THE WELCOME INTRUSIONS OF TB NURSES.
AN INTERPRETIVE PHENOMENOLOGICAL STUDY OF RELATIONAL WORK IN
PUBLIC HEALTH NURSING

by

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ABSTRACT

The Welcome Intrusions of TB Nurses. An Interpretive Phenomenological Study of Relational Work in Public Health Nursing.

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Nurse-client relationships are inherently valued in descriptions of the nature of public health practice and require consideration as intentional work that demands knowledge, skill, and personal engagement. They are also matters of place. In public health, they are largely taken-for-granted, particularly in the area of infectious diseases and the tuberculosis (TB) program specifically. TB nursing is structured within an explicit population focus, which challenges such relationship ideals as client-centered care, autonomy, and empowerment in everyday practice. This interpretive phenomenological study (Benner, 1994) of the relational work of TB nurses was undertaken to understand the nature of nurses’ relational work, wherever it happened, and how it was understood within the mix of assigned program tasks. Carried out in one of Canada’s largest TB programs, this study involved observing nine nurses and 24 clients in their respective visits over time, and interviewing 16 participants. Visits happened in homes and cars, and other assorted locations, highlighting how place shows up in these relationships and how nurses help clients to make sense of TB and broader life concerns shaping the experience of it. How they involve themselves interpersonally in these situations is the stuff that relational work is made of. Through the use of thematic analysis (Benner, 1994; Chesla, 1994), notes and transcripts were analyzed. The resulting interpretation of the nature of relational work is that of ‘welcome intrusions’, a notion that along with three key thematic dimensions: ‘getting through the door’, ‘doing TB but more than that’, and ‘beyond a professional’, addresses the central control-care
tone of relational work. Together these themes identify key areas of knowledge and skill. That is, honesty and respect for privacy, ‘expertise’ in TB, dismantling the effects of stigma and displacement, and socializing-with-purpose. This emphasizes the value of articulating the everyday practices of nurses in population-focused programs that can contribute to successful treatment, and client healing and well-being. This relational work of TB nurses may be supported and enhanced when framed as the skill of involvement (Benner et al, 1996; Benner et al, 1999) and critically examined as part of providing comfort and enacting surveillance.
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Preface: Coming to the Relationship Question

I have chosen to start this dissertation before ‘the beginning’ by offering somewhat of a chronology of the development of my research interest in relationships. But where to start exactly? I could begin by describing personal relationships at memorable moments, in memorable places in my life, but we all can tell similar stories. We all, already, understand relationships and the places in which they happen in some intimately lived way. These are not the stories that constitute my research interest. I ought to begin more specifically in the experiences of my nursing relationships in different health care settings, and my curiosity about the phenomenon of relationship as part of the work of nursing.

As a nurse, I have crossed the worlds of psychiatry-mental health and public health, and hospitals, homes, and community. I’ve spent years developing knowledge and skills in establishing and maintaining therapeutic relationships with clients diagnosed with mental disorders. Early in my career, I learned that the essential work in psychiatric nursing was ‘doing’ relationships, and I learned about the effort required in such work. Perhaps most distressing for me, though, was the realization that while this work was effortful, it often went unnoticed as part of the overall improvement in clients’ mental health. The immediate physical and emotional care being provided by nurses seemed invisible. Psychiatric treatments such as medication and various other therapies were given precedence in team meetings, while nursing care was relegated to a system of reporting in order to keep psychiatrists informed of “their” patients’ progress. The relational skills of nursing so necessary to client care and healing seemed crucially important and yet underestimated.

I moved to community mental health case management, and began to see that much of mental health was relational in nature. All client “goal attainment” and “success”, as well as
“noncompliance” and “decompensation”, seemed essentially related to the quality of relationships. Here came the humbling realization as a nurse that my specific relationship with an individual was often not of central importance to her/his well-being, as we helping professionals often like to think. Other relationships, particularly those with family and friends figured much more prominently. In addition, I witnessed first-hand the combined influences of social-environmental conditions and stress on mental illness symptomatology. Conditions such as sub-standard housing, poverty, violence, and discrimination based on race, ethnicity and gender were no longer as easily ignored as they could be in the hospital setting.

Community practice helped me to see that I engaged not only interpersonally with a “mentally ill” client; I was also engaging within varying socio-political contexts and physical locations in which the person was relationally situated. Any ability to cultivate optimal relationships necessarily involved my ability to think critically about the social and physical contexts. I also became profoundly aware of my situatedness in these contexts as well. My own perspectives, values, prejudices and concerns came into play. My whole self was involved. I came to realize that talking theoretically about ‘relationship’ concepts such as communication, empathy and boundaries, was not enough. These concepts became real only by examining myself - my interpretations, my reactions - in lived relation to this particular person who was my client. I came to understand that relational skills require conscious rehearsal, practice and reflection in the complicated and often uncomfortable contexts that we shared together.

With this background of experiences and assumptions about the work involved in relationships, I moved to a mental health position in public health. It was there, in many consultations and home visits with public health nurses (PHNs), that I learned how intimately dependent public health nursing is on relational skills. I recognized that the bulk of my
consultations were in fact not mere information gathering about particular mental illnesses. Rather, they were discussions about relationship dilemmas that nurses experienced with clients and their families in addressing complex social concerns impacting on well-being. TB nurses in particular, it seems to me, draw on relational skills in particularly complicated daily encounters, not only with people with individual concerns but also with a reportable infectious bacteria. PHNs are called on to utilize relational skills in day-to-day encounters with the very personal needs and concerns of individuals yet these relational skills seem at best minimized, sometimes even negated, as a core ingredient in the success of population health programs.

My experiences in mental health/psychiatry and public health nursing have compelled me to question – if relationships continue to be minimized as work, and if these skills receive only occasional recognition in practice settings, where, when and how do nurses meaningfully talk about best practice in the relational realm? How is relational work in public health understood, critiqued and supported?
Chapter One: Introduction

While abstract principles of therapeutic relationships are taught in nursing school, how do nurses in practice actually take in what they have learned and use it in their encounters with clients, or consciously continue to build their knowledge and skill in this area? Theoretical ideals are a crucial starting point; however, the day-to-day of relating with clients calls on nonreflective knowledge and skill, in the immediacy of the situation. These everyday situations that are often less than ideal, are complicated by many competing demands, not the least of which may be client concerns that have nothing to do with the nurse’s task at hand. These are situations in which ‘relating’ just simply happens.

Relationships generally defy quantification yet they comprise a significant portion of the work of everyday nursing, raising situated issues and concerns that require ongoing critical reflection and skill development. Relationships as “real” work involving a particular skill set have received the most attention in mental health/psychiatry, however theoretically their fundamental importance spans all areas of practice. The nurse-client relationship has been studied according to aspects of it, such as trust (Lowenberg, 1994; Peter & Morgan, 2001; Shea & Effken, 2008), empathy (Gagan, 1993; Kunyk & Olson, 2001; Maatta, 2006; Price & Archibold, 1997), boundaries (College of Nurses of Ontario (CNO), 2006; Liaschenko, 1994; Peternelj-Taylor & Yonge, 2003), and phases (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006; Forchuk et al., 1998). The knowledge and skills required to form relationships implicate the whole self of the nurse as a person, and therefore self awareness and self knowledge on the part of the nurse are critical to relationships with clients. Given that the person, or self, of the nurse is at issue, it often feels more comfortable to simply assume good relationships happen out
of good intentions as human beings, rather than also as a result of regular review of nursing skills in this regard.

The language of “establishing relationships” leaves relationship as a noun, invoking notions of a fixed entity or state, that we are either in or out of, rather than a process we cultivate as we live. The relationship as such is often a taken-for-granted vehicle for the “real” nursing work. A shift in language from ‘the relationship’ to ‘relational work’ is proposed for this study in order to get at the process of relating, the intentional activities of being in relation, the ‘how-to’ of it. Rather than thinking in terms of establishing and maintaining ‘the’ relationship as something external to ourselves, the language of ‘relating’ and ‘relational’ challenges us to think about the involvement of the nurse in ongoing, everyday encounters with clients as work in nursing.

Nursing as work has been explicated and examined as an alternative concept to profession or practice (Liaschenko, 2002; Liaschenko & Fisher, 1999; Liaschenko & Peter, 2004; May, 1992). The concept of ‘work’ does not differentiate tasks, considered “lower level” work, from practice, considered “higher level”; “the idea of work in and of itself does not convey presuppositions about what is valuable” (Liaschenko & Peter, p.493). This is useful for nursing given that much of what nurses actually know and do includes “lower level” work, often an invisible yet necessary dimension of the functioning of the health care system. The topic of relationship fits well here, drawing attention to the invisibility of relational skills as part of ‘lower level’ work, though often discussed theoretically as ‘higher level’. Relationship skills in particular may be understood as the basis of what Liaschenko (2002) has described as the “body”, “emotional” and “in-between” work of nursing, and akin to what Benner and colleagues (1996; 1999) describe as the “skill of involvement”.
This is indeed true in the case of public health nursing where the tasks of the job implicitly and explicitly require relational skills in particular ways. Public health nurses (PHNs) assume a health care role that is ascribed the responsibility of monitoring and promoting population health, while at the same time, managing day-to-day relationships with individual people across the spectrum of health/illness/healing. Social justice is viewed as central in the work, helping communities and individuals negotiate the direct manifestations of the social determinants of health and effecting change in those determinants that impede health. Further, PHNs carry out their work in a whole range of geographical locations, largely with a clientele that is metaphorically and practically located in the social margins, the periphery, outside of the dominant culture.

Relational work in public health is predominantly interpreted through a population and community lens and often is explicated as capacity building, empowerment, or partnership, rather than those relationship concepts listed previously (Braunack-Mayer & Louise, 2008; Sawyer, 1995; SmithBattle, Drake & Diekemper, 1997). Generally stated, a tension exists in public health nursing that involves contrasting nursing care of the individual with population-focused health concerns, which has implications for how relational work is understood. From the system level, interest in populations often precludes or only minimally attends to the particularity of the individual’s situation. The relational skills involved at the face-to-face point between PHNs and individual people are assumed as necessary but often are not openly and reflectively examined.

The TB program is a specific example of nursing work that calls on nurses to act as surveyors of an infectious disease that threatens the public’s health and requires them to function for the sake of the common good of the population. At the same time, TB nurses are interacting
with individuals in personal settings, moments and life circumstances that often involve issues associated with homelessness, struggles of immigration, and the stigma of TB itself. While managing the work of protecting the population’s health, through the surveillance, management, and treatment of TB, they come into close proximity with individuals and families experiencing a variety of other health and social concerns. The success of TB treatment often depends on how nurses address these individual concerns, though this is not the explicit mandate. The success of the TB program relies on the invisible knowledge and skills of relational work.

Specifically, the TB program of public health was the focal point of this study for three main reasons. First, infectious disease in general is an important historical and current public health concern, receiving much recent media attention as both a local and global health issue. From SARS to the threat of a ‘flu’ pandemic, we as a society are interested in the prevention and control of infectious diseases in order to protect our collective health. Secondly, the actual encounters in TB nursing care represent situations that demand critical analysis of theoretical ideals of the nurse-client relationship. This area of nursing work, with its explicit population focus, represents particular challenges to such ideals as client centered care, autonomy, and empowerment. The monitoring and treatment of infectious diseases pose relationship dilemmas that center around issues of control versus care, surveillance versus therapeutic engagement, and the common good versus individual rights. TB therefore represents one area of public health nursing where relational skills take on particular meaning. The driving agenda is clearly a population focused one, and many individual TB clients are not necessarily asking for help, nor inviting the nurse to be involved in their lives. Rather, the nurse must insist on being involved in the interest of public health. And thirdly, the nursing role in the TB program has received far less
research attention than other dimensions of public health practice, which has created a gap in understanding relational work in this role within public health.

Theirs is a role that is not quite like hospital-based nurses who work in the same unit every day where patients come to them – are admitted, treated, and sent home. These nurses come to their clients, meaning that there are multiple locations of TB work including clients’ homes. Neither is their role exactly like other nurses in public health who work largely with groups on health promotion projects, or with ‘healthy’ individuals, like parents and their newborns, who generally invite the help of nurses from the start. TB nurses monitor a disease and work with ‘patients’ who are often sick. Yet thirdly, the role is not exactly like home-care nurses either, who work with patients in various stages of healing from illness but without a population health orientation.

Theoretical understandings of the ideal nurse-client relationship abound, yet relationships as the work of nursing are still largely only the topic of analysis in mental health. The nature of public health nursing has also been well theorized, most notably with its emphasis on the balance between individual and population health interests. The relationship is cited as foundational for public health practice and in fact is inherent in the newly developed core competencies for the public health workforce (Public Health Agency of Canada (PHAC), 2007b). Yet, the requisite knowledge and capacities associated with actually engaging with clients to impact their well-being have been only partially articulated as a part of the everyday work of PHNs. In addition, though community is a well-developed concept in public health, the question of how community as place shapes the relationship remains relatively unexplored.

This study is an attempt to move beyond theoretical ideals and propositions about establishing and maintaining relationships, how nurses ought to be relating to clients, to include
everyday experiences in particular situations, interpretations of how nurses and clients actually do relate to one another, and what affects and informs these relations. Fundamental guiding assumptions were made, including that relationships are central to ethical nursing practice, are inherent in the nature of public health practice, and require consideration as intentional work that demands knowledge, skill, and personal involvement. An additional assumption was that relational work is a matter of place – place being geographical location and lived experience, demarcation of space and creation of meaning. Place is highly relevant in public health nursing, and yet this relevance is not always fully addressed. Common words used to describe public health nursing, such as “community”, “district”, and even “public” all implicate the importance of place as geographical location. They also draw attention to social locations including social and environmental determinants of health. Therefore, in this study, relational work is considered phenomenologically, as situated in everyday practices and concerns of nurses and clients (Benner, 1994), and in particular private and public places of TB. Embodied intelligence, the situation, and place served as key concepts for guiding the research process and generating plausible interpretations. The purpose of the inquiry was threefold: 1) to articulate, through narrative accounts and observation, the meaning of nurses’ relational work wherever it happened, in one of Canada’s largest TB programs, 2) to describe how relational skills fit (or don’t fit) within the complex of assigned program tasks, and 3) to offer an interpretation of relational work that may provide evidence for the importance of including relational skills in the discussion of support and supervision of public health nursing staff, as well as provide data for possible recommendations for practice development in this area.

The overall research question was: What is the nature of relational work in public health nursing? Other questions to guide the inquiry were stated as follows:
a) How do nurses and clients understand and express the meaning of relationships as part of the nurse’s role in TB management and treatment?

b) What knowledge and skills are understood as essential in relational work in the TB program and how are they articulated?

c) How do particular situations and places shape/influence/impact the work?

d) How is the relational work in the TB program supported and developed?

The chapters that follow lay out the project, from preparation and planning, to data collection and analysis, the resulting themes and interpretations, and finally to its implications for practice, policy, and future research. Chapter two provides a brief overview of the public health system in Canada and tuberculosis as background information for this study. The third chapter is a review of the relevant literature addressing nursing relationships generally and public health nursing specifically. This review was vital in helping to frame how relationships have been conceptualized and studied in nursing, and how the work of relationships shows up in public health and TB nursing writing. Interpretive phenomenology as theoretical perspective and as a research methodology is laid out in fourth and fifth chapters respectively. Key concepts are briefly explained first in order to help the reader understand the methods employed for conducting the study as well as the interpretations drawn from it. The results of the study are explicated in chapter six through the articulation of welcome intrusions and its related themes. This is followed by an in-depth discussion of the skill of involvement and two domains of TB nursing practice, providing comfort and enacting surveillance, in chapter seven. In the eighth and final chapter, I address some limitations, suggest some implications, and conclude with some closing thoughts about this whole research endeavour.
Chapter Two: The Public Health and Tuberculosis Background

Public Health in Canada

*Public health is part of every aspect of our lives, from our homes to our workplaces, and our schools to our communities. It encompasses everything we do ... Public health is about the way we live.*

(Public Health Agency of Canada (PHAC), 2006a)

As this quote indicates, the parameters of public health are far-reaching and so broad as to necessitate its distinct place within the Canadian health care system as a specialty unto its own. Public health is distinct from hospitals and acute care, and even community health, and yet is integral across these areas. Summed up simply by PHAC, “an excellent health care system is simply not enough. Unlike health care, which focuses on the individual, public health targets the entire population” (PHAC). A brief overview of Public Health is therefore offered as background to this study. What follows is a description of the organizational structure, purpose and functions of each the federal, provincial and municipal levels of government, with particular attention to Ontario and the city in which the study took place.

The PHAC was formed in 2004 in response to the recommendations made in Dr. David Naylor's 2003 report, *Learning from SARS: Renewal of Public Health in Canada*. It was formed in order to create a level of coordination and collaboration that had not existed previously for public health in Health Canada, and includes governments, academia, researchers and non-governmental organizations. Along with PHAC, the Pan-Canadian Public Health Network and the six National Collaborating Centres for Public Health were also formed. In addition, PHAC serves as the connecting point for Canada's global involvement in public health research and development, linking with among others, the World Health Organization (WHO), and the Centers for Disease Prevention and Control in the U.S. and Europe (PHAC, 2006a).
Acting as the hub within Canada for health surveillance, threat identification and disease prevention and control programs, PHAC administers public health programming at a national level, and coordinates responses to public health emergencies and infectious disease outbreaks. In the case of infectious diseases, PHAC directives govern provincial and municipal strategies. The Centre for Infectious Disease Prevention and Control collects and analyzes all reported cases of particular diseases in order to prevent and control them in the Canadian population (PHAC, 2006a). Prevention and control of tuberculosis (TB) specifically are aimed at 1) identifying and treating infected people, 2) finding and screening people who have had contact with active cases, and 3) screening populations at high risk and providing treatment for them (PHAC, 2006b).

Across Canada, there are significant differences in provincial governance structure, funding, linkages, and official mandates. The very term ‘public health’ does not hold one common definition across Canada, and ‘population health’ and ‘community health’ are often cited in place of ‘public health’ (Canadian Public Health Association (CPHA), 1997, p.18). Furthermore, core guidelines for public health programs do not necessarily exist in every province.

While the regional health authorities in other provinces incorporate public health departments, Ontario’s local health integration networks (LHINs) do not. As the name implies, LHINs are responsible for managing the integration of local health services, with the explicit mandate of system planning and community engagement, and funding to health service providers (Ministry of Health and Long Term Care (MOHLTC), 2008). While LHINs include community health agencies, the relationship between LHINs and Public Health in Ontario is currently less straightforward. Public health remains under the direction of Ontario’s Ministry of Health and Long Term Care, administered under the Public Health Act (MOHLTC).
The Ministry provides directives for public health programming, set out in the Ontario Public Health Standards 2008. These programs are identified under the categories of Chronic Diseases and Injuries, Family Health, Infectious Diseases, Environmental Health, and Emergency Preparedness. The implementation of these programs happens at the municipal level of government, and as a consequence, each public health department looks a bit different, with mandatory programs being interpreted according to the particularities of each municipality’s population and fiscal restraints.

The provincial government has also newly formed the Ontario Agency for Health Protection and Promotion. Its mandate to provide scientific and technical advice and on-the-ground support to health care workers, public health departments, and government has been envisioned as bringing together “the two solitudes” of infection control and worker safety. This group of specialists offers expertise in the areas of outbreak prevention and control, surveillance and epidemiology, health promotion, chronic disease and injury prevention, occupational and environmental health, and laboratory services (MOHLTC, 2008).

Specific to TB, the Health Protection and Promotion Act (HPPA) (2004) is the Ontario legislation that identifies TB among other reportable diseases for the province. Under this Act, public health departments are responsible for collecting and reporting information about all suspected and active cases of the disease to the province.

Toronto, as the city that served as the location of this study, is home to the largest public health department in Canada. It is the responsibility of its Board of Health to implement the mandatory provincial core programs in such a way as to address the unique local needs of this large urban center. The Board does this by setting public health policy and advising city council on a range of relevant health issues, deferring any recommendations with citywide or financial
implications to council for approval. The Board consists of city councillors, school board representatives, citizens, and the medical officer of health (Toronto Public Health, (TPH) 2009a). Staff is comprised of a range of disciplines including nursing, medicine, health promotion, and epidemiology, to name a few. Given its size, the department is organized according to specific programs and geographic regions. It should be noted that nurses practice across the full range of programs, in various capacities and places, and in varying kinds of relationships.

The Tuberculosis Prevention and Control Program of TPH works with the community to reduce the incidence and impact of TB in the city. Strategies of the program are aimed at preventing transmission of the disease, ensuring appropriate treatment, and promoting awareness of TB issues. The program is structured accordingly into six teams (TPH, 2009b), beginning with Case Management Teams who manage TB in the general population. In order to ensure correct completion of treatment, Directly Observed Therapy (DOT) Teams focus on observing clients daily as they take TB medications. DOT is endorsed by WHO (2008) as the strategy of choice in addressing drug resistant TB strains. Three teams are identified according to specific population groups: the Homeless/Underhoused Outreach Team works to decrease transmission in city shelters and drop-ins; the Correctional Team manages TB in detention centers in Toronto; and the Medical Surveillance and Drug Order Team monitors TB in newcomers and visitors to Canada identified through immigration surveillance. Finally the Prevention & Outreach Team focuses on health promotion, community development, education and the creation of appropriate resource materials for at-risk populations. Nurses work in all these teams, and while the role is described in helpful terms such as educating, collaborating, and partnering, their obligation to monitor, manage and follow-up highlights that there are legally sanctioned implications for clients who do not cooperate with treatment, which nurses must enforce. Issues of control and
surveillance in TB therefore play a significant role in nursing relationships; already shaping how the relationship may develop before it begins. Given that nurses’ work is set in the restrictions of a reportable disease as well as the care demands of individuals’ health circumstances, understanding the reportable disease itself is important for understanding these relationships.

**Tuberculosis**

The background of tuberculosis as a global disease is briefly laid out here, followed by some description of the particular areas of concern that most directly pertain to nurses’ relationships with clients; that is, screening and adherence, education, and stigma and socio-political perspectives. Not covered here is the large body of literature that focuses on the microbiology, pharmacology, epidemiology, and biomedical concerns of TB, which is directed more toward understanding the disease than to the relationships with clients, and beyond the scope of this thesis. However, some background is needed since the nature of this disease directs the rationale for how the TB program is structured in public health.

The presence of TB, as one of the oldest known diseases affecting humankind, has been documented in all cultures and geographic regions (Toth, Fackelmann, Pigott, & Tolomeo, 2004). The airborne bacteria causing TB, mycobacterium tuberculosis complex, primarily affects the lungs but other parts of the body, including brain, lymph nodes, and bones can also be involved. TB infection occurs when the bacteria remain alive but inactive in the body, meaning that the person has no symptoms and is not sick. TB disease occurs if the infected person's immune system cannot stop the TB bacteria from growing. HIV infection, end stage kidney disease, diabetes, cancer, abuse of alcohol/drugs, and low body weight are some of the causes of a weakened immune system. Though TB is generally curable with antibiotics, it continues to be a major health problem and kills almost two million people worldwide every year (PHAC, 2006),
and as many as 10% of those infected will become sick/infectious in their life (WHO, 2008). Globalization, migration, inconsistent or out-dated treatments, and the rapid spread of HIV infection are significant contributing factors to the current resurgence of TB worldwide (WHO, 2008).

By Canadian law, TB is a notifiable disease, with almost 2000 new cases being reported across the country each year, and while most people in Canada do not develop TB, certain groups have an increased risk. They include those born in or traveling in countries where TB is widespread, Aboriginal peoples, homeless people, and those living in long-term care or correctional facilities (PHAC, 2006b). Key concerns regarding TB in Canada have been identified as drug resistance and the TB-HIV co-epidemic, and therefore both are closely monitored nationally (PHAC, 2006b). While the annual rate of TB in Toronto has continued to fall, it still represented 24% of the national number of cases in 2006. Of the 314 cases (11.8 per 100,000) in 2007, 95% were foreign-born; 2% were found in the city’s shelter population; 17% were resistant to at least one drug; 4% were HIV+; 68% enrolled in DOT and of those, 81% completed treatment compared to 74% completion rate of those without DOT services (TPH, 2009c).

Treatment involves a combination of daily administered antibiotics. It lasts a minimum of six months, and typically up to nine months or a year. However, for a variety of reasons, many do not follow this required course. This results in greater risk for the development of multi-drug resistant (MDR) strains, which can mean that treatment lasts two years, and spread of a more difficult-to-treat TB in the population (PHAC, 2006). For this reason, screening and medication adherence have been the focus of research, with studies\(^1\) citing factors such as education and

\(^1\) Research studies cited are marked with an asterisk (*) and detailed in Appendix A.

Screening is an important prevention strategy, a first step in eradication of the disease. This is made up of skin test and chest x-ray. Screening of high risk populations has been of particular focus in research. For example, Clark, Cegielski and Hassell (1997) studied response rates for door-to-door TB screening. Reasons cited for not agreeing to a TB skin test were fear, beliefs about being low risk for TB, too busy, and pressure from significant others not to participate. The final reason cited was uncertainty whether they could trust the worker or not. The effectiveness of screening has been examined primarily in homeless and immigrant populations, given the higher rates of infection in these groups (Clark, Cegielski, & Haskell, 1997; Levesque, Dongier, Brassard, & Allard*, 2004).

While screening efforts are vital for curbing the spread of TB infection, they also serve in detecting cases of active disease. Because TB is a bacteria and disease is treated with antibiotics, the importance of adherence to treatment becomes a central aim of practitioners. There are many reasons why people do not strictly adhere to a full course of antibiotics. Some factors affecting adherence are perceived supports, absence of barriers to treatment, capacity to care for oneself, and intention to adhere, which may also be influenced by beliefs regarding usefulness of medications (McDonnell, Turner & Weaver, 2001).

Education is an important element in increasing response to screening programs and improving adherence. The need for multi-faceted emphasis on education arises generally from
limited knowledge of the disease and treatment. This is highlighted by Ailinger, Lasus, and Dear (2003) who found major gaps in U.S. residents’ knowledge and perceptions of risk of TB, in their survey of a large sample from the National Health Interview Survey. Only 78% of participants reported knowing something about TB and while almost half of them said they knew how TB was spread, only 80% of those answered correctly. These authors recommended that education be given priority across all health sectors. Added to this, results of a study of Latino immigrants’ knowledge base about TB indicated the need for education in this particular cultural group, specific to disease process and misconceptions about contagiousness (Ailinger, Armstrong, Nguyen, & Lasus, 2004). No similar Canadian studies were found, so while the research cited may not necessarily reflect the Canadian context, the findings are useful in shedding light on the general concern for increased knowledge about TB through education.

As indicated, education efforts may be more effective when consideration is given to the beliefs and attitudes of those being educated. Cultural differences, as an important related notion, comes to light through the example of international migration. This bears consideration in the case of the city where this study took place, where as previously mentioned, more than 90% of TB cases involve people who have migrated, and who therefore also bring with them a variety of cultural understandings of health, health care, and TB itself.

According to Rosenberg (1998), along with migration comes the adoption and adaptation of “traditional medicine” in the host country by both immigrants and those already living there (p.217). A practical implication of this for TB treatment was explicated by Ailinger et al.(2004), who stressed the value of outreach with groups from countries where “pluralistic health beliefs prevail” (p.521), and the importance of understanding these beliefs, and related “folk medicine” practices, in order to incorporate them into the teaching aimed at increasing understanding of TB
and its treatment. A participatory action study involving Aboriginal and immigrant people in Alberta highlighted that while people with active disease learned about TB from the health professionals treating them, those at high risk for developing the disease knew little about it and relied on general cultural understandings (Gibson, Cave, Doering, Ortiz, & Harms, 2005). The advisory group for the study requested that culturally appropriate, accessible information be made available in these communities.

Stigma is one social barrier to receiving treatment for TB. Stigma exists with the diagnosis of TB itself, reflected in misconceptions about the “contagiousness” of the disease and its historical roots as a powerful cultural metaphor (Sontag, 1978). For example, sanitoriums as historical reference points for many Canadians are present in contemporary notions of TB as a disease requiring removal from society. Jaramillo’s* (1999) survey of residents of Cali, Colombia highlighted the need for education that addresses prejudices against people with TB, finding that stigmatizing attitudes magnify suffering in terms of social isolation.

While TB itself is highly stigmatized, there is also a perception of TB as specifically being a disease of ‘immigrants’. Upshur, Deadman, Howorth, & Shortt* (1999) studied school staff’s attitudes and beliefs regarding the nature of TB and its effect on the culture of their multicultural schools and found that TB was a source of fear and stigma for these focus group participants. Education was highlighted here too - regarding the disease itself and the broader issues associated with immigration. For example, some participants expressed great concern with the “laxness of immigration procedures in Canada regarding communicable diseases” (Upshur et al., p.391), without indicating any specific knowledge of what those procedures actually are.

While newcomers to Canada bear the brunt of stigma based on stereotypes associated with the label “immigrant”, they face a interlinking set of socio-political and cultural factors as
well (Ho, 2004), such as stable housing and adequate income. These factors can in themselves be stigmatizing, and can extend to non-immigrant populations as well. TB clients who are homeless and poor also face prejudicial attitudes and societal judgments regarding their homelessness and poverty (Draus, 2004; Farmer, 1999; 2005; Gibson et al, 2005). Finally, also from a socio-political perspective, TB is closely connected with HIV/AIDS, yet it generally receives far less attention as a health concern. Draus (2004) argues that this is because while both AIDS and TB affect poor people (and poor countries), only TB affects the poor exclusively, both globally and locally. In this sense, TB may be understood not only as a medical problem, but as “an index of graver social ills”, and while treatment focuses on physiological measures, “we must recognize that [TB] has its roots in soil we all share” (Draus, p.55). As a social construction, TB is linked to deeply embedded determinants of health (Lawrence, Kearns, Park, Bryder, & Worth, 2008) that cannot be overlooked in understanding nurses’ relationships with people suffering from it.
Chapter Three: A Literature Review of Nursing Relationships

The topic of relationships in health care is extensive, spanning virtually all helping professions and beyond; however, this literature review is limited to nursing relationships, and this broad area is examined from three general perspectives: nurse-client relationships, public health nursing, and what has been described as nursing geography, which tends to questions of place and space. Databases searched were CINAHL, Medline, PsychInfo, and Social Sciences Citation Index, from 1980 to 2006. The following were the initial key words used: nurse-client relationship, public health nursing, population health, TB, human geography, and health geography. Only English articles were included. Other sources of literature were reference lists, government and Ontario nursing organizations’ websites, and word-of-mouth suggestions. The articles and books that these search avenues produced span theory development, expert opinion, and research studies. Nursing relationships as the first section of review is not an exhaustive review of all literature on the topic. It is only a way to set the background of understanding how relationships have been theorized. The conceptual and empirical themes found in public health nursing literature are home/health visiting, community-as-client, population health, and the socio-environmental context, of which social justice is a part. Explicit attention to TB nursing rounds out this section of the review as the specific area of relational work for this research project. The relational and contextual nature of ethical practice is a thread running throughout these three areas of public health nursing. Also, qualitative research methodologies seem to dominate the empirical literature, perhaps because public health nursing practice has been elusive to fully describe through quantitative methods. Measurable outcomes of practice may not get at the nature of practice in this broadly-focused area of nursing. Place has been addressed in

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2 Research studies cited in this review are marked with an asterisk (*) and detailed in Appendix A.
nursing literature predominantly in the area of nursing ethics, with the home being examined as a place of nursing care, and the nurse-client relationship considered for its spatial dimensions. I have reviewed the literature with an eye for the specific knowledge, skills and self-awareness necessary to relational work. I have also read with attention to phenomenological perspectives and the implaced nature of health and nursing, compelled to wonder how place shows up or is accounted for in the study of public health generally and relationships specifically.

The Nurse-Client Relationship

The interpersonal relationship between nurse and client has been well theorized, studied, and taught as a fundamental of basic nursing curricula. It has been theorized in such ways as an interpersonal relation (Peplau, 1952), the therapeutic use of self (Canadian Federation of Mental Health Nurses (CFMHN), 2006; Ersser*, 1997; Freshwater, 2002; Travelbee, 1971), the I-Thou relationship (Bishop & Scudder, 1990), transpersonal caring (Watson, 1999), and intersubjective engagement (Gadow, 1999), with the self awareness of the nurse being emphasized across all.

Hildegard Peplau (1952) is recognized as the first to fully explicate a theory and practice of nurse-client relationships, shifting attention from what nurses do to clients, to what they do with clients; from focus on the client and nurse as separate entities to the interpersonal as a crucial element in nursing situations (Arnold & Boggs, 2003; Forchuk, 1993; Peplau, 1992, 1997). Grounded in interpersonal psychodynamic theory, Peplau (1997) defined relations as the connections, bonds or patterns that develop in identifiable ways between people. Nursing relations specifically require observation of the behaviours and responses of both the nurse and client (Arnold & Boggs, p.10). Quality purpose, goals, and timing, as well as the qualities of the individual nurse are issues that Peplau’s theory addressed. Nurses must engage in “unflinching self scrutiny and total honesty in assessment of their behaviour in interactions with patients”
(Peplau, 1997, p.162). And, while she does not explore it in depth, Peplau (1997) does mention that ‘interpersonal’ refers not only to one nurse and one client, rather it is broadly understood as relations between and amongst people, including families, groups, and communities.

The unflinching self scrutiny that Peplau emphasizes is described by Ersser (1997) as self awareness, requiring that relationships are not understood only from a rational base of received scientific or abstract knowledge. Ersser points out nurses do not abandon cultural knowledge they have about helping others, that derives from “outside the working sphere” (p.36). His findings support the idea that relationships also rely on such human capacities as genuineness, congruence and authenticity, emotional involvement, empathy and trust. These concepts influence the context of care and underpin intentional nursing actions “associated with being caring, patient-centered, and helpful in learning” (Ersser, p.35). Thus, helpful nursing relationships are less about prescribed therapeutic techniques and more about the “relational stance” of nurses with clients (Robinson*, 1996).

When Robinson (1996) asked families with a member who had a chronic illness about what the nurse actually did that helped to relieve distress and suffering, families consistently spoke of the way nurses related to them and enabled change, rather than what particular interventions were employed (p.160). Families generally saw the helpful nurse as someone able to be touched by their suffering and offer “objective” views, thereby balancing closeness and distance, and able to open up room for dialogue by not passing judgment (pp. 161-2). Robinson (1996) argues that nurses have been “inadvertently blinded to the interventive power of relational activities” through the separation of nurses’ work into activities that either “create a context for change” or those that “elicit change” (the latter being otherwise known as ‘interventions’, and therefore privileged) (p.168). However, she recognized that her findings were limited to
‘voluntary’ clients, and asked a relevant question for this thesis: “is the relational stance congruent with non-collaborative relationships?” (p.169). In other words, in situations where the client is not necessarily ‘voluntary’, such as public health’s TB program, would we hear clients report similar effects of the nurse’s relational stance?

The balancing of closeness and distance described by Robinson (1996) is part of the skill of involvement described by Benner and colleagues* (1996). These authors discuss relationships in their examination of this skill as a key dimension in the development of excellent nursing practice. Relationships are “too often considered a talent or trait rather than skilled knowledge developed over time through experience” (Benner et al., p.242). Interpersonal involvement includes social exchanges, negotiation, noticing, and ultimately a good connection that opens up possibilities in the situation (Benner et al.), or as Robinson described, enables change. The skill of involvement is rarely learned when everything is perfectly manageable; rather, it is learned by doing well and doing poorly in relationships with clients (Benner et al., p.243), by being over-involved or too detached (Benner et al., p.132), and in reflecting on what constitutes a “comfortable and effective zone of engagement” (Benner et al., p.91). These reflections are dependent on such factors as the culture of the workplace, the styles of individual practice, and being able to recognize trust and the need for comfort (Benner et al).

The nurse-client relationship has also been approached as a social construction (May, 1995; May & Purkis, 1995; Wilson, 2001). May, though citing only hospital-based examples, discusses knowing the patient as a central element in conceptualizations of nurses’ work. The notion of the “authentic patient” has replaced that of patients as passive objects of medical attention (May, p.2); the body displaced by the person who subjectively experiences illness (May & Purkis). May highlights two tensions that this has created. First, ‘knowing the patient’
competes with autonomy. It becomes problematic when nurses encounter patients who do not want to share private concerns, do not want the nurse to ‘know’ them beyond the clinical situation, and in so doing, are at risk of being labeled resistant or noncompliant because they do not share in this personal way. A second tension exists with creation of a “technocractic agenda” that uncritically adopts nursing theories that espouse ‘knowing the patient’ as good nursing practice (May, p.3). Driven by this agenda, we run the risk of framing interactions with clients as mechanistic, ‘cookiecutter’ procedures, rather than in what Ersser (1997), Robinson (1996), and Benner et al. (1996) have framed as caring and relational engagement.

Furthermore, in keeping with my own concerns for public health practice, May and Purkis (1995) questioned the extent to which this privileging of the person’s subjective experience may only occur at the rhetorical level (i.e. in formal nursing theory) (p.286). At the practical level, relating with the person calls for a focus on the meanings of situated experiences, rather than the ‘correct’ prescribed questions and responses. The actual encounters between nurse and client require careful attention to positioning and negotiation; “nursing is an intensely grounded activity that takes place between bodies”, in situated social relations that set up “conditions of possibility” (May & Purkis, p.289). This raises questions for the ways nurses are engaged with clients in the TB program, where the conditions of possibility are already limited by the population health mandate of monitoring an infectious disease.

The relationship between public health nurses and clients is also one of surveillance and control, and while the focus by a few authors in this area has been on mother/child services, their arguments are relevant for TB nurses who also fulfill a surveillance role. These authors challenge ‘feel-good’ theoretical understanding of nurse-client relationships by examining the inherently ambiguous role of PHNs as agents of the state, policing families while also working to support
them (Andrews*, 1999; Crisp & Green Lister*, 2004; Marcellus, 2005; Peckover*, 2002; Wilson*, 2001). Marcellus (2005) described the PHN role with at-risk families as one of “watchful waiting”, surveillance within a caring framework. Similar to this, Wilson (2001) described the “gentle surveillance” of child health nurses. While they were concerned about developing a good relationship with mothers, these nurses paradoxically saw the success of their caring work as dependent on implicit surveillance in the home; that is, being able to watch mothers where they live. Considering the perspective of clients, home visits may be seen as “intrusive” and “objectionable” (Wilson, 2001), and as Peckover (2002) identified, mothers need to figure out whether the nurse is there as an authority figure or there to help; is the role one of supporting or policing or both? Marcellus (2005) argues, in the end, that a moral trusting relationship is still possible in situations of surveillance, provided the nurse is critically self reflective and nurse-client encounters are mutually respectful.

Lowenberg (1994) and Spiers* (2002) share the perspective that there is a need to examine relationships as being intensely grounded in concretely situated everyday realities. Lowenberg (1994) identified research gaps in this area, suggesting that in order to move beyond ideology and rhetoric, more studies are needed that critically analyze what actually happens in a range of “concrete clinical encounters” (p.167). She further suggested the need for research that: examines taken-for-granted assumptions, includes perspectives of both nurse and client, includes more participant observation, and addresses nursing interactions in community health (p.180).

Relationships can be viewed as interpersonal, contextual, and socially constructed. While theories about relationship have contributed greatly to our foundational understanding of the interpersonal (and therapeutic) interactions in nursing, they remain focused on one individual
and one nurse. What they leave largely unexplored is how nurses engage with communities and the population as a whole, as well as all the complexities of location, structure, and actual situations in which they happen. A public health perspective on nurse-client relationships is needed in order to account for relationships in and with communities, and out of concerns for the population.

**Relationships in Public Health Nursing**

According to the Community Health Nurses Association of Canada (CHNAC) (2008), public health nursing is distinguished from home care as a practice concerned primarily with population health promotion in “diverse settings… and with diverse partners, to meet the health needs of specific populations” (p.3). While the population is the focus, it is important that PHNs integrate “personal and clinical understanding” of health and illness of individuals and families into this community-based work (CHNAC, p.3). In Toronto Public Health, community-based population-focused work is also task-specific, leading to nurses practising across a range of specialty programs, in various capacities, in varying kinds of relationships. Relationships in public health nursing have been studied in a variety of direct and indirect ways, from the view of home or health visiting with individuals and families, and from perspectives on the nature of nursing’s role in public health, which includes conceptualizations of the community as client, population health as a dominant agenda, and the socio-environmental context that demands attention to questions of social justice.

**Home/Health Visiting**

The client’s home as the site of care implies a ‘guest’ role for the nurse, calling on particular relational skills. The meaning of ‘home’ itself can be perceived as a private domain which preserves the person’s identity and where he/she exercises self-determination (Magnusson
& Lutzen*, 1999). Spiers’ (2002) detailed analysis of home care relationships offers important insight into negotiation as a skill of relational work that is relevant for public health nursing as well. Negotiation was found to be the core of developing nurse-client relationships, and was described as “a complex process” involving issues of trust, legitimacy, authority, autonomy, competence, and vulnerability” for both nurse and client (Spiers, p.1034). In videotaped dyads of home care nurses and clients, Spiers observed that clients wanted to know their nurses “as individual people” and nurses considered their interest in clients “beyond caregiving” as crucial for good practice, which took shape in social talk and storytelling (p.1043). As guests in people’s homes, nurses engaged in negotiating “territoriality” with clients (e.g., where the visits take place, how the room is set up). Negotiation also involved cooperation, which included working through conflicts sometimes with the only compromise being “agree to disagree” (Spiers, p.1043), a sense of belonging, and solidarity as working partners. Rather than focusing teaching efforts on conceptual ideals of communication, attention ought to shift to raising awareness of how negotiation is used as part of “everyday language for therapeutic purposes”, and the importance of identifying “contextual cues” for the effectiveness of the negotiation (Spiers, p.1055).

Spiers’ (2002) study examined home care, where illness, disability, treatment, and basic care are the focus of practice. In contrast, the home or health visiting functions described as part of public health practice often involve a population health perspective and/or less immediate attention on illness per se. One strong theme in the literature addressing this home visiting function is that of competing agendas (the person versus the public). Additionally, much research attention has been on ‘mother and well baby’ visits.
Practice or “client” agendas in home settings/situations often exist in tension with policy agendas (Carr*, 2001; Cody*, 1999; de la Cuesta*, 1994). This tension shapes relational work in several ways. The “depth of relationship” depends in part on the personal needs of particular client agendas, and if they can practically be addressed in “overt legitimate practice or through more covert or fringe activities” (Cody, p.124). In other words, getting to know clients more personally may be considered “fringe work”, compared to population-focused tasks. Because of this, and possibly because it takes place in the privacy of people’s homes, relational work is left largely unarticulated (Carr). Furthermore, “real life” at home does not follow neat routines, cannot be clearly categorized, and therefore creates the potential for situations of great uncertainty for the nurse (Carr). According to de la Cuesta, the relationship is often the “mediating factor” in the nurse’s dual role of control and service. This is particularly relevant when the policy agenda dictates that the nurse must visit (as in the case of TB-DOT). Relational skills in these non-voluntary situations are vital in getting to know the client, producing any sense of reciprocity and even simply just getting in the door, all of which imply the necessity of building trust (de al Cuesta). When “care moves closer to home” (Carr, p.336), not only nursing tasks, but also the location, context and relationship itself become key considerations. Described as open, flexible, and negotiated, community practice in the home calls for different types of assessment and decision-making processes, more inclusion of clients’ perspectives (since it is their home), and acknowledgement of nurses’ feelings of uncertainty (Carr, p.332).

Health visiting relationships in homes were considered by Cody (1999) to be therapeutic in and of themselves, rather than purely as vehicles for tasks and interventions. Careful to acknowledge that health visiting is not psychotherapy, she proposed that a phenomenological approach to relational work has therapeutic effects, identifying its emphasis on an embodied,
situating perspective on care, that tends to the lived experiences and perspective of clients regarding their health needs. Phenomenology, in this way, helps to guide nurses in their home-based efforts to balance “policy” and “people” agendas. For nurses in her study, the policy agenda must be addressed in the home, yet so must the “personal, time consuming, emotional struggles of clients”:

Perhaps there is conflict within health visiting practice as to how to divide time between the two agendas. But when in face to face contact with a client overwhelmed by a problem, the immediacy of the moment necessitates a response (Cody, p.124).

The maternal/child dyad has been the focus of many studies of the relationship between PHN and client, with mothers’ vulnerability and powerlessness (Jack, DiCenso, & Lohfeld*, 2005), the importance of non-verbal communication (Vehvilainen-Julkunen*, 1992) and genuine collaboration (Paavilainen and Astedt-Kurki *, 1997), and timing (McNaughton*, 2001) being articulated as key elements of relationships. Furthermore, place was implicated in two studies. Vehvilainen-Julkunen emphasized, “how people position themselves in situations” is a key aspect of nonverbal communication (p.900). She highlights that where nurses position themselves in relation to clients is important, yet this positioning is not always a conscious act. Elaborating this, “proximity”, which included sitting “quite close”, moving around the room “at the same time” as the mother, and “gaze and eye contact” were found to be significant nonverbal elements of the mother-nurse relationship (p.900). Paavilainen and Astedt-Kurki *(1997) articulated a genuinely collaborative relationship as one in which finding “common territory” was necessary, part of which included developing a familiarity with clients’ living conditions so that nurses could choose the “right” care approaches (p.140). While living conditions were
considered in resource and care planning, I wonder if these ‘conditions’ were also considered in relationship development.

McNaughton (2001) compared her observations of nurse-client dyads with Peplau’s (1952) interpersonal theory with specific attention to the orientation phase of relationship development, finding that nurses did indeed spend most of their time in this phase with clients. Time, as an aspect of relational work, however, is not a linear notion, and in an everyday context relationships with clients are not so neatly lived. PHNs and clients are continually ‘orienting’ themselves while ‘working’ on goals, and the ‘ending’ of the relationship is always looming. Knowing what phase PHN and client are in may not necessarily satisfy the interpersonal and intrapersonal dilemmas of actual everyday situations. Beyond providing a useful basic frame of beginning, middle, and end, such a theoretical stance on the temporal dimension of relational work may not fully answer such dilemmas as may be found in other public health programs. For example, in TB, the client’s participation is not necessarily voluntary, and at times PHNs are actually working against the client’s efforts to end the relationship, or vice versa, the client is working against even minimal orientation. How are we to understand the relational work that does not fit neatly into phases of development, but rather is lived in particular moments of time, situation, and place?

The moral dimension of the relationship between PHN and client has also been explicitly studied. Relationships were found to be key factors by Oberle and Tenove* (2000) and Hoorstman and van Rens-Leenaarts* (2002) in their respective studies of ethical dilemmas and ethical decision-making. Oberle and Tenove found that the context and nature of the relationship, empowerment, and setting boundaries were critical dimensions of relationships in public health, and in tending to these dimensions, PHNs routinely faced ethical dilemmas. The dilemmas they
cite were, knowing how much to do for clients, knowing how to distinguish personal from professional involvement, understanding what clients actually need to make decisions, and at times putting one’s integrity and/or physical safety at risk in the interest of client well-being. Honouring clients’ particular frames of reference was seen as the complicating factor in all dilemmas; while nurses felt they ought to know what to do, there was seldom a right or wrong answer, precisely because it depended so much on the client’s situation and context (p.435).

Hoorstman and van Rens-Leenaarts’ (2002) found that the relationship with parents was seen by nurses as the most important factor in providing information about “cot death”, and nurses felt at times, ethically caught between clinical guidelines and parents’ concrete situations. They observed that nurses are not mere technicians disseminating scientific data, rather, “they actively translate and accommodate scientific claims about risks and risk behaviour in specific contexts” (p 140-1). This literature supports the notion that as PHNs talk about relationships, ethics is implied (Cody, 1999; Jack et al., 2005; Paavilainen & Astedt-Kurki, 1997; Spiers, 2002), and in talking about ethics, relationships are implied (Hoorstman & van Rens-Leenaarts, 2002; Oberle & Tenove, 2000). Therefore, public health nursing is a context-bound, moral activity, dependent on a relational kind of work carried out in the personal situations of people’s home life.

Some gaps in the research in this area of home-based nursing care have been articulated in McNaughton’s (2000) synthesis of qualitative research on home visiting. Gaps identified were, an over-representation of maternal/child and family care, a lack of studies that included clients’ perspectives, and no guiding theoretical frameworks articulated. Since this review in 2000, the predominant population of inquiry has continued to be new mothers and their children (Carr, 2001; Hoorstman & van Rens-Leenaarts, 2002; Jack, DiCenso & Lohfeld, 2005;
McNaughton, 2001), but PHNs work in other areas where nurses’ relational skills are vital to the public health program, and comprise a portion of the work itself. It is important to address the relational work in public health that extends beyond what seems the most obvious area for relationship inquiry (i.e. pre and postnatal care), to include the perhaps less obvious, though no less important, relational work of other programs such as school health, workplace health, immunization, and communicable disease, including TB. These are areas in which the home may not necessarily be the site of care but where relationships constitute a large portion of the work none-the-less.

**The Nature of Public Health Nursing**

The relationship as an interpersonal process between one nurse and one client, is an individually focused perspective, strongly critiqued in public health literature for not capturing the essence of public health practice (Butterfield, 2002; Chooporian, 1986; Drevdahl, 1995; 1999). A focus on individual care in public health nursing generally limits discussions of context to the home, and leaves the concept of environment, so essential to the mandate of public health, largely unexplored. Therefore, several authors have shifted the attention away from individuals, re-focusing the nature of public health nursing to ‘community’ and ‘population health’ as core concepts of practice and examining them as such. Within each area, relational work is described, albeit sometimes in different language. Furthermore, social determinants of health are also considered more explicitly as part of the relationship between PHN and client.

**Community-as-Client**

Community, defined by Kulbok, Gates, Vicenzi, and Schultz (1999), is a collective whole made up of persons in interaction, being and experiencing together, who may or may not share a sense of place or a sense of belonging, and who act intentionally for the common purpose as well
as for the individuals who are parts of the whole (p.1188). The discussion of clients as aggregates has given way to understanding the community as client, or a “plurality of persons” (Smith-Campbell, 1999). In this conceptualization, the community, rather than any one individual, is seen as the recipient of care, and this has been explicated by several authors (Kuenhert*, 1995; Kulbok et al., 1999; Rafael, 2000; Schulte, 2000; SmithBattle, Diekemper & Drake*, 1999; Smith-Campbell, 1999). The culture of public health nursing is one that emphasizes relationships with whole communities (SmithBattle, Diekemper & Drake), or one of “creating [community] connections” (Schulte). Kuehnert developed a model of community-as-client, meaning public health practice is entirely “shaped by and directed toward the community as whole, taking into account the community’s physical features, its social, economic and cultural history and institutions, and its political history and power structure” (p.11).

Community-as-client has offered a theoretical framework for studies of caring in public health (Rafael, 2000; Smith-Campbell, 1999), PHNs’ perceptions of their work (Reutter & Ford, 1996), client competence and empowerment (Courtney et al., 1996; Reutter & Ford, 1997). Rafael (2000) points out that “effective public health nursing practice cannot dichotomize the community from the individuals in it” (p.43) Working with the community-as-client must include building community competencies and information-giving (Reutter & Ford, 1996; 1997), as well as facilitated dialogue and negotiation with community partners (Courtney et al., 1996).

Community-as-client however, has not gone without critical analysis. There are two distinct limitations of the concept. First, this focus on attributing ‘client’ characteristics to a community has partly served to remove the actual physical geography of communities from theory though it remains a material, pragmatic aspect in practice. St. John* (1998) found that in fact, community-as-client may not be a functionally useful concept for practising community
nurses. She proposed a more complex view of community: as geography, as aggregate of population related to specific health issue, as relations ("network" and "unit of care"), and as resource. "Where nurses could not describe the whole community as a connected entity, they used notions of geography, networking, resources and target groups. The most usual description was as a place" (p.68), and place was understood on "abstract global" and "operational practical" levels (p.65).

Similarly, Schroeder and Gadow (2002) point out that community-as-client ignores the significant and "perhaps obvious" differences between an individual person and a community. They also critique the risk it creates for continued traditional interpretations of the nurse-client relationship, namely, with 'client' as passive and dependent recipient of care. Community-as-partner, they argue, speaks more accurately to an ethic of advocacy and better defines the actual work aimed at "enhancing community self-determination" (p.79). Picking up their critique and alluding to the suggestion of viewing communities as partners, Rafael (2005) offers the concept of "critical caring" as a way of understanding community nursing, and viewing this work as praxis, practice grounded in reflective relationships that involve capacity building, being open, and attending to the existential dimensions of health and healing in communities (p.41).

In all the literature cited above, aspects of relational work are identified, though perhaps not fully explicated: empowerment, capacity building, partnering, dialogue and negotiation as particular ways of being relation in the community. Generally, what have not been addressed are clients’ experiences of such phenomena. For example, do clients actually experience themselves as more empowered and competent as a result of their relationships with PHNs? How do they understand partnering, dialogue, and negotiation related to particular health issues? Also, while working with whole communities is a distinguishing aspect of public health work, so too is
infectious disease management and prevention, and only one author (St John, 1998) accounted for this area of relational work that is medically (rather than community) driven, and population focused.

**Population Health**

Most definitions share the premise that the subject of public health is the health of populations – rather than the health of individuals – and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few… Consequently, public health is less interested in clinical interactions between health-care professionals and patients, and more interested in devising broad strategies to prevent, or ameliorate, injury and disease (Gostin, 2001, p.122).

Population health, as described above, is an important theoretical distinction made in public health nursing literature, and brings with it problematic tensions for practising nurses who at times are, and in fact must be more interested in clinical interactions. However, nurses’ awareness of population health concerns is seen as critical to expert “clinical know-how” in public health (SmithBattle, Diekemper, & Leander*, 2004).

Health promotion, as one of the broad strategies to which Gostin (2001) alludes, has been examined as a central dimension of population health by several nursing authors. Health promotion is seen as the foundation of community practice (Shields & Lindsey, 1998). Rafael (1999b) focused on health promotion as an important aspect of public health nursing that requires an explicit population focus. She argued that in current age of program-focused practice, public health nursing needs to reclaim health promotion as part of the historical role of district nursing. Health promotion also requires a critical perspective. Lowenberg (1995) critiqued the
ideology of individual choice in health promotion as victim blaming, advocating instead for a population focus that emphasizes having compassion for vulnerable groups and understanding contexts in which health choices are made. While an important concept for public health practice, the literature does not seem to address all areas of such practice. Specifically, how is health promotion understood in day-to-day relations with TB clients, where infection, disease, and illness are central? What is it actually like to be health promoting in such areas of practice?

Though many PHNs can articulate the population health approach, Grumbach, Miller, Mertz, and Finocchio’s (2004) survey of PHNs found that a population focus is not reflected in practice even though it is cited in theory and policy. While nurses felt their work was population-focused, they did not actually carry it out as such. Added to this, Purkis* (1997) found that though PHNs described their practice as “health promoting”, they in fact were hard-pressed to explain exactly what that meant in their everyday work. This supports Liaschenko’s (1998) observation that even though there is a conceptual differentiation between the two, “it does seem that most of what is called health promotion by nursing is actually disease prevention” (p.74). The point here is that theoretical notions of health promotion need to be scrutinized more closely for what they mean in PHNs’ real life work. It is not enough to espouse population health and health promotion principles without also supporting the individually focused relational skills required to carry out such programs. Furthermore, discussions of population health and health promotion seem to have mostly involved only professional voices. Do clients themselves understand their experiences with public health in terms of population concerns? Do they use the language of ‘health promotion’ to describe PHNs’ roles in their lives? Nurses need to address how health promotion as a concept manifests in real life because they are predominantly the ones
to engage at the face-to-face level of population programs. One answer in the literature has been to include the individual in an account of population health.

The tension between meeting the needs of the individual and the collective needs of the population has a long history in Canadian public health nursing (Duncan, Leipert, & Mill, 1999; Yiu Matuk & Chadwell Horsburgh, 1992), and there are those in present day who call for the incorporation of individually focused relational skills in population-targeted programming as a way of fully articulating practice in public health (Rafael, 2001; Reutter & Ford*, 1998; SmithBattle, Drake & Diekemper*, 1997). SmithBattle et al. critiqued the dichotomy between individual/family and community/aggregate as thinking that “does not do justice to the expertise of working with individuals and families” (p.8). They argued that this expertise in everyday practice is often overlooked, and articulated the “responsive use of self” as a highly developed skill in establishing partnerships with clients, which also requires “situated knowledge”. In further analysis of their 1997 data, SmithBattle, Diekemper and Leander (2004a&b) acknowledge the ability to see “the big picture” as a crucial part of clinical know-how in public health, yet they emphasize that practice must begin in quality relational skills of nurses. Reutter and Ford (1998) argued that the overemphasis on the population-focused primary health care principles as the guide for practice has served to take the nurse away from actual clients and their needs. Keller, Strohschein, Lia-Hoagberg, and Schaffer* (1998; 2004) developed a practice model that emphasizes “population-based, individual-focused interventions”, that is, interventions such as individual teaching and counseling as being always based in population health initiatives such as policy development and advocacy. Advocacy is a term that is used often in reference to public health nursing work, which in turn situates nursing practice as a moral concern.
Balancing of individual and population interests is part of relational work that implies the potential for moral conflict. Nurses in Oberle and Tenove’s (2000) study experienced just such situations, in which they struggled with “the greater good for the community as expressed in law, and the needs of the individual” (p.431). These nurses identified the fundamental issue as how best to balance risk and benefit, within particular client contexts to achieve the greatest good. They cited the “obligation to serve clients at multiple levels (individual, family, community)” as a key factor contributing to the moral complexity of public health work (p.432). This mirrors the competing agenda concerns of nurses in home visiting roles.

**Environment, Political Activism, and Metaphors of Place**

Attention to the importance of individually-focused, population-based practice raises the importance of how place is explicated in the literature. *Where* public health nursing is carried out is an aspect of the work. This is addressed by several authors, through metaphorical descriptions of practice that imply place, through articulation of the “generalist” role, and through explication of the link between environment and political activism as part of public health work.

St. John (1998) conceptualized community practice as being “from the field”. Similarly, “views from the field” was the theme of Reutter and Ford’s (1996) study that gave voice to PHNs’ feelings about their work. In 1998 they described how organizational shifts from generalist or district nursing to program focused care in Canadian public health was causing a shift in care “from hands on to arms length”, raising the question of nurses’ proximity to actual clients. Drevdahl (2002) theorized the contradictions of community as the challenge of working at “home and border”, representing communities as being both spaces of comfort and commonality, and as spaces of discomfort and difference. Zerwekh* (2000) discussed public health practice with marginalized groups as caring “on the ragged edge”. These metaphors of
being located “in”, “from”, “at” and “on” point to how place and the nature of the work inform one another, particularly with regard to encounters with marginalized people. Metaphorical descriptions help to remind us that the site of care and settings for particular relationships has practical and profound implications for how public health nursing is carried out. Relationships happen ‘in’, ‘at’, or ‘from’ a specific place, as well as spatially ‘with’ the client.

The generalist role highlights the practical ways in which place matters in public health work. It is a role historically grounded in neighbourhood or “district” nursing (Buhler-Wilkerson, 1993; Duncan et al., 1999; Rafael*, 1999). This role defines a practice model that assumes that geographical location in part determines the needs of those living there, and in turn shapes the work of the PHN and situates the PHN simultaneously in relationships with individuals, families, and the whole designated neighbourhood (Kulbok et al., 1999; McGarry, 2003; Rafael, 1999a; Reutter & Ford, 1996). Rafael’s historical look at public health nursing in Ontario points to how little of the generalist role remains today, and questions if place is being left out of our current program-focus to the detriment of best practice. Likewise, Chalmers, Bramadat, and Andrusyszyn* (1998) focused on the changes at a system level in public health that served to move PHNs away from the generalist role and further into specialization. By studying the nature of everyday practice, they found PHNs were concerned about the trend away from direct care, the emphasis on demonstrating measurable health outcomes, and increasing specialization to the exclusion of generalist expertise. The generalist role brings to light how place plays a part in practice as both where the work happens (i.e. in the neighbourhood or district) and how the work takes shape (i.e. the spatial interactions of the nurse with individuals and the whole neighbourhood).
Place is also explicitly tied to discussions of health, in which the socio-political and environmental context is called into question and nursing actions are seen through the lens of “public health as social justice” (Beauchamp, 1976). Doing public health means doing justice, questioning what right-to-health means, creating collective definitions of public health problems, convincing the public that we all share in this, questioning the embedded structural values associated with dominant issues that impede health, and challenging medical dominance (Beauchamp). Beauchamp argued that advocacy should be happening everywhere, at all levels, from policy to grass-roots work; in other words, acting out social justice. Nursing literature has addressed this perspective as part of public health practice.

Social justice implies a moral stance and observable action, as well as consideration of the environment and interpersonal relationships. It is not enough to be aware of injustices; nurses must also be acting in just ways, and in ways to counter injustices where they are found (Bekemeir & Butterfield, 2005). This implicates the importance of critical reflection on health as a human right as part of public health nursing practice (Easley & Allen, 2007). The health of individuals and populations is undermined by negative social and political conditions, such as poverty, racism or sexism, as well as by “failures in health and social systems”, and this calls for nurses’ responsibility in addressing these complex issues through social action and collaboration (Bekemeier & Butterfield, 2005, p.154). Encompassing more than simply health status or outcomes, social justice means that equity and equality in society are addressed (Drevdahl et al., 2001). These authors argue that social justice is a mandatory part of public health nursing, a guiding framework for practice that serves as a form of direct resistance to the market justice ideology that drives current health, economic, and political systems.
One thread weaving throughout the public health nursing literature on social justice is the notion of political activism as part of practice (Beikemeir & Butterfield, 2005; Crigger, Brannigan, & Baird, 2006; Drevdahl, 1999; Drevdahl et al., 2001; Easley & Allen, 2007; Hagedorn, 1995; Kendall, 1992; Rafael, 2001). Several nursing writers have implicated an awareness of place in addressing political activism through re-examination of the concept of environment. Chopoorian (1986) critiqued nursing’s traditional notion of environment as being too narrow in definition, and reconceptualized it as social, political, and economic structures, as human relation, and as everyday life. Smith-Campbell (1999), citing Chooporian, identified the environment in the same way, adding emphasis on the communal aspect of environment as a shared “geopolitical locale” (p. 406). Stevens and Hall (1992) conceptualized environment as being partially comprised of “oppressive social structures”, and argued that a community’s health depends on such things as the integrity of the physical environment, the humaneness of the social relations within it, available resources for sustaining life and managing illness, cultural preservation, valuing of diversity, and a sense of empowerment and hope. In other words, one’s physical and socio-political place affects one’s health. They proposed “emancipatory practice”, based in critical theories, and involving dialogue, consciousness-raising, deliberate action and reflection, as the essence of public health nursing. This means nurses’ work involves joining with vulnerable groups to affect change in oppressive health-damaging situations.

Several authors have since picked up Stevens and Hall’s (1992) call for emancipatory practice (Canadian Nurse, 2000; Drevdahl, 1999; Erikson*, 1996; Hagedorn, 1995; Kendall*, 1992; Liepert, 2001; Rafael, 2001). Hagedorn articulated emancipation’s natural fit with caring as a core concept of nursing, proposing “activist primary nursing” as a model for practice. Liepert identified emancipation as the critical connecting point between public health nursing
and feminism, with their shared concern for the environment and political activism.

Emancipation as part of the political work of nurses begins with an understanding the person as being socially constructed according to such categories as race, ethnicity and gender (Drevdahl, 1999) and located in particular places. Drevdahl argued that emancipation requires a critical consciousness of these social categories as they shape health choices, and that nursing actions are aimed at addressing diversity, difference and power in the interest of improved health. By extension, it seems that the places in which care happens ought to bear explicit critical reflection as well, given that particular places are often associated with particular social categories. For example, the location of a shelter is associated with homelessness.

An example of nursing as a political act is found in the case of how Toronto PHNs successfully lobbied for TB screening in homeless shelters (Canadian Nurse, 2000). Identifying something as a political issue requires asking a few important questions, such as, what is causing the problem, who is responsible and who could solve it, and what needs to happen so that affected people can access resources to solve it? The list of strategies offered in this case example included, lobbying, involving those directly affected, creating public support, and using the media, however, the relational skills implicit in bringing these groups - politicians, clients, media personnel, health professionals, concerned citizens - together are assumed but left unarticulated (Canadian Nurse). Certainly political actions occur at system levels, but how do they show up at the personal level? How might we understand relational work as part of political action?

Poverty and related topics of marginalization and homelessness were specific themes of how political activism, place, and individual relationships come together (Canadian Nurse, 2000; Crigger, Brannigan, & Baird, 2006; Erikson, 1996; Kendall, 1992; Zerwekh, 2000). Erikson
argued that in order to diminish this dichotomy, we must understand poverty more broadly, as cultural, situational, and adaptational. We must, according to Kendall ask, “instead of helping people cope with poverty, should not nurses be helping people fight back against the forces that maintain their homelessness, hopelessness, and hunger” (p.2)? Emancipatory nursing understands poverty as both a community and individual phenomenon and involves identifying community needs with the community and establishing individual “trusting therapeutic relationships” (Erikson). Emancipatory nursing actions that address poverty are those that increase the potential for people who are oppressed to take control back from the people and situations that are oppressing them (Kendall). While a necessary part of nursing work may be understood as emancipation from the conditions that exacerbate diseases such as TB, how are emancipatory efforts experienced at the face-to-face level of daily interactions in the TB program?

Nurses working across a range of settings, with people “estranged from the mainstream” may be understood as “caring on the ragged edge” (Zerwekh, 2000, p.47). Her ‘ragged edge’ metaphor addresses issues that nurses face in working with marginalized groups of people. According to Zerwekh’s findings, connection, trust, and self-care are key ingredients for successful relationships in such groups. Self-care here includes both client and nurse. In understanding fear and separation as central themes in marginalization experiences, caring on the edge requires a sharing of one’s own humanity, which centers both a phenomenological perspective on the work and the critical role of self-reflection on the part of the nurse. “Nurses caring on the edge are willing to acknowledge common vulnerability, ‘this could be me’” (Zerwekh, p.59).
Understandings of community and population health are at the forefront of understanding the nature of public health nursing. Both of these concepts, theorized and studied as defining parameters of practice, emphasize the importance of reflecting on the places – social, political, environmental – of relational work in public health. While some have distanced themselves from notions of the individual client in effort to articulate the uniqueness of public health among other areas of nursing, many writers and researchers continue to eloquently defend the importance of not losing sight of the person – the embodied, situated, and socially determined person – as the focus of all public health nursing care. Tied to all of it is a sharp awareness of social justice as an inescapable concern for PHNs working with individuals, in communities, and for populations who are deemed vulnerable for a variety of reasons.

This body of literature particularly emphasizes the need for a political perspective in the work; that is, the ‘self’ of the nurse has power to act in such ways as advocating, lobbying, organizing and strategizing for social change, and in ways that contribute to an increase in clients’ sense of empowerment. This contributes to an understanding of relational work in public health as inherently political work, and nursing actions being rooted in relational notions of trust and respect with regard to understanding the client’s frame of reference, and creating situations that allow for clients to make choices that fit for them.

*Relationships in TB Nursing*

Relational work takes shape in particular PHN roles and responsibilities in TB programs that generally include assessment, monitoring, and education. According to Toth et al. (2004), PHNs assess their clients’ understanding of and beliefs about TB as well as their ability to adhere to medication regime and medical follow-up. As part of individual case management, PHNs ensure that clients are prescribed appropriate therapy consistent with TB sensitivities through
collaboration with all involved healthcare professionals and agencies for the duration of treatment, and also teach clients about possible side-effects of TB medication (Toth et al.). In addition, they educate clients, families, healthcare professionals and the general public about TB; they participate in the screening process, and develop and implement relevant policies (Mayo, White, Oates & Franklin*, 1996; Toth et al., 2004). Implicit in this list of nursing activities are interpersonal skills, which according to some, greatly influence success of treatment. Ailinger et al.* (2004) stressed the PHNs’ ability to develop “trusting relationships” through outreach in order to make teaching meaningful. Barnhoorn and Adriaanse (1992) too confirmed the relational aspect in their finding that “satisfaction with the health care provider contributed positively to the continuation of drug intake” (p.291).

In a study by Swigart and Kolb* (2004), homeless shelter participants reported confidentiality as a significant issue in deciding to participate in TB screening programs in their shelter. Related to this was the importance of the role of shelter staff in developing trust and ensuring confidentiality as part of helping clients to participate in screening. Developing trust and maintaining confidentiality were not fully explicated as relational skills, but certainly their implicit importance is revealed as part of the relationships between staff and clients.

Mayo et al.’s (1996) study of a shelter population emphasized that respect is also a necessary ingredient in positive relationships. They found that respect was conveyed by health workers who completely involved clients in their care, “informing them of the benefits and consequences associated with each stage of testing, diagnosis and treatment, and [considering] their unique life circumstances” (Mayo et al., p.125). These authors found that the unique life circumstances of shelter residents, such as having little or no money and no home, create a foreshortened sense of future, a “here and now” orientation to life that must be honored. This in
turn implies the importance of carefully listening to clients before jumping into health education about TB. There is a need for nurses to examine their own values and beliefs not only about TB but also health itself, the broader social circumstances encountered in a shelter, and their clients as individual persons (Mayo et al.). This study reiterates the complexity of caring for individuals as one ‘agenda’, and the competing population agenda of ensuring TB screening and treatment.

Conversely, how nurses are involved in relationships can have negative effects too. For example, such was the case in a study of adherence in Pakistani DOT programs (Khan, Walley, Witter, Shah, Javeed*, 2005). Findings revealed poor provider attitudes such as cynical, uncaring views of clients, and meetings arranged to suit their own schedules rather than the clients, had a negative impact on adherence. Also, staff may also perpetuate stigma, as indicated in Barnhorn and Adriaanse’s* study (1992):

The practitioner’s poor interest in psycho-social issues such as attitudes, beliefs, norms and knowledge fostered by the patient and his or her situational problems reduces the patient’s acceptance of the treatment procedure. In particular the health worker’s pessimism about the patient’s abilities to change may serve as a barrier in the relationship between health care providers and patients. This is clearly manifested with patients who are economically poor...

Hence, these patients are less likely to be given explanations or information about their treatment” (p.303). (italics added)

While nurses may have sound bio-medical knowledge about the disease and its treatment, this quotation also highlights the power of attitudes and beliefs, and calls for self awareness in conscious and intentional engagement with TB clients. It is a good example of the need for “critical caring” (Rafael, 2005), that involves sensitive and respectful attention to the determinants of health (especially poverty) with which clients must cope. In this sense,
understanding relational work and its effects becomes vital, not only for PHN and client satisfaction, but for the success of treatment itself.

Nyamathi et al.* (2008) explored the efficacy of a nurse-led intervention to support people with latent infection and who were marginalized for a variety of reasons. They concluded that people benefited from several aspects of support offered in this time-limited group format, including incentives and education, and those with ‘depressive symptomatology’ and in ‘emotional distress’ particularly benefited from the emotional support offered by nurses. What is not answered is what the emotional support looked like, or the value of having nurses, specifically, lead the intervention.

van der Walt and Swartz (2002) examined nursing practice in a TB program in CapeTown, South Africa. More precisely, they examined the ‘task orientated’ approach of the DOT program and found it to be highly problematic, primarily because it leads to thinking of everything as a “task”. Most notably, psycho-emotional support, which may be understood as relational work and “essential for adherence”, was seen as yet another task in an already overloaded workday (p.1006). The authors found that “task orientated nursing” in the DOT program was a “depersonalised ritual”, which actually interferes with client engagement, and by extension, with treatment adherence (p.1006). For example, in expressing her unmet need for emotional support, one participant stated that she felt “like a number” (p.1006). By focusing on depersonalized tasks and relying on their professional status, nurses managed their exposure to clients’ emotional states; it may be “safer for nurses to acknowledge the control of the disease and the bacteria, than to open themselves up to the illness experience and the human needs of the person” (p.1006).
In a task orientated approach, nurses may indeed be shielded from the contextual realities and distress of the person that are witnessed daily. However, this self-preservation has implications for clients, both in terms of feeling emotionally supported and their adherence with treatment. Is it possible that by viewing DOT as a kind of relational work from the start, rather than a set of tasks, that the nurse’s self-knowledge and awareness would come to be seen as explicit requirements of the job, validated and supported through regular team discussion and supervision? Is it possible that reflective examination of personal vulnerability and reactions to it, along with one’s knowledge of TB, would become an expectation, a necessary dimension of working in the TB program, in turn, enhancing both client and nurse satisfaction?

While the TB literature cited earlier speaks to the importance of relationships in screening, drug adherence, and education about the disease, the actual relational skills that are part of this work have received much less attention as the topic of inquiry. Trust, respect, inclusion of clients’ perspectives and cultural beliefs, emotional support, and an emphasis on examining one’s own values are such skills that have been specifically and consistently articulated. Furthermore, the place of TB is partly what makes it a population health concern. That is, the infection is contracted, treated and monitored by certain people in close proximity, in certain places. Place in public health nursing is understood in the language of community, environment, and social determinants of health, with the ‘where’ of public health nursing being understood interpersonally and contextually. The context of relational work demands certain attention to ethical considerations, articulated in the language of social justice, empowerment and emancipatory practice. The ‘where’ is an inherent dimension of relational work in public health nursing and TB treatment, and therefore understanding may be deepened with exploration of literature that addresses place.
Places and Spaces of Nurse-Client Relationships

Place as a central concept in this thesis refers to the sites and settings of public health nursing, as well as the spatial considerations within them. The specific sites of nursing work are part of broader home and community settings, all influencing how respect and trust are formed and relational work happens. Place is understood in this thesis not merely as geographical location, but also through what Casey (2003) identifies as interpersonal features; while places have material aspects, they also hold personal, cultural and ideological meanings for people living in them.

The relevance of place in health care and nursing has been addressed in both health geography literature and a growing body of writing characterized generally as a geography of nursing. These areas lend insight into the question of place in this thesis. Namely, how might thinking about the places of public health nursing inform a deepened understanding of the relational work of public health nurses?

Conradson (2005) offers the idea of places as having “relational outcomes”. He reviewed studies in which places were seen as having therapeutic properties and concluded that it is not the place alone that is inherently therapeutic, but rather that the well-being and interactions of people in a place are complex and multifaceted “embodied encounters”. He further points out that a person is never in an isolated singular relationship with a place, but is also always part of a “web of socio-natural relations” within which others participate as well.

Parr (1998) also offered critical questions about the relational aspect of places, coining the phrase, “the peopling of geographies” (p.342). She critiqued research methodologies in this area, suggesting the need for interpretive, embodied, and contextual understandings of place, and for seeing people living in particular places as more than simply containers of information but
rather as thinking, feeling, acting human beings in particular situations (Parr, p.343). This notion provides insight into public health nursing, specifically in the TB program. Rather than seeing TB clients as constellations of symptoms and risk behaviours, do nurses see the places in which their clients live as determining in part how they live? Furthermore, nurses themselves “people” these places, as part of the socio-spatial networking therein, and this raises the question, how, if at all, is relational work carried out with any attention to place?

Geographies of nursing are concerned with how place and space constitute and are constituted by the everyday world of nursing. “Nursing effects the experience of place and, in turn, place affects the experience of nursing” (Andrews, 2003, p.243). There are multiple ways in which questions of place are being taken up in nursing scholarship. The literature has addressed such issues as the importance of health care settings and how they are socially constructed, the relationship between moral agency and place in nursing care, and the spatial dynamics between nurses and their clients within the health care places and spaces of hospital, home, and community (Andrews, 2002, 2003; Liaschenko*, 1994, 1997, 2000; Malone, 2003; Peter, 2002; Purkis, 1996).

Specific to this thesis are questions regarding place as home and as community, and the structural/spatial dimensions of relationships in both. Home is different than hospital; it is “a place offering a wider view of the patient’s life, disease, illness and suffering” (Liaschenko, 1996, p.50). The home is a place organized by and in the direct interest of the client. Boundaries are blurred between the personal and the professional, making home a place that can foster more egalitarian, partnership-focused relationships between nurses and their clients (Andrews, 2003; McGarry, 2003; Peter, 2002; Spiers, 2002). This therefore also implicates places in the power relations of health care provision (Poland et al, 2005).
Questions of power and choice reveal the home as a site for examining place and moral agency. The moral geography of home care, according to Liaschenko (2000), attends to “the nature and quality of the relationship necessary to sustain the person in that particular place” (p.126). Liaschenko (1994) explicated the ‘moral geography’ of home care based on findings from interviews with home care and psychiatric nurses. She made 3 key points: 1) we have authority/power to perform actions in certain places (p.19), 2) our role in the home raises questions of surveillance (p.20), and 3) home is the client’s private space, compared to the more public space of a hospital room (p.23).

Power can enhance or impede nursing care, and inhibit and enhance the power of the nurse and the client (Peter, 2002). “Each person has sources of empowerment and threats to that empowerment” (Spiers, 2002, p.1034). Similarly, a balancing of power was found in McGarry’s (2003) pilot study of community nursing, and she pointed out that this derived in part from an understanding of the nurse as ‘guest’ in the home. She explains that while there is a dearth of evidence that supports the idea that attention to the physical location of relationships contributes to more equitable relationships (p.425), her findings indicated that the longevity and structure of relationships, along with where they took place, were sources of both satisfaction and tension for nurses (p.427). Borrowing from these findings, I wonder how the amount of time nurses have to spend with their clients, the clarity, or lack thereof, in their purpose and goals, and the comfort and safety of the places in which they meet clients all factor into the understandings of relating with TB clients specifically?

Private and public spaces are highly relevant for public health and particularly for people living with TB. Beyond the care of individuals within the private confines of the home, PHNs also work in a variety of public spaces in the community. Unlike hospitals where people are torn
“from the context of their day-to-day lives”, the community and home locations of public health determine a different “gaze of nursing” (Liaschenko, 1994, p.23). This gaze encompasses people in daily living situations, in private and public places that are physical, social, political, interpersonal and spiritual. It encompasses proximal spaces, the ways that nurses get up-close with clients in these situations. Relationships are happening then within these many dimensions of place. Relational work itself then bears consideration according to these dimensions and their spatial implications.

Choices about spatial arrangements, such as proximity of the nurse to the client, are made all the time within constraints of particular personal spaces (e.g. a private home) and public spaces (e.g. a drop-in centre). Nurse-patient relationships, as articulated by Liaschenko (1997), imply an inherent spatiality constituted by relative positions - physical, social, psychoemotional - of both nurse and client, as well as by the particular sets of circumstances that bring them together. They have a definite structure which makes them different from typical personal relationships. The fact that these relationships are role-oriented and related to a person’s specific needs in the context of health and illness, makes it necessary to clarify the relevance of our general philosophical discussion to the context of health care and nursing (Nortvedt, 2001, p.114). Relationships may be delineated as “instrumental”, in that they are the means for providing nursing care related to specific treatments, and “noninstrumental”, meaning that the relationship itself is a source of special responsibilities and professional qualities”, “a moral space for particularized care” (Norvedt, p.116).

One easily recognized traditional concept to address the structural question of relationships as moral spaces is that of boundaries. Standards of practice all include attention to the importance of professional boundaries. Setting boundaries delineates the space; defines the
closeness and distance nurses have with clients in order to ensure that the best interests of the client are met. Both client and nurse set boundaries, but it is the nurse’s responsibility to be aware of them. The language of boundaries, however, is shifted by Liaschenko (1997) and Malone (2003) who have each articulated a view of the moral space of relationships within organizational structures and how these structures impact on spatiality, or the proximity of nurses to their clients.

Liaschenko (1997) emphasized that relationships have both local and intimate, as well as global, structural aspects, but focused on the structural, noting that this aspect receives less attention in understanding the nurse-client relationship. “The social interrelations that constitute the local in nursing are centered in the proximity of nurse and patient, the arena of direct care” (Liaschenko, p.46). The structural aspects are those social, cultural, and political dimensions of place that come to bear on the moral work of nurses. The relationship is seen as that in which the nurse and client dwell together, in which nursing work gets done. It involves invisible “emotional” and “boundary” work. Metaphorical comparison of relationships to landscapes of a geographical setting, helps to understand that just as landscapes reveal and hide certain places, “depending on one’s gaze”, the structural-spatial aspects of relationships can also reveal and hide certain aspects of the people involved (Liaschenko, p.52). This perspective helps in conceptualizing not only how social structures may be hidden, but also how relational skills themselves may be rendered invisible or visible, depending on one’s gaze or level of self-awareness.

Malone (2003) expanded Liaschenko’s (1997) work by explicating proximal and distal nursing. She explored the concept of proximity in more detail, by conceptualizing it as “nested proximities”—physical, narrative, and moral. Physical proximity is the direct, close bodily
contact between nurse and client and may be understood as the ‘nest’ for narrative proximity, which involves listening to the ‘story’, engaging with a person beyond the disease or illness. Finally, moral proximity can be seen as nested within both physical and narrative proximity. Being close with clients, physically and narratively, creates a moral awareness of the client. Being morally proximal means bearing witness to distress, suffering, and healing (Malone). She calls attention to the tension for nurses between the proximal personal care of clients and the organizational demands that force the nurse to move to distal impersonal care.

Malone (2003) theorizes that it has become more difficult to stay proximal to patients in hospital settings; that nurses are forced by structural factors such as staff shortages and lack of time to practice distal nursing. Distal nursing is marked by “highly rationalized, abstract” or theoretical understandings of nursing work, understandings that develop far away from actual patients, in which “patients are only meaningful in the aggregate” (Malone, p.2323). She argues the power structures within hospitals actually serve to take the nurse away from the patient, and that the practice of “proximal nursing” in these settings is “a powerful form of spatial resistance” that re-emphasizes the relational, situatedness of nursing care (Malone, p.2324).

Though the setting of hospital is different than home and community, important considerations for public health practice are raised by this discussion. The discussion is particularly relevant for the TB program, which itself may be understood as a highly rationalized model developed distally from individuals actually living with TB, and making sense only when we understand the client distally, as whole population. Considerations for practice may be: how do organizational structures of public health serve to take PHNs away from the client? How might proximal nursing show up as a form of spatial resistance in public health when the physical locations of the work extend beyond hospital structures into homes and community
settings? What does proximal nursing mean for nurses’ self care when nested proximities involve infectious disease, stigmatization and marginalization?

Yet spatial considerations in developing relationships are not clear-cut; proximity and distance are not mutually exclusive experiences. In many instances, nurses create distance in close proximity as part of relational work. “While proximity calls nurses to act, it can, in some circumstances, lead them to turn away, to abandon” (Peter & Liaschenko, 2004, p.219). We adjust psychologically and emotionally according to social structures within which we work and within which clients are living. As indicated by Benner and Wrubel (1989), nurses often distance themselves emotionally in order to cope with the stressful situations they find themselves in with clients as a means of self-care, and as highlighted by Van der Walt and Schwartz (2002), distancing can take shape in the task-focused work of DOT.

Carmack* (1997) articulated “balancing engagement and detachment” as the core of caregiving relationships. She found that formal and informal caregivers (nurses and friends/family respectively) used detachment “while still engaging” (p.140), doing so by letting go of the outcome of care, and maintaining consciousness and pragmatism. Though these caregivers recognized that their care made a difference, they also knew they could not “fix people or situations”, and therefore could choose not to “take on the problems of the people they are helping”, making conscious choices about what they felt they could handle in a particular moment (Carmack, p.142). This reinforces the notion that proximity and distance are experienced by both nurse and client and are being balanced and negotiated as part of every relationship, in each given moment and situation. At times, it also becomes part of the nurse’s relational work to make choices about such proximity or distance.
Purkis (1996) highlighted that when we move about in places, we “read possibilities into space” (p.109), suggesting that nurses choose how close to or far away from clients they will be, just as clients make similar kinds of choices about the nurse. Relational work calls for conscious understanding of the extent to which a range of choices about proximity is even possible given the particular situation. The choices a nurse makes about proximity are based on who the client is (e.g.: individual/community/population, female/male, adult/child), the life circumstances, the specific health-related situation, and the physical and sociopolitical places in which the work is carried out. These choices require self-awareness, self-knowledge, articulation of limits, and empathic understanding on the part of the nurse, that are listed as areas of requisite knowledge and skill associated with relational work (College of Nurses of Ontario, 2006; Registered Nurses Association of Ontario, 2002).

Peter’s and Liaschenko’s (2004) discussion of the moral distress that proximity can engender has implications for the question of conscious choices about proximity. “The spatiotemporal organization of nursing work demands sustained proximity and consequently results in nurses experiencing the burden of moral responsibility acutely. Nurses may want to flee, but their place in the system, both geographically and politically, prevents it” (Peter & Liaschenko, p.222). This in turn leads to morally distressing situations, in part determined by situational factors such as length of time of engagement, intensity of patient distress, degree of collaboration in relationships, availability of resources, amount of administrative support, and by personal characteristics of those involved (Peter & Liaschenko). The authors suggest adequate resources and good working conditions as necessary factors for nurses to be able to sustain proximity. Dialogue, serving as a space for nurses to theorize their practice, is one means of support, and ought to happen amongst nurses, system administrators, and policymakers, so that
This attention to choices about proximity raises questions for understanding relational work in public health: How does a population health mandate affect a nurse’s choices about how close she/he will get to individual clients? What does it mean to be working in proximity to people with TB infection and disease, in close personal contact not only with the person, but also with the air-born contagion, and the stigma and social conditions such as poverty that are part of such situations? Do nurses’ choices about proximity help to create spaces of healing and health or do they serve inadvertently to reinforce clients’ feelings of being disenfranchised? How do choices about proximity serve as a means of self-preservation for the nurse? What are the resources and working conditions that support critical reflection on the moral ambiguity that proximity brings, and how is space opened up for dialogue across all levels of the organization, from members of the Board of Health to the nurses and clients in direct face-to-face relationships?

Summary

The public health and tuberculosis background of the previous chapter and the literature review described here reveal the importance of the relational work of TB nurses and offers insights and direction for further research on this important topic. Relational work implies a phenomenological perspective; the client is a person who is situated in everyday real world places, and shares health and social concerns with the nurse. This idea stresses the importance of the nurse’s attention to self in the work. That is, nurses are also people and situated in the everyday with particular perspectives and concerns, and become involved with clients in particular ways. Skills associated with relationships are well theorized with a focus on the
individual dyad of nurse-client, however, relational work also manifests in practice with communities, and in jobs designed to address whole population health concerns like TB.

Relational skills have been studied in home visiting, where care is individually focused, but research has been primarily within the area of family health (maternal/child) and concepts of health promotion and empowerment. Little attention has been paid to areas of public health practice where illness is a real and central concern, or where population mandates entirely determine job descriptions. Specifically the relational skills required in infectious disease programs seem to be hidden in the more dominant population health thinking, that encourages task-orientated approaches to not only the prevention and eradication of diseases but also to relationships themselves, leaving relational work generally sidelined as an area of skill review and development.

The competing agendas of the individual and public policy, and the moral dilemmas they raise for nurses who are face-to-face with clients are an important consideration as a dimension of relational work in public health. Public health systemic structures exist generally according to population health mandates and policies, thus relational work remains hidden, albeit necessary, in the functioning of such systems. Such policies create situations in everyday nursing practice in which individual relational work is forced into categories of covert or fringe activities. Yet an exclusive focus on individuals is not adequate in public health either. The home visiting and population focused avenues of public health nursing literature come together to inform the discussion of the nurse-client relationships in this area of practice. Namely, home visiting stresses the importance of negotiation with individuals and the need to openly reflect on ethical tensions of the dual nursing role of service and control. The population focus stresses the sociopolitical dimension of place that often raises questions of inequity and injustice that impact
health, reminding us that relational work is political work that addresses the need for social change through such relational skills as collaboration and active listening. These two avenues merge in their attention to trust and respect as core ingredients for any helpful relationships and the importance of self-reflection on the part of the nurse.

Public health nurses’ awareness of the social determinants of health exists in ways that cannot be known in other nursing settings. In hospital, clinic, or office, nurses only hear about or perhaps partially see the struggles that social determinants create. But by being situated in the everyday places of clients’ lives, nurses experience the determinants of health in more immediate ways; they can hear, see, and feel clients’ struggles as they are living them. The nurse does not only know the social determinants of health as rationalized abstract representations, but also as lived experience. Relational work in public health therefore cannot be fully known by theoretical models or directed by population representations only, but also must be interpreted through conscious engagement with individuals and critical self-reflection with peers, mentors, and supervisors.

The research reviewed overwhelmingly reflects only the views of nurses. While some studies included clients through observation of nurse-client dyads, very few have included the client perspective by directly asking clients themselves about their understanding and experience of public health nursing or what it’s like to be in a daily relationship with a nurse. If we are to have a better understanding of relationships as work in public health, this gap must be addressed.

Finally, with so much reference to context and environment in public health nursing literature, it behooves us to examine the specific places of public health nursing for the meanings they hold about how we engage in relationships. A geography of nursing informs relational work through its spatial-structural considerations of proximity. Places such as home, street, or shelter,
are places that may raise particular questions of spatial closeness and distance in relationships. Nurses and clients ‘people the geography’ (Parr, 1998) of public health; in other words, individuals living with TB and nurses come together every day over a period of time in very private and public places for a very private yet public health concern. The relational work involved in the everyday geographies of nurses and people living with TB involves negotiating the prescribed tasks at hand, balancing engagement and detachment, and navigating physical, narrative and moral proximities. Relational work in TB is embodied, proximal in the everyday of nursing practice, and complicated by its integral part in this distally planned and task-oriented infectious disease program of public health.
Chapter Four: Interpretive Phenomenology as Theoretical Perspective

We constitute and are constituted by the relationships we engage in, the places we live and work in, and the health and illness experiences we are involved in. Convinced of this, I chose phenomenology as the theoretical perspective for this study, viewing nurses’ relational work in public health as embodied, situated and implaced. This choice was fundamentally influenced by my own public health experiences in consulting with TB nurses and their clients regarding a variety of mental health issues, particular to client, nurse, and situation. I watched and listened, as nurses not only managed TB through the administration of daily medication, but also negotiated the concerns – practical, psychoemotional, and familial, of the particular client. By program definition, TB clients are people who do not necessarily want to interact with these nurses and in some cases may do so only grudgingly. They are often in life circumstances that make TB very low on their list of priorities and therefore visits from TB nurses hold the same low priority status. This culminates in what may be described as challenging work with “difficult to serve” people; situations where abstract theory may offer few answers and protocols offer only some direction.

Through reflection on these experiences, I was compelled to wonder about the dominance of a population health perspective in this program, and how such discourses conceal certain aspects of the nurses’ part in contributing to the well-being of clients. In this discourse, there seems to be little room for articulation of the particularities of the actual encounters between nurse and client. It seems to confine understanding of nursing work in this area to issues of disease monitoring, when I know by my own experience that nurses do so much more. It seems to silence considerations of the relational dimensions of the work required of TB nurses, and the implications of such silencing may be felt organizationally in terms of staff retention, time
management, and program effectiveness. I asked myself, is there a way to articulate the relational work of nurses in this program, in order to deepen understanding of the nurses’ role in TB management beyond that of medication police? Interpretive phenomenology offers a way.

Interpretive phenomenology assumes that all human action is inherently meaningful and all understanding of human phenomena comes through interpretation (Schwandt, 2000). Human beings are not objects; human worlds are historical, contextual, and multifaceted, and can only be grasped in finite, situated ways; neither being nor the world can ever be fully explicated or frozen in time, but rather must be understood under certain aspects and conditions (Benner, 1994). Human beings do not interpret or assign meaning to situations after-the-fact, but rather understand them in terms of the immediate meanings for the self (Benner & Wrubel, 1989). This is made possible through three aspects of humanness: 1) human bodies, not just minds, are knowers, and this embodied knowing happens in nonreflective ways, 2) humans are raised in meanings, and these learned meanings shape how one understands the world, and 3) humans have the capacity to care, which causes them to be “involved in and defined by” the things they care about – their concerns (Benner & Wrubel, p.42). Furthermore, human beings are implaced, just as they are embodied (Casey, 1993). Human existence does not happen in wide-open space otherwise described by Casey as an “encompassing volumetric void”, but rather in place, the “immediate environment of the lived body – an arena of action that is physical, historical, social and cultural” (2001a, p.683). The notions of embodied intelligence, the situation, and place come together to underpin an understanding of relational work as thinking-in-action, which in TB nursing, is rooted in concerns for the population’s and individual clients’ well-being, including and beyond a TB diagnosis. Each of these notions is briefly described below.
Embodied Intelligence

All of our perceptions as human beings stem from the body, and the body’s responses to meaningful situations do not require complete intellectual or conceptual understanding (Benner & Wrubel, 1989, p.68). The body is “a knower, an actor, and an experiencer of situations… an expression of being, of action, or of an organized level of functioning” (Benner & Wrubel, p.408). While Benner and Wrubel describe the body as a knower and experiencer, Casey (1993) explains it as being “at once agent and vehicle, articulator and witness of being-in-place” (p.48). The body is that which links self and place through senses, perceptions, and memory, and through a spatial framework of binary opposites such as front/back, up/down, and near/far. An important connected point is that we are rarely indifferent to what feels near or far away because we are embodied creatures of interest and concern (Casey, p.59). It is through our bodies that we also sense, perceive, imagine and remember our relations with other human beings.

Yet bodies for the most part are rarely noticed as knowers and articulators. The body’s unnoticed capacity to ‘know’ or respond “to meaningful situations and to lived cultural meanings” is expressed by Benner and Wrubel (1989) as embodied intelligence. Embodied intelligence refers to a range of activities that are understood in various rapid, nonexplicit and nonreflective ways, such as “emotional responses, habits, and skilled activities that develop over time and in a cultural context, and once learned, require no abstract reasoning in order to enact (Benner & Wrubel, p.43). Embodied intelligence is informed by background meanings; that which “culture gives a person from birth; … a shared, public understanding of what is” (Benner & Wrubel, p.46). Background meanings are learned from society, subcultures within it, and family, and taken in by each person in unreasoned ways. Embodied intelligence, and the background meanings influencing it, is an important way of making sense of the world and our
relations with other human beings. What is taken in and expressed as meaningful through embodied intelligence depends on the situation.

**Situation**

Benner and Wrubel (1989) define situation as “the relevant concerns, issues, information, constraints, and resources at a given span of time or place as experienced by particular person(s)” (p.412). Situations are time/space/place conditions in which we live, and through which we interpret meaning. We are not simply connected to the world in a subject-object way, rather we inhabit the world in an involved way. “People are constituted by their worlds and solicited by them” (Benner & Wrubel, p.49). Nurses and clients encounter one another in particular situations, and the situation in part shapes/gives meaning to the encounter. The concerns inherent in particular situations are shared by nurse and client, though perhaps not experienced from the same perspective or with the same level of interest. This understanding of the situation is different than those that narrowly define situation as a problem or dilemma in need of abstract reasoning or calculated problem-solving. The situations of nurses and clients in this sense always hold both possibilities and constraints (Benner et al., 1996).

Benner and Wrubel (1989) emphasize that the situation itself is a point often missed in the discussion of concerns; that we easily forget that embodied, self-interpreting human beings live in a real world, involved in situations that change over time. There can be no situationless involvement; all personal interpretations of the situation are “bounded by the nature of the situation and the way the individual is in it” (Benner & Wrubel, p.84). Situations such as illness cause breakdowns in functioning for which no amount of mental rehearsal can fully prepare a person, and therefore call for new interpretations. These are the situations where nurses most often find their work. Therefore, this ‘easily forgotten’ point about the nature of situations in
which people live is an important one for nursing. It is especially relevant in the case of TB, where carrying the bacteria physiologically does not necessarily mean being ill, and where a combination of issues, information, constraints and resources is tied to the notable concerns of medication adherence. Though often unrecognized, the ways that nurses are involved in such situations contribute to clients’ interpretations of their experience of TB.

**Place**

Place, like the situation, is easily forgotten or goes by unnoticed in daily nurse-client encounters. The importance of remembering it is picked up by Casey (1993) in his articulation of implacement and displacement.

There is no being except being in place. Put the other way around, there is no utterly placeless existing, even if there are beings deeply alienated in and from place who suffer from the dire state of being out of their native places (Casey, p.313).

The givenness of place in situations begs questions ‘what is a place?’ and ‘how is it part of being?’ Space and place answer “two different senses of our spatial lives: one of them located and oriented in relation to bodily experience, the other disembodied and abstract… Culturally and socially, there is continual movement between place and space as nondichotomously related and ever-shifting” (Casey, 2001b, p.720). This distinction between space as disembodied and abstract and place as location and orientation is important for this study because while spatial language has been used in discussions of nurse-client relationships, as in the case of professional ‘boundaries’, explicit consideration of place as part of relationships has received much less attention. Even more specifically, the terms ‘public’ and ‘community’ immediately call on location and orientation as dimensions nursing relationships. Public health practice implies that
relational work happens in a variety of home-neighbourhood-community locations, and requires nurses and clients to orient themselves bodily in these locations and to each other.

Casey (1993) puts an emphasis on place as part of embodied existence. He furthers Benner and Wrubel’s (1989) articulation of the situation by drawing attention specifically to place as an aspect of the situation that shapes the concerns of both nurses and clients. Casey’s explicit phenomenological perspective is summed up as an interest in understanding the person-in-place and relationships of people-in-place, which fits with a basic assumption of the thesis of this study: that particular places serve to constitute particular relationships. Casey describes the place-world as one that we not only perceive and conceive, but also receive experientially and live out actively. Understood in this way, place adds another dimension to understanding how human beings are involved in the world, and specifically, what it means to be involved as nurses with clients in situations of TB.

To understand what it means to be involved in the world in terms of implacement is to become open to seeing, “in a truly decisive way”, the personal and interpersonal dimensions of place (Casey, 2003, p.2246). Implacement refers to “being concretely placed, which is an intrinsically particular and occasion-bound experience; it binds an actual occasion to a unique “collocation” of space and time (Casey, 1993). It means that our lived bodies are always somewhere in particular, at some particular moment. Implacement begins in the body as described above, and is filled out with landscape and culture.

Landscape is “a term that does not fit neatly into any spatial series”; the landscape exists even where a distinct place cannot be identified (Casey, 1993, p.24). A landscape seems to go on without any apparent end, continuing beyond the usual parameters; it contains everything, including discrete places, yet nothing seems to contain it. Casey proposes that landscape comes
to hold direct meaning only through an embodied experience of it, only by being in identifiable places. “Live bodies play no constructive role in wholly spatialized or temporalized worlds, in which they are merely functional markers”; they do however orient us in a place-world (Casey, 2003, p.2245). Body and landscape come together, body being the inner boundary and landscape being the outer boundary, defining the experience of implacement (Casey, 1993, p.29).

Everyone knows what it is like to live in a place and to be from a place; little ambiguity there. The complexity arises when we ask ourselves just what kind of personal or collective character emerges from a place, what sort of “who” reflects it, and how the reflection is accomplished (Casey, 1993, p.304).

This draws attention to the interpersonal aspect of place; that is, we are not merely involved in the world individually or through a singular body-landscape experience of place. “The places that precipitate out from the body-landscape interplay are cultural entities from the start”; their cultural aspect distinguishes them from bare geographical positions on a map (Casey, 1993, p.30). A place “insinuates itself into a collectivity”, continually altering and constituting that collectivity, giving places both historical and social qualities (Casey, pp.31-32). In other words, place is also a shared experience. It is created not only in the intersection of body and landscape, but also in the relations between and among human beings, relations that help to create a “single complex unit” of people-in-place (p.305). The cultural dimension of implacement is the collective experience of being in and belonging to a place.

Implacement is an important aspect of the way TB nurses and clients are in situations together, and so too is displacement. Casey argues (1993) that it is impossible to actually be placeless, without a place, since this would also imply being without a body, but we may experience displacement emotionally, psychologically or even culturally. Placelessness is
experienced emotionally and psychologically through such “symptoms” as homesickness, disorientation, depression and desolation, all involving a sense of unbearable emptiness (Casey, p.x). We can feel out of place no matter where we are, even in our own homes. Beginning from the home-place of birth, we suffer a series of separations, all of which Casey says involve aspects of place: separations from parents, siblings, childhood friends, from our native regions with their beliefs and dialect, and even from events and actions. Re-finding place, if not possible in physical actuality, necessarily involves a psychological return in memory and imagination “to the very earliest places we have known” (Casey, p.x). Where we are has as much to do with who we are and what we are, and “threats to this implacement are also threats to our entire sense of well-being” (Casey, p.307).

Placelessness is also experienced culturally in what Casey (1993) refers to as “the forced homelessness of the reluctant emigrant” or “the involuntary exile” (p.x). This complicated experience of displacement bears mention for understanding this study and its results, with its relevance to relational work not only in particular places in a large city, but also with people who have experienced just such displacement. ‘Immigrants’, as cultural groups displaced from their native regions, represent this kind of collective separation from place. They also make up more than 90% of TB cases in Toronto, and comprised 87% of the study’s client participants.

We cannot know health and well-being without place, without implacement and indeed without displacement. More specifically, an implaced understanding of well-being holds significance for nurses whose mandate is to protect the public’s health through personal encounters with individual people. Malpas (2003) suggests that to disregard the “placed character” of health, illness, and suffering as we attempt to engage with human life in health
matters is to inevitably fail in some way in that engagement (p.2347). The relational work of nursing is constituted in such engagement.

Nursing is broadly concerned with individual clients’ embodied experiences, particular situations, and places of health and illness. Emotional, psychological, cultural and spiritual dimensions of well-being are central in these concerns (Benner & Wrubel, 1989). In public health, nurses are continually balancing the concerns for individuals with those of many people. Moreover, public health nursing is concerned with place insofar as conceptualizations of environment reflect how landscape and culture are part of well-being, and how geographical, socio-political, and historical locations are inseparable dimensions of all practice situations. Of course, place cannot be considered sufficient in itself for understanding relationships in nursing, but certainly does lend a perspective on what nurses’ relational work means in the public health context.

Benner and Wrubel (1989) identify embodied intelligence, background meanings and concerns as important dimensions of the person, who is situated in the world in particular ways. This is further elaborated with attention to place, and according to Casey’s (1993) articulation of living in a place-world, implaced and displaced in and by particular situations. These aspects of being involved in the world hold significance in considering the relational work of nurses. Specifically, they raise the question of the knowledge, skill, and judgment required of nurses in carrying out this work and how these elements come together in the moment of relating.

**Thinking-in-Action**

Thinking-in-action is one way to understand how clinical judgment, knowledge development, and skillful everyday comportment come together in the practice of nursing. Assumed to be a hallmark of good clinical judgment, it is defined as “the patterns and habits of
thought and actions directly tied to responding to patients and families” in ongoing situations, and is not necessarily reflective (Benner, Hooper-Kyriakidis, & Stannard, 1999, p.3). Notably, it is also distinguished from medical diagnosing and technical intervention. “Critical thinking requires more than placing information into discrete categories” (Benner et al., p.4). Rather than focusing on scientific or procedural knowledge, it is a notion addressing the process of clinical judgment which entails integrating knowledge and the skilful comportment of nurses as they engage with patients and families. The clinical judgment that comes through thinking-in-action is distinguished by styles of practice, or habits of thought and action, and domains of practice, or those strong situations that cluster nursing work around common goals and concerns. Styles of practice may be further understood as: clinical grasp and inquiry, which encompass how the nurse identifies and solves problems; and clinical forethought, which alludes to the anticipation of problems and prevention of them (Benner et al., 1999).

Perceptual acuity is required for accurate relevant problem identification. In other words, good problem solving in clinical situations is not enough if the most critical problem is missed or inaccurately defined (Benner, Hooper-Kyriakidis, & Stannard, 1999, pp.14-15). Furthermore, nurses can only make clinical judgments about what they perceive, and they can only perceive accurately when there is skillful involvement or engagement with the problem and with the person (Benner et al., 1999, p.15). This skill of involvement, cited in the literature review, is explicated here as a central aspect of thinking-in-action.

**The Skill of Involvement**

The skill of involvement is required for accurately identifying and prioritizing problems, and anticipating and effectively preventing them. Yet it encompasses more than addressing immediate medical problems. An assumption of the skill of involvement is that it is experiential,
existential, and socially embedded (Benner, Tanner, & Chesla, 1996). It means that nurses are involved in caregiving moments with clients as fellow human beings and in the clinical situation. It begins, not in the application of scientific information, but in social exchange between human beings resembling the way one gets along with family and friends. Emotions therefore play a key role in understanding the situation and the client, and act as a moral compass for nurses in the midst of making clinical judgments (Benner et al.). Emotional engagement is a required part of what it means to be involved, and reading one’s own emotions for cues about the situation and the person is a foundational part of the skill of involvement.

Emotional engagement with the problems refers to paying attention to “vague or global emotional responses” about not having a good clinical grasp in situations, or acknowledging gut-feelings as a sign of not fully understanding the situation (Benner, Tanner, & Chesla, 1996). Emotions are cues that adjustments in perspective are needed for understanding the problem or different approaches to better appreciating the situation must be tried. Emotional engagement with the person involves responding compassionately to clients as people: perceiving the other’s troubles and reaching out to him/her. It involves bearing witness to the other’s distress (Benner et al., 1999, p.16), which means being open to the range of human emotions associated with the suffering that comes with such experiences as illness, loss, and death.

 Without developing the skill of involvement, without “standing in the right relationship of attachment and respect for the other, one cannot develop excellence in complex relationships and practices” (Benner et al., 1996, p.134). As stated, the skill of involvement is necessarily experiential. Learning it happens by doing, by being involved. Only by practising, which includes making mistakes in understanding the problem, the situation, or the person, does a nurse find the right balance of involvement (Benner et al., pp. 90-91). As nurses actually engage in
better and worse situations with clients, in being too close and too distant, over-stepping and not stepping far enough into clients’ personal situations (and places), they sort out the appropriate level of involvement in each relationship and each situation over time.

Excellence in the skill of involvement requires balancing the tensions of mastering technical demands of clinical work and refining how one engages with clients who each have their own personalities and interpersonal styles. For competent nurses, knowing when and how to balance these can show up as a deliberate choice (Benner et al., 1996, p.91). This highlights another important dimension of the development of the skill of involvement. Nurses learn from one another, and particularly, novices learn from competent nurses. Learning the skill of involvement is guided by watching highly skilled colleagues and their styles of practice, as well as observing what is valued and rewarded as excellent nursing practice in the general workplace culture and by clients and families (Benner et al., p.91). In this sense, the skill of involvement is not the sole responsibility of the individual nurse.

Thinking-in-action and the skill of involvement offer the theoretical grounding for understanding the relational work of TB nurses in public health. Both are underpinned by the phenomenological notions of embodied intelligence, the situation, and place, and the skill of involvement specifically is taken up in more detail in chapter seven. This phenomenological perspective also informed the research methodology, which is described in the following chapter.
Chapter Five: Interpretive Phenomenology as Research Methodology

Interpretive phenomenology adapted from Patricia Benner (1996; 1999) guided the study methodologically. It is outlined in this chapter according to how it informed the overall approach to research, the setting and participants, data collection and analysis, and ethical considerations. Interpretive phenomenology is a perspective that calls on the researcher’s ability to listen carefully before “moving too quickly to a theoretical level of discourse”, thereby allowing “practical meanings and concerns to show up in their own terms”, as ways of being and knowing “in their own right” (Benner, 1994, p.115). Seeking understanding through this methodology means seeing the phenomenon not as an external objective agent but as something in which we actively participate (Benner, 1994). Such is the case for relational work; nursing relationships cannot be understood as external to the people participating in them; they are understood as they are lived and reflected upon. Interpretive phenomenology offers a way to “respectfully understand” participants’ experiences of the phenomenon, critically evaluating both troublesome and positive aspects of it (Benner, 1994, p. 123). For this study, the phenomenon of relational work was explored according to participants’ experiences of it and for what Benner refers to as “sources of innovation and liberation” (Benner, p.123) in these everyday practices of nurses in the TB program of public health.

Relationships are never based on abstract theoretical knowledge alone. Understanding also comes through the experience of already being in relation with others. Relational skills in nursing specifically have a taken-for-granted quality. The teaching of skills-based theory notwithstanding (for example, Bowles, Mackintosh, & Torn, 2001; Dilorio, Resnicow, McDonnell, Soet, McCarty, & Yeager, 2003; Ferraz & Wellman, 2008) nurse-client relationships are largely learned and developed by being involved with each other in particular ways, and then
in thinking back on the relation, through self reflection, conversations with colleagues, and by re-reading of theory. Interpretive phenomenology fit the study of relational work in the TB program of public health because it involves nurses and clients as persons coming together to address particular concerns in particular situations and places that hold both personal and communal meanings. The most pressing concerns of TB nursing may not be the disease itself, but rather those associated with marginalizing situations in Canadian society; situations in which scientific/theoretical knowledge of TB and therapeutic relationships may not be enough for understanding relational moments of nursing care.

Giving the best possible account of the phenomenon under study happens less through strict step-by-step techniques, and more through a consistent set of guiding tenets (Benner, 1994). The phenomenon itself frames the interpretive project, and interpretation must be auditable, plausible, offer increased understanding, and articulate the phenomenon according to the situated practices and meanings of those experiencing it. This methodology involves “a rigorous scholarly reading of texts – questioning, comparing, and imaginatively dwelling in their situations”, which requires the skills of analysis, synthesis, and criticism as part of the articulation of text meanings and generation of interpretive commentary (Benner, p.99). Foundations of such an interpretive process include the creation of lines of inquiry and a process of dialogue, brought to life through observation, interviews, and writing.

**Lines of Inquiry and Dialogue**

Lines of inquiry set the general direction for dialogue, or how observations, interviews and interpretations will generally proceed. Phrased as a series of questions, lines of inquiry must be open enough to allow for alteration, re-shaping and re-examination, and must be critically evaluated for what they include for consideration and what they exclude. In creating the initial
lines of inquiry for this study, consideration was given to how to create space, as Benner (1994, p.106) suggests, for both smooth functioning and breakdowns in relationships. The formal research questions were re-visited at each shift in the interpretive process, and at the beginning of data collection and analysis. While the overall research questions established the initial line of inquiry, pre-set observation and interview guides served as the means of delineating potential areas of observation and conversation with participants, ensuring that I would pay attention to meanings of relationships in terms of both working well and not working well from participant perspectives (see Appendices D and F).

The notion of dialogue is essential to an interpretive design, as a “critical reflective exercise” that creates openness to hearing questions and challenges to questions “that had not been previously considered” (Benner, p.105). Dialogue may be understood as the process of interpretation that occurs at several levels. I began by engaging in a self-dialogue, reflecting on the research questions and my assumptions behind them through coursework, reading, and writing notes to myself. This self-examination was supported also by conversations with my supervisor, committee, classmates, and informally with mental health and public health colleagues and friends. In particular, discussions concerning the nursing relationship as ‘a means or end’, and as ‘way of being or skill set’ were especially valuable in clarifying my assumptions thereby bolstering my vigilance in aiming to stay open to various meanings of relationships and not slip into theorizing notions of ‘the good relationship’.

The research proposal also represented part of the early dialogue. As the study continued, dialogue carried on during observations of participants and the settings, between the participants and me in face-to-face encounters and with written text as parts of the text took shape. All levels of dialogue combined in an iterative process of interpretation, so that in the midst of conducting
the study, distinctions between data collection and data analysis were not always easy and separation of the two on a neat timeline, though necessary in order to provide some structure, felt somewhat artificial. That is, this multi-layered dialogue was at once my vehicle for interpretation and the interpretation itself, with attention to both the particularities of what was said, seen, written and read, and to the themes of the texts as they were being generated.

**Study Setting**

The TB program in Toronto’s public health department was the setting, a place where almost a quarter of all TB cases in Canada are found. Data collection occurred within the range of normal work settings of each nurse participant, which included offices, hospitals, client homes, parking lots and city streets in the north, west, and south regions of the city. Interviews with nurses and clients were held in locations of participants’ choice. For nurses this meant meeting in their respective offices and in one case, in a car between visits. Client interviews were all carried out in their respective homes. Observations happened across Toronto which encompasses a range of geographical locations, neighbourhoods, and living conditions. Clients’ homes included houses, apartments in basements, high-rise and low-rise buildings, and one-room units in supported housing. One client was visited in hospital and one in a motel room. Many visits were observed in nurses’ cars, parked on side streets and in parking lots, hidden from view of school, workplace, and/or home. Hospital visits were also observed: mostly in one client’s isolation room; another’s initial meeting happened in a shared room with a curtain pulled around the bed for privacy; and one visit with a third client occurred in a TB clinic waiting area. The motel visits happened sometimes with door closed and sometimes with door open so we would not have to mask.
Participants

There is no strictly required number of participants for a phenomenological study; but rather participants must be considered according to the size of text being generated and pragmatic factors such as number of repeat observations and interviews, time constraints, and number of researchers involved. A large text with variety in types of situations is more plausible and reliable than a small text, providing “redundancy, clarity, and confidence” in the interpretations and the final text (Benner, 1994, p.107). The number of participants therefore is projected at the beginning of the study to meet this aim, recognizing that the number may change once the study is under way depending on how participants create new lines of inquiry and on the quality of text being generated.

The initial target was 10-12 nurses and three clients for each nurse, and the final participant group was comprised of nine nurses (6RNs & 3RPNs) and 24 clients. While the number of participants did not reach the target set, the observations and interviews with those involved did create a large text, with initial thematic categories being seen repeatedly in the observation notes for the seventh and eighth nurses. Specifically, this number of participants resulted in the generation of 117 separate texts for analysis (see Appendix B). The TB program, as previously stated, is organized into six distinct teams: Case Management, Directly Observed Therapy (DOT), Homeless/Underhoused, Corrections, Immigration, and Prevention. The initial aim was to have representation from a range of teams and in the end, six nurses worked in DOT, one in Homeless/Underhoused (also involving DOT) and two were case managers. Again, while my hope was to recruit from all teams in order to maximize variation of job descriptions, it became evident as I met with managers and nurses that several teams did not work directly with TB clients, but rather with groups in public education (Prevention Team) or in monitoring
‘cases’ on paper and liaising with government and hospitals (Immigration team). The final numbers representing DOT, Case Management, and Homeless teams do reflect where the most direct relational work with clients in this program happens. The table below indicates the number of visits with each nurse-client dyad and those who took part in interviews. The reader will note a variation in client numbers compared with the initial target, which reflects the variation in nurses’ ability to find clients in their caseloads who met the participation criteria. Also, for clarification, two client participants were marital partners with their infant daughter being the identified client receiving treatment (identified as ‘Baby’; not counted in final client number). The pseudonyms which provide anonymity for participants were deliberately chosen to reflect the cultural variations in the group.

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Client</th>
<th>Visits</th>
<th>Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Louisa</td>
<td>Ahmed</td>
<td>3</td>
<td></td>
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<tr>
<td></td>
<td>Jose</td>
<td>4</td>
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<td></td>
<td>Elijah</td>
<td>4</td>
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<tr>
<td></td>
<td>Luka</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eyob</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2. Lynette</td>
<td>Rahim</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kwame</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Akiki</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3. Bev</td>
<td>Namazzi</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Evelyn</td>
<td>Alicia</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Farah</td>
<td>3</td>
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</tr>
<tr>
<td></td>
<td>Hana</td>
<td>4</td>
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</tr>
<tr>
<td></td>
<td>Fatima</td>
<td>5</td>
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<td></td>
<td>Raj</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5. Paulette</td>
<td>Kali</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vlado</td>
<td>4</td>
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<tr>
<td></td>
<td>Hamid</td>
<td>5</td>
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</tr>
<tr>
<td></td>
<td>Daren</td>
<td>5</td>
<td></td>
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<tr>
<td></td>
<td>Rani (+Baby)</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Demographic information was collected at the time of written consent on a standard form and may be found in Appendix B. This information was collected strictly for background description of participants as a group, providing contextual detail for understanding the experiences of these particular nurse-client relationships. Sharing this personal information was voluntary and participants were free to refuse. Several clients opted to have me ask the questions and complete the form for them.

In general, this was an experienced group of nurses with a combined total of more than 70 years in TB nursing (from 5 months to 13 years). All nurses were female and spoke a combined total of three languages, with English being the first language for eight of them. The client group consisted of 14 males and 10 females, speaking a combined total of 17 languages with English being the first language for only one of the 24. Length of time in the relationships varied from a few weeks to more than two years, across “infectious” and “non-infectious” stages of illness, as well as treatment for active disease and prophylaxis. I also had the opportunity to observe the first meeting of one nurse-client dyad, and the last visit of another.

**Recruitment**

Recruitment of participants was in keeping with a phenomenological method, following what Creswell (1998) describes as “criterion” sampling (p.118). The criteria for participation in
this study were as follows: nurses and clients currently engaged in a nursing relationship as part of the TB program of Public Health, and were willing to share their experiences and perspectives by being observed in those relationships and talking with me about them. Leaving the sampling process open in this way served to enhance understanding of the phenomenon of relational work as it is lived by the participants rather than by how I as the researcher theorized it. However, criteria were further refined, given the nature of the research question, to include only those who were mentally capable of participating and able to communicate in English. The intention of inviting all nursing staff in all six teams to participate was to create the greatest possibility for variation in experiences across the scope of program focal points. Recruiting from all four regional offices allowed for the potential of greater variation of work locations across a large city, thereby creating a thorough representation of place in understanding relational work.

Finally, recognizing the importance of minimizing the possible effect of my own understanding of relational work confining the narrative accounts and behaviours of participants, and also attempting to avoid only ‘good relationships’ being represented, I asked nurse participants to identify clients across a spectrum of three descriptors – ‘comfortable’, ‘polite’, and ‘challenging’ – detailed below for possible participation. The steps of recruitment proceeded as follows, with written consent being obtained during the first meeting with each participant:

- I first attended a managers’ meeting to explain the study and ask them to assist in recruitment by distributing an introductory letter to their staff via email. This letter provided information regarding the study and how to contact me (Appendix C).
- After this meeting, the letter and request to participate was emailed to managers of all teams across six TB program areas who in turn forwarded it to staff of their respective teams. Two nurses contacted me and volunteered to participate through this method.
I also attended combined case management/DOT team meetings in all four regions to explain the study and answer questions in person. This was an interesting process, with staff raising concerns of being evaluated, having just completed a DOT program evaluation, and some expressed concern for clients and protection of their privacy. Also, rather than direct questions, some staff offered me tips, suggestions, and directions about conducting the study. I recruited four more nurses as a result of attending team meetings, and the last three contacted me through word-of-mouth recommendation from their participating colleagues. An unanticipated aspect of this recruitment strategy occurred. Managers decided that there would be no benefit in my attendance at Prevention and Immigration team meetings given that these nurses did not deal directly with individual clients.

Also noteworthy, after seeing my email letter two nurses in the Corrections team told me directly that, though interested in the topic of my study, they chose not to participate. They each felt that the secure nature of detention centres and highly bureaucratic procedures for gaining access raised significant barriers for me to observe in the facilities. In addition, the high degree of distrust with this clientele and my presence as a researcher would compromise the trust they had developed with individuals if they brought me along to appointments.

Client participants were recruited through the nurse participants who agreed to provide the initial introduction of the study to the clients in their caseloads. Within this responsibility, they were asked to first identify suitable clients who were willing to participate, mentally capable of participating, and able to communicate in English.
• In order to leave recruitment open to participants’ discretion while also providing some potential range for observation, nurses were asked to approach clients considering the following three categories of relationship experiences, without revealing to me which client fit each category:

1) ‘Comfortable’ – good working relationship; rewarding, satisfying

2) ‘Polite’ – get the job done, but distant; workable, but not very close or friendly

3) ‘Challenging’ – struggle to get the job done; effortful, resistive

• The ideal was to have one client from each descriptive, for a total of three clients from each nurse. As indicated in the table on pages 79 and 80, for each nurse, client numbers ranged from zero to five according to who was willing and able to participate.

• Nurses arranged my first visit with each client ahead of our scheduled observation time, and obtained the client’s verbal consent for my presence during that first visit. At that first meeting, the nurse waited outside while I spent a few minutes explaining the study beyond what the nurse had already shared, answered questions, and obtained written consent. The visit then proceeded. In two situations, female clients verbally consented to participate and invited me to stay for that visit, but told me that before signing the consent form, they would discuss it with their husbands. In those cases, I left the consent form and they each signed and returned it to me at the next visit.

• One of the observed clients for each nurse was asked to participate in an interview without the nurse present. In order to avoid drawing from my own interpretations of the ‘best’ client to interview, I systematically invited the first client I met with each nurse. If that person declined, I asked the second client, and so on. As soon as one client agreed, I did not ask others. For those who agreed, the time and place for interviews was usually
arranged at the same time they agreed. Two clients who initially agreed had to withdraw due to scheduling difficulties, in which case I then asked the next client on the list of visits.

**Data Collection**

Benner (1994) points out that “the study of nonreflective aspects of the person’s life requires observation and dialogue” and recommends that both observation and interviews are necessary in interpretive phenomenology because taken-for-granted habits and skills are “too much part of the participant’s world” (p.118) to be discussed in interviews alone. Data collection in this study happened through observation and interviews, with data being captured in the form of observation notes and transcriptions of audiorecorded interviews, and lasted from February to August 2007. Interviews followed observations, happening generally at the end of five visits with each nurse-client dyad. This was a departure from Benner’s (1994) method in which observation follows interviewing. Choosing to interview first allows participants to share narratives, or to tell the story they want to tell. Details of the narrative are then followed-up by observing nurses in practice. However, I chose to attend visits with nurses before interviewing for three main reasons: 1) to establish rapport and some trust with both nurses and clients; 2) to gain a sense of what visiting was like by joining in it and asking spontaneous questions about the visits as they were happening; and 3) to stay as open as possible to seeing relational work in progress before hearing participants’ reflections on what it meant. Both the participant and I were then able, in individual interviews, to refer back to aspects of visits I attended as a means of filling in descriptions in the narrative accounts or helping with clarification when needed. For example, several interviewed participants used phrases such as “remember when…”, “you were
there, you know…”, “you saw her, she…”, or “you heard him” as starting points for further descriptive details.

**Observation**

Observation is useful for getting at the ‘taken-for-grantedness’ of a phenomenon and how the sites and settings themselves give meaning to the behaviours and beliefs of participants (Benner, 1994; Bogdewic, 1999). It was central to this methodology because relational work is situation-bound, and “in the context of the situation, the sights, sounds, smells, and demands experienced become visible in ways that simply do not occur to the participant outside the situation” (Benner, 1994, p.108). The familiarity of the setting means that aspects of it are often invisible for the nurse and client while for an observer who is not fully assimilated into the setting, these very aspects may stand out (Benner et al., 1996, p.358). Observations generally include the physical environment, and the people and activities within it, with specifically identified beginning and end points.

Observations of each nurse-client dyad were arranged according to participants’ availability and convenience, as well as my own schedule, over the course of a possible total of 5 visits. The nurses and I met at a pre-arranged location prior to the start of visiting to discuss their participation, to review and sign the written consent, and to work out details of scheduling. At the beginning of the first visit with each client, I briefly explained the study, answered questions, and obtained written consent for observation. Clients were informed that they could ask me to leave at any time during the visit. This happened only once as one meeting was finishing and the client wanted a few minutes alone with the nurse.

Given that observation for me spanned a range of locations, the physical environment took in many places. Detailed descriptions of each place were captured in observation notes and
included the lay-out of the locations of visits, furnishings/items in it, noises, smells, and lighting, as well as access routes to these locations. I also noted how nurses knew/found parking, gained entry to apartments, waited and/or searched for the client, and interacted with other people on their way to and from the visits. Gaining entry to clients’ homes was its own discreet activity which was part of all observations, including the greetings between nurses and clients, and taking off and putting on shoes. These details of the physical environment are discussed further in the Results chapter as part of considering place in relational work.

Observations also had a specific beginning and end point. They began when I met the nurse before the scheduled visit. I took a few minutes to briefly clarify the situation and concerns for that particular visit and the nurse’s plans for her involvement that day. Nurses also directed me in regard to the need to mask and details about the person or the place we were entering. Similarly, after the visit, I briefly reviewed with the nurse her perspective of what happened, her general feelings, and if anything stood out for her. During the observation, the following specific dimensions were addressed: 1) the people and how they interacted; 2) the physical place, its energy and noise levels, lighting, and smells; and 3) the situation and concerns, including the topics of discussion, activities, body language and silence, proximity of nurse and client to each other, and what else was happening in and around the interaction.

Benner (1994) recommends positioning oneself during observations “so that the natural flow of practice” is not impeded while still being able to watch and “attend to the nurse’s involvement” in the situation (p.359). This description implies that the researcher is not a direct participant in the flow of practice being observed. However, positioning myself according to these considerations was not so easily done, and in fact, participation was an inevitable part of my observations by virtue of the nature of this nursing work and where it was carried out.
Benner’s reference point is a hospital unit, one same place with clear parameters in which particular technical tasks were being carried out. In such locations and situations of nursing work, it is conceivable that the researcher could introduce herself and then simply stand back from the area of direct patient care and look on without impeding the ‘natural’ flow of practice. However, in this study my presence was necessarily considered within the flow of practice, pointed out to me by the participants themselves. Where a researcher in a hospital is able to stand back so that nurses can work with patients, I could not stand back either literally in the small spaces of some clients’ homes and nurses’ cars or figuratively in conversations. In fact, trying to do so became a distraction and an impediment to the natural flow of the visits.

For example, I drew attention to myself by sitting at Akiki’s dining room table while she and her nurse Lynette sat on nearby couches, and by standing in the hallway rather than coming fully into the living room where Jima and Linda were standing. In each case, the visit was interrupted as participants asked me to move closer to join them. This happened with others too in spite of my explanations that I wanted to simply observe and therefore that they should carry on the visit as usual without giving me specific attention. I then shifted my physical positioning so that I joined them. Yet in my attempts to still remain a silent observer in the threesomes, I was repeatedly invited into conversations through questions and comments directed toward me. I soon realized that some participation was necessary, that sitting and at times chatting with them contributed to a more natural flow of practice. The most direct example of this was my experience with the nurse Karen who after the first visit with Ivan commented that he seemed unusually quiet and wondered if it was because I was too quiet. She asked me to participate more in the conversation next time (observation notes, p.3).
My participation in this way contributed to building rapport with my participants. Rapport is vital in getting to know participants and having them get to know me as part of observations, and in getting to know the rules and rituals of the organization and particular setting. Building rapport involved interacting honestly, identifying myself and my role in the situation, and answering questions. It meant being myself while striving, as Bogdewic (1999) suggests, to remain unobtrusive throughout my observations.

The duration of each period of observation varied according to schedules, individual situations, and moods and concerns of nurse and client on each given day. The overall time frame for observations was up to 5 visits with each nurse-client dyad, which were consecutive days for some and sporadically scheduled for others. While this is a comparatively short time frame for fieldwork in general, it did offer enough opportunity to witness the nature of this daily relational work as it was actually occurring, and to have a sense of nurses’ involvement with clients as well as their general work days in terms of arriving and departing from visits, managing traffic, as well as other time and administrative constraints.

*Observation Notes*

Observation notes are an essential component of data collection given that details of what is noticed “cannot be trusted to memory” (Bogdewic, 1999, p.59). This means that it is vital that notes be written regularly both during and as soon as possible after the observation. The notes I kept included my direct observations, actual statements from participants, and my impressions, emotions, and reflections (Benner et al., 1996), that often included questioning my ‘mental health nurse’ perspective and personal reactions to particular situations and certain aspects of communication. The content of observations was in a narrative format, chronologically written - ‘before the visit’, beginning, middle, end, and ‘after the visit’. They descriptively followed the
dimensions of observations identified in the guide (Appendix F). The process of writing notes was adapted from Bogdewic:

- Observations were recorded before they were discussed with anyone;
- Observation notes were written in full as soon as possible following each visit;
- Observation notes were written without edit, and fell into three categories: observation log, jottings, and notes to self.

The observation log is an overall record of my time spent in data collection, generally accounting for activities of observation. This includes schedule and locations of meetings, cancellations and re-scheduled visits, and length of time spent in visits (Appendix G).

Jottings are quick hand-written point-form memory cues that capture key aspects of the observation, which included descriptors of place, and direct quotes, phrases, metaphors and questions of participants, in keeping with the categories of description in the observation guide (See Appendix F). Jottings were made in a small notebook during the observations themselves or shortly thereafter. At the beginning of each visit, I reminded clients that I would be taking notes and that if there was anything they did not want recorded, they should let me know. There was one such situation in which the client asked me to stop writing for only a portion of the conversation though she did not want me to leave the visit entirely. That portion of the conversation is not part of the data. Nurses’ cars provided generally easier occasions for jotting during the visit given that I sat in the back seat out of the direct view of nurse and client. Where my writing became distracting for participants, I stopped and in some cases closed the book entirely. There were a few visits in which I left the notebook in my bag either because it felt distracting or the visit itself was so short, and jotted quick notes immediately after leaving the visit. Jottings included my observations of the physical setting, the body positioning, gesturing,
tone of voice, and eye contact of nurse and client, as well as barriers to communication and/or other distractions. These included loud televisions, radios, and computers, outside noises, the temperature of the room (very cold or very stuffy and hot), telephone calls, other people, and cooking and meal preparation during the visit.

Jottings were reviewed and written into full sentences as soon after the observation as possible. This often meant writing in my car before leaving the location of the visit. I aimed to allow adequate time after each visit for writing, but depending on nurses’ schedules this was sometimes cut short, and therefore at times I also audio-recorded my thoughts and feelings about the visit en route to next visit. They were then elaborated further within 24 hours of the visit when I transcribed notebook jottings and recordings to my computer through detailed descriptive writing in order to give as full an account as possible of the observation. This was vital in providing the foundation for later analysis as it was done while memories of visits were still fresh in my mind.

Finally, notes to self serve as a record of reflections on the research process itself and the researcher role. They address analysis, method, ethical issues, clarifications, and personal frame of mind and emotions (Bogdewic, 1999, p.60). My notes to self included my queries and questions about what I was observing, and helped me to keep track of biases, early interpretations, and possible new lines of inquiry. The notes to self were written both as separate documents titled ‘general notes’ for each nurse-client dyad and as part of observation notes for each visit, distinguished from the content of the observation by the use of square brackets [ ]. Writing these notes continued into data analysis, in the margins of observation notes as well as interview transcripts.


*Interviews*

Relational work is understood as it is experienced, in the lived moment and place, and in reflecting back upon it. While observations address the former, interviews address the latter. All nine nurses and seven clients agreed to be interviewed in this study. These one-to-one conversations with nurses were held in a location of their choice with the only criteria being that we were able to hear each other and had enough privacy so that the nurse felt comfortable to talk about the topic of her relationships with clients. All clients chose to be interviewed in their respective homes.

In keeping with interpretive phenomenology, the interviews took on a conversational style on the assumption that people tap into their more immediate experiences when left to structure their own narratives. Conversational interviewing is in keeping with the notion of dialogue, intended to maintain space for the back and forth nature of interpretation. It implies that the participants’ stories remain central though the researcher is involved. As Benner (1994) states, there is “no one precise story” but rather “multiple stories that are shaped by the particular clearing created by the interview situation” (p.111). As a method of data collection, it relies on accurate and open phrasing of questions and active listening.

I assumed a position of active listener, interrupting as little as possible as participants spoke, in order to diminish the potential for making false generalities or jumping to conclusions about their intended meaning. Avoiding interruption allowed the participants to tell the story in their own way, which produced more detail regarding concerns and reflections on their experiences that I as the researcher had not considered (Benner, 1994). Rather than interjecting with many direct questions, active listening involves probing for clarification and confirmation.
that I understood what participants’ were describing, their responses to my questions, as well as their body language and actions (Benner, p.111).

Stories, or narrative accounts, emerge from the questions asked; making phrasing of questions another key consideration. Questions phrased in academic or abstract terms run the risk of cutting off participants from their everyday language, thereby cutting them off from their ordinary spontaneous responses (Benner, 1994, p.108). The questions in this study were laid out in written form as an interview guide (Appendix F) and phrased as concretely, descriptively, and openly as possible, in ordinary language, to elicit as detailed an account as possible of the participants’ own experiences and reflections on their relationships. They were also phrased to allow participants the opportunity to reflect on both positive and negative experiences in relationships in order to encourage a variety of narratives. Feedback on questions from my doctoral supervisor, committee members, and public health colleagues provided a range of perspectives on the questions proposed.

I began all interviews by asking the participant to tell me about the relationship with the request: “tell me how you get along with ‘X’”. Participants tended to start by giving accounts of the person rather than the relationship per se and when it shifted to the relationship, all started with accounts of when they first met. Nurses tended to give medical history in the beginning, like a kind of report. When I asked them to describe knowledge and skills, participants all took pause; this seemed to be a confusing question. One nurse, Rosalee, actually told me that what I was asking was difficult to put into words. Participants explained themselves often by sharing examples and at times I asked for examples in order to clarify that I had understood accurately.

Time frames for interviews varied according to participant’s availability and particular circumstances. The general length of each interview was negotiated at the beginning of it, and
lasted until the participant felt he/she had nothing more to add and I had no more probes or questions. At the end of each interview, I offered participants the opportunity to add anything they felt was important for me to think about as I finished this study. Nurse interviews generally lasted for one hour. Clients shared for a shorter time, usually 20-40 minutes.

**Audio-recordings & Transcription**

All participants who agreed to an interview also agreed to have interviews audio-recorded, which I then transcribed into written text. I also kept notes during interviews, though in the moment of conversation this was difficult as it interrupted the flow and therefore written notes only consisted of quick one-word cues for when I listened back to recordings and wrote fuller notes immediately following the interview. These notes included the aspects of the participants’ communication that stood out - speech, body language, and points in the conversation where I asked for clarification due to language barriers, poor audibility, or my comprehension.

Transcription itself already implies a level of interpretation, as decisions about what to include in the transcript are made (Bucholtz, 2000; Lapadat, 2000). Given this, the decision to hire a transcriber or carry out this work oneself is an important one. My choice to transcribe all notes and interviews myself was invaluable in leading me into analysis more formally, as it afforded me the opportunity of staying closer to my memories of the actual observations and interviews. As I listened and transcribed, I recalled physical locations and other distractions like noise especially as I considered my interest in capturing ‘place’ in my interpretations of relational work. Transcription also captured what was said verbatim, as well as the silences. Short silences were marked by the word ‘pause’ and extended silences by the word ‘silence’. Other short sounds that reflected the participants’ pauses were also recorded in the transcript,
such as ‘um’, ‘hmm’, and ‘uh’. This was helpful as it depicts to some extent the participants’ uncertainty or tentativeness in telling the story. Each recording was reviewed for audibility on the same day as the interview and transcribed within the following one or two days.

How to manage the amount of data was also an important decision. Several qualitative data software programs are available, and I specifically explored Nvivo 7, comparing it to Microsoft Word as a program I already owned and was comfortable using. I did this by discussing with my classmates and colleagues who use Nvivo and having them demonstrate it, and by attending a tutorial offered through the University of Toronto Library. Such qualitative software packages are most useful for qualitative studies with several researchers involved and very large amounts of data. Given that mine was a comparatively small qualitative study, I chose to use Microsoft Word given my familiarity with it and the fact that it provides adequate functions for recording, storing, organizing and retrieving data. This decision was also made in the realization that as technically helpful as Nvivo or other software are for managing data, no computer program can replace the reading, thinking, and writing required for thorough qualitative data analysis.

Data Analysis

Data analysis is an ongoing process in keeping with the notion of dialogue. It involved ‘dialoguing’ with, or reading, the texts generated from interviews and observations, namely, the transcripts and notes. For this study, participants’ direct narratives, my descriptive commentary, themes generated from them, and my questioning of those themes came together in one coherent whole interpretation of relational work, through the iterative process of thematic analysis as described by Benner (1994). The aim of thematic analysis is “to accurately present the voices of the participants” and to move the analysis to “a level of commentary that considers the first level
of presentation from various interpretive vantage points” (Benner, p.101). It involves the consideration of “meaningful patterns, stances, or concerns” within each text and across all of them, and brings new understanding to the phenomenon (Benner, p.115). The challenge of this process is not to jump to conclusions or interpretations too quickly; “this struggle must not end in making the practical world more rational, coherent, or consistent than it really is” (Benner, p.115). According to Benner, the researcher’s stance in analysis is continually shifting between understanding the phenomenon as the participant lives and tells it, and a more distant questioning of those narratives, moving in cycles of understanding, interpretation and critique.

The method of thematic analysis for this study was set up according to Benner’s (1994) definition of it as a systematic and rigorous back-and-forth process of reflective reading of text that moves from description to interpretation to critique, and between its parts and the whole. The whole text was made up of the observation notes, interview transcripts, and notes to self. The whole analysis was addressed through the use of interpretive outlines and the specific parts of analysis were captured in the process of ‘naming’. Naming is a means of “capturing examples of patterns of meaning in action, including salient context, that are evident in the text” (Benner, 1996, p.366). The text was critically examined against the iterations of interpretive outline and the naming list, helping to further refine interpretations by comparing the identified themes with the initial lines of inquiry. While reading the whole or specific parts, the same guiding question remained for my analysis: ‘What does this reveal about relational work and the experience of it?’

The process of analysis was guided by a diagram that helped to keep my approach to the text consistent (Appendix G) and by loose adaptation of Chesla’s (1994) thematic analytic process, detailed below:
1) Observation notes were first read as a whole for initial patterns of relational work being expressed; that is, for the practical concerns of each visit, participants’ meanings and ways of relating to one another – both the troublesome and the positive, and emerging broader thematic categories. Notes in the margins were made where the pattern was seen, in specific words, phrases or metaphors and where sections of the data seemed to be addressing a theme. From this a list of thematic categories, themes and subthemes was developed.

2) All interview transcripts were then read as whole narrative accounts of the participants’ experiences through the same process just described, leading to the development of a list of thematic categories, themes and subthemes for the interviews. These ‘first read’ lists of observations and interviews together served as the first interpretive outline (Appendix H).

3) These lists were reviewed with my committee, and the suggested next step was to write narratively in order to get at how these separate lists fit together as a whole of relationship experience. Following the suggestion, I chose the phases of a ‘TB relationship’ – beginning, middle and end – to guide my writing, which included elements of the themes but was not driven by them. While it was not a formal step of analysis, this exercise in descriptive writing was helpful in freeing up my thinking about the data and the initial themes as I moved to the next interpretive outline.

3) The first interpretive outline and the descriptive writing guided the next review of the data. This involved reading across the texts of each nurse-client dyads, which included observation notes for all visits, interview transcripts for those interviewed, and my notes to self (e.g. all visits for Louisa & Ahmed, Louisa’s interview, Ahmed’s interview; all visits for Louisa & Jose; all visits for Louisa & Elijah; etc.). For each dyad, I wrote notes according to how a theme and subthemes were (or were not) expressed as well as identifying salient examples of
each. This reading across all dyads generated the second interpretive outline in which alterations were made to the themes and subthemes lists (Appendix I).

4) The process of naming was important for clearly distinguishing subthemes. Naming each subtheme of the second interpretive outline involved describing the particular idea or experience expressed in the data (e.g. ‘like a friend’; ‘swallowing the pills’). The name assigned to the idea was given a broad definition and transferred into a glossary for quick reference (Appendix J). A list of keywords for each name was also created, and the texts for each dyad were then searched for these words using the ‘find’ function of Microsoft Word. This was done in order to generate a list of direct quotes and portions of text that corresponded to the definition for easy retrieval during later writing.

5) The whole text was read a third time with the explicit purpose of critiquing the interpretive outline. To ensure a careful examination of my interpretations, I re-visited the original research questions, discussed the interpretive outline with my supervisor, and then specifically read notes and transcripts against each theme and name as I had defined them. For example, as I read I asked myself such questions as ‘what did participants actually do or say to make me think of the idea of displacement?’; ‘where is the intruding and not-intruding in this note?’; ‘how do shifts happen from TB to other topics?’; ‘what makes me think this nurse is watching but not watching?’; or ‘why do I focus on fear - aren’t other feelings being expressed here?’

6) This third interpretive outline (Appendix K) along with the naming glossary became the foundation for writing the final interpretive analysis, which also went through several versions that involved balancing descriptive writing with my interpretive account of participants’ stories and the themes of relational work that were generated from the analysis.
7) ‘Outsider’ checks of my analysis occurred through conversations with my supervisor and occasionally with committee members which included reviewing thematic categories, themes, names, and each revised interpretive outline. Also, I left large portions of direct data from transcripts and observation notes in early drafts of the final writing so that others were also reading the data directly and could provide feedback on the interpretations drawn from it.

It must be stressed that while the ‘steps’ above are laid out chronologically, alluding to a linear process, the analytic process of an interpretive phenomenological study is best described as cyclical or iterative, and evolving. The process identified here does not itemize the many occasions of re-reading particular portions of the data at different points in my writing as part of re-visiting memories of the participants, the situations, and the places as part of my efforts to understand and interpret the relational work I had witnessed. Nor does it capture the many informal conversations with my supervisor, committee members, other colleagues and nursing friends that also shaped my thinking about the ideas offered in the following chapters as they were forming.

Finally, “understanding is historical and must be understood historically; thus the researcher keeps track of movements in understanding” (Benner, 1994, p.101). The logs, jottings, and notes to self during observations, interviews, and analysis represent my movements in understanding. They serve as an account of my decisions or turning points along the way during data collection and analysis which has created an invaluable audit trail of the research process. Added to these, my personal calendars provide a record of all meetings with my participants, supervisor, and committee, as do my supervisory and committee meeting notes and email correspondence.
Ethical Considerations

This study was reviewed and approved by the Health Sciences Research Ethics Board of the University of Toronto (Appendix L) and by Toronto Public Health Department in which the study was conducted (Appendix M). It was carried out in accordance with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Interagency Secretariat on Research Ethics, 2005). Key areas of ethical concern are detailed below.

*Risks and Benefits*

It is difficult to declare concrete benefits of participation in any immediate way for either nurses or clients in this study. Benefits for nurses fall broadly within the realm of making a contribution to an understanding of public health nursing practice issues. Their contributions will hopefully have an impact on such things as program development, workload and time management issues and recognition/validation of their work through the presentation of study results at the public health department, which may affect job satisfaction and possibly benefitting future clients of the TB program, in terms of how the program is administered. Several clients articulated their interest in contributing to improved patient care through participation in this study.

There were no known immediate risks associated with participation for nurses in this study. However, I was aware of the inconvenience of my presence in what otherwise were stressful work schedules as well as the discomfort of being watched (interpreted as being evaluated) and discussed this with each nurse, encouraging them to let me know when they needed to re-schedule or have me do anything differently to put them at ease. TB clients are a vulnerable group by virtue of the stigma of TB as well as other marginalizing experiences of HIV, mental illness, poverty, and precarious immigration status. I was aware of the perceived
risk of discrimination based on disclosure of personal information regarding these aspects of their lives that were shared through the course of the study, and therefore safeguarded anonymity by reassuring clients that their privacy was protected and reminding them that the study’s focus was on nursing relationships, not on clients’ TB diagnosis, treatment, or any other personal factors of individuals’ lives (see ‘Privacy and Confidentiality’ section).

Safety issues arose for me as the researcher in considering my own risk for contracting TB as well as where and when I met individually with clients for interviews. For this reason, I had the following safeguards in place: First, though the majority of clients being treated were in fact not infectious I had a TB skin test before starting the study and three months after data collection. I also followed the department’s protocols with regard to infection control that at times involved wearing a mask. Secondly, interviews with clients happened only during daytime hours (between 8a.m. and 4p.m.), the nurse and my supervisor were aware of the meetings, and I carried a cell phone at all times during data collection.

**Privacy and Confidentiality**

Confidentiality maintains the privacy of the participants and is ensured by not using any data that personally identifies study participants. All participants in this study were assigned pseudonyms and no published or presented material arising from the study will describe any identifying details of the person beyond general demographic information. Privacy regarding TB diagnosis in particular was emphasized with clients in explaining the study, given that many clients may feel stigmatized by it. All observation notes, interview transcripts, and audio-recordings were kept on my personal computer that is password protected. All data kept on the harddrive as well as two flashdrives were encrypted. Paper copies and two flashdrives containing participant information and data/texts were kept in a locked cabinet, accessible only to me as the
researcher. Texts will be stored in a secure cabinet at the Nursing Faculty for seven years. Audio-recordings of interviews and notes to self were transferred to my computer, and erased from the recorder after each transcription was finished. They were deleted from the computer at the end of data analysis. Given this is a doctoral thesis, notes and transcripts were shared with my supervisory committee, and all participants were aware of this. All of this information was outlined in a formal letter of consent that was signed by each participant when he or she agreed to be part of the study (Appendices M, N, O).

Compensation

Given my intent to shadow and interview nurses during a normal work-week, nurses participated in this study on paid work time, and no compensation was offered. For clients who agreed to participate in interviews, compensation for their time was provided in the amount of twenty dollars and two transit tokens per interview.

Conflict of Interest

A potential for conflict of interest arose with the fact that I was an employee of this public health department from 1999 to 2003. Given this, there were three nurse participants with whom I had worked, though never in any supervisory capacity. In these situations, I discussed the potential conflict with each nurse in our first meeting, specifically addressing our comfort level with one another regarding our roles of researcher and participant rather than our past roles of mental health consultant and nurse, and our comfort in discussing the topic of the study. In each case, we proceeded with the observations and interviews, and at times I made note of this preexisting relationship as part of my notes to self.
**Informed Consent Process**

While participants at the beginning of all observations and interviews signed consent forms, this constitutes only one dimension of the informed consent process. Consent may also be given verbally, and may be withdrawn at any time, for any reason. The consent process for nurses began with the introductory letter and my presentation of the study at team meetings, through which all relevant information regarding participation was shared. Nurses gave verbal consent during initial confirmation of their interest in participation. On the first day of meeting, I reviewed the requirements and implications of participating and obtained written consent (Appendix M).

Prior to scheduled observation periods, nurses sought verbal consent from clients to bring me along to their next visit. Upon meeting the client in person, I explained the study, answered questions, again confirmed their consent verbally and obtained written consent for observation (Appendix N). In recognizing that consent is fluid and needed to be re-visited, I specifically asked all participants at the beginning of every scheduled visit, ‘Is it ok for me to join the visit today?’ In explaining the study to the clients as I met them, I also asked the first person I met to participate in a separate interview with me. For those who agreed, written consent was obtained at the beginning of the scheduled interview time (Appendix O).

**My Role as the Researcher: Reflexivity**

My role as the researcher bears critical attention for three reasons: I was the sole means of data collection; the interpretations offered in the following chapters are primarily mine; and my presence and participation in the study as a researcher, distinct from a nurse or a colleague or simply my social self, has both methodological and ethical implications. My responsibilities in
this role spanned setting lines of inquiry, being open to changing them, creating dialogue with participants and text, and listening to and critically reflecting on participants’ stories, which Benner (1994) describes as involving a stance of “engaged reasoning and imaginative dwelling in participants’ worlds” (p. 99). Furthermore, I was at once engaged in and interpreting the very phenomenon under analysis: relationships, in which my own assumptions and prejudices as a person, a nurse, and a researcher played a part in my interpretations. Explicit reflection on and articulation of this role was therefore vital throughout the entire project. Maintaining a clear audit trail, as previously described, and reflexivity are specific categories of responsibility that I engaged in within this role. What follows is an attempt to elaborate my reflexivity.

The posing of initial questions is done with the expectation of having those questions challenged, necessitating critical reflection on methodological strategies, personal bias and knowledge, and social context as they influence the expression and understanding of the phenomenon (Benner, 1994). This is done through reflecting on the method as the study is being carried out, and making necessary changes, reflecting on ethical dilemmas that arise and addressing them, and reflecting on personal feelings throughout the process (Bogdewic, 1999, p.60). While she can never escape her own background knowledge, experience and biases regarding the phenomenon, “the ethical stance of the interpretive researcher is one of respect for the voice and experience described in the text” (Benner, p.101). This is the basis for reflexivity in interpretive phenomenology.

My role of researcher required that I declare my own background knowledge of therapeutic relationships as a mental health nurse, and examine my biases about what constitutes a “good” relationship in public health, so that I could free up my imagination for hearing and seeing the experiences of my participants. This declaration of my mental health background in
the proposal for this study represented some understanding of my positionality, or standpoint from which I approached the research, and was the beginning of my reflexivity. Throughout the study, however, I had to be regularly clarifying my position as ‘visitor’ rather than ‘clinician’ or as ‘respectful observer’ rather than ‘intervener’ with myself as well as the participants, especially the three nurses who had known me in a consultative role in which I had offered clinical opinions and suggestions. I had to reflexively examine where, when, and how the boundaries between these positions blurred, and what this blurring meant both methodologically and ethically. I had to carefully consider how to respond to participants, particularly as familiarity developed over our time together. Moving away from my position as researcher and offering an opinion about patient care may have shifted conversation away from participants’ perspectives or experiences, and directed it toward what I thought about relational work as a nurse. For example, after one visit, a nurse asked me what I thought of her ‘therapeutic relationship skills’ and on another occasion a different nurse asked my opinion of the client’s mental status. In both situations I reminded these nurses that I was with them as a researcher not a consultant, so could not comment except to say that from my perspective I did not witness anything to cause serious concern for client safety or well-being. Also, in the midst of many visits, I caught myself wondering about the course of nurses’ questions and responses to clients’ moods or general coping and quickly realized that my natural response as a mental health nurse was different than that of these nurses. If I had shared my perceptions I would have risked limiting understanding of what it means to be in these relationships structured around TB care, not psychiatric care.

My identity as a nurse was shared with clients in the interest of being honest and transparent, yet this raised an ethical question for me in terms of the amount of personal information that was shared with me by some of them – did they do so because of some unearned
trust in the fact that I was a nurse? Sorting out being a nurse and being a researcher particularly heightened my critical reflection on my involvement with TB clients as a vulnerable population. Pinfold (2000) points out that in these situations, the researcher must remember that “being visited for research purposes may be greeted with hostility, especially if there are minimal perceived gains for participants” (p.203). I was aware of this in the study, recognizing that clients could be understood as vulnerable by virtue of their diagnosis and their living conditions. As such I recognized the importance of honesty, respect, and patience in my encounters with them and carried this awareness with me as I explained the study, obtained consent, and met them in every visit.

But in fact I was not greeted with hostility by clients and was somewhat surprised by the number of them who seemed unconcerned with the informed consent process, simply telling me that if I wanted to watch the visits I could. This experience raised a different issue about vulnerable populations than that described by Pinfold (2000). Their ease, rather than hostility, immediately raised my vigilance in guarding against coercion or exploitation. In other words, when they did not treat me with some amount of caution, I felt an obligation to be cautious for them. Herein lies the important point of reflexivity for me. As a nurse, I felt guilty with the level of clients’ self disclosure beyond what I had conceived as relevant information for the study yet once it was shared, as a researcher I realized the depth that such disclosures added to the narrative ‘data’. I was at once pulled to protect privacy out of concern for their vulnerability by perhaps reminding them that they were not obligated to share so much with me, and at the same time felt pulled to ask for details that would add to the ‘richness’ of description. I have highlighted this point about reflexivity not to suggest it as a perfectable strategy of data collection but rather to emphasize my experience of the fluid nature of being reflexive.
throughout the entire study from proposal to analysis to finished document and across the concerns of method and ethics in interpretive phenomenology.

Reflexivity also implied regular review of the assumptions with which I began the study. Namely, all relationships (including mine as researcher) constitute and are constituted in part by the places in which they occur; understanding is embodied and situational; and individuals come to understanding through dialogue in relation with others. These assumptions served as guideposts for explicating my reflexivity, which I came to understand as a kind of self examination which was carried out primarily through reviewing notes, writing, and in conversation with my supervisor as the study proceeded. Debriefing about my time with the participants (while maintaining confidentiality) was necessary to help with clarifying my biases, reactions and judgments that I could not always see on my own and asking critically reflective questions so that the interpretations stayed ‘real’ or connected to participants’ experiences. Writing was also vital in serving this purpose, along with its equally important function of keeping track of developments in the study. Writing produces an audit trail which not only demonstrates that the research was systematic but also that gives the reader a sense of the thematic developments in the interpretive work, which are shaped by my reflexive process as the researcher-writer.

Finally, while debates exist as to the possibility of arriving at one standard list of criteria by which to assess, careful attention to procedural aspects of a qualitative study are important for discerning its quality. In addition to reflexivity and creating a clear audit trail, I addressed the credibility (as described by Sandelowski, 1986) by staying faithful to participants’ descriptions of their relationships, both the positive and negative aspects of them in two ways. First, through detailed direct quotations from observation notes and transcripts offered in the following chapter.
And through triangulation of data in the form of using both observation and interviews to generate data, and recruiting participants across the whole range of TB teams including RNs and RPNs. Transferability (Sandelowski, 1986) has been considered directly in the final chapter, under implications.

Summary

In an interpretive phenomenological study, quality of interpretations is less about “verification of findings” and more about the plausibility of them, since in the end it will still be the researcher’s interpretation (Benner, 1994). A significant cue for quality, as suggested by Benner (1994, p.101) is when the researcher’s own views have been challenged, extended, or turned around. However, the quality of qualitative research must also be judged by others for its substantive contribution as well (Eakin & Mykhalovsky, 2003). Quality therefore relies to some extent on the readers’ conscious examination of not only the structure and phases of study methods but also the plausibility of interpretations of the phenomenon that enhance understanding. The reader is therefore now invited to consider relational work of TB nurses as expressed through the interpretations offered in the following two chapters.
Chapter Six: Welcome Intrusions

The purpose of this study was to understand the nature of relational work in TB nursing and describe this work within the complex of TB-related tasks. It is work that evolves over time, always shifting within two general areas of concern: protection of the public’s health and care of the individual. In this study, relational work in TB nursing is characterized as ‘welcome intrusions’ and the themes of ‘getting through the door’, ‘doing TB but more than that’, and ‘beyond a professional’. Welcome intrusions was seen across the texts as an overarching theme that can hold two key dimensions of these nursing relationships. This notion, along with its corresponding themes, explicates relational work and its inherent tensions that resists dichotomous understandings and emphasizes the integration of competing concerns that are continually negotiated by and between nurses and clients. In other words, the work of relationships is both this and that. The interpretation offered emphasizes the dynamic nature of welcome intrusions. In other words, the paradoxical elements captured in the themes continually shift from the foreground to background of particular situations, thereby shaping participants’ relationships in the moment.

‘Welcome intrusions’ as the focus of this chapter will be explicated through an overall description of the meanings embedded in each word and how the words come together to create an understanding of relational work. Intruding, and guarding against it, was expressed in various ways throughout the visits and interviews, with the word ‘intrusion’ being used directly at times, even though a sense of welcome also prevailed in most visits. This gave me pause as I reviewed notes and transcripts, recalled my experiences and discussed them with my supervisor and committee members. How is it that these relationships were such intrusions into personal lives and yet clients expressed such a sense of welcome in their homes? This seemingly contradictory
understanding is explicated further through the themes of ‘getting through the door’, ‘doing TB but more than that’, and ‘beyond a professional’. However, relationships are context-bound so before turning to the themes themselves, the backdrop of nurses’ relational work in TB is provided as it was seen in the study.

The study was done with nurses working for the public health department. It was carried out in a variety of settings across regions of Toronto. In the broadest sense, the setting was “anywhere” within the borders of the particular region of the city where each nurse worked. Although some contextual information has been provided in previous chapters, this earlier information is enlarged upon in the following four sections that represent my interpretation of the salient dimensions of Public Health as an organization, the locations and time of visiting, and relationship networks as the backdrop of relational work.

*The Organization of Public Health*

Public Health with its mandate to prevent and manage tuberculosis in the population, which includes its legislated power to order and enforce isolation of active cases of disease, is the main institutional structure of this study. While I recognize that other organizations are also part of the context – for example, the World Health Organization and hospital TB units and clinics – the influence of their specific structures was not immediately present in most of the daily work of the TB nurses I observed and therefore will not be addressed here. Toronto Public Health however is the direct employer of these nurses and as such determines the nurse’s role, as well as the policies, protocols and documentation requirements of that role.

Every latent and active case of TB in the city must be reported to Public Health by physicians, laboratories, administrators of hospitals, schools, and institutions with the consent of the person who carries the diagnosis unnecessary. Then a file is opened, forwarded to the
appropriate regional office, assigned a case manager, and the person with TB is contacted. All those who have been in contact with known infectious disease are identified and tested, and offered appropriate treatment. Keeping track of those receiving treatment is the responsibility of case managers and for those who consent, directly observed therapy (DOT) nurses are also involved. Case managers must ensure treatment is being followed without difficulty, and communicate with physicians and other health professionals regarding this. DOT is offered to all affected individuals they meet, and many of these clients accept because of the additional support provided by through the DOT program. DOT nurses are responsible for monitoring clients as they take their daily medication to ensure the treatment regime is being followed accurately and without problems (e.g., medication side effects), intervening when problems do arise, and documenting. They are also expected to provide ‘support’ and ‘help’ with other concerns.

There are also the organizational protocols regarding documentation in the form of files, checklists, and letters. The importance of documentation is self evident, particularly in situations of infringement on an individual’s rights when the individual is not complying with isolation: “I mean, there are various extremes, right?, so… We have to have it documented that we’ve made them aware of the consequences, what will happen, because should [we] need to go to a Section 22 or 35, that needs to be documented, all of that stuff” (Rosalee interview, p.9).

Yet sometimes documentation during visits felt like interference in providing care. Lynette explained that while her documentation was important because it reflected that she saw the client take the medication “all these times”, which provided a record of “good numbers”, “sometimes you’d like to throw the numbers right out the window and just try and do your job…” (interview, p.9). With this attitude in mind, I saw how the client file played a visible role across relationships between nurses and clients. It was interesting to observe how they were or
were not made part of the visits. Pragmatically, sometimes there was simply not enough time to open the file during a visit. Depending on the location, especially public locations, pulling out a file would be inappropriate as it could draw the attention of others. Even in the privacy of a home and with enough time, writing in a file may have felt like an intrusion if the client wanted to talk about other things. The files sometimes served as a helpful tool in the interaction. They provided quick, easy reference in conversations about latest treatment changes, sometimes allowing the nurse to answer client questions immediately. For example,

Rahim begins counting out the days left of his 6 month treatment on his home-made calendar and shows Lynette where he’s written the exact dates. They both look at the list. Lynette has his file open on the steering wheel and looking back and forth, compares his dates on the paper with the dates in the file (observation notes, p.5).

Leslie sits down and takes his file out of her bag. As Akello sits down, he asks Leslie if she has [doctor’s] number. Leslie nods, not looking up, and says that she brought it with her… They discuss this fax number, the necessary information to send and how he will send it… Leslie refers to the file that is now open on the table (observation notes, p.7).

The presence of the file during the visits also at times created a disconnection between the nurse and client. In another exchange between Leslie and Akello, I watched as she focused on writing in the file and Akello watched her, continuing to talk to her (observation notes, p.2).

In his interview, Karen’s client Ivan identified the one thing that didn’t work well in their relationship as the nurses’ checklist system for side effects:

“Questions they have to ask… Seems like a long list y’know, why ask every day for nine months? But if you got the list, you should ask it, or, don’t have such a long list. [laughs a little]… Me: So, maybe the list doesn’t work so well, that form she pulls out every day? Ivan: Yeah” (interview, p.4).

Official letters from Public Health and physicians also represented the backdrop (Lynette & Akiki; Evelyn & Alicia & Hana;). Clients regularly asked nurses to clarify these letters. Also, at times, nurses advocated through telephone calls to appropriate people when letters that had implications for immigration applications and employment were expected but did not arrive
(Bev, Evelyn, Leslie, Lynette). For example, Lynette reminded Akiki in one visit to expect the skin test reminder letter for her family (observation notes, p.4). In a visit with Evelyn, I observed Alicia’s concern about a letter and Evelyn’s response: Alicia told Evelyn when she received it while passing it across the dining room table to her. She quickly glanced at it and told Alicia, “it’s a reminder… for the kids’ skin tests, and your husband.” When Alicia replied that she did not know how to get them done, Evelyn offered to do it. Though concerned that it was “too much trouble”, Alicia finally agreed to this instead of everyone going to a clinic (observation notes, p.3).

This provision for skin tests at home is an example of how nurses individually supported clients in meeting Public Health requirements. The organization also provides incentives that nurses distribute for the same reason. A portion of the program budget is allotted to such items as transit tokens, taxi chits, grocery vouchers, and nutritional supplement drinks. In the case of one participant with access to a city-owned vehicle, she could provide rides to appointments occasionally. Arrangements are also made between Public Health and a few motel owners in the city to occasionally provide rooms for those who have been discharged from hospital, must continue isolation because they are still deemed infectious, but have no accommodation. Such was the case for one client during my data collection.

Isolation is a long-standing public health strategy for containing communicable diseases. In most cases of active disease, the person is asked to isolate her/himself at home, and nurses are at the forefront of ensuring isolation in this situation is properly maintained. The Public Health Protection and Promotion Act (HPPA) forms the legal backdrop, providing the structure for enforcing isolation in situations where the known infectious person refuses to comply, as explained to me by Rosalee:
“… everyone who’s infectious gets told that they need to wear a mask and they need to stay in isolation, and they’re explained why that needs to be done. If we find out that someone isn’t complying with that, then you need to take it to the next level. And of course the next level is, they get a section. A section 22, a legal document... 22 is where they’ve broken isolation. And if they’ve broken 22, the 35 is, you will be hospitalized. It’s like a [searching for words]… Me: Like incarceration in a hospital? Rosalee: Pretty much. It will be [Hospital K] with a guard outside your door… In order to get a 35, you need to break a 22… So, if someone gets served a 22, they can still be at home… But, if they get caught… Me: Sneaking out? Rosalee: Yeah, and they’ve already been served a 22, that’s when it would come to a 35” (interview, pp.14-15).

The enforced confinement in hospital described by Rosalee was observed in only one situation in the study. However, several visits involved clients who were voluntarily isolated in their homes awaiting the ‘ok’ of clear sputum tests. Isolation as part of TB care highlights place in particular ways.

**The Locations of Visiting**

“Where I do DOT?... I’ll do it anywhere (looks puzzled; I laugh). I will!” (Lynette, interview, p.5). As stated, public health TB nurses’ work is not carried out in a single place. I observed visits in a variety of places and a range of spatial arrangements that raised my awareness of relational work in terms of interconnecting notions of proximity, familiarity, and privacy. Understanding places as part of the backdrop of visiting categorized according to geographical locations, private and public spaces, social locations, and safety concerns.

Data collection took place across three of four regions of Toronto: north, south, and west. Regions are artificially bounded areas, mapped out by Public Health as a way of organizing services. An administrative office exists in each region in which TB nurses have individual desks and other workspace, used primarily for paperwork, phone calls, team meetings, and consultations with other program teams. Very rarely do they meet clients here. Only 2 out of 101 observed client meetings took place in an office. This is distinguished from acute care or other community settings such as community health centres that are typically understood as nurses’
places. Rather this area of public health is similar to home care nursing, where the work is carried out in clients’ places. This is an important distinction because this arrangement influenced how nurses and clients were involved with one another.

Understanding the clients’ place begins in having a sense of their neighbourhoods. The neighbourhoods I visited ranged from inner-city to suburban. Most of them were termed ‘priority neighbourhoods’ by the city, generally identified by concerns of: community safety, inequitable access to services, and limited economic investment and development. The places where specific visits happened were homes, temporary residences, and what I interpreted as rendezvous locations. Homes included houses; apartments – high-rises, walk-ups, basements in houses; supported housing units; and a shared room in a boarding home. Two clients could not be at home during their isolation period. For this reason, I also observed visits in an isolation room of a hospital with a security guard outside the door and a motel room located in the opposite end of the city from client’s family. There were also places of rendezvous, or transitory public locations: lobbies of apartment buildings, a public bench in a shopping plaza, and notably, nurses’ cars parked on side streets or in parking lots of plazas, shopping malls, workplaces, and schools. Most of the visits happened in homes and nurses’ cars.

Homes were as individual as the people living in them. Meetings here most often took place in the living room or dining room, though on several occasions, participants moved to the kitchen. There were times when the nurse and I were left alone briefly while the client went to other parts of the home, and occasionally the client asked the nurse to come along to another area in the place to be shown something. There were also a few visits just inside the front door.

The physical layouts of places varied greatly, as indicated by these examples: The kitchen/eating area where the visit takes place is very dirty and empty, with open, broken cupboards and a small table in the corner and no chairs. The table is covered with what looks like
garbage – pizza boxes, coffee cups, crumpled paper. The only window is wide open (and it’s a cold winter day). Pigeons sit just outside the window, cooing and eating from a pile of bread crumbs. I can hear the street traffic and people’s voices loudly through the window, and occasional voices and shouts in the hallway outside the apartment door (Louisa & Luka, observation notes, p.1).

The apartment is clean and sparsely furnished. There are no plants, knickknacks, books/magazines or personal items. There are two small pictures on the living room wall. The solid balcony door is open, with a breeze coming in the screen door. I can see there are tomato plants growing in pots on the balcony. There are distant street noises: people talking, traffic. The cat comes out of the kitchen and greets us both, still meowing loudly (Karen & Ivan, observation notes, p.1).

We stand just inside the door of the apartment in a small foyer that opens to a large living room over-crowded with big furniture. The curtains are drawn; it’s very dark. The only light is from the kitchen, and I can smell and hear breakfast cooking. I can see the shadow of a child laying on one of the couches watching the loud television. A pretty bird flies past my head startling me and lands on the top of its cage near the kitchen doorway (Linda & Jima, observation notes, p.1).

The nurse’s car was a unique kind of location in two ways: a location-within-a-location and a location-between-locations. As a location-within-a-location, the car itself served as a place for visits when other places were not suitable. This meant that the client arrived at the car’s parked location at a pre-arranged time, got into the front passenger seat, and the meeting ensued (Fatima, Vlado, Selva, Hamid, Afua). On very cold days, the nurse would periodically turn on the engine for heat and on very hot days, windows were wide open. The car also was a location-between-locations, meaning that nurses’ work included the travel between visits. They all regularly used their cell phones sitting in their cars or standing next to them, talking to clients, colleagues, physicians and other health professionals, to arrange appointments, answer questions and offer support, consult and pass along information. Some used the car as a place to write; to update files. This kind of work was an obvious part of the job. However, it is also important to acknowledge the less obvious, taken-for-granted aspects of the ‘between-locations’: traffic, detours, parking restrictions, and road conditions. In getting to visits myself, I drove an approximate total of 3,280 kilometres, sat in traffic jams during heat alerts, slowly drove through
heavy snow, searched for addresses and missed turns, occasionally made use of public transit, and relied on my cell phone to communicate with nurses when either of us was running late.

The spaces within geographical locations are also important to note in the backdrop, specifically the private and public nature of them. The home is generally assumed to be a private location, while city streets or coffee shops are commonly understood as public locations. Yet there may in fact be limited private space within a small apartment, while the public location of a busy sidewalk, as two nurses explained (Louisa, Lynette), can be a remarkably private space. The nurse’s car, as a location-within-a-location also fits here, as a private space within public locations. While observed visits involved only the nurse and client, other people were part of living arrangements. The following are categories of clients’ living arrangements: living with spouse and/or children: 11; with other family members: 3; with roommates: 4; alone within supported housing: 3; alone: 4. Relationships were shaped by this private or public nature of spaces as nurses managed such spaces by meeting clients ‘on the sly’ and by using careful discretion. For example, in arranging my first visit with Akello, Leslie demonstrated her awareness of being discreet. We agreed to meet outside his building; she gave me directions and told me where to park. She explained she does not park in front of the building, but a bit further away, “in case I’m doing notes or have to make calls; so he doesn’t see me sitting there; maybe he doesn’t want me hanging around” (observation notes, p.1).

Also, a private home may not be a private space for discussing TB treatment. When Linda and I arrived for a visit with Aliya, a furnace salesman was there. The client showed us to the sofa where we waited while she spoke to the man sitting at the dining room table in the same room. After a few minutes, Aliya got up, went to the kitchen, and came back past the man carrying a glass of water with the other hand clenched in a fist. Coming over to us, still standing,
she swallowed the pills with a long drink of water, standing with her back to the dining area. Linda stood up as Aliya took the pills, and leaning in very close beside her, whispered “three more days”, holding up three fingers. Aliya nodded and they both laughed like they were sharing a good secret (observation notes, p.4).

Public places for meetings raised concerns for privacy in different ways for different participants. While some found public places challenging for maintaining privacy, others felt that public places offered an ironically private setting, as described by Lynette:

“I have met clients in coffee shops and I find that difficult because it takes away some of the privacy and I find those are hard places to do it, but if that’s where the client wants to do it, doesn’t matter, I’ll manage that and somehow try and make it a private event, but it’s harder to do. It’s even easier to do it on a street corner than in a restaurant… Me: Why do you think that is? Lynette: It just is. Because you can, sort of [position] of your body (moves her shoulders away from me) with the client… People are busy, they’re passing, they’re not stationery, or have time to study what’s happening in their environment so… although it’s a public place it’s not as much of problem” (interview, p.6).

However privacy in public in the space of nurses’ cars was more complicated. In a sense it is the nurse’s place, but unlike hospital or clinic, the car is personal space. Paulette talked about this after one visit that happened in her car. Spontaneously, she commented that she preferred to meet in clients’ homes. In her car she always felt “a bit weird” because it’s her space and she thought the client “could feel that” (observation notes, p.2). This nurse seemed less concerned about clients intruding in her private space and more about putting them in an awkward situation. Clients echoed this feeling. Afua told me it was more uncomfortable in the nurse’s car because it felt “very secretive; like something’s up” when they met outside her workplace (interview, p.6). In the same way, Paulette met Vlado around the corner from his school after he asked her to park there because people had seen him get into her car and were “starting to ask questions” (observation notes, p.4). These client examples suggest that feelings
associated with the privacy of spaces in public and private locations are important considerations given the contagious nature of TB, its associated stigma as well as that of certain social locations.

The size, appearance, and in some cases overcrowding, of the places in which people lived, including the neighbourhoods, revealed glimpses of social locations as well. Social location refers to a range of categories which position individuals within society. The issues of income/poverty, employment, and race/ethnicity were such locations seen in this study. To clarify, social location and geographical location are distinct yet related in understanding place; each one to some extent determining and being determined by the other. For example, two clients in the study were educated professionals from other countries, but here in Canada one was employed in a minimum-wage job that required a three hour commute each day, and the other was unemployed as a result of TB isolation and immigration status. Their social location in terms of class shifted drastically through migration, and their homes in Canada reflected this shift.

In my initial visit to Kwame, I noticed his sparse living conditions in the bachelor apartment he shared with his wife: a double mattress on the floor, three chairs (one broken) and a small computer table with a computer. Heavy curtains covered the window so it was dark, and I could hear and feel the winter wind whistling in the balcony door. In visits Kwame gave us the two functional chairs and brought a stool from the balcony for himself (observation notes, p.1). Yet, his nurse Lynette described it without comment on the sparseness: “It’s one room…. And there are no partitions other than there’s a bathroom and a closet… And they have a balcony”; when I asked directly if she thought the place affected their relationship, she simply replied, “not for me” (interview, p.6). Later she told me “his housing isn’t all that fantastic” but that Kwame and his wife did not complain or ask for help with finding something more (interview, p.10).
In the next quote, Leslie is aware of the physically run-down appearance of Akello’s apartment building and unit but positively frames what she observes, and expresses embarrassment for noticing something that reflected negatively on his living conditions:

“His apartment building is probably the worst one that I’ve been in, in terms of being run-down. I know they try very hard, they’re always…vacuuming and cleaning… but it’s extremely run-down, and the elevator, I got in one day and thought, ‘wow, that was dumb’. Because it looked like the walls could collapse on you and it was peeling and, it’s a tenement house basically. But you go into his apartment and it’s neat, it’s tidy… they’ve got a bible verse, which is interesting [and] other artifacts from his culture… I think they do take pride in it. I was there one day when a cockroach ran behind his head, and I thought it was a spider and next I said, ‘oh I think there’s a spider on the wall’, and he turned around. I think he was embarrassed and then I was embarrassed that it was a cockroach and I had pointed it out. And I said, ‘oh it’s gone anyway’ and we just kind of skipped over it and kept on talking” (interview, p.7).

At first glance, these apartment descriptions may lead to assumptions of poverty, which was often the case, but the nurses, by knowing the circumstances of these clients’ lives, were cautious of working from these kinds of assumptions alone. Their open attitudes in general emphasized that while it is important to know places as part of the person’s situation, the place does not necessarily reflect social location. For example, Farah’s cramped damp basement apartment may be perceived as a condition of poverty:

We go in, down small narrow stairs, Evelyn is ahead of me. At the bottom of the stairs is a laundry area and we step into another doorway beside the washer/dryer to greet Farah. We do not take off our shoes. The basement apartment is very small, very dark and very crowded. I can smell mold. We sit at a small dinette table just inside the door, with a hanging light overhead (observation notes, p.1).

However, the state of the apartment did not necessarily reflect financial status accurately. Evelyn explained that Farah and her husband had a comfortable income and could likely afford a “better place”, but they sent most of the money to family in their home country.

A final note regarding place is nurses’ concerns for personal safety. As Leslie commented in an earlier example, getting into an elevator without thinking “was dumb”, and Karen, another nurse, commented in passing that a bright apartment felt “safer” than a dark dingy one. Personal
safety arose spontaneously as a topic only once; more often it was something that I witnessed and asked about directly in specific locations. After one visit, I asked Evelyn how she felt being the only woman in an apartment full of men and she answered simply by saying she has “a different awareness”, adding “you know what I mean” (p.4). I also noticed that Evelyn, like the other nurses, chatted with almost everyone she met in apartment buildings. In the elevator one day, she conversed with a man, joking so easily that I thought she knew him. After he left, I asked and Evelyn laughed, telling me that she chats with people “especially in buildings like this, so in case something happens to me, people will remember me (general notes, p.2). Lastly, after a visit, Karen suggested we take the stairs “for exercise”. Opening the door to the stairwell, she first paused telling me she always listens before going in, which we both then did before proceeding down (p.6).

**The Time of Visiting**

Time structured the relational work in two significant ways: the duration of treatment and the duration of visits. Relationships changed from beginning to end of treatment, from visit to visit and in between. TB treatment lasts a long time compared to other antibiotic regimes, usually a minimum of six months. I met clients at various stages of treatment in this study, ranging from the first week to almost two years. Some were seeing DOT nurses 5 days/week (considered daily); 3 days/week (considered intermittent); and once a week (see Appendix E – observation log). Case managers spent more time in telephone contact, only visiting clients at the start of treatment and then as needed.

Clients experience time across a continuum of sickness to wellness. At the beginning, those with active disease have symptoms that make them feel sick but after treatment begins, they quickly start to feel better. Clients undergoing treatment as prophylaxis were never
symptomatic and therefore do not experience the same shift from being ill to being well.

However, whether addressing latent infection or active disease, TB medications can cause significant side effects that also are generally experienced more severely at the beginning of treatment. Clients I observed were, on average, three months into treatment and therefore most did not have symptom complaints, but there were individuals who did report specific concerns throughout, and nurses and clients alike would recall the time of being sick and regularly refer to the future end to treatment. For example, Ahmed remembered feeling like he would die at the beginning of treatment in hospital: “I stayed there three months… because all depends if you can put out of yourself your illness... Or you continue it, sick” (interview, p.4). And, Luka told Louisa, “I don’t want that again. I was really sick! In the hospital. Not again, no thank you!” (observation notes, p.1).

The end of treatment implied a future orientation in the relationships between nurses and clients. Paulette talked about preparing for the end, giving clients time to “let it sink in” by talking about it long before the final day was upon them (interview, p.9). Karen noted the shift in the energy level that happens near the end; they “lighten-up when they know it’s the countdown”; “they start re-evaluating how you helped them, and they start appreciating you more” (interview, p.16). The anticipation of the end was raised in some conversations that I witnessed. For example,

Hana has picked up her dosette and is shaking it slightly, looking at Evelyn she says, “so, 4 months to go, maybe 6 months.” Evelyn: “I think 6 months. We got it early. Your symptoms weren’t exacerbated”… Evelyn talks about how well people generally progress and this has a lot to do with how long they have to stay on treatment (observation notes, p.3).

“Everything’s going so well with this”. Lynette looks down at the table and points to the tissue where the pills were, “we’ll be saying goodbye before you know it”. “Oh no!” Akiki quickly responds before the last words are out of Lynette’s mouth. “Well you can always call me if you need to, but…”, Lynette smiles at Akiki, “things are going so well” (observation notes, p.7).
Attachments like these shown in the examples were weighed against creating ‘dependence’. Nurses explained that they needed to avoid having clients depend on them ‘for everything and insisted on arrangements such as teaching clients to fill their own dosettes (Paulette, Bev). Related to this, nurses described the need to “wean off” clients as the end of the relationship approached, which also applied to nurses themselves:

“Sometimes I think it’s hard for patients to actually give up the nurse to visit, and, there are some… that we have to wean off at the end… And so it’s hard, they kind of feel sad that you’re not coming back again. And you know what, sometimes I feel sad too” (Evelyn, interview, p.8).

For Paulette, the hardest part of the job is “weaning clients off us”. She pauses and then adds, “but harder than that is weaning myself… like [client] today…I’m really going to miss that family, those sweet kids… but I have to let them go. Nurses, eh?” she laughs a little… “We really have to do that a lot because we work with them for so long. They get used to us, to having us around… but we don’t really talk about how we have to wean ourselves from them too” (general notes, p.2).

As I witnessed how the end of relationships loomed in visits, I wondered about ‘weaning off’ as a natural part of most relationships and an acknowledgment of the significance of saying goodbye. This awareness of ending the long period of treatment took on affective meanings not only because the treatment lasts a long time, but because of all that has happened across innumerable interactions between nurses and clients in many visits. It is not the duration of treatment alone that effects relational work but also its everydayness.

Understanding relational work in the everyday is most relevant for DOT since this is a daily-visiting program. The everyday of relational work refers to the ordinary quality of relating to people on a daily basis, and nurses expressed an awareness of it as an aspect of relational work. Evelyn explained, “you do get involved in a lot of the personal things, because you’re seeing them every day for at least six months, so you do know a lot about them” (interview, p.8). Paulette highlighted that “with this program it’s sometimes a little bit more of a challenge to feel that reward at the end of the day because it doesn’t just happen at the end of every day that we
work” (interview, p.8). And, Karen described the shift that happens in the first month or so, when “you start feeling like you’re not that awkward person coming every day… they make you feel at home a little bit more” (interview, p.1). Clients too alluded to it. For example, Afua explained the importance of the quality of time spent with nurses aside from convenient scheduling:

“If [nurses] are going to feel like, ‘I have to go see another patient’, and they’re like, ‘ahhh’, [then] the patient is thinking, ‘and that nurse is going to come here again?’”, and you know it’s a very long time. Me: And you could feel that? Afua: Of course you could tell and you’d be dreading the person coming every day. Especially at the beginning, when it’s every day, right?” (Afua, interview, p.10).

Conversely, Ivan felt comforted by Karen’s daily visits:

“I was glad to have Karen come by… she was very personable and very nice to talk to and everything. Made me feel like, ‘it’s not going to last forever. Y’know, this isn’t your life.’ Me: She would say things like that? Ivan: Yeah. ‘It’s only three weeks, and then it’s only nine months and, y’know, it’ll be ok.’” (Ivan, interview, p.9).

Nurses were aware of needing to “lighten things up” given the mundane quality of the everyday, especially after the person has been feeling well for a while. This was best described by Karen as we talked about her preference to meet new clients outside the home:

“I’m hoping it will make the person relax a little bit more… just to lighten it up. And also just to change scenes. Because remember, I’m going to be seeing this person for about eighteen months. Do you know what I mean? It just seems like monotony?... And I think it keeps the patient… from getting bored… The worst thing I hate to do is walk into a person’s house, go through the checklist and say goodbye, and watch them swallow their pills… even two to three minutes of conversation… Something that happened on the weekend, something light, something small. Me: And that makes a difference? Karen: Yeah. It gives you something to talk about each time you go. You can follow up, and sort of keep it interesting. Because, it does get monotonous. You imagine, you’ve done five visits and,… sometimes I do a hundred and fifty visits and sometimes they’re exactly the same[both laugh]. I think it keeps my brain stimulated too” (interview, p.11).

Humour is the best example of how the everyday was lightened up, consciously by nurses at times, in the form of jokes and some teasing with clients they knew well. Most of the time however, it was just part of the flow of many interactions. In other words, nurses and clients
were often seen simply laughing together about an incident or story (Evelyn & Alicia; Lynette & Kwame; others). For example, I witnessed such teasing in a visit between Louisa and Ahmed who had known each other for two years:

He talks about how [his addictions counsellor] told him that if he came to Ahmed’s place when these [drinking friends] are around he would kick them out himself. He says [counsellor] also joked that if Ahmed doesn’t follow through on the current plan, he would send Louisa to get him. Ahmed is laughing telling me this and pointing with his thumb at Louisa while still looking at me. Louisa smiles, sits up straight, sucks in a big breath and motions like she is showing her bicep muscles, which makes Ahmed really laugh. Louisa lets out the air, her posture relaxes and she laughs too (Louisa & Ahmed obs notes, p.5).

Humour witnessed in this way reflected a comfort between nurse and client. Evelyn explained it this way: “I think once you use a bit of sense of humour, you’re kind of laid back and… not so total *business-like*. You have… a personality where they enjoy you coming, they look forward to the visit, but at the same time, you know what you’re there for” (interview, p.5).

Individual visits themselves were as quick as five minutes and one visit lasted two hours, as the nurse was assisting with housing. The majority of visits lasted between fifteen and thirty minutes (Appendix E). There were also several missed appointments and cancellations, and negotiation of schedules to accommodate staffing coverage. This continual need to adjust individual timetables was an ever-present part of relationships. The following is one example:

Evelyn: “How was your appointment?” Alicia: “Fine.” She then says it took her all day to travel down to the clinic wait, have the appointment and come back. Evelyn nods… Alicia says, “I waited for you yesterday. I don’t wait for you today” and laughs. Evelyn looks surprised, and says she is sorry; “you were expecting me yesterday? But you had your appointment?” Alicia clarifies her appointment was on Tuesday. Evelyn says she is embarrassed and apologizes again, saying she didn’t come because she thought Alicia was at her appointment. She then says, “Alicia, you should have called me”. Alicia: “I didn’t want to bother you. You are busy.” Evelyn: “yeah I’m busy but you can always call me. Even if I don’t answer, I will call you back.” Alicia tells her it was ok, she took her pills anyway, and she goes back toward the kitchen (Evelyn & Alicia, observation notes, p.3).

Two more examples highlight the negotiation of time when nurses were going to be away which was a disruption to clients’ routines. A different person means a different schedule and
level of comfort. In one visit, I watched as Paulette raised a discussion of her up-coming vacation with Kali who was particularly hesitant. Paulette explained the exact dates and that another nurse would be available. Kali replied with a quiet “I like only you”. Paulette acknowledged her feelings, attempted to reassure her, and left it until later in the conversation (observation notes, pp.1-2). Linda’s client Afua shared a story of having a different nurse meet her on a lunch-break at work while Linda was covering yet another nurse’s caseload. Emphasizing that she really didn’t get to know this nurse, Afua disliked the arrangement because it was “hurried”. She felt rushed, but this was the most convenient time for the nurse, so she acquiesced (interview, p.6).

I was with Linda and Paulette when they were covering caseloads of colleagues. On those days, the nurses’ ability to fully engage with people was affected by time constraints. They admittedly rushed the visits that day in order to fit all of them into their schedules. Paulette acknowledged feeling impatient when one client was late (Paulette & Hamid, observation notes, p.10), and “grumpy” not due to the interaction itself but rather because of the time pressure (Paulette & Daren, observation notes, p.8). Linda explained her busy schedule for the week she spent with me, with 12 people to see every day, and 13 on Friday. She also had 2 return visits on the day prior to our conversation. One woman called after Linda had just been there insisting that Linda needed to come again to see the rash that was developing. Though rashes do not typically develop so quickly, Linda said this was an anxious person so she went back to reassure her. When I asked how she felt about needing to do this, she shrugged and said it is just part of the job; it was better to be cautious and put in the extra visit (observation notes, p.5). While feeling the pressure of time, concerns for the person’s emotional state played equally on Linda.

**Relationship Networks**

A final aspect of the backdrop of relational work is the fact that visits were rarely only about two people – one client and one nurse. These dyads were happening in networks of other
relationships, and how nurses were part of them and worked within them was apparent throughout the study. Nurses engaged with and referred to relationships with others in the client’s personal life, which included family, friends, and roommates. There were also networks of relationships with other service providers, including doctors and public health colleagues. Knowing these other people in clients’ lives added another dimension to knowing the client. For example, as Louisa and Rosalee talked about their clients, it was clear that they knew them within a network of relationships:

“… he’s a very social person in spite of his wanting on some level to keep things quiet, to be able to read in his room, listen to music, watch the news, have a quiet life. If somebody knocks on his door, it’s party time and he loves that. It’s as much a part of him as the quiet. And I acknowledge that and I remind him that that’s something that’s important to him… I’m just thankful that he has [addictions counsellor] and he has [friend] and [friend]… to help him with his addiction issues” (Louisa, interview, pp.9-10).

“His family relies on him entirely. He has three children. And his wife does not speak English, y’know, she can’t really help out with too much. He’s sort of the breadwinner, the whole support, everything. So he’s going through a very difficult time…. not only is his health the major issue, but we just need to make sure he has enough” (Rosalee, interview, p.1).

Being part of these networks not only helps in getting to know the person, but means that nurses’ concerns often extend beyond that individual to others in the family. This was seen most often in relation to contact-tracing yet nurses had relationships with families in other ways. There were situations in which family members were practically helpful in connecting with the client. For example, Lynette talked about connecting with Kwame through his wife sometimes. Paulette made contact with Vlado through his aunt. And in both these relationships, the nurses reciprocated by answering family member’s questions about other health and social issues. Nurses’ stories of clients also included family who were simply present in the home during the visit, part of the situation in indirect ways such as passing through the room, or more distantly as topic of conversations. Nurses also dealt with concerns related to family members’ TB status. In
the midst of observing such, I would ask nurses for clarification of who exactly was the official client. Bev considered every contact a client and Linda explained that from her perspective marital partners were also her client in terms of ensuring they go for follow-up testing. As Evelyn explained her relationship with Fatima she included the family:

“She’s a mom with two young kids… our conversations are always about family, about the children. And y’know, I do share some parenting aspects with her…. She’s also married and her husband is also having some health difficulties. So at the same time, she would ask questions, not only about her own health status, but also her husband’s health status. So that came up several times through our conversations” (interview, p.1).

There were also negative implications of these networks. For example Louisa encountered a situation of questionable abuse, being then compelled to secretively meet with the client.

“So even though we didn’t have much opportunity to speak on a private basis, I would say things just to even get a minute alone with her… I would say ‘just walk me out to the front door of the building’, just so that we would have 10 or 15 seconds when it would be just her and I... she would have all my attention... I mean, to be in her position where she’s living in somebody else’s house, she’s being told constantly... that she’s not part, that she’s a guest, she’s being taken advantage of, she’s not being allowed to participate in anything extra-curricular at school” (interview, p.12).

There were also situations in which clients’ networks were limited, highlighting social isolation as a concern. Specifically, nurses noted loneliness in their assessment of many client situations (Louisa, Lynette, Evelyn, Paulette, Karen, Linda). For example, I asked Louisa about Luka’s support system. She told me that he had no friends, “he just knows people”, explaining “Luka is a true loner. He doesn’t like people… He’s someone, if he was starving hungry would never say ‘I’m starving hungry’” (observation notes, p.6). Similarly, Karen discovered by asking directly that Ivan had no close friends: “… he said, ‘when I was younger, I always thought it was my friends that I could count on,…‘but now that I’m older and wiser, I realize that you cannot count on your friends. The only people you can really count on is your family in the end.’ And I really felt sad for him. Because I
really felt that he needed a buddy outside of his brother, because his brother he can only take in small doses” (interview, p.13).

The networks also incorporated friends and roommates. Unlike most family situations however, those involving roommates seemed to be problematic in terms of nurses’ engagement with these people, bringing protection of privacy into sharper focus. This was made apparent in visits with Leslie and Akello who had a roommate:

His roommate walks past in the bedroom hallway wearing only a small towel, nods in our direction and says good morning. Leslie quickly introduces me as the roommate keeps walking past. He stops briefly and nods in my direction again and keeps going (observation notes, p. 2)… After the visit Leslie comments, “how did you like the roommate, eh?” We both laugh. “I’ve only ever seen him like that, but that’s part of this job I guess” (p.3).

“Sometimes his roommate is playing loud music and tends to walk around with just a towel on. Uh, was that getting too explicit?... [both laugh] So there is always that challenge… He’s part of the place and sometimes he would be sitting at the table having his breakfast, while we had our interview… I didn’t do it in front of the roommate but the next time I came in I said, ‘you know, I felt a little awkward because I don’t know what your relationship is, if it’s ok to ask you about your TB and your other health problems.’ ‘Oh, yeah, fine.’”(Leslie, interview, p.7).

There were also networks of collegial relationships with doctors and other service providers, as well as within the TB program, most often between case management and DOT colleagues. This primarily involved liaising and sharing information to ensure accuracy of treatment and proper reporting. I watched as Louisa discussed Luka’s doctor’s appointment with him. This was not a quick reminder statement but rather a whole conversation about why bloodwork was needed before the appointment, the special arrangement for where it could be drawn, the time of the appointment and how he was planning to get there (observation notes, p.4). This along with an example from Bev highlights the interdependence in professional networks for ensuring treatment:

“with one of the girls, her x-ray changed from one visit to the next visit, so the best test is the CT, because it gives them a clearer image of what’s going on… She and her mother were to go, but they didn’t want to go because they’d been exposed to too much radiation with all these x-rays… So. Finally, because the nurse practitioner there had a photo, and she’s very – she’s not
there anymore which is a tragedy – good with people. Good at explaining and reassuring, and calm, y’know, with all of the others that nobody else has patience for” (interview, p.4.)

There were, as may be expected, also frustrations of miscommunication in these networks as described in the next example:

“The doctor down there is a very caring, kind person. And he spends a lot of time with them and educates them. So you’ll be there, and then the next [doctor’s ]visit, you don’t go for some reason,… she goes on and on to him… she doesn’t want the nurse coming every day. He wants us doing this DOPT five days a week, but if he gets pressured he backs off and says to the mother, but not us, ‘they only need to come twice a week’. So then you get a call saying,… ‘I only want you twice a week. Didn’t he tell you?’ And I say, ‘nope. And he’s gone on vacation for three weeks, so we’ll have to carry on the way it is until he gets back.’ And then we call the nurse practitioner down there, so that maybe we can all talk about this… He can’t fold so easily” (Bev, interview, p.11).

To curb these breakdowns in communications, nurses often explained the network to clients and advocated for them, acting as intermediaries with physicians and investigating gaps in services outside of TB. I asked Leslie about a joke she and Akello shared about his difficulties in communicating with his doctor. Leslie responded casually, “oh, yeah… she doesn’t surprise me; you just have to manage her”, and telling me that much of nurses’ relationship work is just clarifying doctors’ comments for patients, “translating things for them”. “Can you imagine having to try to understand all these systems and the treatment?” (observation notes, p.5).

Lynette talked about visiting TB clinics with her clients to advocate “in terms of ‘ok now what’s going to be happening?’” (interview, p.11).

This extended to other service providers. For example, when Louisa began working with Jose she discovered in his file that his disability income was managed by the Public Guardian & Trustee (PG&T). Boarding home rent was paid but he did not receive any direct cash. By inquiring with the PG&T, Louisa discovered there was “a pot of money sitting there” but because directions were never received, nothing was done. Louisa explained this to Jose and
subsequently I observed as Louisa helped him open a bank account and arrange weekly deposits from the PG&T (obs notes, p.1).

The advocacy described in each example was not an explicit expectation of these nurses. Translating medical information and softening doctors’ demeanour, or attending clients’ appointments with them, or arranging finances does not appear in job descriptions and yet were integral to relational work of all nurses in the study. These many invisible aspects of working with other professionals highlight another dimension of relationship networks; that is, DOT nurses and case managers worked together to meet clients’ needs and also learned from each other as team members, drawing support from each other in an otherwise solitary job.

“Since I’ve started this, I’ve tried to listen to what the other nurses do… we shadowed each other initially… and I tried to watch what they did and how they did it and what they said, and take what I learned from there, from their relationships and how they conducted themselves and how I am, how my personality is, and just incorporate all of those things” (Lynette, interview, p.12).

The roles of case management and DOT teams were often blurred in the actual visiting, and this blurring highlights the importance of communication between nurses across the teams.

“I didn’t do a joint home visit with the case manager. I was meeting him, sort of like, a ‘cold visit’ I call it. So, I was hoping that he’d meet me at the [coffee shop]. Me: So… the first time you meet someone, it’s a joint visit? Karen: Yes, yes. And I always push for that, because I feel it’s a really good hand-off between the case manager,… them seeing the role between me and them, because if they don’t, I end up doing all of the case management stuff as well. Because they don’t understand that, I’m not taking over for this person … we do have overlapping, but if we don’t do that joint visit, sometimes they just see that I’m exactly what they were, and then more… And they don’t rely on the case manager at all. They won’t call her, they won’t ever bring up any issues. Everything falls on my lap. Me: So Ivan never did meet you in [coffee shop]? Karen: No, and I would have liked that, just to get a feel for him first…. the other case managers, I find, will say, ‘when you go in, sit here, and I wouldn’t say this’, you know? They kind of give you the little in’s-and-out’s. Me: Like tips almost? Karen: Yeah. Like, ‘when you get to the lobby,… they have a cell phone, so you won’t be able to get in’, things like that, and then they’d think you’re late for your first visit, and you’ll feel like you’re starting off on the wrong foot” (Karen, interview, pp.9-10).

Finally, there was a group of people in the network made up of others whom nurses encounter in their daily situations. They were people who do not neatly fit into a category, but
were indeed part of the everyday of TB care. They were building superintendents, maintenance/cleaning staff, housing workers, and boarding home staff, all of whom were important for practically assisting the nurse to get to the client, but also those with whom the concern for protecting privacy was heightened. These were people who at times were curious about the nurses’ regular visits, yet had no personal connection to the client and therefore, nurses were careful not to share identifying information about themselves or the people they visited.

In summary, the authority of the state, the diversity of places and spaces, and the everyday and long-term nature of treatment, as well as the networks of relationships come together in particular ways to form the backdrop of relational work in TB. What shows up as meaningful in these relationships is a collection of experiences set within a relatively long time frame, over many visits, and in specific geographical locations, private and public spaces, and all structured to some extent by the institutional mandate of Public Health. These experiences are informed at the same time by each person’s previous experiences and understandings of TB, nursing, and broader social ways of relating in such contexts. Understanding how this came together in the lived relations between TB nurses and clients in this study is represented in the notion of welcome intrusions.

**Welcome Intrusions**

To intrude, according to dictionary definitions, is “to thrust oneself in without invitation, permission, or welcome” (Merriam-Webster online); or “to go into a place or situation in which you are not wanted or not expected to be” (Cambridge online). These definitions are good starting points for understanding the intrusion referred to in this study. Public health nurses are thrust into clients’ lives generally for the purpose of medical surveillance. They enter into situations where they are not, at least initially, expected or wanted, and their presence is an often
uninvited interruption of daily routines. Though the word intrusion was directly used by only three nurses (Leslie, Lynette, Evelyn), related ideas were expressed by several participants (“over-stepping” (Linda), “being a hindrance” (Karen, Lynette), “scaring away” (Paulette)). Welcome, on the other hand, is defined as “to greet hospitably and with courtesy or cordiality”; or “to accept with pleasure the occurrence or presence of” (Merriam-Webster, online), and this was equally visible in the visits. Welcome and intrusion were implicit in behaviours being communicated verbally and nonverbally between participants, and in reflective statements that called these notions to awareness as a kind of choice: “Will I welcome this nurse or not?”; “How can I lessen my intrusion in this client’s life?”

Tuberculosis is the first intrusion in terms of its effects aside from the physiological ones like coughing and pain: missed days of work, loss of employment, and disruptions in social relationships and normal routines. Related to this is the intrusion of Public Health and its authority over individual lives in matters of contagious disease. The intrusion also shows itself in the nurse’s immediate presence, which is the pivotal point in relational work. While the microscopic bacteria and the faceless ‘they’ of the public health department might be easily understood as the intrusion, individual nurses carry out the intruding in actual face-to-face encounters. Intrusion holds the meanings of surveillance – control and limits on freedom and autonomy, the foundational element of the job that nurses openly wrestled with in all interviews. Surveillance as a mandate of the role ascribed to TB nurses implies a power over clients that nurses uneasily acknowledged as needing to be exercised:

That’s part of my job. On the one hand, I’m setting up all these things, helping him out. But on the other hand, he knows that I’m kind of the bad guy. In that, ‘if you don’t comply with this, this is what’s going to happen’, that sort of thing. Anyway, it can be difficult. So, I don’t necessarily want to be perceived as the bad guy… it’s much easier to be the person who’s helping and that sort of thing. But that’s just part of our job, so…” (Rosalee, interview, p.2).
“You go in knowing that they’re not happy with having to do this. Even knowing that they’re unhappy that they have TB,… this is all an intrusion… versus when they come into a clinical setting. Because when they’re there, they brought themselves there and they’re seeking help versus this is being forced on them. So after you get over the initial stuff, where you say, ‘hey, I’m really a nice person here’, and you know, ‘don’t shoot the messenger, it’s my job, and we can work around’, … that’s when you start to maintain the relationship… you really have to be cautious when you go in. And that’s a very different role from most nurses” (Leslie, interview, p.16).

As explained, Sections 22 and 35 of the HPPA are the legal means of enforcing isolation. The execution of this law is perhaps the clearest example of intrusion as infringement on personal freedom. One set of observations involved a DOT nurse who continued to visit a client while he was being held in hospital under a Section 35. In one visit, the nurse’s concern for protecting both his health and the public was contrasted with his frustration related to the intrusion on his freedom that hospitalization represented.

Elijah says he just wants to go out once in a while, “three times a week from 9 in the morning til 5 or something”. Louisa asks him what he would do in that time and he responds with various ideas including a strip bar and casino, “even if they want a guard to come with me….” Louisa reminds him that he has been in trouble with his drinking in the past, and that the hospital is concerned about treating the TB. She reminds him that the TB drugs he is now taking are “the last ones they can use and if they don’t work it won’t be good”. He seems not to hear this concern about the disease itself, and focuses again on being “in jail”… He says “Public Health doesn’t understand that. The hospital and Public Health don’t care. They don’t understand how hard it is to be in here so long. They have to let me out.” Louisa: “I don’t have power over that” (observation notes, pp. 3-4).

The statement ‘I don’t have power’ seems to reveal Louisa’s distancing of herself from the intrusion he felt in being restricted from his usual activities, yet her calm reminders about TB treatment and past troubles are examples of her explanation of the need for this intrusion. Interestingly, this client shared that Louisa is a “good nurse” whom he likes and he did not think of her as part of Public Health. When the intrusion is at the forefront of awareness, the nurse does more explaining and negotiating possibly in effort to minimize the associated negative feelings. But over time and through regular daily involvement, the intrusion fades to background,
and what was experienced as intrusive visits by a public health official shift to non-intrusive and even welcomed meetings with a familiar nurse who feels more like a friend or one of the family. ‘Welcome’, as part of the overarching theme, represents this shift in relationships, seen in this study as something that simply happened often without particular reflection. Working on the assumption of being an intrusion, nurses behaved in ways that seemed aimed at not intruding. Lynette, a DOT nurse, made sense of this tension in the following way, demonstrating both awareness of her authority and desire to reframe it as helpful:

“I know we have the public health enforcement behind us but I don’t feel that… I mean, as a case manager, you have to get all the contacts… I would say the case manager has more sort of enforcing things. I know we’re there to make sure that they take their medication and that’s a type of enforcement, but I don’t look at it that way, I [see it] more as encouragement” (interview, pp.15-16).

Similarly, as Leslie explained her perception of her client’s feelings about their relationship, she imagined what the intrusion feels like, and out of this, a discomfort with her surveillance role.

“I wasn’t at that part where they say, ‘you will be having someone come in daily to watch you take your pills’. And I’m sure every person must resist that. Because it is such an intrusion on their normal autonomy, right? … I think he realizes this is something that goes along with TB and having to follow the rules” (interview, p.6). “…and maybe I reflect my own thoughts about this… there are days when I don’t put my kitchen dishes away and clean up the place. Ha! There are days when I clean, alright? But, if you have people come into your house every day, that’s an intrusion. You have to have your house neat enough. You have to be dressed, you can’t be in your jammies, and all sorts of stuff” (p.9).

Leslie’s ability to imagine what it feels like to be the client was picked up by her client, Akello. In a separate interview, he talked about Leslie’s ability to “walk in my shoes” and identified the importance of such an affective relational experience as part of minimizing Public Health’s control over his life:

“But if somebody is like, where the relationship is ok, first of all, upstairs [points at head], you will be relieved. You will be ok. You will feel better and you feel normal. So, her coming in is
not like, ‘oh, ah, *again* they have come’. You feel like, ‘Oh! Again they have come!’ (smiling) It will become a normal thing’” (interview, p.6).

Imagining what it’s like to be under surveillance and experiencing the discomfort of their surveillance role fuel nurses’ efforts not to intrude. Such efforts were aimed at being accepted. “I’m always ambivalent that I won’t be accepted. That they won’t want the intrusion of having someone come into their home. Because it is, it is an intrusion into their privacy… And, maybe there’ll be something about me that for some reason they won’t want to have me come in. So, I’m always happy when I’m past that part [and] I feel they’ve accepted me” (Lynette, interview, p.3).

Lynette’s comment demonstrates her reflection on being accepted generally. By contrast Paulette, expressed her sense of not being accepted after a visit with Daren. In the elevator she told me, “Daren doesn’t really want me there at all. He’s polite about it but it’s like ‘oh Paulette you can go now’…” When I asked if it bothered her, she told me it was “just an observation”. It is “part of the job to read things like this” and recognize that nurses have to be there even when they know people don’t want them there. She did not think it really had anything to do with whether he’s a nice person and she couldn’t “blame him” (observation notes, p.9). In this she emphasized her desire to be accepted even though she knew it was not always possible.

There was a flow in being an intrusion and being welcomed that changed visit to visit and over the course of the whole relationship. Sometimes there was more ‘intruding’ than ‘welcoming’, and at other times, there was more ‘welcoming’ than ‘intruding’. This seemed to give rise to tensions that may be understood relationally (how do nurse and client pragmatically get along with each other?) and morally (what is the ‘right’ way to get along?; is this a ‘good’ relationship?). These are tensions of power, proximity, and formality. Power here refers to how authority is exercised by nurses and clients in particular situations. Proximity is a spatial term that captures the closeness and distance between people in every encounter. It refers to physical nearness to each other, as well as a felt nearness that comes through hearing personal stories
without prying for more information. Formality refers to the overall tone of the exchanges between nurse and client. There were encounters observed in which the nurse seemed more strict and vigilant in directives related to treatment. And at other times, a casual and relaxed manner was seen that resembled something more like friends chatting. The formal-informal tone was also influenced by nurses’ choices of whether to accept or refuse things that clients offered to them, which poignantly exemplified the tensions of welcoming and intruding.

Organizational policy clearly states that employees may not accept gifts from clients and certainly the College of Nurses of Ontario (2006) standard on boundaries in therapeutic relationships supports this. However, nurses accepted things from clients all the time, mostly in the form of food and drink, but also in the form of small gifts. My own experiences as researcher reflected this. For example, Ivan prepared tea in the kitchen as I prepared for our interview. How could I refuse it when he brought it to me? Why would I refuse it? It was moments like this that attuned me to watching how nurses handled these situations. Offers of food and drink were common in most visits and in nurses’ stories, and there seemed to be an unspoken understanding that accepting these things was not a breach of the policy. To accept things was at times a formal gesture and at others a completely informal part of ordinary exchanges. Two experiences with Evelyn demonstrate the tension of formally guarding against being rude and informally or personally enjoying what is offered.

Alicia offers us breakfast and asks if we can stay. Evelyn thanks her and declines, saying we don’t have time. As we put on our shoes, Alicia shows us the roti she is making in a pan and asks if we want to see how it is done at the same time she begins demonstrating. We stand in the kitchen doorway, and Evelyn says she would like to spend a whole day with Alicia learning how to cook. Alicia laughs. After the visit, Evelyn tells me that she eats with them sometimes; that she may have even stayed today if she was alone. She tells me that she has eaten breakfast with other clients too. “Sometimes I just know it would be rude to refuse… [she laughs] and it’s good food; I get well-fed.” (observation notes, p.4)
Raj goes into the kitchen, sticks his head out the doorway briefly and asks if we would like tea. From our seat in the living room, Evelyn asks him (shouts for him to hear) if he’s making breakfast; he nods and smiles, and quickly glances at me. He asks again, “tea?” Evelyn and I look at each other, she nods and then we both accept the offer. Raj gives a quick nod and disappears into the kitchen again…. He comes back bringing two small ornate glass tea cups with little saucers and spoons. He gets the bowl of sugar from the cluttered dining table… brings it to us, holding it out for us to take some. First watching us taste it, he then goes back to the kitchen to get his breakfast… as he eats and we sip tea, the visit turns to how he’s feeling. After the visit I comment on how he served us the tea (not his usual manner); Evelyn nods and laughs (observation notes, pp.3-4).

While offers of tea and breakfast do not necessarily mean the client is welcoming the nurse, as it may simply be a cultural practice done out of habit, the offer of a gift may be a clearer sign of welcome feelings. However, while gift-giving perhaps holds welcoming meanings for clients, gift-receiving may feel intrusive for nurses since gifts are neither expected nor invited, and in fact the organizational policy forbids it. It seems clear to simply say no to gifts but the immediate encounters between nurses and clients where offers of gifts are made raise a range of feelings for both, and decisions for the nurse about what to do. While gifts are sometimes refused for a variety of reasons, and often in the interest of the ‘no gifts’ rule, small gifts are often accepted in the interest of the relationship and acknowledging the feelings that the gift represents. The ‘no gifts’ policy creates a moral tension in terms of judging if, when, and how bending this rule might be a good thing to do.

It seemed that clients in this study wanted to give things to nurses whom they had known for a long time largely out of a sense of gratitude. As Rosalee indicated, clients may not often give nurses positive feedback verbally, but try to show appreciation through gifts: “… lots of clients will try to give you little gifts or whatever, but I don’t know that anyone’s ever given very specific feedback” (interview, p.19). While she did not explicitly say if she has ever accepted any of these little gifts, Rosalee’s comment reveals that these offers may often be behavioural expressions of how clients’ feel toward the nurses who have helped them, which has implications
for their relationship. Offers of small gifts to two nurses were witnessed and provide example of contrasting interpretation of policy. While each nurse’s response was different, the tensions felt were similar. The first situation arose in a DOT visit during the week of Valentine’s Day.

Ahmed leans forward… taking a red gift bag out of the plastic bag he’s been holding, and sets it on the desk. As Louisa sits down he points to it. She simply says, “Oh, Ahmed” keeping her hands folded in her lap, not touching it but looking at him… They move to another subject and the gift bag just sits there on the desk between them… [Near end of the visit] Louisa asks him to come back on Monday because she would like to check on his other health problems and appointments. He just smiles and pushes the red bag in Louisa’s direction. She says ‘oh Ahmed’ again, as she finally opens the bag – it’s a box of chocolates. She says “Thank you Ahmed. I will share them with all the staff in the office. But please, Ahmed, no more gifts” (observation notes, p.2).

Louisa expressed both the rule and how she was bending it, stating that the chocolates would be shared, reminding him that she works as part of a team, and he seemed satisfied with this. By contrast, the next situation highlights the discomfort for both people when the policy was strictly followed. In the final visit, after many months of treatment, Linda and Aliya were saying goodbye.

Leaning against the kitchen counter, Aliya takes the pills, and Linda tells her that she needs to collect all of the leftover pills. Aliya nods and goes down the hallway leading to the bedrooms, disappears into one room and then another. She returns and hands a few pill bottles to Linda, who puts them in her bag immediately. I can see that Aliya is also holding a bag from a women’s clothing store, which she then holds out in Linda’s direction as they stand quite close to one another… Linda’s back is slightly blocking my view, but I can hear Aliya say ‘thank you for everything’. Linda gently touches the hand that is holding the bag. I can see her shaking her head no. Aliya insists that Linda take the gift, that her mother-in-law bought it especially for her “to say thank you”. Linda now clasps her hands in front of her and thanks Aliya for her “thoughtfulness”. Linda says she “really appreciates” it, but “it’s against policy for me to accept gifts.” There is a long silence and the two are looking at one another. The initial smile on Aliya’s face when she came out seems strained now, more like a grimace. Linda: “I can’t accept. And I want to thank you. You are a very good client.” She gently strokes Aliya’s arm. They are looking directly at one another. This exchange of ‘please take it’ and ‘I can’t accept’ goes back and forth a few more times. Aliya persists: “Accept it as a friend. I give it to you as a friend, not a nurse.” She pushes it into Linda’s hands but Linda does not hold onto it. Linda says more about how much she enjoyed getting to know Aliya and her family… She again says she cannot accept gifts as a nurse. Aliya: “Well, if I come to your office next week, when you are not my nurse anymore, you have to accept it as a friend.” They both laugh, but Linda does not reply. They stand there in silence. Aliya’s smile eventually fades. Linda gives Aliya a little hug and thanks
her for the thought of the gift. More silence. Linda then takes a few steps back and turns toward me. She says that we will get going… As we move toward the door, Aliya leans and holds Linda’s shoulders. Looking into her face, she thanks her again “for everything” and wishes her well. I notice that Aliya is barely smiling. After the visit I ask Linda, “how was that for you?” She looks at me for a moment. Then she shrugs a bit and smiles. “It’s hard to say goodbye. These clients, we know them for a long time. We see them get better.” I ask about the gift specifically. Linda tells me that it’s difficult to refuse, “but we have no choice”; that this is a difficult part of the job (observation notes, pp.6-7).

Linda raised this situation again in her interview and told me, “I knew she appreciated my job, right? What I have done for her, she appreciated that, but at the same time, I just can’t… And actually she’s not the first client… I have experienced this so many times” (p.17).

A final important yet challenging point is that the relational and moral tensions of welcome intrusions must not be considered from the nurse perspective alone. Rather, experiences and responsibilities of these tensions are shared by client and nurse. Clients too exercise authority, even under surveillance, yet are held accountable for doing so in different ways than nurses, and this bears consideration in relational work. That is, clients who may be strict and distant with nurses are often, as a result of this stance, labelled as ‘difficult’:

Louisa tells me that all she knew about Eyob from hospital staff was that she would be getting a new client who would be discharged on Monday and that he was “demanding and difficult”. She adds, “I knew he was ‘demanding and difficult’ before I knew anything about his TB”. She told me she doesn’t listen to anything hospital staff tells her about the patient except TB information: “I’ll listen to what they tell me about the TB and the treatment. But I don’t listen to anything they tell me about the person, about their personality. Nope. I’ll see that for myself.” She explains that she does this because she has had so many experiences where the judgments about a client were inaccurate or simply wrong (observation notes, p.2).

Evelyn tells me she started working with Raj when she heard about him at a team meeting, and how he “was creating lots of havoc at [hospital]”. Hearing that “he was giving them trouble, I said I wanted him” she tells me, smiling. I repeat this to clarify: she wanted him because he was ‘trouble”? She nods and laughs. I ask her to explain what ‘causing trouble’ meant. “Oh y’know, they just didn’t like him; he was questioning everything; telling them what to do; stuff like that. They don’t like the bad ones, the ones who don’t behave the way they want”. I ask why, if she heard all this about him, she wanted to work with him. “Oh, I said give him to me; I like taking the tough ones”. She laughs and then goes on to tell me that tough ones aren’t really so bad when you get to know them. “It’s all in how you handle it” (observation notes, p.2).
These are people with whom the sense of intrusion may always be in the foreground. Two nurses explained that while these situations offered little opportunity for fuller relationships that may have opened up possibilities for addressing other health/social concerns, nurses could still feel satisfied that the goal of completing TB treatment was accomplished. “If it’s not going to become a friendly relationship… [and] if you still have the same goal, which is the completion of TB treatment, unscathed by side effects, that is what you focus on… So you don’t sit for 15 minutes and chitchat, you still have a kind-of relationship but a narrow focus” (Louisa, interview, p.5).

In this study, I witnessed these ‘kind-of’ relationships, the ones where the intrusion could be felt, as well as those in which intrusion had faded. In all cases, relational work as welcome intrusions came to be understood within three key themes. ‘Getting through the door’ was a regular part of all visits and described in most interviews. It is understood here as a metaphor for addressing the intrusion of surveillance. ‘Doing TB but more than that’ is a phrase that captures the importance of nurses’ knowledge of TB as well as all that which comes together in the word ‘support’. The last theme, ‘beyond a professional’, addresses the ways that nurses are professionally-personally engaged with their clients; their ways of being with people with TB. These key themes are discussed in the remaining sections of the chapter.

**Getting Through the Door**

Getting through the door represents at once the intrusion and the means through which least-intrusive relations could begin. An obvious goal of surveillance is to physically get in and see the person, yet only focusing on surveillance duties once inside may create negative consequences for getting through the door again, to carry out those same duties. All nurses experienced this and therefore had learned to work to avoid it. Karen declared that she felt like “a
TB-police officer” with Ivan, like she didn’t have “that humanistic side” with him, qualifying this by pointing out that sometimes, especially when there are many patients to see, when there is a police-like tone, but that she works to avoid it: “I just feel that they may start to despise me; ‘she’s just this woman, she comes into my home, she sits down for three seconds, I take my pills, and she never asks how I am, and she just leaves’... I want to seem a little bit more friendly” (interview, p.10). Avoiding the policing feeling was also expressed by a case manager, Rosalee: “… whether they see you as helping them or whether they see you as a hindrance to their daily life, or whatever. You might have one client, so thankful because you’re giving them all this information, you’re sending them all the medication… But then you have another client, where you’re doing the exact same thing, but you’ve told that client that he can’t go to work and he needs to remain in isolation and they’re very angry about that. Forget that you’ve given them all that information or whatever… The only thing that they’re going to focus on is the fact that they can’t go to work. And they’re going to worry about getting paid and that sort of thing. So, depends where you go from there… you can try to redeem yourself by helping them… They’ll still be upset. So I find really, that first piece sets the tone immensely” (interview, p.20).

Nurses in the study were aware that how they entered the home held significance in terms of reinforcing the intrusion or diminishing it, speaking of it as “getting through the door” and “what gets you through the door” (Lynette, Bev, Evelyn, Paulette, Rosalee, Leslie), and I observed them all in this regard. They thought of it like this: the quality of the first visit leads to a second visit; a good second visit leads to a third, and so on. Part of the goal of each visit was to be invited back.

“That’s the other thing I love about this job… is that generally once we’re in the door and the client shows an openness to accepting us… we can see it through, we can see them through their treatment” (Lynette, interview, p.15).

“…thing about DOT, when you’re going into somebody’s home and you’re wanting them to do something…to keep themselves healthy, you better have some good interpersonal skills, to first, get through the door, to make the client want to trust you, and for them to believe that the therapy’s going to work, and for them to want you to come every day” (Evelyn, interview, p.17).
From clients’ perspectives, deciding to open the door to the nurse seems to be a way of maintaining their power in the situation, and all nurses have had the experience of knocking on the door and finding no one at home, or hearing noises/voices inside but getting no answer.

“I didn’t hire them… I mean, when you go to the hospital, you go to the hospital, right? I didn’t hire her to come to my home. It’s like the city says, ‘you live in the city, we’re sending her to your home’. Right, well, I’m not sure about that” (Ivan, interview, p.8). “We get along much better than had she’d been somebody who I’d have to repeat everything to… If they had sent me somebody who couldn’t understand me, I would’ve lost my patience and never opened the door” (p.9).

“[If] you don’t create that environment of friendship or, relationship… what I can say?, you are likely to get challenges, because I might even decide to harass you, might even, like, you come, you are knocking on the door, and I don’t open. I feel like, ‘oh god, she has again come. Me: You might not even open the door? Akello: Yeah. Might not even, because I’m fed up. But, now, like Leslie, she always meets my door open. As early as possible, when I get up, I don’t even wait for them to call and then I open, no. The moment is already all the time they are coming, I make the door open” (Akello, interview, pp.1-2).

Getting through the door then is a sign of some level of acceptance or welcome. Tangible items, “incentives”, would get nurses through the door. As stated, Public Health supplies items that assist with practical needs and while in some situations, these things may be understood as incentives to comply with treatment, there were other situations in which giving things to clients and doing things for them would be more accurately understood as outright acts of nursing care irrespective of surveillance motives, offered sincerely out of concern for clients’ health and well-being. Furthermore, I watched nurses bring things that were not within Public Health’s standard supplies, depending on particular situations: an ice pack, a school course catalogue, cigarettes, and even holiday candy for clients to share with family and friends. The nurses also acted as resources themselves by doing things for patients. On occasion, nurses arranged rides and appointments (all), helped with moving (Louisa), shopped for groceries (Louisa, Evelyn, Lynette, Paulette), clarified and helped complete official documents (all), made reminder phone calls to patients, and often made phone calls for patients (Lynette, Louisa, Karen, Leslie).
To a larger extent, it was their respectfulness, trustworthiness, and honesty that seemed to have strong influence. Getting through the door and being inside so that observation could happen was facilitated through respect for privacy, notably the privacy of clients’ life situations and the TB diagnosis. Nurses are obligated to ask certain types of personal questions (general health, symptoms, who else lives in the home, etc.) Yet I was struck by the many questions these nurses did not ask. Respect for privacy was held in the forefront of relating with clients. It seems to convey that the nurse would not intrude further into the client’s life than she already was, as shown in the following examples:

“They sometimes find it is important… I’m not going in to intrude [on] anything, because I respect their privacy. A lot of things, they may not want people to know... Like, for example, the client we visit [looks at me, raises eyebrows], right?... I suspect his wife, maybe she is doing some babysitting for neighbours… Not every day. Maybe just on some occasions. And I’m not sure if she is getting paid or not. But I suspect there is something going on… this is not my job, to find out whether she is working under-the-table” (Linda, interview, pp.14-15).

After the visit: I ask Paulette if she knows where Kali works or what kind of work she does. Paulette tells me she doesn’t know – she shrugs and stares off as if thinking for a moment. “I try not to ask about things. Y’know, unless the client shares that.” She tells me that she’ll have to ask Kali where to meet her when she goes back to work, and then she may learn that piece of information… Paulette tells me that though there are many times when she would like to ask questions because clients live in such “interesting situations”, she sees it as a boundary issue. She tells me clearly that she cannot ask about clients’ lives “just because I’m curious”. She tries to focus on the TB, if other things come up, she would “certainly” do anything she can to help them, but she feels strongly that it is not her role to start asking about other things in the person’s life “especially if I can’t do anything about it anyway. Like stuff a social worker would do” (observation notes, p.8).

It is important to understand that respecting privacy is not an all-or-nothing notion of either respecting complete privacy or having no regard for it at all. At times, nurses needed to enquire into clients’ situations, push a little into their privacy as their job demanded, especially in terms of contact-tracing. However, when personal information about clients’ lives was revealed, especially regarding situations not directly related to TB, nurses navigated how far to go with their questions. One visit with Evelyn offers an example of this during which I was aware that
someone else was in the small apartment, yet neither Evelyn nor Farah acknowledged this. I asked Evelyn about it after leaving the visit, and her response reflected her attention to not intruding beyond what she had already done.

I can hear whispers and laughter in the next room, the door is open slightly and I can see that a small TV is on in the corner of that room… After the visit: I ask Evelyn if there was someone else in the apartment, and Evelyn tells me about Farah’s 17 year old son. She says “oh yeah… he’s been there in other visits too, I’m sure, but today I could hear his girlfriend with him.” She says, “there are problems there”, but that there was not much she felt she could do. She mentions that he is not finished high school, does not have job and refuses to work. I ask how he spends his time. Evelyn says she doesn’t know, and “it’s not a good situation, I know it stresses Farah out, but….” She tells me that she has made queries with Farah before, and she did give Farah some ‘youth services’ information, but she doesn’t think anything happened with that. Farah hardly mentions her son, doesn’t ask for help with him, so Evelyn doesn’t probe more (observation notes, p.6).

Meanings of privacy were also set within cultural contexts and therefore respecting privacy involved conscious consideration of these meanings. Evelyn shared an example of talking with devout Muslim women about their need to consult with husbands on all decisions because wives belonged to their husbands. When I questioned her about her expressed disagreement with this idea, she explained her belief that it is possible to respect a person’s private life without necessarily endorsing it, and to have a “good discussion” without intruding on their personal choices, which she has done on this particular subject (Evelyn, interview, p.12).

In another example, Leslie seemed to put great emphasis on not asking questions despite curiosity, and though this was not an explicit discussion of cultural practices, she was aware of cultural influences in this situation, which led her to decide that asking questions would be “nosey”. This client immigrated to Canada, for reasons not shared, and left his wife and family in his home country.

“We have talked about his wife at home, but not enough. I don’t want to ask those kinds of questions where I think I’m being nosey… If he brings it up and we start talking about it, I’ll say
how tough it is to be here when his family is there… just to acknowledge how difficult it is. Me: Why don’t you want to ask those questions? Leslie: Oh, because I don’t want to say, ‘how’s your wife managing at home without you? I’d be mad as heck that you’re here.’ [laughs]… but then I think to myself, well it’s a different culture, and maybe it’s that the extended family is much more supportive and that she really isn’t alone. So I can’t come out and say,… ‘isn’t she disappointed you’re not there?’, because it’s not the same, it’s a different culture, right?…, if he doesn’t want to go that route, then it’s his lead” (interview, p.10).

Interestingly, while Leslie expressed a conscious concern for ‘not asking those kinds of questions’, she in fact indirectly shares details about Akello’s family throughout the interview, indicating that she has learned a great deal about him, his wife and his family over the course of their relationship. Furthermore, in his interview, Akello shared that he appreciated her questions about his family which showed her care for him, an important part of why he continued to welcome her in his home. Here a tension in respecting privacy is revealed. When does enquiring about non-TB issues become an intrusion and when does it express concern? How many personal questions are too many?

Respect extended to people’s schedules as part of getting through the door. This was demonstrated in keeping appointments, being punctual, and being flexible with schedule changes (Ivan, Kwame, Kali, Akello, Afua). Particularly for clients who did not feel well and even for those in isolation, respecting time was a significant part of not intruding further than necessary. Punctuality in keeping appointments was a reflection of the nurse’s respect for this person’s life situations beyond TB treatment. For Akello, time-keeping was very important, which he attributed to his up-bringing “back home”: “So if you’re telling me… you are coming here at nine-thirty and you come at nine-forty-five, that’s already disgrace to me. I don’t like it” (interview, p.5). Kali explained that she liked Paulette partly for her politeness with regard to being on time: “… if there is a delay, or like something new, she always, always call me to let me know. Maybe she will be late, maybe she will be early. If she be early, she will ask me
permission; ‘Is it, can I come early?’ I like this… And if she came late… she always say, ‘excuse me, I’m late’” (interview, p.2).

Mutual flexibility in scheduling seemed to reflect the shifting nature of welcome intrusions, as it required negotiation on the part of both nurse and client, each feeling the challenge of welcoming schedule changes yet feeling imposed upon by them. Clients had busy lives and nurses acknowledged this by accommodating them whenever possible. For example, Louisa described her communication with new clients:

“I always say, ‘I realize this is a big inconvenience, and it’s a big adjustment that you have to make… for you to make time for me to come and see you every day. And I’m going to try to work around your schedule as much as I can, and where you want to meet. If you call me in the morning and say, we’re going to meet at this place today, that’s fine with me’… it has to be that way. I don’t think we should be forcing people… ‘you have to be here at 2 o’clock because that time is good for me’. I think there has to be a negotiation” (interview, p.6).

However, accommodating immediate schedule changes took effort. For example, Paulette’s visits with a family had been challenging to schedule since the client was a baby whose nap and feeding times had to be considered. While aiming to respect this, over the course of the observed visits I could sense Paulette’s exasperation as she negotiated time in her already-planned workday:

Paulette gives a heavy sigh as we wait for the elevator. I ask her if she is frustrated because she seems so. She answers, “He always does this, and I tell them all the time to call. They never call me… Even when I’m right on time, ‘oh Paulette, I had to…”’. She goes on to say that they either feed [baby] before Paulette comes or put her to sleep, even though she asks them specifically to just hold off, and that if she is running late she will always call ahead (observation notes, p.7).

On one of the last days before this family was moving to another region (and therefore another public health department) we arrived for the visit to discover that the child had been fed and was sleeping. Paulette stood in silence just inside the door after hearing this news, as if thinking what to do next. Looking at her watch, she began a series of question-and-answers:
how good is she at getting back to sleep?” Daren: “not so good.”; “what if I come early
tomorrow?” Daren: “I don’t know. You know babies. She’s unpredictable”. From my notes,
This is a day that Paulette has 10 clients to see. She has told me in an earlier visit that she is
feeling grumpy today and that she doesn’t have much room for late or changing appointments. I
wonder how she is going to handle this situation... She then says, “So if I try to come in earlier,
and it seems better, then you can tell the new nurse to come at 10. It won’t be so disruptive for
[baby].” Daren: “Ok, we can try it.”... Paulette sits down, takes out her day-timer and talks out
loud about her schedule. She says that she will switch the client that she sees at 10, makes a note
in her book, closes it and puts it back in her bag... (observation notes, p.10).

Finally, getting through the door included respect for clients’ places. Respecting clients’
homes showed respect for clients themselves, and this was evidenced through taking off shoes,
waiting to be shown where to sit, and even continuing in distracting conditions such as cooking,
answering telephones, watering plants, and the many loud televisions and stereos. Culture
factored into nurses’ awareness of respecting place. Muslim clients were most often referenced
as example:

“Whenever I enter a Muslim’s house, I say ‘Salem malekum’ and that’s their greeting. And then
they know, ‘this girl knows about our religion, she knows how to greet us’. And... I’m careful,
depending on how strict they are, I wouldn’t wear shorts. I wouldn’t wear a short skirt. I
wouldn’t wear that stuff. And you always take your shoes off when you go in the home because
that’s a big thing too. And I know that, and they see me remove my shoes, whatever. So I think
it’s your first impression at the door, is so important” (Evelyn, interview, p.19).

Respect for privacy, time, and place allowed nurses through the door. As clients felt
respected, trust also developed. Likewise for nurses:

“I think it’s a trust thing. Because I’m going into their house, they’re not coming to my office.
I’m on their territory. What makes a relationship work is based on trust because once a patient
trusts you, they take your advice... I’m in their home and their trusting me with being in their
home. And also... I’m trusting them, being in their home” (Karen, interview, p.4).

Trust evolved slowly over the range of each course of treatment. In clinical situations
where clients typically seek the help of a nurse (including other public health programs) and
welcome their presence from the start there may be a sense of implicit trust that clients have
toward nurses as care-givers and nurses may intervene with the assumption of such. In the TB program however, trust is not assumed as something so easily bestowed, considering the surveillance aspect of the nurses’ role. Though trust was certainly cited as a vital part of relational work, it was not expressed as a given in all relationships. Neither nurses nor clients assumed that getting in the door once automatically meant getting in the door again. Getting through the door involved less conscious effort over time only in situations where trust was growing. Notably, four nurses (Lynette, Paulette, Evelyn, Leslie) told me that they had other clients who would be “great for the study” but with whom trust felt tenuous and they did not want to jeopardize the connection they were cultivating.

The notion of trust emerged in the data as being closely tied to honesty. Several nurses explained, because TB is a reportable disease, clients are required to identify all others who may have had contact with them while they were infectious. This disclosure often has social implications for clients, meaning they were concerned that sharing this information would have repercussions in other areas of their lives. In short, clients often lied to nurses unless and until they trusted them:

“They’ll lie about who lives in the home, how many contacts they may have. They don’t trust you, so they feel they can’t give you that information without ruining their relationships with those people they may have had contacts with. Because I’ve had people come out of the closet at the end of visits and say to me, ‘uh, I’ve lived here all along and I was afraid to tell you’” (Karen, interview, p.5).

“Sometimes… you build a relationship with your clients and they’re hiding, y’know, their second or third cousin in the closet, and they finally come clean after four or five months, like, ‘oh yeah, this is Jose’. Well they’re going to be a little… reluctant to have a DOT nurse that they don’t know come in because they’ll have to hide him again. A lot of the time that will happen where eventually, it’s like ‘ok, who’s that guy, I haven’t seen him before’ by accident or whatever” (Paulette, interview, p.5).

Related to this, Bev highlighted the complication of trusting for some clients in light of Public Health as a government institution. Specifically, she pointed out the situations involving
refugees. “People come from places of war. Well, I’m the government, and their government was corrupt. So I can say, ‘oh you can trust me’. And they do not feel that way” (interview, p.19).

However, while the sense of intrusion by Public Health as authority may never go away, over time most clients develop some sense of trust in individual nurses, and intrusion fades into the familiarity of the relationship. This comes about because weaved into nurses’ respectfulness and trustworthiness was honesty – in an interestingly secretive way.

All nurses talked about honesty as an important element of getting through the door. Specifically, it was important to be honest about the program (and its intrusive nature) and their role in surveillance. Several nurses’ interpretations of honesty about the program were set in a broader conversation of honesty as a way of being a nurse, a colleague, and a person.

“You have to be a very honest person to have a good relationship with somebody. Whether… it’s a colleague, or it’s a patient that you’re caring for, I think that you have to be very honest and up-front because I think that’s one thing that’s very easy for people to read. Me: How do they read it in you as a nurse? Paulette: Well, it’s specific to what we do. So… when a patient enquires about ‘why do you have to come to watch me swallow pills? I’m not six’, I’m very quick to say, ‘I don’t blame you, I know it sounds silly, but give me five minutes to explain that there’s a heck of a lot more than just that’… it starts with honesty… that’s how you build a good working relationship with somebody, and I think that patients pick up on that very quickly” (Paulette, interview, p.16).

For Leslie, saying one has respect and trust is not enough; it has to be conveyed to clients, notably through honesty, to have any positive effect in the relationship:

“Not that you have respect, but that they understand you’re sincere or honest or trustworthy… you truly have to be trustworthy! And honest. Y’know, do what you say you’re going to do. Be there when you say you’re going to be there” (interview, p.14).

Honesty was also seen in nurses’ clarity with clients regarding what they could and could not do, and what they did and did not know (Louisa, Lynette, Paulette, Karen, Leslie). For example, I witnessed Lynette’s honesty in a visit with Akiki. In reviewing official looking papers that Akiki passed to her when we arrived, Lynette told the client that she wasn’t sure what they
were, mentioning also that she thought they may relate to ODSP and adding, “I need to learn more about that, about applying” (observation notes, p.2). And, Louisa explained, “my clients know that I will be honest with them and as clear as I can be. They know that if they are in a bind, I will see if I can find some way to at least lift the pressure for a while” (interview, p.10).

While both examples indicate honesty about what they knew or could do, they also show that honesty connected with cultivating trust. Both these nurses were quick to follow up with clients, keeping them informed of phone calls made, people consulted, and other services explored for missing information. Their actions matched what they said they would do, the important aspect of respect and trust that Leslie identified above.

This notion of honesty was not neatly expressed as a fixed state of being either honest or dishonest. Nurses seemed to decide how honest to be at a given moment, with a particular person. Beyond the respect for privacy described earlier, protecting privacy blurred the distinctions between honesty and dishonesty. For example, Louisa reflected on her approach to relationships:

“My style is always very straightforward and matter-of-fact. Now depending on the client, I may withhold on that a little bit because I know how they’re going to react and I know it’s not going to get me anywhere. The message is not going to get in and it’s just going to be a wall created” (interview, p.4).

In some situations, honesty-dishonesty was also necessarily blurred in dealing with people who were not the client. Nurses were compelled to become evasive and even secretive at times:

“… people say, ‘well, why are you meeting this person in the parking lot?’ And then you kind of tell little white lies. One client introduced me as a nurse he met in the hospital because they knew he’d been sick in hospital the year before, and that we had struck up a friendship… So then you kind of go with the flow… and then if people stop you in the apartment where you come every day, ‘why are you coming?’ then it’s just, it’s your friend… You have to be careful. People, wherever you’re going, are identifying you as somebody regular” (Leslie, interview, p.9).
As evidenced in the last quote, honesty takes a twist when caught in situations that call for the protection of privacy yet also demand a response. That is, withholding certain truths about oneself or the purpose of the visit is a way of protecting clients’ privacy. Louisa shared an example of keeping TB treatment a secret within a family that highlights serious possible implications:

“I had a situation where… in the house there was the grandmother, the daughter, the son-in-law, the baby…The grandmother had TB, but we can’t let the son-in-law know because he will kick her out. So I had to go in and give prophylaxis to the baby and on the sly, secretly DOT the grandmother. And the father was always pumping me for information about ‘who is it that has TB’… because they received a letter saying ‘you’ve been in contact and you need to be tested’ etcetera. So, ‘who is it?’ I mean he was calling everybody in the health department trying to find out who it was. And she…got through her TB treatment without him ever knowing… they were very frightened that he was going to know because it could have repercussions even on mom. Me: Even to that extreme where she would be kicked out? Louisa: Oh, yes, the grandmother would be kicked out and the wife probably beaten because she knew… So I had to assure them that I could carry this off without him knowing, y’know. And they were terrified. But after the first visit or two they just settled right down, because they saw I wasn’t going to spill any beans” (interview, pp.7-8).

In describing her visits with Ivan, Karen demonstrated her awareness of his need for privacy, which also extended to other health information, in the presence of a roommate as well as family:

“He actually did live in another apartment before… that was a different set-up there because there was a roommate. And the roommate was always there and I was wearing a mask and the patient was wearing a mask, so it made a really awkward situation for the patient. And I feel that… would have been a bigger hindrance, because I think he likes his solitude… And also, keeping in mind his dad was there during the visits and his dad is not aware of his HIV status” (interview, p.6).

Protecting privacy was also understood as the telling of ‘little white lies’ or simply not answering questions directed to them. This was particularly the case in situations of needing to gain entrance to apartment buildings or meeting someone at a place of work.

“People sometimes ask, ‘do you live in the building? Are you working?’…People ask you questions when you’re in the elevator. And they want to know, even the landlord if you can’t get in to the buzzer code, they want to know what apartment you’re going to. And I’ll say, ‘I’m not
telling you, just let me in the building.’ ‘Well, who are you?’ ‘Well, I’m somebody from government that wants a visit, whatever, just let me in the building’. So you kind of have to tip-toe about who you are because you don’t want them to know all the business, right? Me: But you want them to let you in? Evelyn: Yeah, exactly. ‘I need to get in just for fifteen minutes, you’ve seen me here before’, and there’s one guy who doesn’t ask me anymore because I haven’t told him, but he does let me in… he’s probably still wondering [laughs]” (Evelyn, interview, p.10).

Getting through the door, in summary, means using incentives not simply to entice people to open the door but to practically aid with successfully completing TB treatment and enhance overall health. It also involves respect, trust, and honesty, inseparable and necessary dimensions of not intruding. For nurses to be welcomed in the context of surveillance, client privacy is central, both in terms of respecting and protecting it. While respect for clients’ time, place, and privacy go far in being accepted and building trust, the protection of privacy is equally vital, requiring honesty as well as certain dishonesty at times. Getting through the door however represents only part of relational work. Nurses’ expertise in regard to tuberculosis is key, and is explicated in the next theme in terms of what it includes and how nurses incorporate this within relational work, which at times does not explicitly tend only to TB.

**Doing TB, But More Than That**

The second theme begins in the knowledge and skills of TB treatment and how nurses share this with clients. Conveying biomedical information, sometimes understood as health education, comes into relational work under this theme, along with the practicalities of isolation, masking, and antibiotic treatment. From filling prescriptions and dosettes to watching clients actually swallow them, the pills hold a central position in doing TB. But more than that, relational work involves that which is commonly labeled ‘support’. The meaning of support emphasized in this study is tending to psychological and emotional well-being, specifically through addressing fears and challenging the stigma that accompany TB, along with helping with other health concerns.
All participants talked about the importance of nurses’ solid knowledge of TB infection, disease, and treatment. It seems common sense to say that TB nurses need to know about TB. But how is this knowledge part of relational work? This knowledge is fundamentally tied to trust, and as seen earlier, trust is key in minimizing intrusion and navigating surveillance. The nurses’ TB knowledge cultivated clients’ trust. In turn, trust in that knowledge cultivated the relationship. Alternatively, some clients expressed the importance of a “comfortable” relationship first, and trust in the nurse as a person cultivated confidence in her advice and actions regarding TB treatment. Finally, what doesn’t work in TB relationships is “when we tell them what they’re going to do and how they’re going to do it” (Bev); “preaching won’t work” (Louisa). This highlights that how TB information is conveyed is as important as the information itself.

Clients in the study had TB of the lungs, lymph nodes, and pericardium. Nurses also told me about people in their caseloads with TB in the arm and brain. Biomedical knowledge of TB includes: the bacteria and how it spreads; signs of infection versus disease; diagnostics – skin tests, x-ray, sputum samples; course of treatment – for prophylaxis and active disease; and medications – indications, administration, and side effects. Nurses understood that this knowledge was necessary for having good relationships with clients. “Well of course you need the knowledge about the disease… but that’s sort of basic stuff” (Lynette, interview, p.13). “Knowledge is obvious, right? We have to know; we have to be well-educated on TB, and be prepared to be asked questions that we have to have answers for” (Paulette, interview, p.17). “When they ask you questions, they’re not asking… just to talk, they’re actually asking you for advice… I think that’s when I feel that I’ve done my job, when they have a really good grasp of TB and all of the fears that they had in the first few visits diminish…” (Karen, interview, p. 3).
Such specialized knowledge is exhibited in the following examples of Bev describing the prophylactic treatment for a family, and my observations of Lynette and Louisa.

“Three of the girls went to [hospital] and remained on the prophylaxis. Then their liver function tests went up so they had to stop. So really, the follow-up is, they need a medical assessment and chest x-ray every two years, to make sure they don’t break down, when it’s multi-drug resistant TB. Because they’re all infected, they’ve all got positive skin tests… But they can’t take INH, the normal prophylaxis, because his TB was resistant to both INH and Rifampin… So they start off with other drugs, which… in their case, they couldn’t tolerate… So they go every six months, have an x-ray. They compare it. With one of the girls, her x-ray changed from one visit to the next visit, so the best test is the CT because it gives them a clearer image of what’s going on” (Bev, interview, pp.3-4).

Rahim opens his paper and points at the vitamin B6 pill on the list and asks Lynette why he needs that, saying he doesn’t want to take it because he gets B6 in his food. She agrees that the vitamin is in many food sources, but explains that Isoniazid uses up the body’s B6, so this is intended to replace it. He repeats his comment about food, and she agrees again but reinforces that it’s important to take it to stay healthy (Lynette & Rahim, observation notes, p.5).

Louisa: “How are you otherwise, with the medications? Any side effects?” Eyob: nodding, “Ok… no problem, after few weeks is ok.”Louisa: “Well, not always; people can still have problems. You are correct usually, but it can happen. For example, PZA can cause a build up of uric acid. That can cause joint pain.” Eyob is nodding. “Ethabutamol, the blue one, can cause eye damage. Have you had your eyes checked?” Eyob: “My eyes checked?” Louisa: “Yes they should be checked because you’re on it” (Louisa & Eyob, observation notes, p.6).

Sharing knowledge in this way was tempered with an awareness of the affective dimension of understanding the disease that also plays a part in adherence to treatment.

According to Bev, nurses cannot deal with “just TB”, but must also “figure out” why clients act the way they do in regard to treatment. Sharing the example of an uncooperative client, she explained that the angrier he became, the less help he received from practitioners, and until his anger was heard and acknowledged he would remain ‘uncooperative’ (interview, p.8). The following comment from Evelyn also highlights that simply giving directions about treatment is not helpful: “when they ask questions, you have to be able to give them the information and they have to believe that what you’re saying is true” (interview, p.21).
All clients, in articulating what worked well in their relationships, described their knowledgeable nurses. For example, Ahmed offered this comment: “it’s important, very important the nurse know… with what kind of illness they are fighting together with the patients” (interview, p.16). In describing his relationship with Lynette, Kwame linked his adherence directly to her knowledge as well as her approach to him as a person:

“The first day… I was feeling weak, I was feeling nauseous, I was feeling very tired, no appetite… So second day when Lynette came to give me the medicines I was thinking to tell her what can we do about it? … But she started on her own to tell me… Plus she told me about the disease. About what TB is and what is bad about it, how it can spread and all that, you know? And then she told me that ‘the medicine you are taking is this strong or that… and after some time, the reactions will become less.’ So… that is the main reason why I somehow kept on taking the medicines. Otherwise, I would have seriously stopped, and had she not come or had she not be so friendly, I would have found some way to throw out the medicines” (interview, pp.1-2).

The expression of TB knowledge involves the ability to answer questions in understandable ways. The modes of reviewing and explaining information are therefore important to note. In the exchanges between nurses and clients, medicalized language (e.g. ‘smears’, ‘cultures’) was used but more often nurses spoke in ordinary everyday language (‘bug’, ‘something’) and used gestures to explicate medical details as seen in the following examples:

As Hamid is [filling the dosette], she explains that the bacteria is dying through this treatment, but that they damage the tissue where they grow while they are alive. She gives the example of TB of the lymph node; how it starts as a small bump that becomes very big and finally will burst “because the bacteria are trying to get away from the medication and so they have nowhere to go but out…”. She motions with one hand as if touching a small bump on opposite forearm, using her fingers to show how the bump grows, and shooting her fingers in an outward motion and opening her hand wide to show ‘bursting’. Hamid is watching her; he has stopped filling the dosette for a minute… Paulette: “But yours is in the lung. The lung cavities are the same thing. The infection creates cavities in your lung tissue and those cavities are still healing. Even though the bacteria are dying, the cavities are still there” (Paulette & Hamid obs notes, p.7).

Lynette asks how Akiki is feeling. Akiki shrugs, smiles, and takes another pill. She pats her chest and coughs (sounds phlegm). Lynette: “Are you still coughing?” Akiki: “Yes, coughing at night”. Lynette sits back in her chair, looking at Akiki, her brow is slightly furrowed. She pulls out 2 sputum bottles and tells Akiki to try to “get something” (observation notes, pp.1-2). In the
next visit a few days later, Lynette asks, “How’s this?”, tapping her chest. Akiki: “It’s ok. It’s better”, mirroring Lynette and tapping her own chest… Lynette: “You sound better” (p.6).

Implicit in this was nurses’ understanding that patients are often sick people at the beginning of treatment. They may be fatigued, weak, nauseated, and in pain. This understanding of feeling sick was addressed by nurses listening well to the patient, offering suggestions for managing symptoms and side-effects, and encouraging the person to keep going with treatment when they felt they couldn’t. Lynette explained, “…it’s constantly, ‘you’re on the right track. This is going well.’ Or, if it’s not going well, ‘let’s try this… Should you take it with meals, without meals, should you take it at a different time of day? We’ll figure this out’” (interview, p.16).

Lynette’s example of encouragement highlights another aspect of ‘doing TB’. At the most rudimentary level, the pills themselves represent a conceptual and practical reference point in understanding relational work, especially in DOT, and particularly in regard to nurses’ observation skills as fundamentals of the job. An exchange between Lynette and Kwame, a client who suffered greatly from medication side effects exemplifies how the pills can be the central concern of a visit.

He tells Lynette that the doctor told him he can stop taking one pill today, “one of the white ones”, but he doesn’t know which one. Lynette asks, “Didn’t he tell you?” Kwame tells her no, and then says he tried to see which one the doctor was pointing to on the page, “somewhere in the middle of the list?” He asks if Lynette knows or if she can call. They look at each other as Lynette sits, holding the file in her lap, and Kwame paces about the apartment. Lynette takes out her cell phone, looks at her watch and says she’s not sure she will be able to reach the doctor now. She pauses, then calls the doctor’s office and leaves a message. She hangs up and dials again, telling Kwame that she will try to reach the case manager, and leaves a message. Kwame has all his pills in his hand and has a glass of milk in the other. He frowns as he comes closer to Lynette and looks at her, holding out his hand so that she can see the pills. She looks down at them, and then looks back up at him. She says, “usually they stop the blue pill first”. Silence. He pushes the pills around in his hand with one finger, staring down at them as if contemplating them. Lynette says that given they won’t know when the doctor will call back, she thinks it’s best if he takes everything now; “when we hear for sure which one it is, you can stop it tomorrow. I would rather you take them all than stop the wrong one”. Still frowning, he looks at
her, grimaces and then nods. “Yeah” he says in a quiet voice, and with one motion puts the handful of pills in his mouth, followed by a long drink of milk. The conversation then changes to what he did on the week end” (observation notes, pp2-3).

This example shows that at times, there was verbal as well as non-verbal exchange about the pills. At the same time that they are ensuring that treatment is being followed, nurses are also explaining and clarifying treatment plans, and supporting and encouraging clients in taking what for many are troublesome medications. Also, nurses are concerned with ‘the pills’ more broadly, monitoring physicians’ prescription changes according to bacterial cultures and health status. The nurses ensure that these changes and the rationale for them are communicated clearly to clients.

Helping clients to keep track of daily doses of pills was done through the use of weekly dosettes, given that TB treatment usually involved more than two medications and as many as five. Decisions regarding who kept and/or filled the dosette were not discussed in any visits I observed. In some visits I saw that the nurse (or housing staff) kept the dosette and handed only that day’s dose to the client. These were situations in which the client’s cognitive functioning and/or life circumstances seemed unpredictable day-to-day (Louisa & Jose; Louisa & Luka). There were also situations in which clients kept the dosette, filled it as necessary, and had the daily dose ready when we arrived. In these visits, nurses checked only the daily pills, did not ask to see the dosette and only sometimes asked about the need for prescription refills. In most observations, the client kept the dosette but either the nurse or the client filled it during the visit, sometimes with clients being coached by the nurse. For example,

Sitting across from each other at the table, Paulette says to Hamid, “now we need to fill your dosette. I’ll let you do it.” She pulls the paper bag a bit closer to her and takes out the pill bottles. Hamid says “yeah, ok”, pulls the dosette toward him and opens the compartments. Paulette begins, “So this one is the Rifampin”. She hands the bottle to him and he fills the dosette. She glances at the bottle as she does this and adds, “Going to run out eh? So you need to ask for a prescription at your appointment next week”. She reminds him to fill it at the pharmacy before
leaving the hospital. Hamid then takes out the next bottle. “That’s the INH”, Paulette says, “You know that one, it tastes bitter.” Hamid looks up at her quizzically. Slightly laughing, Paulette clarifies that she doesn’t actually know what it tastes like but that “some clients say that. Do you think it tastes bitter?” Hamid laughs, “Yeah.” Paulette says, “This one is PZA”, as Hamid takes out the next bottle, “remember this one?” Hamid nods, filling the dosette with each medication as they talk about it. As he finishes with each bottle, he passes it still open to Paulette who, while glancing at him also checks the label, puts the lid back on and sets the bottle on the table (observation notes, pp7-8).

To describe this aspect of doing TB as simply watching people swallow their pills does not account for how the watching is done or accurately reflect all that is happening between nurses and clients in these situations. Nurses watched the pills for the correct drug and dose. They watched the person for their actions and facial expressions. Yet rather than a direct gaze, I often witnessed sideways glances, looking away and back again, as nurses watched but not exactly. Watching clients actually swallow pills is an important detail to which nurses in this study certainly attended. Yet they often did so without entirely looking, and only rarely talking directly about the ingestion of pills. To watch without watching is important when considering clients’ feelings and perceptions. Being observed in this regard was most often described as an infantilizing feeling for clients (Bev, Leslie, Paulette, Ivan, Akello, Afua), an experience in keeping with the overall intrusion.

The nurses’ awareness of such feelings seemed to translate into their observation skills. In situations when direct requests to see the pills were necessary, nurses did so in casual ways, sometimes with small jokes about needing to watch (Evelyn, Leslie, Karen, Paulette). One situation of direct communication was observed with Raj, a client who was in the early stages of treatment and the relationship with Evelyn was still new. After we were offered a seat, Raj sat at the table across the room. As he poured the pills into his hand, Evelyn got up and asked him to wait until she could see what he was taking; “I just have to check to make sure, you know.” Raj
nodded and laughed, Evelyn moved closer and they both looked at the pills. She said “ok” with a thumbs-up gesture and he swallowed them (observation notes, p.2).

Nurses often chose more indirect ways of observing so that the person would not feel being watched, requiring more creative efforts in some situations. This was clearly described by Karen:

“You’re trying to take the attention off the fact that, bottom line is, I need to watch you swallow your medication. And until I see that being swallowed, I can’t leave. And there are patients who do that, where they’ll have their dosette open and they’ll start taking their pills, and you get ready to leave and you see there’s one pill still on the napkin. So you’re just lingering around in the hallway, trying to make conversation with them,… sometimes you’re trying to make the small talk hoping that they’ll open the dosette and take the medication, and take the attention off the fact that [you’re] there to observe, because they feel threatened by that. Me: So how do you manage it when they don’t take it? Karen: Oh, it’s very hard. You do point out the fact that you noticed… You always try to err on the side of giving them the benefit of the doubt. ‘Oh. You missed a pill.’ And they’ll say, ‘oh, no I didn’t, I’m going to take it later’. Or, they’ll sometimes keep their pills in their hand. I had a patient who used to do that. Like peanuts, he used to pop one in his mouth. Do you know how people do that? Or where people spit out seeds. So he used to pop the pills in his mouth [makes the gesture] sort of like that. And I always wanted to wait til he opened his hand to see if they were all gone, and it is awkward. So I’ll come up with anything. Like, shake their hand so that I can see their palm is open. Things like that. You have to come up with, little tricks, right? Just trying to let them know that you are watching but that you’re not guarding them” (interview, p.11).

The many visits in which nothing was verbalized about TB also highlighted that the pills are often seen as only the starting point; that there is more to these relationships than just the pills. With each nurse, across every visit, I saw what participants later explained in interviews:

“Sometimes we don’t even talk about TB. They take their pills in front of me, and we’re talking about recipes, we’re talking about just generalized things. We don’t even talk about their illness the whole visit. Just, ‘so how are you feeling today, are you having any problems… with the medications?’ ‘No, no’, and then we go on to something else. Right?” (Evelyn, interview, p.16).

Certainly relational work was about the pills, but these nurses downplayed the pill-swallowing with clients as only one aspect of the program. Also, as a straightforward task of doing TB, checking pills may be understood as a system of reporting: from doctor to client, from nurse to client and doctor, from client to nurse, and so on. However, to conceptualize it in these
ways alone misses how nurses are engaged in these moments of watching, communicating messages of reassurance and encouragement, and thereby tending to the affective, not just behavioural, dimension of a person’s experience of treatment. In the following example, the nurse’s knowledge of TB extends to interpersonal and social dimensions as well. Her understanding of isolation requirements serves in recognizing the need for clarification of information for all those involved.

“There isn’t a lot of flexibility when you go into somebody’s home and there’s twelve other people in the house and they’re not educated about TB so they, and justifiably so, they completely isolate this one infectious person in a tiny little port-a-poddy size room, right? So the home visit is much different there, y’know, where you feel, ‘kay, wait a second, do these people not understand? I mean, okay fair enough, they were told to isolate them, but after a month and they’re no longer infectious and we’re still going upstairs in this tiny little room, ‘hold on a second, let’s back up…” (Paulette, interview, p.12).

Along with the pills, isolation and masking are necessary to prevent the spread of active disease and the theoretical and practical knowledge regarding both were part of doing TB. Isolation and masking were observed in this study as strategies being maintained as precautionary measures while nurses and clients waited for final laboratory results that would indicate the ‘official ok’ on non-infectious status. These strategies that accompany early treatment can be debilitating in their own right, and reassurance and encouragement in this regard were important. While necessarily serving as barriers to the bacteria, the mask was an identifier of disease, and nurses did their best to don masks only when immediately necessary. For example, when Leslie and I arrived for a visit with Akello, she told him we would be masking “just to be careful until we get the official word”. He nodded and only then did we put on masks before he came closer to greet us (observation notes, p.1).

Masks also served as barriers between people, creating interferences in communication that nurses navigated regularly. It was perhaps my own lack of experience with masks that raised
my awareness of the ways that nurses incorporated these cumbersome things as a routine dimension of their work, and adjusted their communication accordingly. For example, by speaking louder and enunciating more clearly, as well as more frequent eye contact. Afua described the discomfort of masking in an emotional way:

“I was in isolation I think it was the first two weeks. You know, taking the pills you still have to wear the mask, [and Linda] had to wear the mask and I didn’t feel uncomfortable… I was already feeling uncomfortable because I had gone to the hospital and I had to wear it and I was panicking, like I would scare myself’ if that was me. Like, I understand the feeling around it that so many people have…” (Afua interview, p.4).

Similarly, Hana describes the worry felt by her daughter, which seems to be the focus despite Evelyn’s clarifications about Hana’s particular situation:

She talks about how she had to mask when she was in public when she first had TB and how the mask caused her daughter to worry about her and that she would have to console her daughter, telling her not to worry… Evelyn tries to point out that Hana’s TB wasn’t in her lungs anyway, but Hana keeps talking over her. When she stops speaking, Evelyn says, “But just to reassure you, you are not infectious. It’s not in your lungs.” (observation notes, pp.5-6).

As well as responding to feelings associated with masking, nurses also noticed the effects of isolation on clients’ psychological and emotional well-being, such as low mood/depression and loneliness. For example,

After the visit: Louisa tells me that he has been very cheerful and positive but today he seemed different, more subdued. Louisa says, “a bit stir-crazy maybe” and comments on how difficult it must be to be in isolation in a small motel room like this (Louisa & Eyob, observation notes, p.6).

After the visit: Evelyn and I discuss his quiet despondent demeanour. She wonders if he’s depressed. I ask her if my presence may be affecting him; she doesn’t think so. She shrugs and says she will keep an eye on his mood; that she wonders if it’s about not being able to go to his job today. “Although when I told him I will come to him, he didn’t seem to want that either.” Evelyn observes that it seems odd that he’s out of isolation now but he doesn’t want to go anywhere. I ask where he has to go besides work. She pauses and thinks perhaps that’s part of the problem; “he’s really quite alone here” (Evelyn & Raj, observation notes, p.8).

Psychological well-being was impacted not only by the experiences of isolation and wearing masks, but also more broadly by TB illness and the social meanings attached to it, which
manifested in such ways as a sense of alienation and denial of ‘really’ having TB. The word “support” was most often used to explain what participants understood as the larger part of relational work. Support is the ‘more than that’ aspect of this theme and highly valued by clients as a dimension of their relationships with nurses. For example, descriptions of support came through in clients’ comparisons between their current nurse and relationships they had experienced with other nurses. They categorized them into those who were “concerned about the pills alone” and those who were not.

“Ok, with Linda,… she makes you feel comfortable. Because, if she came and was like, ‘ok, just take the pills’ and was very, like, ‘ok, did you do that? did you do this?’, very formal and very, ‘ok I’m just here to do my job, did you take your pills or not?’ or just watch you, then I would feel uncomfortable with her coming around, just coming, like, ‘oh, I have to deal with that person every day’, for nine months” (Afua, interview, p.2).

“So, if you are not professional, you will just… come in because you are supposed to come in. Not even knowing how I slept or if there is anything bothering me, so you just come in and like, [claps hands a couple times] ‘ok, let’s take our medication, and…’ [picks up dosette and slaps it on table in front of me] and you move out, and the next time you come I can even lock you outside. Yeah. Because I know your work is just to take money. You are paid to come and see me take the pills, the medication. Me: And you can feel that? Akello: Exactly.” (interview, p.4).

This is the tension in relational work conveyed through this theme: while a focus on TB is necessary – in fact, is the reason for the relationship – and nurses’ expertise in this regard is essential, there were many situations in which the TB illness, medications, or isolation strategies were not the focus of the visits, or in situations when, as nurses’ described, “staying in the box is not possible”.

“Just doing TB, giving the TB pills, that’s such a small part of it. The rest of it is support. Because TB does have that stigma, and they’re afraid of it or they’ve come from a country where they’ve seen people die from it. And so you realize your real objective is much bigger. Or your scope is much bigger than just watching them, y’know, making sure the right pills going at the right time… or monitoring for symptoms and that kind of thing. It’s really about how they’re feeling, and about how you’re going to help them get through the whole thing” (Leslie, interview, pp.5-6).
The data revealed the relational work of doing TB as interpreting biomedical information, but also doing more than that, reflected in nurses’ simultaneous efforts to convey the seriousness of TB as a debilitating infectious disease, confidence in successful treatment and cure, and disassociation of bacteria/infection from personal characterizations. A balancing of verbal and nonverbal communications served to distinguish medical facts from myths and social generalizations, and individual behaviour from value judgment. Calming fears and challenging stigma were key dimensions of this, along with addressing other health concerns. While the nurses were there for TB, they were often helping clients manage the effects of these identified problems.

Fears were articulated by clients in interviews and seen in some moments of observed visits, at times spoken but more often unspoken. Nurses allayed these fears through direct and indirect means, at times focusing conversations on other things or simply letting the silence hang. The importance of reassurance as a way of calming fears was seen in several relationships. For example, there were many pauses in Afua’s recollection of her first meeting with Linda. These silences seemed to express as much as the words in communicating the fears she felt at the time:

“…like the first day, she was really nice, she gave me all the information. I was really nervous. Um, cuz you really think you’re going to (pause). Well mostly cuz my mom kind of scared me because she (pause). Before TB was, didn’t really have (pause), was longer to get a cure and she really scared me. But then when they sent me the nurse, at the beginning I was a little (pause), I really wasn’t sure if I wanted to have someone to come every day” (Afua interview, p.1).

Fear of TB itself seemed to be indirectly expressed through questions about changes in health status or bodily conditions. For example, Hamid asked Paulette to look at a bump on his back and though he did not state it directly after doing so, Paulette asked if he felt worried:

“No, just, you were talking about bump. Could it be (pause) TB?” Paulette says “TB?” at the same time… She shakes her head, “No, that bump is not a lymph node and your treatment is going well. And it’s your lungs, TB was in your lungs” (observation notes, p.7).
Similarly, Hana expressed her worry that a pinching pain she had felt in her side was related to the pills. Evelyn normalized by saying she gets little pains like that too, and that only if the pain is severe and persistent is there cause for concern. She ended by emphasizing that the pinching feeling would not likely be from the TB medication (observation notes, p.12).

Fear seemed to be an unnamed element in the exchange between Evelyn and Fatima in which they discussed a recent CT scan that showed changes in her lungs. Evelyn responded to the client’s silences by naming ‘worry’ and trying to calm it.

Evelyn: “Sometimes that bug can get tricky in there.” They both laugh. Pause. Fatima smiles at Evelyn and again looks down. Evelyn: “We’ll see, so don’t worry. Until we know what’s going on no point in worrying, right?” Pause. Fatima only glances up quickly and continues to look down and quietly responds, “Yeah.” Evelyn: “We’ll get it looked after. But there’s no sense in worrying, doesn’t help. We’ll get it looked after.” With each pause in her sentence, Evelyn is leaning forward a little closer toward Fatima, looking directly into her face. Silence. Fatima starts into the story of how her coughing and difficulty breathing started ‘back home’. She talks about how it felt, how it worried her and how she went to the doctor who told her it was asthma and she ‘knew’ it wasn’t (Evelyn & Fatima obs notes, p.7).

Fear was described by Ivan through an explanation of a Monty Python comedy sketch about a “worry-meter”. After we laughed about the scene, I asked about an earlier reference he made to Karen’s vigilance during a visit in checking the status of an inflamed lymph node in his neck:

“Oh, she checks on it all the time…. Puts my worry-meter down…. That’s why I like nurses… She’s like, ‘oh everything’s going to be ok’ [laughs]. Me: I know as soon as you say Monty Python, that it’s kind of a joke, but you’re also serious about that, I guess? Ivan: Yeah, my worry-meter goes down, and I don’t have to get up at eight o’clock tomorrow morning and go down to the hospital, deal with all that…” (Ivan interview, pp.3-4).

Later in the interview when I asked him what he considered the most important point about his experience of TB and the program, unhesitatingly Ivan named fear: “I was so scared. But they saw me every day, or phoned me or whatever, but they took the fear away… Once in a while, say, I’m coughing. I cough a lot but the fear is gone” (interview, p.14).
I observed the situation of Ivan’s inflamed lymph node, and have chosen the following lengthy note to show how Karen communicated her concern in the visit which may have served in lowering Ivan’s worry-meter. Noticing the significant change in the lymph node myself that day, I watched as Karen balanced attention to the urgency of the inflamed node, the pills routine, social topics like what he did on the weekend, and his expressed agoraphobic feelings, which culminated in calming his fears:

The node on Ivan’s neck is very large and purplish red. Karen immediately notices this as we walk into the dining room and makes a comment: “that looks ready to blow”. She is cringing and squinting as she sits down, still looking at his neck… Karen then asks about his weekend. He tells her that he went to his brother’s place… with the cat rubbing against his leg and meowing, Ivan says, “the cat missed me.” Karen looks up again at Ivan’s neck and tells him that she wants to call [case manager] to let her know about the change in the node… calls and leaves a message, briefly describing the appearance of the node and asking her to call back. She ends the call and while still holding the phone, she looks at Ivan and asks, “Did your dad go too?” Ivan tells her, “No, I was just with my brother.” Karen nods as if to acknowledge she heard his answer, but verbally responds with, “[the node] looks worse since yesterday”. She shoots quick looks my way with raised eyebrows that seem to say she is worried but is also trying to stay calm. Ivan holds the bandage lightly, says it is more painful and that he too thinks it looks bigger. Karen asks if it’s open and draining underneath the bandage and he says there is one big pustule and two smaller ones. She asks him about the doctor’s instructions in the last appointment. Ivan says the doctor drained it and told him to come back if it looks like it needs it again. Karen suggests in a quiet voice that she believes it needs it again now. Ivan does not respond, walks to the computer, leans in and starts clicking the mouse. Karen tells him that she wants to talk to the doctor about the change in the node. He doesn’t say anything. She calls the hospital and… each time she is put on hold, she turns toward Ivan and continues the conversation about his weekend… then ends the call. Karen looks at Ivan as he continues at the computer and tells him “the options”: “If it gets bigger, or looks like it’s going to blow, you can go to emerg today or tomorrow. It’s up to you.” Silence. Ivan keeps looking at computer screen. Karen glances at me and shrugs slightly, then looks back at him. “You don’t want to go?” Ivan shakes his head no, without looking up from the screen. Karen: “You know what? I can get a taxi chit.” [It is a long commute by transit to the downtown hospital.] Silence. Ivan: “Is it really necessary?” He pauses and then says that he is “slightly agoraphobic”; “I have to build up to these things.” Karen: “Well, yeah, I think so.” Silence… “what are you going to do if it bursts?” Ivan shrugs, looks at her, and tells her that he will just keep covering it with a bandage and if it bursts he would go the hospital… Karen: “Ok… How’s the dosette?” Ivan: “It’s ok for today.” Karen then offers to get a taxi chit from the office and bring it back in case he decides to go to hospital today… She tells him again that she thinks he should go today, but adds that it’s his choice. “Maybe you will go tomorrow?” Ivan just shrugs. Karen suggests that we will leave and repeats that she will see him later today with the taxi chit. Ivan gets up from the computer as we walk to the door… When we first leave the apartment, Karen tells me that she is very worried about the node on his neck,
explaining that if it bursts and it is TB, the TB can aerosolize, which would make him infectious. She also says that she didn’t want to worry him too much; that she didn’t know he was agoraphobic, but she really wanted to insist that he goes to the hospital today, “but, it is his choice at this point, eh?” (observation notes, pp. 4-6).

Karen’s last remarks to me indicating her own worry in this situation highlight that calming fears not only applies to clients but to the nurses themselves who worried for their clients’ health. After the visit between Evelyn and Fatima described earlier, Evelyn expressed her worry that “something’s up” with Fatima’s CT scan. When I asked if these results are typical, she explained that Fatima has been “compliant with treatment and fully sensitive”, so this was worrisome because results like these indicate something abnormal (observation notes, p.5).

I was also present as Hamid told Paulette that he had been experiencing chest pain and she asked many detailed questions about it before moving on to TB treatment questions and other topics. Later, Paulette returned to the chest pain, expressing her worry directly:

“My main concern is your chest pain, ok?” Hamid nods and looks down. If it’s pain that doesn’t go away, you need to seek medical attention right away”, looking directly at him. He says nothing; she keeps looking at him and asks, “ok?” Hamid nods and says ok. Paulette: “Being a nurse, y’know, I care.” They both laugh. “It’s really important. Nobody knows your body like you. I’m just concerned. You need to take it easy. You need to pay attention to that.” She maintains direct eye contact and Hamid says “I know now. I know this for sure” (observation notes, p.6).

After the visit, Paulette’s concern seemed to show on her face and I asked how she was feeling about the visit. She thought the chest pain scared him and that he understood now his lungs were healing. She also hoped she “got through to him” but still questioned herself on this.

Fear of TB is often fuelled by stigma. The stigma of TB was raised as a significant concern by both nurses and clients as myths of TB continue to abound socially, tying up contagiousness with personal moral judgments. Myths were expressed in several interviews and observations. Bev and Rosalee described the following:
“He had no concept of why he needed this treatment, why it was going to be so long. And we even got to the point where he wanted to get on plane, fly back home and get his gold teeth removed and then his TB would be gone. So, it’s been a challenge” (Bev, interview, p.1).

“There are some relationships that are difficult I guess because of cultural beliefs. I had a client, they were refugees from [Asia], and education, extremely minimal. The family in general didn’t really understand that you had to take medication for a long time. They were under the assumption [that] you take four pills, you’re cured and that’s it” (Rosalee, interview, pp.14-15).

The label of TB affected personal relationships for some clients as indicated in three examples from my observation notes: 1) In my first visit with Farah, she spent some time explaining the contagiousness of TB to me and describing how her brother and sister-in-law had avoided visiting her since they heard that she had it (observation notes, p.1). 2) Lynette’s client Rahim had to leave the apartment where he rented a room every day because his roommate ran a business from this location and his presence would interfere. In explaining this arrangement, Lynette emphasized that she also meets him on a side street because this man is not aware of Rahim’s TB and discovery of this would mean immediate eviction. 3) The following example began when Hana mentioned the return of a friend into her life to her nurse Evelyn:

“while [Hana] is on the phone, Evelyn explains to me that Hana is referring to someone who stopped visiting when she found out Hana had TB. I question if perhaps this was coincidental with something else. Evelyn tells me, no, this friend actually told Hana she would not come near her while she had tuberculosis… Hana returns to talking about her friend’s visit. She tells Evelyn that she told her friend “you hurt me… and I told her she has the wrong attitude.” Her friend apologized but Hana still feels hurt and somewhat cautious about their friendship now. She turns to me, “the stigma of TB is very strong”; “people don’t understand; they think they will get it and they stay away” (observation notes, p.5).

Hana’s example also highlights the elements of stigma that come from cultural beliefs and attitudes. Nurses considered culture in their understandings of the effects of stigma:

“There is a lot of keeping the diagnosis within the cultural group secret. Like, if a Filipino person has TB, they probably will not want a TB nurse who is Filipino because in their mind, it’s going to get all through the Filipino community, that they have TB, and it’s not something that you want. Me: And so this is something you actually think about as a nurse even going into the case?… N1: Absolutely. Absolutely. Yup. You have to” (Louisa interview, p.8).
“Some patients, I think it’s from [African country], because they have a small community, they don’t want to have anybody from their own community to go to do the DOT” (Linda, interview, p.12).

Bev’s explanation of contact-tracing in a workplace, highlights this along with other important points about stigma: dispelling myths, recognizing cultural beliefs, and the nurse’s awareness of stigma and communication aimed at challenging it.

“Sometimes in a small workplace, the recommendation is always that we go in and meet with the group that’s considered to be contacts. So, the whole workplace. Because, rumours are out there. Me: Rumours about? Bev: The person having TB. So… it’s nothing to be ashamed of, to have TB or whatever, but it’s in your best interest to say you’re off for medical reasons. Then when your co-workers ask, you’re being treated for a respiratory infection. It’s not a lie. But people, because of a lack of education and their cultural beliefs, when you say ‘TB’, freak. And when they freak, they’re going to freak on you and they’re going to treat you differently than when you left work. So our goal is always to make sure… we’ve looked closely at who are the contacts” (interview, p.17)… “To say, this is what happened, this is what’s going on, and only the people affected are getting screened; ‘just so you know’. [I] find that works really well… And their biggest claim-to-fame is, they have to know who the individual is. It’s always revisiting, ‘would you want [your employer] telling me or you that you’re HIV-positive? Or you have TB? It’s not anyone’s right to know and it doesn’t change what you have to do. It doesn’t change that you’ve been exposed’… It’s not because, like, only people in certain cultures or poor people get TB, only unclean people get TB, only bad people get TB… how a bacteria can make a bad person, uh, doesn’t make sense to me” (interview, p. 19).

Nurses counteracted the effects of stigma through their attitude of acceptance and normalizing through such direct statements as those made in above examples and through actions body language. For example, Paulette described her deliberate choice to sit close to clients even while they are still infectious: “Like if I’m going in, I’m masking, they’re already alienated and the stigma attached, ‘ooh you’re dirty and nobody wants to touch you’. I try not to do that with my body language when I meet them” (interview, p.11).

The importance of nurses’ actions in this regard is reflected in the following client examples. The first is an expression of what Afua appreciated about her nurse. In the second quote, Akello shares, by way of contrast, a negative experience of someone who is not his current nurse.
“I’m like, ‘how could you work coming in...?’ It’s very scary, I would be scared, but... when she started coming, she didn’t make me feel like, [leans away from me; stretches out hand toward me] ‘Here take this. Don’t touch that’” (Afua, interview, p.4).

“By the time I see you, you already have the mask on, then it seems like, ‘oh this one is too much scared of me’. So we talk two or three words, you are gone, you are like, ‘ah, ok, I have other business’... those are the reactions which shows me that you are really scared of me” (Akello interview, p.10).

Finally, by the very nature of TB, care is often complicated by other serious health concerns that tend to be loaded with their own stigmatizing social meanings. In keeping with statistics, several clients in this study were dealing with HIV, diabetes, addictions, and mental illness. Nurses did not focus on the negative connotations commonly assumed, and thereby reinforced an acceptance of the person. Several clients had long histories of substance abuse. In interactions with them, their nurses referred to the connection, for example, between heavy drinking, the immune system, and TB, without value judgment about the drinking itself (Louisa & Ahmed, Elijah, Luka; Lynette & Rahim; Karen & Ivan; Linda & Jima). They stayed with the immediate needs in the situation as they affected TB treatment. For example, complicated by ongoing substance abuse, Luka’s diabetes was addressed by Louisa’s small strategy of buying groceries in efforts to improve his nutrition.

Because his blood sugar is consistently very high, and his overall nutrition was discussed [with the doctor], Louisa suggested and Luka agreed to have her buy $10 worth of groceries for him weekly which he could keep in the fridge in his room. This week she took him bread, peanut butter, juice, yogurt. She was feeling good about this knowing that he was at least eating that much.... The meeting was short and took place in the lobby. Two other people walked through as we stood there and there was a man outside the door, buzzing someone on the intercom and talking to them; it was not a very private place but Luka didn’t seem to mind... Louisa took out the pills, and he swallowed them with a drink from a dirty plastic bottle full of water... (observation notes, p.5).

This exchange about groceries represents Louisa’s open non-judgmental attitude about the living conditions in which diabetes and TB can flourish. As this visit continued, Luka described his latest ‘partying’, the stranger in his room when he woke, and his disappointment
when he discovered that his cellphone was stolen. Louisa listened throughout (as in similar visits and stories of other chaotic situations) and responded with, “Oh, Luka, it’s too bad; you really can use that phone.” This seemed enough for Luka, as he nodded, smiled and briefly made eye contact (observation notes p.5).

There were also other bodily concerns unrelated to TB. Nurses were called upon to assess, answer questions, and give advice in this way too; all clear examples of how nurse were doing TB, but more than that. One situation stands out, not only for its lack of focus on TB, but for its revealing sense of familiarity and comfort between nurse and client, evidenced by the nurse’s actions in this home and the amount of laughter in the following exchange:

Kwame points down to his knee and starts rubbing it, “now look at this, it’s really paining up.” Lynette is looking at his knee as he pulls up his pant leg and tells her that its really swollen, she bends down to look more closely. He stands up straighter and rubs both knees… “nothing I can do”. Lynette: “Oh but there is.” Kwame: “Yeah?” Lynette: “for starters, ice. I will bring a bag that you can put on it. Do you have anything in your freezer?”; and before Kwame has even a chance to answer, she walks to the fridge and opens the freezer door. Kwame moves to stand beside her with his hand on the door at the same time, pulling it open with her and laughing. They look inside and she reaches in and takes out a bag of frozen peas telling him “this is perfect”. She notices it’s a solid hard chunk, promptly bends over, and bangs the peas on the floor as she tells him again that frozen peas are perfect, that it’s important to keep something cold on it to reduce swelling, and that the pain will subside. She has loosened the peas and says, “I’ll show you”, placing it on his knee. Kwame puts his hand over the bag. Lynette lets go of it and stands up straight, gazing from the knee to Kwame’s face and back to his knee. This has happened like a whirlwind and Kwame starts laughing, it seems at Lynette. She is laughing too… After holding the peas there a short time, Kwame comments that it already feels better, his head tilts back and he closes his eyes, “ahh”. Lynette continues, suggesting that the plastic bag is too cold on the skin directly, looking around while she says it would be good if he had a cloth to cover it. She says again that she will bring a proper ice pack tomorrow (observation notes, p.5).

In summary, doing TB but more than that has two dimensions: Nurses must have TB knowledge and skills. How this is all conveyed is as important as the information itself, as this connects to trust. There is also all that is not associated with TB directly, experienced as ‘support’ and including psychological, emotional, and social well-being – fears and stigma specifically and other health concerns. This leads to thinking about the meanings of being a
professional in such situations. The last example offered above also shows a certain level of personal involvement, the depth of which is interpreted through the last theme, beyond a professional.

**Beyond a Professional**

Moving beyond professional-personal boundary discussions, this theme speaks to the ways nurses and clients get to know each other over the long course of treatment. Knowing each other in these circumstances includes socializing-with-purpose, knowing the person-in-place, cultural learning exchanges, understanding displacing experiences and communicating through language barriers. According to clients interviewed, their nurses were “beyond a nurse” (Akello), “more than a nurse” and “like a friend” (Ahmed, Kwame, Rahim, Fatima, Afua, Hana, Akiki, Kali).

“Oh, she has been very helpful. By and by she become a very good friend. Initially she was just a nurse, y’know, that’s what I thought. But by nature she’s a very good lady. You know I think of her more as a friend. And I know after this, maybe six months the course will be over, right? So, I’ll surely keep in touch with her” (Kwame, interview, p.2).

“Sometimes she told me from about her life and her experience and her job. And I told her my experiences… Then I begin in a couple of months, I trust in Louisa like a wife, like a sister. And I begin… some personal” (Ahmed, interview, pp.8-9).

While nurses talked about being firm, setting limits, and having clients understand their role, they also accepted the ‘friend’ label that clients bestowed on them even if it somehow felt wrong to use the word themselves. For example, Kwame described Lynette as his friend in one visit, and she later said, “which is lovely… y’know, it’s just strictly a professional relationship but it’s nice that he feels open enough… that he could tell me things that he wouldn’t [otherwise] tell me” (Lynette, interview, p.2). Nurses described sharing things in common with clients as helpful in forming the bond, out of which they were able to offer support and suggestions on TB
and non-TB matters. Client and nurse perspectives on the comfort of this bond are expressed in these excerpts from Evelyn and Fatima’s interviews about their relationship.

“We are just friends, like friend. I am more comfortable with her when she speak with me… she speak with me most simple, and I feel comfortable. That’s all. I can ask her about my TB, about otherwise things, that help me, tell me something” (Fatima, interview, p.1).

“So anything would come up… we have this relationship where I think she feels comfortable with me. She can ask maybe some private questions that she wouldn’t be able to ask somebody else. First of all, I’m a professional, I’m a nurse, I’m a woman, and I’m around the same age as her, and I do, I talk to her in a way that she’s like my sister” (Evelyn, interview, p.2).

Furthermore, portions of interviews with Evelyn and Paulette highlight that this is not something only the client feels, but is also experienced by nurses themselves.

“I know some clients, as we go through our relationship, often refer to you as a friend. And, I see how they can see you as a nurse but at the same time also as “the friend”… Often they say to you, ‘after DOT’s over, I’m going to see you again, aren’t I?’ And I’m like, ‘you know what….our relationship is finished.’ I think sometimes this is hard for them. Because they do feel a bond, and y’know, same for me. Because you do get involved in… a lot of the personal things, because you’re seeing them every day for at least six months, so you do know a lot about them” (Evelyn, interview, p.8).

“Sometimes I think it’s only natural after you build these relationships with people and you’re still seeing them six months, a year down the road… y’know, when you’re the same age, you have things in common, and you’re not always going to sit there and talk about TB every day. You have maybe similar interests and you want to let the person know, ‘you know what, I’m in the position where, yes I’m caring for you, I help, I’m participating in your care, but I’m still human.’ Like, I still have feelings…” (Paulette, interview, p.4).

While the bond contributed to a feeling of comfort, it also created a degree of discomfort for some nurses. They knew they should not be friends with patients, as revealed in Paulette’s remarks, “I mean, nurses aren’t supposed to use the word friend, right?... for her to use the word, I know that it’s not morally accepted by the CNO but it says a lot to me that she’s comfortable in the relationship that we built together” (interview, p.4). And at times there was vague sense of guilt about ‘liking’ clients. For example, before my first visit with Lynette and Akiki, Lynette told me that she felt a bit embarrassed to have me see her with this client. When I asked why, she
laughed and said she “really likes” Akiki, that I was “probably going to see that” and she was afraid I may think she’s “not very professional” (observation notes, p.1).

This theme is seated within understandings of the nurse as a professional. This word was used many times by all participants, but never quite the same meaning. For example, for Akello being a professional implied empathy. He compared his nurse Leslie with others he has known when I asked him to clarify his meaning of ‘professional’: “it means somebody who knows what to do, at the right time… if you come, much as you are paid for doing what you are doing, you go as much to make an initiative to show to me that you really care. And you’ll feel, somewhere, somehow, the pattern of how I feel… That’s being professional” (Akello, interview, p4).

Alternatively, professional seemed to be a way of describing a more distant relational stance. This was made explicit by Ahmed as he described his first meetings with Louisa:

“… the relationship is like professional and client [pointing with both hands to one side of himself and then to the other, gesturing as if two people are sitting side-by-side]… Then I saw Louisa like a professional; she speak with me like a professional… And I was very cold with her” (interview, p.1).

Several nurses emphasized the importance of having clients understand their nursing role as part of the professional relationship. For example, when I asked about how they thought particular clients perceived their relationships, two nurses responded as follows:

“I think that it’s a professional one. I think that he knows what my role is. And he’s been very compliant, and very supportive of what we have to do” (Leslie, interview, p.1).

“I have some issues with him when if he’s not wearing his mask, and he’s putting his children at risk… y’know, I have to explain and be a little bit firm. It’s not a bad relationship, because I think he understands my role. That’s all been explained to him. So, it may have taken a few times of talking to him firmly, that sort of thing. I think he gets that” (Rosalee, interview, p.4).

As long as clients understood the nurse’s role and the overall purpose of the relationship, the notion of professional boundaries was left to only vague references of something learned in nursing school (Louisa, Lynette, Paulette, Leslie). For example,
“... it sounds terrible, but I don’t think [nursing school] taught me at the level that I’m at with the kind of relationships that I’ve built since having this job. Of course it taught me other things about people skills, what to say when they’re down and out, and what not to say when they’re ready to commit suicide, y’know,... but I just think that if you want to learn about people, it doesn’t take a textbook to learn it” (Paulette, interview, pp.19-20).

Considering this, the concept of professional boundaries seems to hold limited usefulness in fully understanding relational work. Rather, the unavoidable professional-friend tensions were just part of knowing each other. The ways that participants got along with each other in my observations often bore a strong resemblance to socializing. However, upon reflection, it seemed to be a kind of socializing-with-purpose, which involved mutual personal sharing.

Clients and nurses often shared bits of their personal lives with each other all the time – good news and bad, tips, advice, and lots of stories. They spent many visits in this kind of socializing. For example,

Alicia asks Evelyn if she told her that she’s taking driving lessons. Evelyn, smiling, says ‘no you didn’t tell me, that’s great!’ They begin a long discussion about how the lessons are going. Evelyn shares own memories of learning to drive, and they debate which is easier: manual or automatic transmissions... Alicia says “it will be good for me”. Evelyn agrees and comments that being able to drive will make it easier for the family. Alicia says she will take the test in September and feels that gives her enough time to practice. Evelyn interjects often with “good for you”, “you’ll do great”, “you’ll be fine” (Evelyn & Alicia, observation notes, pp.1-2).

Many of these exchanges were remarkable, not because they were exceptional accounts of professional experts at work, but rather because they were part of the flow of particularly ordinary conversation. Moreover, though the depth of personal detail differed, clients clearly knew much more about their nurses than I expected to witness. The implied mutuality of socializing was an important dimension of these relationships. That is, while it is expected that the nurse ‘knows’ the client, it is important to note that the client ‘knows’ the nurse, though what they know about the nurse seems to be shared with purpose. While clients knew personal bits of information about the nurse, they did not know for example intimate details or deeper personal
struggles. Ahmed, Kwame, and Afua refer to such personal information about nurses that was typical of all observations:

“He then tells her that he thought of her the other day because he was reading something about [tropical island], and asks about her friends. Louisa tells him they are fine, they smile, he nods and says that’s good. Louisa turns to me and says, “I love [tropical island]. I have friends there and go a lot”, and Ahmed and I have talked about [it]. Ahmed continues, saying they also talk about [other] countries, including his own country” (Louisa & Ahmed, observation notes, p.2).

“She is very interested in knowing about what is our culture and what we are doing, right? And I was interested, like I ask her, ‘what will you do when you go and meet your parents on the weekend?’ She goes every weekend to meet her parents. And I also want to know what… like, her kids are there… she says that she has worries always, y’know? … we try to know about each other” (Kwame, interview, p.4).

“After a while, we started talking about personal stuff… And I found out she likes to dance. I had no idea… [both laugh] She does ballroom. She probably dances more than me [laughs]. Yeah, so we talk about that. Or about what I’m doing on the weekend” (Afua, interview, p.1).

As an observer during visits, I was often uncertain about topics of discussion, noticing that nurses and clients seemed to be jumping into many conversations that were apparently based on some previous understanding between them. This called my attention to how much of all communication, particularly social conversation, occurs in this way, continuing from one meeting to the next, and that the development of familiarity relied on this dynamic. I also realized how this familiarity was perceived as a significant ingredient in what made these relationships helpful, distinguishing socializing-with-purpose from socializing generally. Clients felt nurses’ interest and concern by their responses to clients’ stories as well as through the nurses’ own sharing, especially regarding similar life experiences with parenting and job-hunting. TB treatment was being infused with the familiarity of knowing one another as persons, so as to make the official purpose of visits go by unnoticed. The following observation note highlights this:

They begin talking about Akiki’s younger daughter, who went skiing today with her class. Lynette says she’ll have fun and talks about how much she enjoys skiing herself. Akiki tells
Lynette how excited her daughter was to go. Lynette then says she forgot a birthday card for [younger daughter] and so will make one now. She pulls out a piece of bright yellow paper, pulls her chair a bit closer to coffee table, leans over and starts to draw. Akiki is watching her as she takes the first pill, laughing, and tells Lynette that birthdays are not that special in her culture, but that her daughter will like the card. Lynette looks up from her drawing occasionally… Throughout the visit, there are many references to [both daughters] (their school work, spare time activities, love of TV). It is apparent that Lynette has spent time with these girls (Lynette & Akiki, observation notes, p.2).

Nurses also drew on this familiarity as part of their assessments of clients. It seemed to be a filter through which they took in information. Being familiar with each other helped nurses to discern what was important to focus on and what to let go by in the particular moment.

Part of the personal information taken in by the nurse included meanings of identity drawn from physical locations. In other words, they got to know the person-in-place. Such interpretations arising from clients’ homes and the items therein contributed to the cultivation of relationships and influenced nurses’ concerns for client well-being. Karen expressed this most directly:

“His apartment [has] got lots of sun exposure. He likes that. He keeps his place very tidy and orderly. He likes to know where his things are. I feel that it’s lacking a homey feeling though. I just feel that he doesn’t have enough of his own personal belongings around. It doesn’t show his identity. His place is very neutral. I don’t feel that I really can get a sense of his personality based on his apartment. Other than the guitar that he has leaning up against the wall, which he claims he can barely play, so I don’t know if that’s more like a… what would you call it?, an ornament… I’ve never gone anywhere other than the kitchen and the living room… And I think he keeps it fairly clean. I don’t know about the floors… But his other apartment was very smoky and it had dirty carpet and dirty couch, it was very grungy… I think it creates a better mood, because the other apartment was very dark and dingy, the curtains were closed, it was depressing. I felt, after he made that move… not only safer, being in a bright exposed place, but also that he took more pride… Maybe he’s not the type that would decorate or anything… Well, he does have one picture on the wall… when I pointed that out to him one day, he was very interested in telling me about where this picture was…who took the picture, and those kinds of things. So maybe that is his way of expressing himself, by having pictures of his family around him… Me:… Can you think of other examples, maybe other clients, where the place does tell you something about their identity?… Karen: Cultural. I think because Ivan is basically a Canadian-born white person living in Toronto. Most of my patients have been… new immigrants to Canada… and I feel when you go into these homes, you get a real feel for their culture. Their decorations, for example. Flags, to show their heritage, artwork, things like that. Also, just the smell of food, a whole homey feeling. When you go in there [Ivan’s home], it could be
anybody’s home. You would never know whose it was… I don’t feel there’s a real sense of homey-ness there. But I think that’s because he’s a single guy living by himself, but… he does have those tomato plants out on the balcony. Which is showing a side of him which I like…” (interview, p.6).

Nurses noticed homes and the things in them, drawing on what they noticed about the places to start conversations and to connect. This was particularly the case in situations of cross-cultural understanding. For example, as Evelyn and I approached the door of a client’s apartment, I noticed pieces of paper on the wall above it, with the writing, ‘Praise to Allah’ and ‘Praise to God’ on them along with other Arabic characters. When I pointed at them with a questioning look, the nurse commented that this family was devoutly Muslim and that small indications of their faith like this helped her think about how she approached the relationship (Evelyn & Alicia, observation notes, p.2). In Evelyn’s interview, she explained a visit and ensuing conversation she had with another client, a retired police officer, learning this fact by asking about a photograph she noticed hanging in the hallway of his home (p.14). Also, I witnessed the change in a client’s demeanour as Paulette commented positively on the new furnishings in his apartment:

Hamid gestures toward the couches inviting us to sit down. Paulette comments, “so this is it?... this is a nice place!” as she looks around the room. She sits down at one end of the couch and strokes the arm of it, “so this is the new furniture, eh?” Hamid is nodding and smiling and answers with a firm “yes”. He looks happy and relaxed as he looks around the room [I feel like he is proud of his new place and likes that Paulette noticed.] (Paulette & Hamid, observation notes, p.1).

Conversely, Paulette shared an example of trying to connect with a client early in the relationship by commenting on the plants in the apartment and not having it well received:

“She just…was very stone-faced, like she didn’t give a lot of expression even if I would talk about her plants that I was so impressed with, wow! Y’know,… I had somebody tell me that all you need to do is water the plants – because I kept complaining that they were always dying on me, and I said, ‘oh so you must water your plants’ and she’s like, ‘uh, yah, hello, like of course I water them’ [laugh], so to try, I don’t know…” (Paulette, interview, p.2).
Removing shoes when entering a place is a familiar practice for anyone involved in home visiting work. This action means different things to different people. Sometimes it is a matter of habit or particularities of cleanliness, and sometimes nurses do not remove their shoes depending on the situation. For Muslim clients in this study it was connected to faith practices. Arriving for the first visit with Raj, the hallway was full of shoes that we had to step over to get in. Evelyn asked him, “everyone’s here for prayers eh?” Raj nodded and looked down at our feet. Hesitating for a moment, Evelyn and I removed our shoes, seeing and smelling that the place was not very clean (Evelyn & Raj, observation notes, p.1). Another client directly asked me to remove my shoes at the front door when we met. After the visit Hana apologized for this request and asked Evelyn and I if we thought it was okay that she insisted on this with everyone who comes into her home. When we both answered that it was fine she added it was for cleanliness and the importance of proper prayers (Evelyn & Hana, observation notes, p.4).

Cultural practices, such as this, and artifacts in the home were taken in as part of getting to know clients. Other cultural influences came through in verbal and nonverbal communications between people. An important point is that while many cultural topics were directly discussed, they were often not necessarily named as such. Rather culture was pervasive in the situations themselves, always shaping the interactions. Culture was both a highly valued aspect of knowing each other and yet still seemed completely mundane. I became specifically aware of this as each nurse told me that culture factored into the relationships – “absolutely”, “definitely” – and yet all clients, when asked, said that it was not factor for them.

Cultural learning exchanges addressed a range of topics. Food and cooking were commonly seen as examples. Several nurses and clients regularly shared recipes or discussed where to find particular food items in Toronto. For example,
“They’re so comfortable with that pressure cooker. That pressure cooker makes me nervous [both laughing]… That is partly cultural and they have taught me that because… their fuel is so expensive back home, they use the pressure cooker as a means to shorten the cooking time…and, y’know, they get really good results with it” (Lynette, interview, p.7).

“Sometimes you’re there around lunch time… You know, you get all these smells as you walk in the door. I want to know what they eat, what they’re cooking… And so they’re generally interested to show me. ‘Oh I use this, I use that’. Sometimes we talk about recipes. You were with me; sometimes we don’t even talk about TB” (Evelyn, interview, p.15).

Sometimes cultural learning happened by asking co-workers of same ethnic background about specific issues, but much of their learning seemed to be in the moment of the visit, by making mistakes of etiquette or language, and being corrected by clients themselves. Several nurses cited the example of learning culturally appropriate greetings.

“Nobody gives you a whole book before your first home visit and says, ‘ok, [this] culture, don’t do this, this and this, and do this’, right? So… you have to laugh at yourself because it’s like, ‘oh nice to meet you I’m here to help your wife’ [reaching out as if shaking a hand]. ‘Oh, no m’am. We don’t touch the females’ hands’ [Takes a big gasp. We both laugh]… And I’m like, ‘ok how stupid do I feel; now does my patient feel I’m making a pass at her husband or what?’ So it’s hard sometimes, but I think… that’s why I’m so eager to learn. Because I’m thinking, the more I know about their culture, the more I can also relate. They can also relate to me, if they know that I’m making the attempt to learn about them” (Paulette, interview, p.14).

Learning from each other in this way seemed to build connection and familiarity, and a sense of familiarity contributed to a comfort level that created more space for questions and further learning for both client and nurse. For clients, these conversations involving cultural comparisons seemed to serve as a pragmatic way of learning about Canada, perhaps even impacting the acculturation process for some. I watched as Louisa established some comfort in every visit with her new client, Eyob, partly by asking him to compare life in Canada and his home country. The following is one example of such an exchange:

Louisa comments that it is a rainy day and wonders if Eyob will go outside today. He says “no”, and she persists with, “it’s good to try to get out for a bit every day. Do you have an umbrella?” Eyob laughs, “Umbrella for old people”. Louisa laughs too, and asks why it’s ok for young people to get wet. Eyob laughs and shrugs. Louisa then asks what other differences there are between the cultures of “home and here”. He first tells her that not everyone goes to school, like
here…. that moving from a small village to Toronto is very different and would be difficult,… He tells us that women older than 50 yrs don’t wear lipstick or high heels; “all they do is go to church”. He tells us that men never cook and goes on in some detail about how men don’t know how to cook even the “simple” things “like omelette”. He then shares stories of his friends’ cooking skills. They are both smiling and laughing as he describes this (observation notes, p.7).

Observations in Lynette’s visits also shed light on the familiarity and comfort coming through cultural learning exchanges. In particular, I often noticed Lynette explaining English idiomatic expressions to her clients. For example, while discussing Rahim’s plans for the weekend, she commented that he had “all the bases covered” and then asked if he had heard that expression before. With a noncommittal “hmm” from him, Lynette asked if he knew baseball. He smiled and then launched into a detailed explanation of a similar game, ‘Rounders’, using lots of hand gestures. Lynette smiled and nodded, telling him she may have played that game before (observation notes, p.10). In another visit, Rahim commented on the warm spring weather and Lynette responded:

“Oh, did I tell you I saw a robin?” Rahim: “Hmm” [a ‘so what?’ kind of look on his face]. Lynette then explains that many birds fly south for winter and return in the spring, including the robin, and that therefore, “robins are a sign of spring for us. I always like to see the first robin, it means spring is coming”… He smiles and nods (observation notes, p.11).

While clients were learning about Canada through their involvement with nurses, several nurses articulated a sense of job satisfaction because they learned so much about other places in the world (Louisa, Lynette, Evelyn, Paulette, Leslie, Karen). Paulette described it in detail:

“All the different cultures that we get the chance to have the opportunity to learn about… so the culture does play a role into the type of relationship I build with them… And it’s been an extremely eye-opening experience that way, and that’s one of the bigger reasons why I love my job. Even putting aside nursing, it’s an opportunity of a lifetime for me to come to feel a lot more empathetic towards the newcomers to Canada, because I never really stopped to think about them before... ‘I’m just a boring Canadian and you come to our country, and how hard must it have been for you’… and it’s usually like that unfortunately, you don’t ever find yourself saying, ‘oh it’s so easy…’. No. It was very difficult, they’re leaving their families back home and some have come from refugee camps” (interview, p.13).

She went on to connect this cultural learning to relational work specifically:
“You have to be interested enough in other people to develop your people skills. And from my own experiences, if I’ve kept myself open and receptive to hearing somebody’s story, it makes it easier to be empathetic… y’know, ‘oh man, that’s got to be rough, oh that sucks, that’s unfortunate’… with all those experiences of people sharing their stories with me, it’s made me that much more eager to get to know the next person and their story” (interview, p.18).

It was precisely such emotional responses of nurses, according to several clients (Akello, Afua, Eyob, Alicia, Kwame), that contributed to clients feeling heard and understood which directly impacted their overall experience of TB treatment. While culture per se was not articulated as a factor in their relationships, it seems that clients’ sense of feeling understood did indeed have cultural underpinnings.

Cultural learning exchanges were frequent in this study given the range in ethnocultural backgrounds of clients. Nurses seemed to carry out what may be theorized as cultural translation as part of what it means to be a professional. Yet this was not identified as such by participants; rather culture seemed to be simply part of knowing each other. The pull to understand culture within and beyond meanings of ‘professional’ came through the next dimension of this theme; specifically, in client experiences of displacement and nurses’ understanding of and involvement in them.

The immigration experiences of clients were overwhelmingly apparent in the study, and situations of immigration beg questions of implantation (practically moving from one place to another) and give rise to concerns of displacement (feeling out of place). Clients in this study were supported in their immigration process by these TB nurses who often filled in the gaps of settlement.

“I think in terms of what it must be like for him to immigrate here… I’d love to talk to him about what conditions he left. Because many of the people I visit had servants and maids… and then come here and they’re at the bottom of what you can have here in terms of housing or servants and all that kind of stuff. So it’s a real contrast and a cultural shift that some deal well with and others don’t” (Leslie, interview, p.8).
There were three sorts of displacing experiences for clients that were acknowledged and at times directly addressed by nurses through efforts that seemed focused on supporting clients’ sense of belonging: 1) the separation from family and efforts to stay connected across physical distance; 2) settlement issues; and 3) experiences of prejudice and discrimination. First, clients were dealing with being alone in a new country, many separated from family and disconnected from community ‘back home’. Acknowledgement of the difficulties and the range of feelings that go with this experience seemed to be a simple, ordinary and yet important part of relational work. For example, some clients explained that their relationships worked well with the nurses who expressed concern for the well-being of family back home as well as the client’s own homesick feelings. Such was seen in the following examples:

He tried to call his wife to make arrangements for whole family to meet up in [South Asia], but because war has broken out again in [home country], it has been “so difficult”… his wife and family have had to go to an evacuation centre. When they get settled, Rahim will try to arrange a conference call with [all of them in different places]. He explains a bit about the war and about how people… need to go to evacuation centres if the fighting is in same area as their home. Lynette is turned toward him, nodding, commenting occasionally, ‘oh’ and ‘hmm’ as he speaks… She asks if he is looking forward to seeing his family and he says ‘yes’. Silence. Lynette: “so you have a lot on your mind?” Rahim: “Yeah”, looking out the front of car (Lynette & Rahim, observatin notes, p.7).

We begin talking about Namazzi’s family, and Bev asks where they are now all living – spread out around the world. Bev then makes reference to ‘living in the camp’. She asks Namazzi about her choice to move to Canada and Namazzi explains that she didn’t really choose it; that they are just given a list of possible places to go and assigned one of them. She also clarifies that she has extended family here, but none of her immediate family (Bev & Namazzi, observation notes, p4).

There was also the displacing experience of being disconnected from communities here in Canada, which applied to both immigrant cultural groups as well as those situations in which the person was born in Canada yet still disconnected from family and community. For example, Kwame talked about the isolation that he and his wife felt because they were here without any family and it was difficult to get together with the few friends in their cultural group here.
because everyone is very busy (interview p.3). Canadian-born Elijah had a long-standing separation from his community, but he talked with Louisa about being re-connected through an elder in the city:

Part of getting reconnected with his band and an expectation of them helping him was for him to think about coming back to speak with youth… “about problems and addiction… and how to stay out of trouble”. He looks at Louisa, raises his eyebrows and smiles, as if waiting for her to comment. Louisa says she thinks he would be good at that. He smiles… He then talks about specifics of the abuse in his childhood and when he started drinking… She gives more positive reinforcement about his renewed connection to the band, and how it seems to have been “uplifting” for him… As she shares this observation it seems to affect Elijah – he shifts, sits up a bit straighter, opens his arms wide, smiles and says, “we’ll see” (observation notes, pp.6-7).

There were clients in the study who, having recently arrived, were in the midst of adapting to life in Canada, a stressful time for most, and nurses were pivotal in this process. They acknowledged these displacing experiences and related feelings, provided practical resources and clarified information related to housing, employment, language support and immigration procedures. A comment from Akello encompasses all these dimensions:

“Because, now, if somebody has never even asked, to ask about, ‘how is your family back home? Have you communicated to them these days?’, then it means you are not concerned. What your only concern is, am I taking your medication… But [Leslie] is now a lady [who] really shows you even more than the nurses, to be interested…, ‘How are they getting on? Do you have any worrying issue as far as your family is concerned?’ Now, like, the second thing you are seeing is now she is taking the initiative about my work permit. She is concerned” (interview, p.2).

Coping with prejudice and discrimination was a particular concern in the settlement process. Several clients shared stories of discrimination they have experienced in relation to race, ethnicity, language, and being an immigrant which all may be understood, however inaccurately, as social markers of being from a different place. The following are examples of such:

He went into some detail about the difficulty of “being immigrant”, telling me he came as a refugee. He explains… how difficult it was to come and settle here, in some ways how it continues to be difficult, aside from having to deal with being sick with TB and HIV. He gives the example of simply learning to ride a bus or buy food (including finding food from “own culture”)… “And so Canadian people, they see, they think…”, he points to his head, cocks his head and makes a crazy face, “as immigrant, as refugee, you don’t know things. To ask, I am not
stupid if I don’t know.”… he says he expects such “stigma” from the general public but not from health professionals. He then points to Louisa as she is walking toward us and says, “but this lady. She my friend…She understand. She help.” Louisa smiles saying only, “oh, well” and shrugs… He apologizes to her for his anger earlier in the week, and says he was feeling “upset about the big stigma” (Louisa & Eyob, observation notes, pp.3-4).

“There are so many areas in Canada where I have been and I’m treated like I’m not a normal person. Or, somebody looks like, ‘uh, you are from Africa?’ I say, ‘yes’, and it’s like his mood is not…well to do with the Africans. There is always somebody behaves strange…Me: And you have had those experiences? Akello: Yes. I have ever been to places where really somebody directly shows you that he or she is not interested in Africans. There is maybe a big gap. So her service, or his service, to you, will be minimized… Rude. Harsh…. But as far as this Leslie is concerned, there hasn’t been any difference. It’s like we are same people, besides me being Black from Africa, her White from here” (Akello, interview, pp.8-9).

“I ask two time, three time, ‘please repeat. Please more simple, I can’t understand’. He was upset. He said, ‘if you can’t understand why you didn’t bring with you interpreter?’ I think they… not much accept, they should accept, be nice. Because people from other countries, they coming, they don’t know, not very well, because they have to learn first, language, and they are long ways from this country. That’s why I think they should be… more specifically help” (Fatima, interview, p.7).

Lastly, nurses expressed an awareness of their own implacement in relation to clients’ displacement. Specifically, by knowing clients beyond the TB situation at hand, the nurses in this study seemed to become more aware of the privileges they enjoy in their lives that were felt to be serendipitous; that is, it was privilege afforded to them largely through their place of birth. Speaking English and a lack of hardships such as poverty and war were the references most often given in this regard, as indicated in the following examples:

“… a number of clients have asked where I come from and what my background is. And I always feel they’re not going to like the colour of my skin, they’re not going to like the fact that I’ve lived here and that I’m not from another country… I haven’t had adversities perhaps like they have had in their life, trying to get here… so I’m always worried that my lack [laughs] of colour… and my lack of other languages will cause me not to be accepted by them. But in terms of me accepting my clients, I am open and [have] a big desire to find out about everybody” (Lynette, interview, p.6).

“…with my experiences of getting to know the patients that I’ve cared for in the last eight or nine years, it’s, ‘wow, hold on a second here, ok so you don’t speak any English but you have a story too, and just because you don’t speak my language doesn’t mean that you don’t have a right to share it with me” (Paulette, interview, p.13).
This awareness seemed to compel them to act. Professionally their role was to monitor the TB treatment and connect clients to resources, but as nurses became involved with clients and their situations more personally, they often seemed to take up other concerns which could be argued were not in their professional scope, yet seemed completely within it. For example, one nurse brought college course catalogues for a client. Another spent time encouraging one client in her career goals with practical suggestions, and someone else by explaining government programs for setting up education funds for her children. Another nurse discussed nutrition facts and suggestions for a client’s small children, and helped them with their homework. Finally, Lynette shared the following:

One of the things I did that I really enjoyed doing, and it wasn’t even the client, it was his wife, she wanted to learn English so… she would always have a list of words and I would speak them into a recorder and because of the fact that we did that… she eventually did separate from this man and she was eventually able to get a job as a receptionist” (interview, pp.11-12).

The above example highlights the final aspect of knowing each other within and beyond notions of the professional. Of 24 clients in the study, only one spoke English as a first language, and while conversational English was a requirement for participation, language barriers were still apparent in the data, continuing the implications of culture in relational work in the TB program. Nurses’ awareness of language barriers was clear and they addressed this challenging aspect of communication in three ways. Formal and informal language translation and interpretation happened routinely. I did not witness encounters with formal (paid) interpreters though nurses referred to this service often as they talked about their jobs. Informal translation was also indirectly understood only through these conversations. Family members often acted as informal translators in the home (Bev, Rosalee, Paulette) though as the following statement by Evelyn
indicates, translation by another person was not always necessary throughout the whole course of treatment:

“I had one lady who only spoke Spanish… no word of English. Well, I knew enough Spanish to get through the door, do the DOT, say it’s a nice day, ‘bonita clima’, whatever, and she’d go, ‘Si, si’, that kind of thing, and then, y’know, I’d have to get the family… to get some of the other bit of the job done or whatever. But, y’know, I could have a little conversation with her, and do my thing, so it was good” (interview, p.20).

Evelyn and Paulette emphasized the value of learning a few words in the client’s language for the sake of the relationship. It was not so much for the purpose of communicating details of TB treatment, but rather to cultivate a bond based in mutual learning and interest.

“The biggest kick that any of them get is that when you will take the time to learn their language… I go to [colleague] and say, can you teach me some words?... little things so that I’m showing them, I can appreciate what it’s like not to know a language, and here I am, I’m probably not saying it right but it makes her giggle… but I’m saying it well enough that they go, ‘oh you know [our language]!’… Me: So you don’t have to speak the language well? Paulette: No, I just do it out of respect. Because I think a lot of the time the patients that we care for… they find out that they’re sick and they just came in the last six months, and they’re going through ESL classes the moment they arrive here… And it’s always about, y’know, how they can’t speak our language, well how about us… showing them that [their] language is equally important, and I’m attempting, I mean it’s a meager attempt none-the-less, and it’s more to just say I respect that it is not easy to learn a language and [laughing] and here it is, proof” (Paulette, interview, pp.14-15).

Throughout the visits, I also witnessed nurses’ efforts in addressing language barriers through the daily and sometimes tedious work of repeatedly clarifying the smallest of words or expressions and through shared gestures and small games of charades. For example,

In trying to understand Hamid’s chest pain, Paulette asks, “Are you speedwalking when you go out?” Hamid looks puzzled and half smiles, “What?” Paulette looks puzzled for a moment too and repeats, “speedwalking… walking fast”, standing up and motioning with her arms as if she’s vigorously walking, “do you do that?” Hamid laughs [at her, I think], shaking his head, “I don’t think so.” They both laugh. Paulette: “Ok… just if you walk fast, maybe you need to slow it down a bit” (Paulette & Hamid, observation notes, p.6).

Clients’ awareness of language barriers came through in their explicit statements of the difficulty of English, as well as deep sighs and facial expressions that seemed to convey
exasperation and frustration in trying to communicate in English. Nurses noticed, acknowledged the feeling and patiently encouraged clients to continue, as seen in the following exchange between Louisa and Jose:

Louisa asks about the receipts for his new things. He tells her “no receipt”. She looks surprised; says that might be a problem. He sits on the bed directly across from where she sits on a small chair. He repeats “no receipt. Lost. I take out cigarette, receipt go with wind”. Louisa is frowning a bit, yet nods as if to encourage him to keep talking. Jose is gesturing to act out what he is saying as he says it. Louisa: “The receipts blew away?” Jose: “yes, in pocket, blow away.” She shrugs and holds up both hands, “oh dear. I will tell the Public Trustee” (observation notes p.5).

Being professional in this study held meanings of personal involvement for nurses and clients. Beyond a professional more generally refers to knowing each other and how descriptions and lived experiences of nurse-client relationships regularly blurred with analogies of friendship. This theme encompassed socializing-with-purpose that involved a kind of mutual personal sharing, the influences of place in knowing the person, particularly how one’s home is part of one’s identity, learning about cultures other than one’s own, and related to this, understanding displacing experiences of moving between cultures and language barriers.

**Summary**

Together, the themes of getting through the door, doing TB but more than that, and beyond a professional explored in this chapter highlight relational work as the continual navigation of being a welcome intrusion. While the intrusive aspect of TB care often faded to the background, it was never quite completely absent from the situations of these study participants. Indeed while the experience of having nurses visit over time may bring about more friend-like feelings for clients, the nurses could never forget their fundamental responsibilities for surveillance as well as client well-being. The surveillance aspect of the role can never go away, but respect, trust, and a complicated honesty went a long way in diminishing its intrusive sense.
Relational work in this sense begins simply with getting through the door and moves on to treatment and monitoring once inside the door.

As may be expected, doing TB is fundamental to relational work. Nurses and clients, although they may not have liked it, knew the disease had to be monitored. Clients knew this partly by living through it, as well as through learning about the disease and its treatment from nurses. Theoretical as well as practical knowledge associated with managing the disease is a vital part of TB nursing. However a surprise for me in this study was in how often TB – the symptoms, the pills, the appointments – was not discussed. The experience of support came through as the equally, and at times, more important part of relational work. Support was defined to some extent as practical resources, or incentives, but to a greater extent as nurses’ cultivation of psycho-emotional well-being, most notably through calming fears and challenging the stigma of TB that persists even today. Also, health concerns did not stop with the disease alone, especially given its high correlation with other illnesses. Nurses’ support implied addressing HIV, diabetes, addictions and mental illness.

These relationships in general were identified as professional yet like friendship, and knowing each other was central in the meanings that participants ascribed to both these dimensions. As nurses became involved in the personal situations of clients lives, their relational work always entailed socializing-with-purpose, knowing people through the influences of particular places, and the relating that happened was also inseparable from working to understand across the divides of culture, race, ethnicity, and language.
Chapter Seven: The Skill of Involvement, Providing Care, and Enacting Surveillance in TB

From the outset of the study I was interested in the dominance of a population health perspective in the TB program and how such discourses conceal certain aspects of the nurses’ involvement in contributing to the well-being of clients. I also wondered throughout the study about the biomedical focus which though vital for effective practice seemed to overshadow considerations of the relational dimensions of the work required of TB nurses. As a result of the study, I made seemingly contradictory interpretations of relational work through participants’ experiences that were explicited in the notion of welcome intrusions and the themes of ‘getting through the door’, ‘doing TB but more than that’, and ‘beyond a professional’. In this chapter, I return to the research questions that guided the study, offering answers through articulation of the skill of involvement and identification of two domains of TB nursing practice that reveal relational work in specific ways. Welcome intrusions is the defining idea for understanding the nature of relational work in TB, yet questions regarding the knowledge and skills essential to this work, how they are supported and developed, and how place influences the work require further exploration. The skill of involvement (Benner, Tanner, & Chesla, 1996; Benner, Hooper-Kyriakidis, & Stannard, 1999) provides a frame for exploring these questions of knowledge, skill, and place, along with specific attention to two areas of TB nursing practice that seemed to best address the themes of the study: providing comfort and enacting surveillance.

Welcome intrusions is a notion that captures the particular meanings that are generated in the lived experience of a reportable contagious disease, from the perspective of the client living through sickness and treatment as well as the nurse protecting the population while caring for that individual. Intruding without intruding, getting through the door, doing TB and more, and getting to know people beyond traditional professional labels are suggested as the central aspects
of this relational work. These study themes may be further interpreted as the thinking-in-action
carried out by TB nurses through the skill of involvement.

Thinking-in-action broadly accounts for nurses’ practice in everyday situations and
moments of caregiving in TB nursing. It implies that sound clinical judgments derive from
nurses integrating their knowledge of TB, accurately interpreting the client’s illness experience,
and opening themselves up enough to emotionally engage with the client as a person and with all
manner of problems. The overall aim of relational work, as thinking-in-action, is to help make
sense of TB symptoms, suffering, and treatment regimes, and to potentially create positive
meaning in what may be considered negative or marginalized social situations associated with
TB. This is further understood through the articulation of the skill of involvement for TB nurses
who are engaged in providing comfort and enacting surveillance, thereby holding the tensions of
welcoming and intruding.

**The Skill of Involvement Revisited for TB**

The skill of involvement is a useful way of thinking about the knowledge and skill of
relational work in TB. As previously indicated, it refers to integrating understandings of the
disease, the client’s interpretation of it, and the client’s life context, and responding in particular
situations to both the problem at hand and the person (Benner et al., 1996, p.90). TB nurses are
engaged with the problems associated with the disease and more notably, the treatment. They
anticipate, prevent, identify, and solve problems such as those arising from symptoms, side
effects of antibiotics, and scheduling of medication, visits, and appointments. They are also
engaged with clients as people who are often poor, unemployed, under-housed, struggling with
immigration, or sick with other diseases, and whose concerns include and go beyond the physical
manifestations of tuberculosis. Responding to these situations and people, equally important
aspects of the skill of involvement, requires listening, and attunement to clients’ as well as one’s own feelings.

TB nurses’ involvement in clinical situations, or emotional engagement with problems, was seen throughout the study and was captured in the first dimension of the theme of ‘doing TB’. Some examples of problems to which nurses responded by cuing into their emotions are: Kwame’s intense nausea, Ivan’s inflamed lymph node, Hamid’s chest pain, Kali’s phlegmy cough, and Luka’s uncontrolled diabetes and poor nutrition. The nurses involved in these situations described these problems with comments like “it is concerning” or “has me a bit worried”. Their attention to these vague feelings was also displayed in facial expressions during the visits, such as frowns and furrowed brows. The nurse in each situation responded to her emotions as part of asking detailed questions, probing about other aspects of the situations, and deciding what to do. By being engaged with the problem they were able to draw in their knowledge of TB at appropriate points during the visit, to communicate accurate honest information about the particular problem in relation to what the clients were experiencing, and to offer suggestions that fit with the specific circumstances.

The communicable nature of TB also means that nurses are engaged with problems of infectiousness and drug resistance. This work distinguishes the ‘population health’ aspect of clinical situations in this area of nursing practice. Infectiousness and drug-resistance complicate the clinical situation in TB nursing, requiring nurses to respond to individual clinical problems with implications for the population in mind. These situations of active disease call for emotional engagement with the problem of the spread of infection in terms of how it is a problem for the individual, such as learning how and when to mask, and solving accommodation dilemmas during isolation; and in terms of risk to the population, which may mean paying attention to gut
feelings about people misusing masks or breaking isolation. Closely related to this, nurses are emotionally engaged with problems of multi-drug resistant TB, a ‘scary’ strain of bacteria that defies existing antibiotics, as it manifests in individual clients and as a very troubling risk for the population. These nurses are involved in clinical situations that blur into population health situations that call up simultaneous problems of alleviating suffering, stopping infection, and limiting drug resistance, as well as other marginalizing health problems such as HIV and mental illness.

TB nurses are also involved in social circumstances, highlighting their implacement alongside clients living these circumstances. The community or home as location of practice brings them into situations that require engagement with the social determinants of health more directly than the clinical settings of hospitals. The fact that these nurses emotionally engage with social problems means that their skill of involvement, though perhaps focused on clinical and public health goals and concerns, is not limited to these alone, as highlighted by the second aspect of the ‘doing TB’ theme, ‘but more than that’. Given that they are practising in a range of locations and across a spectrum of sickness and health, nurses’ involvement extends beyond the disease itself to the social conditions that complicate the experience of TB, such as poverty, crowded and substandard housing, language literacy, low education, and barriers to accessing health care services. It is in this way that theimplaced experience of being ‘here’ in these situations with clients, as opposed to the more distant sense of being ‘here’ in a medical facility/role while clients are ‘there’ (in a cramped, dark basement apartment, or in the shelter, or in Toronto without family), comes to bear on emotional engagement. Reading emotional cues that arise to some extent from one’s implacement in such locations is a required part of the skill of involvement so that perceptions and interpretations of such complex social problems can be
accurately adjusted as needed. This often means that nurses are also involved with addressing concerns of stigma and protection of family members. Finally, nurses’ involvement in the social realm of clients’ lives also refers to the many visits in these non-hospital locations that are often characterized less by explicit medical clarification or symptom management and more by friendly socializing and topics unrelated to illness. In this sense ‘social’ implies the connection in the skill of involvement between engaging with problems and engaging with people.

Nurses are involved interpersonally in the caregiving moment which means they emotionally engage with the client as a person, interpreting concerns of that person’s illness experience in relation to his/her life more broadly. “Because personal concerns determine what is at stake for the person in any situation, the challenge for the [nurse] is to interpret those concerns that influence the person’s understanding of his or her own illness” (Benner et al., 1996, p.88). Being emotionally engaged in the caregiving moment with TB clients and interpreting their concerns accurately means being open to their fear, worry, and alienation, as well as a sense of displacement felt as loneliness, longing, and homesickness. This was seen in the study as Louisa consoled Elijah on a day he was feeling particularly lonely and depressed about his confinement to hospital, and when Lynette listened as Rahim expressed his longing for his wife in a home country in the midst of war. It also bears noting that TB caregiving moments require engagement with clients considered noncompliant or difficult, and therefore means withstanding emotions (one’s own and the client’s) such as frustration, impatience, or anger, and staying open to the cues they offer for alternative perspectives in understanding. Conversely, engaging with the person also means bearing witness to positive emotions of healing and recovery from TB, and celebrating life milestones and achievements along the way in a long course of treatment. Examples of such in the study were the birth of a child, birthdays, and new jobs. The theme of
‘beyond a professional’ addresses the skill of involvement in this regard: getting to know the client as a person in the everyday, socializing-with-purpose, and engaging in cultural learning exchanges with them. This all includes being attuned to personal identities and meanings of home as part of being with clients in their homes.

The spatial arrangements of visits in homes highlight proximity as a dimension of being engaged with the person, particularly in the ways it has been described by Malone (2003). Judging physical proximity by knowing where to sit or how close to stand, or when to don a mask and when to remove it was significant for clients in this study in terms of de-bunking myths of contagiousness, challenging stigma, and ultimately calming fears. The sharing of personal stories as well as humour and laughter in visits evolved into a familiarity between nurses and clients that may be interpreted as narrative proximity. There was also moral proximity to challenging life circumstances of clients, such as financial, housing, immigration, or other health problems. Perhaps the most stressful kind of closeness for nurses, moral proximity was seen in nurses’ responses to client needs that could be interpreted as ‘outside the box’ of their TB roles. Characterized in this ‘nested’ way, proximity highlights that the skill of involvement requires navigating closeness to and distance from the client at multiple levels, an often not-so-simple endeavour especially in community or home locations.

The consideration of proximity raises another important point about the emotional engagement required in the skill of involvement; that is, it has both effective and problematic aspects. The effectiveness of engaging closely can be seen in clients’ reports of feeling comfortable, being put at ease, adhering to treatment, and even simply in the smaller daily successes of nurses getting through the door. However, the perils of proximity (Peter & Liaschenko, 2004) are such that by emotionally engaging with the person in particular locations
and circumstances, the nurse opens herself up to her own anxieties. This happens as she bears witness not only to physical suffering while the person is sick or undergoing treatment but also the suffering associated with the social determinants of health and hardships of life. Furthermore, tolerating the anger and resentment that may come with enforcing isolation or treatment can be distressing. Bearing witness in these ways therefore may compel nurses to distance themselves from the person or the situation or both, or become under-involved (Benner et al., 1999).

Likewise positive emotions elicited in caregiving moments with likeable clients can pull nurses to being too close or too involved. Lack of recognition of this distancing or extreme closeness is problematic because either level of involvement may shift the center of concern from clients’ needs to nurses’. It is precisely in recognizing and reflecting on one’s proximity or under/over-involvement in the situation or with the person that nurses learn and develop their skill of involvement.

The experiences of nurses in this study highlight this learning and reinforce that developing the skill of involvement does not rest on each individual nurse alone. Several of them articulated the importance of learning from colleagues about unwritten parts of the job like how to get in the door, where to sit, or how to communicate with particular people. Lynette explained it as ‘shadowing’, taking what one learns from watching others’ relationships and incorporate it all into how one ‘is’ with clients. TB nurses generally work autonomously, but are constantly learning from colleagues across a network of teams. Case managers and DOT nurses in this study learned from each other as they worked closely at particular moments, yet usually at a physical distance from each other. There were informal supportive networks via daily telephone calls and socializing outside of work, and formal and regularly scheduled team meetings. They also learned these aspects of involvement directly from clients, for example in how they invited
nurses in and greeted them, or offered (or didn’t offer) the nurse a seat or something to drink or eat. Because intrusion is necessary and not intruding is a partial goal, the skill of involvement always implicates negotiation in TB.

The workplace culture of Public Health also played a part in nurses developing the right level of involvement. Nurses’ comments about ‘staying in the box’ were a poignant example of a workplace culture that for some felt like a compartmentalized approach to TB care. That is, the workplace endorsed the ‘right’ level of involvement as being ‘inside the box’ of TB-specific problems, and leaving non-TB-specific concerns for referral to other services. Added in the mix of organizational culture is the endorsement of TB standards and guidelines for directing policy and protocols, and in turn, setting general expectations for direct relational work with clients. The skill of involvement as an aspect of TB nurses’ thinking-in-action however, cannot be learned from simply reading and applying such standards and guidelines.

Reconciling TB Standards and Guidelines with the Skill of Involvement

The phenomenological perspective of thinking-in-action brings into sharp contrast the importance and limitations of biomedical frameworks, often in the form of standards and guidelines, for understanding TB nursing practice, specifically with regard to relational work. TB standards and guidelines lay out details of the disease, strategies for curing it, and monitoring it in the population, and nurses have been identified as playing a key role in this (International Council of Nurses (ICN), 2008; Public Health Agency of Canada (PHAC), 2007a; Tuberculosis Coalition for Technical Assistance, 2006; Williams et al., 2007; World Care Council (WCC), 2006; World Health Organization (WHO), 2003; 2008). A side point to remember is that nursing practice in general also follows standards and guidelines for an array of nursing activities, including maintaining parameters of nurse-client relationships (e.g., Community Health Nurses
Association of Canada, 2008; College of Nurses of Ontario, 2006; Registered Nurses Association of Ontario, 2002). Taken together, these documents can be understood as “protocols, procedural accounts, and descriptive accounts of what constitutes skilful practice use of technology and science” (Benner et al, 1999, p.2), and TB documents certainly do provide vital information regarding this well-studied disease. Information about the bacteria, where and how it lives, the damage it causes to the human body, the effects of each antibiotic on the bacteria and on the human body, and the procedures and legalities of isolation is part of the knowledge required for curing the disease and stopping its spread in a population. Yet “presentations of taxonomies… as useful as they are for codifying and retrieving information are not the same thing as being able to actively think about the issues and clinical conditions to which they refer” (Benner et al, p.4). Standards and guidelines reveal little of the day-to-day relational work of nurses. The skill of involvement, as it has been articulated here, helps to shift understanding of nursing work from orderly strategic intervention comprised of a series of rational activities to a relational encounter of contextualizing and integrating TB knowledge within broader life experiences.

The skill of involvement is inferred in TB standards and guidelines, through their identification of a “patient-centered approach” as the key strategy to foster adherence. A patient-centered approach is said to encompass education and support, and is further delineated in some documents by the terms “counselling” and finding “mutually acceptable interventions” (ICN, 2007; PHAC, 2007; WCC, 2006). To follow guidelines and say that TB nurses’ relational work is a patient-centered approach, and to leave it at that, is not enough to account for what I interpreted in the relations between actual nurses and clients. Theoretical identification of education and support, however functional such categorization may be in phrasing job descriptions, stops short of understanding the nuanced dimensions of each in daily practice.
Education and support are constituted in everyday meetings of clients and nurses, and require the skill of involvement as it has been described in this chapter if the education and support rendered is to be received as helpful.

Patient and public education holds a substantial focus in TB literature as a key strategy in controlling the disease with the assumption that if people are properly educated about the disease, they will know what to do to: a) avoid contracting it; and b) properly adhere to treatment. Many direct references to patient teaching or health education were made by nurses throughout the study. ‘Health education’ assumes an imparting of information from the nurse to the client through various means that leads to clients understanding and adjusting behaviour according to that new information. By contrast, observations and participants’ descriptions revealed the practical know-how of explaining, describing, watching and demonstrating that seemed to first reflect the skill of involvement. Nurses in this study were regularly repeating facts, paraphrasing, translating medical nomenclature into ordinary language, translating complicated English idioms into simple English words, using metaphors and analogies, and explaining them, asking questions and carefully withholding others, and being silent. Clients regularly described bodily sensations and symptoms, asked questions about a range of topics including TB, shared detailed personal and family stories, and silently watched the nurse as she chose where to sit, greeted others in the home, and carried out activities such as filling the dosette or writing in the file.

When framed within the skill of involvement, the discussion of education shifts to a discussion of engaging in dialogue about TB that is primarily comprised of asking and answering questions, and is regularly interrupted with other occurrences of daily living. Rather than a linear process, the skill of involvement denotes a back-and-forth of interpreting biomedical information
into plain language that makes information useable for the client and offers opportunities for new understanding of symptoms, suffering, and necessity of treatment from the perspective of public health. It implies an ongoing conversation over the course of their time together, as nurse and client together interpret theoretical knowledge of TB and the illness experience within the client’s life more generally. TB nurses are regularly refining explanations of TB to suit clients’ level of understanding as well as the situation. This kind of ongoing explaining and responding to one another seems more an indication of dialogue rather than didactic teaching. It is evidence of the skill of involvement through daily presence and communication, and implies the need for attunement that comes with careful listening.

Attunement is also required if the support that nurses offer is to be received by clients as supportive. As another key term in standards and guidelines, support is explicitly referenced in descriptions of fostering adherence, yet is not well elaborated. Beyond the notable definition of support as medical or material resources, what are its other dimensions? The participants in this study often used the word, yet usually not in reference to resources. Rather, support referred to how nurses contributed to a sense of well-being, described through such phrases as “makes me feel comfortable”, “puts me at ease”, and “shows concern for me” – all terms that can imply a level of emotional engagement which implies nurses’ involvement.

Like education, support may be framed within the skill of involvement which shifts its meaning beyond the provision of resources to being involved interpersonally. This may also be named as emotional engagement with the person through respect for person, place, and privacy that was described in the previous chapter as part of getting through the door. Being emotionally engaged with clients as part of support was seen in the study in the listening and silences between participants.
When asked what skills were necessary for a good relationship in TB, several nurses answered with listening. Likewise, clients described how they felt heard by nurses, which for them meant that their nurses cared about them and not just the treatment protocols. By listening, nurses affirm their openness and attentiveness that contributes to a sense of being supported. As nurses focus on their skill of involvement, their engagement both in the clinical and public health situations of TB and with the person holds educative and supportive potential in contributing to clients’ healing, recovery, and well-being.

Though standards and guidelines generally name the patient-centered approach and highlight education and support as necessary components of it, nurses’ work as part of TB care is not fully answered in this way. The skill of involvement highlights how TB nurses tend to their potentially contradictory responsibilities to the public and to the individual, to clinical and social problems, and to clients’ experiences in the midst of everyday life. The skill of involvement however, is only one dimension of answering the question of knowledge and skills of relational work. Thinking-in-action is more fully explicated by understanding the skill of involvement within relevant domains of practice. As a situation with particular clinical and caregiving goals and concerns, providing comfort is one domain of TB nursing practice that shapes and is shaped by the level of nurses’ involvement according to the demands of each situation.

**Providing Comfort**

Domains of practice vary according to the particular areas of nurses’ work, yet many may be common to all of nursing as they shape thinking-in-action. They are understood as situations that give rise to particular clinical judgments as part of carrying out nursing work (Benner et al., 1999). They overlap with one another though at times specific domains come to the foreground and others fade to the background. Though Benner et al.’s nine domains of practice have been
articulated for critical care nurses and several have relevance for TB nursing, one in particular resonates with this study’s themes: ‘providing comfort’ comes to the foreground in regard to relational work of TB and ties closely to the skill of involvement.

Comfort is “necessary in healing because it offers the person space to regroup, to recover, and to grow”, and is a critical indicator of most clinical judgments in nursing (Benner et al., 1999, p. 246). Comforting means “to strengthen, aid, and encourage, as well as to soothe and console”, and the need for it comes about in experiences of distress, loss, or suffering (Benner et al., p.244). Because “comfort is never fully born of freedom and choice” and means different things to different people, providing comfort is an ambiguous practice (Benner et al., p.244). Therefore, for the comforting efforts of nurses to be received as comforting depends on timing, trust, openness and acceptance. “The capacity to comfort and be comforted lies fully within neither the nurse nor the patient” (Benner et al., p.244). In other words, comforting is relational from the start and so here is the challenge of providing comfort: to co-discover what it means in particular situations since one’s comfort depends on “past socially learned, embodied responses, and these must be called upon in a new context” (Benner et al., p.247).

Some examples of providing comfort are holding a hand, wiping away tears, talking soothingly, darkening a room, or quieting a space, and because it is impossible to identify all the ways to provide comfort in procedural steps, this domain of nursing practice can appear trivial, ordinary, or less important when compared to powerful scientific interventions that ‘cure’ and therefore is often left out of scientific discourse (Benner et al., 1999, p.244). Cure and management of disease are certainly the dominant discourse of TB and yet a significant part of what clients in the study seemed to value during treatment was feeling comfortable, a sense they attributed to nurses’ involvement with them. This was captured in the themes ‘doing TB but
more than that’ and ‘beyond a professional’ and taken up in the ‘welcoming’ aspect of the overall notion of welcome intrusions.

Nurses’ efforts in providing comfort begin with first perceiving that comfort is needed and this requires attentiveness, noticing and presencing. It calls for “solidarity and connection rather than distance and control” (Benner et al., 1999, pp. 244-5) that necessarily relies on proximity. By being up close, attentive and present to clients in experiences of distress, nurses necessarily connect with clients’ personal meanings of comfort as well as their own. Just as the skill of involvement requires emotional engagement which may raise anxiety, part of providing comfort is the acknowledgement of suffering which calls nurses to admit their own vulnerability to suffering. Providing comfort in this study took two main forms: comforting through connection and relationship; and being available without being intrusive (Benner et al., 1999). A connection sets up the possibility of comforting and again emotions play a role. “Fear of the unknown, harm, loss, damage, and dying may be foremost in patients’ thinking, but they may not be able to speak their fears, or if spoken, their fears may go unheeded” (Benner et al., p.259). Providing comfort through connection and relationship acknowledges such feelings. It refers to “meeting another in ways that sustain a sense of trust and being cared for… engaging with them as persons rather than as diseased or damaged bodies” (Benner et al., p.258).

Signs of disease and damage were evident as clients in the study recalled troubling experiences of difficulty breathing, coughing, and pain. Sputum tests, chest x-rays and CT scans also served as reminders of a diseased body, along with the side effects of antibiotic treatment such as nausea, fatigue, blurred vision, and changes in liver function. Though clients did not often directly state their fears of TB, their indirect questions and silences at times conveyed it, and nurses responded through attentive body language, gestures of affirmation, and verbal
reassurances. Additionally, in the public health situation, bodies are identified as receptacles and vectors of disease, and being contagious is part of the suffering experienced by clients. Comforting through connection therefore is particularly important for diminishing feelings of stigma and alienation. Contagiousness also implies the need for sensitivity with regard to closeness and distance. With this in mind, choice about one’s proximity in client meetings is an important aspect of what being “physically comforting in style and tone” means (Benner et al., p. 258). As seen in this study, getting up close to infectious clients, offering a quick greeting before masking, or sitting next to them, goes far in sustaining a sense of trust and being cared for.

For nurses, knowing how near or far to locate oneself in relation to clients in their home, in an apartment lobby, a coffee shop, or on the street implies a spatial positioning that in such ordinary circumstances goes largely unnoticed and is navigated for the most part nonreflectively. However, as part of creating a connection that is comforting, such issues of proximity are often pulled to awareness. Nurses enter homes as guests, but not exactly guests, and are aware of this ambiguity every time they enter. In choosing where to sit, when to mask, or how close to come when greeting the person, meanings of social etiquette and infection risk are stirred for both the nurse and the client. How close or far nurses are has bearing on clients’ experiences of connection in terms of feeling stigmatized and afraid, or accepted and comfortable. This proximity in visits highlights the importance of place in engaging with the person. Beyond such spatial considerations, part of connection in TB nursing is integrating the meanings that particular places hold for clients, and being sensitive to experiences of displacement.

In order for the connection to be a comforting one in TB nursing, the places of visits have to be considered. This study emphasizes the privacy of places, and nurses’ discretion and even secrecy at times is important in meeting clients in such a way that trust is sustained. However, in
situations of TB, meanings of places expand beyond privacy to such notions as healing, safety, confinement, and even transition. Particularly for the large number of TB clients who immigrate to Canada, meanings of far away places and being displaced from them shift to the foreground of providing comfort. Connecting with these clients means being attentive to their stories of home, journeys to Canada, and dilemmas of immigration and settlement. Providing comfort involves engaging with people in making sense of their experiences of displacement.

The experience of placelessness described in the theory chapter can be identified through such “symptoms” as homesickness, disorientation, depression and desolation (Casey, 1993, p.x), aspects of which were displayed in several visits in the study. While being placeless geographically is not possible, separation from places or feeling displaced is possible and gives rise to such feelings as identified above. Such experiences, tied closely to those of loss and suffering, can threaten one’s well-being, calling on the need for comfort. Hence, providing comfort does not come only through connection as it has been described thus far. For these clients it also comes through a kind of re-connection. Re-connection opportunities are opened up in engagement with nurses as they remember their original home places in other countries in sharing stories of these places and the people there, and as they vent feelings of worry about situations of loved ones back home.

A final point about this form of providing comfort is that “a comfortable relationship is in itself a comfort measure” (Benner et al., 1999, p.262). Nurses’ cultivation of such is seen in the study results in terms of how they socialized-with-purpose and lightened things up with humour and laughter. Furthermore, connection and relationship happen over long periods of TB treatment and in places of clients’ choosing, which allows time and space for the relationship
itself to develop a tone of comfort that is born out of a sense of familiarity that does not happen in shorter-term or hospital-based situations.

Providing care that comforts, strengthens, and protects depends on well-honed skills of involvement, so that patient and family are given the space they need to experience their own ways of comforting. Discerning how close and far away to be with patients and being available without being intrusive are critical distinctions in learning to be comforting (Benner et al., 1999, p.273).

Being available without being intrusive is the second form of providing comfort that is relevant to the work of TB nurses. One of its core features is the issue of proximity. Being available to the client in the moment, and at times to family members, requires being up-close, present and open in ways that have been articulated previously in terms of emotional engagement with the person, attentiveness to him/her, and attuned to the need for comfort. Within this, however, is also the need to recognize when one is too close. Being too close is a possible indication of being intrusive, and therefore as part of providing comfort, nurses must also step back so that clients can soothe themselves, do for themselves, and make decisions that are good for them.

Reflection on closeness and intrusiveness raises the question of the nurse’s power in providing comfort. Discourses of power and control are grounded in the body, “where we live out the direct, immediate understandings of domination and subordination in our stances, our gestures, expressions, distances and proximities” (Benner et al., 1999, p.274). Bodily communication of these understandings has direct bearing on clients’ sense of comfort, with intrusiveness representing a domineering kind of power in the situation. However, the openness and attentiveness of being available leads to better understanding of situations and creates space
for clients to exercise their power and control. Being available without being intrusive therefore also means that nurses must assess clients’ responses and honour any indications of withdrawing or retreating (Benner et al.).

Yet TB clients cannot always choose to withdraw or retreat. By law they cannot refuse treatment or isolation when the disease is active. The nurse’s role in surveillance as a strategy of enforcement calls for understanding domination and subordination in terms these situations of explicitly ascribed power and control. Providing comfort in this sense does not entirely address the intrusion of surveillance that is a reality in TB nursing practice. Nurses may want to honour clients’ signals of withdrawal or resistance, thereby comforting them, but the situation of surveillance may demand that they remain present and keep clients in view. Because intruding is central in the nature of relational work, indicated by the overall theme of welcome intrusions, enacting surveillance is proposed as a distinct domain of practice for TB nursing in public health. It begins in re-thinking adherence so as to cast light on the surveillance role as a valuable opportunity for other caring forms of engagement in the contagious illness experience.

**Enacting Surveillance**

Whether named ‘compliance’, ‘adherence’, or sometimes ‘concordance’ (Bissell, May, & Noyce, 2004; Booker, 1996; Carpenter, 2005; Cederfjall, Langius-Eklof, Lidman, & Wredling, 2002; Lerner, 1997; Murphy & Canales, 2001), the general notion so identified can stir uneasy feelings related to ethical concerns of infringing on clients’ personal freedom by insisting that individuals must undergo treatment for certain conditions. While recognizing the importance of these distinctions of language, as well as the fact that nurses often used the word ‘compliant’ in the study, adherence is the word used in this section because of its consistent presence in the language of TB guidelines. Adherence is an important concept in discussions of nursing
relationships in TB because implications of accepting or rejecting treatment create a complex mix of infection-illness situations including and beyond one individual’s well-being which in turn implicates the nurse’s skill of involvement in these situations. Adherence as a main goal of the TB program is defined as “the patient’s and health care provider’s ability to follow management guidelines appropriately. It most often refers to the strict adherence by the patient to the prescribed regimen of anti-tuberculosis drug treatment or preventive therapy” (PHAC, 2007, p.375). While this definition acknowledges the professionals’ responsibility to follow protocols for treatment, it emphasizes clients’ responsibility to cooperate with medical experts’ treatment regimes. The onus of adherence is ultimately on the client, yet involves a fundamental question of the quality of the relationship between health care professionals and clients. Relationships in the DOT program are of particular interest for this domain of practice given it is a program that exists the world over to expressly answer the growing concern of high rates of multi-drug resistant infections. Its clear aim is client adherence to treatment.

Approaching the discussion from the perspective of relational work rather than that of guidelines or organizational goals casts adherence not as a pejorative directive but rather as matter of mutual concern for nurse and client that must be negotiated. Addressing treatment adherence in day-to-day visits then involves interpreting concerns, taking into account mandates of the program, effects of illness and treatment on clients, and broader life circumstances. Understanding each client’s given situation in terms of possibilities and constraints for being able to adhere to treatment is the starting point for negotiation, which in the study took such forms as practically working out schedules and locations of visits, affirming and encouraging, and providing resources. But to claim that relational work in TB is based in equal negotiation power is false, given that TB is a contagious disease and nurses hold the tension of population
safety in all individual caregiving situations. Nurses can and do initiate the process of
‘sectioning’ clients under the Health Protection and Promotion Act (HPPA) without necessarily
negotiating such with those clients.

Adherence is much less a concern while clients are still feeling sick. For any of us, taking
pills is generally easy and even gladly received when the result is the alleviation of symptoms.
We adhere to treatment without needing to be reminded (Bayer & Dupuis, 1999). Adherence
becomes a concern however when symptoms dissipate and the bacteria is easily forgotten.
Moreover, not adhering to the full course of TB treatment creates problematic situations for the
client and also for the population in terms of the development of drug resistant strains of bacteria
and the spread of infection to others. Therefore monitoring of adherence comes to the foreground
of concerns, and invites thorough examination of surveillance as an inseparable dimension of the
nursing role. Because it is in daily moments of people’s lives where forgetting or resisting the
pills arises, this is also precisely where surveillance must happen, and therefore where nurses’
skill of involvement is implicated in how that surveillance is enacted.

Enacting surveillance is an important area of relational work for nurses charged with
protecting the public’s health. The situation of TB is unlike many other illnesses in several
senses: it is an airborne disease that can be transmitted to people who may be unaware that they
are at risk or who possibly cannot take precautions to protect themselves; yet effective treatments
exist to cure it; and its spread in the general population can be interrupted through medical
intervention with the individual (Bayer & Dupuis, 1999, p.228). The ethical concern for public
health is finding the balance between “broad and relatively unfettered coercive state action” and
“reliance on solely voluntary measures that may not prove sufficient to protect vulnerable
communities” (Bayer & Dupuis, p.229). As a result the harm principle is commonly accepted as
the justification for surveillance in its assertion that the state may intervene when one’s exercise of personal freedom causes harm to others (Bayer & Dupuis; Upshur, 2002). Discussions that assume or critique the harm principle have been addressed in the literature of other communicable diseases, and similar issues associated with the isolation and surveillance of infected people have been taken up there (for example, Francis et al., 2005; Smith et al., 2004; Sokol, 2006; Wynn & Peter, 2003). Surveillance as a central part of public health’s mandate is most often carried out by nurses, or health care workers whose work is usually delegated by nurses.

In the everyday TB situations of this study, surveillance was understood as a “necessary evil” by nurses and clients alike. The intrusion that surveillance represented was acknowledged especially at the beginning of treatment. Nurses’ mandate of control did not seem hidden in the study but rather openly and directly identified, and appeals to the harm principle were made often as the rationale for the intrusion. With an understanding of the necessity of surveillance from a public health perspective, nurses set about to minimize the intrusion of surveillance in the person’s life. The surveillance seen in this study was less a clear-cut manifestation of nurses’ power and control over clients and more a set of paradoxes of power understood in the notion of welcome intrusions. For example, though watching people swallow their pills was expressly understood as the job of DOT nurses, they did so without always directly looking. Also, their surveillance role positioned them in the health care system in such a way as to allow them to advocate for clients. Yet also, friendly socializing often stood out in interactions. With the nurse’s authority just below the surface, her TB expertise was always available and called upon depending on the situation.
Critical perspectives on power in nursing literature contribute greatly to understanding this complicated aspect of nursing work from a sociological level of analysis (Johnson, 2005; Perron, Fluet & Holmes, 2005; Stevenson & Cutcliffe, 2006). But what is it like to be the nurse who is relating daily with clients who need to be watched? With much critique of surveillance as a power-over relationship, the importance of this aspect of nurses’ relational work has been rendered invisible in overall success of treatment programs (Dodds & Bowles, 2001; Hamilton & Manias, 2007; 2008). A few studies of public health nurses working in child protection have highlighted the blurry nature of the surveillance role; that is, nurse as agent of the state and supportive caregiver (Andrews, 1999; Marcellus, 2005; Peckover, 2002; Wilson, 2001). The essential moral concern lies in the recognition that while wanting to care for individual clients, the overall success of the work depends on surveillance, on watching them and their environment.

In a critique of empowerment as the desired aim of public health nursing, Andrews (1999) challenges the privileging of individuals’ power over that of the ‘expert’ health professional which the notion of empowerment can imply. She argues that while public health nurses may want to see their role as an enabling one to improve autonomy, many clients look to them as experts to provide information and solve health problems. In other words, empowered ‘non-experts’ still hold expectations of the ‘experts’ as professionals with knowledge and skill. Also, with empowerment as the central message, nurses in surveillance roles face the dilemma of needing to conceal the controlling or power-over aspect of such roles while carrying out daily work with clients. Marcellus (2005) suggests reframing surveillance as “a caring construction of watchful waiting or watching over” as a useful way of understanding nursing work (p.416). Using relational ethics as a guide, she suggests that a focus on having “engaged interactions” with clients leads to
opportunities for discussing the underlying elements of surveillance (Marcellus, p.418), such as the nurse’s power. And though she does not elaborate on what engaged interactions look like, this is language that fits within the understanding of the skill of involvement presented here.

Hamilton and Manias (2007; 2008), from their study of psychiatric nurses’ activities in an inpatient unit, take the discussion one step further by shifting from simply acknowledging elements of surveillance in nurses’ relationships with clients to embracing it as central. Psychiatry is an area of nursing practice that shares similarities with TB/communicable disease control in public health. Notably, both are highly ordered by laws surrounding the infringement on personal freedoms in the name of protection made explicit in the Mental Health Act and the Public Health Act. Therefore the reflections of these authors offer relevant and compelling insights for the discussion of surveillance here. They found observation to be a significant portion of the work and yet disregarded as a valuable repertoire of skills and knowledge, arguing that observation in in-patient psychiatric settings remains a form of nursing knowledge subjugated to the idealism of therapeutic engagement with individual clients. They assert that “nurses’ everyday observation and other tacit, situated nursing practice deserve greater investigation and articulation” (Hamilton & Manias, 2007, p.341).

These authors laid out three dimensions of surveillance: the situated nursing gaze (made up of the scan of the whole place and all people in it), the clinical gaze (made up of observing evidence of symptoms, absence of symptoms, and coping despite symptoms), and the engaged intimate gaze (made up of empathic and personal looking or watching). There are similar dimensions in the surveillance carried out by TB nurses, which are all infused with the skill of involvement. The situated nursing gaze extends beyond scanning one same ‘whole place’ of a hospital unit to the whole places of homes and neighbourhoods. The clinical gaze encompasses
presence and absence of TB symptoms and medication side effects, as well as changes in mood and general affect. Observation also goes beyond coping ‘despite symptoms’ to include coping with multiple layers of social concerns. Finally, the engaged intimate gaze was witnessed in regular friendly socializing, and noticing, for example, concrete details of the person’s dress or items in the home, that conveyed something about the person.

Surveillance has been traditionally cast as part of custodial, as opposed to therapeutic care; yet as Hamilton and Manias (2007; 2008) point out, without skillful observation or watching over patients and their collective safety, programs guided by high humanistic ideal alone are useless. The same can be said of TB programs. Surveillance in TB is often oversimplified and thereby devalued as a custodial task of ‘watching them swallow their pills’. Yet their awareness of the obligation to watch and the watching itself are essential dimensions of nurses’ developing the skill of involvement.

Watching, gazing, watching over, or watchful waiting (Hamilton & Manias, 2007; 2008; Marcellus, 2005) are notions that start to get at enacting surveillance as a domain of practice. However the words ‘watching’ or ‘waiting’ on their own suggest the possibility that doing surveillance well does not necessarily require the emotional engagement explicited as part of the skill of involvement. Furthermore, this study highlights that TB nurses watch without always watching. This does not imply they do not pay attention or tend to tasks at hand, but rather that their scan of the environment, observation of clinical symptoms, and engaged intimate gaze are integrated into choices of when and how to watch. These choices in turn influence clients’ experiences of feeling heard and respected while being under surveillance, thereby contributing in a potentially positive way to interpreting meanings of illness and infection.
Building on the ideas of the authors referenced earlier, and in keeping with Benner et al.’s (1999) phenomenological perspective, being watchful is proposed as the mode of enacting surveillance in TB nursing. Being watchful is presented as a stance of the nurse rather than a strategy. It is part of the physical, narrative, and moral positioning of engaging with the person and with TB (and non-TB) problems. Assuming a stance of watchfulness does not mean that nurses are necessarily directly looking. Such watchfulness without always watching helps to convey respect for the person's privacy even under surveillance and to diminish the sense of being scrutinized, guarded, or judged. Being watchful as a way of enacting surveillance emphasizes the skill of involvement in working with TB clients that is a required part of making good professional judgments in a range of clinical, public health, and social situations.

Summary

The skill of involvement, providing comfort, and being watchful are key aspects of the relational work of TB nursing. It is work that requires presence, openness, and attunement to immediate problems, the broader situation, and the person. Understanding relational work from this perspective is helpful for filling in gaps between standards and guidelines, and everyday practice. These documents are vital for explicating the details of a complex disease and treatment protocols. And though they stress the importance of a patient-centered approach, which includes education and support, they cannot account for everyday challenges and dilemmas of being involved in the clinical situation and the caregiving moment. These standards and guidelines do not approach TB nursing work as relational work first, as was done in this study. Therefore the implications of this study described in the next chapter are taken up with attention to the ‘theory-practice gap’. Researching the relational work of TB nurses, however, was not without its challenges and limitations. The final chapter begins with an outline of some of them.
Chapter Eight: Conclusion

The implications of this study and its limitations together inform thinking about future directions for practice, policy and research in the area of relational work in public health nursing, and specifically TB and other infectious diseases. In concluding this dissertation, I have highlighted specific limitations and implications that stand out to me as those which reinforce the idea that the understanding of relational work is always developing, and therefore also always dependent on regular dialogue and collaboration if it is to be understood well in the practice and study of public health nursing.

Limitations

Recognizing challenges and limitations of the study raises ‘what about?’, ‘what if?’, and ‘why not?’ questions that offer good starting points for future research questions. In this sense, the limitations are not presented as what was done wrong in conducting the study per se, but rather as the drawbacks to the methodological choices made and those unforeseen shortcomings of a research project involving human beings. Thoughtful review of these limitations leads to further considerations about relational work in public health nursing as well as the experience of living with an infectious disease. The limitations are categorized according to the nurse and client participants, methodological choices regarding observation, and the location of the study.

Only nurses were included; there were only nine of them; most worked in DOT; and they all loved their jobs. I chose to focus on nurses who were registered as part of a self-regulating profession. The relational work of registered nurses and registered practical nurses was of interest precisely because their everyday relationships are partly bound by the standards of the profession. I chose to focus on relationships as work partly to highlight the distinctions and tensions between personal ways of relating with clients and standardized and regulated ways of
doing so. But I recognize that DOT, and indeed many other areas of ‘nursing’ care, is also provided by unregulated health workers. These caregivers employed by Toronto were left out of the study, which means that fully understanding relational work in DOT specifically is limited. This is important given that many DOT programs across the world employ unregulated health workers, volunteers, and even family members. Several questions about health care workers have not been addressed by this study and warrant attention: What do their relationships with clients look like? How are their relational knowledge and skills different and similar to nurses? Do clients view these helpers as different from nurses and are those differences significant? How do health workers and nurses work together and support one another?

The never-ending concern for many regarding phenomenological research is the small numbers of participants, and I recognize this concern for my study. Certainly a larger number of nurses would have meant more observation and interview data which would add to the amount of descriptive detail and potentially create a wider variation in experiences. However, the plausibility of interpretations drawn from the data does not rely on numbers of people or ‘amount’ of data alone. The nine nurses in this study articulated their experiences in individual ways and provided varied observation opportunities. Equally, it was possible to cluster experiences and concerns that rang true across the group into meaningful thematic categories. In this sense, by observing and talking with the nine nurses over time, I have been able to offer a perspective on relational work that could only have come from these particular involvements and yet may also resonate with other areas of community nursing practice.

I do however recognize the limitations of this nurse participant group in terms of variation of team-focus. Given that only DOT and Case Management were represented, questions arise as to the other teams. A larger number of case managers could, for example, shed
light on the particularities of telephone-based relational work. Also, the particular relational
skills required in situations of screening clinics in shelters may not be quite the same as those
required of longer-term relationships. Could getting through the metaphorical door in these
situations perhaps dominate the work and what does this look like? There are also those nurses
who spend much time in workplace and public education. Educating large groups about TB
would understandably call on other dimensions of relational work with many people not
explored through this study’s participants.

Finally, maximum variation in the participant group is important for showing a range of
relational experiences and I built strategies into my recruitment process with this in mind. What I
did not take into account was variation in job satisfaction. These nurses, unsolicited by any direct
question from me, talked about loving their jobs. What about those nurses who do not love their
jobs – those who perhaps view it only as a set of tasks, or feel unsatisfied, or at a more extreme
level even burned-out? How do they and their clients experience relational work, and
specifically, its emotionally demanding aspects?

Nurses comprised only part of the participant group. Clients also had to volunteer to
participate and while there was a range in terms of age, gender, race, ethnicity, and TB treatment,
they all fit within some level of satisfaction in their relationships with nurses. Clients who were
least trusting, most dissatisfied, or most difficult to serve were not part of the study, and
therefore the relational work in situations with these people were only described by nurses and
not observed. This limitation with regard to clients stands out alongside the one that follows.

*Only English-speaking clients were included.* While the decision not to include non-
English speaking people in the study was made for sound pragmatic reasons, I realized that this
excluded a large number of potential participants. English as second, third, or fourth language is
common in this city, and the nursing work of public health and notably TB often happens through interpreters. While adding an interpreter to the mix may complicate understandings of relational work, this is indeed the reality of many nurse-client relationships in TB. Furthermore, by excluding those who could not converse in English I am aware that I limited the range of clients’ understandings of nursing relationships, particularly from explicitly different cultural perspectives. In so doing, I have not attended to the profound importance that speaking the same language may hold in relational work. For example, how does speaking the same language underpin providing comfort and feeling comforted? While I do not believe this detracts from the interpretations of this study, it does raise questions of language barriers in care and in research.

Only individual visits were observed. Observations during data collection included only the actual visit between nurse and client. Though conversations with the nurse before and after each visit were part of this, the data generated in this way do not account for the nurse’s whole workday, the meetings and conversations with other people in professional networks, or joint visits with these professionals and the clients. Notably, all aspects of nurses’ day-to-day activities involve relational work to some extent, and more specifically, have some influence in the direct relational work with clients. For example, how does the nurse describe the client and/or their relationship to others in team meetings? What labels are used? What is discussed and what gets left out? How does feeling supported by one’s team contribute to developing one’s skill of involvement? To observe nurses in the context of their whole job could form an understanding of nurses’ relational work with clients that accounts for these indirect influences on it.

Only a large, urban, and well-resourced public health department in a ‘developed’ country was included. It is important to recognize distinctions of both Toronto and its public
health department as the location of the study. There were several benefits to such as location: a
well-developed TB program, a pool of many nurses to draw from, heterogeneity of the client
group, and diversity of places. But even given all this, a question remains. Do the interpretations
made about relational work in general, and about the skill of involvement, providing comfort,
and surveillance specifically, ring true in smaller public health departments in rural or remote
areas of Canada where for example the populations may be more homogenous? For instance, this
study does not reflect the fact that the highest incidence of TB in Canada is in Aboriginal
communities, and therefore it remains to be seen what the relational work of TB nurses in these
communities looks like.

Also, though the cultural diversity of Toronto highlights TB as an important immigrant
health issue, these interpretations cannot be simply applied to pre-migration parts of the world
where TB rates of morbidity and mortality are extremely high and trained health professionals
are few. I am cautiously aware that for some it may seem a luxury of affluence to even
contemplate relationships as a topic of inquiry in such circumstances. However, I believe it will
always remain that even in the direst of population health situations, relationships matter.
Therefore full appreciation of this limitation of the study may be a springboard for future studies
of the relational work of nurses and frontline care providers in TB-ravaged countries.

Reflection on these limitations has been incorporated into the considerations of the
implications of the ideas about relational work presented in this dissertation. Limitations being
what they are, the skill of involvement remains a valuable perspective from which to approach
the question of nursing relationships. It provides grounding for examining the practice and
policies of TB and public health nursing, and to explore related research topics and
methodologies.
Implications

The remainder of the chapter is devoted to the implications of this study for practice, policy, and research that link the theoretical and the everyday in public health and relational work. “Learning to make good clinical judgments and be a good practitioner requires ongoing experiential learning, reflection, and dialogue with patients and families” (Benner et al., 1999, p. 17). Dialogue with colleagues, mentors, and administrative leaders is also needed. Furthermore, the same may be said of making good professional judgments as part of being good managers, policy-writers, and researchers. Therefore the suggestions for enhancing practice, examining policy, and developing research are offered from the perspective of valuing experiential learning and critical dialogue as the key to collaborative efforts in all these areas. I acknowledge that qualitative studies, particularly a phenomenological one, may hold many general and far-reaching implications depending on how readers take up the interpretations. However, in keeping with the entire study’s thrust toward the particular, the implications presented below center on the detail of one or two specific ideas.

Enhancing Practice

As indicated previously, ample guidelines and practice standards already exist for TB and nursing that provide ‘expert’ direction for best practices. But also indicated throughout the study is the assumption that relational knowledge and skills can never be fully developed or supported through ‘how-to’ manuals or occasional workshops alone. Certainly these strategies are useful guideposts and hold significance in familiarizing newer nurses to the practice. But the nurses in this study emphasized their experiential knowledge in understanding relational work; learning on-the-job and life experience specifically. How may these forms of knowledge be enhanced, supported, and critically examined? As stated, nurses informally support one another as peers
and there are regular team meetings that bring nurses together to discuss client issues. These relationship networks that already exist are highlighted here as foundations of support for ongoing professional development and practice. However, over and above being taught about relationships in school, directed by standards and job descriptions, or supported by managers and teams in getting the job done, practising nurses can benefit from having time, space, and people with whom they can deeply engage in conversations about their relational work. These conversations would be opportunities to reflectively examine their skill of involvement.

Clinical supervision, or consultation, is suggested as a valuable way of augmenting the existing formats of support, which specifically addresses the area of relationships. The notion of clinical supervision is often met with apprehension by nurses, either as a managerial tool or a form of counselling. Though some elements of both may be present, clinical supervision “is principally a relationship concerned with monitoring the progress of clinical work and with a nurse's attainment of both safety in practice and excellence in the provision of care” (Jones, 1999). Given the potential confusion in the word supervision and its implication of a hierarchical relationship (Walsh et al., 2003), clinical consultation is suggested in order to emphasize a more collaborative relationship between consultant and nurse.

As a structured form of supportive dialogue, clinical consultation begins in the assumption that relational work is already happening, and nurses already know something of the skill of involvement by watching other nurses and by doing it. Jones’ (1998; 2001; 2006) articulation of clinical supervision for mental health and palliative care fits well for TB nursing and other areas of public health. Its purpose is to allow time for “contemplative, anticipatory, operational and strategic ways of thinking”, help nurses to cultivate good working relationships with themselves and others, view their part in health care realistically, and tolerate the
uncertainty aroused by competing demands of the work (Jones, 2006, p.583). It can happen individually or in groups, and lies “somewhere between an educational process and therapeutic experience” (Pedder, 1986, as cited in Jones, 2006).

In TB nursing, clinical consultation could provide a forum for ongoing mutual support and feedback that may take shape in several ways. Some possibilities are: sharing practice narratives in order to critically reflect on how comfort was provided, examining personal assumptions and biases that perpetuate or diminish clients’ feelings of displacement, assessing one’s own sources of comfort and anxiety in particular situations, communication tips for language barrier situations or practical advice on mental health system resources. Additionally, being watchful is a dimension of the TB skill of involvement that can create care-control dilemmas and which is often over-looked as something needing to be discussed. Debriefing about this surveillance role in clinical consultation could help to reflect on one’s power in relationships so that more oppressive power-over dynamics are diminished or avoided altogether.

These descriptions of clinical consultation mirror elements of developing the skill of involvement in nurse-client relationships described in the previous chapter. With the consultant emotionally engaging with the nurse and the problems, dialogue centers on the situation and the person’s responses to it. Such consultation may happen between a consultant and an individual nurse regarding a client, a situation, or others in the situation. Possible points of dialogue could be: the nurse’s gut-feelings about the problem, emotional responses to the person or the place, or what the nurse did or said that may indicate either under- or over-involvement and how to make adjustments accordingly.

Consultation in a group of TB nurses would give each nurse opportunity to learn from the consultant as well as others. It offers an occasion for discussing and learning from one another’s
relationships that are satisfying or troubling, safely questioning out-loud one’s level of involvement with particular clients, or re-creating situations through role-playing in order to get at what one may not have noticed about the client, the relationship, or one’s involvement in it. Groups could be formed within the same program teams across regions (e.g., all DOT nurses; all case managers), or a mix within each region.

This is not to suggest that clinical consultation is always the best approach or only approach for supporting relational work. Nor is it without challenges that would require careful consideration, like the financial and time burden placed on the organization to provide this service or the emotional burden placed on consultants as they make themselves available to nurses. Also, before the skill of involvement can be developed, it must be learned. How it may be taught in the clinical courses of undergraduate nursing programs cannot be fully answered through the kind of consultation described here. Yet answers to this question are certainly worth examining more closely as a separate concern of nurse educators. Bearing all this in mind, clinical consultation still represents a good way of honouring the ongoing and ever-evolving nature of both relational work and experiential knowledge.

**Examining Policy**

The first brief consideration of policy arises from my observations of gift-giving and gift-receiving. The CNO (2006) standard for nurse-client relationships offers a helpful ‘decision tree’ for such circumstances as this, but also emphasizes the importance of consulting the employer’s policies on ‘boundary’ issues. A policy forbidding the acceptance of gifts was in effect in this public health department, and the study has helped to contrast literal interpretations of this rule and the realities of relational work. From this, it seems that concrete language of policies
regarding this issue may need to be re-assessed in light of how things are actually accepted or refused by nurses as part of their everyday relational work.

Other public health policy recommendations are tricky here since relational work and the closely linked ‘psychosocial’ or mental health elements of care do not in themselves comprise a mandated program of public health. Therefore to delve deeply into an academic discussion of ‘relationship’ or ‘mental health’ policy runs the risk of going nowhere, given these programming realities. However, enough references to the realm of relational work are made in existing policy documents that warrant further examination in light of this study. Two areas in particular are called to mind. First, as discussed in the previous chapter, TB standards and guidelines cite the patient-centered approach to care. While this nod to relational work is important, the term conjures many meanings. Further refinement of what being ‘patient-centered’ means and what such an ‘approach’ entails would help to delineate its aspects that are specifically relevant to actual TB situations.

Secondly, the Core Competencies for Public Health in Canada (2007b) is a critical document for setting a structure within which the key aspects of public health practice can be discussed. This document outlines seven categories of competence, or “knowledge, skills, and attitudes necessary for the practice of public health,” (p.1) and identifies their grounding in values of equity, social justice, sustainability, and respect for diversity, autonomy, empowerment and community participation (p.3). While the themes of relational work presented in this study span several of these categories, I highlight the sixth category, communication, as an area in need of further articulation. For example, the need for public health practitioners to be effective communicators and to interpret information for audiences (p.5) seems self-evident, but how is competence determined here? This study has highlighted back-and-forth sharing of information
and personal stories as that which makes communication meaningful. Also, effective communication must include perceptual acuity and engaged understanding of client perspectives. Such details of language may be helpful in describing competencies so that practitioners’ use of these descriptions for structuring and interpreting their practice will lead to better recognition of competence where and when it happens.

**Developing Research**

There are research implications that arise from this study in terms of both substantive areas of research and methodology. This study highlights immigrant health and mental health dimensions of infectious diseases as important topics of research that dovetail with one another. The area of immigrant health in general spans a broad range of topics, and critical social perspectives on TB and other infectious diseases in this area arise from this study’s themes. Specifically, there is a growing discourse of globalization and the migration of infectious diseases. Though this is a crucial concern from epidemiological and biomedical perspectives, what is the impact of such on the displacing experiences of newcomers to Canada? For example, experts’ messages of protecting the public from life-threatening diseases ‘brought here’ by immigrants may reinforce negative connotations of the ‘immigrant’ label. What may be the long-range effects of stigma on the well-being of those who migrate or on their trajectory of illness when active forms of disease develop?

Another broad and often nebulous area of research is the mental health dimensions of TB. Certainly the relational work of TB nurses involves these dimensions. Small areas of TB literature are the psychiatric symptoms and disorders associated with TB (see Vega, Sweetland, & Acha, 2004), and the notion of psychosocial or emotional support (see Chalco et al, 2006). These are important areas for further investigation given the vague definitions of what counts as
a psychiatric symptom and what constitutes emotional support and both have direct implications for nurses’ relational work. Identity is an area of research that is well suited to blending the notions of immigrant health and mental health in the context of TB care. The effects of particular life experiences such as mental illness or migration on one’s identity formation or re-formation call attention to the need to understand nurses’ involvement with people experiencing one or both. The themes of this study call for extending identity research to include questioning, for example, a ‘contagious’ identity, how it blurs into these other categories, and how then this influences physical, psychological, emotional, social, and spiritual well-being.

This study also highlights the notion of surveillance as having productive value in nursing, both in hospital and community locations of care. How does thinking about surveillance, or being watchful, as a domain of practice show up in other areas of public health nursing? There have been child protection studies cited, but research questions remain about the value of being watchful in, for example, school health, environmental, or shelter programs.

Implications regarding research methodologies also arise in reflecting on the method employed for this thesis. Specifically, this study, with its emphasis on lived experience as a form of knowledge, has highlighted the importance of observation and participation of the researcher in understanding the relational work of nurses. These aspects of the research method are indications of an ethnographic attitude blended with the goal of understanding the particular individual experience of the phenomenon as it is lived. In conducting this study, I renewed my respect for the narrative as a powerful means for understanding nursing practice. More powerful still has been the first-hand experience of the importance of observation ‘in the field’ and a deepened conviction that participation as an interpretive researcher in that field is inevitable. This leads to pondering how phenomenologically-informed ethnography and participatory
methods may be particularly valuable for understanding and in turn, enhancing the relationship knowledge and skills in nursing practice in population health programs.

Clinical ethnography has been suggested as a methodological iteration of Benner’s interpretive phenomenology. This is a method with the ethnographic goal of collecting data that leads to rich descriptive interpretations of cultural phenomena of biomedical processes and the human experience of illness (Doolittle, 1999). “This approach can help the clinician better understand the issues of caring for an illness” (Benner, 1999, p.122). While this is an interesting and potentially useful methodology to propose for TB and other infectious illnesses, the use of the term ‘clinical’ still invokes images of nurses in acute care, and the focus on the illness rather than its social determinants potentially confines understandings of public health nursing.

To that end, ‘street phenomenology’ (Kusenbach, 2003) is put forward as a methodology that holds promise for future research involving practising public health nurses and their clients. As a sociologist, Kusenbach emphasizes a ‘go-along’ method in her suggestion of street phenomenology as a form of ethnographic research. This is a way of concurrently capturing the experiences and interpretations of human beings about the situations/environment in which they are involved as they are involved in them. The limitation of traditional ethnography’s emphasis on observation is that “being a privileged insider does not provide automatic clues to other locals’ lived experiences” (Kusenbach, p.461). Also, traditional key informant interviewing is a “static encounter” which cannot access all aspects of lived experience because there will always be topics that informants simply will not or cannot talk about because they are not aware of them as topics to discuss (Kusenbach, p.462). The ‘go-along’ refers to accompanying individuals on their ‘natural’ outings in order to actively explore, partly by questioning along the way, their streams of experiences and practices as they carry out their normal routines in the everyday
environment. One advantage of the go-along with its explicitly phenomenological perspective is that the researcher is able to observe “informants’ spatial practices in situ while accessing their experiences and interpretations at the same time” (p.463).

Street phenomenology captures both the particularities of everyday and broader cultural practices as well as participants’ interpretations of both. It could be another way of conceptualizing the methodological process of this study that offers interesting food-for-thought on conducting future research in public health nursing. Street phenomenology would shift more attention to the situation, and even more to the socio-cultural context, yet maintain a phenomenological perspective on the everyday practices of nurses as they move about in their usual routines.

Finally, my participation as the researcher led to reflections on the meaning of ‘participant’, as described in the methodology chapter. But as I engaged with these nurses, several conversations about the research project itself arose that also caused me to wonder about the meaning of ‘researcher’. These nurses and others I met in the recruitment process contributed something to my thinking about the research method as well as the topic. Furthermore, I have suggested in this dissertation the need to address gaps between theory and practice. Together these realizations point to the need for more participatory methods that actively employ practising nurses in the research process itself, especially in the areas I have mentioned: nursing relationships, tending to the mental health dimensions of infectious diseases, and the effectiveness of clinical consultation. Studies that include practising nurses in the design and development of the project itself have the potential to change practice more directly and more quickly. They would also then be direct disseminators of research projects. For example, a study of clinical consultation in a TB or communicable disease program could involve some
nurses as researchers while they participate in that consultation process. Participatory research methods that involve nurses would also benefit the research community in terms creating research questions that are most relevant for daily practice.

Finally, in my journey of exploring relational work with practising nurses and their clients, I have also learned a great deal about tuberculosis infection and disease, and have come to appreciate the potential value of teams of researchers working together to cross the divides of microbiology, epidemiology, sociology, and areas of professional practice and patient care. Such collaborations as formal mixed methods studies or a series of consecutively planned projects offer great opportunity for marrying the broad with the particular, the social with the personal, and the whole picture of treatment with the daily parts of undergoing it. They would make for richer accounts of TB as an important population and individual concern.

**Closing Thoughts**

I close with thoughts of what I was surprised to learn in studying this relational work. First, it is profoundly clear that TB nursing must be understood in a global context. It is far too easy for me along with many Canadians born here to become complacent in assuming that most infectious diseases are easily treatable or not really a risk ‘here’. My early reading about TB deepened my understanding of global health and ongoing reading continues to raise surprisingly emotional responses as I learn about this treatable, curable, and yet still deadly disease. More specific to the focus of this study, I caught myself taking these nurses’ relational work for granted in light of the TB; thinking about it at moments in the writing process as so common-sense as to wave it away as not worth discussing especially when bacteria counts or clients gone missing were the real and pressing concern. Both of these points have helped me to fully appreciate my own experiential learning, and to see that understanding TB in this city in Canada
and the relational work of nurses here has important implications for understanding it elsewhere and vice-versa.

My second surprise was having a fundamental assumption about the nature of relational work challenged. That is, the tensions of population and individual concerns are not necessarily distressing or morally problematic for nurses as I first may have assumed, being an outsider passing judgment on the ‘policing’ role of these nurses. The articulation of ‘welcome intrusions’ as the nature of relational work has hopefully explicated this. Nurses carry out their work compassionately and empathically, and are responsible and accountable to the public. These are not mutually exclusive ways of being.

A related third surprise in carrying out this study was the strong parallel between these nurses’ work and particular memories of my own community mental health practice, which at the beginning were not evident. Similarities were called up especially as I came to understand the watchfulness of surveillance, and in the valuable support of peers in talking to one another about stress and pleasure on the job. This is a good reminder of the fact that much of community nursing happens through the work of sole practitioners with clients in very personal places and spaces, and therefore why supportive relationship networks are crucial for doing the work well.

Also in seeing this parallel, I remember well how, in some community nursing practice, the ordinary often takes over the grand ideals about relationship knowledge and skill. Relational work that requires being watchful with vulnerable marginalized people is often not extraordinary life-and-death intervention but simply rather a question of, how are we going to get along with each other knowing I have a job to do and you don’t want me here. In summing up the skill of involvement and valuing the welcome intrusions of TB nurses, I leave the reader with the words of one participant:
When I was in nursing training we were told, you don’t get emotionally involved. And at the time… I’m thinking, ‘so why are we doing this then?’… See I don’t think we have any business being in *this* business if we aren’t willing to invest something emotionally and be able to accept that something. Otherwise a machine might as well do it. And that reciprocal learning can’t happen if you’re not willing to share (Louisa, interview, p.13).
References


Pinfold, V. (2000). ‘Building up safe havens… all around the world’: users’ experiences of living in the community with mental health problems. *Health & Place, 6*, 201-212.


Toth, A., Fackelmann, J., Pigott, W., & Tolomeo, O. (2004). Tuberculosis prevention and treatment: occupational health, infection control, public health, general duty staff, visiting, parish nursing or working in a physician's office - all nursing roles are key in improving tuberculosis control. *Canadian Nurse, 100*(9), 27.


# Appendix A: Relationships Research Studies

<table>
<thead>
<tr>
<th>Author/Date</th>
<th>Purpose</th>
<th>Methodology</th>
<th>Location</th>
<th>Sample</th>
<th>Findings/Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ailinger et al. (2004)</td>
<td>To examine TB knowledge of Latino immigrants rec’ing treatment</td>
<td>Descriptive correlational 15-item ‘TB Knowledge Instrument’ questionnaire</td>
<td>U.S county with 20% Latino population</td>
<td>Convenience sample 82 adults (TB clients or parents/guardians of TB clients)</td>
<td>Most frequent incorrect answers: whether person with TB can transmit the germ by coughing (53%); Most frequent correct answers: importance of keeping appts (96%); meds effectiveness in killing germs (90%); need for meds with +ve skin test (90%)</td>
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<tr>
<td>Ailinger, Lasus &amp; Dear (2003)</td>
<td>To examine knowledge and perceived risk of TB among U.S. general population – as part of meeting the overall goal of reducing # of TB cases</td>
<td>Survey data from 1997 National Health Interview Survey Core questionnaires on AIDS knowledge containing 5 TB questions</td>
<td>U.S.</td>
<td>19,127 U.S. residents response rate for TB questions: 14,727</td>
<td>Some knowledge/awareness; Several misconceptions; Overall low concern about contracting TB; “Evidence that there are major gaps in the knowledge of TB and its existence in U.S. society” (p.213).</td>
</tr>
<tr>
<td>Barnhoorn &amp; Adriaanse (1992)</td>
<td>To study compliance behaviour of those who were part of a TB control program Based on ‘Health Beliefs Model’</td>
<td>Survey as part of ongoing TB control program</td>
<td>Wardha District, India</td>
<td>773,493 surveyed; 1282 diagnosed with TB; of them, 868 completed treatment</td>
<td>Compliance rate: 80%; Compliance relied on: motivation through personal home visits by social workers &amp; positive reinforcement, active orientation toward TB (rather than fatalistic perspective), feeling of some control over disease, and “major finding”: social support from a significant other, i.d’ed as family, doctor, social worker</td>
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<tr>
<td>Carmack (1997)</td>
<td>To investigate how caregivers balance engagement and detachment to cope with demands and loss</td>
<td>Qualitative, descriptive – Grounded theory Open-ended interviews</td>
<td>California, U.S. – interviewed in their homes</td>
<td>Theory-based sampling 14 ‘high functioning’ caregivers</td>
<td>Themes: letting of the outcome; maintaining consciousness &amp; pragmatism; Overall comments: caregivers learn about setting limits and self care</td>
</tr>
<tr>
<td>Carr (2001)</td>
<td>To explore meaning of community nsg</td>
<td>Hermeneutic phenomenology – multiphase – focus gps, observation, interviews</td>
<td>UK community health depts</td>
<td>43 participants community nurses and students</td>
<td>5 core concepts – article focused on 1: ‘the practice agenda’</td>
</tr>
<tr>
<td>Chalmers, Bramadat &amp; Andrusyszyn (1998)</td>
<td>To explicate the nature of community health nsg practice, for which student nurses must prepare</td>
<td>Action research – focus gps</td>
<td>Western Canadian province</td>
<td>118 participants in 27 gps nurses, educators, administrators</td>
<td>Themes: change in practice in last 10yrs, how it will evolve, and how the PHC framework that guides practice</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Methodology</td>
<td>Location</td>
<td>Sample Size</td>
<td>Themes and Findings</td>
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<tr>
<td>Clark, Cegielski &amp; Hassell (1997)</td>
<td>To pilot a TB prevention and early detection program</td>
<td>Used a computer-based geographic information system to locate high-risk neighbourhoods</td>
<td>A Texas city, U.S.</td>
<td>Not identified</td>
<td>Screenings identified positive skin test reactions at rates of 15-20% (compared with Texas prison rate of 6%) Area of concern: nonresponse, i.e. refusing the skin test. Reasons cited in text of proposal, and suggestions for increased participation based on these: making advance contact, offering incentives, adequate preparation/training of field workers</td>
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<tr>
<td>Crisp &amp; Green Lister (2004)</td>
<td>To explore nurses’ understanding of their professional responsibilities in relation to child protection</td>
<td>Qualitative interviews – group and individual (only some interviews tape-recorded; otherwise used verbatim written notes)</td>
<td>Scottish city</td>
<td>99 nurses – 'public health practitioners'</td>
<td>Themes of ‘identification, detection, &amp; reporting’; monitoring; supporting families, client education, service development</td>
</tr>
<tr>
<td>de la Cuesta (1994)</td>
<td>To gain insight into the processes underlying health visiting</td>
<td>Grounded theory (Glaser &amp; Strauss) Formal interviews Participant observation</td>
<td>NW England</td>
<td>Theoretical sampling 21 female health visitors</td>
<td>Overall theme: the relationship is a resource in health visiting work Specifically: relationship as an ‘enabling mechanism’ to 1) know the client &amp; family, 2) gain &amp; maintain access to the home, 3) produce reciprocity</td>
</tr>
<tr>
<td>Draus (2004)</td>
<td>To consider how historic and economic forces and the intervening influences of hospital and PH agencies dynamically play out within actual lives of people with TB</td>
<td>Ethnography and Narrative Participant observation and interviews Seven years of fieldwork “Used the disease as a guide and the role of the PH field-worker as a lens” (p.10).</td>
<td>New York and Chicago, U.S.</td>
<td>20 semiformal interviews with people in the TB control program “countless more informal interviews”</td>
<td>“TB must be seen not only as a problem in and of itself, but as an index of graver social ills. Though we may treat the disease in isolation, we must recognize that it has its roots in soil we all share” (p.11). Themes addressed: epidemiology of TB in the 1990’s; homelessness &amp; addiction; coercion, care &amp; compliance, the role of TB</td>
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<tr>
<td>Study</td>
<td>Objectives</td>
<td>Methodology</td>
<td>Setting</td>
<td>Participants</td>
<td>Data Collection</td>
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<tr>
<td>Erser (1997)</td>
<td>To explore the nature &amp; prevailing assumptions about nsg as a therapeutic activity To examine nurses and pts views about nsg actions on pts, by describing and comparing them</td>
<td>Ethnography Participant observation &amp; interviews</td>
<td>UK hospital</td>
<td>Hospital nurses and pts</td>
<td>Core concepts: presentation of the nurse (nonverbals, symbolic/expressive character of nurse, proximity/distance), relating to the patient (developing rapport), specific actions of the nurse (instrumental/technical actions, clinically-related, what the nurse does for the pt, info-giving, helping with everyday activities)</td>
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<tr>
<td>Gibson, Cave, Doering, Ortiz &amp; Harms (2005)</td>
<td>To examine the complex net of socio-cultural factors that influenced behaviour related to TB prevention in high risk groups in Aboriginal and immigrant populations</td>
<td>Participatory action research - using community advisory committee, community research associates Group interviews</td>
<td>Alberta, Canada</td>
<td>133 – 30 Aboriginal; 103 immigrant</td>
<td>Themes: explanatory beliefs models; social stigmatization of TB; medication and treatments; problems taking medications; the legacy of sanitoriums for Aboriginal people, TB education, relationship between perception and knowledge of TB, preferred methods of learning</td>
</tr>
<tr>
<td>Grumbach et al. (2004)</td>
<td>To investigate the practice activities, priorities, and education of PHNs</td>
<td>Survey Self-administered mailed questionnaire</td>
<td>California</td>
<td>All PHNs in five ph depts. (412) surveyed; 289 completed questionnaires (response rate: 75%)</td>
<td>In actual practice, few nurses perform community level interventions Findings indicate a wide gap between goals &amp; theories of PHN and reality of practice and training</td>
</tr>
<tr>
<td>Hoorstman &amp; van Rens-Leenaarts (2002)</td>
<td>To understand the character of the moral work/dilemmas of PHNs, using cot death as case example</td>
<td>Qualitative – intensive empirical ethics research In-depth interviews</td>
<td>Netherlands</td>
<td>15 PHNs working in 4 rural child health centers</td>
<td>In cot death prevention, several moral dilemmas come to the fore Prevention is an area of practice where scientific claims on risk are not morally neutral; nurse do more than just communicate scientific knowledge, do not focus on isolated risk factors, rather on well-</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Methodology</td>
<td>Location</td>
<td>Key Findings</td>
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<tr>
<td>Jack, DiCenso &amp; Lohfeld (2005)</td>
<td>To develop a theory of how new moms engage with PHNs &amp; family visitors</td>
<td>Grounded theory – interviews</td>
<td>SW Ontario public health depts.</td>
<td>Engagement is basically a social process of 1) overcoming fear, 2) building trust, 3) mutuality</td>
<td></td>
</tr>
<tr>
<td>Jaramillo (1999)</td>
<td>To explore the correlates of prejudice as an attitudinal component of stigma of TB</td>
<td>24-item survey, 3-point Likert-type social distance scale – administered by telephone</td>
<td>Cali, Colombia</td>
<td>‘having scientifically unfounded beliefs about TB transmission and being fearful of PWT are significant predictors of prejudice PWT are rarely blamed for having the disease, rather contagiousness and severity of illness are better predictors of prejudice.</td>
<td></td>
</tr>
<tr>
<td>Keller et al. (1998)</td>
<td>To develop a model of PHN practice, to better describe PHN interventions</td>
<td>Collaborative model/theory development</td>
<td>Minnesota PHNs at state and local levels</td>
<td>The Public Health Nursing Inteverentions (PHI) Model was developed, with 17 interventions identified at both individual and community/systems levels</td>
<td></td>
</tr>
<tr>
<td>Keller et al. (2004) (Part 1 &amp; Part 2)</td>
<td>Evaluation of revised PHN model (above): To examine the evidence underlying the interventions in the model</td>
<td>‘Evidence critique’ of the model</td>
<td>Minnesota</td>
<td>‘expert’ panel reviewed the revised model Recommended changes to the model: clear definitions of each of the 17 interventions; e.g.’s of each, best practices. Model is in practice in state of Minnesota</td>
<td></td>
</tr>
<tr>
<td>Kuenhert (1995)</td>
<td>To examine a model of community-as-client</td>
<td>Cross-sectional descriptive survey</td>
<td>mid-west U.S.</td>
<td>The model was useful. A community focus was found to translate across all areas of public health programs</td>
<td></td>
</tr>
<tr>
<td>Khan et al. (2005)</td>
<td>To establish the effectiveness of the direct observation component of DOTS programs. Social studies component: to understand pts’ perspectives and experiences of TB care</td>
<td>Randomized control trial and Social studies including survey and indepth interviews</td>
<td>Pakistan</td>
<td>Key findings: 13 out of 39 interview participants did not comply with assigned DOT approach b/c of inconvenience of method Pts reported several barriers to regular attendance for DOT drug taking (most common: time, travel costs, ill health and need to work) Poor provider attitudes toward pts in care Conclusion: DOT should be flexible and convenient; emphasis should shift in practice from “tablet watching” towards treatment</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title of Study</td>
<td>Study Focus</td>
<td>Methods</td>
<td>Key Findings</td>
<td>Notes</td>
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</tr>
<tr>
<td>Lashley (2006)</td>
<td>To identify LTBI cases and improve treatment among inner-city homeless</td>
<td>Intervention study: nurse and student-nurse administration of TST and TB symptom assessments to residents of a homeless shelter – those with infection offered prophylactic treatment and ‘intensive coaching’</td>
<td>Faith-based inner city mission shelter, Baltimore city</td>
<td>327 symptom assessments; 282 TSTs</td>
<td>98% of shelter population were screened; 46 cases of LTBI identified, with 30 of these requiring treatment – 33% completed 6 months of prophylactic treatment. While the 65% program goal was not achieved, there was threefold increase over the city’s 11% treatment completion rate among homeless. Participating organizations learned about providing ‘culturally competent’ care; students reported this having profound impact on their view of homelessness. Study shows the value of partnerships with faith-based organizations and health care practitioners. To improve treatment completion, incentives and ‘relationship supports’ should be built into screening programs for the homeless.</td>
</tr>
<tr>
<td>Levesque, Dongier, Brassard &amp; Allard (2004)</td>
<td>To identify factors linked to the acceptance of TST and assess completion rates for LTBI among refugee claimants</td>
<td>Assessment of asylum seekers consulting medical personnel for a health complaint or immigration medical exam. Hospital files were used as data sources</td>
<td>Medical clinic in Quebec that takes in many immigrants and refugee claimants</td>
<td>409 patients of the clinic who were refugee claimants and met the inclusion criteria</td>
<td>49 patients had positive TST, 10% of them accepted LTBI treatment. Suggestion: to extend coverage of reimbursed care of refugee claimants to enact a preventive approach to LTBI.</td>
</tr>
<tr>
<td>Liaschenko (1994)</td>
<td>(data from 1993 dissertation) To understand the ethical concerns experienced in everyday practice</td>
<td>Narrative Interviews, with one question: “Tell me a story from your practice that highlights some ethical concerns you have about your practice”</td>
<td>California 9 home care nurses; 10 psychiatric nurses</td>
<td>Narrative accounts revealed many spatial descriptions, “thus showing an awareness of the importance of place of the work and ethical concerns of nsg practice” (p.18). Themes: place and identity; and place, power, and division of labour.</td>
<td></td>
</tr>
<tr>
<td>Author (Year)</td>
<td>Study Details</td>
<td>Methodology</td>
<td>Location</td>
<td>Sample Size</td>
<td>Findings</td>
</tr>
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</tr>
<tr>
<td>Liaschenko (1997)</td>
<td>(data from above study) Article focus: the n-c relationship, as a central theme of the study, is examined ‘as geography’; according to the local and structural aspects</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>Relationships are inherently spatial Themes: spatial vulnerability, exploitation of pts, homogenization of identity, fragmentation of care, the geography of gendered space, invisibility, relation to other nurses (instrumentality) “Getting the interpersonal relationship right was a matter of ethical concern because the correct relationship protected the integrity of the patient in the face of the spatial vulnerabilities to which he was subject. The correct relationship was a matter of the correct distance between patient and nurse, a balance between connection and boundaries…” (p.57).</td>
</tr>
<tr>
<td>Mayo et al. (1996)</td>
<td>To study the problem of TB among shelter residents, effectiveness of screening measures, and provide learning opportunities for nursing students</td>
<td>Epidemiologic study (citing Grimes and Grimes, 1995)</td>
<td>A shelter in Charleston, South Carolina</td>
<td>All shelter residents and staff, public health nurses connected with the shelter</td>
<td>The success of mass-screening process of this shelter relied on: nurses’ awareness of client history, caring for unique needs of individuals, client education, mutual participation, collaboration</td>
</tr>
<tr>
<td>McDonnell, Turner &amp; Weaver (2001)</td>
<td>To identify the antecedents of adherence to TB treatment</td>
<td>Correlational study Using Orem’s self-care deficit theory of nursing as theoretical framework Self-as-Carer Inventory 40-item questionnaire TB Adherence Determination Questionnaire TB General Adherence Scale</td>
<td>Georgia, U.S</td>
<td>62 English-speaking adults with clinically active TB age range: 21-79 71% African American</td>
<td>Scores indicated high level of adherence (mean adherence score of 92.6%) Demographic factors most affecting adherence: alcohol use, education level and income Intention to take meds directly influenced by beliefs about benefits of doing so Individual factors: presence of supports, intention to adhere, capacity to care for self Satisfaction scores had no direct relationship with adherence</td>
</tr>
<tr>
<td>McGarry (2003)</td>
<td>To explore how nurses define the nature of their work &amp; the term community itself</td>
<td>Pilot study - Interviews</td>
<td>UK PH depts</td>
<td>10 district nurses working in rural &amp; urban locations</td>
<td>The ‘home’ is central in defining the essence of the work and nature of relationships in community practice</td>
</tr>
<tr>
<td>McNaughton (2001)</td>
<td>A naturalistic test of</td>
<td>Prospective multi case study</td>
<td>Suburban</td>
<td>5 nurse-client</td>
<td>All relationships began in orientation phase</td>
</tr>
<tr>
<td>Researcher(s)</td>
<td>Title</td>
<td>Methodology</td>
<td>Sample</td>
<td>Outcomes/Findings</td>
<td></td>
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<tr>
<td>Peplau’s theory, Observation</td>
<td>Reflecting Peplau’s phases of relationship development in her theory</td>
<td>U.S. PH dept dyads and some moved to working phase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitnick, Shin, Seung, Rich, &amp; Atwood, et al. (2008)</td>
<td>To describe the management of XDR-TB and treatment outcomes among patients referred for individualized outpt treatment</td>
<td>Retrospective study of patients referred for individualized TB treatment – including: free drugs, resective surgery, adverse-event management, nutritional and psychosocial support, Standardized chart extraction (frequency of adverse reactions not abstracted)</td>
<td>Lima, Peru (through the National TB Program)</td>
<td>810 patients treated unsuccessfully for TB, and a few being exposed to MDR-TB strains</td>
<td></td>
</tr>
<tr>
<td>Nyamathi, Nahid, Berg, Burrage, Christiani et al. (2008)</td>
<td>To determine whether a validated nurse case-managed intervention with incentives and tracking would improve adherence to LTBI in homeless subpopulations</td>
<td>Prospective 2-group, site-randomized design</td>
<td>12 homeless shelters in Los Angeles, US</td>
<td>520 homeless adults</td>
<td></td>
</tr>
<tr>
<td>Oberle &amp; Tenove (2000)</td>
<td>To examine ethical problems faced by PHNs and identify strategies to support ethical PH practice</td>
<td>Qualitative – exploratory, descriptive Interviews</td>
<td>Western Canada PH depts</td>
<td>Nominated sampling technique; 22 PHNs – urban and rural work settings; sampling ceased with saturation</td>
<td></td>
</tr>
<tr>
<td>Paavilainen &amp; Astedt-Kurki (1997)</td>
<td>To examine the ways that clients and PHNs cooperate &amp; collaborate</td>
<td>Hermeneutic phenomenology – essays and interviews</td>
<td>Not identified</td>
<td>11 PHNs</td>
<td></td>
</tr>
<tr>
<td>Peckover, S. (2002)</td>
<td>To examine the</td>
<td>Qualitative</td>
<td>North England</td>
<td>Both convenience</td>
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</table>

Itemized the effectiveness of specific drugs & surgery
Also identify frequent contact with health workers and regular bacteria assessments as beneficial

Achieved an overall completion rate of 91%, but IV drug-users and daily alcohol users had poor completion rates (48-54%), and those not of African-American descent (50%). Incentives appear to be a good foundation for adherence, but other socio-structural supports are needed for those at greater risk of non-adherence.

Themes: relationships with health care professionals, systems issues, character of relationships, respect for persons, putting self at risk “realities of ethical decision-making in phn appeared to be in contrast to most extant ethical frameworks… ethical issues in phn are so rooted in context, and so interwoven and complex that they are seldom amenable to this type of analysis… ethical concerns in phn are highly relational in nature…” (pp.435-6).
practices of health
visitors in relation to
women experiencing
domestic violence

Article focus: drawing
on Foucault’s notion of
disciplinary power, to
discuss the practices of
British health visiting
can be understood as
supportive or as
surveillance

- semistructured interviews

National Health
Services

and purposive
sampling

Health visiting
nurses (#not
identified)

followed later by
16 mothers who
had experienced
violence and rec’ed
health
visiting services

relationships from the perspective of the
wellfare of the children; included: asking
questions, engaging in directive
conversation, talking and listening

Theoretically linked to Foucault’s ‘pastoral
power’; and mothers practised resistance to
this power

“Understanding the policing role… alongside
their supportive role, draws attention to the
exercise of power and the discourses that
produce health visitors and mothers…”
(p.375).

| Rafael (1999) | To describe the nature of public health nsg in district and program-focus programs | Feminist postmodern oral history - interviews | SW Ontario PH depts | 14 PHNs – with average of 20yrs of experience in PH | District nsg seen as having integral connection to community; Program-focus seen as a loss of that connection. |
| Rafael (2001) | To identify PHNs’ conceptualizations of empowerment, strategies and outcomes of empowerment | Qualitative – exploratory Nominal group technique | Ontario, Canada | 24 PHNs, 17 of which participated in all 3 focus groups (9 group sessions) | Empowerment: active, internal process of growth that is rooted in one’s own belief system
Empowering Activities: development of a trusting relationship, advocacy, providing info and developing skills, capacity building
Outcomes of Client Empowerment: changes in self, changes in relationships with others, changes in behaviours |
| Reutter & Ford (1996) | To learn about the experiences and perspectives of PHNs: what do they do and how do they feel about it? | Qualitative – exploratory, descriptive Individual interviews and focus groups Content analysis | Alberta, Canada | 17 nurses interviewed; 11 more in 3 focus groups | Themes of nurses perceptions: valuable and worthwhile, enjoyable, demanding, not well understood by others
Themes gave rise to 3 issues: setting priorities, evaluating effectiveness, marketing services
“a generalist practice based on a geographic area provides great variety, but even those nurses engaged in a focused practice targeted toward a defined population were able to maintain variety by engaging in both individual and group work” (p.13) |
<p>| Reutter &amp; Ford (1997) | (data used from above) | As above | As above | As above | Nurses work to enhance client competence |</p>
<table>
<thead>
<tr>
<th>Article focus</th>
<th>Methods</th>
<th>Findings</th>
<th>Themes/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reutter &amp; Ford (1998)</td>
<td>(data used from above study) Article focus: to describe PHNs’ perceptions of changes in their practice, in Canadian context</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>Robinson (1996)</td>
<td>To explore the process and outcomes of family systems nsg interventions – this article focuses on one finding: relationships</td>
<td>Grounded theory Video-taped therapeutic sessions Research conversations</td>
<td>Western Canada, family systems therapy unit</td>
</tr>
<tr>
<td>Schulte (2000)</td>
<td>To describe culture of PH nsg in urban PH dept</td>
<td>Ethnography – interviews, observation</td>
<td>Midwest U.S.</td>
</tr>
<tr>
<td>Searle, Park, &amp; Littleton (2007)</td>
<td>To document and analyze the nature of the process of care in the population of European-descended New Zealanders (a minority of TB cases but who are older with a number of other health complications)</td>
<td>Repeated semi-structured interviews, participant observation, patient records, and media accounts of TB</td>
<td>Auckland New Zealand, public health</td>
</tr>
<tr>
<td>SmithBattle,</td>
<td>To explore how</td>
<td>Clinical exemplars – group</td>
<td>U.S.</td>
</tr>
<tr>
<td>Author/Reference</td>
<td>Community Practice</td>
<td>Methodology</td>
<td>Setting</td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td>Diekemper &amp; Drake (1999)</td>
<td>Community practice evolved in response to organizational changes</td>
<td>Interviews and observation (Benner)</td>
<td></td>
</tr>
<tr>
<td>Smith Battle, Drake, &amp; Diekemper (1997)</td>
<td>To examine the expertise that is often unrecognized in the everyday practice of community health nurses</td>
<td>Interpretive phenomenology (Benner) – Individual and small group interviews Observations</td>
<td>Midwest U.S. metropolitan area</td>
</tr>
<tr>
<td>Spiers (2002)</td>
<td>To explore the interpersonal processes that constitute the goals and conditions for negotiation in home care</td>
<td>Qualitative ethology for video-based research (Bottorff) Video taped dyads Previsit and postvisit Interviews</td>
<td>Western U.S. large metropolitan home health care agency</td>
</tr>
<tr>
<td>St. John (1998)</td>
<td>To critically examine community-as-client in practice</td>
<td>Grounded theory - interviews</td>
<td>PH depts. - 3 states in Australia</td>
</tr>
<tr>
<td>Swigart &amp; Kolb (2004)</td>
<td>To describe the factors that homeless persons report as influencing their decisions to accept public health TB screening program</td>
<td>Qualitative: In-depth semi-structured interviews; constant comparative content analysis method</td>
<td>7 city homeless shelters, Pennsylvania, U.S.</td>
</tr>
<tr>
<td>Thiam, LeFevre, Hane, Ndiaye, &amp; Ba et al. (2007)</td>
<td>To assess the effectiveness of a contextualized intervention strategy</td>
<td>Cluster randomized controlled trial Intervention: reinforced counseling, decentralization</td>
<td>16 government health centers in Senegal.</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Methods</td>
<td>Setting</td>
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<tr>
<td>Upshur et al. (1999)</td>
<td>To explore school staff knowledge and attitudes toward TB</td>
<td>Qualitative: Focus groups</td>
<td>East York, Toronto, Canada</td>
</tr>
<tr>
<td>Van der Walt &amp; Schwartz (2002)</td>
<td>To explore task orientation in the PH system and examine the explicit/implicit reasons for its continued existence. Larger study: to study the work of nurses in the TB program</td>
<td>Focused ethnography</td>
<td>Cape Town, South Africa</td>
</tr>
<tr>
<td>Wilson, H.V. (2001)</td>
<td>To explore surveillance discourses within NZ child health nursing and identify whether surveillance practices have implications in this context of power relations.</td>
<td>Foucauldian discourse analysis semistructured interviews</td>
<td>Auckland, NZ</td>
</tr>
<tr>
<td>Zerwekh (2000)</td>
<td>To understand the</td>
<td>Hermeneutic phenomenology</td>
<td>U.S.</td>
</tr>
<tr>
<td>Nature and meaning of caring on the ragged edge of society: ‘what is it like to care for people when mainstream society often does not care?’</td>
<td>(Ray) Interviews</td>
<td>in community, school, critical care, mental health and health promotion</td>
<td>Meanings of nursing practice: meaning as challenges overcome, meaning as calling, meaning as family legacy, meaning as an experience of common humanity Caring metathemes: the human connection, the community connection, making self-care possible Caring on Ragged Edge fit with Swanson’s Caring for the Well-being of Others, including: maintaining belief, knowing and being with, doing for, enabling</td>
</tr>
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</table>
### Appendix B:
Final Participant Group

**Nurses:**

<table>
<thead>
<tr>
<th>Participant</th>
<th>TB Program</th>
<th>Nursing Designation</th>
<th>yrs in PH</th>
<th>yrs in TB</th>
<th>Age Category</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1 Louisa</td>
<td>DOT Homeless Team</td>
<td>RPN</td>
<td>30</td>
<td>13</td>
<td>50-65</td>
<td>F</td>
</tr>
<tr>
<td>N2 Lynette</td>
<td>DOT South Team</td>
<td>RPN</td>
<td>14</td>
<td>5.5</td>
<td>50-65</td>
<td>F</td>
</tr>
<tr>
<td>N3 Bev</td>
<td>Case Mg’t West Team</td>
<td>RN (BSc) (PHN)</td>
<td></td>
<td></td>
<td>50-65</td>
<td>F</td>
</tr>
<tr>
<td>N4 Evelyn</td>
<td>DOT North Team</td>
<td>RN (Dip)</td>
<td>14</td>
<td>12</td>
<td>40-49</td>
<td>F</td>
</tr>
<tr>
<td>N5 Paulette</td>
<td>DOT West Team</td>
<td>RPN</td>
<td>8</td>
<td>8</td>
<td>30-39</td>
<td>F</td>
</tr>
<tr>
<td>N6 Rosalee</td>
<td>Case Mg’t North Team</td>
<td>RN (BSc) (PHN)</td>
<td>4</td>
<td>2</td>
<td>20-29</td>
<td>F</td>
</tr>
<tr>
<td>N7 Leslie</td>
<td>DOT West Team</td>
<td>RN (Dip)</td>
<td>5mos.</td>
<td>5mos.</td>
<td>50-65</td>
<td>F</td>
</tr>
<tr>
<td>N8 Karen</td>
<td>DOT West Team</td>
<td>RN (BSc)</td>
<td>12</td>
<td>12</td>
<td>30-39</td>
<td>F</td>
</tr>
<tr>
<td>N9 Linda</td>
<td>DOT North Team</td>
<td>RN (Dip)</td>
<td>25</td>
<td>8</td>
<td>50-65</td>
<td>F</td>
</tr>
</tbody>
</table>

**Clients:** (daily = Monday-Friday; intermittent = Monday, Wednesday, Friday)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age Category</th>
<th>Sex</th>
<th># visits with TB nurse</th>
<th>Time in Tx at time of study (contact with TB nurse)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1-1 Ahmed</td>
<td>50-65</td>
<td>M</td>
<td>&gt; 20</td>
<td>1.5-2yrs (sporadic) * tx completed</td>
</tr>
<tr>
<td>C1-2 Jose</td>
<td>40-49</td>
<td>M</td>
<td>&gt; 20</td>
<td>6 weeks (daily)</td>
</tr>
<tr>
<td>C1-3 Elijah</td>
<td>40-49</td>
<td>M</td>
<td>&gt; 20</td>
<td>&gt; 1.5 yrs (sporadic)</td>
</tr>
<tr>
<td>C1-4 Luka</td>
<td>40-49</td>
<td>M</td>
<td>&gt; 20</td>
<td>5-6 months (intermittent)</td>
</tr>
<tr>
<td>C1-5 Eyob</td>
<td>30-39</td>
<td>M</td>
<td>1-5</td>
<td>One week (daily)</td>
</tr>
<tr>
<td>Code</td>
<td>Name</td>
<td>Age</td>
<td>Gender</td>
<td>Duration</td>
</tr>
<tr>
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<td>----------</td>
</tr>
<tr>
<td>C2-1</td>
<td>Rahim</td>
<td>50-65</td>
<td>M</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(intermittent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2-2</td>
<td>Kwame</td>
<td>40-49</td>
<td>M</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(daily)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2-3</td>
<td>Akiki</td>
<td>30-39</td>
<td>F</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(intermittent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3</td>
<td>Namazzi</td>
<td>30-39</td>
<td>F</td>
<td>6-10</td>
</tr>
<tr>
<td></td>
<td>(sporadic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4-1</td>
<td>Alicia</td>
<td>40-49</td>
<td>F</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(daily)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4-2</td>
<td>Hana</td>
<td>50-65</td>
<td>F</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(intermittent)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4-3</td>
<td>Farah</td>
<td>40-49</td>
<td>F</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(daily)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4-4</td>
<td>Fatima</td>
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<td>18-29</td>
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<td>Hamid</td>
<td>18-29</td>
<td>M</td>
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<td>(3mos.)</td>
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<td>F</td>
<td>18-29</td>
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<tr>
<td>C5-6</td>
<td>Dad – Daren</td>
<td>(dad)</td>
<td>M</td>
<td>18-29</td>
</tr>
<tr>
<td></td>
<td>(3mos.)</td>
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<tr>
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<td>M</td>
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<td>&gt; 20</td>
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<td>Afua</td>
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<tr>
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<td>Jima</td>
<td>40-49</td>
<td>M</td>
<td>&gt; 20</td>
</tr>
<tr>
<td></td>
<td>(daily)</td>
<td></td>
<td></td>
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</table>
Nurse Participants (total 9)
TB Programs: DOT – 7; Case Management – 2; Regions: North – 3; South – 2; East – 0; West – 4

Nurse Designations: RPN – 3; RN(Dip) – 3; RN(BSc) – 3

#Yrs in PH: 5 months – 30 years

#Yrs in TB: 5 months – 13 years

Age Categories: 20-29: 1; 30-39: 2; 40-49: 1; 50-65: 5

Sex: Female - 9

Citizenship: Canadian - 9

Race/Ethnicity: Canadian – 7; Italian – 1; Chinese – 1; (“White” – 9)

Languages: Cantonese – 1; English – 9; French – 1; Friulano – 1

Client Participants (total 24 (+1))
Age Categories: (< 1yr - 1); 18-29: 8; 30-39: 3; 40-49: 10; 50-65: 3

Sex: Female – (1) 10; Male – 14

Citizenship: Citizen – (1) 11; Landed Immigrant: 9; Refugee: 3; Status Indian: 1

Race/Ethnicity: Canadian (French, “Caucasian”) – 2; “Mixed Blood” (White/Native) – 1; Spanish/Hispanic – 3; Indian – 2; Sri Lankan – 3; Pakistani – 2; Ethiopian – 3; Somali – 2; “Black” Congolese – 1; African/Kenyan – 2; African/Ugandan – 1; Tajikistani – 1; Turkish – 1

Languages: Amharic – 3; Arabic – 1; Bengali – 1; English – 24; Farsi – 1; French – 4; German – 1; Hindi – 2; Igbo – 1; Luganda – 1; Oji-Cree – 1; Oriya – 1; Punjabi – 1; Sinhalese – 1; Somali – 2; Spanish – 2; Swahili – 1; Tamil – 3; Turkish – 1; Urdu – 2
Nurse Participant Demographic Information

The following information is being collected strictly for background description only. This description of participants will provide a general picture of some factors that are part of relationships. These forms will be kept, along with all notes related to the research, in a locked cabinet at the faculty of nursing. Filling out this form is completely voluntary. You may choose not to share this information.

*Please circle one of the choices in each section below.*

**TPH Job Title:**

**Nursing Credentials:**  Diploma RPN  Diploma RN  BScN  Masters  PhD

Certificates (please list)

Education Other than Nursing (please list)

**# of years in Public Health:**  < 1  1-5  5-10  10-20  > 20

**# of years in TB program:**  < 1  1-5  5-10  10-20  > 20

**Age category:**  20-29  30-39  40-49  50-65

**Gender:**  Female  Male

**Citizenship Status:**  citizen  landed immigrant

**Languages Spoken:** (please list)
Client Participant Demographic Information

The following information is being collected strictly for background description only. This description of participants will give a general picture of some factors that are part of relationships. These forms will be kept, along with all notes related to the research, in a locked cabinet at the faculty of nursing. Filling out this form is completely voluntary. You may choose not to share this information.

*Please circle one of the choices in each section below.*

**Age Category:**  18–29  30–39  40–49  50–65  older than 65

**Gender:**  female  male

**Citizenship:**  citizen  landed immigrant  refugee  without status

**Languages Spoken (please list):**

**# of Visits with TB Nurse:**  1–5  5–10  10–20  more than 20
Appendix C: Request for Participation

I am a doctoral student in the Faculty of Nursing, University of Toronto, interested in relationships in public health nursing, and specifically in the TB program. I am writing to ask you to consider being a participant in my research study on this topic. Below is a brief description of my thesis proposal, and some details regarding what participation in the study will involve.

The purpose of the study is to examine the nature of relational work in the TB program of Toronto Public Health (TPH) as part of the job of caring for people with this infectious disease. I believe that by understanding what it is really like to be involved in establishing and maintaining relationships, we can also begin to discuss how the knowledge and skill required may be developed and supported. I hope to contribute to this understanding by providing qualitative evidence that may be used in recommendations for such things as policy development, staffing issues, and practice guidelines for practice in this area. My hope is that this study will contribute to deeper understanding of the nursing role in TB, the importance of relationship skills in that role, the effort required of nurses who do this work, and the kind of support and supervision that is most useful.

My assumptions about relationships as work stem from my clinical background as a psychiatric-mental health nurse and a former member of the mental health team at TPH. In my experience at TPH, I discussed with nurses the relationship skills they used every day, and also came to see how much these skills seemed taken-for-granted as part of the job. I found this to be especially true in the TB-DOT program, where even making a simple connection seemed to be a significant accomplishment. The work of all TB nurses is of particular interest to me because it represents well what I consider the unique situation of public health practice: balancing the needs of the individual with concern for the public’s health. The eradication of infectious diseases like TB is certainly an important population health issue, yet I find that the emphasis on this aspect overshadows the very personal concerns that are also a necessary part of the program and usually fall within the realm of nursing work. By studying the experiences and perspectives of nurses and clients, I hope to raise awareness of how necessary relational work is in the success of any population health focused programs.

The research methodology being used is interpretive phenomenology, which generally seeks deeper understanding of human phenomena that are difficult to measure and to a large extent are understood through the daily lived experience of them. Relational work is just such a phenomenon. Participation in this study will involve being observed, or ‘shadowed’, by me, the researcher, for up to 5 days in a regular work week (mutually agreeable times to be arranged). During that time, I would like to join you in as many client visits as possible (with clients willing). I would also like to have a more focused conversation with you, an ‘interview’, about your perspective on your relationships with clients. Finally, I am hoping also to be able to have a conversation with one of your clients about his/her perspective on the relationship (arranged during our joint visits).

I will review specific details such as consent and scheduling once you have agreed to participate. Please contact me at your earliest convenience if you would like to participate, or if you have more questions. Phone: 647-401-7574 Email: amy.bender@utoronto.ca. You may also contact my supervisor, Dr. Elizabeth Peter. Phone: 416-946-3437 Email: elizabeth.peter@utoronto.ca.

Thank you for taking time to consider this.

Amy Bender RN, MN, PhD (candidate)
Appendix D: Observation Guide

Prior to the Observation:
- What is the nurse’s perspective on the situation?
- What is the nurse’s plan for involvement?
- Does the nurse want me to be aware of anything specific? (protocols, safety issues, etc.)

Overall Observation:
- What do I see?
- What do I hear?
- What do I smell?
- What do I feel?

The People
- Who’s there? Who’s involved in the interaction?
- What are people doing?
- Body language – how are they sitting/standing/moving/touching?
- Proximity to each other/to me
- Voice – tone, volume
- Eye contact – lots, some, none, occasional-when?
- Are they listening to each other? What are the clues?

The Setting
- Physical setting, layout of room (draw it), amount of light
- What objects are there? Furniture? – how do they facilitate interaction? How do they interfere with it?
- Noise – part of interaction? Interfering with interaction?

The Situation
- Time of day; Is the meeting on time/running late, cut short?
- Is the purpose of the visit clear?
- What are the topics of conversation?
- How much is TB-related? How much is other issues?
- What are they actually saying? – words/quotes/phrases
- Is there conflict? Resistance? Power struggles? What are the clues? How are they addressed/resolved?
- Do boundary issues arise? How are they addressed?
- Awareness of relationship itself? What are the clues?
- Is there evidence of theoretical relationship knowledge and skills being used?

After the Observation
- How did nurse think/feel it went?
- Does the nurse think the plan happened?
- Any surprises?
### Appendix E:
Observation Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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### Observations

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<th>Participant Dyad</th>
<th>Total # of Visits</th>
<th>Dates and Length of Each Visit</th>
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<tbody>
<tr>
<td>Louisa &amp; Ahmed</td>
<td>3</td>
<td>Feb 14/07 (45mins); Feb 19/07 (60mins); Mar 2/07 (30mins)</td>
</tr>
<tr>
<td>“ &amp; Jose</td>
<td>4</td>
<td>Feb 14/07 (15mins); Feb 15/07 (45mins); Feb 22/07 (20mins); Mar 2/07 (15mins)</td>
</tr>
<tr>
<td>“ &amp; Elijah</td>
<td>4</td>
<td>Feb 14/07 (75mins); Feb 21/07 (60mins); Mar 2/07 (40mins); Mar 15/07 (50mins)</td>
</tr>
<tr>
<td>“ &amp; Luka</td>
<td>5 (2miss)</td>
<td>Feb 16/07 (20mins); Feb 19/07 (20mins); Feb 21/07 (15mins); Mar 2/07 (10mins); Mar 9/07 (20mins)</td>
</tr>
<tr>
<td>“ &amp; Eyob</td>
<td>5</td>
<td>Mar 2/07 (5mins); Mar 9/07 (120mins); Mar 15/07 (25mins); Mar 22/07 (75mins); Mar 23/07 (45mins)</td>
</tr>
<tr>
<td>Lynette &amp; Rahim</td>
<td>5</td>
<td>Mar 1/07 (30mins); Mar 5/07 (35mins); Mar 6/07 (30mins); Mar 12/07 (35mins); Mar 13/07 (25mins)</td>
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<tr>
<td>“ &amp; Kwame</td>
<td>5</td>
<td>Mar 1/07 (45mins); Mar 5/07 (35mins); Mar 12/07 (20mins); Mar 13/07 (25mins); Mar 14/07 (20mins)</td>
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<tr>
<td>“ &amp; Akiki</td>
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<td>2</td>
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<td>Mar 21/07 (45mins); Mar 30/07 (30mins); Apr 2/07 (35mins); Apr 4/07 (70mins); Apr 5/07 (50mins)</td>
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<tr>
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<tr>
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<tr>
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<td>“ &amp; Jima</td>
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### Duration of Visits:

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<th>40</th>
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<th>60</th>
<th>70</th>
<th>75</th>
<th>120</th>
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<td>16</td>
<td>10</td>
<td>19</td>
<td>7</td>
<td>11</td>
<td>8</td>
<td>5</td>
<td>8</td>
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### Distances Traveled:

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<tr>
<td>Lynette</td>
<td>160</td>
</tr>
<tr>
<td>Bev</td>
<td>50</td>
</tr>
<tr>
<td>Evelyn</td>
<td>510</td>
</tr>
<tr>
<td>Paulette</td>
<td>1012</td>
</tr>
<tr>
<td>Rosalee</td>
<td>(56 by transit)</td>
</tr>
<tr>
<td>Leslie</td>
<td>256</td>
</tr>
<tr>
<td>Karen</td>
<td>216</td>
</tr>
<tr>
<td>Linda</td>
<td>402 (+28 by transit)</td>
</tr>
<tr>
<td>Team Meetings</td>
<td>76 (+54 by transit)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3260 (+138 by transit)</strong></td>
</tr>
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</table>
Appendix F: Interview Guide

Question Guide for Nurses

I’m interested in understanding your experience of relationships as a nurse with clients in the TB program.

1. Tell me about a relationship that has gone well/is going well.
2. Tell me about one that hasn’t gone so well.
3. What does it mean to say a relationship is working? Not working? How do you know?
4. What do you think your relationship means for your client?
5. Describe the places where your relationships with clients happen.
6. How do you think the place affects the nature of the relationship?
7. If you had your way, how would your relationships with these clients be different? What do you wish you were able to do, that you aren’t currently doing?
8. Describe what having knowledge and skill in relationships means. Where does this knowledge and skill come from? How have you personally acquired relationship skills?
9. Is there anything else you’d like to tell me?

Question Guide for Clients

I’m interested in understanding your experience of the relationship between you and ‘Nurse X’ in this TB program.

1. Tell me about your relationship with ‘Nurse X’.
2. How do you get along with each other?
3. Describe what works well and what doesn’t work so well in your relationship.
4. What do you think affects how well you get along? How do you know?
5. Where do you usually meet? Do you think where you meet has any effect on how you get along with each other?
6. Describe what your relationship with ‘Nurse X’ means to you.
7. If you had your way, how would your relationship with ‘Nurse X’ be different?
8. Are there things about ‘Nurse X’’s nursing knowledge and skills, or her personality that you see as important for all nurses in the TB program to have?
9. Is there anything else you’d like to tell me?
Appendix G: Data Analysis Process Diagram

Observation Notes

Interview Transcripts

Interpretive Outline #1 & 3 Narratives (begin, middle, end)

What does this reveal about relational work and participants’ experiences of it?

Interpretive Outline #1 & Descriptive Writing

Nurse-Client Dyads (obs notes & transcripts & notes to self)

Interpretive Outline #2 & Naming List

What does this reveal about relational work and participants’ experiences of it?

Interpretive Outline #2

Naming List

Whole Text (Dyads again)

Interpretive Outline #3 & Names Glossary

Overall Narrative & Themes
(Answering research questions: The nature of relational work? The meanings expressed by participants? How place shapes it? The knowledge & skills that are part of it?)
### Appendix H:  
Interpretive Outline #1 (First Read: Observation Notes)

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<tr>
<th>Category</th>
<th>Themes</th>
<th>Sub-themes</th>
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<td>Location</td>
<td>Home (apartments, houses, supported housing/boarding homes)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Car</strong> (parking lots, side streets)</td>
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<tr>
<td></td>
<td></td>
<td>Public place (coffee shop/community centre, plaza)</td>
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<td></td>
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<td>Hospital/TPH office</td>
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<tr>
<td></td>
<td></td>
<td>Furnishings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taking off our shoes</td>
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<td></td>
<td>Distractions/Interruptions (noise, smells, other activities light/darkness)</td>
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<td></td>
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<td>‘Risky’ neighbourhoods/safety</td>
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<td><strong>Moving between locations</strong></td>
<td>Geographical distances</td>
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<tr>
<td></td>
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<td>Stress of commuting</td>
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<tr>
<td></td>
<td></td>
<td>Importance of cell phones (how did it work before cell phones?)</td>
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<td><strong>Private/Public</strong></td>
<td>Privacy in public places</td>
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<tr>
<td>(links to stigma)</td>
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<td>Privacy in private places (confidentiality in roommates’ presence)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Going public (with friends, at work)</td>
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<tr>
<td></td>
<td></td>
<td>Not identifying as a nurse in public</td>
</tr>
<tr>
<td><strong>Proximity</strong></td>
<td>Close/very close/nearness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distance (in room, talking between rooms)</td>
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</tr>
<tr>
<td></td>
<td>Physical touch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feeling close to client (“really like this client”)</td>
<td></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>Arranging meetings</td>
<td>Missed meetings (no show’s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Running late</td>
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<tr>
<td></td>
<td></td>
<td>Watching the clock</td>
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<tr>
<td><strong>References to past and future</strong></td>
<td>Continuation of conversations</td>
<td>conversations over time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Planning ahead</td>
</tr>
<tr>
<td><strong>Length of time of knowing each other</strong></td>
<td></td>
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</tr>
<tr>
<td>Relationship</td>
<td>Like a Friend/Sister/One of the Family</td>
<td>&quot;like a friend&quot; vs. &quot;intrusion in their lives&quot;</td>
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<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Surveillance role</td>
<td>Monitoring Treatment (checking pills)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Managing Contagiousness</strong> (checking up on/supporting ‘isolation’, wearing masks)</td>
<td></td>
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<tr>
<td></td>
<td>Checking about others in the home</td>
<td></td>
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<tr>
<td>Virtues</td>
<td><strong>Honesty</strong></td>
<td></td>
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<tr>
<td></td>
<td>Trust</td>
<td></td>
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<tr>
<td></td>
<td>Empathy</td>
<td></td>
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<tr>
<td></td>
<td>Respect</td>
<td></td>
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<tr>
<td></td>
<td><strong>Giving Comfort</strong></td>
<td></td>
</tr>
<tr>
<td>Incentives, Gift-giving &amp; Exchanges</td>
<td>Giving things (Official: Ensure, ttc tokens, groceries, food vouchers, taxi chits, dosettes; Unofficial: school course calendars, holiday treats, cold pack, file folder, cigarettes)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doing for: phone calls, letters, faxing, accompanying to appointments, advocacy, trips to food bank, assisting with moving</td>
<td></td>
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<tr>
<td></td>
<td>‘Getting back’: personally, sense of reward, new learning, emotionally</td>
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<tr>
<td></td>
<td>Accepting/not accepting gifts</td>
<td></td>
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<tr>
<td></td>
<td><strong>Eating and drinking together</strong></td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>Crossing language barriers</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Clarifying/ translating metaphors and idiomatic expressions</strong></td>
<td></td>
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<tr>
<td></td>
<td>Using a few words in other languages</td>
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<tr>
<td></td>
<td><strong>TB language</strong>: “sputums”, “cultures”, “fully sensitive”, “resistant”</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>Sharing/comparing values &amp; customs</td>
<td></td>
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<tr>
<td></td>
<td><strong>Experiences of immigration</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural translation</td>
<td></td>
</tr>
<tr>
<td>Networks of relationships</td>
<td><strong>Other people</strong> in the situation/context (who's the client?, how is 'client' understood?), family, roommates, friends</td>
<td></td>
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<tr>
<td></td>
<td>organizational constraints/supports</td>
<td></td>
</tr>
<tr>
<td>Communication (styles, skills, means, methods?)</td>
<td>Colleagues – team members, case management/DOT connections</td>
<td></td>
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<tr>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Verbal</strong></td>
<td>information-giving/teaching, social chatting, <strong>clarifying, negotiating</strong>, directing, asking questions, apologizing, reminding, seeking/giving opinion</td>
<td></td>
</tr>
<tr>
<td><strong>Nonverbal</strong></td>
<td>open body language, face-to-face, eye contact, <strong>laughter</strong>, physical touch</td>
<td></td>
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<tr>
<td><strong>Silence</strong></td>
<td>Purposeful silence: ‘use of silence’, giving time to answer; not asking questions/turning a blind eye</td>
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<tr>
<td></td>
<td>Silence that hangs: the unknown, creates distance</td>
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<tr>
<td></td>
<td>Situational Silence: circumstances, change in topics</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Content: TB &amp; treatment</th>
<th>The Pills</th>
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<tbody>
<tr>
<td></td>
<td>Checking/filling dosette</td>
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<td></td>
<td>Prescriptions/re-fills/dose-changes</td>
</tr>
<tr>
<td></td>
<td>Watching them swallow the pills (talking about them/<strong>not talking about them</strong>)</td>
</tr>
<tr>
<td>Assessing/Monitoring the TB</td>
<td>Symptoms</td>
</tr>
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<td></td>
<td>Side effects/the checklist</td>
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<td></td>
<td>Diagnostics/skin tests</td>
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<tr>
<td>Appointments</td>
<td></td>
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<tr>
<td>Stigma of TB</td>
<td></td>
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<tr>
<td><strong>Addressing Feats of TB</strong></td>
<td>“the problem”, “the bug”, “the enemy”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Content: TB-related</th>
<th>Medical conditions/problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td><strong>HIV</strong> (discussed overtly and covertly)</td>
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<tr>
<td></td>
<td>Addictions</td>
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<tr>
<td>Nutrition</td>
<td></td>
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<tr>
<td>Returning to work</td>
<td></td>
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</tbody>
</table>

| Organizational red-tape                         | TPH reminder letters, DOT update letters to docs, immigration letters                     |

<table>
<thead>
<tr>
<th>Content: not TB-related</th>
<th>Finances (?poverty)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employment</td>
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<td></td>
<td>Education</td>
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<tr>
<td></td>
<td>Housing</td>
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<tr>
<td></td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td>Health/Mental health issues</td>
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<tr>
<td></td>
<td>Social contacts/friends</td>
</tr>
<tr>
<td></td>
<td>The Weather</td>
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</tbody>
</table>
### Interpretive Outline #1 (First Read: Interviews)

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| Relationship              | Policing/Surveillance Role         | • “intrusion” vs. “being there”  
• More than just swallowing pills  
• Watching without watching  
• “more than a TB police officer” |
| Virtues                   |                                    | • Honesty (being honest and “telling little white lies”/ “tip-toeing around”/ keeping secrets  
• Respect (time/busy lives; privacy)  
• Humility (openness/being open; non-judgemental; acutely aware of client’s privacy/being an intrusion) |
| Mutuality and Reciprocity |                                    | • “goes 2 ways”; “back-and-forth”; “give-and-take”  
• Mutuality with regard to honesty, trust, respect, & personal sharing  
• Reciprocity with regard to giving things to each other, sharing stories, scheduling, learning |
| Choice                    |                                    | • Clients’ choices/having no choice (TB tx/DOT; sharing; place & proximity)  
• Nurses’ choices/having no choice (organization/program mandates – “stay in the box”; personal sharing; personal safety, place & proximity) |
| Culture & language        |                                    | • Nurses: ‘yes’ it’s a factor; Clients: ‘no’, not a factor  
• Gender role – cultural differences  
• Importance of language (working across language barriers; learning few words as means of connection)  
• Nurse’s curiosity, interest conveys concern for client |
| Networks of relationships |                                    | • Roommates – issues of privacy  
• Family – who’s the client?; issues of privacy  
• Colleagues – Case Management vs. DOT roles (“behind-the-scenes” vs. “real relationships”); communicating with doctors  
• Relationship with nurse vs. relationship with Public Health |
| Support & advocacy        | Personal-professional              | • “Like a friend” (…sister/mother/family)  
• Personal sharing; knowing each other  
• “Professional”- positive and negative connotations (empathy & concern vs. too |
| Expectations                      | “Clients become dependent on us” – limit setting  
|                                 | Client knowing nurse’s role  
|                                 | Nurses’ sense of reward  
| Communication Skills             | Empathy & self reflection  
|                                 | “she understands what it’s like”  
|                                 | “I just imagine if it was me…”  
| Reassurance & Encouragement      |  
| Teaching/Explaining/Clarifying   | TB and related health problems  
| Use of humour                    | Builds connection; trust  
|                                 | “lighten things up”  
| Asking questions                 | Personal questions and TB questions  
|                                 | Not asking questions  
| “Really listening”               | To clients’ stories  
|                                 | To what they don’t say  
| “Reading” the client/body language |  
| Incentives & Gifts               | ‘Giving to’ and ‘doing for’ the client  
|                                 | Ensuring tx adherence?  
|                                 | Obligations/duty as nurse (beyond TB program)?  
|                                 | Care and concern for the person/situation?  
| Accepting/not accepting gifts from clients | It’s the policy, but bend the rules and accept  
|                                 | It’s the policy – cannot accept  
| Time                             | Long time  
|                                 | Getting to know each other  
|                                 | “doing time together”  
|                                 | “it’s a long time but it passes quickly”  
|                                 | Every day  
|                                 | Scheduling (and time it takes to schedule)  
|                                 | Combating the monotony; “have to keep it interesting”  
| Phases of relationship           | Beginning: “getting in the door”; “being accepted”; “getting past hump of resistance”; as time of illness/sickness/ ‘not at their best’  
|                                 | Ending: “weaning them off”; difficult endings (dealing ‘well’ with goodbyes; abrupt endings when ‘file’ is transferred); as a time of health; well-being; “feeling better”: “not the sick person anymore”  
| Place                            | Home as indicator of identity  
|                                 | Physical location of residence  
|                                 | Feeling at home in Canada vs. missing home country (connected to culture, immigration, and
| Comfort level of client & nurse | • Light vs dark  
| | • “dirty and dingy” vs. “clean and bright”  
| | • Nurse’s sense of personal safety  
| | • Client’s sense of privacy  
| Isolation | • Related to contagiousness of TB  
| | • Related to immigration (far from home – ‘displacement’)  
| Private vs. Public | • Private nature of TB dx & tx  
| | • Private nature of daily living (what nurses see and don’t speak)  
| | • Privacy in public: “More privacy in coffee shop than at home”  
| | • Car as place of privacy for client and nurse’s private/personal space  
| | • Privacy in private: roommates lack of understanding; family secrets  
| Proximity | • Masking  
| | • Importance of sitting close (?connects to stigma): “would never sit away from her, y’know?”;  
| | • “these are people who sit here, just next to me here [pulls his chair much closer to me]  
| “Happens anywhere” | • Car  
| | • Workplace  
| TB Concerns | Symptoms/side effects/treatment (the pills) | •  
| Fears | •  
| Stigma | •  
| Non-TB Concerns | Immigration & assimilation | •  
| Finances & employment issues | •  
| Other health concerns | • HIV (talking about it and not talking about it)  
| | • Cancer; diabetes; pregnancy; mh & addictions  

Appendix I: Interpretive Outline #2

General Ideas:

PERSON

- Policing/Surveillance Role
- “intrusion” vs. “being there”
- More than just swallowing pills “more than a TB police officer”
- Watching without watching
- Clients’ choices/having no choice (TB tx/DOT; sharing; place & proximity)
- Honesty (being honest and “telling little white lies”/ “tip-toeing around”/ keeping secrets)
- Respect (time/busy lives; privacy - Difference between personal questions and TB questions - when not to ask questions)
- Trust
- Humility (openness/being open; non-judgemental; acutely aware of client’s privacy/being an intrusion)
- Empathy
- Humour – “lighten things up”; laughter & jokes
- Really listening
- Mutuality and Reciprocity – Knowing each other
  - “goes 2 ways”; “back-and-forth”; “give-and-take”
  - Mutuality with regard to honesty, trust, respect, & personal sharing
  - Reciprocity with regard to giving things to each other, sharing stories, scheduling, learning
- Nurse’s sense of learning and reward
- Personal-Professional (“boundaries”?)
  - “Like a friend” (…sister/mother/family)
  - Personal sharing; knowing each other
  - “Professional”- positive and negative connotations (empathy & concern vs. too formal, too strict)
  - “More than a job/more than a nurse”
  - “Clients become dependent on us” – limit setting
- Knowing TB
  - Managing fears and stigma
  - taking the pills
  - Being sick and getting better
  - ‘Health matters beyond TB’ – HIV, mental illness, diabetes
- Giving things to and doing things for – what’s gift-giving; what’s incentive?; what’s need?
- Culture and language (barriers)?
  - Importance of language (working across language barriers; learning few words as means of connection)
  - Nurse’s curiosity, interest conveys concern for client
  - Nurses: ‘yes’ it’s a factor; Clients: ‘no’, not a factor
- Networks of relationships
  - Roommates – issues of privacy
Family – who’s the client?; issues of privacy
Colleagues – Case Management vs. DOT roles (“behind-the-scenes” vs. “real relationships”); communicating with doctors
Relationship with nurse vs. relationship with Public Health

**PLACE**
- Physical locations – “happens anywhere”
- getting through the door
- “dirty and dingy” vs. “clean and bright”
- Nurse’s sense of personal safety
- Client’s sense of privacy
- Proximity
  - Importance of sitting close (?connects to stigma): “would never sit away from her, y’know?’’
  - “these are people who sit here, just next to me here [pulls his chair much closer to me]
  - masking
- In Isolation
  - Related to contagiousness of TB
  - Related to immigration (far from home – ‘displacement’)
- Between Visits
- Organizational Structures
  - staying in the box
  - bending the rules
- Social locations
  - ‘immigrant’, ‘poor’ – therefore, nurse becomes advocate in immigration & assimilation; employment and finances issues
- Meanings of Home (for client and nurse)
- Feeling at home in Canada vs. missing home country (connected to culture, immigration, and displacement)
- Private nature of TB dx & tx
- Private nature of daily living (what nurses see and don’t speak)
- Privacy in public: “More privacy in coffee shop than at home”
- Car as place of privacy for client and nurse’s private/personal space
- Privacy in private: roommates lack of understanding; family secrets

**TIME**
- Everyday
  - “doing time together”
  - “it’s a long time but it passes quickly”
  - Combating the monotony; “have to keep it interesting”
- Getting to know each other
- Scheduling (and time it takes to schedule)
- Running late
- Scheduling
- Relationship over time (beginning middle end)
• Beginning: “getting in the door”; “being accepted”; “getting past hump of resistance”; as time of illness/sickness/ ‘not at their best’
• Ending: “weaning them off”; difficult endings (dealing ‘well’ with goodbyes; abrupt endings when ‘file’ is transferred); as a time of health; well-being; “feeling better”: “not the sick person anymore”

Themes:
What is the nature of relationship work in public health nursing?
How do nurses and clients understand it, from their own lived experiences of it?
What are the knowledge and skills used? How are they supported?
Why/how does place play a part?

1) Intruding without intruding
Being an intrusion – whose the intruder? – trying not to intrude
Representative of TPH – surveillance role – feeling comfortable in the role
Moral sense of commitment to ‘public’ competing with commitment to individual
Don’t want to be the ‘bad guy’
Incentives

2) Watching without watching
Infection control/managing contagiousness – this a real concern – practically have to address this issue, to protect themselves, protect others, protect the client – meeting clients in isolation; masking
Observation/assessment
Keeping track of the pills – nothing spoken about pills through many visits
Swallowing the pills, but more than that
Surveillance

3) Getting through the Door
Place in terms of the actual buildings and social relations
Maintaining privacy in public; respecting privacy in private
Building Trust
Being Honest

4) Knowing TB (and it’s relatives?)
Nurse’s knowledge of TB disease and treatment – clients’ trusting it
Client’s lived knowledge of it – nurses’ respecting it
People are sick at the beginning – improve & need encouragement through middle – are well at end
Stigma of TB – respecting privacy, “really listening” – proximity: importance of sitting close (?connects to stigma): “would never sit away from her, y’know?”;
“these are people who sit here, just next to me here [pulls his chair much closer to me]
Educating/clarifying/reminding
Calming Fears
Advocacy
Knowing about related health concerns – HIV, diabetes, mental illness
5) Knowing each other – Mutuality
Personal sharing
Clients know nurses; not only nurses knowing client– seems to fly in the face of professional boundaries discourse, and not so easily slotted into the ‘self-disclosure’ rhetoric???
All nurses ‘love their job’ – new learning; get to go around the world in a day; see people get better
Nurse as part of the family; “like a friend”

6) Knowing the Rules and Bending Them

to bend or not to bend
knowing the policy but not following it/following it to the letter
e.g. gift-giving; sharing food & drink
Institutional elements present – managing schedule; covering for other nurses/having others cover for her, files in the visits/not in the visits

7) The Locations of Work: In and out of Isolation
At Home:
Physical elements: “dirty and dingy” vs. “clean and bright” – that play on nurse’s sense of personal safety and client’s sense of privacy
Private nature of daily living (what nurses see but don’t speak; ‘not why I’m there’; ‘none of my business’)
Acknowledging the Far-away Home (newcomers – missing home, being alone in new country, feeling ‘displaced’)
Meanings of Home (for client and nurse) – as a way of knowing the person (as marker of identity); privacy in private: roommates lack of understanding; family secrets (ie when ‘home’ is not necessarily ‘haven’)
In Isolation:
The need for masking
Client depends on nurse for bringing things; combating loneliness and boredom
In Public:
Privacy in public: “More privacy in coffee shop than at home”
In-between home and public: Car as nurse’s personal space, place of privacy for client
Being Between Visits: Connected by cell-phone; Call when running late – finishing one, beginning the next; Taking calls from physicians and CM’s for other clients during visit vs leaving phone in car; On the road, in traffic

8) “Every Day, Every Single Day”...
The daily-ness of it, including the monotony – lightening things up, keeping things light – use of humour, being playful with one another

9) Beyond TB (– addressing ‘determinants of health’?)
Immigration issues, experience as immigrant – how to keep ‘immigrant’ labels in check?
Employment and Financial issues
Language translation, advocacy
Appendix J: Names Glossary

Accepting-refusing things:
All the items which clients offer to nurses and nurses choose to accept or refuse (food, drink, small gifts); the communication and actions involved in accepting and refusing; how nurses reflect on this with me.

Advocating:
The ways that nurses help out the client in terms of receiving resources and services to which they are entitled and yet do not have. This also includes ensuring that clients get information and timely appointments related to TB treatment.

Calming fears:
The responses of nurses when clients expressed fear and anxiety related to TB and in general. This includes both nonverbal emotional expressions witnessed during visits and descriptions of these feelings by participants and how nurses address them.

Cultural exchanges:
Cross-cultural learning about one another’s cultural beliefs, practices, foods, religion, as well as practical information about geography, climate, and politics of birth countries (ie nurses learning about clients’ cultures and clients learning about nurses’ cultures).

Displacement:
All the ways that people experience a sense of being out-of-place or a lack of sense of belonging. This includes issues of immigration and settlement, including practical and emotional concerns of living in Canada and maintaining connections to home country and family there.

Every day, every single day:
The daily nature of TB treatment, most notably DOT and how participants express an awareness of this everydayness, or of time in general.

Getting through the door:
The practical ways that nurses enter clients’ homes as well as the meanings associated with this from nurse and client perspectives. This encompasses more than the directly knocking on a door; also includes everything leading up to approaching the door, the ways nurses and clients greet one another, and how they begin the visit.

Home as identity:
Indications of the person’s character revealed through items in the home and the physical set-up of the home. How nurses take in this information; how it becomes part of the relationship.

Honesty:
Nurses telling the truth about the TB treatment and program especially in regard to its status as a legally reportable disease, and clarifying voluntary nature of DOT program. Also includes being transparent/authentic in regard to acknowledging what they do not know or questions they cannot answer.
**Humour & laughter:**
All occasions of intentional use of humour through jokes, teasing, etc as well as the situations giving rise to laughter between clients and nurses.

**Incentives:**
Items given to clients in the interest of having them adhere to treatment and/or to support them in being able to complete treatment.

**Intrusion – policing & surveillance:**
All the direct and indirect ways that nurses carry out their responsibility of ensuring/enforcing TB treatment; how nurses and clients express their awareness of surveillance rationally and emotionally; may include power struggles/tensions.

**Isolation & masking:**
Situations in which nurses and clients visit with one another while the illness is still deemed infectious, and the ways they communicate in isolation and masking procedures and about the emotional aspects of being infectious.

**Language barriers:**
The words/language used by clients to express themselves and the ways nurses respond; including direct and indirect identification of language barriers. The ways that English words/phrases are explained by nurses; moments of miscommunication based on language.

**Lightening things up:**
The ways that nurses work to identify and address the monotony of daily visiting. Closely relates to ‘humour and laughter’.

**Like a friend:**
The social aspects of nurse and client communications; the ‘friendly’ or familiar ways they interact; descriptions of the relationship that are not medically/health related.

**More than pills:**
All the ways that nurse assist or support clients that are non-TB specific; the content of conversations that is not about swallowing pills.

**Mutual personal sharing:**
Personal information that is shared between nurses and clients that encompasses topics not associated with TB, medical concerns, health system (including nurses’ self disclosure).

**Nurse as professional:**
All the ways that ‘professional’ is understood by participants; the ways that nurses communicate their professional limits, obligations, and clients perceptions of ‘professional’ behaviour of nurses.
**Nurses’ safety:**
The concerns of personal safety directly expressed by nurses and the ways they carry an awareness of their safety as they move from place to place without necessarily speaking about it.

**Other health concerns:**
All non-TB diagnosed illnesses, ailments, nutritional concerns, etc. discussed by nurse and client

**Places:**
The physical locations of nurses’ work and how nurses used and/or navigated these places as part of relating to clients

**Privacy in the home:**
Spaces in the home that were understood as private by nurse and client, and how visits happened within these spaces. This includes the rooms, things in the rooms, presence of other people.

**Protecting privacy:**
The privacy in public places – how nurses ensured confidentiality, concealed their identities as TB nurses in order to protect the private nature of TB diagnosis.

**Relationship networks – personal:**
All the other people in the clients’ lives with whom the nurses interacted or knew about, and sometimes directly helped out.

**Relationship networks – professional:**
All the professionals/workers in the clients’ lives with whom the nurses worked. This spanned TB as well as other health-related issues and social services workers. This group also included colleagues within public health department.

**Respecting time and place:**
Keeping appointments, being punctual, communicating about scheduling, from both nurse and client perspectives. How location of visits is discussed/decided.

**Sick to well:**
Descriptions of the trajectory of TB illness from initial experience of symptoms, through treatment, to elimination of symptoms and completion of treatment.

**Social determinants:**
The social issues that clients are dealing with and are discussed with the nurse in terms of finances, housing, transportation/access to services, violence/safety.

**Stay in the box:**
A metaphor used by several nurses to describe the administrative directive of public health department for nurses to stay focused on TB only and not to involve themselves in non-TB issues.
**Stigma:**
Expressions of myths and value judgments about people with TB; experiences of prejudice and discrimination related to TB diagnosis and other aspects of person’s identity, and nurses’ awareness, acknowledgment, ways of addressing.

**Structural elements of the job:**
All the ways that the nurses’ assigned tasks show themselves. This may be in explanations of job descriptions, references to policies or protocols for work, documentation, scheduling client appointments around such administrative tasks as team meetings, staff coverage etc.

**Swallowing the pills:**
The ways that nurses help the client with pills, dosettes, prescriptions, and how they watch clients actually take the pills. This includes verbal and nonverbal communications.

**Trust:**
A feeling of ease, comfort, familiarity between nurse and client that contributes to ability to listen to each other; clients’ ability to take advice, suggestions, direction from nurse. May be named directly by participants or expressed nonverbally.

**Tuberculosis knowledge - bacteria & treatment:**
All the ways that nurses express or utilize the medical knowledge of the infection/disease and treatment and how clients understand it through nurses’ communications.

**Weaning off & saying goodbye:**
The termination of treatment, the end of the relationship – how this is addressed by nurses and clients; the ways that they say good-bye to each other; ‘weaning off” as a metaphor to refer to the attachment clients and nurses feel toward one another given the long-term nature of treatment.
Appendix K: Interpretive Outline #3

The working ‘story’?: Negotiating paradoxes?
The overall paradox - competing agendas of public policy and individual concerns
- role of control and service
- ethical stance of common good and duty to care

1) Intrusion, but not intruding
Representative of public health – surveillance role – notion of enforcement, nurses were acutely aware of how the program was an intrusion, and they actively sought not to intrude, “invade personal space” (N8) – it seemed like a way of minimizing the intrusion
Infection control/managing contagiousness – this a real concern – practically have to address this issue, to protect themselves, protect others, protect the client - Moral sense of commitment to ‘public’ competing with commitment to individual
Being the ‘bad guy’ vs. being accepted; selling the program, what is voluntary & not voluntary
Incentives
Respecting time and privacy
Building Trust
Being Honest
Empathy

Influences of Place:
Getting through the door (getting buzzed into the building, taking off shoes, sitting close to client) Private nature of daily living (what nurses see but don’t speak; ‘not why I’m there’; ‘none of my business’)
In efforts not to intrude, meet “anywhere” – maintaining privacy in public
Privacy in public: “More privacy in coffee shop than at home”
In-between home and public: Car as nurse’s personal space, place of privacy for client

Key Search words:
1. ‘The Intrusion - Policing & Surveillance’: intrusion, intrude, police, surveillance, control, authority, guard
2. ‘Honesty’: honest, truth, true
3. ‘Getting through the Door’: door, get, through
4. ‘Incentives’ (giving things, bringing things, doing things): incentive, ensure, tokens, voucher, chit, groceries, give
5. ‘Trust’: trust (works both ways)
6. ‘Respecting Privacy’: private, privacy, personal especially in the home
7. “Respecting Time and Place”: time, place, respect, early, late, punctual

2) Focus on TB, but not only TB
All participants talked about importance of having solid knowledge of TB and its treatment:
Nurse’s knowledge of TB disease and treatment – clients’ trusting it
Client’s lived knowledge of it – nurses’ respecting it
People are sick at the beginning – improve & need encouragement through middle – well at end
Social determinants of health were apparent – especially issues of income/poverty
Immigration as a striking determinant; raises questions about TB treatment and care outside of southern Ontario, and particularly TB as a global concern; raises importance of treading carefully in this discussion given that TB still carries strong stigma as does the label of ‘immigrant’ (nurses and clients expressed awareness of this in varying ways).

Stigma of TB – respecting privacy, “really listening” – proximity: importance of sitting close (?connects to stigma): “would never sit away from her, y’know?”;
“these are people who sit here, just next to me here [pulls his chair much closer to me]
Skills of teaching and clarifying most prominent? clarifying/reminding

Calming Fears
Knowing about related health concerns – HIV, diabetes, mental illness

Influences of Place:
Isolation - need for masking
Client depends on nurse for bringing things
Combating loneliness and boredom

Key Search Words:
1. ‘Tuberculosis Bug & Treatment’: TB, side effects, feeling, medication, (names of meds), bug, lungs, pulmonary, disease, sick, appetite, stomach
2. ‘Isolation & masking’ (managing contagiousness): isolation, mask, infect, contagious
3. ‘Calming Fears’: fear, afraid, scared, worry, anxiety, nervous
4. ‘Other Health Concerns’: HIV, diabetes, psychiatric, mental health, addiction, drinking, health, sick
5. ‘Social Determinants’ (?): finance, economic, money, education, school, job, work, social
6. ‘Stigma’: stigma, fear, afraid, scared, away, TB
7. ‘Protecting Privacy’ (esp in public): privacy, private, public, lie, secret

3) Watching without watching
Keeping track of the pills – filling prescriptions, filling dosettes, teaching clients to fill dosette, clients taking the pills, suggestions for how to take them (with food, with water, one/time, all-at-once)
Swallowing the pills – but more than that – many visits I witnessed nothing spoken about the pills, and many participants actually said it was what the nurses were there for, but it wasn’t.
Nurses mostly aware of both; clients mostly aware of how much ‘more’ they felt the nurses did.
Skills of coaching and observation seem to show up here?

Key Search Words:
1. ‘Swallowing the Pills’: pill, medicine, medication, swallow, dosette, watch, swallow, observe
2. ‘More than the Pills’: pills, only

4) Knowing each other, but keeping it professional
Mutual personal sharing - Clients know nurses; not only nurses knowing client– not so easily slotted in to professional boundaries discourse
While there was overwhelming use of the term ‘friend’ and ‘friendship’ by all nurses and clients, they also all seemed to be very clear that the nurse was not a friend
While all distinguished the ‘friendship’ with the nurse from other personal friendships consistently, there was more confusion in the use of the term ‘professional’
Another way of talking about this theme is ‘knowing each other’, and though there is a discourse in nursing of ‘knowing the patient’, I think there is less discussion about how much the client knows the nurse. The mutuality of sharing personal information was striking for me. All nurses ‘love their job’ – new learning; get to go around the world in a day; see people get better
Nurse as part of the family; “like a friend”

Relationship networks - colleagues/other nurses/other ph programs; hcp’s; roommates, family members
Knowing the person beyond TB (– addressing ‘determinants of health’?) - immigration issues, employment and financial issues
Skills of active listening and empathy (different than ‘discomfort’ of intruding; more about personal parallels e.g similar age, kids, etc.) are particularly connected here?

Language translation
Advocacy

Influences of Place:
Acknowledging the far-away home (newcomers – missing home, being alone in new country)
‘Displacement’ (Casey)
Meanings of home: as a way of knowing the person (as marker of identity)
Privacy in private: roommates lack of understanding (stigma); family secrets (ie when ‘home’ is not necessarily ‘haven’)
Physical elements: “dirty and dingy” vs. “clean and bright” – part of nurse’s sense of personal safety

Key Search Words:
1. ‘Nurse as Professional’ (connects to ‘rules’): profession, nurse; phrases like ‘not a mere nurse’; ‘more than just a job’
2. ‘Like a Friend’ (or sister or one of the family): friend, family, sister
3. ‘Mutual Personal Sharing’ (cultivating familiarity): person, friend, family, husband, wife, father, mother, child/kid, daughter, son, home
4. ‘Home as Identity’: identity, place, person
5. ‘Cultural Exchanges’: culture, learn, country, language, custom, food, cooking, (names of ethnic groups)
6. ‘Acknowledging Displacement’: displace, disconnect, separate, home, country, far, family, immigration
7. ‘Dealing with Language Barriers’: language, English, (other specific languages), accent, understand, translate, interpret
8. ‘Advocating’: advocate, advocacy, help
9. ‘Personal Relationship Networks’: family, friend, support
10. ‘Professional Relationship Networks’: doctor, nurse, case manager, team, public trustee, public health, hospital
11. ‘Nurses’ Safety’: safe, stairs, elevator

5) Knowing the Rules and Bending Them
the organizational/structural factors that constrain and/or support nurses in their relationships with clients and raises question of knowing which ‘rules’ to follow, when; and, that in order to hold to one rule others would need to be bent/overlooked/put aside
to bend or not to bend – knowing the policy but not following it/following it to the letter
e.g. gift-giving; sharing food & drink
Institutional elements present – managing schedule; covering for other nurses/having others
cover for her, files in the visits/not in the visits
Several used the term ‘stay in the box’ and all talked about how they do not stay in the box –
shows the paradox of top-down program directives about job description/roles that do not always
translate well in face-to-face encounters
i.e at times, the ‘rule’ of pt-centered care seemed to trump the TB focus, and at other times, the
TB/Public Health role focus was adhered to quite strictly (also in best interest of client?, but
‘best interest’ narrowly defined. E.g. ‘we are here for the TB, that’s it.’)
Following the rules seemed to come up as important in terms of avoiding the development of
client “dependence” on the nurse

Key Search Words:
1. ‘Accepting things, Refusing things’: gift, present, food, feed, drink, coffee, tea, cooking, give
2. ‘Structural Elements of the Job’ (work schedules/coverage; documentation): schedule,
document, file, note, policy, job
3. ‘Staying in the Box?’ (program structure): box, program, rule, policy, job

6) “Every Single Day”: Short Visits but a Long Time…
Importance of time – dailyness – good days/bad days; exciting/mundane; satisfying/frustrating
Acknowledges the ordinariness of these relationships, and the importance of addressing the
boredom of visits (I wonder if anyone has talked about boredom in nursing? – seems sacrilegious
to even say it?)
Acknowledges that, the opportunity to follow someone through sickness to wellness; several
nurses commented on the ‘reward’ of seeing pts get better; clients commented on importance of
having nurse there at beginning when they were feeling the most sick, the most afraid, for
encouragement and support; both nurses and clients talked about shifting from not wanting the
nurse there to welcoming the nurse.
Several nurses spoke of ‘weaning clients off’ near the end, and a few even acknowledged that the
nurses needed to wean themselves too. Clients referred to wanting to stay in touch with nurses
after treatment; that the nurse had become one of the family
Lightening things up, keeping things light – use of humour, being playful with one another

Influences of Place:
Connected by cell-phone
Call from car when running late – finishing one, beginning the next
Taking calls from physicians and CM’s during visits vs leaving phone in car
On the road, in traffic

Key Search Words:
1. ‘Every day. Every Single Day’: every day
2. ‘Lightening Things Up’ (humour & laughter): humour, laugh, joke, funny, lighten
3. ‘Sick to Well’ (seeing them get better): sick, better, well, fine, feeling
4. ‘Dependence, Weaning, & Saying Goodbye’: depend, wean, goodbye, end, last
5. ‘Cellphones’ (?) (as way of carrying on to next visit; communicating about tx with other
professionals in the moment): cellphone, phone
Appendix L: Ethics Approval

University of Toronto
Office of the Vice-President, Research
Office of Research Ethics

PROTOCOL REFERENCE #18551 now #21675

December 6, 2007

Dr. Elizabeth Peter
Faculty of Nursing
155 College St.
Toronto, ON M5T 1P8

Ms. Amy Bender
Faculty of Nursing
155 College St.
Toronto, ON M5T 1P8

Dear Dr.:

Re: Your research protocol entitled “Relational Work in Public health Nursing: The People, Situations and Places of TB as Example. An Interpretive Phenomenological Study”

ETHICS APPROVAL

| Original Approval Date: October 13, 2006 |
| Next Expiry Date: October 12, 2008 |
| Renewal: 1 of 4 |

We are writing to advise you that the Health Sciences Research Ethics Board has granted annual renewal of ethics approval to the above referenced research study through the REB’s expedited process. Ongoing projects must be renewed prior to the expiry date.

During the course of the research, any significant deviations from the approved protocol (that is, any deviation which would lead to an increase in risk or a decrease in benefit to participants) and/or any unanticipated developments within the research should be brought to the attention of the Office of Research Ethics.

Best wishes for the successful completion of your project.

Yours sincerely,

Jenny Peto
Research Ethics Coordinator

McMurrich Building, 12 Queen's Park Cres. W, 3rd Floor Toronto, ON M5S 1S8
TEL: 416-846-3273 FAX: 416-946-5753 EMAIL: ethics.review@utoronto.ca
Appendix M: Toronto Public Health Approval

December 18, 2006

Ms. Amy Bender
Doctoral Student
Faculty of Nursing
University of Toronto
155 College St.
Toronto, ON M5T 1P8

Dear Ms. Bender:

Thank you for submitting your research proposal entitled, *Relational Work in Public Health Nursing: The People, Situations, and Places of TB as Example. An Interpretive Phenomenological Study* to Toronto Public Health for review and consideration. I am pleased to inform you that the proposal has been approved. The research you propose is relevant to Toronto Public Health.

Please see attached revised introduction letter. If at any time during the course of your research deviations are made from the original proposal, you will need to inform the Professional Practice unit of these changes.

We request that on completion of your research you submit a summary of your findings to the Professional Practice unit for Toronto Public Health files.

Best of luck in conducting your research.

Yours truly,

Maureen Cava
Manager, Professional Practice
Planning and Policy

cc: Jann Houston
Appendix N: Nurse Consent Form

(on Faculty of Nursing Letterhead)

Researcher: Amy Bender, RN, MN, PhD (candidate)
Doctoral Supervisor: Elizabeth Peter, RN, PhD

This consent form is only part of the process of informed consent. It should give you a basic idea of the research project itself, and the expectations of you as a participant. If you would like more details about something written here, you should feel free to ask either the researcher or doctoral supervisor. Please take time to read this carefully and to understand what is involved.

The Study:
This study is about gaining deeper understanding of the relationships between nurses and clients in the Tuberculosis (TB) Program, and you are being invited to participate because you are part of the nursing staff in this program. While studies in TB screening and treatment adherence have identified the importance of having good relationships with clients, they have generally not addressed what it’s like to actually be in these daily relationships, the skill and effort involved, or the settings in which they happen. I am hoping, through observation and interviews of approximately 10-12 nursing staff and clients to address this.

Your Participation:
In this study I am hoping to observe and hear about your experiences and perspective as someone doing the actual work of building relationships, which is not always easy to describe in words. In order to do this, I am asking:

- to ‘shadow’ you in your usual work activities, except those in which you think my presence would be ethically or clinically problematic, for up to 5 days depending on scheduling;
- as part of that shadowing, to attend your visits with approximately 3 of your clients, as identified by you;
- that you ask for verbal consent from each client prior to our scheduled time together. When a client does not give consent, I will not attend.
- to interview you, at a convenient time during the shadowing period, for approximately one hour. In that conversation, I will ask you to share your thoughts, feelings, and experiences of the relationships you have with your clients.
- I will be keeping notes of what I observe during the shadowing period, including client visits, and with your permission will audiotape our interview.

Risks & Benefits:
- There are no foreseeable risks to you as a participant. You are not obligated to talk about anything that makes you feel uncomfortable.
- While there is no foreseeable direct benefit to you, it is hoped that your input will contribute future TB program planning with attention to the nursing role specifically

Compensation:
- Participation will take place during normal working hours, so there is no direct payment or reimbursement for your participation from me as the researcher.
Privacy & Confidentiality:

- The audiotaped interview will be transcribed into notes, and all notes will be kept as a file in my personal computer that is password protected. All notebooks, audiotapes, and memory sticks will be kept in a locked cabinet, and the tapes will be erased at the end of the study. Transcripts and notes will be kept in a secure cabinet at the faculty for seven years.
- When you prefer that I don’t make a record of what you have said, I won’t.
- As a doctoral student, I will be sharing the information from the tapes and notes with my supervisory committee. No one else will have access to this information.
- There are certain things that are not confidential. For example, breaches of the Regulated Health Professions Act and concerns about client safety must be reported to the proper authorities. Should concerns of this nature arise for me, I will let you know and together we can discuss how best to address them.

Participation is completely voluntary and you are free to withdraw from the study at any time. You should feel free to ask for clarification or new information throughout our time together. I will inform you of any changes in my intentions and seek your permission for any specific changes that impact on your participation as they arise.

For further information regarding the study or your participation in it, please contact:
Myself: Amy Bender: 647-401-7574, amy.bender@utoronto.ca
My supervisor, Dr. Elizabeth Peter: 416-946-3437
Associate Dean of Research, Dr. Diane Doran: 416-978-2866

Your signature on this form indicates that you have understood to your satisfaction the information regarding your voluntary participation in this research project and agree to participate.

Participant:                      Date:

Researcher/Witness:             Date:
Appendix O: Client Consent Form for Observation
(on Faculty of Nursing Letterhead)
Study Title: Relational Work in Public Health Nursing: The People, Situations, and Places of TB as Example. An Interpretive Phenomenological Study
Researcher: Amy Bender RN MN, PhD (candidate)
Doctoral Supervisor: Elizabeth Peter RN, PhD

This consent form should give you a basic idea of the research study, and the expectations of you as a participant. If you would like more details about something you read here, feel free to ask either the researcher or her doctoral supervisor. Please take time to read this carefully and to understand what is involved.

The Study:
I want to understand relationships between nurses and clients in the Tuberculosis (TB) Program better because other research says these relationships are important in taking care of people with TB. I am inviting you to participate in this study because you are a client of this program.

Your Participation:
These are the important things you need to know about being in the study:
- I will be joining your nurse for up to 5 days as she/he visits clients.
- If you agree, I will be part of your visits with the nurse. The nurse get your permission for me to ask you to be part of my study before I come. I will only be watching what happens in the visit and will not interrupt you and your nurse as you are talking.
- As part of the study I will keep written notes of what I see and hear.
- Your participation is completely voluntary. It is up to you to decide if you want to be observed or not.
- Deciding NOT to be observed will not affect your TB treatment or the nursing services you receive from public health.
- Even after you agree to be involved, you may change your mind and choose not to be in the study. You can leave the study at any time. Also, please ask any questions you have at any time.

Risks & Benefits:
I do not think there any risks to you by participating in this study. If my presence during the visit is bothering you, please let me know and I will leave.

The benefits of participating may not directly affect you personally, but watching your nurse as she/he works meets you will help in making suggestions for improving the TB program.

Compensation:
There is no compensation for your participation in the study.

Privacy & Confidentiality:
If you do not want me to stay for the whole visit with the nurse, I won’t. For example, some things you talk about may be too private for me to hear, and then I will leave. You will not be asked about your TB diagnosis or treatment. You do not need to talk about anything that makes
you feel uncomfortable, and if you do not want me to write notes about what you have said, I won’t.

Because I am a student, I will be sharing the information from my notes written during the visit with the committee that supervises me at the nursing school. I will not share your name with them, and the committee members will keep all information secret. No one else will see this information.

There are some things that cannot be kept secret. If your safety or the safety of someone connected to you is a problem, I am obligated by law to report it (e.g. abuse). If I am worried about something like this, I will let you know and we will find a way to help.

During the study, all notes will be kept as a file in my personal computer that is password protected, and all notes and computer memory sticks will be kept in a locked cabinet at the nursing school. The notes are kept for seven years after the study in a locked cabinet at the nursing school.

Parts of my notes may be used in presentations and articles that arise from this study. In these situations, you will be anonymous; neither your name nor any information about you will be used.

**For further information regarding the study or your participation in it, please contact:**
Myself: Amy Bender: 647-401-7574, amy.bender@utoronto.ca
My supervisor, Dr. Elizabeth Peter: 416-946-3437
Associate Dean of Research, Dr. Diane Doran: 416-978-2866
Ethics Review Office, Health Sciences, Jill Parsons: 416-978-5806

**By signing here, you are indicating that you have understood everything explained in this form about your voluntary participation and agree to be observed during visits with the nurse:**

Participant: Date:

Researcher/Witness: Date:
Appendix P: Client Consent Form for Interview
(on Faculty of Nursing Letterhead)

Study Title: Relational Work in Public Health Nursing: The People, Situations, and Places of TB as Example. An Interpretive Phenomenological Study
Researcher: Amy Bender RN MN, PhD (candidate)
Doctoral Supervisor: Elizabeth Peter RN, PhD

This consent form should give you a basic idea of the research study, and the expectations of you as a participant. If you would like more details about something you read here, feel free to ask either the researcher or her doctoral supervisor. Please take time to read this carefully and to understand what is involved.

The Study:
I want to understand relationships between nurses and clients in the Tuberculosis (TB) Program better because other research says these relationships are important in taking care of people with TB. I am inviting you to participate in this study because you are a client of this program.

Your Participation:
These are the important things you need to know about being in the study:

- I will be joining your nurse for up to 5 days as she/he visits clients.
- If you agree, I will be part of your visits with the nurse. The nurse will get your permission for me to ask you to be part of my study before I come. I will only be watching what happens in the visit and will not interrupt you and your nurse as you are talking.
- You will participate in a private interview with me, without the nurse present. We will arrange a time for this meeting, separate from the visit with the nurse.
- This meeting, between only the two of us, will probably be at least 20 minutes, but you can end it at any time. In this meeting, I will ask you to share your thoughts, feelings, and experiences of your relationship with your TB nurse.
- What you choose to tell me about your relationship with your nurse will not be shared with her/him.
- As part of the study I will keep written notes of what I see and hear, and with your permission, I will tape record the interview meeting.
- Your participation is completely voluntary. It is up to you to decide if you want to be interviewed or not.
- Deciding NOT to be interviewed will not affect your TB treatment or the nursing services you receive from public health.
- Even after you agree to be involved, you may change your mind and choose not to be in the study. You can leave the study at any time. Also, please ask any questions you have at any time.

Risks & Benefits:
I do not think there are any risks to you by participating in this study. However, we may talk about things that you have not thought about before and this might upset you. Please let me know if this happens. If anything we talk about is upsetting, I will help you find someone to talk to.
The benefits of participating may not directly affect you personally, but what you tell me will help in making suggestions for improving the TB program.

**Compensation:**
For the separate interview without the nurse, you will be given 20 dollars for your time and effort. I will also provide TTC tokens if needed for this meeting.

**Privacy & Confidentiality:**
You will not be asked about your TB diagnosis or treatment in the interview. You do not need to talk about anything that makes you feel uncomfortable, and if you do not want me to write or tape-record what you have said, I won’t.

Because I am a student, I will be sharing the information from the tapes and notebooks with the committee that supervises me at the nursing school. I will not share your name with them, and the committee members will keep all information secret. No one else will see this information.

There are some things that cannot be kept secret. If you tell me that you are not following your TB treatment plan, I am obligated to let your nurse know because by law TB is a reportable disease. Also, if your safety or the safety of someone connected to you is a problem, I am obligated by law to report it (e.g. abuse). If I am worried about something like this, I will let you know and we will find a way to help.

All tape recordings will be transferred into written notes, and all notes will be kept as a file in my personal computer that is password protected. All my notes, tapes, and computer memory sticks will be kept in a locked cabinet, and the tapes will be erased at the end of the study. All written notes are kept for seven years in a locked cabinet at the nursing school.

Parts of my notes may be used in presentations and articles that arise from this study. In these situations, you will be anonymous; neither your name nor any information about you will be used.

**For further information regarding the study or your participation in it, please contact:**
Myself: Amy Bender: 647-401-7574, amy.bender@utoronto.ca
My supervisor, Dr. Elizabeth Peter: 416-946-3437
Associate Dean of Research, Dr. Diane Doran: 416-978-2866
Ethics Review Office, Health Sciences, Jill Parsons: 416-978-5806

**By signing here, you are indicating that you have understood everything explained in this form about your voluntary participation and agree to be interviewed by me, the researcher:**

Participant: Date:

Researcher/Witness: Date: