

In summary, genealogy examines the association between history, discourse, bodies, and power in an attempt to better understand the social practices or objects of knowledge (Markula & Pringle, 2006) which "continue to exist and have value for us" (Foucault, 1980, p. 146). This study is focused on the present and aims to utilise this aspect of Foucault's methodological 'toolbox' to investigate how the current thinking about touch has been made possible; rather, than examine how thinking about touch has emerged from the past.

Foucault, discourse, and power

As Foucault's analytical gaze became more fluid through his academic life, so too did his thoughts of power. Simons (2005) suggested the most important thread, running through Foucault's diverse and complex oeuvre was the study of power. Mills (2003) suggested Foucault's work on discourse and power is valuable as it enables reflection, and questions how we know what we know, where the information originated, and under what circumstances it was produced. Using this knowledge, we can question if is it possible to think differently? It also allows us to question why something that we believe is "true, is kept in that privileged position" (Mills, 2003, p. 66). The Marxist conceptualisation of power that flourished in the 1960s saw power as having a macro-structure; for example, the state, which acted in support

of capitalism, visible through some of the major public services such as the police, law, and the church. In contrast, Foucault believed power to be something that was localised and diffused, often-through social systems and acting at a more micro level (Turner, 1997). Foucault (1978/2000a) explained:

> If power were never anything but repressive, if it never did anything but to say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no; it also traverses and produces things, it induces pleasure, forms knowledge, produced discourse. It needs to be considered as a productive network that runs through the whole social body. (p.120)

Throughout his text *Discipline and Punish,* Foucault (1977/1995), moved from the initial confronting description of power as being controlling, used directly to subjugate the body, to describing more subtle forms of power. As a text, *Discipline and Punish* serves as "a historical background to various studies of the power of normalisation and the formation of knowledge in modern society" (Foucault, 1977/1995, p. 308). Power should not be viewed as something to be reckoned with and to be freed from. Rather, power is something to be made visible, to allow those living with it the ability to see how it operates in a specific context (Foucault, 1977/1995). In a Foucauldian sense, power is productive. He stated, "power produces; it produces reality; it produces domains of objects and rituals of truth", (Foucault, 1977/1995, p. 194). Joanne Finkelstein (1990) expanded on Foucault's thoughts:

> Power is a strategy of relations that gives some individuals and groups the ability to act and keep acting for their own advantage. Power is also the ability to bring about a desired situation and to prevent the actions of those who would want to thwart such desires (p. 14).

Foucault (1977/1995) argued that a dominant group does not necessarily impose power from above via repression or force; rather, it comes from all around via all aspects of living:

> We must make allowances for the complex and unstable processes whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it". (Foucault, 1978/1998, pp. 100-101)

Since power is embedded in discourse, we are all vehicles for its establishment and workings, and it is, therefore, found forming part of the interactions of daily life. Thus, power is everywhere (Foucault, 1978/2000d). As Foucault's thoughts around power evolved, so too did his thinking about how it interacted with knowledge. In his early analyses, he problematised

power and knowledge, postulating that the formation of knowledge occurred within relations of power. He continued this thinking in his later texts where he expanded on notions of power (*Discipline and Punish*, 1977/1995, & *The History of Sexuality Vol 1,* 1978/1998). How we understand people and how knowledge pertaining to people is constructed is a function of power (Foucault, 1972/1980).

Foucault made two important French distinctions about knowledge. First, Foucault uses the term 'savoir', referring to a learning process whereby we construct knowledge about ourselves through experiences and interactions with others. This type of knowledge is constantly transforming and modifies the way a subject participates in the world. Second, the term 'connaissance' is introduced, which differs from savoir in that it relates to knowing something, and being familiar with it; for example, knowing a person (Foucault, 1969/2002). Foucault furthered his thinking of power and knowledge and espoused they are inseparable; that there is a constant merging of one with the other, meaning one cannot exist without the other (Foucault, 1975-76/2003). Thus, his offering of the power/knowledge coupling was founded. This convoluted amalgamation of power/knowledge or 'pouvoir-savoir' and the subject is a critical theme underpinning much of Foucault's work. He began to view power/knowledge as not necessarily oppressive but providing the opportunity to create new possibilities and freedoms to shape life. Foucault suggested that in a situation where power exists, the self either accepts or resists. It is this self-creation that defines 'authentic subjectivity' (Bishop, 2009). The power employed by health practitioners does not necessarily suggest coercion or control of the patient; rather, it enables knowledge to be used productively through assisting in diagnosis and/or treatment of a patient. The relationship between power and knowledge is further explained by Foucault (1977/1995) as:

> We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (p. 27)

In summary, the fundamental Foucauldian premise is that power is a characteristic of all social relationships.

> Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here and there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals

> circulate between its threads; they are always in the position of simultaneously undergoing and exercising power. (Foucault, 1980, p. 96)

Engaging in Foucault's suggestion of power analysis is particularly "well suited to study local forms of power that are constantly negotiated through day-to-day interactions immersed in local contexts" (Kannabiran & Petersen, 2010, p. 698). The working environments and the relationship between health practitioners and patients has an inherent power dimension where they are faced with having to negotiate power relations. They may be challenged with using power productively. Discourse analysis emphasises the power that permeates all social relationships and, as such, provides an ideal methodology for this thesis as it made possible the exploration of constructions that enabled or constrained acts of caring touch.

Foucault asserted that a modern society governs many of the aspects of life particularly social and biological, and his later writings introduced the notions of biopower and governmentality (Oksala, 2007).

Bio-power and governmentality

Biopower is a term coined by Foucault in 1975 in an effort to make transparent a mode of power working in modern democratic society, working as a technology to manage populations. Foucault (1978/1998) described biopower as "a modality of power that is exercised through our relationship to demography" (p. 39). He suggested that biopower operates in a way that takes care of the population. Thus, it utilises notions of health and well-being.

Foucault (1978/1998) stated that prior to the 18th century, governments did not acquire details on the population (in terms of income, gender, place of birth as examples). However, by the end of the 18th century, with the aid of statistics, it was possible to acquire and analyse the activities of the population leading to the production of new knowledge. In this context, came the advent of governments caring for public health (Devisch & Vanheule, 2015). The acquisition of this knowledge was all part of Foucault's description of bio-power. With the move away from sovereign power, bio-power surfaced as a recognised form of power in conjunction with the development of capitalism (Lemke, 2001). Bio-power refers to having power over bodies through "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault, 1978/1998, p. 140). Foucault (1978/2009) later embellished this definition of bio-power by stating:

> By this I mean a number of phenomena that seem to me to be quite significant, namely, the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of

> power, or, in other words, how, starting from the 18th century, modern Western societies took on board the fundamental biological fact that human beings are a species. This is what I have called biopower. (p. 1)

He did not define bio-power as either good or bad. Rather, it is an observation of the change in operations of power and shapes the way we think of ourselves in relation to the rest of the population (Fendler, 2010). Nevertheless, Foucault suggested the rise of demography made way for social control and provided the argument for 'managing' a 'population'.

In the *History of Sexuality volume 1*, Foucault (1978/1998) suggested bio-power has two forms: anatomo-politics and bio-politics. The concept of anatomo-politics is centred on the human body as a machine and, according to Foucault, involves individuals becoming docile:

> [anatomo-politics is] … centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterised the disciplines: an anatomo-politics of the human body (Foucault, 1978/1998, p. 139).

Bio-politics is concerned with aspects of life: birth, illness, reproduction, and death. Bio-politics is, therefore, broadly linked to interest in population wellness (Foucault, 1978/1998). It is with this understanding that I employed the concept of bio-power in my study.

In 1978, Foucault (1978/1998) proposed a shift from bio-power to the broader concept of governmentality. From the commonly understood term of traditional power over people, as espoused by a monarch, whereby sovereign power operated primarily in a repressive manner, governmentality is a type of power that creates and legitimises notions of state and population (Foucault, 1978/2000a; Lemke, 2015). However, enabling a government to 'take care' of the population can only be realised by penetrating into the private lives of people, screening and 'managing' to push in the 'right' direction (Devisch & Vanheule, 2015). Governing referred to a continuum, extending from modern-day understandings of political government to a form of self-regulation which Foucault termed 'technologies of the self' (Foucault, 1978/2000a; Lemke, 2015).

> The contact point, where the individuals are driven by others is tied to the way they conduct themselves, is what we can call, I think, government. Governing people, in the broad meaning of the word, governing people is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself. (Foucault, 1993, pp. 203-204)

By governmentality, Foucault endeavoured to illustrate how a modern sovereign state and a modern independent person work together to determine each other's emergence. He alluded to a triangulation between sovereignty, government, and discipline, which emerged in the 18th century as a mechanism for regulating and controlling population (Lupton, 1997). Foucault (1988) expressed triangulation as the "contact between the technology of domination of others and those of the self I call governmentality" (p.19). Mitchell Dean (1999) offered a definition of governmentality as being:

> Any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes. (p. 11)

Dean (1999) expands on this definition by suggesting there are two broad meanings of governmentality. The first is the exploration of what we think about governing and the differing mentalities of government. The second meaning marks the emergence of thinking about and the employment of power in society. It is this second meaning that is used when referring to the approach adopted in my study. I am both interested in the 'why' and, analysis of the 'how'. Foucault's work on governmentality problems allows examination of familiar problems from a new vantage point (Seale et al., 2010). This is useful when exploring the notions of acceptable touch between members of society, specifically in the working lives of health professionals.

Governmentality operates as much through health practitioners as it does through the patients in their care. For health practitioners, it problematises both the freedom and regulatory practices of touching patients. Although the roles may be distinct, neither is more free than the other from government. It is not something Foucault suggested should be resisted or accepted; but he did problematise both the freedom and the regulation brought about by governmentality. It is merely a way of allowing us to see how we regulate ourselves in a given situation (Fendler, 2010). Kendall (1997) stated, "Governing thus comes to be seen not so much as the imposition of one's will over another, as the insertion of a certain way of thinking and doing within the fabric of everyday life" (p.225). Similarly, Fendler (2010) suggested governmentality is something that allows us the vision of how democratic power functions, thus permitting the mechanisms by which we regulate our own thoughts and behaviour. These notions will be unpacked through the analysis of data in this thesis. As Foucault's notions about power developed, so too did his reflection on the concept of

governmentality. Foucault's self-regulation or 'technologies of the self' are reflected in his later works marking the transition in his thinking about governmentality and bio-politics.

Foucault's technologies of power

Foucault was both well known, and often criticised, for his generation of new terminology, arguably redefining words for his own purpose (O'Farrell, 2005). The word technology is another example of how he used language/words in new ways to express particular ideas. For Foucault (1984), the use of the word 'technology' highlights the ways in which power relations operate and involves "the government of individuals, the government of the souls, the government of the self by the self, the government of families, the government of children, and so on" (p. 256). He used technology to propose an understanding of power in a way that assumes a more neutral, if not positive stance (Behrent, 2013). His technologies of power encompassed a number of modes, including bio-power (as mentioned previously) and pastoral power. Foucault used the word 'pastor' to explain this mode of power. Pastor comes from the word pasture, the place where a shepherd keeps and looks after a flock of sheep (Carrette, 2013). The metaphor of the shepherd and flock of sheep is referred to in Christian language and serves to highlight this mode of power. Members of the flock, the sheep, are dependent on the shepherd to facilitate their well-being (Carrette, 2013; Martin & Waring, 2018). Foucault (1978/2000c) elaborated, stating "a power we can call pastoral, whose role is to constantly ensure, sustain and improve the lives of each and every one" (p. 307). While Foucault did not define types of caring, pastoral power, is in a sense, a caring mode of power.

Much of Foucault's texts focus on technologies of power, but his later work showed a shift away from technologies of power to technologies of the self with his iconoclastic studies shedding light on the concepts of personal self and individuality (Foucault, 1984/1986, 1988, 1978/1998, 1984/2006). With the concept of technology stretching across many facets of society, the various types of technologies are hardly ever able to operate independently, and Foucault suggested all technologies are associated with an aim to control the conduct of people (Foucault, 1988; Markula, 2003). However, it was technologies of the self and the related practices that Foucault stated he was most interested in, and where he emphasised a mode of power unlike that which controls or dominates (Fendler, 2010; Foucault, 1988). He provided his reasoning behind this interest as:

> Perhaps I have insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of self. (Foucault, 1988, p. 19)

The particular complexities of Foucault's technologies of the self only became apparent during a series of lectures at the College de France (Foucault, 1975-76/2003) and with the publication of his series of volumes on *The History of Sexuality* in the 1980s (Peterson & Bunton, 1997). However, such technologies of the self are everyday practices. Foucault defined technologies of the self as practices of power that allow an individual to effect, by their own means, alterations on their body, mind, and lifestyle; transforming themselves in order to attain a certain state of happiness and quality of life. In other words, technologies of the self are the way we shape ourselves through ethical practices. One of the main features of technologies of the self is that of expertise (Rose, 1998) and the way this manifests in practice. 'Technologies of the self' include acts of self-discipline, where a person (in terms of this study, the heath practitioner) may enact changes of behaviour, knowing that by doing so their actions are more accepted and/or expected by the people and the environment in which the act takes place. Such technologies were important to this study where multiple constructions of caring touch were possible. Another concept of power used in this study is Foucault's notion of disciplinary power.

The clinical gaze and the practitioner-patient relationship

Disciplinary power is exercised through surveillance and knowledge. One form of surveillance suggested by Foucault (1963/2003) was 'the gaze'. The clinical gaze was one of the major concepts of Foucault's text *The Birth of the Clinic* (1963/2003). At the end of the 18th century, medical clinicians gave priority to visible diagnosis. By looking for abnormal symptoms the body may show, they could proffer a diagnosis. However, Foucault noted a discursive shift as medical understanding of disease moved from the notion that illness exists separately from the body to the idea that it could be mapped directly through the body (Fendler, 2010). Foucault called this the 'medical gaze'. He used the term 'gaze' to describe what the health practitioner (or doctor in Foucault's description) sees when they observe the patient. Foucault suggested the nature of the gaze and how the patient was perceived, changed over the years. What was observed by the doctor, in relation to the patient, could alter depending on what philosophy was guiding practice at a particular time (Krips, 2010). According to Foucault, the clinical gaze enabled disease to be viewed from a new perspective, which changed the course of medicine and healthcare (Foucault, 1963/2003; Lachman, 2013). However, this development of the clinical gaze changed the health practitioner/patient relationship by emphasising the importance of the health practitioner's view over and above that of the patient; thus, arguably, providing the medical practitioner with a greater balance of power (Krips, 2010). Health practitioners were able to use knowledge, from their perspective and

years of training, to assess and diagnose, which then guided treatment for the patient. This was considered a positive move forward by those in medical practice. However, despite the improvement of care for some patients, others problematised the 'gaze' to signify increased medicalisation and less focus on the individual needs of the patient (Fendler, 2010; Lachman, 2013). The concept of problematisation emerged in Foucault's later texts when he asserted this term presented a broad account of his analysis of historical conditions of possibility (Foucault, 1986).

Unmasking problematisations

The concept of problematisation focuses on the "problematic conditions of possibility that both motivate and constrain the elaboration of responsive practices" (Koopman & Matza, 2013, p. 827). Furthermore, Foucault (1986) stated that although problematisation is an object that illuminates that which is hidden, it may also make something constructed as ordinary more problematic. Similarly, Foucauldian methodology asserts that 'becoming problematic' is something that shifts over time, meaning any area of health practice will be problematised at some point as it is a function of discursive shifts.

Foucault suggested problematisation is the intersection of discourses that create tensions between power and knowledge thus exposing practices that could be construed as being problematic (Cooper & Blair, 2002). Foucault (1984/2006) rationalised problematisations at the intersection of discourses as "not an effect or consequence of a historical context or situation, but is an answer given by definite individuals" (p. 16). Aspects of caring touch have historically been problematised and continue to be so, as outlined in Chapter One. However, problematisations should not necessarily be viewed in a negative sense, as they may be the catalyst to enable easing of tensions by the emergence of solutions (Koopman & Matza, 2013). Furthermore, the concept of problematisations is often linked closely to notions of truth on a given topic. In this thesis, problematisation are shown in the constructions of caring touch where the taking up of certain subject positions provides opportunity for conflict. This is particularly evident when a certain behaviour or group of people is identified as being problematic as may be shown, for example, in the actions of health practitioners caring for patients.

Notions of truth

Throughout Foucault's writings on power, knowledge, and the subject, he contended that truth is an event that takes place in history. He suggested that truth is something that

'happens' and is shaped by a variety of techniques he called 'the technology of truth' (O'Farrell, 2007). Foucault (1997) stated:

> How is it that in Western Christian culture the government of men demands on the part of those who are led, not only acts of obedience and submission but also 'acts of truth', which have the particular requirement not just that the subject tell the truth but he tell the truth about himself, his faults, his desires, the state of his soul and so on. (p. 81)

Foucault was at times accused of being nihilistic, suggesting he took the philosophical stance that there is no basis on which someone can deem something as true (Fendler, 2010; Lamb, 1995). However, Foucault's philosophy does not assert there is no such thing as the truth. Rather, he wanted to understand how people make rules for deciding what is true and what is false (Fendler, 2010). He referred to this as 'games of truth' (Foucault, 1972/1980). Initially, Foucault referred to games of truth as being associated with coercive practices (Nilson, 2016), but he later shifted this meaning to practices of self-formation of the subject (Fornet-Betancourt et al., 1987). My study sought to explore the truths of the participants and how these played out in the constructions of caring touch throughout their practice. Garratt et al. (2013) suggested that moments of crisis in one specific area of social discourse, have the effect of spring-boarding into other aspects of social and professional life. The consequence of this is that those who are subsequently affected create a discourse that is accepted and functions as truth: referred to by Foucault (1972/1980) as "general politics of truth" (p. 131).

During one of the last interviews Foucault gave prior to his death in 1984, he spoke about his concern that western culture was obsessed in the search for truth. Foucault believed this need to find the truth was at the exclusion of other aims and purposes. One of the most important messages to grasp from Foucault's genealogical studies is the notion that nothing can lay claim to being, "a defensible truth that exists independently of its construction in social practices" (Springer & Clinton, 2015, p. 90). Foucault argued that we should never assume we have reached a point where we have discovered the final truth about a topic of interest (Mills, 2003). By doing so, we limit the development of knowledge. Hence, when varied but significant accounts of a topic are selected and brought together, they have the opportunity to conspire and produce insights of knowledge and potential 'truth' (Garratt et al., 2013). Such aspects of truth may be regarded as a product of the "effects of power" (Foucault, 1978/2000e, p. 132). When observing truth through a Foucauldian lens, the topic of touch may identify itself through various guises. That is, the subject of touch will have "several pasts, several forms of connection, several hierarchies of importance, several networks of

determination, several teleologies" (Foucault, 1969/2002, p. 5). As such "discourse must not be referred to the distant presence of the origin but treated as and when it occurs" (Foucault, 1978/2000e, p. 28). Notions of truth was an important consideration during the analysis of the data in this study.

Summary

This chapter has provided a background into the philosophy underpinning this study and has described the epistemology of poststructuralism as located in this thesis. Whilst challenging to accurately summarise and pay respect to his work, I have provided a broad overview of Michel Foucault's theoretical notions that underpin my analysis and, which I draw upon throughout this thesis. By offering this overview I do not wish to minimise or define the limits of Foucault's breadth of work; rather, I have addressed the concepts drawn upon and important to this study. Using these concepts, I aim to explore the topic of caring touch in health practice.

The following chapter positions touch in the context of this thesis by presenting the literature that illustrates the multiple and intersecting constructions of human touch.

Chapter Three: Touch in Context

Introduction

Throughout this study, caring touch is considered as an object of knowledge, constantly constituted in and transformed by discourses (Foucault, 1969/2002). The purpose of this chapter is to present the discourses constructing touch as identified in academic literature. It does not seek to generalise the academic literature on caring touch, nor was the intent to involve a systematic search. Additionally, there is no suggestion that the information can be replicated for use in other reviews as this is consistent with Foucault's notion of truth. Rather, this chapter draws on literature across many decades, from seminal work to more current studies. In doing so, I will show the shifts in understandings that highlight the various constructions of touch, particularly the various 'truths' that have emerged relating to caring touch in health professional practice. Rather than deconstruct these 'truths', the intention of this chapter is to explore the conditions of possibility constructing caring touch and prevailing at particular times. By presenting potential 'truths' I offer context for the reader and provide justification for implementing a poststructural approach to this study.

Although there was a volume of research on touch evident in the literature, there was a lack of qualitative approaches to the topic in the published literature. The more quantitative studies tended to focus mainly on procedural touch measuring physiological outcomes. The qualitative studies that did focus on caring touch were largely atheoretical with a small number only examined through a hermeneutic phenomenological or ethnographic lens.

A comprehensive search of the available literature revealed no post-structural studies exploring caring touch in health practice, identifying a gap in the literature. An absence of poststructural studies encouraged me to pursue this approach to add to the literature and to open up alternative viewpoints pertaining to human touch.

Although the focus of this thesis is centred on constructions of caring touch, this is an act that forms part of the wider concept of caring. As such, I open this chapter with an introduction to the ways caring is constructed broadly in the health care arena. I then present an insight into touch as it is manifested broadly including other modes of touch, particularly procedural touch.

In this chapter, I suggest that although caring touch has been constructed as valuable to health and well-being, conversely, its appropriateness has been contested, particularly in the sense of professionalism, and its effects have been problematised. The literature examined is gathered from an extensive search of international sources. I began by specifically searching for

literature that provided insight into constructions of caring touch in health practice. However, it quickly became apparent that studies did not always differentiate between types of touch, and that caring touch was conceptually merged with other forms of touch used in health practice. This was perhaps understandable given a significant part of practice requires health practitioners to use procedural touch (i.e., touch, to carry out a task). In contrast, and of interest, were the studies that placed emphasis on caring touch; although many of these came from professional literature in psychology, psychotherapy, and teaching where, in theory, work can be carried out without procedural touch.

I used multiple data bases to compile this review. CINAHL Complete, AMED, Cochrane, Medline, and Google scholar. Key words/phrases included: caring touch, comforting patients in distress, touch in health practice, touch in nursing, caring in paramedicine, touch in medicine, touch in midwifery practice, touch in professional health practice, caring in health practice, negative touch, lack of touch, policies around touching, and problematic touch in health care. The diverse phrases relating to various aspects of touch resulted in a vast number of articles in the search results. Although the literature search spanned over 50 years, from the 1970s to present day, significant in this search were the number of studies that were published in the 1980s when there was renewed interest in the subject. This was possibly due to the amount of media coverage investigating the detrimental effects of lack of caring touch on children and, acts of touching as problematic (see Chapter One).

Literature that linked to touch outside the field of health or presented research on harmful touch that had detrimental effect, such as domestic violence, was excluded as not relevant to this study. Initially I set no parameters on the specific years I searched. By doing so, I was able to ascertain if and when shifts in the constructions of touch had occurred. Towards the end of my study, I returned to this review and focused on the last 5 years to ensure I had maintained currency in the literature.

The following sections outline how knowledge of caring and specifically caring touch has been constructed in the academic literature, particularly as it constitutes possibilities of caring touch for health practitioners. The constructions of caring touch that follow are discursive constructs represented in the literature and explore some of the conditions of possibility that construct what is thinkable and doable and understood as 'true' about caring touch.

Caring in health practice

The ability to care is constructed as a universal human attribute that people demonstrate towards each other (Boykin & Dunphy, 2002). Caring for others is a discursive practice woven

throughout health practice and is the foundation upon which its principles are founded (Adams, 2016).

> One of the essential qualities of the clinician is interest in humanity; for the secret of the care of the patient is in caring for the patient (Peabody, 1927, p. 882)

Although the above quote may resonate with many people, what caring means, and to whom, is complex. This is of particular interest in health professions where, arguably, caring remains central to practice. Blasdell (2017) suggested caring constitutes many meanings, making a universal definition impossible, supporting the Foucauldian notion that multiple realities and truths exist at one given time (Foucault, 1972/1980). Whilst it may be 'impossible' to define caring, it is pertinent to explain how I situated the meaning of caring for this study.

Adams (2016) stated that the essence of caring "transcends the material and phenomenal world" (p. 2), ensuring its meaning is contested and complex across both health practice and wider society. Nevertheless, I draw my notion of caring from Madeline Leininger and Jean Watson, nurses who spent much of their career in health care ruminating what it means to demonstrate caring. Leininger (1988) developed her own notion of caring and defined caring in the generic sense as "those assistive, supportive, or facilitative acts towards or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (p.900). She considered professional caring as learned systems and practices bounded by biophysical and psychological dimensions that produce a holistic approach to care (Blasdell, 2017). Jean Watson (1979), stated caring is both an art and a science, where the fragile balance between scientific knowledge and humanistic behaviours merge in complex interactions.

Other writers take a less broad approach to caring. Good and Good (1993) stated that caring in medicine places focus on the non-technical aspects such as relationships and emotions, "a common-sense language of interpersonal engagement, not a language of knowledge and facts" (p.92). Throughout the 1990s several writers suggested caring was becoming less of a focus in healthcare, being dominated by increasing technological advancement (Barker et al., 1995; Farmer, 1992; Thorne et al., 1998). More recently, MacLeod (2011) stated writers such as Goldenberg (2006) suggest acts of caring are considered the 'softer' side of health care, deemed of lower importance in terms of curricula, or an "add-on that is nice to do" (MacLeod, 2011, p. 380). These latter proposals of the meaning of caring appear to disregard the possibility of caring being defined as conducting an assessment and administering subsequent treatment. Rather, they position caring external to these 'primary' acts. As a consequence,

notions of bioscience have become the gold standard against which other knowledge is compared, and discourses of caring, when constructed in this way, are considered as being of secondary focus, despite being recognised as valuable to health practice (Adams, 2016).

Burstein et al. (2022) stated there are multiple contradictions and lack of consensus across concepts of caring; meaning, a unified concept is yet to be acknowledged and the interaction of discourses will ensure that aspects of caring such as caring touch will always be contested (Swanson, 1993). Similarly, Blasdell (2017) stated that only through understanding epistemology and philosophical underpinnings can we really appreciate all perspectives, suggesting different levels of caring can occur between different health practitioners and in different contexts. However, in order to situate the focus of caring for this study, I have chosen to draw on the notions of caring from the ideas posed by both Watson and Leininger stated above. Their notions of caring are a suitable 'fit' not only for nursing, but the other three health professions that comprise the participant groups – medicine, paramedicine and midwifery. Leininger (1988) stated caring is a "learned humanistic art and science that focuses upon personalized care behaviours, functions and processes directed toward promoting and maintaining health behaviours or recovery from illness" (p. 901). It is through this statement that I situate the concept of caring for this study. I continue this chapter with the focus specifically on caring touch and its potential in health care.

Caring touch constructed as essential to wellbeing[2]

Notions of wellbeing appear to proliferate throughout media reporting and discussions pertaining to health. In Western society, measures of well-being capture dimensions of standards of living, physical and mental health, aspects of spirituality, and general happiness (Lambert et al., 2020). Wellbeing, therefore, is a multidimensional set of concepts traversing the age spectrum that are not able to be reduced to one single aspects of living (Stevens & Jarden, 2019). Universal throughout the available academic literature is the importance of supporting the multiple facets of wellbeing, one of which I suggest is caring touch.

Literature across the lifespan presents a discourse whereby the ability to access caring touch is significantly important to the wellbeing of people, suggesting people are adversely affected if they do not experience positive forms of caring touch throughout their lives (Beckett et al, 2006; Takeuchi et al, 2010). Since the work of John Bowlby in 1969 drew attention to the effects of attachment between parent and child, there have been continuing connections

[2] In the context of this thesis wellbeing is a holistic term acknowledging that health comprises several principles including, physical, spiritual, emotional, social, and economic.

made that link a human's ability to survive and thrive to positive and welcomed physical contact. The discursive construction of caring touch as essential to survival converges with the literature on caring touch within health professional practices where caring touch is constructed as important for wellbeing.

With a significant body of research espousing the connections between caring touch and wellbeing, it also follows that in a situation where wellbeing is being supported (e.g., while under the care of a health practitioner, acts of caring touch may be useful). Across the health, anthropological, and sociological articles that were included in this review, the construction of caring touch as complementary to good health and wellbeing was so dominant that there was little to contest it. Most of the literature on this topic linked to physical health reported on studies that explored the effects of touch on the recipient. In all cases, this was a patient in a hospital or other clinical setting. The most dominant construction of caring touch in health practice studies is as considerably beneficial, reporting correlations between physically touching a person and numerous positive effects. Situations where acts of caring touch are reported to demonstrate benefits include the recovery of hospitalised patients (Airosa et al., 2013; Bush, 2001; Chang, 2001; Currin & Meister, 2008; Henricson et al., 2006; Routasalo, 1999); the physiological and psychological development of babies and children (Bellieni et al., 2007; Field, 2014); assisting people in pain (Airosa et al., 2013; Currin & Meister, 2008; Estabrooks & Morse, 1992; Field, 2010; Smith et al., 2002); and comforting people nearing the end of their life (Bush, 2001; McCann & McKenna, 1993). Within this literature, the act of physically touching is constructed as caring touch, a phenomenon that has a much deeper meaning, going beyond the simple act of one person laying their hand on another. It is seen as a way of conveying respect and channelling positive feelings between people to create the feeling of comfort (Chang, 2001; Kearney, 2021).

To look at this phenomenon in more depth I have selected two specific areas of academic literature on caring touch that were dominant in the literature. These areas were chosen as they are particularly relevant across the working contexts of all four categories of health practitioners interviewed for my thesis. These comprised studies that explored the effects of caring touch on infants, and caring touch focused on pain, stress, and anxiety.

Caring touch as beneficial to infants' development

The literature presented in this section focuses on studies where touch has been defined as caring, comforting touch, used to show compassion, and initiate positive physical changes in the body. Given the challenges of communicating with participants in this age group, the

studies identified in this review based their findings on quantitative objective outcomes relating to infant health. The majority of the literature on pre-term infants came from areas of neonatal and paediatric medicine, and also a small number of studies on behavioural psychology. Studies on pre-term infants suggested when caring touch was able to be given to these vulnerable babies the responses were very favourable (Field, 2014). For example, early studies purport finding infants who experienced caring touch whilst in hospital were developmentally, physiologically, and behaviourally advantaged. They showed increasingly stable heart and respiratory rates, greater catecholamine excretion, and experienced a shorter length of hospital stay (Field et al., 1986; White-Traut et al., 1993; White-Traut & Tubeszewski, 1986). Likewise, Modrcin-Talbott et al. (2003) examined the effects of what they referred to as gentle human touch on the physiological and behavioural reactions of infants of 27 to 32 weeks gestational age, reporting several positive effects such as a decrease in behavioural stress cues, weight gain, heart rate and oxygen saturation stability. Similar findings were reported on full term babies (Gordon, 2010).

Several studies argued the importance for nurses and doctors to understand the effects of caring touch on pre-term infants as an effective intervention to promote overall growth and development, and similarly they need to acknowledge the uniqueness of infants' behavioural and physiological cues (Modrcin-Talbott et al., 2003; Moszkowski et al., 2009; Smith, 2013). Although the dominant construction of touch was caring touch as essential to well-being, there were studies that challenged this construction. Based on physical measurements such as tachycardia, bradycardia, hypoxia and tachypnoea, which are all suggested to be indicators of ill health, it has been proposed the stimulation from caring touch could be distressing to pre-term infants (Ardiel & Rankin, 2010; Modrcin-Talbott et al., 2003).

Of significance to all the studies was the importance of the pressure used when touching the infant. Most studies were randomised controlled trials and used one of two techniques, a) Gentle Human Touch (GHT), and b) Field massage (Asadollahi et al., 2016; Harun et al., 2021; Pourazar et al., 2018). GHT is a technique whereby one hand is placed on the forehead of the infant and one on the lower abdomen. Field massage comprises three, 5-minute massage phases using the tips of the fingers, with a progression of the techniques over several days (Asadollahi et al., 2016). The majority of studies agreed that touch was crucial for premature and full-term infant growth and development, providing opportunities to enhance both recovery time and overall wellbeing.

Recent decades have produced a significant number of quantitative studies focusing on the importance to both mother and baby of early skin-to-skin contact (Cascio et al., 2019; Cekaite & Goodwin, 2021; Davis et al., 2017; Elkiss & Jerome, 2012). Skin-to-skin contact refers to a baby being laid directly onto the mother's chest as soon as possible after birth for at least one hour. This initial touch in the hour following birth is deemed an essential contribution to infant wellbeing supporting an array of physical and developmental benefits such as increased stability of the cardio/respiratory functioning, a decrease in salivary cortisol and stability of body temperature (Moore et al., 2016; Vittner et al., 2018; Widström et al., 2019; World Health Organization, 2020). As such, skin-to-skin contact has been reported as being part of standard practice at births in Aotearoa New Zealand whenever possible (Ministry of Health, 2022; Te Whatu Ora, 2022).

Caring touch as beneficial in reducing stress, anxiety, and pain

Stress and Anxiety

Literature gathered and analysed on the topic of stress and anxiety is another example of where caring touch is overwhelmingly discursively constructed as of benefit, particularly in the hospital setting. Although the studies came from a variety of clinical professions, they were most numerous within fields of mental health. However, given that all the practitioner groups in this study will work with patients who are experiencing stress and/or anxiety, it is of interest to explore the academic literature.

The physiological effects of stress and anxiety on the body are well documented (Cohen et al., 2015; Kivimäki & Steptoe, 2018; Marieb, 2015). Short-term stress increases the hormonal release of cortisol and adrenalin, which increases heart rate, blood pressure, and other metabolic activities. Long-term exposure to stress and anxiety has the potential to suppress the immune system. This may lead to propensity for physical ailments as the body has reduced capacity to protect itself (Marieb, 2015). Consequently, acts that are able to reduce the effects of stress and anxiety are of long-term benefit to wellbeing.

Psychotherapy and mental health nursing offer an alternative perspective to touch than the more physically engaged health practices because when working with patients experiencing mental health issues there is no practical necessity to engage in physically touching them (i.e., no procedural touch is required). However, the issue of touch for wellbeing is still prominent. Salzmann-Erikson and Eriksson (2005) reported on a small qualitative study interviewing patients who had been treated for psychosis. The patients reported that caring touch provided a means of comfort, support, and connection. Although the desire for physical contact was

more intense when these patients were experiencing distress, staff both in the hospital and the out-patient clinic did not initiate caring touch with the patients (Salzmann-Erikson & Eriksson, 2005). This disconnect and tension between the academic literature that supports caring touch as assisting wellbeing, and concerns relating to physical acts of caring touch to show support, are of importance to my analysis, and I return to them later in the review.

Literature focusing on the hospital and clinical environment articulated the merits of using caring touch to reduce stress (Davin et al., 2019; Elkiss & Jerome, 2012; Lecat et al., 2020; Papathanassoglou & Mpouzika, 2012). From the patient perspective, the process of hospitalisation has been identified as extremely stressful where the need to accept prognosis, treatment, and intervention can raise stress levels and increase anxiety, having negative consequences on the wellbeing of patients (Williams, 2001a). Nist et al. (2020) argued the importance of human touch in the provision of critical care nursing, stating caring touch provides both physiological and psychological benefits. Reduction of the stress hormone cortisol was demonstrated in multiple studies across the age span when caring touch was incorporated into patient care (Asadollahi et al., 2016; Bales et al., 2018; Dreisoerner et al., 2021; Morrison, 2016). Using an experimental design, Dreisoerner et al. (2021) analysed the results of 159 participants who received hugs as a mechanism for relieving stress. They found that receiving touch in the form of a hug was a simple yet powerful means to reduce stress; but suggested the relationship with the 'hugger' is an additional factor yet to be analysed in depth.

Caring touch as pain relief

Engaging in touch to reduce pain has been studied across many decades (Mancini et al., 2014). Much of this research is quantitative and sourced from the area of neuroscience. Recent research has placed focus on C-Tactile afferent sensory fibres found in human skin where hair is present. These C-Tactile afferents are activated by slow stroking of the skin, something termed 'affective touch' (Di Lernia et al., 2020; Liljencrantz et al., 2017; McGlone et al., 2014).

Contemporary qualitative studies exploring mechanisms of touch to aid pain were limited. One content analysis study from Sweden with older adults suggested that gentle touch was useful in reducing chronic pain, and facilitated positive relationships (Stöckigt et al., 2019).

Di Lernia et al. (2020) stimulated the C-Tactile afferents of 60 participants with chronic pain and showed the potential for stimulation to reduce levels of pain. Similarly, Liljencrantz et al. (2017) employed an experimental design to quantify the effect of slow stroking on 44 participants experiencing pain generated by heat. Using a State Anxiety Questionnaire,

participants reported less anxiety, increased calmness, and a reduction in pain. Positive findings were also reported in studies by López-Solà et al. (2019) and Goldstein et al. (2017), but in these studies touch was provided by a person emotionally connected to the participant, such as a partner. Although findings demonstrated a reduction in pain the authors acknowledged the potential influence on final results of the emotional connection between the two parties engaging in the touch.

Studies such as these provide a snapshot of the numerous ongoing explorations of using touch to reduce aspects of pain. Although these studies are of interest in understanding the role of caring touch in health practice, significant for my study is acknowledgment that the type of relationship between the patient and health practitioner may be a factor in enabling acts of caring touch to be most beneficial.

Caring touch as not part of standard practice

As previously stated, a plethora of studies suggest that in the presence of illness, stress, anxiety, and pain, caring touch may provide comfort, trust, and analgesia. However, MacLeod (2011) suggested caring touch is often constructed as an additional form of treatment rather than a core element. For example, Airosa et al. (2013) suggested caring touch is a highly beneficial act, but they considered it complementary to standard processes and procedures rather than a vital component. The authors justified this suggestion by prioritising the examination and treatment of patients. It appears there is not an obvious argument for the placement of caring touch in health practice, where it is often constructed as an adjunct or simply taken for granted as part of some types of practice, perpetuating the concept of the mind-body dichotomy. Exploring these discursive constructs of caring touch suggests yet another level of complexity navigated by health practitioners.

The place of caring touch in health professional education.

Given the significant number of empirical studies that acknowledge the benefits of using caring touch in health practice, it was of interest to explore how the academic literature addressed caring touch in health professional education and particularly how its inclusion, or not, is constructed discursively.

Drawing on constructs of caring touch in health practice as being beneficial, Nicholls (2012) stated, “It is imperative that people working in the health care and disability support sector have a sound appreciation of the power and importance of touch” (p.195). Modrcin-Talbott et al. (2003) made a call for the “global issue of touch be redirected, and nursing care re-centred, upon loving, interactional touch versus the procedural, reactional touch that is the standard

operating procedure…" (p.66). In support, many of the later studies I located suggested that undergraduate and postgraduate health programmes should incorporate the effects of caring touch and teach touch interventions in a systematic way, intimating there had been no significant change in the education of health practitioners regarding caring touch in recent years (Davendralingam et al., 2017; Davin et al., 2019; Harding, 2008; Kelly et al., 2018; Keogh & Gleeson, 2006; Papathanassoglou & Mpouzika, 2012; Schimidt & Silva, 2013; Verghese, 2009).

Davin et al. (2019) stated the concept of caring touch in health practice was rarely mentioned in health professional education textbooks. This may be significant given a textbook, as a compulsory resource for students in health professions, has potential to legitimise certain knowledge and practices. The absence of touch as a topic in many texts suggests touch is marginalised as a topic worthy of inclusion. Furthermore, although much of the academic literature constructs caring touch as a topic important to integrate into the training of health practitioners, this position does not translate into explicit education on the benefits of caring touch in health professional curricula (Davin et al., 2019). With the exception of midwifery training in Aotearoa New Zealand, other aspects, such as processes and procedures of practice, dominate, and, consequently, caring touch continues to be largely marginalised in the education of most health practitioners (Hofmeyer et al., 2018; Norris & Wainwright, 2022). Discursively, although there is support for caring touch as important to patient wellbeing, it is generally constructed as not necessary.

Aside from the exclusion of caring touch as part of a curriculum, more broadly, health practitioners construct acts of caring touch through their educational experience and continued practice. It is the broad discourses prevailing during these experiences that may enable or constrain caring touch in practice. Exploring the ways caring touch was constructed in educational contexts and engaged in across different health disciplines was, therefore, of interest to this study. The next sections discuss health care and the discipline constructions of 'caring'.

The health practitioner as caring

Within the literature, it is the nurse who is constructed as the health practitioner most apt and able to offer care (Adams, 2016; Karlsson & Pennbrant, 2020; Nursing Council of New Zealand, 2021; Pedrazza et al., 2018), whilst literature presenting other practitioners as caring remains

vague (Paley, 2001). Such is the dominance of this discourse for nurses that I focus the following section on the nurse practitioner[3].

Nurses as caring

There is a discursive construction in the Western world where a consistent message suggests the primary motivating factor drawing people into the nursing profession is the desire to care and nurture others (O'Connor, 2015). Lukose (2011) stated "nursing is caring science… human beings are connected to each other through the caring process" (p. 27). Nursing emerged as 'women's work' in the 19th century. Women chosen to be employed as nurses were sourced from working class or immigrant groups because, as Zelek and Phillips (2003) explained, women from this position in society would be more likely to carry out nursing duties without challenging authority. Additionally, Tasker and Higgs (2014) proposed the apparent second-class status of women in nursing was a result of the assumptions founded on a reductionist sociobiological model of gender role differentiation. This model suggested the maternal nature of a woman meant they possessed emotional and caring qualities absent in men who were constructed as more rational, scientific, and decisive (Pedrazza et al., 2018; Porter, 1992). Arguably, if this gendered construct persists, it may affect the ways in which people engage in acts of care, and the societal expectations of how acts of care can be played out.

Media commentary from the 1990s particularly, proposed nurses were the profession most likely to be tasked with the act of caring touch (Clapham, 1992; Gullo, 1998). This construction of the nurse was endorsed in an ethnographic study by Bottorff (1993) who suggested acts of caring touch from a nurse supported patients to cope with illness. Similarly, findings from a descriptive mixed methods study by Adomat and Killingworth (1994) identified caring touch assisted with reassurance and comfort. A phenomenological study exploring the patient expectation of nursing care by Davis (2005), stated that although caring touch is not expected by patients, it is appreciated as an element of good practice. Sørlie et al. (2006) suggested "the way they [nurses] talk to them [patients], how they can give the patients a friendly or encouraging pat on the shoulder, are as important to the patients as is the professional, medical care they experience" (p. 1242). Consequently, caring touch is generally constructed

[3] Although midwives in Aotearoa New Zealand work independently and are considered completely independent from other health professionals, this is not so internationally. Outside the Aotearoa New Zealand context, many nurses who choose to focus on obstetrics work with a team led by an obstetrician, and as such do not take up the title of midwife. Therefore, I posit the international literature may combine its definition of the nurses to also include midwives.

as an essential component of nursing care, providing the main behavioural mode to give comfort, and acting as a mechanism to convey empathy and understanding about how the patient is feeling (Chang, 2001).

In the 1980s and 1990s caring was argued as something distinctive to the domain of nursing, not expected by other health professionals (Morse et al., 1990; Yam & Rossiter, 2000). These studies did not suggest that other health practitioners do not demonstrate caring as part of their practice; rather, that the emphasis of caring was constructed as being more closely aligned to the role of a nurse. More recent decades have witnessed a shift in the construction of the professional nurse and their role in patient care, and there is a suggestion that care is no longer central to nursing practice (Chitty, 2007; Lemermeyer, 2022; Piscotty Jr. et al., 2015). Nevertheless, I suggest where gendered and societal discourses of caring converge with the discursive construct of the nurse, actions of caring touch may be legitimised, anticipated, perhaps expected, and unquestioned by patients.

Context of caring touch relationships

Literature suggests the development of a relationship between a health practitioner and their patient is something important to establish before the valuable effects of caring touch can occur (Cronfalk et al., 2008; Durkin et al., 2021; Suvilehto et al., 2015). The dynamic relationship between a health practitioner and a patient, however, is complex and is produced within multiple discursive constructs. In most interactions between the health practitioner and the patient, the patient is constructed as the vulnerable party, where the mere presence of a health practitioner in a room can result in the patient being susceptible to feelings of disempowerment (Blee & Dietsch, 2012; Harrison, 2018). Other studies contest this view, suggesting the patient is an equal in the relationship, where active participation in decision making pertaining to their treatment and empowerment through increased knowledge are common emerging themes (Agner & Braun, 2018; Deledda et al., 2013; Greene & Hibbard, 2012). The complex interactions suggest power relationships in play between patient and practitioner, where the integration of caring touch within this dyad could be challenging. However, many studies propose that when trust is forged in the relationship between the patient and practitioner, it assists in creating an environment where caring touch can be used most beneficially (Adams, 2016; Chang, 2001; Cronfalk et al., 2008; Gleeson & Timmins, 2005; Suvilehto et al., 2015). Benner (2004) writes of a “disclosive space” (p. 349) created by the relationship between the patient and practitioner, where reassurance and trust are enacted and where touch is deemed safe. Conversely, some studies argued many health practitioners shy away from using caring touch as a way of reducing an emotional connection with the

patient (Kruijver, Kerkstra, Bensing, et al., 2000; Pedrazza et al., 2018). All of these findings demonstrate there are multiple constructions of caring touch in play for health practitioners, some offering opportunities and some constraints.

Having articulated how concepts of caring are constructed in health literature, I turn to concepts of professionalism and how the notion of being part of a profession plays out in the health practices that were integral to this thesis. The inclusion of the following section is designed to provide context to the role of a health professional. In doing so, readers of this thesis external to Aotearoa New Zealand are able to situate the four groups of health practitioners taking part in this study accordingly.

Professions and professionalism

Until the 19th century, the only occupations deemed professions were law, medicine, and theology (Malatesta, 2010; Nicholls, 2022; Švarc, 2016). Subsequently, these three professions became the reference points by which further professions were defined (Nicholls, 2022; Williams et al., 2009). In the last century, more occupations in the health sector have been awarded this status such as physiotherapy and podiatry, although Freidson (1985) suggested the transitions to professional standing in health were at the behest of the dominant medical profession who bestowed professional status accordingly.

There are a number of characteristics that have come to define a profession, and although variations abound, there is a general consensus that the hallmark is one that has a code of ethics, specialist knowledge, scope of practice, and the ability to regulate itself (Halldorsdottir & Karlsdottir, 2011). Although the stated characteristics provide a generic understanding of a profession, similar to the challenges of defining caring stated earlier, Evetts (2013) suggested that attempting to reach a consensus on one definition is now regarded as a wasted effort as there are an infinite number of possibilities reflecting different discourses about what constitutes a profession. Nevertheless, Saks (2012) argued that in terms of knowledge and area of expertise, defining a profession is "not a pointless exercise" (p. 1), and is actually at the root of understanding the role of professions and how they operate.

Having no unified agreement about what it means to be a professional or what is professionalism supports the suggestion that discourses continually compete and shift focus (Foucault, 1977/1995; Reed et al., 2019). However, in terms of health practices, several authors suggest there is a dominant discourse that signals a professional as someone who is technically competent and has capacity for making decisions based on a specific context

(Birden et al., 2014; Koch, 2019; Saks, 2012). There is also the proposal that health professions have their understandings of practice embedded in science (Cruess & Cruess, 2008; Hendelman & Byszewski, 2014; MacLeod, 2011).

Whilst it is not the aim of my study to give a detailed historical analysis of professions and professionalism, by providing a brief overview my intent is to show the changing constructs, and thus convey Foucault's (1977/1995) notion that things do not remain static.

The health professional

Liaschenko and Peter (2004) suggested the social construction of a health professional includes being the holder of a unique body of knowledge, autonomy in work, and a selfless service to the communities in which they serve. Additionally, Evetts (2013), Saks (2012), and Williams et al. (2009) stated the attributes of a professional include trustworthiness and altruism. However, within health care, where there are similarities in practice, what constitutes a profession is unfixed. Such challenges are possibly due to health care being a moving entity that is never set, with changing perceptions and multiple interpretations of health and technology (Evetts, 2013; Nancarrow & Borthwick, 2005).

Similarly, there is debate between what renders a profession as different to an occupation. Although Evetts (2013) suggested drawing a line between a profession and an occupation is not important, the difference between these two terms is contested in the academic literature (Garcia & Barbour, 2018; Timmons et al., 2014). However, when a societal discourse constructs professionals as having expert knowledge, this classification brings with it the promise of status (Barbour & Lammers, 2015; Garcia & Barbour, 2018; Timmons et al., 2014). This notion is supported by Black (2017) who stated professions evolved from occupations when a specialised programme of learning legitimised its societal status. In health, this status demonstrates professions are acknowledged as having the insight and significant skills with which to do good. If this is so, it may explain why careers such as nursing and paramedicine, have strived for the professional status they now occupy.

Nursing as a profession

Constructs of the professional nurse have undergone several iterations. Historically, nursing was constructed as a vocation or calling, where a variety of social factors shaped the ways it situated itself, in particular, being subordinate to doctors (Freidson, 1985; Nelson, 2000). Florence Nightingale considered the nursing profession as equal to, rather than subordinate to, the medical profession, but the male dominance of medicine strongly influenced the image and position of nurses who were predominantly female (Black, 2017; Hoeve et al., 2014). It

was not until the mid to late 20th century that nursing as a career became accepted as a profession (Gage & Hornblow, 2007).

In 1901, New Zealand became the first country in the world to have registered nurses, under the Nurses Registration Act, and in 1909 the New Zealand Trained Nurses' Association was founded (DeLaune et al., 2019). Following years of training nurses through the hospital system, in the 1970s, training was transferred to the tertiary education environment where nurses undertook academic studies. The transition into tertiary educational training witnessed a shift in nursing, where the nursing community and others began to strive towards its recognition as a profession (Liaschenko & Peter, 2004). In pursuit of the goal for professional recognition, nurses made the argument that in applying their knowledge through clinical practice for the improvement of others, it made "nursing a discipline and its practitioners, professionals" (Martinez, 2021, p. 83). Nurses in New Zealand have since secured their place in the Health Practitioners Competence Assurance Act (2003) as a recognised health professional.

Professionalism in nursing has been studied in depth (Black, 2017; Poitras et al., 2016), and whilst there has been a shift towards a more biomedical and technical model of care, the intrinsic essence of the professional nursing discourse continues to be holistic. As such, a person is constructed as a 'whole' where an attempt is made to meet social, spiritual, physical, and psychological needs including acts of compassion and aspects of care that may include caring touch (Black, 2017; Chinn et al., 2021; Halvorsen et al., 2008).

Medicine as a profession

As one of the earliest occupations classified as a profession, doctors have been constructed as trustworthy 'pillars' of a community and the holder of important knowledge (Birkhaèuer et al., 2017; Jacobsen & Lindqvist, 2009; Petrocchi et al., 2019). Prior to World War II, many doctors worked as self-employed practitioners who, at times, referred patients to hospitals where they were cared for by nurses and other allied health professionals (Karazivan et al., 2015). Under this system doctors were a dominant profession and, guided by discourses based on evidence-based objective science, gave direction to other health care 'workers'. (Freidson, 1985; MacLeod, 2011). Lacking the struggle of other health practitioners to gain professional status and having an exclusive licence to practice medicine, prescribe medication, and admit people to hospital, doctors were gatekeepers of access to health care, holding the monopoly on health services (Karazivan et al., 2015). In more recent times, as doctors work interprofessionally with other health professions, arguably their dominance in health practice has lessened (Coburn, 2006). With continued acknowledgement of the need for doctors to

work in partnership with patients and colleagues, where respect and monitoring of personal standards are important, the Medical Council of New Zealand made inclusions into guidelines that acknowledge the wider values of being a professional, including practice that encourages effective communication and caring (MacLeod, 2011; Medical Council of New Zealand, 2021).

Midwifery as a profession

The Midwifery Act (1904) is arguably the point at which midwifery was designated a profession. At this time, midwives were usually married mothers from the local community and were constructed as playing a central and valuable role for the families with which they worked (Stojanovic, 2008). Similar to the nursing profession mentioned previously, the midwifery profession encompassed caring for the holistic health of mothers and their babies (Khakbazan et al., 2019). However, in Aotearoa New Zealand, following the passing of the 1971 Nurses Act, autonomy was removed from midwives and, consequently, they worked under medical supervision where a more medical approach to childbirth was taken up. It was not until 1988 with the formation of the New Zealand College of Midwives that midwives began to challenge the role played by the medical profession in their work. Consequently, with the passing of the Nurses Amendment Act in 1990, midwives became autonomous health practitioners where patient and practitioner work in partnership (Guilliland & Pairman, 2010; New Zealand College of Midwives, 2022a). This autonomy provided the opportunity to focus on the natural birth discourse that constructs birth as a normal physiological event, something that may be achieved without significant external intervention (Frost et al., 2006; Walsh, 2007).

Midwives in Aotearoa New Zealand are able to work through a District Health Board or independently as a Lead Maternity Carer (LMC), and they care for women and their families throughout pregnancy and birth (Gilkison et al., 2015; New Zealand College of Midwives, 2022a). Additionally, and unlike most countries in the Western world, the professional role of midwives in Aotearoa New Zealand incorporates continuity of care, something available to all women (Crowther et al., 2022). This refers to a multi-faceted model of care whereby a midwife is the primary health professional caring for a pregnant woman in a partnership that begins in pregnancy, continues through birth, and into the postpartum weeks (New Zealand College of Midwives, 2022a). This model of care provides a consistent experience of care for the woman, and may improve birth outcomes and overall satisfaction (Soltani & Sandall, 2012). This partnership between the mother and midwife encourages a relationship whereby the midwife becomes constructed as a caring and trusted health professional (Lewis et al., 2017).

Paramedicine as a profession

Since the days of stretcher bearers and horse drawn carts used as makeshift ambulances, the rise of paramedicine has most recently undergone a rapid trajectory towards professional status (Williams et al., 2009). During World War I, stretcher bearers were expected to provide rudimentary medical intervention until they could transport the wounded to a higher level of medical support (Wallis & Boyle, 2014). Knowledge gained from these experiences ensured the wounded in World War II received a higher level of care whilst on route to medical treatment (Makrides et al., 2022). These experiences hastened the improvement of emergency care, reduced mortality rates, and thus became the foundation of the ambulance service.

Paramedics now form a key role in health practice and, despite a comparatively small body of research in paramedicine, professionalisation is now a topic of interest (Johnston & Acker, 2016; Williams et al., 2009). In 1994, the first paramedic degree commenced at Charles Sturt University in Australia, followed in 1996 by a similar degree programme at the University of Hertfordshire in England. Similar to nursing, the move to tertiary education and having a profession-specific body of knowledge was acknowledged as a major enabler in legitimising paramedicine as a profession and obtaining full professional status (Makrides et al., 2022). In 2020, paramedics transitioned from semi-professional to professional status and are now recognised as such under the Health Practitioners Competency Assurance Act (2003).

Professionalism in health practice

The previous sections outlined the background of how the four health practitioner groups participating in this study became constructed as a profession. I now link the notion of a professional health practitioner to acts of professionalism. Professionalism is a concept related to the conduct of a profession, the focus of which is a set of specific principles and commitments (Egener et al., 2017). Hodges et al. (2011) suggested that although professionalism has a social purpose of high order, the status of a profession is largely constructed by society, making it a multi-dimensional and complex construct. Studies on professionalism and what it means to be a professional have generated a comprehensive field of work. Much of this work is filled with contradictory constructions because professionalism has particular meaning and significance depending on the field of health practice (Švarc, 2016). This was of interest to the current study as it provided context and enabled participants to speak about their practice in a particular way.

Constructing professionalism

> I do not strive for a clear and unambiguous definition of "professionalism" because I do not believe one is possible. (Erde, 2008, p. 7)

It is the multiple, fluid constructions and complexity of professionalism, and the many contexts in which the concept of professionalism operates, which may explain the difficulties experienced by those attempting to classify and analyse its essence. There have been significant attempts over many decades to define its meaning in health practices. Despite the ongoing discussions, a united definition of what professionalism in the health care professions entails has proved elusive (Birden et al., 2014; Erde, 2008; Koch, 2019; Reed et al., 2019). Kerasidou and Horn (2016) suggested professionalism could be described as a health practitioner's moral compass, but for those wanting a depth of understanding, this simplistic explanation may not suffice. Hodges et al. (2011) suggested the presence of three main discourses dominating the concept of professionalism. The first discourse suggested was characteristics of the individual, observable as "a complex set of cognitive, attitudinal, personality characteristics" (Hodges et al., 2011, p. 357). The second discourse was identified as an interpersonal discourse, where professionalism is constructed or supressed through interactions between people. Consequently, it is contextually determined. The third discourse related to the professional group and its place in society, a key notion being the possible modification of professionalism through the interaction of particular groups. The proposal by Hodges et al. (2011) demonstrated that translating concepts of professionalism across professions and contexts is never going to be straightforward. Whilst there was no intention in this section to proffer one generalisable statement constructing professionalism, this background is offered to consider how or why health practitioners may construct particular acts of professionalism, and what that means to them in terms of acts of caring touch.

Components of professionalism

Alternative perspectives of professionalism produce different views, some of which encompass aspects of power, autonomy, and status (Reed et al., 2019). Hays et al. (2013) suggested the broad content of professionalism in health practice incorporates values; tolerance of diversity, moral, ethical, and legal dimensions; as well as interpersonal skills, accountability, self-awareness, and respect for patients. These characteristics of professionalism are embedded within the councils and registering bodies that set the boundaries of professional practice (Medical Council of New Zealand, 2021; New Zealand College of Midwives, 2022b; Nursing Council of New Zealand, 2021; Paramedic Council of New Zealand, 2020).

As suggested, the challenge of arriving at a consensus for the collective meaning of professionalism in health practice is arguably due to the variety of components that individual professions subscribe to in their practice. However, within the four health practices that formed the basis of this study there were commonalities founded on a code of ethics, scope of

practice, registering body, and specific knowledge base. A professional association and/or licensing body was also characteristic of all these professions, with each group operating under their own autonomy. Additionally, each suggest that health professionals have obligations to maintain a quality of healthcare beyond their profession to the wider communities they serve (Cruess et al., 2002; Patey et al., 2022).

Using the profession of medicine as an example, Hendelman and Byszewski (2014) suggest there is a societal expectation that doctors will uphold the highest of professional standards. Cruess et al. (2002) stated this entails a societal contract whereby the profession is trusted with knowledge about the body, and the self-regulation of this knowledge. There is an expectation, therefore, that with integrity and professional competence, the public good is placed above their own. The Medical Council of New Zealand (2021) stated that trust, respect, partnership, and ethics are the mainstay of professionalism but asserted that care for the patient is the primary concern. This was reiterated in comparable professional bodies internationally (Medical Board of Australia, 2020; Medical Council of Ireland, 2019).

For the health professions related to this study, understanding, implementing, and maintaining standards provided a benchmark by which to gauge acts of professionalism. This was of particular interest to the current study in terms of exploring if notions of professionalism enabled or constrained acts of caring touch.

Touch as sexualised and problematic

This chapter opened with several sections exploring literature in which the discursive constructions of caring touch as being essential to wellbeing was dominant. As such, in most areas of health practice the construction of caring touch as an important and valuable resource is accepted, if not always actioned. Given that one construction of caring touch is essential to wellbeing; I needed to consider wider literature and particularly literature that problematises caring touch, to look at why, at times, it is marginalised and/or constructed as problematic. To explore this notion meant reviewing all modes of touch in health practice, particularly expanding into the literature on procedural touch.

Notions of trust, protection, and dependency are evident in professional and gender discourses that respect the relationship between one human and another when engaging in physical touch. However, within particular cultures and groups, different discourses of touching, and what constitutes appropriate and inappropriate touching compete with one another (Swade, 2020). Furthermore, the heterogeneity of touch makes it problematic, demonstrating complex meanings and blurred boundaries (Ratcliffe, 2012). This produces

uncertainty in the activity of touching another person and the need to engage in on-going reflection and evaluation. This uncertainty is particularly so in the working lives of health practitioners where, for some, acts of any type of touch have become problematised (Cekaite & Goodwin, 2021). Although health practitioners have license to touch, touching is an act where people rethink, reshape, and reinvent their way of touching others on a case-by-case basis, suggesting touch is complicated (van Dongen & Elema, 2001). Of all the senses used in health practice, touch is arguably constructed as the most problematic and open to misinterpretation, suggesting it is a "nuanced and complex behaviour, defying rigid regulatory guidelines" (Davin et al., 2019, p. 560).

Throughout my search and analysis of the literature, it became apparent that it was not until the 1980s that the discourse of touch as problematic gathered momentum and gained the increased attention of Western societies. Subsequently, there was a shift in the academic literature. Constructing touch as a problematic act has since become commonplace, particularly in areas such as education, sport, and psychotherapy (Fletcher, 2014; Fuller, 2016; Jones, 2003; Jones et al., 2013; Lang, 2015; Piper et al., 2013b; Piper & Stronach, 2008). Although the literature in health practice generally continued its focus on the more positive aspects of touch interactions, these conflicted with studies published in the mental health arena, specifically counselling and psychotherapy where, as stated previously, touching the patient was spoken about differently. Professional guidelines for clinical therapists and psychologists recommend abstaining from any physical engagement with the patient, despite feedback from patients suggesting they would benefit from health practitioners enacting caring touch (Berendsen, 2018; Fuller, 2016). The professional guidelines appear to construct the patient as potentially problematic in circumstances where caring touch might be initiated. The suggestion being that a patient in a fragile mental state may misconstrue acts of caring touch from the health practitioner. Caring touch in the field of mental health is layered with uncertain meanings making the engagement of touch with a patient problematic. Consequently, concerns manifest when touch as a modality of communication forms part of therapy (King, 2011; McGuirk, 2012; Swade, 2020; Westland, 2011).

The paucity of studies focusing on touch as problematic in other health practice is arguably due to practitioners having a professional licence to touch. As such, they are somewhat distanced from the shadow of suspicion that may be cast on those outside the professions where procedural touch does not form a necessary part of practice. Conversely, engaging in touch as part of daily practice means these health practitioners may also be at more risk of having acts of touch constructed as problematic (van Dongen & Elema, 2001).

Acts of touch have, in recent decades, seen an increase in media scrutiny and public suspicion, further revealing acts of human touch as having the potential to be problematic. Reticence to touch across genders and between adult and child has been well documented, where concerns of inappropriate touch are frequently cited (Cushman, 2005; Del Prete, 1997; Hedlin & Åberg, 2020; Jones, 2004; Martin & Nuttall, 2017; Piper et al., 2013a). Although the body is considered a privileged element in health care, it is also felt to be a source of problems, unease, and negative feelings (Picco et al., 2010).

Touch from men

A significant number of studies suggest touch is constructed as problematic when it is initiated by men (Baker et al., 2021; DeMayo, 2018; Jamieson et al., 2019; Kronsberg et al., 2018). The reporting of inappropriate and harmful touch may have led to increased surveillance of men during touch encounters (Jones, 2004). As a result, it could be argued that acts of caring touch by men as a positive form of human interaction have waned (O'Lynn, 2007; Sørbye, 2021). The suggestion that men need to monitor their use of touch in daily life has been articulated in numerous studies spanning sport, education, health, and psychology (Cushman, 2005; Fisher, 2009; Fletcher, 2013; Harding, 2008).

In health practice, touch between a male health practitioner and a patient has also become an area of interest. Studies in this area are particularly dominated by the experiences of touch for male nurses and male midwives (Blee & Dietsch, 2012; Cottingham, 2019; Gray, 2010; Kronsberg et al., 2018; Mokdad & Christensen, 2021; O'Lynn & Krautscheid, 2011; Sasa, 2019). Acts of caring touch from a male are presented as having the potential for misunderstandings and may leave the male health practitioner both vulnerable and fearful of possible misinterpretation. As such, they may not always feel able to engage in caring touch with female patients (Evans, 2004; Keogh & O'Lynn, 2006). Additionally, an exploratory qualitative study by Gray (2010), and an inductive content analysis by Mokdad and Christensen (2021), suggested when treatment necessitates touching intimate areas of the body, such as the genitalia, the touch from a female health practitioner is generally more accepted by patients than from male practitioners. It is these gender stereotypes and professional taboos that may affect the quality of care offered by health professionals. Such stereotyping is a product of a discourse whereby it is not only caring touch, but any form of touch from a male, particularly when conducting an intimate procedural examination on a female patient, that is a major concern for most male health practitioners, many who are mindful of the potential for suspicion (Baker et al., 2021; Sasa, 2019). However, despite the empirical findings in the aforementioned studies, a study by Wallen et al. (2014) surveyed women's attitudes to the

placement of a 12 lead ECG on the breast tissue and found that although anecdotally the male paramedics conducting the procedure experienced some anxiety placing the electrodes, the women preferred accurate placement of the electrodes irrespective of the gender of the paramedic. Their health outcome was more highly valued than modesty.

Touching parts of the body that are deemed intimate, such as the genitals, inner thigh, and breasts, has the possibility of being interpreted as having sexual motivation and produces health practitioners who are anxious and vulnerable (Harding et al., 2008; Inoue et al., 2006). The unease of touching or being touched often experienced by both patient and practitioner is due to the intrusion on personal boundaries, and to suggestions of inappropriate touch. Indeed, touching has been at the centre of many high profile legal cases (Hine & Smith, 2014), often involving doctors found guilty of sexual misconduct, meaning a discourse that constructs touch as problematic is in play. Examples of criminal cases were highlighted in Chapter One. Such is the problematic nature of intimate touch that some health practitioners may choose to defer to another practitioner or refrain from conducting a physical examination (Hine & Smith, 2014).

Summary

Touching is the foundation of Western biomedical health care practice, enacted frequently by most health practitioners as part of routine everyday practice (Wearn et al., 2020). As such, it is important to question the taken-for-grantedness, to determine what enables and constrains the different practices of touch. This review has highlighted that throughout the academic literature, caring touch is constructed as essential to human wellbeing across the lifespan. The literature exploring the health professional's perspective generally constructed caring touch as favourable, having a useful place in patient care. Nevertheless, caring touch involves taking up a diverse range of subject positions that vary between the various health professions, specifically between one individual and another. Hence, it was important that this thesis explored the constructions of caring touch across a variety of health practices.

Discourses also construct touch as problematic. Touch is problematic because of the many ways it can be actioned, the area of the body touched, and the relationship between the parties, suggesting touch has potential to cause harm. Studies exploring constructions of caring touch by the health practitioner emphasise the challenges of all types of touch. These challenges were often gendered, where male health practitioners constructed any form of touch as problematic.

Whilst I do not intend to suggest the significance of empirical knowledge included in this review is defined as truth, the information derived from this literature review confirms the need for further exploration into the constructions of caring touch. Of particular interest is how discourses interact to construct what is considered beneficial, safe, and appropriate; and conversely, harmful, unsafe, and inappropriate when it comes to caring touch in health professional practices. Of the various modes of touch, it is caring touch that has received least attention particularly when explored from the practitioner perspective. This thesis explores how, within a complex network of understandings, health practitioners construct caring touch and subsequently are enabled or constrained to embed acts of caring touch in their practice.

In the following chapter I outline the process undertaken to bring the original idea of the research question to fruition. I discuss the selection of participants and the method used to obtain data for this study.

Chapter Four – Method

Introduction

In Chapter Two, I described the chosen methodology for this thesis and provided an explanation of Foucault's notions that are pertinent to this study. Informed by those notions, this chapter outlines the research procedures adopted – the method. Articulating the method is important, as there are a variety of approaches that are possible to adopt when embarking on Foucauldian methodology. Foucault's methodological principles are made the more ambiguous as he never stipulated a specific way to integrate his ideas comprising a complete methodology (Kendall & Wickham, 2003; McHoul & Grace, 1993/1998). Seale et al. (2010) also suggested that precise methodological tools are not on offer when embarking on discourse analysis using a Foucauldian framework and the lack of specifying clear guidelines has been criticised by philosophers such as Jürgen Habermas and Jacques Derrida (Allen, 2012). However, what makes this form of discourse analysis a useful method to adopt is that, as alluded to in Chapter One, it allows the researcher to draw on the 'tools' in Foucault's 'tool box' so they can utilise the most ideal 'fit' for the research (Garland, 2014; Hope, 2015).

The aim of utilising a Foucauldian framework is to take a known outcome and explore how the outcome was reached (Kendall & Wickham, 2003). Seale et al. (2010) suggested embarking on a Foucauldian approach is akin to putting the pieces of a puzzle together whereby there are sufficient conditions for the emergence of the problem to become evident. It was with this understanding that I embarked on this thesis. Through my prior understandings I was able to acknowledge that acts of caring touch held diverse points of view, but it was the possibility of exploring the dominant discourses that had enabled multiple constructions which captured my interest. In this study, I have also integrated notions of discourse analysis from scholars influenced by Foucault such as Sara Mills, Claire O'Farrell, Alec McHoul, Wendy Grace, Joanna Fadyl, David Nicholls, Gavin Kendall, and Gary Wickham.

This chapter comprises an overview of the research process, including the recruitment and description of participants, the method employed for data collection, and the subsequent analysis. The chapter will conclude with consideration of the ethical approval and the strategies employed to ensure rigour.

The method in action

In terms of this study, Foucauldian discourse analysis provided a lens through which to explore how some health practitioners constructed caring touch and how the mechanisms, whether personal, cultural, professional, or organisational, enabled or constrained its use. By inquiring

into the constructions and discursive practices of health practitioners, Foucauldian discourse analysis makes explicit the complex meanings of caring touch. The following sections outline the conceptual framework for participant selection and recruitment.

Recruitment

Participant selection should fulfil the specific purpose of the research question (Collingridge & Gantt, 2008) and be congruent with the conceptual framework (Cleary et al., 2014). The selection of participants for a study is based on their knowledge or experience of the topic under investigation (Reybold et al., 2013). For my study, I wanted text provided by the participants to generate rich data that enabled me to identify the dominant discourses that produced particular subject positions to be taken up.

The aim of interviewing health practitioners from various fields was to examine the multiple discourses across the disciplines and the discursive practices influencing their use of caring touch. For this study, 20 experienced health practitioners were recruited from the practices of nursing, paramedicine, medicine, and midwifery. Experience in this context was defined as accumulating over 10-years working in their professional field. These specific groups of health practitioners were chosen as I considered them to have most relevance to the discursive object of investigation. In other words, they represented professions that generally had more cause to either employ or avoid touch in their everyday practice, in diverse ways. Although all groups, as part of their practice had to engage in procedural touch, additionally, all had possibilities of experiencing emotional, possibly traumatic situations in which caring touch may be called for.

Purposive and snowball sampling were the main recruitment tools used to gather participants from the specific groups. Initially, purposive sampling was undertaken as I wished to recruit experienced health practitioners from specific fields. The Auckland University of Technology Ethics Committee (AUTEC) granted ethical approval for this study (Appendix A), as detailed later in this chapter. Following recruitment of several participants via the staff notice boards and advertisements; information sheets were passed onto colleagues, and thus snowball sampling became a second mode of building the pool of participants. Recruitment occurred relatively quickly and, consequently, I did not need to seek recruitment via newsletters and journals. After expressing an initial interest, potential participants were sent the information sheet (Appendix B) and asked to contact me if they wished to continue as an active participant. After receiving signed consent forms (Appendix C) an interview date and time were organised.

All participants recruited lived and worked across the greater Auckland area in the north island of Aotearoa New Zealand.

During initial recruitment, experienced health practitioners were sought to obtain the rich data required for the purpose of this study. Participants needed to be able to draw on a range of experiences that may, in some cases, have been gained from prolonged periods of clinical work. Additionally, I wanted to explore whether shifts in their constructions of caring touch had occurred during their years of experience and what discourses had prompted this adaptation to practice. However, early in the recruitment process, through feedback from interested parties, I identified the need to acknowledge the valuable years of training medical doctors experience prior to graduation, thus, an amendment was made to the original ethics application (Appendix D) which changed the inclusion criteria for doctors from the original 10-years to 5-years post-graduation. An additional benefit to this change in recruitment was the ability to engage more participants.

Participants

Within each practitioner group there was no specific strategy to recruit from one area of their practice (e.g., all hospital doctors). Diversity of roles within one area of health practice was welcomed and similarly, situating the 20 participants in their work environment reflected multiple spaces, contexts, and potential discourses. The five midwives in this study had experienced working from both hospital and home-based practices. Similarly, the four paramedics drew on experience that was primarily in larger city areas, with two having international experience in the field. However, the nurses, and particularly the doctors, were drawn from multiple areas of practice. Six nurses were recruited for the study and, of these, five had always been hospital based but worked across several areas of speciality. Of the five hospital-based nurses, two had worked for many years in the area of oncology, whilst the others came from the areas of intensive care nursing and surgery. One of the nurses no longer worked in a mainstream hospital, choosing to practice in accident and medical clinics external to the hospital. The five doctors in the study comprised two GPs. The others worked in major hospitals in the Auckland area. One from gynaecology and obstetrics, one from general surgery, and another from paediatrics. Summary of the participants is shown in the following table:

Mode of health practice	Ethnicity	Identified gender	Specific area of practice	Range of years of practice
Paramedicine	All NZ European	n=1 female n=3 male	N/A	11-17yrs
Nursing	4x NZ European 1x Filipino	n=4 female n=1 male	4x Hospital 1x Accident and medical clinic	10-21yrs
Midwifery	5x NZ European	n=5 female	1x Homebirth 1x Hospital 3x Independent	10-23yrs
Doctors	4x NZ European 2x Chinese	n=3 female n=3 male	2x GP 4x Hospital	5-21yrs

Data collection - The interview

Interviews are a social interaction where generally two people collaborate in producing retrospective and prospective versions of their past or present actions, feelings, thoughts, and are the most widely used method of generating data in qualitative social research (Nunkoosing, 2005; Rapley, 2010). Importantly, in relation to the methodology adopted in this study, the interview may also create the opportunity to articulate knowledge that is subjugated, devalued, or disciplined (McCabe & Holmes, 2009). Simplistically, this refers to exploring knowledge that is often overlooked or considered less important, "beneath the required levels of cognition and scientificity" (Foucault, 1972/1980, p. 82). Whilst interviews are versatile in nature (Rubin & Rubin, 2012), and superficially they appear unsophisticated and non-problematic, in reality they are often inherently complex (Banner, 2010). A wide range of approaches may be adopted, and each must be considered for its own merit in supporting the chosen research methodology. Moreover, they are considered to be particularly useful when researching areas where little is known (Stroh, 2000), making them an appropriate method of collecting the data required for this investigation. Additionally, Lowes and Paul (2006) suggested when studying a subjective topic, in this case caring touch, the interview may be a useful fit to explore the possible constructions that may be present.

Rubin and Rubin (2012) suggested that qualitative interviewers listen not simply for what a person has to say about an experience or topic but more importantly, for what has not been said. They surmise that a "willingness to acknowledge what is not understood and the ability to ask about what is not yet known" (p. 13) is an attribute necessary to enable the researcher to uncover potential discourses. Fontana (2001) noted that:

> Given the irremediably collaborative and constructed view of the interview, a post-modern sentiment would behove us to pay more attention to the 'how's", that is, to try and understand the biographical, contextual, historical, and institutional elements that are brought to the interview and used by both parties. (p. 166)

Rapley (2010) stated "the interview has been deconstructed and theorised and consequently re-emerged in various guises" (p. 15). Academic literature proffers many names for interviews including in-depth, active, collaborative, non-directed, open ended, reflexive, semi-structured, unstructured, biographical, life-history, non-directed etc. (Edwards & Holland, 2013; Olson, 2011; Seale et al., 2010). However, most commonly the literature discusses structured, unstructured, and semi-structured interviews (Flick, 2009; Stake, 2010). Burnard (2005) suggested a continuum ranging from structured interviews to the unstructured interview. Structured interviews ensure that all participants are asked the same questions with similar emphasis on words, inevitably making analysis of the data also more structured. The unstructured interview commonly starts with a broad open question with the researcher taking the lead from the participants reply. This often results in participants sharing dissimilar topics making the data analysis much more nuanced. Straddling the previous two options is the semi-structured interview. After analysing the merits of each type of interview, I chose semi-structured interviews as the most appropriate for this study. This decision was also guided by Willig (2013) who suggested that if more understanding is needed to uncover how people construct meaning pertinent to a particular topic, transcripts of semi-structured interviews are a useful 'tool'. In terms of employing semi-structured interviews to explore the discursive practices in this study, they were useful to inquire what enabled health practitioners to speak of themselves as particular subjects, and explore the mechanisms and processes at work to produce a health practitioner who engages or otherwise in caring touch (Bonham & Bacchi, 2017).

Semi-structured interviews offer a flexible schedule of questions to guide the interview process permitting the flow of conversations which I believed was important given the complexities of caring touch. Having flexibility with the wording of interview questions allows different types of language to be used and furnishes the interviewer with the ability to seek clarification allowing the exploration of spontaneous issues or unanticipated responses raised by the participant (Banner, 2010; Edwards & Holland, 2013; Ryan et al., 2009). I was mindful that semi-structured questions facilitated an environment whereby I was receptive to hearing additional reflections that may have been important to the participant. This provides a disruption to the hierarchy that can manifest in the participant/researcher relationship and enables both parties to gain through the "establishment of mutual respect" and is a space where "both the researcher and the individual engage in expanded reflexivity" as subj ugated discourses are explored (McCabe & Holmes, 2009, pp. 1523 - 1525). As such, prior to engaging in the interview, the aims and approaches of the interview process should be rigorously

managed. For me, this involved checking and rechecking that the potential questions were positioned appropriately, and engaging in a practice interview to establish the use of the language and active listening skills. Banner (2010) suggested such a 'trial' may also highlight inadvertent use of leading questions or overlooking opportunities to explore statements made in more depth. It was useful in ensuring mindfulness of researcher positioning and participation and provided an opportunity to ensure I maintained neutrality about caring touch despite my personal background.

The process

All participants were invited to have a support person with them if desired, but all declined. Participant interviews were conducted at a location and time convenient to the participant, with consideration given to a neutral environment safe for both participants and myself. McCabe and Holmes (2009) suggested the researcher needs to be aware of the potential influence they may have on the participant and, therefore, needs to ensure the environment is one that is mutually safe. This may encourage a confession of thoughts, acts, and 'truths' (Dreyfus & Rabinow, 1983). Whilst most participants chose to conduct the interview at their place of work, three requested to meet in their home. When this was requested, I initiated the safety protocol that gave me the security of knowing that should I, as the interviewer require assistance, it was close at hand. There is surprisingly little written about the safety aspects of the interviewing process in a research study (Olson, 2011). Furthermore, at the time of developing the safety protocol for this study the University had no official guidelines. Therefore, with guidance from other researchers and my prior experience, a safety protocol was developed (Appendix E).

The interviews were recorded on two separate digital devices to mitigate any potential technical failure. Following the interview, the data were downloaded, again to two computers as a safeguard. Both computers were password protected, only known to me.

I began the interview with a question pertaining to the participant's place of work and the role they performed within this environment. The conversation then progressed to aspects of caring touch. However, I began with a broad question that encouraged and invited the participant to share their thoughts and experiences such as, "can you talk to me about touch in your daily practice"? I was interested in listening to how participants spoke about touch, and the ways they did or did not use caring touch in their practice, as well as the less overt information that may have made visible some of the discourses pervading their working lives. The semi-structured, open-ended questions were used to provide the opportunity for

participants to articulate their thoughts in a conversational, naturalistic manner (Adams, 2010; Doody & Noonan, 2013). I was mindful throughout to reflect on the participants' responses. I ensured I clarified any statements that were initially ambiguous and found there were moments when this clarification elicited powerful additional detail.

Questions were asked specifically about caring touch, such as:

- How did you learn to use touch in your professional capacity?
- Tell me about using caring touch in your practice today, (in what situation, how, when and with whom?)
- What factors (if any) influence your decision to touch?

The overview of interview questions can be viewed in Appendix F.

Keeping field notes, or as Dearnley (2005) suggested a "researcher's notebook", was another form of data collection I adopted. On several occasions, once the recording devices had been turned off and the interview had in a sense, come to an end, some participants recalled aspects of touch in their practice that were an interesting addition to the audio recording. Consequently, immediately after leaving the participant, I added notes to a journal for a source of additional data. Field notes were useful for recording inflections in the voice, and body language. Additionally, I made notes with regard to statements that pointed towards a possible discursive construct. I chose not to take notes during the interview because, as suggested by Olson (2011), it may have been distracting to the participant and I was mindful to give my full attention to the participants' replies. Following each interview, I reflected on the process, pondering on any possible changes for interviews with future participants and reflecting on my own role. I asked questions of myself relating to the effectiveness of my questions and subsequently after the first two interviews, I reworded "what factors influence your decision to touch?" to, "if caring touch is part of your practice, what prompts you to use it?". Whilst I wanted my questions to elicit rich data it was also important to avoid leading questions.

The transcription

Once the interviews had been completed the process of transcription commenced. The creation of the transcript generally follows the interview to facilitate the analysis process (Olson, 2011). This process was shared between myself and a designated transcriber recruited through the university postgraduate office, unknown to me or the participants. I spent time debating the merits of employing a transcriber as opposed to completing all the transcriptions myself. I was initially keen to conduct the transcriptions personally as previous experience had

facilitated a connection with the data that enabled analysis to begin immediately. However, time constraints of the study and the numbers of interviews undertaken resulted in using the services of a transcriber for seven of the interviews. I carried out the other 13 transcriptions. As suggested by Rubin and Rubin (2012), it is important to revisit the transcripts provided by an external transcriber as they are not present at the interview and therefore often lack context and understanding of the chosen topic. As such, I took time to re-listen to the recordings in conjunction with verifying the script provided by the transcriber.

When transcribing data for post-structural Foucauldian studies, Silverman (2015) suggested transcriptions do not require the absolute precision required in other research approaches. As suggested by Bonham and Bacchi (2017), my interest was not on 'what *they* said', but '*what* they said', therefore placing focus on the substance and the discursive meanings articulated. Nevertheless, despite emphasis not specifically on language, it was important that prior to commencing transcription of the audio recordings that communication with the transcriber confirmed the format of transcribing and the requirements for noting pauses, hesitations, and interruptions as these may have indicated particular constructions. Following discussions, the transcriber signed the confidentiality agreement (Appendix G). Transcriptions were returned as a password protected word document. This password was only known to myself and the transcriber. The correct names of the participants were not obvious from the recordings and to support confidentiality participants were given a coded number only known by myself. This code only identified their profession and gender. The attention given to anonymity facilitated confidentiality at the point of analysis. Later, pseudonyms were used in the text of the thesis to provide a more relatable read and protected the participants from identification in any publications that may ensue. These pseudonyms were chosen by me and not the participant. Dearnley (2005) outlined several problems with self-selecting a pseudonym including not choosing a name that is appropriate for an academic thesis and choosing names of children or colleagues that may still expose their true identity to a reader.

Additionally, while conducting the transcription I found it useful to have a secondary file that provided the means to document thoughts that occurred as listening took place. This was useful later in the analysis and became a valuable process that allowed me to develop my interview skills.

I was mindful from the beginning that the topic of touch could be a barrier to recruiting participants, so it was important to create an atmosphere where those that did participate felt safe and able to talk about this sensitive topic. I was also aware that any male participants may find it more challenging given they were being interviewed by a female. Studies suggest that

researcher gender may influence the experiences and information offered (Fontana, 2001; Nunkoosing, 2005; Williams & Heikes, 1993). Fontana (2001) stated male-male interviews can achieve rapport more easily, as opposed to male-female interviews that can be prone to bias based on social desirability. Of the 20 interviews conducted in this study, five were with male participants. I cannot state that my gender impacted either negatively or positively to the information they chose to share, but I did note that all the interviews with the male participants were shorter than those with women. I remain unsure whether this was due to my gender or the characteristic of some females to engage in deeper and/or lengthier conversation. Following the first two interviews with male participants I did consider the employment of a male interviewer to conduct the remaining interviews with men; but on reflection, after reading through field notes and analysing the transcriptions, I considered the data from the male participants as in-depth and as rich as that from the females. They appeared to talk about their experiences in a more succinct manner. Moreover, participants had made the choice to engage in the interview process fully aware of the topic to be discussed, so I argue the topic of caring touch had limited effect on their willingness to share their thoughts.

Returning transcripts

Olson (2011) suggested that to return transcripts to participants is sound research practice. It is argued that it aids in the validity of findings and provides the opportunity for participants to withdraw statements or include additional thoughts. This strategy is founded in a philosophy of partnership and openness and thus seemed appropriate for this thesis. However, as I reflected on this process and my increased understandings of Foucault's notions of truth, I considered the original plan to return the transcripts to the participants somewhat inconsistent with Foucault's philosophy. By this I refer to Foucault's proposal that there is no permanent truth or reality; rather, multiple realities and truths exist in one given situation (Fendler, 2010; Foucault, 1972/1980). Thus, what was articulated at the time of the interview was the participants 'truth' in that moment. In this sense, the quest for truth is not related to an absolute truth that can be uncovered and acknowledged as a permanent fixture; rather, it is a "battle about the rules according to which true and false are separated" (Foucault, 1998, p. 121).

Similarly, other research suggests that returning transcripts to participants can be problematic (Dearnley, 2005). However, wanting to maintain consistency with the participant information sheets and the consent acquired, I did return the transcripts. For those that engaged with the return of transcripts, there were no alterations requested. This permitted me to continue with

my new understanding of Foucault's games of truth, meaning what is enabled to function as true is dependent on the types of discourse taken up by society (Foucault, 1977/1995, 1978/2000e; Lorenzini, 2016).

Interviewing using Foucauldian discourse analysis

As this study sought to explore the person-centred practises of health practitioners making decisions about caring touch, it seemed appropriate that individual interviews provided the data. However, some researchers have questioned the appropriateness of interviews as a source of data for Foucauldian studies suggesting they interfere with the philosophical and methodological aims of the analysis (Fadyl & Nicholls, 2013; Toll & Crumpler, 2004). Indeed, Foucault (1978/1998) suggested that social research techniques, such as interviewing, engage the participant in the confessional, the production of essential subjective truth through which power extends a hold. Similarly, Fadyl and Nicholls (2013) proposed interviews may not provide the researcher with access to the discursive practices effected through a person's life.

Burnard (2005) suggested the subjective nature of qualitative research makes the processes used "slippery ones" (p. 6). He argued that if participants were asked the same questions on different days, they might well provide different answers. Similarly, they may give different responses dependant on who the interviewer is. He concluded that "in the end, the subject matter – the human being in the present moment – is constantly changing and very hard to pin down with any certainty" (Burnard, 2005, p. 6). Whilst I do not argue the fluidity of a person's truths, this thesis does not make claims to truth about caring touch. It offers an exploration of the discourses that effect the integration of caring touch into the working lives of these health practitioners.

Indeed, Foucault altered his thinking throughout his oeuvre, particularly his notions of power and truth (Besley, 2002). His work, his truth, was not fixed; as such, Foucauldian discourse analysis offers different ways of viewing practices, effects of possibilities, and lacks a rigid set of principles (Mills, 2003). Foucault (1978/2000e) advised users of his work to make sense of it freely, without being tied to specific interpretations and, as mentioned previously, referred to this as a metaphorical 'tool box' (Hope, 2015). As such, I argue that interviews as a source of data for this thesis are consistent with a Foucauldian approach.

Through semi-structured interviews I sought to offer up the opportunity for participants, who positioned themselves within complex often subjugated discourses, to articulate aspects of caring touch. In doing so, I acknowledged that poststructural interview data analysed discursively would present a multiplicity of potential 'truths'.

While some may see interviews as problematic to a Foucauldian study, I argue the validity of analysing interview data through a Foucauldian lens is dependent on the overall aim of the study. The data collected from this study was but a snapshot to add to a much larger body of knowledge pertaining to human touch. I was not merely interested in what and why these health practitioners enact caring touch in their practice, I wanted to know 'what *what* they do does' in terms of opening or closing possibilities in the wider context. Gavey (2011) suggested if a researcher becomes too beholden to the pure methodology undertaken that it becomes "difficult to engage with questions … where the material and relational conditions of people's lives matter" (p. 187).

In the context of this study, I believe employing the interview enabled examination of how health professionals are able to speak and act in relation to human touch and illuminated the subject positions available to individuals currently in this role.

As Fadyl and Nicholls (2013) stated, there is a paucity of discussion pertaining to interviewing using a poststructuralist approach and, as such, I argue that further debate and conversations need to be conducted to draw a consensus on the value of interviewing when using a Foucauldian philosophical research lens.

Data Analysis

The approach

The analysis for this study was guided by Foucauldian principles. However, when engaging in a Foucauldian analysis, as mentioned previously, there are diverse opinions regarding the best way to implement his approach to analysis, particularly as he was resistant to specifying one set method (Cheek & Porter, 1997). Graham (2011) suggested that finding a coherent explanation of how to analyse a discourse using a Foucauldian approach is challenging and confusing due to limited information to guide the researcher. Foucault's lack of 'direction' in stipulating a specific set of guidelines was due to his belief that regular evaluation and reflection was important to the various aims to be achieved (Kendall & Wickham, 2003). Foucault (1978/, 1978/2000b) himself stated, "I take care not to dictate how things should be" (p. 288), and encouraged people to consider his work as a 'toolbox' from which to choose an appropriate approach to analyse discourse (Hope, 2015). Mills (2003) additionally suggested Foucault resisted the use of formulaic methods or methodologies because researchers do not examine concrete phenomena; rather, they make sense of social phenomena. Taking guidance from these authors and previous Foucauldian research studies (Bonham & Bacchi, 2017; Fletcher, 2013), I began to clarify my approach to conducting my analysis. The analysis as

applied to this study was grounded in key poststructural and Foucauldian approaches and drew on his concepts of discourse, subjectivity, technologies, governmentality, and biopower.

Drawing on these concepts I set about making more visible the discursive conditions that enabled or constrained acts of caring touch with my participants. With no specific direction other than Foucauldian concepts to guide my analysis, I was inspired by Kendall and Wickham (2003) who suggested five steps to navigate the analytical process of discourse: 1) recognition of a discourse as a set of statements whose organisation is regular and systematic, 2) the identification of rules and the production of statements, 3) the identification of rules that limit the sayable, 4) the identification of rules that create the spaces in which new statements can be made, and 5) the identification of rules that ensure practice is material and discursive at the same time. Although these steps assisted in providing some sense of organisation to the way I approached my analysis, particularly at the beginning of the study, the Foucauldian 'tool-box' provided me the opportunity to develop my own questions that shaped and better suited my study.

To enable me to open up the topic of caring touch for analysis I used Foucault's (1969/2002) concept of the statement as central to discursive formations. I aimed to analyse the patterns and relationships between the statements and the objects they construct (Foucault, 1969/2002).

The process

To begin the process of analysis I employed NVivo as an electronic filing cabinet to manage my thoughts and the participants' words. I was mindful to ensure NVivo did not influence my analysis; rather, it enabled me to get to a point where analysis for this study could commence. As a complex subject that is unique to individuals, the analysis needed to be a merging of my theoretical knowledge, the philosophical methodology underpinning the subject, and the participants'. Given, this multiplicity, the use of NVivo provided a useful way to initially 'manage' the data.

Once I had a sense that the data were organised, I re-read the transcripts to establish a deeper connection with the data. Reading the transcripts several times enabled me to formulate ideas to approach the analysis, always reminding myself that discourses are able to co-exist and support particular meanings but, conversely, may compete, producing alternate meanings. I noted ways that caring touch was spoken about, specifically the statements that could be a "sentence or a series of signs" (Foucault, 1969/2002, p. 98) and highlighted statements I considered would contribute to the analysis.

I followed this initial stage of analysis with the use of mind-maps which I created for each of the practitioner groups. The statements I had previously highlighted were then placed into a category on the mind-map which allowed me to ascertain what was sayable and, what limited the sayable within each group. This began to highlight how practices of caring touch were constructed across the different practitioner groups.

As these preliminary data were mapped, a number of discourses became evident to me. Each discourse was noticable when perceived knowledge at a given time made it possible to say something was constructed as 'true'. Once these discourses were established, I used additional mindmaps to explore each one, some of which were priviledged and others marginalised. Throughout this process I reminded myself that knowledge is always contextual. In the context of health this means that while there are continuities, there are also discontinuities. Dominant discourses, related subject positions, and subjectivities became the focus of analysis. Whilst I was interested in the statements provided by the participants, I continually re-engaged with the absences in their narratives. I looked for the relationship between the discourses, how and when they intersected, and how they operated alongside each other.

Participant interviews provided a substantial amount of data that was analysed over an extended period with the aim of determining dominant discourses. Thus, selecting specific extracts as examples was difficult. Initially I selected extracts that simply illustrated the dominant discourses. However, as I examined the data more deeply, changes were made as I began to distinguish extracts that were pertinent to the discursive argument I was making because of their contrast with those showing dominant discourses. Additionally, I was also mindful of contrasting excerpts that showed the complexity and subtle differences in the way the discourses were constructed and operated.

Throughout the analysis I continued to ask myself several questions that I had posted on my wall to refer to during this process: What was enabled and what was constrained? What was said and what was not said? What was taken for granted? How did they reach the point where they could make these statements? How are they constructing caring touch? I completed a table for each discourse as they were identified which asked: a) what was being constructed (objects), b) what were the surfaces of emergence, c) what subject positions were taken up, d) what were their understandings of the world (subjectivities), and e) what were the actions and behaviours related to these subjectivities (discursive practices). These tables provided a useful broad overview from which to analyse the data. The time spent engaging deeply with the data allowed me to see what had not been clear at the beginning. I realised that rather than explore

what they were saying, I needed to focus on what enabled them to say the things they did. Consequently, I returned to the transcripts. As part of this process, I chose to use hard copies of pertinent excerpts and physically placed these onto the mind-maps of each discourse. As I grouped the excerpts, I colour coded them according to which practitioner group they had been taken from. This gave me the opportunity to identify the particular subject positions taken up within both discourse and, each group.

Initially, I felt the analysis was raising more questions, but this in itself was useful in directing me to the dominant discourses prevailing in the workplace of the participants that formed my final analysis. At times I was frustrated with the lack of guidelines provided when undertaking Foucault's methodology, but I came to realise that this provided me with the freedom to employ a method of analysis that was a suitable fit for my topic.

Continuing with the analytical strategy mentioned above, I became comfortable and confident with the process. As the analysis unfolded, the intersection of multiple discourses and the overall complexity of caring touch as a subject to explore became apparent.

Rigour

Once the methodological approach and process was determined, I needed to give attention to how rigour would be established and how I would manage the nature of truth statements. Analysis of research should be as rigorous as possible and demonstrate coherence with the philosophical approach and trustworthy processes (Graneheim & Lundman, 2004). Lincoln and Guba (1985) suggested the concepts of rigour and trustworthiness were a) credibility – confidence in the findings, b) dependability – findings are consistent and could be replicated, c) confirmability – extent to which the research reflects the participants' opinions and not those of the researcher, d) authenticity – ability of researchers to accurately reflect the diversity of respondents' opinions and experiences, and e) transferability - findings may be applicable in other contexts (Amankwaa, 2016; Kyngäs et al., 2020). Qualitative research studies often adopt these concepts to ensure that analysis of the data and subsequent conclusions are worthy of academic attention. I have chosen not to dissect these concepts in any more detail as I consider them intertwined and interrelated, meaning the examination of these as individual components for a Foucauldian study may incorrectly suggest there are specific truths that maybe discovered. Moreover, together with the broad concepts suggested by Lincoln and Guba (1985), and researcher reflexivity, I also drew on Richardson's (2000) discussion of crystallisation. Much has been written on the rigour of qualitative research, but in relation to the methodological approach adopted in this study, the notion of crystallisation

was appropriate. Unlike other ways to establish rigour, crystallisation aims to capture multiple aspects of research knowledge (Avner et al., 2019). Richardson (2000)stated:

> Crystallization, without losing structure, deconstructs the traditional idea of "validity" (we feel how there is no single truth, we see how texts validate themselves), and crystallization provides us with a deepened, complex, thoroughly partial, understanding of the topic. Paradoxically, we know more and doubt what we know … we know there is always more to know. (p. 934)

Echoing Foucault's (1972/1980) notion that that multiple realities and truths exist in one given situation, as an approach to rigour, crystallisation similarly does not claim to legitimise a particular claim as truth. Consequently, I did not seek to find the 'truth' pertaining to acts of caring touch; rather, I was guided by my research question that sought to explore the ways in which caring touch was discursively constructed. Discourses produce various possibilities of 'truth'. Suggesting otherwise limits the development of further knowledge (Foucault, 1972/1980).

In an attempt to acknowledge preconceptions and assumptions about the topic prior to commencing the study, I had several discussions with peers and supervisors articulating pre-understandings. Speziale et al. (2011) suggested this helps us to be open towards differences in thought between ourselves and participants. Although from a poststructural perspective I acknowledge it is not possible to remove ourselves from the discourses constructing our subjectivities and the way we see the world, I felt these discussions were prudent to frame my approach. In this way, I was able to consider the direction of the questions asked and my potential responses. The process of in-depth discussions with my supervisory team occurred regularly throughout the research process, and continually challenged and questioned my approach. Additionally, I chose to journal personal thoughts relating to caring touch and the influence this may have had on the study. Some of these reflections, including aspects of reflexivity, are highlighted next.

Using the aforementioned tools, rigour has been achieved. I suggest that those who engage in reading this study can do so with confidence that the methodology guiding this study was appropriate to the topic of caring touch.

Reflexivity

As a thesis that drew upon a poststructural framework, the part played by the researcher in a study is a key feature (Hickey, 2010). As such, offering an understanding of the researcher's positioning, including acknowledgement of self-awareness and the influence of researcher subject positions, is an important statement of intent and practice (McCabe & Holmes, 2009).

The notion of reflexivity has widespread acceptance in qualitative research where it is acknowledged as something that is not merely a measure of transparency and credibility, but a mechanism for informing both the researcher and the research process (Alejandro, 2020; Berger, 2013; Reid et al., 2018). Reflexivity supports the rigour expected and required for research studies and includes awareness of how the presence of the researcher may affect participants (Finlay & Gough, 2003). However, reflexivity is more than a mechanism to control 'bias', it is also an acknowledgement of the "nature and function of power" (McCabe & Holmes, 2009, p. 1524).

Researcher reflexivity is complex as qualitative researchers are subject to the interplay of multiple discourses at any one time (Whitaker & Atkinson, 2019). The contextual and intersecting relationship between researcher and participants should be reflexive to extend awareness of the topic under exploration (Dodgson, 2019). In short, reflexivity is being actively engaged in the fluctuating practice of checking positionality, how this is interpreted by others, and what effect this positionality has throughout the research process (Soedirgo & Glas, 2020).

When a discourse analysis study is inspired by the work of philosopher Michel Foucault (as this thesis is), the study is inevitably reflexive in nature and thus has a significant effect on the researcher's subjectivity (Lincoln & Guba, 1985). The ability and importance of a researcher to be mindful and practicing of self-reflexivity permits exploration of "the ways in which they themselves, in terms of their experience and prior assumptions, and the theoretical and methodological processes they have chosen, shape the data collection and the analysis" (Giddings & Grant, 2009, p. 128). Additionally, the researcher needs to be cautious about static positionality; rather, they need to engage in continual reflection throughout the research process (Soedirgo & Glas, 2020).

Researcher positioning and reflexive practices

In Chapter One I discussed my background and its importance in terms of this thesis. Rather than seeing these personal experiences as problematic to the study, they positioned me as someone whose background informed the research process. I had naïvely believed from the onset that I would be at ease in placing myself outside personal subjectivities. Instead, I learned to acknowledge the impossibility of detaching myself from the study topic. Rather than trying to hide partiality as something to apologise for, it should be accounted for (Richards, 2013; Stake, 2010; Wetherell et al., 2001). "The analyst is very much an 'insider' and must start with a recognition of the cultural assumptions they carry into the project and their own ways of interpreting a discourse event" (Fairclough, 2001, pp. 279-280). As such, by

adopting a policy of openness, I hoped to make clear my place within the research process. I was inherently aware throughout the planning, data collection, analysis, and writing, that my background in this subject matter would have an effect on the research. As such, I continued to exercise rigour and implemented processes in an attempt to be open to other ways of thinking about caring touch.

From the very first discussions about this thesis, I was mindful of the need for constant reflection on my method, approach, interview questions and technique – indeed, the entire process from start to finish. My background denoted that I entered this study carrying existing beliefs and values towards the support of caring human touch; yet, I was resolute to try and metaphorically 'park' my own judgment in order to allow reflexivity throughout the entire process. As above, part of the 'parking' process was to make explicit the beliefs and values I held regarding caring touch. Another was to be open and non-judgemental to other ways in which caring touch was spoken about and constructed. However, I acknowledge that it is impossible to suspend judgement and detach oneself. My perspective remains and becomes part of the reflexive work I undertook. My background informed the research process in conjunction with supervisory meetings, journalling, and discussions with peers.

Berger (2013) suggested an increased focus on self-knowledge can raise awareness of biases which, if not monitored, may be misrepresented by subjective interpretation. However, there is an alternative view. Rather than a single unequivocal reality, multiple realities exist. This is a philosophical stance articulated by Foucault (1978/1998) and intimates that subjectivity is not problematic and should not be rejected as bias. Soedirgo and Glas (2020) suggested that in order to turn the potential problem of subjectivity into an opportunity, the researcher should engage in reflexivity directly and openly. This facilitates the opportunity for the researcher to see the various discourses in the participants' statements.

Ethical process

Gaining approval to conduct a research study is one of the most important steps in the research process (Green & Thorogood, 2005). The Auckland University of Technology Ethics Committee (AUTEC) approval process required me to safeguard both participants and myself, as the researcher throughout the research. Furthermore, the subject of caring touch can be constructed by some people as a sensitive topic to explore. I was asking health practitioners to articulate personal thoughts and experiences to a complete stranger. As such there was a requirement for me to employ stringent strategies to address confidentiality and to provide participants a safe space where their anonymity was protected (Gubrium & Holstein, 2002).

As part of the preparatory work for ethics, I consulted the AUT Health and Wellbeing Centre to request support for any participant for who may have required assistance following the interview. Three appointments per participant were granted at no charge (Appendix H). Prior to developing the ethics application, I consulted with the Kawa Whakaruruhau Komiti within the School of Health Care Practice (now Department of Nursing) for support and advice prior to embarking on further planning. This consultation provided guidance as to how I could be mindful of practices and protocol that would both support any participants that identified as Māori and the environments, particularly marae based, where I may have conducted interviews. I was offered on-going support from this group as my research progressed (Appendix I). Additionally, I was required to ensure confidentiality of the data and the use of plain language in communications with participants, reducing the risk of confusion or misinterpretation. As mentioned earlier in this chapter, my ethics application also outlined a safety protocol that was employed when conducting interviews in an environment where I was lacking support.

An integral part of the ethical process is the acquisition of informed consent. All those wishing to research on others have an obligation to gain consent. This must be done in such a way that any information provided to a potential participant is complete and not misleading (Lee, 2018). Informed consent was required for this study as I was exploring the constructions of caring touch from a health practitioner's perspective. Once potential participants had been furnished with the study outline in the form of an information sheet (Appendix B), and prior to commencing with any data collection, it was essential to gain written consent. All prospective participants who maintained an interest in becoming a study participant were asked to provide consent using the form given in Appendix C.

Once I had undertaken these processes, I applied for approval for the study from AUTEC using their stated guidelines. As this study took place in Aotearoa New Zealand, I also integrated the three principles of Te Tiriti o Waitangi (Treaty of Waitangi), - partnership, participation, and protection. No additional information was requested from the committee and approval was granted on 15th May 2015 (AUTEC reference number 15/119; Appendix A).

Summary

In this chapter I have detailed the study design that emerged from the methodological principles outlined in Chapter Three. I have outlined the recruitment and interview process including a rationale to employing interviews with Foucault's methodology. Additionally, I discussed the data collection process, ethical considerations, and the approach to analysis.

This thesis sought to explore the dominant discourses that enabled or constrained the integration of caring touch into the practice of health professionals. Drawing on key elements of Foucauldian philosophy, particularly discursive formations, subject positions, and technologies of the self, I examined how caring touch was discursively constructed for these health practitioners. Multiple constructions of what it means to be a health practitioner and the corresponding relationship to acts of caring touch were identified throughout the data. In the following three chapters I present the analysis where it became clear that discourses participating in acts of caring touch in health practice were numerous, complex, unstable, and competed in the various work environments. The first of these, presented in the next chapter, examines the constructions of professionalism and caring touch.

Chapter Five – Professionalism and caring touch

Introduction

This thesis sought to explore the dominant discourses that enabled or constrained the integration of caring touch into the practice of health professionals. Drawing on key elements of Foucauldian philosophy, particularly discursive formations, subject positions, and technologies of the self, I examined how caring touch was discursively constructed for these health practitioners. Multiple constructions of what it means to be a health practitioner and the corresponding relationship to acts of caring touch were identified throughout the data.

Overall, analysis of the data identified categories of three dominant discourses that produced the subject positions taken up by participants in particular ways. It was the dominance of these discourses that shaped choices pertaining to acts of caring touch. These discourses were: 1) discourses of professionalism, 2) discourses of caring, and 3) discourses of touch as sexualised. I have chosen to present each of these dominant discourses as individual chapters.

In this first analysis chapter, I present constructions of professionalism and caring touch. There is always more than one discourse participating in the construction of a health professional and often these are observable as discourses that conflict with each other. This conflict resonated in the transcripts where discursive practices of caring touch were particularly evident and acted upon. I offer an insight into how various discursive constructions of professionalism and caring touch produced participants who acted in differing ways. Whilst some took up subject positions that integrated caring touch as part of practice, others argued it was not part of their professional remit. Several constructions of professionalism in relation to caring touch were evident: a) professionalism as excluding acts of caring touch, b) caring touch as intrinsic to professional health practice, and c) caring touch as contextual to professional practice. I begin by presenting the construction of professionalism that suggested an exclusion of caring touch.

Exclusion of caring touch

Aspects of professional practice that involved the possible exclusion or marginalisation of caring touch were complex. The section discusses how some participants chose to take up subject positions whereby they detached emotionally from the patient, and/or delegated the responsibility of caring touch to others.

In the subject positions taken up by some participants, caring touch was constructed as having little significance to their professional role. This is illustrated in the opening quote from Mike, an experienced doctor based in a city hospital:

> Well, I think it's [caring touch] probably more just allaying fear and worry. Although touch is probably quite good to aid any pain, because there's only so much pain relief you can give somebody. So, you know hanging on to them while they are going through real bad pain is probably quite useful, but I don't do it, it's not part of my professional role. (Mike – Hospital doctor)

As a professional doctor Mike, was able to assist a patient in pain by using his knowledge, experience, and the resources around him. This included both pharmacological means and through human acts such as caring touch. Although there was acknowledgement that caring touch was at times a useful resource, where it could be useful to assist a patient in pain, it was not included within the spectrum of care. Boundaries of caring existed that segregated certain aspects of care from others. When Mike articulated, "I don't do it, it's not part of my professional role", his reasoning was a product of his construction of the doctor. For Mike, this construction signalled he should refrain from engaging in caring touch. Although his professional registering body, states that care of the patient is primary (Medical Council of New Zealand, 2021), his construct of care was one that did not encompass caring touch. The discourses that position Mike as a doctor for whom caring touch was not in his scope of practice conflict with a humanistic discourse that carries an emotional response to assist someone in need, possibly with acts of caring touch. Mike was speaking from a subject position as a doctor taught under the Western model of training constructed within dominant discourses such as biomedicine. He was also speaking from the site of a hospital, where the position of the doctor is seen as the receiver of observations, the producers of observations (e.g., palpating an area), and the producer of analysis and clinical decisions.

When caring touch is constructed as not necessary within the spectrum of care offered, it produces health practitioners that may consider it an act that does not form part of professional practice. However, when the primary aim of a professional doctor is stated as being the care of the patient, confusions exist as to what this care means. It could be constructed as care shown through diagnosis and treatment or, alternatively, care as demonstrating compassion through acts such as caring touch. Consequently, there are confusions and tensions existing that enable practitioners to integrate or withhold caring touch in practice. Although tensions existed in Mike's constructions of professionalism, particular discursive formations became more dominant and, subsequently, caring touch was marginalised. However, the 'potential' for its integration into professional practice maintained its presence despite being constructed as out of scope. Mike did not engage in acts of caring touch even though it may have been of benefit to the patient. Such contradictions are important as they demonstrate discontinuity in that a discourse does not function by itself;

rather, it may compete for dominance with other prevailing discourses (Foucault, 1969/2002; Mills, 2003). This construction of caring touch was echoed by Callum, a male nurse:

> I don't hold their hand or anything like that. I'm not one of those touchy, feely nurses. I'm not sure it's really professional. (Callum – Nurse)

Explicit in this statement is a proposal that engaging in caring touch as a nurse is an unnecessary act and its action questionable as part of professional practice. Although a commonly held construct of the professional nurse is one who is focused on acts of care (Adams, 2016), for Callum, acts of care as a health professional did not include caring touch. Negative connotations are suggested to the meaning 'touchy feely' and as such, the touchy-feely nurse is constructed as a particular kind of nurse rather than a general characteristic. Engaging with this construction suggests those that do employ caring touch are possibly not conducting themselves professionally. Consequently, caring touch is constructed as something to be managed and in Callum's case, withheld. Taking up the subject position of the nurse who does not employ caring touch constructs particular understandings of professionalism and, in doing so, the marginalisation of caring touch in practice is possible.

Emotional detachment

There were additional constructs of caring touch as not forming part of professional practice that produced participants who withdrew from caring touch to reduce an emotional connection with the patient. Several participants spoke to the notion of hardening themselves emotionally to enable them to maintain their construction of professionalism, which for these practitioners, entailed eliminating acts of caring touch. Many of the daily tasks undertaken by the participants involved either witnessing someone in distress, or by way of fulfilling their professional role they were themselves the agent causing distress. To explore this notion, I use excerpts from Robert and Karen.

> I think it's important to harden yourself to the patient's pain and discomfort. I can be more professional then and not give that caring touch. (Robert – Paramedic)

Although much of the work carried out by paramedics does not involve emergency urgent care (Eaton et al., 2021), as a paramedic working in Aotearoa New Zealand there are occasions when, as first responders, they are required to provide primary acute care. For some participants, limiting acts of caring touch were legitimised. Not engaging with the emotional response to witnessing a patient in pain enables focus on the body, the disease, and the process of making a diagnosis. Robert enacted self-discipline when seeing people in pain through the employment of a metaphorical hardening. This action is one that enables a health

practitioner to disengage from the possibility of emotionally connecting with the patient which may distract from what may be perceived to be more urgent medical needs. By emotionally distancing themselves from the patient, they are able to complete the tasks expected of their practice. This reveals a particular construction of professionalism that affects practice. When caring touch is linked to emotional connection it becomes problematic and, therefore, excluded from 'professional practice' which is focused on the urgent assessment and treatment of the immediate medical needs. Similarly, the act of emotionally detaching from the patient was articulated by Karen, a hospital-based doctor:

> We were told it's inappropriate to show emotion and touchy stuff as the professional, and you need to have this professional veneer. So that's what I try and do. (Karen – Hospital Doctor)

Karen's statement raised several questions about being a professional doctor. In this construction of a doctor, the implication is that to be professional, one needs to withhold emotional expression and caring touch. As explored in Chapter Three the justification to detach emotionally is constructed as necessary in order to have an objective focus on medical needs (Cadge & Hammonds, 2012; Kerasidou & Horn, 2016). Although she acknowledged the expectations of herself as a doctor, Foucault's notion of discipline is again evident. Karen implied she worked on developing a "professional veneer", an invisible shield, that enabled her to restrict the emotional connection with her patients.

When health practitioners implement a form of barrier to reduce emotional connections with the patient, it draws on a number of discursive constructions pertaining to professionalism. It constructs assessment and treatment as more important than other acts of care and may serve to preserve their ability to focus on the task in hand rather than responding emotionally. Karen and Robert were able to distract themselves from offering sympathy and comfort through caring touch and, in doing so, they were able to fulfil the required needs.

Demonstrating an emotional connection was constructed as being a hinderance to carrying out the necessary tasks required to support the patient. Participants suggested that an emotional engagement with empathy may distract from the treatment required. However, when these participants spoke of disengaging from the emotion of seeing someone in pain, at no point did they consider this may be problematic to the patients they encountered. On the contrary, excluding emotional attachment was understood to be ensuring the patient received a 'higher' quality of treatment. This understanding demonstrated that in this discursive construction of professionalism, biomedical interventions are considered more important than emotional support for patient safety and care. Furthermore, emotional support and high-competence

biomedical intervention were constructed as mutually exclusive, creating a need to eliminate caring touch in order to offer the best care. Interestingly, there was little discussion of engagement with caring touch in non-critical situations, suggesting for some participants they remained steadfast in their construct of the professional health practitioner and appeared reticent to shift subject positions to include caring touch, depending on the context.

Delegation of caring touch

Empathy is stated as being integral to the role of a health practitioner (Medical Council of New Zealand, 2021; New Zealand College of Midwives, 2022a; Nursing Council of New Zealand, 2021), and for some participants empathy was demonstrated by engaging with acts of caring touch. Whilst several participants stated caring touch was an empathetic act occurring between themself and the patient, other participants developed a way of integrating caring touch using an alternative 'resource'. The following quote from Mike highlights the allocation of touch to the nursing profession.

> Like I said before, I think it [caring touch] might help them [patients], but I rarely touch them in those circumstances. The nurses seem to do it much easier and because it could be seen as unprofessional… so I don't do it, the nurses take over that… I don't see it as part of my role. (Mike – Hospital Doctor)

Although caring touch can be a useful resource when tending to the needs of a patient, there is an implication in Mike's excerpt that caring touch is out of scope to a doctor's care and, therefore, not part of professional practice. Rather, there is a suggestion that it is part of the professional practice of a nurse. As such, caring touch is devolved to the nursing staff despite the possibility that some nurses may also construct caring touch as an "unprofessional" act (as exemplified by Callum above). Nevertheless, Mike drew on particular constructions of the professional doctor and the professional nurse, which (re)produced the notions of the objective detached doctor and the caring nurse. Rather than enacting caring touch, this doctor withheld caring touch from a situation, and allocated it to nurses who, he suggested, would fulfil that particular mode of care. I suggest this construction of professionalism demonstrates a system existing in the hospital environment that implies practices of caring are different between a doctor and a nurse.

I follow the previous excerpt with this statement that further demonstrates how professional constructions of care in medicine and nursing at times conflict, showing an interplay between discourses and the subjectivities they create. Sharon, a nurse, expressed her frustration about what constituted the role of the doctor and the nurse in terms of caring touch and how, legitimised by discourses of professionalism, it continued to affect her working life and the

possible wellbeing of patients.

> Mmm… they leave it up to us most of the time. I don't know if it's cause they don't want to do it, but I get the feeling its more that they think it's not their role to do the caring side of practice and somehow it's ours. Pisses me off really. Where did it come to be that nurses are the ones to do that stuff? What if I don't want to, and if they don't want to, what happens to the patient - they miss out. (Sharon – Nurse)

In this example, rather than constructing acts of caring touch as designated to a particular profession (e.g., nursing), caring touch is deemed an act assigned to all practitioners. Sharon deployed a counter discourse to that which produces a division of tasks and scope of practice, including or excluding caring touch. This excerpt indicated a concept that permeated her working life, and perhaps that of other nurses, whereby the models of caring demonstrated by doctors, particularly in the hospital environment, were constructed differently to the nurses, and midwives specifically. This was particularly so regarding acts of caring touch for the hospital doctor, where such a model of caring was considered not a component of professional practice. Through the allocation of roles based on meeting the patient's needs, actions of caring touch were transferred from doctors to nurses. I argue that constructions of professionalism influence the way nurses take up subject positions that may enable caring touch. Furthermore, a construct in which caring touch has the potential to enhance a patients' emotional, psychological, and social needs, and constructing the role of a health practitioner as being able to meet these needs, may provide the impetus for some health practitioners to engage in caring touch as part of their treatment, even if it is not their inclination to do so.

Caring touch as part of professional practice

Contradicting the construction of professionalism as excluding caring touch were constructions of caring touch as a key part of professional practice.

> I use what you call caring touch because that's part of what we do as a doctor. We care… and showing compassion when they're upset is normal isn't it? I've never thought I shouldn't do it. That would make me feel like I wasn't giving 100% of me as a doctor. (Catherine – GP)

This GP drew on an alternative construction of what it is to be a health professional which included acts of caring touch. Although professionalism was drawn upon by all the participants discussed in this chapter, the varying constructions of professionalism resulted in the variety of subject positions being available to take up. Within certain discursive constructions of professionalism, acts of caring touch were normalised. Catherine articulates this in her

statement, suggesting caring touch demonstrates compassion which is a 'normal' part of her professional practice.

As briefly noted in the previous section pertaining to hospital systems, clinical context participated in the construction of what is considered possible and appropriate in terms of caring touch for these participants and what is not. Of note is the particular environment in which these practitioners work. When a health practitioner works in an environment where they are the sole provider of care, such as the GP, the context may necessitate a construction of professionalism as different to those working in other environments (e.g., the hospital). For most GPs there are no other colleagues to 'defer' acts of caring to as seen in previous excerpts. Reminiscent of Catherine's statement, for Jen, a midwife, deployment of caring touch was a characteristic of her working day. Explicit in her statement is the notion that refraining from acts of caring touch would conflict with her construction of the professional midwife.

> It's sort of a no brainer really, isn't it? When you see someone in pain and you know it'll help to rub their back or put a reassuring hand on their leg, of course you do it. We're told it's important, and to be honest if I was with another midwife that didn't use it [caring touch] when it's a good idea, then I'd question her practice. (Jen – Midwife)

The normalisation of caring touch between a health professional (in this case, the midwife) and a patient is clearly articulated in this excerpt and contrasts significantly to the 'unprofessional' constructions of caring touch discussed in the previous section. Jen's statement implied that a midwife who did not engage in caring touch with her patient was falling short of attaining the professional standard expected of a midwife in terms of patient care. Shown here was an acceptance of caring touch in midwifery practice and an expectation of its integration into practice, where it is enacted as a resource to comfort and ease distress. Another midwife reiterated the construction of caring touch as an essential aspect of the midwifery profession which was introduced and reinforced during training.

> Sure, I recall we had a few discussions about it [caring touch]. I remember because I was surprised about how many in the session were reticent to touch, and I remember thinking why would you be a midwife if you were funny about touching. It's part of what you do, caring, it's important as a midwife. (Caroline – Midwife)

As a midwife, Caroline was accepting of touch and unlike some of her fellow students, did not question the part it played in her training. Midwives in Aotearoa New Zealand care for a woman through pregnancy and birth where acts of care denote caring touch. Caroline's statement shows how explicit legitimisation of caring touch during the training of midwives constructs caring touch as the professional thing to do and produces midwives who expect its

integration into practice. It is part of their professional remit, their scope of practice, and is exemplified by its inclusion as a necessary component of training. This construction of caring touch as expected, created the space for using caring touch with relative freedom compared to many of the practitioners interviewed.

The excerpts presented thus far in this section are comparable in the sense that the statements are made from practitioners who are usually the primary 'carer', (the GP and the midwife), and potentially the only interaction the patient may have with a health professional. As such, there are arguably greater possibilities to connect and produce a safe space where caring touch can be enacted without the concerns expressed by some professionals working in hospital or pre-hospital contexts. Similarly, all the excerpts in this section are provided by females and as argued in Chapter Three, this may provide additional opportunities of engagement in caring touch than their male counterparts have. However, although these similarities may indicate gendered acts of caring touch, the construction of caring touch as an aspect of professionalism was also a significant part of practice for this male paramedic.

> It's a good way to connect with a patient especially if they're quite distressed or panicky. A hand on their arm or sometimes I even hold their hand. I don't think about it as it's part of what we do you know, it's all part of our role to look after people, whatever it takes to put them at ease and make them more comfortable. I don't know what the others are saying, they might not want to say in case you think it's not kosher, but most of us do it [caring touch]. (Tony - Paramedic)

Tony enacted caring touch as one of the possible options of care he had at his disposal. Akin to the previous participants, caring touch is constructed as part of professional practice where it is one of many potential resources called upon when required to support patient wellbeing. Implied in this statement was the possibility that not all paramedics share with others how they perceive the meaning or appropriateness of caring touch. Tony does not suggest his colleagues do not engage in caring touch. Rather, there is the implication that constructions of caring touch may be contested within the profession of paramedicine to the point of constraining what people are willing to discuss about how they care for a patient in distress. As discussed later in this chapter, there were statements that conveyed similar issues, suggesting there was a lack of training with regard to what was acceptable in terms of professionalism and caring touch.

The construction of caring touch as being part of professional practice was also articulated by nurse participants who stated an absence of caring touch would not be fulfilling their professional role. Some of the nurses spoke of caring touch as being an unspoken and essential part of being a nurse.

> I don't think I'd be doing my job if I didn't offer that type of compassionate care when they need it [caring touch]. (Lyn)

> I think it's [caring touch] really huge. I think you lose most of what a nurse is if you don't use it. It's not just the physical care, it's the other stuff as well. (Lois)

Both Lyn and Lois spoke of losing identity as a professional nurse if they were not enacting caring touch in the care of a patient. The construction of being a nurse is dominated by a professional nursing discourse where acts of compassion are integral to practice. Within this construction of professional practice, lack of compassion (and caring touch as part of that) is linked with the subject position of a nurse that is not effective in their work. Additionally, the discussion of needing to meet both the physical and emotional needs of the patient suggests resisting the mind/body dichotomy that biomedicine constructs - the construct in which caring touch can 'interfere' with professional practice.

The construct of "compassionate care", articulated by Lyn constructs 'being human' as someone who acknowledges the importance of providing comfort to a person in need of emotional support. I suggest constructions of the professional nurse and being human intersected to reinforce the essence of a nurse, supporting caring touch as an essential aspect of professional practice. However, acts of compassion are not exclusive to the discursive construction of the professional nurse. Arguably, all the professions that comprised participants for this study would agree they are members of a profession where compassion is integral to practice. Nevertheless, compassion was not always linked with the need for caring touch.

All of the participants had remained in their chosen health profession for the entirety of their career, with the exception of Lucy who was a practicing doctor but began her career as a nurse. In her interview, she noted the change in her practice of caring touch associated with her change of profession. For Lucy, taking up the subject position of the doctor after previously being a nurse inferred reducing acts of caring touch.

> I think probably as a doctor I would feel that a greater proportion of interactions with touch would be task orientated. Whereas when I was a nurse there was probably more caring touch because that's what we do, and it was good to help the patient. I'm mindful that I was a nurse and now being a doctor, I need to behave like one. (Lucy – Doctor)

The transition from nurse to doctor highlighted a shift in the construction of professionalism for Lucy. As a nurse, engaging in acts of caring touch were part of professional practice and she drew on her construction of a nurse by stating "that's what we do". However, since taking up

the position of a doctor, she needed "to behave like one [a doctor]", which entailed constraining caring touch. As a doctor, she indicated touch interactions were more related to conducting an assessment or procedure rather than emotional caring. The adjustment to patient care was not questioned by Lucy; it was constructed as an integral part of her new subject position as a doctor. The transition from one practice to another and the subsequent constructions of professionalism were taken for granted. Rather than transferring understandings of caring touch through to a new model of practice, the construction of being a professional doctor overrode any constructs regarding the role of caring touch that may have carried through from her time as a nurse.

Acts of self-discipline

Just as there were participants who disciplined themselves to detach from caring touch in response to constructions of professionalism, in contrast there were participants who worked on themselves to ensure they engaged in acts of caring touch constructing it as a professional expectation. Shelley, a midwife, experienced challenges with the integration of caring touch into practice despite professional licence to do so, demonstrating that employment of caring touch into practice is not always straightforward.

> I have vague memories in my training of being told to rub their [women in labour] back and let them squeeze your hand and feeling very awkward about it. But it's something that's expected of us as a midwife, so I guess I've taken up the challenge over the years although it doesn't always come… sort of easy… I do it [caring touch] as I know we should… like, part of our practice. (Shelley – Midwife)

Similar to the participants that drew on the caring nurse discourse to integrate caring touch into practice, likewise, Shelley was influenced by midwifery discourses. However, unlike the nurses in this study, caring touch was also reinforced in her training ensuring its legitimisation as a practice of this health professional. Shelley drew on the construction of the professional midwife communicated in her early years of training. She took up the subject position of the midwife for whom caring touch was an expectation of professional practice despite facing challenges to do so. Such was the dominance of this construction that she felt she needed to work on herself, denoting the notion of self-discipline. Shelley's example demonstrates that when a dominant construction of professionalism fosters acts of caring touch, as well as producing health practitioners who are enabled to enact caring touch, there are also practitioners who are required to make a shift in their personal practice to accommodate professional expectations. The ease at which this integration occurs for a health practitioner is dependent on other prevailing discourses that are unpacked in the following chapters.

Observing others

The data revealed uncertainty and caution regarding acceptable occasions to implement caring touch that were related to the lack of guidance during professional training. Participants intimated this lack of understanding produced confusion and a subsequent lack of engagement in acts of caring touch. Consequently, most drew on the observations of others to guide them, as exemplified in the comment from Steve, a paramedic.

> It wasn't until I saw other paramedics be more caring – you know, touching their [the patient's] arm or shoulder that I thought about it. Until then I thought they might think I was being a bit unprofessional. It wasn't something we were ever taught about. (Steve – Paramedic)

Steve waited until he had confirmation through the observation of others before engaging in caring touch as it provided him with the reassurance that his acts of caring touch were professional. In this example, it was not that Steve was averse to integrating acts of caring touch into practice; rather, he lacked the formal understanding about caring touch that constructed it as an acceptable aspect of professional practice. There is the inference from Steve and other participants of a requirement for some formal guidance surrounding acts of caring touch, and in receipt of this information the act would be legitimated. In the absence of such guidance, some participants were conflicted regarding possibilities available to them as a professional health practitioner. Whilst some constructed no guidance as a signal to abstain from caring touch, others constructed an absence as needing to draw on their personal constructs of professional care to enact caring touch when required.

However, I suggest it goes beyond Steve being able to draw on constructions of professionalism and deficits in training. I contest there are additional discourses in play that led participants to suggest they needed guidance about their acts of caring touch. When a dominant societal discourse perpetuates the notion of caring touch as something to be cautious of, particularly between two people who are unknown to each other, it diminishes possibilities of care. It is this discourse that underpins the suggestion from Steve that he would have benefited from understandings during his training that guided what was doable and what was not. When some health professionals are unprepared to make decisions about caring touch due to an absence in training, it points to the presence of competing discourses that cause uncertainty. In the absence of competing discourses there would be no uncertainty because messages pertaining to engagement with caring touch, whether implicit or explicit, would be consistent.

When health professionals transition from general society, where acts of touch are often constructed as something to be cautious of, to a profession where practice requires touch to fulfil a scope of practice, it makes such a shift complicated. There are requirements to place primary focus on care of the patient (Medical Council of New Zealand, 2021; Paramedic Council of New Zealand, 2020) which further complicates understandings of where acts of caring touch 'fit'. Without specific guidance to clarify what is acceptable in terms of touching a patient, health professionals are faced with finding alternate ways to elucidate what is possible for them particularly in terms of caring touch. However, the potential integration of caring touch into the curricula of health practitioners is complex and outside the context of this thesis.

Professional caring touch in context

The previous section demonstrated how a number of participants constructed the integration of caring touch as standard practice. For them, it was an aspect of care and part of professionalism. Significant in the statement from a paramedic below was the integration of caring touch into professional practice when she was confronted with a specific need in a particular situation, and when caring touch was unquestioningly the 'right' thing to do. Jo recalls an event where she felt her professional calling was to comfort using touch.

> It was ages ago, but I still remember it. It's still so vivid. We arrived at a scene to find an unresponsive baby and despite doing everything the truth was we knew when we got there the baby was gone. A second team had arrived to assist, so I was watching on with the parents. When we all knew the baby had gone the mother was… well you can imagine, distressed to the point of collapse and the dad was unable to barely move. I sat with her for a long time, I don't know how long, just holding her in my arms. It was so awful. It was all I could do in my capacity as a paramedic to hug her... so tight … it was awful. (Jo – Paramedic)

Jo's recollection of this tragic event demonstrates how her professional construct permitted caring touch used in a way that differed from many of the other excerpts. When enacted by the participants in this study, caring touch was mostly used to relieve distress for the patient they were 'treating'. In this case it changed. This was not an act of caring touch for the patient; rather, it was enacted with an 'observer'. Jo suggested that engaging in an embrace with the mother was the right thing to do. She suggested she drew on her role as a professional paramedic to guide her in this situation. However, also in place were constructs of being human where witnessing a person in significant distress would produce acts of care such as caring touch. She took up the subject position of the professional paramedic and the subject position of one human showing compassion for another at a time of unimaginable tragedy.

Examples such as this demonstrate that health professionals are required to work at the intersection of multiple discourses that are never static.

Summary

Throughout this chapter I have shown that constructions of caring touch in professional practice were contradictory and contested by some participants. Contradictions were demonstrated between those who constructed caring touch as part of professional identity where it was normalised as an important aspect of care, and alternately those that constructed it as an unnecessary aspect of professional practice and a distraction from assessment and treatment. However, not all study participants positioned themselves firmly within these categories. Some participants stated caring touch had potential to benefit the patient but maintained a resistance to engage in caring touch that demonstrated tensions in play across and within the professional groups. Similarly, confusions pertaining to what was doable and what was not in terms of their professional practice found some participants at a discursive impasse, at times seeking confirmation to enable their acts of caring touch. Accordingly, they referred to other sources, taking cues from colleagues or looking to professional guidelines. This complexity revealed an unknowingness of where caring touch was positioned within professional practice and points to wider constructs of touching another person that dominated practice for some participants.

These contradictions suggest an interaction of discourses that, at times, functioned to place doubt on acts of caring touch. I suggest there was an undercurrent that discourses of gender and the sexualisation of touch, knowingly or otherwise, influenced the actions of some participants.

When multiple constructs dominated practice, it produced some health professionals who took up specific subject positions whereby they comfortably integrated caring touch into professional practice; but it also produced some that monitored and re-thought their acts of caring touch in practice. Consequently, acts of caring touch were enabled for some and precluded for others; and, as revealed throughout this thesis, suggests the presence of discourses that jockey for dominance in circumstances where caring touch may be possible.

The following analysis chapter explores the constructions of the role and purpose of caring touch in health practice.

Chapter Six: Constructions of the Role and Purpose of Caring Touch in Health Care Practices

Introduction

Caring is often spoken about as an attribute that is fundamental to humanity (Adams, 2016), and in Chapter Three I offered insight into the ways in which caring is constructed. It is an act demonstrated between people and is woven throughout health practice, being one of the main motivating factors drawing some people to the health care professions (Boykin & Dunphy, 2002; Karlsson & Pennbrant, 2020; Van Hooft, 2017). The literature in sociology, health, and psychology speaks to numerous expressions of caring, and one of the acts of caring taken up by some health practitioners is that of caring touch.

Building on the previous chapter, this chapter continues the focus on ways in which participants take up multiple subject positions as they negotiate their acts of caring touch, but more specifically focuses on the multiple constructions of caring touch. I present three constructions: a) the role of caring touch as comforting, b) the interplay between caring touch and the fostering of relationships, and c) caring touch as a distraction.

Prior to embarking on the various constructions of caring touch, I begin this chapter with a notion introduced previously, that a focus or absence of caring touch in the training of health professionals often produced practitioners who constructed acts of caring touch as legitimate or otherwise. I present this as a starting point to this chapter as for some participants it was the integration or not of caring touch in the early years of training that produced health practitioners where acts of caring touch were enabled or constrained.

Learning about caring touch

Discussions with some participants showed caring touch was spoken about as complex. Accordingly, they sought guidance to legitimise their integration of caring touch in health practice. The current inclusion of touch within the curricula of undergraduate programmes in Aotearoa New Zealand is generally what, in this thesis, I have termed procedural touch and it involves actions where the health practitioner engages in touching a patient to complete a task necessary for their treatment and/or recovery. Procedural touch, (e.g., palpating an area, assessing for injury, or suturing a wound), was part of clinical training for all of the participants. Contrasting significantly were insights into caring touch. With limited direction from training or professional guidelines to outline the boundaries of touching, these participants gained their understandings and models of caring touch from other sources. As identified in the previous

chapter, whilst some suggested the discursive practice of engaging in caring touch emerged through childhood, many gained their understandings and confidence through the observation of colleagues. With the exception of the midwives, none of the participants could recollect any formal inclusion of caring touch within their curricula.

> I don't recall ever being taught about that [caring touch] in our training. (Tom – Hospital Doctor)

A few participants argued against the need to educate about caring touch. Mike confirmed there was little information about caring touch in his medical training and he constructed caring touch as something relatively simple, meaning there was little need to integrate this as a subject into the curriculum.

> There was nothing specific that I can remember being taught about touch… but I guess there wasn't much to be taught. (Mike – Hospital Doctor)

When Mike stated, "there wasn't much to be taught", he does not imply caring touch is unimportant; rather, as a topic, it had limited content needed to be communicated to him as a doctor. This statement about any formal teaching of caring touch was echoed by other participants and speaks to a construction of caring touch as inconsequential in terms of patient care.

For Mike, and others in health practice, the marginalisation of caring touch in training may modify the ways in which they position themselves within the constructs of caring touch. However, in contrast, some participants were introduced to caring touch as a useful resource in their formal training. In this example, Caroline, a midwife, takes up the subject position of a health practitioner who embeds caring touch in her practice to support the women in her care.

> We talked a lot [in training] about showing care through touch in labour, sort of to help the woman, make her feel more relaxed, less stressed when I need to. I use it all the time to complement the other care we need to do. (Caroline – Midwife)

By drawing on the knowledge she had gained from her training, Caroline identified caring touch as a resource she had at her disposal to assist the labouring woman. I suggest this legitimised her use of caring touch, meaning she had no concerns or requirement to justify her choice to engage in this specific act of care. She constructed caring touch as one of many approaches of care she deployed when attending to the needs of the women in her practice, suggesting also that she adapted her acts of caring touch to the unique needs of her patients.

Caring touch to comfort

Throughout this study, the way participants most often constructed acts of caring touch was as a resource to comfort a patient in pain or distress, and to encourage a safe environment. There were many instances when a health practitioner was 'encouraged' to provide caring touch, not as a practitioner but as a human showing empathy and care to another human in an environment where they needed support. This constructed one of the functions of caring touch as being part of humanness. Within all four groups of practitioners there were participants who made statements regarding times when caring touch was enacted to comfort and benefit the patient.

> And then, of course, there are other occasions where the patient might be quite distressed or crying or whatever. You know? Sometimes I'll give them a hug or sometimes I'll touch them on the knee, something like that. "Are you okay? Do you want to keep going or do you want to stop?" And I've had many occasions where patients just reach out and just give me a hug at the end of the consult. (Sue – GP)

As a GP, Sue is an example of a health professional who often works in an environment where they see the patient alone and perhaps over a number of years. Sue took up the subject position of a health practitioner who was comfortable incorporating caring touch into her practice when necessary. She employed a variety of caring touch acts including hugging and knee touching and was accepting of being the recipient of caring touch. This excerpt presented several constructs of caring that enabled acts of caring touch. When a health practitioner positions themself in this way, caring touch is deployed as a means to demonstrate compassion. In this example, caring touch was constructed as part of a professional remit, a resource to be called upon at a chosen time and appeared to be actioned without the tensions experienced by others in this study. Furthermore, when caring touch was enacted by a female health practitioner it was generally not constructed as problematic, meaning engaging in acts of touch are not as constrained as they may be for male health practitioners.

The subject position taken up by Sue contrasted to other participants particularly, her peers in the hospital where, as shown in the previous chapter, such acts were constructed as unprofessional. Lois, a nurse, introduced an alternative way to use caring touch to bring comfort to a patient.

> I feel for them when they come to us. I know some can be unpleasant but some of that comes from fear of where they are and cause they're in pain. Many of them look really vulnerable so I guess it's part of my job to care for them, so they feel safe. So, if a

> touch on the arm or the shoulder can help then I think it's a good thing to do. (Lois - Nurse)

The notion of caring touch as helping to create an environment that was deemed safe suggests particular constructions of both the patient and the health practitioner. By constructing the patient as vulnerable, Lois considers an approach in which she may be able to assist the patient additional to assessment, diagnosis, and treatment. She constructed her role as a caring nurse, one who is required to manage the multiple needs of the patient, physically but also emotionally, and takes up the subject position of a nurse who engages in caring touch to encourage the patient to feel safe.

Caring touch as an aspect of relationship

Across the health disciplines, the ability or not to develop relationships with patients is diverse (Feo et al., 2017; Morgan, 2008). The practitioner groups in this study contrasted considerably regarding opportunities available to them to develop such relationships. For example, the paramedics and emergency doctors arguably spent the shortest amount of time with the patient, often focusing on the significant urgent care required. The opportunity, therefore, to develop a relationship with the patient, whereby acts of caring touch are more likely to be accepted, and perhaps expected, is significantly reduced compared to others, for example, GPs and midwives. For the participants, there were subject positions taken up whereby the opportunity to develop a relationship with patients offered an increased opportunity to engage in acts of caring touch. Discussion indicted that the subject positions taken up were influenced by the specific condition of the patient. As some states of ill-health are invested with more emotion than others, the capacity to consider acts of caring touch are similarly diverse.

Caring touch to foster relationships

For some participants, acts of caring touch occurred spontaneously, without considered thought, as an innate part of their practice. Often describing themselves as 'touchy feely', these practitioners constructed acts of caring touch as an asset, a resource they brought to practice that produced benefits to the wider care they were able to provide.

> I decided after a few years to follow my natural instinct and just use it [caring touch] as part of me as a doctor, my practice. I've come to realise that using it [caring touch] with a patient allows you to connect with them more. I learn to 'read' them better by having a better relationship … what do I mean by that, umm, maybe how they are feeling. I think I'm better doctor for it. (Tom – Doctor)

Tom's early experiences as a young doctor enacting caring touch are quite different to what he described in this quote and are discussed in the following chapter; but as an experienced health professional he shifted his understandings and began to act in a way that he suggested made him a better doctor. When a health practitioner constructs caring touch as an important resource which enables the development of a positive relationship with a patient, it may offer opportunities to 'know' the patient in a way not otherwise available. Constructing caring touch in this way implies increased ability to understand the cues from the patient that in turn may contribute to other facets of practice such as assessment and diagnosis. Tom positioned himself accordingly drawing on what he articulated as a "natural instinct" to better assess his patients' needs. Caring touch, as one approach to care for a patient, merged with another mode of care which engaged a biomedical focus. In this example, various constructions of caring coalesce rather than compete.

Lyn, a nurse, echoed Tom's suggestion that embedding caring touch into practice holds the potential to benefit a patient.

> I wonder sometimes if someone will pull me up on it [using caring touch], but it's me, part of me, part of how I show care, and patients seem to respond well to it. They seem to be more open to talking about how they are feeling. (Lyn – Nurse)

Despite a concern that she may be chastised for her actions, Lyn's open acts of caring touch feature as part of her practice. When these health practitioners talked about their personal approach to care, some described acts of empathy and compassion, which included caring touch as being fundamental to their practice. Similar to the previous excerpt, this practitioner suggested acts of caring touch encouraged valuable communication with the patient which may offer opportunities to assist the patient in a broader capacity, such as articulating any uncertainties about treatment. Although most interview participants drew on constructs of professionalism and biomedicine to describe their care for patients, Tom and Lyn also took up the subject position of a practitioner who engaged in acts of caring touch to provide additional patient care. Once again, this created an intersection of multiple constructs of care where these participants were able to practice in a way that they described as fostering the relationship with the patient.

Relationships enabling acts of caring touch

In the previous section, Lyn and Tom suggested it was the initiation of caring touch that enabled/enhanced their ability to connect with their patients, and consequently form a relationship with them. This section considers a slightly different construction of the caring

touch/relationship dyad. Several participants suggested that building a relationship in the first instance, was important for enabling caring touch. Once the relationship between patient and health practitioner had been established, the integration of caring touch was constructed as more acceptable. Sharon and Fiona, both hospital-based nurses, suggested this approach facilitated their use of caring touch.

> Although I tend to use caring touch as part of me being a nurse, I think I do this more when the patient is with us for a while. (Sharon)
>
> It does make it [caring touch] easier when we know them. You know? We know they know us and seem really happy to get that more friendly approach. (Fiona)

Statements from Sharon and Fiona suggested that when nursing practice facilitated the opportunity to spend more time with the patient, there were further possibilities to develop a positive relationship where acts, such as caring touch, could be introduced. This notion links to the previous suggestion by Lyn (a nurse) who implied caring touch assisted patients to feel safe. The availability of time was an important part of building relationships, particularly as being an enabler of caring touch. When a patient is constructed as the unknown, it may preclude caring touch. Likewise, when a practitioner is unknown to the patient, it may indicate a resistance to accepting acts of caring touch. In Sharon's quote, time in the presence of the other is constructed as a medium for enabling caring touch.

So far, I have discussed caring touch as either enabling a relationship or being enabled by a relationship, with a positive relationship being the main goal. There was further discussion by some participants where, because of its role in a relationship, caring touch was constructed as having utility for the management of patients, as articulated in the following section.

Caring touch as gaining compliance

Extending the notion of the patient/practitioner relationship, I propose a further construction of caring touch. When a health practitioner endeavours to put a patient at ease and reduce their discomfort through engaging with caring touch, the practitioner knowingly, or otherwise, could also be gaining patient compliance, as demonstrated by the following statements.

> I think being able to care for them [the patient] with using caring touch means they seem to trust what you are saying or what you need to do. (Fiona - Nurse)
>
> In my experience they relate to what you're saying much better when you're holding their hand or got an arm around their shoulder. It also makes it easier to get other things done, like getting a line in. (Jo - Paramedic)

The concept of compliance, shown in the excerpts above, refers to compliance that facilitates treatment. Health practitioners often engage in the practice of caring touch, but perhaps unspoken is a knowledge that through using caring touch to build a relationship and feelings of safety, they also have increased capacity to reduce a patient's resistance to a proposed medical examination or treatment. However, at such times, rather than constructing these acts of caring touch as being a manipulative use of power, the health practitioner talks about it as using caring touch productively to assist the patient in the path to recovery.

Previously, caring touch has been constructed as a resource to demonstrate compassion and empathy; however, in these examples, it is enacted to encourage treatment. The statement that "caring touch means they seem to 'trust'", constructs it as being of value to a much broader context of caring for a patient. Once trust is established, it suggests the notion of safety is present, and arguably this produces patients who are more accepting of examination and treatment. Foucault (1977/1995) referred to this as the 'docile body'. In the clinical practice environment, particularly when the patient is undergoing examination or treatment, the notion of docility is most evident. This notion is articulated in Robert's statement.

> Some [patients] resist [treatment] and the pain they were okay with in the ambulance seems worse. Others might feel some relief as they know they can get help and they seem to just give themselves up to whatever the team want. I know when I place a hand on the shoulder or the arm it helps... I know it does. (Robert – Paramedic)

Robert assists a diverse number of patients where some surrender to treatment and others do not. At times he constructs caring touch as a tactic, a way of reassuring them. When Robert said, "they seem to just give themselves up to whatever the team want", he indicated the notion of the docile body. Robert's comments suggested the creation of an environment whereby a patient is willing to capitulate and implied that docility was a necessary pre-condition for ensuring the treatment was able to be provided. Therefore, when a patient, the subject, becomes docile in the care of the health practitioner, it is possible that compliance is attained whereby they are able to continue with the treatment required. Furthermore, there is an additional effect of the "hand on the shoulder" articulated in this statement in helping to alleviate some of the pain experienced, which again may contribute to the compliant patient.

Although it was continually suggested that using caring touch as a means of attaining compliance, provided benefit to the patient, there are possibilities of alternative constructions to these actions. There were no occasions when participants stated that in using caring touch to aid compliance, they may be disempowering the patient, in the sense that it was being used

as a tool to counteract resistance. Nevertheless, these health practitioners constructed caring touch as something that mattered to them. Caring touch became a useful resource to facilitate what the health practitioner deemed was necessary to support the health of the patient.

Caring touch as a distraction

The diversity of caring touch discourses are also evident when employing caring touch to assist in the relief of pain (Mancini et al., 2014). This was apparent throughout the data where its function as pain relief was commonplace. In this study, midwives used caring touch more frequently for this purpose, arguably as they were caring for women whose pain did not generally originate from a place of injury or physiological dysfunction. Their focus of using caring touch was, therefore, not usually redirected to attend to other more pressing medical needs.

> When a woman is in pain from labour, I know that by giving her back a rub, or foot rub for that matter, that it will, to some degree, take her mind off focusing on the pain. People think it's just because touching is what we do but there's good evidence to say that it really does work as a distraction. It's all about the route that the nerve message travels. (Jen - Midwife)

Although many midwives in Aotearoa New Zealand care for women who are healthy, which in turn facilitates a practice constructed by natural birth, Jen's statement draws on scientific evidence to support her use of caring touch. She raised the physiological concept of the gate theory of pain (Campbell et al., 2020), whereby it is possible to subdue feelings of pain by introducing an alternative sensation for the brain to focus on. This suggests that although many midwives subscribe to the construction of natural birth, it does not preclude biomechanical constructs. They are not mutually exclusive. When Jen drew on the physiological disruption that caring touch can offer in reducing signals of pain, she demonstrates that health practitioners have the ability to draw on multiple discourses to determine what actions are doable and thinkable to enable practice.

Caring touch as the object of distraction was also called upon by others, who found it particularly useful when attempting a medical procedure that may produce discomfort.

> I know that when I have an anxious patient and I have to get a line in, if there is another colleague at hand, and usually there is at this point, I get them to stroke the forearm of the arm I'm not working on to distract them [the patient]. It's something we do on kids, but it works well on anyone that needs a sort of diversion (laughs). Works a treat. (Robert – Paramedic)

Robert provided an example of an approach that demonstrates the numerous ways in which caring touch is enacted in health practice. Despite caring touch being marginalised by some

participants, this area of touch and its ability to distract is well documented in the scientific literature (López-Solà et al., 2019; Nursanti et al., 2020; Sparks, 2001). In his interview, Robert constructed this distraction technique as a resource to benefit both the patient, in terms of their pain relief, and himself, in terms of ensuring he is enabled to provide good care. This construction of caring touch as simultaneously aiding distraction and care demonstrates the multiplicity of caring touch and illustrates that various enactments of caring touch can occur synchronistically. The following section demonstrates a further example of where touch is used for multiple purposes in a way that incorporates caring touch.

Merging acts of touch

Using caring touch as a resource to divert patients' attention connects closely with the descriptions from some of the participants who discuss caring touch in a way that does not construct it as a stand-alone act. They spoke of their integration of caring touch merging it with acts of procedural touch.

Similar to the other health practitioners, the predominant type of touch used in paramedic practice is procedural touch, enacted generally to assess patients' physical health and, in certain cases, administer treatment. However, Tony articulated how he employed a strategy whereby he took up the subject position of a paramedic who was able to integrate both types of touch within his practice.

> I will go in and sit down and just holding someone's hand also gives you the chance to assess skin tone ... that's part of the reassurance and it comes with experience (Tony – Paramedic).

Tony constructed his level of experience as a paramedic as enabling him to comfortably use caring touch and at the same time perform the procedures his practice required of him to assess the patient. There was an integration of touch practices that incorporated caring touch with a more clinical use of touch that was necessary to assist the patient. The two occurred together, which was different to the accounts given by most other practitioners participating in this study. Jo also gives an example of how she was able to accomplish the merging of both forms of touch.

> My go to, when I arrive at a call where the patient is conscious is to provide some comfort by holding their forearm while I'm asking them what happened or how they're feeling, that sort of thing. Besides sort of giving comfort by holding their forearm, I'm also at the wrist checking to see what their pulse is doing. That way I can multitask which as a paramedic, we do a lot. (Jo – Paramedic).

These paramedics described the integration of caring touch or the opportunity to give comfort whilst concurrently completing other tasks as a useful 'skill'. Caring touch in this context was constructed as an act that could be integrated into practice with apparent little effort, describing a functionality of caring touch. However, within this functionality, Jo and Tony clearly constructed caring touch as being able to provide comfort and reassurance, enabling them to also focus on the emotional needs of the patient.

For these paramedics, the discourses that construct procedural touch and caring touch do not fight for dominance; rather, they may be enacted alone or simultaneously. There is no suggestion that caring touch is only possible in certain situations. Their construction of these types of touch is that both have value in caring for a patient. The discursive construction of touch is all encompassing, and they are able to enact caring touch without too much deliberation. This construction of caring touch contrasts significantly to excerpts in the previous chapter where possibilities of caring touch were constrained by its construction as being outside of the professional scope of practice. Furthermore, both excerpts above demonstrate that it is thinkable and doable for some health professionals to integrate caring touch into practice without an overwhelming concern of it being 'out of scope' or becoming too time consuming.

Caring touch as time consuming

I have previously discussed the notion of time in the context that does not necessarily exclude acts of caring touch, and earlier in this chapter, time in the context of building relationships. Another way in which time was discussed by participants suggested available time was a factor in the decision to use or not use caring touch in the care of a patient. Previous studies have illustrated a construction of time where it is a concern of health professionals experiencing a lack of time to spend with patients. This was particularly so for doctors and nurses in hospitals and clinical environments (Gerada et al., 2018; Westbrook et al., 2011). In this study, while there were several statements where a constraint on time was drawn upon as a rationale to not incorporate caring touch into practice, there was no consistency in disciplines or contexts associated with this construction. Some participants stated that reduced time to interact with patients also reduced opportunities to administer caring touch.

> Maybe we don't do it enough? I don't know… Sometimes we are in too much of a hurry. We have too many patients and although I'm attentive to everything the patient tells me, I may not go the extra mile if you know what I mean. (Lucy - Hospital Doctor)

> I think one of the biggest drawbacks is we [the doctors] give ourselves 15 minutes or less to solve the problem and it's actually not enough time to do it, so there certainly

> isn't the time to think about holding a hand or giving a hug. (Mike – Hospital Doctor)

Lucy and Mike acknowledged that whilst caring touch may be a useful addendum to patient care, it was not a priority. They both stated the ability to engage in caring touch was constrained by the time they were able to spend with the patient. Of interest is the fleeting suggestion made by both Lucy and Mike that providing caring touch was an 'extra'; an additional aspect of care only given if time permitted. This contrasts to the earlier statements made by other participants who suggested the integration of caring touch into practice was not dependant on 'extra' time; rather, it was an act that could be included whilst performing more clinical aspects of care. The subjugation of caring touch as revealed by Lucy and Mike constructs it is an unnecessary act and focus is given to the consultation and examination process.

I propose when participants discussed the restriction of time as constraining acts of caring touch, time was being used as a strategy to reinforce and make primary a particular construction of the need to prioritise clinical acts. In doing so, caring touch was marginalised.

To further illustrate this point, the same construct of constrained time can be discussed in quite a different way. Although Tony concurred that time was often limited, his way of managing practice to enable caring touch contrasted with those quoted above. He directly challenged the notion that caring touch was not important and therefore should be considered part of practice. Tony found a way to integrate caring touch without impeding on his time to medically treat the patient.

> We don't get a lot of time with the patient, but I think whatever time we do have means we need to accomplish a whole lot. As much as many of the young paramedics would assume getting leads on and checking stats is first up, actually just taking a few moments, seconds actually, to touch a patient on the arm or shoulder and let them know you are going to take care of them is just as important – for me anyway. Maybe that's experience talking, but I can imagine people think they don't have the time for hand holding when really a few seconds is all it takes, and it can make a difference. (Tony – Paramedic)

This practitioner expressed the notion that even the briefest act of caring touch to reassure a patient was a worthy use of limited time. The brevity of this act was constructed as important enough to enact prior to commencing with more clinical care. Similar to other paramedics, being able to transition between acts of caring touch and the technical skills needed to assist the patient was part of practice. Although Tony alluded it was his lengthy experience that granted him the understanding of when to integrate caring touch into his practice, all of the

health practitioners in this study had extensive experience, yet not all practiced similarly, indicating experience was not necessarily an enabler of caring touch. Rather, it is the discourses prevailing at a particular time that produce health practitioners who take up subject positions enabling or constraining acts of caring touch.

Being able to integrate caring touch with practice was an important aspect of work supported by other participants who discussed the ease of integrating technical/procedural activities with caring touch. As a nurse in an emergency department, Lyn suggested colleagues often used lack of time as an excuse as to why caring touch could not be actioned.

> I hear colleagues say, 'we don't have time to for all the nicey nicey things like holding a hand or hugging', and it makes me really mad. I mean, it's just a friggin excuse. They either don't want to do it or don't think about doing it. I mean how long does it take? Seriously, what's wrong with them? A hand on the shoulder as a patient leaves, or a pat on the leg as they're standing up from a consultation. Even the odd touch on an arm when they are looking anxious. It's crap. If they want to be caring in their practice, they do have time. They're making excuses. (Lyn – Nurse)

Like Tony, Lyn indicated the ease at which caring touch could be incorporated during treatments or appointments with little impact on time to complete other acts. Lyn suggested the resistance to caring touch is situated within the decision making of the practitioner, a matter of choice rather than a lack of time. This is consistent with my argument that discussion of time constraints in this way is a strategy to reinforce a particular discursive construction of caring touch as 'extra' or 'nice to have'. Notable was Lyn's quote from a colleague suggesting that caring touch was a "nicey nicey thing", that would take up valuable time during the consultation process. When caring touch is constructed in this way it positions it as superfluous to other practices carried out. However, Lyn argued the notion that lack of time constrained acts of caring touch.

Lyn's frustration with her colleagues and her statement that "if they want to be caring in their practice, they do have time" obscures other possible underlying constructions of caring touch that may limit her colleagues' use of touch. Her reticence to acknowledge that colleagues may be responding to constructions of caring touch as problematic (discussed in the next chapter) suggests the construction of caring touch as important and helpful was so dominant in her practice that other constructs may have been rendered invisible.

Within the given context of patient care, practices are shaped that enable alternative approaches, and in their ability to construct caring touch as a valuable asset to patient wellbeing Lyn and Tony were able to take up subject positions that were contrary to some of

their colleagues. It was Tom and Lyn's construction of caring touch that enabled them to suggest that with brevity and simplicity, caring touch could be prioritised and considered important enough to be incorporated into the consultation without imposing on available time to examine or provide treatment. Nevertheless, their constructions of available time to initiate acts of caring touch were contrary to the statements made by the doctors earlier in this section. Whilst for some participants caring touch is constructed as fundamental to caring, for others it was a possible adjunct to other constructions of caring which took priority.

Summary

Throughout this chapter I have shown there is no single discourse of caring touch. Rather, multiple constructions of caring touch were identified. Specifically, caring touch to comfort, caring touch as producing relationships, caring touch as a distraction, and caring touch as time consuming. These constructs generally did not exist within particular professional groups but were present across participants from the various practices.

There were contrasting statements and contradictions throughout the data that presented caring touch as vital in some constructions and unnecessary in others. Whilst caring touch was constructed by some participants as an act employed to form relationships with patients, conversely it was constructed by others as difficult to employ until a relationship with a patient had been established. Nevertheless, the relationship formed between the health practitioner and patient was significant in producing possibilities of caring touch. Throughout, there were connections made between forming relationships and the time in which to do so, noting again opposing constructs of available time. Embedding caring touch into practice for some participants was complementary to other tasks and integrated with little difficulty. Others, however, constructed caring touch as a time-consuming 'extra' that restricted time for diagnosis and treatment. Consequently, it was often disregarded. Nevertheless, some participants suggested an approach whereby types of touch interactions occurred simultaneously, ensuring both the physical and emotional needs of patient care were met. Accordingly, there existed possibilities for an interplay of discourses, demonstrating discourses of caring touch do not always complete with other discourses in practice.

Such contradictions demonstrated constructions of caring touch in health practice as diverse. Whilst some participants integrated acts of caring touch into practice with little challenge, there were occasions when the tensions articulated by others made caring touch in health practice problematic. The following, and final analysis chapter discusses these tensions further and explores the construction of caring touch from a male as sexualised.

Chapter Seven – Male Touch as Sexualised

Introduction

This is the final chapter analysing discourses that construct acts of caring touch in the working lives of these health practitioners. The act of one human touching another is an act discursively produced and as such, can be constructed as acceptable in some circumstances and not in others depending on who, where, and when the touch is actioned. Although previous chapters have introduced the concept that caring touch may be problematic at given times, this chapter takes these suggestions further by arguing it is not only caring touch, but any act of touch, that may be constructed as problematic. When human touch is constructed in this way it suggests actions that are questionable and open to multiple interpretation. As a consequence, the capacity for caring through human touch may be diminished.

Chapter Three introduced the notion that touch is most often reported by the media in ways that problematise its use. Through storylines and media reporting, discourses that promote caution regarding acts of touch dominate, and certain subjects such as the predatory male are constructed. In the context of this chapter, those who reproduced the discourse that constructed male touch as sexualised were male practitioners, who experienced their touch in practice as being questionable and suspect. In terms of touching patients, what is doable for male health practitioners' contrasts with their female colleagues. In this chapter I identify and analyse the dominant discourses and discursive practices deployed by these male health practitioners that structured actions and enabled touch to be spoken about as being problematic. I argue that touch from a male health practitioner to a patient is constructed in ways that circumscribe its use in health practice, and the discourse of male touch as sexualised dominates practice. To open the analysis for this chapter I introduce the notion of touch as risky.

Touch as risky

Throughout my analysis of the data from the male participants, it became evident that, regardless of their profession or place of work, they identified that misinterpretation of their touch was likely. The construction of touch as risky and the notion of vulnerability was articulated by the male doctors who expressed confusion regarding making choices about using touch.

> I know I'm generalising and there are plenty of doctors that are like me, but I know as a male I'm at risk with patients. (Tom – Doctor)

Tom is challenged by the knowledge that touch could be problematic in his career, and he positioned himself as an "at risk" professional when engaging in touch with a patient. Although he speaks of being "at risk" he does not articulate exactly what this means. Such is the dominance of the male sexuality discourse and its relationship to touch that he assumed I (the interviewer) knew what he meant without explicitly stating it. It is shared knowledge. The implication in Tom's words: "I know as a male…" suggests he was drawing upon the discourse that constructs men as having the potential to be sexually predatory, and thus his touch could be constructed as inappropriate and result in accusations that disputed his professional practice. This dominant discourse that constructs some acts of male touch as sexual permeates wider society and is reinforced through various sources, specifically media reports (as outlined in Chapter Three), making the male a subject of suspicion in situations where physical human interaction takes place. I argue that when this dominant construct of men as potential sexual predators is linked with constructions of caring touch, confusion and uncertainties begin to surface. The ambiguous nature and sexualisation of touch creates the subjects and practices seen with these health practitioners. When a discourse constructs men as potential sexual predators, it suggests there is always the possibility of sexual intent in their actions. Tom suggested he had to construct the patient as a risk to himself because of the implied meaning in his embodiment as "male" and, therefore, the possibility of and reading the meaning of touch in a particular way.

When touch is readily implied as inappropriate and is problematised, health practitioners may enact a form of resistance and refrain from engaging in caring touch. Touch is perhaps also made problematic because of the power imbalance constructed in the relationship between a health practitioner and a patient - in this case, the doctor, and the patient. However, as discussed in Chapter Two, power does not stay in the hands of one party; rather, it is continually negotiated by those in the relationship. It is at times fluid and dependent on the discourse that conveys and produces the power (Foucault, 1972/1980), and most importantly the subject positions that are produced and taken up. Although Tom's perception that he was the vulnerable party was real, this perception always has the potential to be destabilised. This notion is supported by Foucault (1997), who suggested that in order for power relations to occur there must be a degree of freedom for those within the relationship.

As argued in Chapter Three, discursively, touch is constructed as both important in its contribution to human wellbeing, but also as something that has the potential to be harmful and problematic. Dominant discourses may position people in particular ways, but this positioning is not always transparent, leaving people with little understanding of the way these

discourses take effect (Gavey, 2005). As such, in the eyes of these health practitioners, the ways in which a patient constructs the touch of a male health practitioner is complex. In Tom's excerpt, while he positioned himself as vulnerable to being accused of inappropriate touch, his subject position as a medical doctor enabled a degree of autonomy in his decision making. However, the discourse of touch as sexualised is so dominant that he becomes a subject of the discourse that sees the touch of a male as problematic. Other male participants echoed Tom's feelings of vulnerability, showing that from a poststructuralist view, touch is contested.

> I'd hate to have my professional career taken away from me from a misinterpreted hug or something. (Mike - Doctor)

As a male, the act of touching someone is a complex and a difficult act to negotiate. Although both Tom and Mike make statements that identify touch from a man is prone to misinterpretation, neither is explicit in what they mean by this. Similarly, Steve, a male paramedic had concerns about using caring touch.

> It's always an advantage when you are not breaching a gender barrier or perceived barrier. And likewise, I'm very cautious if I am dealing with a young man. I'm very cautious that because of who I am as a gay man, that if there is someone else about there is that… there is some mutual support there. (Steve – Paramedic)

Steve also identified his use of touch as risky and thus himself as the vulnerable subject. Furthermore, positioning himself as being an openly homosexual man, he explicitly identified that he was anxious about touching a young man. He took up the subject position of a male at risk when enacting touch in general, but the discourse of the sexually promiscuous gay man (Davies, 2004), adds to the complexity of touch interactions for him.

Similar to Tom and Mike, Steve acknowledged his use of another person when he felt vulnerable. The recruitment of another person to enact caring touch when a patient needed solace, was a strategy employed to remove the possibilities of risk and reduce concerns for these male health practitioners. The pervading worry that was experienced for these men produced practices in others, namely their female colleagues, who were able to engage in caring touch with less fear of recrimination.

> I feel for them [male colleagues]. I know they want to ease the distress of patients by touching them, but I also know there's fear in the background of any touch that isn't say part of what we need to do. So, if we are partnered up, I'll take on that role. It's easier for me. I'm a middle-aged woman so I haven't got the worry that they might. (Jo - Paramedic)

Here, being a female practitioner enabled acts of all types of touch in a way not easily available to men. When the touch from a male is constructed adversely, it produces male practitioners who may be constrained in the ways they can care for a patient. The dominant discourse of male touch as sexualised affects practice for the male practitioners, who wish to enact caring touch as a tool to assist their patients. Furthermore, it may affect the patient themselves, who may lack care in the form of touch that may be of benefit to them. The discourses of touch as sexualised and discourses that construct gender roles combine to produce actions that may marginalise what are seen as aspects of best practice.

Practicing in an environment where the multiple discourses of touch as sexual, touch as problematic, and touch as beneficial to wellbeing compete, gives rise to opposing ways of giving meaning to the working world of a health practitioner, and this was evident in the analysis of the male participants in this study. Throughout the data there were times when contradictory statements were evident, exposing the presence of multiple discourses that contributed towards the complexity as articulated by Robert.

> I have watched patients over the years and seen how comforting them by holding their hand or rubbing their arm can make them feel better, or maybe it's just having someone, knowing someone is there to help them, I'm not sure. Anyway, I know it can help, but I don't. I just don't because I worry. Do you get that? I think maybe I'm worried that I shouldn't do it [caring touch]. Maybe it won't help, or someone might think it's wrong. (Robert – Paramedic)

There are contradictory statements made in the excerpt by Robert that suggest, like the other male participants in this study, the presence of competing discourses. In his excerpt the discourses of touch as assisting wellbeing, caring, sexual, and professional all compete to produce complex and murky understandings of what can be constructed as acceptable boundaries for a male health practitioner in terms of caring for a patient. Both spoken and unspoken in this statement, and those of other male participants are concerns regarding accusations of unprofessional and possible criminal behaviour. This perhaps indicates that men are subject to ongoing scrutiny whenever they are in close contact with others, constructing a particular kind of person, a male, who makes touch dangerous. However, unspoken are the practices of being human. These male health practitioners are constrained by the discourse that constructs their acts of touch as sexualised in ways that supress the act of one human caring for another.

Surveillance as a safeguard

The construction of men in western society as articulated above, leads to the production of a large number of male health practitioners who carry out their practice being cautious and

experiencing a heightened sense of anxiety over their actions (Fisher, 2009; O'Connor, 2015; Whiteside & Butcher, 2015). All of the male health practitioners in this study, at some point, constructed any type of touch activity, particularly intimate procedural touch, as problematic. Professional guidelines, both nationally and internationally (Medical Board of Australia, 2018; Medical Council of Ireland, 2019; Medical Council of New Zealand, 2021), recommend the use of a chaperone for male doctors specifically. The direction from registering councils aims to provide male doctors, in particular, with the confidence to complete the examination of their patient without fear of recrimination and potentially reduce the risk of facing accusations of inappropriate touch. It could be argued that such guidelines perpetuate the ongoing climate of fear that overshadow all male touch; nevertheless, these recommendations were taken up by some of the male doctors in this study.

> That's why we all have a nurse with us these days if we're doing any type of intimate procedure. It didn't use to be like that but I'm afraid we live in a more litigious society. (Tom – Doctor)

The use of a third party to observe is a type of surveillance, used to monitor activities. Gore (1998) suggested surveillance can be defined as "supervising, closely observing, watching, threatening to watch, or expected to be watched" (p.235), and Foucault (1977/1995) wrote about acts of surveilling in his text '*Discipline and Punish'*. To illustrate the techniques of observation and supervision, Foucault (1977/1995) drew on Jeremy Bentham's plans for a model prison, the Panopticon. The model situated a guard tower in the centre of the prison with a series of cells arranged in a circular fashion around the tower. It was suggested the glass-sided cells led the prisoners to believe they were under constant surveillance even though they could not see into the tower and were unaware when they were being surveilled. Nevertheless, the effects of this were such that they monitored their own behaviour which Foucault suggested would produce aspects of self-discipline (Cole et al., 2004; Foucault, 1977/1995). Surveillance of the health practitioner at work appeared to have a similar effect. O'Farrell (2005) suggested there are complex systems of surveillance that result in the decision of health practitioners to have someone witness their practice. Being observed by a designated chaperone, was not forced upon them by a government department such as the Ministry of Health but was a step that many felt necessary to protect themselves. However, surveillance from an assigned chaperone is questionably not the only surveillance experienced by male health practitioners. Other colleagues, patients, and wider society have the opportunity to surveil them on a daily basis.

> Well, I guess it's unfortunate that we live in a world where the physical contact of a man with a child can be misinterpreted so I use another person as a sort of modern-day chaperone. (Mike – Doctor)

Drawing on the dominant societal discourse that constructs the touch of a man adversely, Mike chooses to use a chaperone. However, for most of the male health practitioners the option of calling on a colleague to act as a chaperone, was not possible. Given the low levels of staffing in most healthcare facilities, the availability of a secondary practitioner to act as the 'chaperone' is challenging (Mitchell et al., 2018). There are, however, alternatives to the officially designated chaperone that is used in health practice when a practitioner feels at risk. The presence of a member of the public, another adult, or a nearby patient were, without a request from the patient, called upon to attest to good practice if required.

> Now that I think about it, although I do touch my patients on the arm and rub their back or shoulder if I think they need support, it's usually when other people can see. Weird now you say, not sure I think about it but maybe it's a subconscious thing and in the back of my mind that I only do it in sight of others. Come to think of it, I'm not sure I would do it if I was alone with a patient in a room. (Callum – Nurse)

As articulated by several male participants, there was a level of safety that ensued when an observer was witness to actions that appeared to reduce underlying anxiety pertaining to the possibilities of misinterpretation. Being visible implied safety, a protective mechanism employed to guard one's professionalism. Interestingly, there was no suggestion from any of the health practitioners that there may be potential for observation from a third party to also misinterpret the actions of the said health practitioner. Whilst one person may construct acts of caring touch as a positive way to demonstrate kindness and compassion; for another, it can be constructed as inappropriate and/or unprofessional. Nevertheless, placing trust in the observer is something these health practitioners do not question. Inherent in this placing of trust, is the sense that these health practitioners know their practices of touch and caring touch are legitimated by the professional and caring practitioner discourses. Again, it was the shared knowledge and understandings that, I suggest, reassured the health practitioners that the observation of another would not result in a misinterpretation of their actions. Callum's reflection shows how the unknowingness about how male touch will be interpreted leads to an internal vigilance for some of these men, ensuring that the situation/environment is safe. I argue the discourse of touch from a male as sexualised is so dominant that the thoughts and actions it produces never gives Callum pause for questioning. Only when questioned about his practice did he reflect on the way his touch could be constructed by others.

The discourse of touch as sexualised produced a practice of keeping oneself safe by taking up the use of a chaperone whenever the male doctors constructed a procedure or situation as having a particular meaning where their action may have been seen as problematic. Furthermore, this type of surveillance as proposed by professional guidelines seemed to provide these doctors with some sense of ease in their working day. In this sense, the chaperone becomes a subject, created in a discourse whereby touch between a doctor and patient has the potential to be problematic. The adoption of a chaperone to enact surveillance, constructed an environment whereby there was less room for speculation and ambiguity in the procedures they were performing. However, unspoken was the possibility for the presence of the chaperone to change what occurred discursively in the interactions between a doctor and their patient. As such there are intended effects of having a chaperone present during examination, but also unintended effects.

The patient

Within the data that constructed touch as risky for male health practitioners was a particular kind of subject who may present risk - the patient. It was this construction of the patient that gave concern and prompted comments pertaining to the vulnerability experienced.

> … it only takes one unstable patient to accuse me of something and who knows. (Tom – Doctor)

In addition to Tom's concerns for himself, it is interesting to note how he constructs the patient who 'misreads' touch in a particular way. He identified them as "unstable", hence problematic, and possibly irrational, in contrast to his own apparent rational position as a health professional. Tom does not explicate what he means by "unstable" because it is inherent in the context of his statement and demonstrates, once again implicit shared knowledge. When touch is readily implied as inappropriate and problematic, health practitioners may enact a form of resistance and refrain from caring touch in particular. However, the choice to limit aspects of procedural touch for these male practitioners was more complicated; thus, the recruitment of a chaperone was sought.

Most professional guidelines suggest the use of a chaperone is two-fold; that is, it is about providing a safe environment for both the health practitioner and the patient (Medical Board of Australia, 2018; Medical Council of New Zealand, 2021). Nevertheless, as exemplified by Tom previously, doctors suggested the presence of the chaperone stemmed from the desire to safeguard themselves rather than to be of benefit to both the doctor and the patient. Such lack of clarity over the suggested function of a chaperone produces male doctors who

construct the patient differently. Whilst Tom suggested the potential of the unstable patient, other practitioners suggested reactions from patients to touch are constructed through a lack of understanding about the procedure being undertaken.

> Having so little time with the patient, you don't know what you're getting, sort of how they'll respond when you touch them. They don't get it sometimes, even when we explain why we need to touch them. It's sort of unknown territory, so most of us err on caution. (Robert - Paramedic)

Some health practitioners constructed the patient as someone who may not understand the reasons for touch interactions, specifically intimate touch. In these circumstances, the possibility is raised that a patient could misconstrue and react adversely, and the patient is therefore seen as someone who has the ability to cause problems. As such, the patient is seen as holder of power. Foucault's notion of power is that it is relational and operates between people, which is more nuanced than the professional guidelines suggest; where it is the health practitioner that has power over the patient (Medical Board of Australia, 2018; Nursing Council of New Zealand, 2012). From a Foucauldian perspective, the subject positions of both the patient and the health practitioner are created or recreated within each interaction. They both have aspects of freedom pertaining to the power that exists in the doctor/patient relationship. It is this freedom that produced the uncertainties many of these health practitioners experienced. The proposal, therefore, that power lay in the hands of either the health practitioner or the patient is somewhat misleading. Rather, power is embedded in current discourses, moving amongst the network of the individuals involved and thus never in the hands of one particular group.

Self-discipline

The data from the participants demonstrated significant tensions in operation between the desire to enact caring touch and the problem of touch's ever-present potential to be interpreted as sexual for these male health practitioners.

> There are times when making physical contact with another human being is important. Saying all that, if a child, or person for that matter, tries to hug me when there isn't anyone else around, I sometimes find myself challenged by reciprocating the hug, even though I know it's the right thing to do, I sort of hold back in an attempt to make them stop … … I guess if I'm honest it's because I am always thinking in the back of my mind, what would happen if they thought the meaning of the hug was different to what I meant. So, I sort of watch my own actions knowing that people can interpret things very differently. (Mike – Doctor)

This tension exists because it is problematic when health practitioners cannot do what is needed to care. In everyday common situations outside the realms of health, it is

inconsequential that touch is absent from the interaction with another person; for example, purchasing an item in a shop or eating at a restaurant. However, its significance is much heightened when the person is a health professional where acts of caring are arguably more important. Consequently, when the discourses that construct touch as sexualised, essential to wellbeing, and professional, conflicted, and collided, it proved difficult for these practitioners to negotiate. Moreover, as a culture and society people are caught at this impasse: allow touch and risk sexual misconduct (because prevailing discourses construct this as a perpetual risk) or, refrain from touch and risk lack of care (because discourses construct touch as a critical part of human care). As such, although use of a chaperone or third party was a practice adopted by some male health practitioners, an additional aspect of surveillance was taken up. Some male participants disciplined themselves by self-checking their actions and withdrew from situations where there may be a need for caring touch. Acts of self-discipline became more problematic when health practitioners wanted to provide comfort via caring touch.

The worries that Mike and many of his male colleagues had stem once again from the discourse that touch from a male is sexualised. Therefore, touch between a male and (in Mike's excerpt) a child, is constructed as unpalatable to many people, who suggest men should refrain from caring touch. Mike's statement "what would happen", suggests he was concerned about the ramifications of someone misconstruing his actions of caring touch. Fear of potential punishment from within the institution of the hospital, and perhaps beyond, is clear. The discourses that produced the male participants' constructions of gender and touch clearly overlapped and resulted in multiple and unstable subjectivities. These discourses produced a monitoring of one's own actions demonstrating an emphasis on the self-management of risk. The concept of disciplining of self was similarly evident for Steve.

> …the touch from a male to someone, whether they are male or female, seems to be always tainted with the potential for inappropriate touch. It's a hard call for men. Unless you know a person well, you have no idea how they'll receive your physical touch, so although it's not what I'd choose, I make sure I generally reduce physical contact just in case. (Steve – Paramedic)

Steve identified that the touch of a man is always subject to multiple subjectivities (the caring health practitioner, the sexual predator, the professional), and problematised the use of touch in his practice as a paramedic. This produced an uncertainty whereby he, and other males, encountered the need to practice self-surveillance and self-discipline. Consequently, these tensions produced health practitioners that withdrew caring touch when tending to their patients.

Safe spaces and places

When dominant discourses construct acts of touch as sexualised and problematic, particularly when linked to touch between two comparative strangers, it has an effect on health practice in that it invades the way male health practitioners use caring touch. However, any concerns about acts of caring touch were superseded by concerns about other types of touch. Throughout interviews with the male participants, it was the act of touching required during an assessment or treatment (defined throughout this thesis as procedural touch), a necessary part of their practice, that caused more concern. For some participants, it was the specific environment where these acts of procedural touch were conducted that appeared to either reduce the concern and produce practitioners that felt more at ease or, conversely, increase feelings of disquiet.

> It's part of what we have to do, you know, so when you're in an open space like in A & E when there's people around, you feel a bit safer, you know, less risk of someone thinking you're up to something weird. (Mike - Doctor)

The knowledge that their actions were visible to their colleagues appeared to reduce the burden of being the "at risk" doctor. The construction of the 'safer' open working space experienced by Mike contrasted significantly to the paramedics where they may be the solo health practitioner caring for a patient in the confined space of the ambulance.

> … so, when you're alone with a patient that you don't know from Adam, in the back of the truck, it can feel, you can feel a bit compromised, maybe I mean vulnerable. I don't know, but once the initial work has been done to maybe stabilise them then sometimes, I think about it. Nobody can see me. What could happen? It hasn't, but I don't want to touch them in any way that's not necessary, just in case. (Steve – Paramedic)

Once again, a male health practitioner takes up the subject position of the at-risk professional. The rear of the ambulance does not always offer the opportunity for Steve to be seen by a colleague or another member of the public. As previously, although it is not overtly articulated, he referred to the discourse that dominates the practices of male health practitioners that constructs acts of touch as sexualised.

Although the statements made by the male practitioners prompted less response about acts of caring touch than their focus on procedural touch, there still remained a cautiousness to engage in touch that demonstrated sympathy or support. In contrast to the necessary and expected acts of touch, caring touch for most health practitioners is a matter of choice, not an essential part of practice. It was this choice that created conflict for some male participants, as

the discourses of touch as sexualised and the caring health professional competed. During times when acts of caring touch were enacted, they were restricted to specific areas mapped on the body. Many suggested if they felt emotional support was required by the patient, they may use caring touch via the action of putting a hand on a shoulder, arm, or upper back.

> Could be upper arm generally, or just the shoulder. (Tony – Paramedic).

The areas indicated were constructed as less risky and caring touch in these areas was regarded as a useful tool at certain times. What deems these areas as 'safe' for male health practitioners draws on the discourse that proposes touching other areas of the body carries the potential for being suspicious and possibly inappropriate. However, discursive practices of touch between people vary greatly across the globe (Classen, 2012; Kinnunen & Kolehmainen, 2018). Working within cultural mores, social and professional boundaries, created tensions for these health professionals which, I argue are heightened for male practitioners.

The subject positions adopted by those enacting touch in health practice places them in a context different to where discourses constructing acts of male touch as sexualised are operating outside health practice. This means the touch of a health practitioner could be considered differently to the discourse that sees the touch of a stranger as problematic – the problematic other. As such, touch from a health practitioner to a patient, particularly when given in the context of a medical setting, is generally considered as a safe and necessary action. This designates the health practitioner as being in a trusted position and denotes a significant shift in the way touch is constructed within a particular environment. The shift of subjectivities that construct particular spaces, such as the ambulance, as safe places for acts of touch to occur, arise from the discourses of professionalism whereby the health practitioner holds licence to touch. However, underlying this prevailing discourse there remained an unease about the male health practitioner engaging in touch. Although having license to touch by way of their professional practice validates male health professionals' acts of touch, the male participants in this study maintained that touching specific areas of the body was problematic.

The benefit of experience – Discontinuity of discourse

To draw together the main points of this chapter I offer the experiences of one participant: a male hospital-based doctor. He showed how experience and authority have altered his practices. Nevertheless, as seen previously, when multiple discourses circulate and intersect, contradictions and discontinuities emerge. Tom takes up the subject position of the

experienced confident doctor, with an understanding of caring touch. As such, he existed at the intersection of discourses, embodying the tension that is the subject of this entire chapter.

> I remember when I first started my training in the hospital and was doing a rotation in the children's ward. I'd been really looking forward to it. After a few days, I was looking after a little boy with cancer, and he'd been really sick. His parents weren't there at the time and I felt so sorry for him. He was in a lot of distress. I sat him on my lap and just held him for a while. I remember him clinging to me so tightly. After a few minutes, his tenseness relaxed, and we sat for a while in silence. I just rocked him. His parents came back and thanked me for taking the time to give comfort to their little boy. I felt like I'd done a good thing. However, the senior nurse that came back with them pulled me to one side and told me there wasn't the time to do that sort of thing and that it'd be better in the future if I didn't enter the personal space of a child in case others thought it was inappropriate and unprofessional. I've often thought about that over the years. For a long time, I listened to her suggestion and removed myself from that caring type of behaviour, but as I gained more confidence and experience with people, I decided that offering comfort is important to patients and it was important to me in enabling me to look after all dimensions of a person's wellbeing. I've stopped worrying about what others think and that it could get me into trouble. I know I've been observed in the past by others that disagree with giving patients that type of comfort, but it's a risk I'm willing to take. Maybe if I was a woman, it would be viewed differently. (Tom – Doctor)

I have used this excerpt in its entirety as an example of the matrix of discourses influencing the working lives of these health practitioners. This statement shows the ways in which discourses and subjectivities interacted to produce particular actions. I opened this chapter with an excerpt from Tom that stated for him the sexualisation of touch led to the avoidance of touch. However, the quote above shows contradictions to his earlier statement. In a poststructural sense, these contradictions outline the concept of subjectivity as being fractured and contextual. This became apparent throughout the statements made by the participants in this study demonstrating that discourse is not a static entity.

The caring discourse provides the impetus for many people to embark in health practice and is one that sustains them in their career (Adams, 2016; Hamilton et al., 2016; Rhodes et al., 2011). It is this caring discourse that became more dominant for Tom when he (and others) witnessed the benefit to the patient. Inherent in Tom's words are the power of an experience where, for him, caring touch was constructed as the right thing to do for the distressed patient.

Although it was theoretically possible for Tom to enact caring touch earlier in his career, after the rebuke from a senior colleague, he did not. Influenced by dominant discourses such as a

particular professionalism discourse, and the discourse that sees touch from a male as sexualised, he refrained from contact. The inexperienced health practitioner (and the experienced as well) are subject to Foucault's (1972/1980) description of power-knowledge. Furthermore, those working within the hospital walls are influenced by the hierarchical power dynamics existing between staff, and by the hospital environment itself which is a product of the biomedical discourse.

Tom's experiences contributed to his construction of professional practice. However, he questioned what his experience would have been if he were a female. This again demonstrates the interplay of the gender role discourses and the construction of touch as something potentially unsafe when offered by a male. Nevertheless, contradictions in his statement identified with the experiences of others who embody fluctuations in subjectivities. In Tom's experience, the dominant discourse that constructs male touch as sexualised was presented by a senior staff member who suggested future punitive consequences. The potential for some form of punishment to be enacted if he did not comply with the 'recommendations' of the senior nurse demonstrates how hierarchical systems are enacted to subjugate health practitioners. Foucault's (1972/1980) suggestion that power is constituted through accepted forms of knowledge is supported within health practice where experience often awards high status. Tom struggled with the conflicting ideas about professional practice, and he experienced that discourses construct gender as a modifier of appropriateness in touch situations. As such, early in his career, Tom adopted an alternative subject position which, for a time, subdued his inclination to use a model of care that engaged in caring touch practices. However, at some point later in his career, another shift occurred. Tom found himself at the intersection of discourses that constructed male touch as potentially inappropriate and discourses that constructed caring touch as essential to good practice. Tom's experience and growing confidence as senior doctor acknowledged the many dimensions of wellbeing that support patient care. He drew on his personal understanding of professional practice to legitimise his use of caring touch as he acknowledged that health care is more than a disease that must be diagnosed and treated.

The confidence gained through Tom's experiences as a senior doctor and/or his professional understandings produced a health practitioner that constructed caring touch as a tool that can be used to great effect. In contrast to his previous years of practice, he took up the subject position that constructed the suppression of caring touch as problematic. He resisted the dominant discourse that permeated the working lives of many of his male colleagues and he "takes the risk". He was able to aspire to what his peers could not, and Tom took up the

subject position of the confident, senior doctor who, guided by the discourse of caring touch as beneficial to reducing stress, anxiety, and pain, adopted acts of caring touch. However, although he had status as a senior member of staff, of note was his suggestion that he remained at risk. I argue that Tom and many other male health practitioners remain subjects of the discourse that constructs touch as sexualised and therefore, a risky action to engage in. Furthermore, I suggest these multiple constructions of touch practices are the reason why many participants displayed contradictions in their thinking and are arguably the reason for the on-going confusion experienced.

Summary

In this chapter I have identified and analysed the dominant discourses that constructed caring touch as sexualised: touch as risky, the need for surveillance, the unknown patient, and safe spaces and places. The co-existence of these discourses was particularly challenging for the male participants who constructed acts of touching a patient as having the potential to put their professional reputation at risk. When these discourses were linked to sexuality, they subjugated the males in this study which led to the taking up of specific subject positions.

Notable is the self-discipline adopted by these males whereby measures were put in place to negotiate any touch interactions. Being at risk produced male health practitioners who felt safe when touch actions were witnessed by a chaperone/third party, linking closely to Foucault's effects of surveillance. Despite not always knowing the partiality of the third party there was an assumption from the health practitioners that a third party was predominantly support for them, rather than the patient. I have argued that circulating continually around surveillance and self-discipline were aspects of power playing out in the negotiation of touch activities.

Additionally, analysis of the discourses revealed environments where the practitioners felt their touch could be constructed as appropriate and as such, safe. Not only was being visible an important part of reducing their risk, but the workspace (e.g., clinic rooms or ambulance) allowed them to draw on the biomedical discourse, and the professional discourse that provided them with licence to touch. This licence also provided some certainty that the patient would consider touch, enacted to carry out a procedure or assessment, acceptable. In contrast, 'unnecessary' caring touch might produce alternative responses from the patient. Consequently, the interaction of discourses produced conflicts and tensions as the male health practitioners experienced situations of uncertainty and concern during touch interactions.

The interplay between discourses unsurprisingly, also presented contradictions in the statements from these men. These uncertainties and anxieties grew when the patient was constructed as the unknown factor. Being unsure of how touch would be received gave pause for reflection as practitioners, most of whom were generally at ease providing comfort through caring touch, found the 'not knowing' hindered their actions. Furthermore, the patient and the practitioner are equally entangled in the discourse that constructs touch as problematic, meaning the patient is likely to view touch as challenging as the practitioner may do. It was this general perception of males that prevented a number of health practitioners in this study from using caring touch safely regardless of what their actual experience or understanding of caring touch was. However, having experience was constructed as being of benefit, producing a health practitioner that had the confidence to resist discourses that were dominant for others and limited their caring touch practices.

The plurality of discourses present meant the manner in which a health practitioner constructed and responded to the needs of the patient was open to interpretation. In response, each health practitioner found their own way to negotiate situations where competing discourses continued to circulate. Most inferred they constantly negotiated what the continuum of acceptable caring touch meant. Thus, there were always underlying tensions present when touch was actioned. Overall, from the findings presented in this chapter, I argue that the health practitioner navigates and strategises what touch to use, where, when, and how. Whilst current discourses offer the possibility of caring touch, others will constrain its use. For these male participants, the multiple discourses at play in the work environment created blurred boundary lines that ensured acts of caring touch served to be too complex to negotiate, resulting in most making choices that limited touching interactions with patients.

Chapter Eight – Discussion: Constructs of Caring Touch

Introduction

The aim of this chapter is to review, consolidate and extend the analysis presented in the previous three chapters. The primary objective of this thesis was to explore how caring touch was constructed by discourses most predominantly deployed by the health practitioners and identify the effects of these constructions on practice. To this end, I explain the key assumptions and unchallenged accepted practices. Throughout I re-engage with my original argument pertaining to caring touch to show that current understandings of caring touch are complex and contradictory.

Using a Foucauldian approach provided me with the opportunity to explore how caring touch is "questioned, analysed, classified and regulated" during "specific times and under specific circumstances" (Deacon, 2000, p. 127). Foucault's approach to inquiry is to question that which appears self-evident. In the context of this thesis, touch, more specifically caring touch, is integral to the work of most health professions as they are required to enact various types of touch throughout their daily practice. However, as shown throughout, acts of touch are complex and contested. Underpinned by poststructuralism, a Foucauldian approach facilitated analysis of health practitioners' interviews in a way not previously reported. It enabled the identification of discursive themes that are woven throughout my findings and the ability to challenge taken for granted truths about caring touch (Foucault, 2005; Peters, 2003). As such, this thesis adds to health scholarship by highlighting where discourses produce effects that constrain the practice of caring touch, despite assertions in the literature that it is an important aspect of health care (Nicholls, 2012).

In this chapter I present how this research not only extends current understanding, but also, how it both differs from and reflects that which is currently known about caring touch in health practice. The discussion is guided by the dominant discourses identified in participants' accounts and subsequently, the associated subjectivities. Competing discourses produced some health practitioners who articulated significant concerns and confusion about the professional boundaries pertaining to caring touch.

I begin the discussion of the findings of this thesis by offering a summary of the ways in which constructions of caring touch were at times juxtaposed. I turn first to the contrary discursive constructions of caring touch in professional practice where health practitioners work within an environment dominated by particular discursive practices that, at times, create contradictions and misunderstandings. I then further the discussion by unpacking the

constructions of caring touch as having the potential to be problematic. Statements from some health practitioners showed discourses of professional practice and touch as problematic, were so dominant that practices of caring touch were at times concealed or marginalised. Additionally, my analysis demonstrated there were times during practice when participants deployed multiple discourses at one time.

In the final section of this chapter, I discuss the limitations and omissions from this thesis. Foucault's histories of the present (Foucault, 1977/1995) encouraged ongoing exploration of what else may be possible and, guided by this suggestion, I offer possibilities for new avenues of investigation that may continue the exploration of possibilities for caring touch.

Negotiating caring touch

The act of one human physically touching another is discursively produced and, as such, can be constructed as acceptable in some circumstances and not in others depending on who, where and when the touch is actioned. In this thesis, the various discourses that constructed caring touch in different and sometimes conflicting ways created blurred boundary lines that produced uncertainty for some of the practitioners. Discourses of professionalism, caring, and male touch as sexual were in play as the participants articulated their use of caring touch. Within these interactions, acts of caring touch were constructed differently by health practitioner groups. Although caring touch was constructed as an act of compassion, it was also problematised and consequently practitioners limited its use, echoing constructions of caring touch from previous studies (Kelly et al., 2018; Pedrazza et al., 2018; van Dongen & Elema, 2001). In contrast, other participants drew on the knowledge gained from their experiences and used caring touch in ways to assist the patient, thus demonstrating the multiple constructions of this human act.

What became evident throughout the analysis was the negotiation of any act of touch, whether procedural or caring, was constructed differently both across and within disciplines. Whilst some health practitioners did not construct procedural touch as materially different from caring touch, enacting both without undue concern, others were much more wary.

Notions of professionalism

Throughout this study participants regularly drew on concepts of professional practice. This professional commitment to competence, morality, ethics, and integrity form the basis of a contract between a health professional and society, which in turn offers professional autonomy (Cruess et al., 2002). Drawing on these notions of professionalism and the obligations necessary to sustain it provided justification for models of practice. However, the

ways in which a health practitioner constitutes professionalism is influenced not only by the professional body guiding practice, but also by aspects of biomedicine and public perception. As identified in Chapter One, absent from most health professional guidelines is direction about touching the patient, specifically acts of caring touch, arguably indicating that it may not be considered by the relevant body as part of 'professional' practice. For some health practitioners, the broad generalised statements that defined professionalism (articulated throughout training and present in professional guidelines) were drawn upon to guide their practice of touch. For others, these statements did not aid with their decision making. Apparent was a complex interplay of multiple constructions occurring which, at times, collided, creating confusion about the role of caring touch in professional practice. The following sections outline how the varied constructs of professional practice influence acts of caring touch.

Hierarchy, gender, and the emotional caretakers

Foucault (1972/1980) proposed that powerful social structures and hierarchical bodies have extensive influence across every situation a person may experience and noted that this is particularly prevalent in professions that wish to protect their dominance, such as medicine. In 1967 Stein described the 'doctor-nurse' game where he suggested roles had not changed over time, and although nurses had important input into a patient's treatment, they had to find ways to passively communicate information to doctors to avoid usurping them. Female nurses were seen as the caring party in the health practitioner/patient relationship where they took direction from the doctor and completed their given tasks whilst ensuring the patient was given empathy and comfort (Stein, 1967). However, over time, health practice has changed, particularly in gender balance. More females are trained as doctors and more males are becoming nurses. As such the 'doctor-nurse game' has become less commonplace (Zelek & Phillips, 2003). Nevertheless, as identified in statements by the participants in this study, the hierarchy inside the hospitals particularly maintains the notion that acts of caring touch are the domain of the nurse. Gordon (1992) stated that in a patriarchal and highly individualistic society, caring has been maligned by men and suggested nursing was unequivocally created as subordinate to medicine. Similarly, Gray (2010) stated medical doctors were detached from caring touch and "leave nurses to pick up the emotional pieces" (p. 356) suggesting actions of caring touch continue to be constructed as the responsibility of others. In this thesis it was the female nurses, in particular, who were constructed by both doctors and male paramedics as the most appropriate to take up the subject position as provider of caring touch and emotional caretaker. Based on the findings reported in this thesis, I contest the idea suggested in the

previous literature that the gender and hierarchical discourses prevailing in some health care environments are the only, or even the most dominant, discourses in play when it comes to the relegation of caring touch to female staff. This suggestion supports claims made in other academic literature (Gordon, 1992; Weber et al., 2019; Wingood & DiClemente, 2002; Zelek & Phillips, 2003). As discussed later in this chapter, the discourse that constructs touch from a male as problematic dominated the thinking for many of the male health practitioners who appeared to take comfort from being able to delegate acts of caring touch to their female colleagues.

Time

Although many studies, as identified in the literature review, make claim to the benefits of caring touch for patients, the presence of alternate discourses in the working lives of the health practitioners in this study appeared to restrict the opportunities for caring touch. Lack of time was often mentioned as problematic, reducing capacity to engage in caring touch. Reduction in the number of health practitioners in Aotearoa New Zealand, and similarly internationally, has caused changes in the workplace, and the subsequent reduction of time to spend with patients has been well documented (Gauld & Horsburgh, 2014; Lyndon, 2016; Schmeidel et al, 2012). Many health practitioners, primarily nurses, comment on their frustration regarding the inability to give time to patients in their practice (Glantz et al., 2019; Molina-Mula & Gallo-Estrada, 2020). Similar frustrations were echoed in the statements made by several participants in this study. Lack of time was identified by the participants as being the reason for the loss of opportunity to engage in caring touch, and other aspects of care are arguably prioritised. Nevertheless, as articulated by several participants, small acts of caring touch require no additional time and can be seamlessly integrated within examination and treatment of the patient. Again, contradictions are revealed that mean for some health practitioners, the construction of caring touch as an act to be included in care of the patient if time allows, conflicts with others who experience an effortless integration of caring touch into their time with the patient. Although time may be constructed as a reason to reduce acts of caring touch, I suggest the presence of other discourses, such as those that construct the touch of an adult male as problematic circulate the work environment maintaining underlying tensions.

The science of touch

Throughout the 1960s and 70s Foucault was particularly interested in the way that positivism had become the ultimate form of rational thought (Foucault, 1970/2002; O'Farrell, 2005). It had become widely accepted that sciences, such as statistics and chemistry, were the most

effective way to discover what was important to know about people and the world around them. What became known as the 'hard' sciences (e.g., chemistry and biology), became legitimate to prioritise over other topics of learning (O'Farrell, 2005). Similarly, Western modern medicine that took its lead from this scientific evolution became known as biomedicine, and became the foundation of practice for most health practitioners (Lloyd, 2012; Valles, 2020).

Tests, medication and/or surgery can return a person to good health; thus, biomedicine is integral to most Western cultures where it proves to be an effective model of health care (Payne et al., 2007). This has led to a technical approach to the patient whereby they are the object of investigation under the gaze of the doctor and where the mind-body dichotomy dominates (Findlay, 1992; Lange & Lu, 2014). Despite the biomedical discourse dominating health care practice, as with all discourses, they do not remain static. Biomedicine is a dynamic entity, shifting its focus over time constructing health professional practice in alternate ways (Payne et al., 2007). As research continues to explore and demonstrate the effects of caring touch, and contradictions and discontinuities arise, the link between the dominance of biomedicine and other contributors to good health, such as caring touch, may contribute to continual shifts in health practice.

Of interest throughout this thesis was a general thread that inferred caring touch and its effects on humans was not a practice based on empirical scientific evidence. Rather, it was constructed as an additional extra to be used if required, but not part of evidence-based medicine. However, an extensive body of academic literature positions the effects of caring touch as proven to initiate significant physiological and psychological changes (Field, 2014; Linden, 2016; Montagu, 1986). As such, a paradox exists whereby the doctors, in particular, called on the empirical scientific evidence of biomedicine to support their core system of practice yet ignored the empirical scientific evidence that supports the benefits of using caring touch to aid recovery. As this thesis progressed, it became clear that this 'omission' of scientific knowledge supporting the practice of caring touch had constructed health practitioners in a particular way. This was a major finding of the current study and I argue this construction of caring touch as 'external' to science is one of the reasons that research on the benefits of caring touch is still mostly absent from the education of health practitioners in Aotearoa New Zealand.

Pedagogy of caring touch

As shown in Chapter Three, there is a strong body of empirical evidence on the benefits of caring touch. Despite this salient support for its effectiveness in health practice, it does not have a place in most health practice curricula, arguably marginalised as a topic for inclusion. From a Foucauldian perspective, this is of interest as the absence of caring touch suggests it has little importance in the training of health practitioners.

While a detailed analysis of the specific content of curricula was outside the scope of this thesis, what was of immediate interest were the ways the integration of caring touch in their training was articulated by the participants. Several suggested they had given little thought to caring touch prior to their participation in this study. Reasons for this seemed to be varied. Some did not consider it as something necessary to concern themselves with, suggesting it was an assumed part of their practice. Others suggested the lack of discussion or absence of transparency about caring touch in their training meant it was of little importance. As such they either refrained from any form of engagement in caring touch or, alternatively, thinking it may be a useful resource, observed colleagues and followed their example. This was articulated by several participants who stated they took their 'lead' from the observation of nurses, in a sense gaining permission to enact caring touch.

Deficient in knowledge about caring touch through their undergraduate training, the newly trained health practitioners may have been able to turn to guidelines from professional bodies for clarity. However, also notable is a significant number of professional guidelines that favour avoidance of touch in practice when possible.

Notions of risk – Safe places and spaces

Discussions pertaining to risk have been written about as a societal construct since the 1990's when the work of Ulrick Beck (1992) described a direct correlation between greater knowledge exchange and increased ontological fear. In other words, the more informed we become about the world, the more we are 'exposed' to the possible dangers around us. For the study participants, the notion of being at risk encompassed acts of both procedural and caring touch, and, I would argue, was driven largely by the discursive constructions and regular media reporting of touch as dangerous. Concerns driven by these constructions of touch influenced some health practitioners to question the place of caring touch in their own practice.

When the discursive construction of touch is such that it is perceived as producing risk, it has an effect on the way in which people communicate through touch. In health practice, when caring touch can occur between two comparative strangers, touch is sometimes constructed as

challenging. In turn, this may have an effect on how it invades the way some health practitioners enact caring touch.

However, the discourses operating throughout wider society that construct touch as problematic and possibly sexualised may not be functioning in the same way inside the clinical or hospital environment. Within these physical spaces, the meaning of touch from a health practitioner could be considered differently to the discourse that sees the touch of a stranger as problematic – the problematic other. As such, procedural touch from a health practitioner to a patient, particularly when given in the context of a medical setting, is constructed as having a single altruistic purpose to benefit the patient – to assess, diagnose and treat the condition. The discourses of professionalism construct the health practitioner as trustworthy, acting in the best interests of the patient. This denotes the interpretation of touch as contextual to the setting. The shift of subjectivities signalling touch, both procedural and caring, within the spaces of a hospital, ambulance, and medical centre as being safe, emerge from professional discourses that support health practitioners as having licence to touch.

Licence to touch

Discourses of professional practice legitimise procedural touch by way of a licence to touch. However, I suggest that tensions potentially arise when health practitioners have limited information and understanding to guide their use of caring touch specifically. Unsure of whether their acts of caring touch are complicit with, or disruptive of the professional body, has the potential to cause confusion and in this study led to some participants worrying about touching patients. This was particularly so from some of the male practitioners.

Having license to touch by way of their professional practice should afford a degree of confidence, but male participants in this study suggested engaging in any form of touching was problematic. Constructing touch in this way has been documented in academic literature and is challenging for health practitioner and patient alike, male or female, particularly touch involving intimate areas of the body (Harding et al., 2008; Hine & Smith, 2014). I would argue that although professional practice provides licence to touch, in some way it complicates acts of touch as there are inevitable tensions that occur between the discourses of professional practice and the discourses that construct touch as sexualised. However, concerns relating to touch were often focused on acts of procedural touch rather than caring touch. Concerns relating to acts of procedural touch have been well documented (Blasdell, 2017; Nicholls & Holmes, 2012; While, 2021), but caring touch appears to have been overlooked in the practices of many health practitioners, arguably due to its construction as an action not necessary for

practice. This conflation of procedural touch and caring touch was a common thread that wove through the statements by the male participants where it was clear that any form of touch could give cause for concern. During data collection the participants often focused their thoughts on procedural rather than caring touch. For these practitioners their discursive practices required them to engage in acts of touch to complete daily tasks and it was this touch they often ruminated upon. Caring touch was constructed as optional and often not considered necessary to integrate into practice. Acts of caring touch were a personal choice which many of the male participants chose to disengage from. As shown in Chapter Seven, the risks, perceived or otherwise, were too challenging to contemplate; hence, they removed acts of caring touch from their practice.

Professional guidelines

Professional guidelines on touch practices examined as part of this thesis, did not differentiate between procedural and caring touch. When acts of touch were mentioned, the focus was primarily on examination and treatment. The wording found within these professional guidelines demonstrated the authors constructed touch as problematic, legitimising concerns and allowing certain discourses surrounding touch to circulate and pervade in health practice. The Medical Council of New Zealand (2018) recommends that best practice is to offer a chaperone for all examinations involving an intimate area of the body. They state, "Intimate examination… is likely to include examinations of breasts, genitalia, and rectum, but could include any examination where it is necessary to touch or even be close to the patient" (p.1). The Medical Council of New Zealand (2018) does, however, make a statement confirming that their guide is to safeguard both patient and doctor; "A chaperone acts as an independent person within the consultation, for both the safety of the doctor and of the patient" (p.79). The competencies outlined also acknowledge the importance of being able to respond compassionately to the patient's thoughts, feelings, and emotions. Since 1998, the American Medical Association has stated, "From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended" (2020). However, Tarutis (2015) suggested that due to the lack of clarity from the American Medical Association, and mixed interpretations of meaning, this non-binding protocol is not routinely followed by doctors. The suggestions for conduct are not a direct mandate, meaning it has retained a superficial non-conformity, leaving the individual practitioner to take up a particular subject position. In a bid to safeguard their professional reputation, I suggest the ambiguous statements in professional guidelines result in some health practitioners being caught in a risk averse stalemate, unsure of what the parameters of caring touch allow.

It would be relatively straightforward to criticise the ambiguity of professional guidelines, but Foucauldian discourse analysis encourages exploration of what discourse does rather than simply what it says (Fadyl et al., 2012; Foucault, 1981). Foucault (1981) called this the 'principle of exteriority'. There is a discursive function of such ambiguity which supports the notion that acts of touch are complex and contentious. I argue that if the guidelines were mandated, setting a protocol of when, where, or how caring touch was actioned, it would curtail the ability for health professionals to practice in a way that offers flexibility to their personal methods of patient care. Nevertheless, absence of specific guidelines or protocol at times produced health practitioners, in this study, who circumnavigated caring touch, feeling constrained, uncertain, and, at times, vulnerable.

Although most professional guidelines suggest a two-fold purpose of the use of a chaperone; that is, it is about providing a safe environment for both the health practitioner and the patient (Hawken & Wilson, 2017; Medical Board of Australia, 2018), the statements from the participants were contrary. They suggested the presence of the chaperone stemmed from the desire to safeguard themselves rather than to be of benefit to both health practitioner and patient. Such lack of clarity over the suggested use of a chaperone raises questions as to how the patient is constructed. Some participants suggested there was a possibility that the patient could misconstrue the need for the chaperone and react adversely. As such, the patient was constructed as holder of power. However, several professional guidelines (Medical Board of Australia, 2018; Nursing Council of New Zealand, 2012), and indeed some of the participants, suggested it is the health practitioner that is holder of power in the relationship, demonstrating that discourses of professional practice and the 'vulnerable' patient often interact and have the potential for conflict. From a Foucauldian perspective, power is relational and operates between the parties involved. As such, the subject positions of both the patient and the health practitioner are created and recreated within each interaction. Whilst the notion of a power imbalance is commonly drawn on in critiques of health structures (Bozorgzad et al., 2017; Entwistle et al., 2010; Fochsen et al., 2006), Foucault (1977/1995) suggested power is not something held by particular people, neither is it primarily a force, repression or hindrance:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (p. 194)

This quote suggests that power does not only repress; rather, it is related closely to the production of the object and truth. In terms of this thesis, the object of caring touch is continually circulating and is located in all interactions producing the forces that structure our lives.

Acknowledging the perspectives of these different professional practicing bodies highlights the surfaces of emergence that define for these practitioners what is deemed legitimate and what is rejected. Accordingly, professional bodies set the margin of tolerance for caring touch which guides practice. I suggest there is some irony in the implementation of professional guidelines. Limiting acts of touch from the health practitioner in an attempt to 'safeguard' the patient means the potential benefits of wellbeing may be absent. Beck (1992) referred to this phenomenon as the 'boomerang effect' and is a notion that has not yet been explored in the context of touch in health practice. Furthermore, the emergence and ensuing notions of self-protection, as articulated by the participants in this study, suggests that risk awareness is operating, producing health practitioners that reduce or abstain from acts of caring touch, distancing themselves from a threat of blame.

The contradictory nature of caring touch creates challenges for all those working in or writing guidelines for professional practice. Competing constructs mean any attempt to simplify guidelines of touch interactions are fraught with complexity pointing to the subtlety and nuances of all parties involved in touch interactions. The complexities and contradictions that permeate acts of touch suggest the responses of the participants in this study are shaped discursively and as such, blame should not be attributed to the decision-making process where acts of caring touch are involved. Rather, the health practitioners in this study moved dynamically within and external to the dominant discourses generating the discursive dance.

Notions of self-protection

Continuing with the construction of caring touch as being complicated and potentially risky for some health practitioners, findings from my research demonstrated how the object of caring touch has been problematised in the ways it is constructed culturally and socially. At times, participants commented on the lack of discussion with colleagues relating to concerns pertaining to caring touch. The inadequate transparency, both from professional bodies and within the working environment, arguably disabled these health practitioners, in the sense that making clear decisions was difficult, possibly generating anxiety over acts of caring touch. As an unspoken aspect of health practice, acts of caring touch are hidden and, I would argue,

the operation of dominant prevailing discourses sustain the various and complex ways caring touch is constructed by health practitioners and indeed the wider population.

Several participants made a statement about living in a more litigious society, speaking to a discourse whereby an underlying swell of anxiety constructs acts of touching as risky and potentially punitive behaviour. Building on the work of Beck (1992), sociologist Frank Furedi (2006) suggested the anxiety produced by touching interactions results in people being risk averse and, as such, people approach relationships with a heightened sense of risk. I argue that males, particularly those in a workplace where direct physical contact with others is required as part of their practice, are subject to a discourse that constructs touch from a male as open to the scrutiny of others. Although not all of the male participants in this study explicitly spoke about the notion of touch being problematic in their practice, many nevertheless positioned themselves as at risk, and acts of caring touch as problematic.

However, the discourse of touch as problematic is not simply gendered; touch is risky because it is sexualised. Although touch as being sexualised was not articulated, neither was it silenced. It was left unsaid as assumed knowledge. Dominant discourses of masculinity construct male behaviour as motivated by sexual desire. This discourse permeates wider society and is reinforced through various sources, specifically media reports and fictional representations (Fennell, 2020; Jackson, 2009; Krieger, 2018; Schlondorff, 1990) making the male a subject of suspicion in situations where acts of touch take place. I suggest that the ambiguous construction and sexualisation of touch combine to create the subjects and practices seen with these male health practitioners.

According to Gavey (2005), the 'male sex drive' discourse has a "pervasive and powerful influence on male sexuality" (p.204). In this study, it was the possibility of being constructed as always sexual that prevented male participants from using caring touch, regardless of their actual experience of touch. Through the reproduction of these constructs of men, particular types of identities are produced, and multiple subjectivities arise. Additionally, when these dominant constructs of men and masculinity are linked with the constructions of caring touch, confusion, and uncertainties surface. When some of the health practitioners constructed their patients as having the potential to misinterpret acts of care (see Chapter Seven), they demonstrated technologies of the self whereby acts of self-protection became overt and formed part of a wider need to enact self-surveillance. Implicit in the participants' statements was the production of male health practitioners who were unable to engage in caring touch for fear that it would be interpreted as being sexually motivated.

Participants constructing caring touch in this way are part of broader discursive practices that have ramifications across society, potentially affecting many men in both their working and personal lives. I suggest this dominant discursive construction ingrained in many aspects of social interaction perpetuates the ongoing concerns of the use of caring touch for the male participants in this study. Furthermore, this discourse is so pervasive that the male participants who articulated these concerns did not even feel the need to explain why they felt their touch might be interpreted as problematic. It was assumed knowledge. A discourse that constructs touch from a male health practitioner as problematic gives cause for genuine concern. Subsequently, this construction sustains caring touch as challenging for men. I would argue that it operates not only in the hospital environment, but in a variety of settings across society where its presence reinforces the concerns these men have. Perhaps, not often articulated by health practitioners, it is this implicit construction of touch that may indicate why the decision making of health practitioners has not been explored and is not clearly understood.

Acceptance and trust

When a person is in need of health support, they seek diagnosis and treatment from a particular medical practitioner. This generates the need for legitimate health practitioners. As mentioned previously, inherent in this legitimacy is the professional licence to touch. Arguably, when a person calls on one of these 'trusted' professions, there is a type of implied consent whereby procedural touch will form part of diagnosis and treatment. However, despite this implied consent constructed by the licence to touch, some health practitioners continue to acquire verbal and/or written consent from the patient before making physical contact. Consequently, acquiring consent is linked strongly to aspects of trust. Internationally, surveys have regularly placed health practitioners as the most trusted professions. The 2021 American GALLUP poll has nursing ranked as the most trusted profession for the 20th year running and it is suggested that nurses uphold the highest ethical standards of all health professionals (Saad, 2021). In Australia, doctors and nurses were placed in the top two most trusted professions (Morgan, 2021). This was similar to a survey in Aotearoa New Zealand where nurses, paramedics, and doctors were only topped by firefighters (Research New Zealand, 2020). With reference to this thesis, I should mention that midwives were not included in the surveys mentioned above. As such, the health practitioners recruited for this study form part of the group of most trusted professions, arguably constructing acts of procedural touch as taken for granted.

For some people, trust and/or consent is challenged when touch is enacted by a male. The interplay between the trusting professions and the notion that touch from a male is less trustworthy is evident even if he is part of the world's most trusted professions (Brekke & Nyborg, 2010; Hayes & Tyler-Ball, 2007). This suggests a discourse that constructs the touch of a male as always questionable. It conflicts and contradicts with the notions of the trusted health practitioner. Arguably, it is the trust that is formed between individuals and the emotional security of these people that creates an environment where caring touch can be used most beneficially.

Notable in the interactions between the health practitioner and the patient is the need for the practitioner to acquire verbal consent from a patient for acts of procedural touch (Medical Council of New Zealand, 2021), but not so for caring touch. Acts of caring touch do not appear as part of this acquisition of consent. Whilst I do not propose that caring touch should meet the same consensual requirement as touch enacted when performing examinations or treatment, I raise this point to demonstrate the further complexity of this human interaction. Unlike an examination in a clinical room, the brief touch of a hand on an arm or a shoulder to convey empathy is not always preconceived. It is often enacted spontaneously. The licence to touch and patient consent permits acts of procedural touch, but caring touch is understandably not afforded such negotiated consciousness. The lack of demarcation between the two may produce confusion, speaking again to the complexity of this form of communication for these health practitioners.

Acceptance of caring touch by a patient was also linked to the positive relationship with the health practitioner. Most of the nurses, GPs, and midwives in this study, suggested the possibilities of regular time spent with patients facilitated relationships whereby trust and, therefore, acceptance of caring touch could be developed. As such, time spent with the patient worked to cement the discursive subject positions taken up by the health practitioners. I argue this speaks to my concept whereby, time = relationship = trust = consent = touch, working in a reciprocal way, giving the health practitioner the confidence to enact caring touch, and the patient the confidence to receive.

The patient

For some participants, namely those that had limited time with a patient, the patient was the 'unknown', specifically in terms of being receptive and responsive to caring touch. Their potential appreciation or not of this act was difficult because people are unique and products of multiple discourses. Although some participants spoke of having a sense that a patient

would benefit, none articulated the way in which they ascertained the potential acceptance for caring touch. In a poststructuralist sense this is noteworthy as it aims to highlight aspects of social interaction that are marginalised, lost, or hidden (Peters & Burbules, 2004). The participants positioned themselves as believing their choice to engage or not in caring touch was universal for all patients, thus deploying aspects of the professional practice discourse. Consequently, they replicated their chosen engagement with caring touch on all patients, rarely deviating from this construction of their professional practice. Only when I asked if acts of caring touch might differ dependant on the individual needs of the patient, did any of the participants consider alternative practices.

However, it could be argued that the patient also participates in the discursive practices of touch interaction by not explicitly requesting comfort through caring touch. This possibly indicates the presence of a discourse that constructs the patient as the lesser party in the relationship. By this I suggest patients have a sense of being a passive recipient of care, one who does not make requests for a mode of care external to the boundaries of assessment and treatment. The patient may not feel empowered to ask for these acts of comfort which possibly highlights the hierarchical structures that exist between the patient and the health practitioner (Chipidza et al., 2015; Fox & Reeves, 2015). If people generally feel comforted when receiving caring touch, there are discourses prevailing that constrain the patient from requesting this action. The reticence to ask for comforting touch comes from the discourses that make any physical interaction between relative strangers uncomfortable and possibly inappropriate for many. Whilst a person may feel at ease with asking for a comforting hug or holding of a hand from their family or a close friend, this may not be so for other relationships.

A complex system of discourses interacted and were exposed throughout this thesis. Gender, age, cultural, and sexual discourses merged in the decision-making process when a health practitioner offered physical comfort to someone not well known to them. Just as health practitioners face difficulties in making decisions about when to demonstrate compassion and empathy with physical touch, similarly patients may be challenged with how to ask for physical comfort when in pain and distress. Competing and complicated discourses such as the 'vulnerable' patient and professional practice are responsible for actions of all parties involved in the health practitioner/patient relationship.

Compliance

The positive effect of using touch to gain compliance is well documented in social psychology literature. Most research on acts of compliance have been centred around understanding the

psychology of touch within facets of business (Dolinski, 2010; Erceau & Guéguen, 2007; Vaidis & Halimi-Falkowicz, 2008), but little has focused on compliance in the health care arena. However, patients that were touched on the forearm by their GPs during consultations were found to have had a greater rate of compliance in taking their prescribed medication (Guéguen & Vion, 2009). In addition, touching more than once during a single appointment further increased the potential for compliance, raising awareness of the potential of caring touch in health practice (Vaidis & Halimi-Falkowicz, 2008). Throughout the statements made by participants, particularly those who engaged in caring touch with patients, there was minimal acknowledgement that their acts of caring touch may possibly encourage compliance. For the one participant who did acknowledge the possibilities of compliance, she constructed this as only a positive outcome. However, there are ethical concerns, complex interactions, and psychological responses to consider regarding the use of touch during interactions where it may be seen as an act of persuasion that may breech boundaries of consent and patient choice.

When caring touch is incorporated into daily practice, the possible compliance that may result could be deemed unacceptable in terms of patient autonomy and personal decision-making. In this way, discourses of patient centred care and caring for vulnerable people, possibly conflict and add to the uncertainty that some health practitioners may face when caring for a patient. Discourses that produce practices of patient centred care encourage acknowledgment that the patient/practitioner relationship is a partnership whereby treatment considers perspectives other than the clinical, including the emotional, social, and spiritual needs of the patient (Molina-Mula & Gallo-Estrada, 2020; Zhao et al., 2016). In this capacity, acts that encourage compliance are seen as negative. Alternatively, discourses that construct concepts such as caring for vulnerable people may view certain acts of coercion as being in the best interest of the patient, suggesting the health practitioner is best placed to make decisions for them. Such actions that may increase compliance demonstrate a shift in what could be seen as a direct force of power from 'above' to the much more docile form of power that Foucault was interested in, something he termed governmentality (Foucault, 1977/1995). As explained in Chapter Two, Foucault suggested governmentality as being a type of power enabling the government to control the population for the 'benefit' of all its people, but is neither external control or individual autonomy (Fendler, 2010). In this thesis, acts of caring touch that increased compliance showed governmentality operating through the health practitioner to be of benefit to the patient. Although the discourses of patient centred care and caring for vulnerable people co-exist in health practice, their presence may cause confusion for some

health practitioners who are not constrained by one or the other. I refer to this as a 'discursive dance' whereby they make decisions using their professional judgement, influenced by the discourses in play at that specific time in that specific place. Gibson et al. (2020) suggested on-going internal questioning relating to what to do for a particular person at a particular time is an important aspect of patient care. In some circumstances, this 'discursive dance' showed itself as contradictory practices and was seen at times with the participants in this study.

Methodological considerations

Discourse analysis is an interactive process that is strongly linked to the maintenance of power. Through this power, there is the potential to privilege certain perspectives and silence others (Foucault, 1981; Kendall & Wickham, 2003). This was echoed in my thesis where my exploration of the ways in which health practitioners specifically constructed caring touch limited my research gaze. As such there lies the potential for other discourses to be overlooked or neglected.

As primary researcher in this study, I made decisions pertaining to recruitment of specific groups of health practitioners. My rationale for choosing to focus on only four groups of practitioners, whilst limiting, was to contain the likely depth of their discursive milieu. In hindsight, I may have excluded the midwives from the choice of health practitioners as their autonomy of touch, relationships, and aspects of gender arguably differed significantly from the others. However, the data from this group of health practitioners was useful regarding potential conflicts of the construction of caring touch between groups of practitioners; and the midwifery participants allowed me to see the contrast that I may not have seen had these participants been omitted. I also reflected on the diversity of practices even within one profession; for example, recruiting doctors who all worked in a hospital setting rather than across the medical spectrum.

A secondary interview may have provided confirmation of statements made by the participants and possibly a deeper understanding of the dominant discourses. However, in staying as close as possible to a Foucauldian lens, I drew on Foucault's regimes of truth whereby he suggested the historic mechanisms that produce the discourses which act as true for that specific time and place are important. Foucault (1969/2002) suggested a text's "frontiers… are never clear cut…it is always caught up in a system of references [to other texts]". (p. 23)

Implications for education and clinical practice

Suggesting specific implications from the findings of Foucauldian discourse analysis is generally perceived to be inconsistent with an approach drawing upon the ideas of Foucault, which focuses on opening up and revealing the complexities and realising contradictions and tensions. Nevertheless, in terms of the broad implications from this study, unpacking the complexity of caring touch practices at a tertiary education level may illuminate more nuanced understandings enabling the multiple constructions of human touch to be more widely acknowledged and disseminated.

Empirical scientific evidence suggests simple acts of caring touch in health practice are a useful 'tool', but actions of caring touch are made more complex and problematic due to the multiple competing and contradictory discourses identified in this thesis. This complexity constructs caring touch in a way that means some health practitioners are left unsure of when, where and how this act of humanness can be integrated into practice. It is the multiplicity or possible interpretations that have the potential to create a 'paralysis' for health practitioners whereby acts of caring touch become marginalised from care.

Explicit discussion of the tensions and contradictions relating to caring touch identified in this study may be a way of moving this forward. For clinicians, this would have to occur in a safe place (e.g., in professional development or postgraduate education settings), and may be one way to open up critical engagement and change future possibilities.

Recommendations for further work

Recommendation one: Findings from this study suggested caring touch was constructed as not holding enough importance to be embedded into the curriculum of health programmes. When a topic is not integrated into the training of health practitioners it marginalises its significance. Consequently, I recommend creating curricula for a postgraduate programme or other professional development modules where health professionals have the opportunity to consider the complexities of caring touch and examine the discourses in circulation that might be implicitly affecting their practice. This would offer opportunities to shift practices through more explicit awareness of the forces at play and more conscious decision-making around what will be accepted and resisted.

Recommendation two: In guidelines for professional health practice, differentiation of caring touch and procedural touch was absent. Rather, touch was generalised. Whilst I do not recommend prescriptive actions of touch that would detract from the need for flexibility in patient care, I suggest creating an appendix within practice guidelines that discusses

distinctions between different types of touch and their potential effects for patients and for patient-practitioner relationships.

Recommendation three: Evident throughout the academic literature and the data from this study was the limited acknowledgement of cultural perspectives of a health practitioners' touch. This is specifically so in Aotearoa New Zealand where, to date, there has been no exploration of Māori and Pacific perspectives of caring touch in health practice. Accordingly, a collaborative research project that acknowledges Kaupapa Māori would aim to highlight the ways in which caring touch supports or opposes the wellbeing of Māori health practitioners and patients. Kaupapa Māori is a research methodology that encompasses research by Māori, with Māori, for Māori, meaning, as a non- Māori, I would develop and implement this study in conjunction throughout with Māori colleagues.

Possibilities for exploration

Throughout this thesis I have drawn attention to the contradictions and paradoxes that revealed themselves. There are extensive possibilities for future research. A focus on alternative practitioner groups may extend further understanding, particularly in how different working environments create opportunities for caring touch.

Similarly, an exploration of the ways caring touch is or is not integrated in the training of health practitioners would have the potential to open up spaces to gain additional understanding of how caring touch is constructed.

In broadening research findings from previous decades, it would be useful to explore in current times how we learn to construct touch from an early age. The influences of family and media, and subsequently the subject positions taken up due to prevailing discourses, may affect the normalisations and problematisations of caring touch and thus overall wellbeing. It follows, therefore, that rethinking the possibilities for integrating touch into curricula via exploring the understandings of those teaching health practices in tertiary education could be a useful addition to the body of knowledge.

Most recently, the worldwide COVID 19 pandemic resulted in a deliberate restriction on physical contact between those outside one's 'bubble'. For those living alone and/or those in the hospital setting left devoid of human touch, the effects of touch deprivation may have been significant. My father died from COVID 19 in 2021, and the knowledge that he had no direct physical touch from any health practitioner or, more importantly, from any family

member in his last 2-weeks leaves me wondering what this meant for him. These times are unique in our lifetime and the separation from others and the inability to comfort those in distress is a topic worthy of further exploration.

Conclusion

Findings from this thesis seek to contribute to an increasing body of knowledge exploring multiple constructions and acts of touch practices. Unlike other studies, this thesis explored constructions of caring touch across several health disciplines and is unique to the Aotearoa New Zealand context. As a discourse centred thesis, the data provided by the participants were not privileged as objective and indicative of truth, rather as local and contextual. There can never be resolved conclusions from this study, no mysteries solved. Instead, the deconstructing of statements opens up a range of understandings, all of which offer potential for change. An important finding of this thesis showed that despite the discursive shifts in the understanding of caring touch across the last three decades, health practitioners continue to be challenged by dominant discourses that constrain their use of caring touch in practice. There remains a reticence to engage in any type of touch not required as part of professional practice, particularly for male health practitioners.

I have shown that for some health practitioners maintaining physical distance, and an increased reservation to engage in caring touch, has come to undermine the genuine experiences of those in health practice. The arguable hypersensitivity to acts of caring touch has encouraged an atmosphere to emerge that has created health practitioners who are on self-watch, fearful of the potential repercussions if their desire to demonstrate humanness via care and empathy is misinterpreted. Those who chose not to participate in such touch interactions are unaware of the intrinsic subtleties of this communication (Meyer & Streeck, 2020). It is perhaps the understandable inability to understand the reciprocal subtleties of touch that produce contrasting interpretations of this complex topic. Wearn et al. (2020) stated, “It is what we learn in the process of using and reflecting on touch that transforms us” (p. 752), suggesting that the reciprocal and indeterminate nature of caring touch is something both difficult to research and to define. However, underpinning acts of caring touch is a discourse that constructs humans as having the capacity to empathise and have compassion for one another. I argue that for some it is this discourse that can motivate these health practitioners to engage in caring touch with patients, even when their personal inclination is not to do so.

My findings show that these dominant discourses predominantly shaped the health practitioners' perspectives of caring touch. Inferences offered throughout this thesis via the identified discourses, although provisional, are a significant contribution to understandings pertaining to caring touch in health practice. True to Foucault's approach, this thesis does not offer its findings as a final word on the topic; rather, it hopes to stimulate further exploration of the complexities implicit in caring touch and has important implications for education, professional practice, and future health research.

Final reflections

> There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go looking and reflecting at all. (Foucault, 1984/2006, p. 8)

When I embarked on this thesis journey, I imagined as the process unfolded the progression of my thinking would follow a relatively straightforward trajectory, taking me from the naïve researcher to one who oozes maturity about my improved knowledge, developing ideas in an undeviating manner. However, Foucault has enlightened me that the learning process should not be experienced in such a simplistic fashion. He viewed the ability of being able to rethink the past as an essential part of the development of thinking (Mills, 2003). Indeed, my journey has been so. I have reached a point for this specific topic having more questions than I started with. The study of caring touch is not complete, as I believe understandings of this complex subject are infinite.

Certainly, my thesis has provided me with important additions to my knowledge; but, informed by Foucault's thinking, I understand the need to be critical of my positioning and acknowledge that I will never discover the 'final truth' about caring touch in health practice, because there is no final truth.

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Appendices

Appendix A – Ethics approval

AUTEC SECRETARIAT

14 May 2015

Deborah Payne
Faculty of Health and Environmental Sciences

Dear Deborah

Re Ethics Application: **15/119 Constructions of touch in health practice.**

Thank you for providing evidence as requested, which satisfies the point raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 14 May 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 14 May 2018;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 14 May 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz. All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Nicola Power nicola.power@aut.ac.nz

Appendix B – Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

16th April 2015

Project Title

Constructions of touch in health practice

An Invitation

My name is Nicola Power and currently I work as a senior lecturer at Auckland University of Technology. As well as being a lecturer I'm also a student studying towards a doctoral qualification. Part of my study involves interviewing experienced health practitioners in the fields of nursing, midwifery, medicine, and paramedicine. I'm studying the use of touch in everyday practice.
I would like to invite you to be part of this study so I may build a deeper understanding of the different ways touch is used by a variety of health practitioners.

Your participation in this research is voluntary and you may withdraw from the project at any time. In the event of this happening, no information gathered from you at that time will be used in the study.

What is the purpose of this research?

To date there is little information about how New Zealanders use touch in everyday practice. Bringing this information to light may result in showing the different ways that health practitioners from a variety of professions use touch. The findings from this research will form part of a PhD thesis and may be shared with others through presentations, journals, and other publications.

How was I identified and why am I being invited to participate in this research?

Any health practitioner in the field of nursing, midwifery, medicine or paramedicine with extensive experience (that being defined as 15 years or more of practice) is invited to participate.

What will happen in this research?

If you consent to be part of the study, I will arrange a time and place convenient to you for an interview. The interview will take up to 60 minutes. The interview will be recorded and later

transcribed. Interviews can also be held through Skype if this option is more convenient and/or preferred. If you would like to bring a support person to the interview you are welcome to do so. However, they are not required to participate in the discussion. A copy of the transcribed interview will be returned to you for comment, and you are able to add or delete any information without question.

What are the discomforts and risks?

It is unlikely that you will experience any discomfort or risk.

How will these discomforts and risks be alleviated?

If you feel you need support after the interview you are be advised to contact AUT Health, Counselling and Wellbeing Centre, phone (09) 921 9992 and tell them that you are a participant of the research study 'Constructions of touch in health practice' at AUT University. There will be no cost associated with this appointment.

What are the benefits?

Participating in this study may provide an opportunity to talk about practice. For the researcher, this is an opportunity to understand what drives the health practitioners' use of touch. Publishing the findings will result in showing how different health practitioners use touch particularly in the New Zealand context.

As the researcher this study will contribute towards my PhD qualification.

How will my privacy be protected?

If you choose to participate in the research, you will be asked to sign a consent form that will be stored in a secure location by one of the research team. Following the interview, once the set of data has been recorded and collated, all identifying information will be removed. Other members of the research team will not have access to any data until identifying information is removed. Your name will be replaced with a pseudonym following transcription of all interviews. Throughout the research project and beyond, all email communication with you will be copied and transferred to a secure external hard drive that only I have access to. Inbox copies will be deleted from my AUT address, to ensure your privacy. No information which could identify participants will be included in any presentations or publications. Confidentiality concerning the identity of participants will be assured. At the completion of the study all data will be held in an AUT secure ethics storage facility and will be destroyed after six years.

What are the costs of participating in this research?

The only cost associated with your participation is the time for the interview and confirmation of the transcription.

What opportunity do I have to consider this invitation?

After receiving this information sheet, I would appreciate you contacting me within 3 weeks if you are able to participate.

How do I agree to participate in this research?

Please email or phone me if you are keen to participate and I will post out a consent form.

You can contact me on: nicola.power@aut.ac.nz OR ph: 9219999 ext 7319

I will contact you as soon as I receive the consent form and we can arrange a suitable interview time.

Will I receive feedback on the results of this research?

A summary of the findings will be made available to you. If you wish to receive this summary, you will be asked to indicate this on the consent form.

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, Ass Prof. Deborah Payne, dpayne@aut.ac.nz ph: 921-9999 ext 7112

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Researcher: Nicola Power, nicola.power@aut.ac.nz ph: 921-9999 ext 7319

Project Supervisor Contact Details:

Project Supervisors : Ass Prof. Deborah Payne, dpayne@aut.ac.nz ph: 921-9999 ext 7112
Dr. Simon Walters, simon.walters@aut.ac.nz ph: 921-9999 ext 7022
Dr. Joanna Fadyl, joanna.fadyl@aut.ac.nz ph: 921-9999 ext 7675

Approved by the Auckland University of Technology Ethics Committee on *14th May 2015*, AUTEC Reference number 15/119.

Consent Form

Project title: **Constructions of touch in health practice**

Project Supervisor: **Ass Prof. Deborah Payne**

Researcher: **Nicola Power**

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 16th April 2015.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also 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:

(email) .....

(mob. ph) ..... (wk. ph)..... (hm. ph) .....

Date: .....

Approved by the Auckland University of Technology Ethics Committee on 14th May 2015 AUTEC Reference number 15/119

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

Appendix D – Amendment to Ethics

AUTEC SECRETARIAT

27th August 2015

Deborah Payne
Faculty of Health and Environmental Sciences
Dear Deborah

Re: Ethics Application: **15/119 Constructions of touch in health practice.**

Thank you for your request for approval of an amendment to your ethics application.

I have approved the minor amendment to your ethics application allowing a change to the inclusion criteria.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 14 May 2018;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 14 May 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Nicola Power nicola.power@aut.ac.nz

Appendix E – Researcher Safety Protocol

RESEARCHER SAFETY PROTOCOL

To ensure my personal safety when conducting interviews away from Auckland University of Technology (AUT) I will adhere to the following researcher safety protocol, in accordance with AUT researcher safety requirements.

The interviews for this study will last approximately 45-60 minutes long. Participant interviews will be conducted at a location convenient to the participant. However, it is desirable that a safe neutral venue be arranged if at all possible. All participants are invited to have a support person with them if desired, but this party will not be involved in the interview process. In the event that the participant requests to meet in their home, or at an isolated venue, the interviewer will initiate the safety protocol (see below).

- If the interview is to be held at the participant's home (or another environment that is not public) the researcher will take a colleague with them. The colleague will not be present in the interview room but will remain close by.

- In the event that it is not possible to find a colleague at the time of the interview, details of the interview time, participant's name, address, expected arrival/departure time, phone number at the intended venue, and my mobile phone number will be furnished to a colleague at AUT. A text or phone message will be sent to the colleague when arriving and leaving the interview. If I do not confirm arrival and departure from the interview location, the colleague will be asked to call my mobile phone to verify my safety and whereabouts. If there is no reply, the colleague will be asked to contact the phone number location to verify my safety and whereabouts.

- I will only schedule interviews during the hours of 9am-5pm. Adhering to this time frame for conducting interviews during daylight hours will contribute to my personal safety and covers the crossover of morning and afternoon clinical roistered shifts.

Appendix F – Interview Questions

The interview will begin with a broad question that encourages and invites the participant to share their thoughts and experiences, for example – could you outline for me your role as a health professional? It is hoped that commencing the interview in this way will allow the interview to progress in a conversational manner that makes more sense to the participant.

Depending on the direction of the initial opening question, I will be asking participants to discuss the ways touch is used generally in their daily practice.

Questions may then focus specifically on caring touch, such as:

- How did you learn to use caring touch as a health practitioner?
- Was caring touch something that was a part of your personal upbringing, and, if so, did you give much thought about including it as part of your practice? If it was not a feature of your upbringing, what prompted you to include it in your practice?
- If you use caring touch in your practice, what prompts you to do so? (Particular situations, circumstances).
- Tell me about the factors that influence your decision to touch.
- Tell me about the physical ways you integrate caring touch into practice, for example, hand holding, hand on the arm or back.

Confidentiality Agreement

For Transcriber

Project title: **Constructions of touch in health practice**

Project Supervisor: **Ass Prof. Deborah Payne**

Researcher: **Nicola Power**

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: Monique Susilla

Transcriber's Contact Details (if appropriate):

.....

.....

Date: 6th January 2017

Project Supervisor's Contact Details (if appropriate):

Ass. Prof Deb Payne

Email: dpayne@aut.ac.nz Ph: (09) 9219999 ext 7112

Approved by the Auckland University of Technology Ethics Committee on 14th May 2015
AUTEC Reference number AUTEC 15/119

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

Appendix H – Health and Wellbeing Participant Support

MEMORANDUM

TO Nicola Power

FROM Kevin Baker

SUBJECT Psychological support for research participants

DATE 31 October 2014

Dear Nicola,

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

"Constructions of human touch in health practice: A discourse analysis."

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors on our website: http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Kevin Baker

Head of Counselling

Health, Counselling and Wellbeing

Appendix I – Kawa Whakaruruhau Komiti (confirmation of support)

School of Health Care Practice
Kawa Whakaruruhau

Minutes of Meeting

Date: *21 November 2014*

Present Tui O'Sullivan (Chair), Michelle Cox (Admin), Coral Skipper, Caroline McKinney, Naumai Smith, Audrey Hall, Holly Alexander, Alicia Berghan, Deb Payne, Maria Rameka, Colleen Leauanae, Annabel Farry, Naumai Smith.

Item	Discussion	Action	By
2111.1	***Karakia:*** by Caroline McKinney		
2111.2	**Apologies:** Tineke Water, Placid Briggs, Graham Howie, Denise Wilson, Kate Haswell, Paula Ryan, Mahia Winder		
2111.3	Correspondence: • 30/10/2013: Email from Heather Donald – to present to KWK a small research project AUT is undertaking in conjunction with Counties Manukau Health Service. (to Feb Agenda) • 30/10/2013: Email from Nicola Power – to present to KWK: beginning PhD re the constructs of human touch in health practise • 11/11/2013: Email from Graham Howie: First ever Doctoral proposal by operational paramedic – forward to Kawa Whakaruruhau Komiti • 12/11/2013: Email from Amor Hirao to AUT University Maori and Pacific Research Hui 25 Nov, AUT South Campus – to Kawa Whakaruruhau Komiti • 18/11/2013: Email from Audrey Hall re additions to Agenda. Report to be available on Thursday •		
	Minutes of the Previous Meeting		
2111.4	Previous Minutes confirmed as a correct record		
	Agenda Items		
2111.5	**Nicola Power Research Presentation:** • Introduction by Deb Payne (one of Nicola's supervisors in her PhD research. Has a Masters in this subject – topic: Male teachers use of touch in Education. Is very keen to extend to encompass touch used by health professionals. The caring touch. How touch is constructed. Deconstructing the meanings and ways condoned in Health Care Practice from those who know and have knowledge. • Has been much research from patients point of view, little from Health Care professionals. • Hoping there will be some Maori participants and that the guidance received will ensure participation works well for these people. • Nicola is a senior lecturer in the Interdisciplinary Centre at AUT University • Nicola seeking Kawa Whakaruruhau Komiti support and advice early in the process.		

	• Nicola is seeking advice and how best to keep Maori participants safe in the research process. • Recommendations re reference material made to Nicole: books by Joan Metge, especially 'In and Out of Touch' and 'Talking Past Each Other'. Informative re appropriate touch with Maori and is relevant. This is coming from a non-Maori viewpoint. • Maori terminology re touch: miri miri, whakamaa, • Acknowledged that many forms of touch – more definition of 'touch' in the dictionary than any other word. Includes touch with voice, in building a relationship, therapeutic touch, touch, communication through touch. Not just physical but also a spiritual contact that affects people. Reciprocity and how the interaction of people and elements beside the physical could become a consideration of this study. • Consideration for the impact of domestic violence and its effects on participants. How to protect these participants. • Interviewing process will be undertaken at home. Easier than the Marae as so many protocols to be observed in order to work on the Marae. Interviews could be focus groups or 1-1 interviews. • Participants will include those outside of AUT. Caroline McKinney happy to be a contact for the Maori Nurses Council. • Suggested to look at the elements of the Treaty and to incorporate more than the 3 principles of the Treaty of Waitangi. Many 'fish hooks' which Nicola is aware of. Welcome to come and discuss the next stage and support through this process.		