Journal of Applied Hermeneutics
ISSN: 1927-4416
July 31, 2026

DOI: 10.55016/rnhkng05

To Touch With Care

Carina Zhu

Abstract

In this paper, I present some findings from my doctoral research study on understanding women's experiences of infertility. Methodologically informed by Gadamer's philosophical hermeneutics, I interviewed ten women and invited them to bring an image of meaning to their interviews. In part one, I begin with study participants' experiences with health care providers (HCPs) that were, in sum, "*a mixed bag.*" In part two, I interpret what remains of participants' experiences with infertility as traces of family that is still unfolding. Infertility was inviting of grief and confusion, and the family continued to grow. I end with the suggestion that these findings signal a return to the I-Thou relationship at the heart of caring for others. When HCPs take up what the (clinical) world presents to them, there is something in there for them too.

Keywords

Infertility, health care experiences, women's health, hermeneutics

Corresponding Author:
Carina Zhu, RN, MPH, PhD candidate
Faculty of Nursing, University of Calgary
Email: cjyzhu@ucalgary.ca

In this paper, I share some of the findings from my doctoral research study on the topic of infertility. Guided by Gadamer's philosophical hermeneutics, I interviewed 10 women, most of them residing in Alberta, Canada, about their experiences of infertility. Infertility is defined as the inability to achieve a pregnancy or carry a pregnancy to term after 12 months of regular unprotected sex (World Health Organization, 2025). Historically and within the research literature, infertility has been understood through a narrative of deficits, pathology, absence, and finality. My research revealed that infertility was a generative experience – it was inviting of grief and confusion, it produced multiple forms of labor for participants, and the family continued to grow – in the strengthening of the dyadic relationship, in nourishing the bonds with children no longer alive, in the trying for a child which took up its own space, and in the inclusion of work colleagues and other children for whom they cared. Some of the losses participants suffered were recognizable but unthinkable, as in the birth of a stillborn child; some losses were shrouded in darkness, obscured as they were by the brightness of hope that came with the engagement with medical technology.

In part one of this paper, I focus on participants' experiences with health care providers. Women's experiences of infertility were not confined to fertility clinics, but showed up in primary care, public health, and emergency departments. Participants' encounters with health care providers (HCPs) were, to use one participant's description, *"a mixed bag."* Sometimes, HCPs approached participants with understanding and other times, with indifference. I suggest this indifference was a callused touch. Drawing from Risser's (2025) conceptualization of a sensible humanism rooted in understanding and in friendship, I suggest it is in the *striving* for understanding that HCPs might remain in touch with and be touched by the patients we encounter. I suggest it is a matter of friendship, as in engagement and participation with the other in shared life (Risser, 2025), that underpins this touch of understanding.

In part two, I turn the focus to the concept of family. I consider what appears when we read the remainders of participants' experiences with infertility not as debris, but as traces of family to come. I suggest that family is not a fixed destination nor a foundation upon which to build, but a dynamic source of commitment, bond, and belonging that is continually negotiated and revised. As family related to the experience of infertility, it was through interpreting the remainders of participants' experiences that I could see their significance – they were not badges of honor, or baggage that participants continued to carry, but evidence of family that is still unfolding.

In the final part, I conclude with the suggestion that when nurses take up what the clinical world has to offer, when we strive to understand our patients and clients knowing that sometimes (often) we might fail, there is something in there for us too.

Part I - Experiences with HCPs

> *I had to go to the hospital because I was bleeding, and I remember I was just devastated. I went to the intake desk, the nurse doing my intake kind of like rolled her eyes, "well, did you self-diagnose the miscarriage?" And I was like, "Oh no, I'm having one, a doctor told me, I just need some support." The nurse who helped me in the room, she came in, held my hand, and she shared with me that she had been through infertility as well. She said, "I promise you, we're going to do what we can to help you." It was night and day,*

> *between people who might be less empathetic to the situation and someone who recognized that was the worst day of my life. It'll stick with me for the rest of my life, the way she treated me. Both of those interactions will stick with me for two very different ways. That nurse turned my day around. She made me feel safe, heard, and cared about.*

In the 20 years that I have been a nurse; I have never worked in the emergency department. Deep down, I know it is because I would not be able to handle the demands of the practice setting. Emergency departments receive all people, all illnesses and diseases, and at varying levels of acuity. There is no telling what may come through the doors. They are the confluences where chaos meets technology, urgency meets waiting, and suffering might meet nonchalance. For this participant, in the confluence of chaos and complexity, her moment of crisis returned a look of dismissal by the triage nurse that touched her deeply. Part of it might have to do with how, for HCPs who have not had personal experiences of pregnancy loss, it is understood as a medical diagnosis and not death (Punches et al., 2019). Chronic and repeated exposures to difficult situations can leave one hardened, much like skin exposed to friction or pressure turns into a callus to protect the body from further injury. To put it another way, one hardens to difficult situations in order to continue. Perhaps in a practice environment where something worse is always around the corner, the triage nurse's eye roll and callous comment about the miscarriage was a callused response, borne out of a need to protect what may be a diminished capacity for understanding. I suggest this diminished capacity for understanding is a turning away from a sensible humanism (Risser, 2025) and from friendship.

On friendship, Aristotle (ca. 350 B.C.E./2002) wrote "when people are friends there is no need of justice, but when they are just there is still need of friendship, and among things that are just, what inclines toward friendship seems to be most just of all" (*Nicomachean Ethics,* Book VIII, Chapter 1). By this, he meant that friendship is about living well with others, in a polity, and flourishing (*eudaimonia*) as a whole. This idea of friendship is distinctively different from the contemporary understanding of friendship as a personal relationship of likeness. Following the Aristotelian concept of friendship as the basis for social life, Risser (2025) located hermeneutical understanding, in its experience of the other, in friendship. On the experience of the other in understanding, Gadamer (1960/2013) wrote

> Belonging together always also means being able to listen to one another. When two people understand each other, this does not mean that one person "understands" the other…Openness to the other, then involves recognizing that I myself must accept some things that are against me, even though no one else forces me to do so. (p. 369)

Thus conceptualized, understanding is linked to friendship because of an engagement and participation with the other in shared life. Risser (2025) proposed that this link between understanding and friendship delivers a sensible humanism that involves sense, as meaning, and sensibility, an affective component of caring and concern for the other. At the level of seeing, hearing, and touching, a sensible humanism is inseparable from touching life and being in touch with life. This sensibility is not a matter of technique or expertise (*techne)* but guided by *phronesis,* a kind of thoughtfulness in deciding how to act in a specific situation (Risser, 2025). If a sensible humanism is being in touch with life, then the triage nurse's response might be understood as a callused touch, an inability to touch and be touched by life. Callused skin is not

sensitive to what it touches – it feels rough and scratchy – and a callus cannot sense. The sensation that touch provides is mediated by a thick layer of skin meant to protect from further injury. In this way, the participant felt unseen and unheard because a callused touch has a reduced capacity to discern difference, it is perhaps even indifferent. Without the capacity to sense, to see what something means, the triage nurse no longer differentiated between people but saw cases to be triaged and treated. In saying this, I recognize that triage nurses are in the precarious and unenviable position of translating whatever presents to the emergency department into the language of clinical diagnoses, and they do this under the immense pressures of limited time and space. In mastering a string instrument, such as a guitar, one must practice. A callus is necessary in playing it well. Perhaps the callused touch of triage is a sign of proficiency in the difficult position of deciding who waits to be treated when everyone feels they cannot wait. From the experience of participants, however, this touch resembled indifference.

I suggest that it is a matter of friendship between nurse and patient that determines whether they touch with indifference or understanding. By friendship, I mean engagement and participation with the other in shared life, in living well with-one-another (Risser, 2025). I am careful in associating the nurse-patient relationship with the idea of friendship, given the professional and regulatory standards of practice that caution against over-involvement, including boundary crossing (see for e.g., College of Registered Nurses of Alberta [CRNA], 2023). Whereas boundary violations are distinctively defined as involving acts of abuse in the nurse-patient relationship, the concern with boundary crossings is that they may lend themselves to becoming boundary violations (CRNA, 2023). Nursing scholars elsewhere have pointed to the relational complexity of the nurse-patient relationship beyond the mere differentiation between power and vulnerability, public and private, and professional and personal (see for e.g., Webber, 2024). The participant's encounter with the nurse who disclosed her own challenges with infertility eased her pain. It was not the promise of a cure (if there was one) that was healing, but that of recognition and understanding. Webber (2024) considered self-disclosure as "tangible acts of blurring the lines between one's professional and personal life" (pp. 106-107). The participant felt *"seen, heard, and cared about"* because she was touched by the nurse's sense, her seeing what something meant. In *Touched by Touching*, Wood (2015) wrote:

> Here is perhaps one of the richest sites of a carnal hermeneutics – experiences of joyful explosion of boundaries, and of the anxious defense of such boundaries. Some of these boundaries are, as we say, real, and others merely constructed, perhaps manufactured, the better to manipulate us. Touchings of all sorts do not merely disclose such boundaries, they open them to scrutiny, transformation, and renegotiation. (p. 181)

Following Wood (2015), the charge of over-involvement dissolves as the nurse's understanding touch, in her disclosure and physical contact with the participant, was that of sense, of an uncallused touch that could sense. Perhaps the boundary of provider-patient needed to be blurred and then renegotiated in the moment of recognition between one person and another, both of whom have lived through the challenges of infertility.

As the participant noted, *"both of those interactions will stick with me for two very different ways."* She was touched, by indifference and by understanding. I suggest that the dismissive response was neither intentional nor accidental, but the consequence of a kind of nursing work

that leads to refrain from being fully in touch with life. Although the practice environment of the emergency department might predispose a turning away from a sensible humanism, it is not entirely deterministic. Equally possible is the turning towards friendship, in the way participants experienced care from other HCPs. One participant spoke of her aftercare by the attending physician from the emergency department that attests to this possibility.

> *They did a bedside ultrasound and they still saw the sack there, but they couldn't find the heartbeat. So they sent me, the following day, to get an ultrasound. Actually, the emerge[ncy] doc[tor] called me the next day to be like, "We looked, your hCG had been decreasing steadily between when you got to emerg and when you left", and she's like, "I am so sorry, where are you right now?" I told her I was in the ultrasound office waiting for my name to be called. She's like, "I'm so sorry…" For her to take time out of her busy day, being in an emerg doc to call me, I was just blown away.*

Part II - Traces of Family

We could not talk about infertility without also talking about family. What, exactly, counted as family? Family could be those to whom we are bonded via biological connection, genetic origin, or legal contract (i.e., marriage or adoption; Rose & Hebblethwaite, 2020). It might also refer to a group of people bound together with "strong emotional ties, a sense of belonging, and a passion for being involved in one another's lives" (Wright & Bell, 2009, p. 46). Involvement in one another's lives might include functional responsibilities, such as socialization of children and emotional nurturance (Vanier Institute, n.d.). More broadly, "family is who they say they are" (Wright & Leahey, 2013, p. 50) and "those who give a damn about you" (Wright & Bell, 2009, p. 47). Family was, then, made of bonds that we inherit and bonds that we forge. In this sense, family could not be confined to a fixed entity, nor a foundation on which to build, nor a goal one aimed to reach, but something that was continually negotiated and revised. Family was the dyad that seeded the desire to expand, and, for at least one participant, the reason for stopping treatment in order to protect what family they already had – the two of them. The family was also expanding to make space for the presence infertility was beginning to occupy. Infertility became a topic of conversation (and sometimes avoidance) and a major focus of their lives; some participants talked about being consumed by it. "It" encapsulated many things – getting a positive pregnancy result, monitoring their monthly cycle, managing the medications and tests, what activities/foods to do and what to avoid, what to say to friends and family, and the cycles of hope and disappointment. Through the foreign and sometimes hostile terrain that was infertility, participants were faced with practical, emotional, and relational challenges resembling that of raising a young child. There were the logistical demands in coordinating medical appointments and diagnostic tests; the undercurrents of anxiety and worry about the future (i.e., I can lose this pregnancy even if I conceive); and the conversations about how to cope with infertility and its impact on their relationship. Drawing from my experience as a spouse and as a mother to two young children, these are not unlike the demands placed on new parents. Our kids took up space - in the house, in our daily routines, in conversations, in our individual aspirations, and our collective vision for the future. For me, being a parent was partly about adapting to the space our children were taking up. What I heard in the interviews was that same space was *already* being occupied by a child-to-be, a child hoped-for and tried-for. In a way, the experience of infertility thrusted participants into the practical, relational, and emotional work of parenting before they

became parents. The labor of navigating infertility resembled the work of early parenthood. In making that comparison, I am not claiming infertility is like parenting. I recognize the crucial difference is that, along with the worry, exhaustion, and doubt, parenthood meant having live children, whose wonder at the world brightens the world. Instead, I am pointing out the similarities between parenting and infertility, in terms of its impact on the family. In both cases, the dyad relationship had to accommodate a growing presence of children – living children, children yet to be, and children who remain only in memory. Family expanded and contracted, as study participants welcomed new additions, grieved the absence of others, and cared for other children as their own. Family was, at times, a deliberate choosing in the inclusion of close work colleagues and pets. At other times, family happened, as some participants joined the community of loss parents who also lost a child in stillbirth. Family was also the source of unsolicited, insensitive, and sometime malicious comments, such as when a participant was told by her aunt that being in a same-sex marriage was *"a reason why your baby was taken from you."*

Figure 1: Carry-on Luggage

Figure 2: Needles and Vials

One participant, who was receiving fertility treatments from a clinic away from her home community, brought two images to the interview. One was a picture of her carry-on suitcase for

the flight, filled with medications and supplements in preparation for her IVF transfer (Figure 1). The other was a picture of used syringes and empty vials (Figure 2). She kept every syringe and vial from the past eight years of fertility treatments. This was her medical records in pictorial form. She did not know why she kept them, only that she could not throw them away. I was struck by this, and by the significance of what was, to my medical gaze, debris. Perhaps it was in this world of needles and vials, in the phenomenological sense of a meaningful horizon, that she could chronicle an experience that was difficult to explain. Perhaps it was also in this world of needles and vials that she could continue to carry, if only in memory, the two miscarriages she had. When a loved one dies, they might leave a collection of documents and artefacts that comprise an archive of a life lived (Moules, 2017). This participant's collection of syringes and vials, of the means to a pregnant end, was both an archive of two (short) lives lived and the early artefacts of a life that is hopefully to come. It was through reading what remained of the experiences of infertility – the needles and medication vials, the surplus embryos, the pregnancy tests, the particulars that could not be thrown away – that I could understand this unfolding of family. Trying for a child took up its own space within the dyadic relationship, and not having a child was its own event (Kitamura, 2025). Perhaps hanging onto these remainders was one way to prevent that erasure, one way that others might know not of the absence of child but the very presence of its trying. The remainders, in their occupation of physical space, rendered this unfolding of family – as a dynamic source of belonging, commitment, and bond – recognizable.

Part III - Implications for Nursing Practice

These research findings point to a kind of sensitivity that nursing work asks of us, wherever we might practice. Sensitivity means that we respond with an awareness that what we can see – their experiences of pain, loss, and uncertainty – is never all we need to know (Thorne, 2013). These expressions of suffering are invitations to step into understanding something more that is unfolding in the background. In primary care where investigative workups often initiate, sensitivity might mean being careful with our words in the discussion of risk factors for infertility – obesity, use of alcohol or drugs, older age – that comes with an element of blame, intentional or otherwise. In emergency departments where experiences of pregnancy loss show up, sensitivity might mean following the patient's lead in exploring how they language around their pregnancy loss that is healing for them. Sensitivity might also mean that we pause between gravida and parity in the taking of a personal health history to open up the possibility of re-enfranchising grief experiences of their reproductive past. One might sum this up by saying sensitivity is knowing the illness narrative matters as much as the disease narrative (Kleinman, 1988) in determining treatment, and the amassment of patient information in the medical record is not a replacement for but the beginning of understanding.

This sensitivity, I suggest, is no different from a touch that can sense, in a clinician who touches and is touched by the patients they encounter. In the case of infertility, it is the cultivation and maintenance of a sensitive touch that allows nurses to care for women with infertility differently. Thus, and contrary to the common recommendation of more education on the topic of concern, I suggest it might be a return to the I-Thou encounter that can help to recover a nurse/patient relationship rooted in understanding. On the experience of another person in the event of understanding, Gadamer (1960/2013) wrote that we encounter the other in one of three ways. In the lowest moral order, we do not see the other person as having their own voice, but as being

predictable of a typical event or behavior in confirming what we may already know. In the second order, we might acknowledge the other as a person, but there remains a self-related way through which we "out do the other…to claim to know the other's claim from his point of view and even to understand the other better than the other understands himself" (p. 367). In the highest order, we "experience the Thou truly as a Thou – i.e., not to overlook his claim but to let him really say something to us" (p. 369). George (2022) summarized these three levels of the I-Thou encounter as acts of instrumentalization (lowest order), subjugation (second order), and "letting others come freely into their own" (highest moral order; p. 110). I suggest it is the I-Thou encounter of the highest moral order that delivers on a touch that can sense.

From a nursing perspective, nursing theorist Barbara Carper (1978) wrote about the I-Thou encounter as part of the personal way of knowing in her conceptualization of nursing knowledge. In the I-Thou encounter, we leave behind categories and classifications to see a patient as a "unique particular and not an exemplary class" (Carper, 1978, p. 18). Carper's framework has been critiqued, revised, and expanded since its inception (see for example, Chinn & Kramer, 2018; Thorne, 2020). I do not intend to revive the fundamental ways of knowing but point to the significant and central position of the I-Thou relationship in nursing practice. The I-Thou encounter is what delivers on the ability to understand each patient as an individual and a particular, as opposed to being representative of the pre-interpreted categories – women who complain about pain, women who are desperate to get pregnant, women who self-diagnose their miscarriage – we might have already slotted them into. In his foreword to Moules et al. (2015), Caputo (2015) offered his insight about how understanding is the discernment between singularities and universals, "only individuals exist, while universals are abstractions…For the individual is what is real. The individual is the first truth, the true being…We have everything we can do to rise to the occasion of the individual, to ascend to the thick, dense, rich, complexity of the individual situation, instead of lolling lazily amidst the thin transparencies of universals" (p. x).

So far, I have positioned the I-Thou encounter as benefiting patient care. I end with the suggestion that when nurses engage with an orientation that strives to understand our patients, in an I-Thou encounter of the highest order, there is something for us too. "Being that can be understood is language" (Gadamer, 1960/2013, p. 490) and language is not limited to the linguistic. It is through practice that the biases and assumptions that have perfused my nursing work might be revealed to me. The ontological power of hermeneutical understanding discloses who we are in the world (Palmer, 1969), it allows how we interpret the world to be read back to us. In my encounter of a patient, I encounter myself, too, in understanding my nursing practice differently.

In Closing

Infertility was an experience of determination and acquiescence, deep sorrow and gratitude, filled to the brim with moments of levity and grave loss. Above all, the experience of infertility revealed that, sometimes, family is a path of our choosing, and other times, we are swept up and carried along by its unfolding[1]. When nurses take up what the clinical world offers to us, when we respond with a striving to understand our patients and clients in the I-Thou encounter of the highest moral order, there is something for us too.

Acknowledgements

My grateful thanks to my supervisor, Dr. Nancy J. Moules, who has been a key part of this research study since its inception. Her support – in dialogue, in application of the philosophy, and in practical guidance – has been indispensable. I also thank the study participants who entrusted me to share and interpret their stories.

References

Aristotle. (2002). *Nicomachean ethics* (J. Sachs, Trans.). Focus Pub./R. Pullins Company. (Original work published ca. 350 B.C.E.).

Caputo, J.D. (2015). Foreword: The wisdom of hermeneutics. In N.J. Moules, G. McCaffrey, J.C. Field, & C.M. Laing, *Conducting hermeneutic research: From philosophy to practice* (pp. ix-xiii). Peter Lang.

Carper, B.A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23. https://doi.org/10.1097/00012272-197810000-00004.

Chinn, P. L., & Kramer, M. (2018). *Knowledge development in nursing: Theory and process* (10th ed.). Elsevier.

College of Registered Nurses of Alberta. (2023). *Professional boundaries: Guidelines for the nurse-client relationship.* Retrieved from: https://www.nurses.ab.ca/protect-thepublic/standards-for-rns-and-nps/guidelines/.

Gadamer, H.-G. (2013). *Truth and method* (J. Weinsheimer & D.G. Marshall, Trans.: rev. 2nd ed.). Bloomsbury Academic. (Original work published in 1960)

George, T. (2022). *The responsibility to understand – Hermeneutical contours of ethical life*. Edinburgh University Press.

Kitamura, K. (2025). *Audition.* Penguin Random House.

Kleinman, A. (1988). *Illness narratives: Suffering, healing, and the human condition*. Basic Books.

Moules, N.J. (2017). Editorial: Grief and hermeneutics: Archives of lives and conflicted character of grief. *Journal of Applied Hermeneutics*, Editorial 1. https://journalhosting.ucalgary.ca/index.php/jah/article/view/53316/pdf.

Punches, B.E., Johnson, K.D., Acquavita, S.P., Felblinger, D.M., & Gillespie, G.L. (2019). Patient perspectives of pregnancy loss in the emergency department. *International Emergency Nursing*, *43*, 61–66. https://doi.org/10.1016/j.ienj.2018.10.002.

Risser, J. (2025). *Understanding as sensible humanism* [Unpublished manuscript and keynote address at the 2025 Canadian Hermeneutic Institute in Calgary, Canada, June 4-6]. Department of Philosophy, Seattle University.

Rose, H., & Hebblethwaite, S. (2020). Expanding the definition of family to reflect our realities. *The Conversation.* Retrieved from: https://theconversation.com/expanding-the-definition-of-family-to-reflect-our-realities-131743.

Thorne S. (2020). Rethinking Carper's personal knowing for 21st century nursing. *Nursing Philosophy*, *21*(4), e12307. https://doi.org/10.1111/nup.12307.

Thorne, S. (2013). Interpretive description. In T. Beck (Ed.), *Routledge international handbook of qualitative nursing research* (pp.295-306). Routledge.

Webber, K.M. (2024). *"Friendship, or whatever it is": Understanding nurse-parent relational complexity in pediatric oncology contexts* [Doctoral dissertation, University of Calgary]. Open Theses and Dissertations. https://doi.org/10.11575/PRISM/43578.

Wood, D. (2015). Touched by touching. In R. Kearney & B. Treanor (Eds.), *Carnal hermeneutics* (pp. 173-181). Fordham University Press.

World Health Organization. (2025). *Infertility – Overview.* https://www.who.int/news-room/fact-sheets/detail/infertility.

Wright, L.M., & Bell, J. (2009). *Beliefs and Illness: A model for healing*. 4th Floor Press.

Wright, L.M., & Leahey, M. (2013). *Nurses and families: A guide to family assessment and intervention* (6th ed.). F. A. Davis.

Notes

[1] I am indebted to Dr. Karen Davis, a facilitator of the Hermeneutic in Practice (HIP) working group, who offered her thoughts on *Sache* that led me to consider what, exactly, was the matter conducting us in the research interviews.