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Abstract

Women's Experiences of Their First Pelvic Exam: An Arts-Informed Narrative Inquiry

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Canadian women usually have their first pelvic exam by the age of twenty-one, and then every three years until older adulthood. Reviewed literature demonstrates that women's first pelvic exam experiences are a turning point in their healthcare trajectory. Yet, no research was found that addresses these experiences as told by women in their own words. Using Arts-Informed Narrative Inquiry, three young women were invited to tell and draw stories of their first pelvic exam experiences. From their accounts, two narrative patterns emerged, trust and voice. These were analyzed using the Narrative Inquiry three-dimensional space of experience theoretical framework, from a Critical Feminist perspective. The analysis reveals that women's first pelvic exam experiences inform their understanding of how healthcare providers, in positions of power, value and respect their personhood and dignity. These experiences go on to inform not only women’s future healthcare interactions, but other social encounters.
Acknowledgements

This thesis would have been impossible without my partner, Fawcett. His unending love and care supported me immeasurably through this journey: celebrating every milestone with me, listening to my process, nourishing me when I didn't know I needed it, and when I did. Love you.

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To my first teacher, my mom. Thank you for your enthusiasm, passion, support, and for showing me what a powerful woman is: one who embraces vulnerability as a strength, and is constantly learning in the face of the unknown. I am also grateful to my stepdad Ed, for his consistent support of my academic work. I deeply appreciate my family and friends for encouraging me, feeding me, checking in on me and reminding me of self care. To my best friend Kristy, thank you for the park chats, which kept me grounded.

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Finally, I am grateful to my three co-participants. Without their courage to speak, this thesis would not exist. It has been my honour to listen, and I will carry your wisdom forever. Thank you.
Dedication

To Andrea, Celeste and Claire,
and to all the young women around the world:

May we listen to your voices,
your experiences, and your wisdoms

May we honour your personhood,
and earn your trust

With gratitude,

Emma
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Preamble

It is my honour and privilege to be in a position to re-present young women's stories of their first pelvic exam experiences. Written in the midst of a global pandemic and overwhelming social and racial tensions, this thesis has provided a refuge from the unknown and the unprecedented, a space for reflection in isolation and a source of motivation during difficulty.

This work has invited me to reflect on my values, beliefs and goals in the pursuit of my own best self. In keeping with Narrative Inquiry (Clandinin & Connelly, 2000), I reflexively engage with stories of experience. In so doing, I co-construct knowledge alongside my co-participants. Dear reader, I invite you to consider these stories, entering your own meaning-making process.

I took up knitting during my graduate education, and I use the metaphor of knitting to understand my thesis journey. Please join me as I pull apart, disentangle, examine, investigate and, eventually re-assemble women's first pelvic exam experiences into a colourful tapestry, with new knowledge woven in.

I start with my own experience, a knitted square of yarn. Its stitches are thick, dense and pliable. To describe this knitted piece, I tell my story, share a metaphor of my experience, and reflect on its meaning (Schwind et al., 2012). I dig my fingers into the soft crevices, and together we begin the inquiry.
An Invitation for Self Care

This inquiry necessarily explores difficult truths and realities about women's experiences with pelvic exams, and healthcare in general. The details of such experiences may cause difficult emotions to arise.

As I experience this inquiry, I set an intention to be gentle with myself. In a similar spirit, dear reader, I invite you to do the same for yourself. To help you along the way, I include the image of a ball of yarn throughout this thesis. At these points, as well as at any other, I welcome you to take a breath with me, check in with your body, and be gentle with yourself.

Figure One

*Take a Breath, 2020.*

*Note: by Emma MacGregor, 2020.*
As a young girl in a strict religious home, I am taught my body is a pearl, to guard until marriage to a man of faith. Despite de-conversion in my teens, I remain private about my body and sexuality. I am nineteen, and I am avoiding my first pelvic exam, fearing embarrassment, judgement and a lack of confidentiality. I do not have any symptoms but feel compelled to have a pap test. I see the pink Toronto Public Health advertisements on the subway, reminding me of my perceived truancy. I feel guilty I haven't already done it.

“It’s fine, just go”, my sister reassures me, and tells me about the public sexual health clinic nearby. I decide it would be best to stop procrastinating and just get it over with. I enter the large, cold concrete waiting room without an appointment. At reception, I check in through a microphone and glass window. Through a slot, I am given a clipboard with a pen and questionnaire. I sit down and answer honestly, believing the inclusive and thorough questions indicate a non-judgemental environment.

A member of the staff leads me to a small exam room, where I sit and wait, noticing cotton balls neatly in their jar. A woman enters and introduces herself as a doctor. Right away, she reviews my questionnaire. Her tone admonishes me as she reads aloud my responses, shaking her head pitifully as I nod my confirmation. Next time I’ll just lie, I think, consoling the heat of shame in my gut.

The doctor leaves the room and I change into a crunchy paper gown, sitting awkwardly at the edge of the exam table. When the same doctor re-enters, she immediately describes the
position I am to assume for the procedure she will perform. I ask no questions. In an effort to
gain her approval, I obediently shuffle down the table to her satisfaction. Uncomfortably
exposed, I wonder, *Should I have shaved my legs?*

Without much introduction, she inserts the speculum. I breathe deeply and am glad to feel
only a twinge of discomfort as she swabs my cervix. When she removes the speculum, I exhale a
sigh of relief. “OK, now for the bimanual”, she says. I am surprised. *Is this part of the routine?*
“It’s for ovarian cancer screening”, the doctor volunteers, reading the confusion on my face. She
lubricates her gloved fingers and lets me know she is going to begin. I hesitantly comply. I have
no family history of ovarian cancer, symptoms or concerns, but *better safe than sorry*, I think. *I
have already come this far.*

With one hand pressing my now-sensitive cervix, her other hand is firmly pressing into
my abdomen. The strength of her pressure is alarming. Now, with her hand still inside me, she
begins to ask about birth control. I tell her I use condoms and am not interested in hormonal
contraceptive. She scoffs and tells me, “Condoms don’t work.” She presses on, harder into my
abdomen, demanding, “What would you do if you got pregnant? Would you have an abortion or
keep the baby?” Overwhelmed by her questions and forceful hands, I mutter about emergency
contraception and fall silent until she finishes the exam and leaves the room.

Dressed again in my street clothes, a nurse knocks and enters the room. She introduces
herself, sits with me and helpfully answers my questions. To my relief, she doesn't press about
birth control. I feel her gaze and wonder if her kindness is an apology for her colleague.

In the parking lot, I feel hollow. My *pearl* is trampled. I drive home and struggle to enjoy
the satisfaction of completing a much-avoided task. I promise myself not to let that happen
again.
Engaging in Metaphor Reflection

Over the years, I have processed the anger I carried from this experience. As I think of my story, I consider the beliefs that this experience reinforced: *Cast not your pearls before swine.*

With paint and a canvas, I portray a scene, which centres me, the oyster, at the bottom of an underwater crevice, looking up at a glowing ship at the water's surface.

**The Time has Come**

**Figure Two**

_The Time has Come, 2019._

*Note:* by Emma MacGregor, 2019.
My Interpretation of My Metaphor

As an oyster safe at the bottom of the sea, I am becoming aware of the world around me. I am in nursing school, creating a pearl of hope for a bright future in a trusted field, healthcare. I crave the light of education to bring me independence and stability. While I trust the healthcare community, I also sense a foreboding shadow at the water's surface. I know the same community I seek to belong to still requires certain things from me. Regardless of my profession, I am a person. This means I am required to behave like a patient from time to time.

An anchor from this shadow rests on the stone nearby, taunting me. I feel a professional obligation to be a good patient and co-operate with the divers on the ship. Besides, it seems like all the other oysters have already gone up. And they seemed all right.

After my first pelvic exam, I was cautious to disclose personal information to my healthcare providers. I learned to anticipate objectification and coercion in relation to my reproductive and sexual health. Following my first pelvic exam, it would be another three years until I have another pelvic exam, and six years until I decided to start hormonal contraceptive. By not trusting healthcare providers’ inquiries, it took eight years for me to understand I was in an abusive relationship.

Reflecting on My Story

I note the contrast between the hope I express and the sense of foreboding obligation I feel as I offer my body to the gaze of healthcare professionals. My social conditioning towards obedience and being perceived as nice cause me to be silent in the face of objectification. As I consider my metaphor painting, I remember the heartbreak I felt as a child seeing baby oysters being sung to their death in Alice in Wonderland (Walt Disney Productions, Armstrong & Carroll, 1951). As the poem goes:
The Walrus and the Carpenter
Walked on a mile or so,
And then they rested on a rock
Conveniently low:
And all the little Oysters stood
And waited in a row

The time has come', the Walrus said
'To talk of many things:
Of shoes – and ships – and sealing wax
Of cabbages – and kings –
And why the sea is boiling hot –
And whether pigs have wings.'
(Carroll, 1871, p.75-76)

Looking Back, Looking Forward

I now see how my first pelvic exam experience inspired my early reflections on the kind of healthcare provider I wanted to be, and perhaps more importantly, the kind of healthcare provider I did not want to be. Years later, as a primary care nurse chaperoning and sometimes providing pelvic exams myself, I reflected again on this experience. I began to wonder how other women experienced their first pelvic exams, and the impact of this experience on their subsequent engagement with healthcare providers. How could I more intentionally and supportively engage with women in my care?

I know there is much to learn from my experience alone. However, in order to better understand my own and that of others, I need to learn more. The next chapter of this inquiry, the Introduction, contextualizes pelvic exam experience, exploring the historical, social and spatial context of women's first pelvic exams in North America.
Chapter One: Introduction

In order to more deeply understand women's first pelvic exam experiences, I must first orient myself to the pelvic exam experience more broadly. In structuring this exploration, I follow the lead of the creators of Narrative Inquiry (Connelly & Clandinin, 1990, 2006), who posit that an experience exists in three dimensions (or commonplaces): temporality, sociality and place. As such, I examine pelvic exams more broadly through the lens of time, relationships and place.

In so doing, this chapter provides a brief journey through the history, policy, procedure, setting and location of pelvic exams. In keeping with the nature of Narrative Inquiry, inquirer as co-participant, this exploration is augmented with my own reflections in italicized Times New Roman font. With this introduction, I invite you to move into narrative proximity with the pelvic exam experience.

Before I begin, a brief note on language. In this inquiry, I focus on cis-gendered women's experiences of pelvic exams. It is worth noting that gender diverse and non-conforming persons also experience pelvic exams. However, for the purposes of this inquiry, I use the term 'women' to denote cis-gendered female women, whose gender identity is harmonious with the sex they were assigned at birth. I also use the term 'healthcare provider' as an umbrella term to denote a regulated healthcare professional such as a nurse, physician, or nurse practitioner.

Temporality: The Historical Context of Pelvic Exams

Pelvic exams have evolved over time into the procedure that women experience today. An entire thesis could be written on the history of pelvic exams alone. However, for the purposes of this thesis, a brief historical review provides critical context to this unique experience.
Before the invention of the speculum, healthcare providers avoided giving women pelvic exams. Diagnoses were made based on symptoms or externally palpating abdomens (Sandelowski, 2000). When required, pelvic exams were done by hand, without visualizing the woman's genitals in an effort to preserve modesty and morality (Sandelowski, 2000).

The invention of the speculum changed the feasibility of pelvic exams. The story of its invention begins in the eighteen-forties with Anarcha Wescott, a seventeen-year old Black enslaved woman living in Montgomery, Alabama (Gamble, 2017). Anarcha Wescott developed a severe vesicovaginal fistula as a result of a traumatic birthing process. Through an arrangement between her owner and a local doctor, J. Marion Sims, Anarcha Wescott was subjected to nearly thirty experimental surgical treatments without anaesthesia, often in the presence of Sims' peers (Gamble, 2017; Sims, 1884; Wailoo, 2018).

Anarcha Wescott was not alone. Sims expanded his research over four years, conducting experimental surgeries on ten Black enslaved women. However, he only recorded the names of Anarcha Wescott, Betsey Harris, and Lucy Zimmerman. (Gamble, 2017; Judd, 2013; Sims, 1884; Wailoo, 2018; Wall, 2007). Sims tested the first speculum prototype on the body of Betsey Harris and went on to develop the speculum as we know it today (Sandelowski, 2000; Sims, 1884).

For his work, Sims is considered the "father of modern gynecology" (Wailoo, 2018, p.1529). In the image below, Anarcha Wescott and Sims are portrayed by artist Robert Thom, who was commissioned in the nineteen-sixties to paint a series of illustrations to depict the achievements of medicine.
After these experiments, Sims went on to New York City, to introduce his speculum and techniques among wealthy, white women (Gamble, 2017; Sandelowski, 2000). The speculum drew mixed reviews. Although physicians acknowledged the need to visualize women's genitals and internal structures for better assessment, the speculum was seen as an infection risk and "an instrument of female and even physician corruption" (Sandelowski, 2000, p. 76).

By the nineteen-seventies, the speculum is seen as an artefact of torture and gynocide (Daly, 1978). Early feminists, largely white middle-class women, reclaim the speculum for their own empowerment. They acquire their specula, use mirrors to see their own cervixes, and in some cases, self-diagnose and treat themselves (Sandelowski, 2000). This draws critique from the medical community, and women eventually win a court decision defending their right to inspect their own bodies with specula (Dreifus, 1977).
Today, women use the speculum and their bodies as teaching tools for healthcare providers, training on technique and approach to pelvic examination (Sandelowski, 2000). The speculum has not changed much from Sims’ original design, and it continues to be a powerful symbol, often featured in art on women's health (Chenoweth, 2019; Jordá, 2018).

Pelvic exams in general seem to be avoided by both healthcare providers and women throughout history, and the first pelvic exam experience is not clearly presented or discussed. What is further clear to me is that the history of pelvic exams belies a violent power struggle over the bodies of women.

When I review this research, I am furious. Anarcha Wescott, Betsey Harris, Lucy Zimmerman and the other Black enslaved women endured horrifying pain and indignity in pursuit of a cure for their health concerns. I am disgusted with the use of white supremacy, misogyny, violence and the glorification of Black women's pain to justify the pursuit of scientific knowledge and the development of medical instruments. Yet, I know that as a woman and a healthcare provider today, I benefit from the use of the speculum. I struggle to resolve how to express my gratitude to these women, while wishing this had never happened.

Although these violent events occurred generations ago, I know some women still, in the twenty-first century endure indignity while seeking healthcare. As an inquirer, I turn to the women of today: How far have we really come? How much is this history still alive with us today?
Sociality: Women's Relationship with Pelvic Exams

Today, women have pelvic exams for a myriad of reasons. Broadly speaking, the purpose of a pelvic exam is to conduct an internal assessment of a woman's vaginal canal, cervix and ovaries. Pelvic exams are clinically indicated to investigate symptomology, test for certain infections, and for insertion of medical devices such as intrauterine devices (IUDs).

Advancements in urine diagnostics have reduced the need for pelvic exams, and in 2016, the Canadian Task Force on Preventative Health Care adopted the recommendation not to perform pelvic exams, including bimanual exams, for non-cervical cancer screening and other gynecological conditions (Tonelli et al., 2016). Healthcare providers are recommended not to perform a pelvic exam unless a person is symptomatic (Bloomfield et al., 2013). However, some women still receive pelvic exams in routine wellness checks.

The most common reason for a routine pelvic exam is the Papanicolaou ('pap') test. In Ontario, women aged twenty-one to seventy are recommended to have a pap test at a minimum of every three years (Cancer Care Ontario, n.d.). Pap tests check for cell dysplasia, an early sign of cervical cancer. As such, pap tests are a mainstay of cervical cancer prevention, and for good reason. Cervical cancer poses a serious threat to women's mortality. This is especially true in developing and lower income communities (Small et al., 2017). The Canadian Cancer Statistics Advisory Committee (2019) reports that Canadian women's cervical cancer rates have been declining since 2010, but still represent 1.3% of new cancer cases in women.

Promoting access to cervical cancer screening is rightfully a public health priority. In Ontario, pap tests are fully funded through the provincially managed, publicly funded, Ontario Health Insurance Plan (OHIP). Furthermore, public health units promote cervical cancer
screening by advertising the age recommendations, educating the public about the importance of
pap tests, and offering cervical cancer screening at public health clinics.

A Relationship with Surveillance

Besides promoting testing, public health also administers surveillance programs to
monitor cervical cancer screening rates. The Ontario Ministry of Health and Long-Term Care
uses OHIP billing information to infer who is due for a pap test and sends notices to women
when they are overdue. The Ministry sends this same list to primary care physicians, as a part of
the preventive care bonus program, which monetarily rewards physicians for the percentage of
their eligible patients who receive their recommended pap test (Ontario Ministry of Health and
Long-Term Care, 2020).

Incentive programs for certain health services are not exclusive to Ontario (Campbell et
al., 2009; Constantinou, Sicsic & Franc, 2017; Otávio, 2015), or to cervical cancer. Notably, the
program has been found to have little to modest impact on cervical cancer screening rates in
Ontario (Hutchison & Glazier, 2013; Kiran et al., 2014; Li et al., 2014), suggesting women
require more than a reminder in order to undergo a pap test. Some have raised concerns about the
unintended influence of this program on health counselling (Booy, 2018), as the program also
was not found to improve quality of care in Ontario, as was originally intended (Li et al., 2014).

Another aspect of surveillance can be found during the pelvic exam itself. Some
healthcare providers, particularly male ones, use chaperones. This may be a patient's family
member or friend, a nurse, or a member of the clinic staff. The chaperone observes the pelvic
exam and provides support to the patient, with the intention of reducing the risk of liability for
the healthcare provider (Bates, Carroll & Potter, 2011; Vogel, 2012). There is no evidence that
chaperones are effective at preventing litigation (Bates et al., 2011), but for their part, some
women do find chaperones to be a source of comfort (Bates et al., 2011). Even still, others view chaperones as voyeurs (Potter et al., 2015) or complicit actors in their sense of objectification (Sandelowski, 2000). The use of chaperones adds another layer of observation to the pelvic exam experience. As an inquirer, I ask myself: Who benefits from chaperones: the healthcare provider or the patient?

I come to understand that young women's first pelvic exam experiences are informed by their relationships with their individual healthcare providers and chaperones, as well as the public health programs, which promote, incentivize, document and report their experience. In this way, during the first pelvic exam experience, young women engage, not just with their healthcare provider, but also with the larger healthcare system.

I recall a situation several years ago, when I was working as a primary care nurse. A female doctor gave me a list of names from the preventive care bonus program and told me, "These women are due for their first pap. Can you call and remind them?" Her request made me feel uneasy, as I saw this to be a form of healthcare system surveillance of young women's bodies. I was concerned about the impact this would have on these young women’s sense of safety and trust, and thus consent, especially as it would be their first pelvic exam. I respectfully declined the physician’s request. To help my colleague see her request from my perspective, I asked her: How would I explain this list to the young women? "Well, you don't have to tell them", she replied. This insinuation of deception jarred me anew.
I never did make those phone calls. In my role as an inquirer, I am curious how such systems of surveillance affect young women’s first pelvic exam experience.

Place: Pelvic Exams in Ontario, Canada

Ontario is the most highly populated province in Canada. Despite this, many individuals struggle to access primary care. In 2007-2008, 7.1% of Ontario's adults were without a family doctor (Hay et al., 2010). Most of the population resides in the south part of the province, where resources are pooled. In less densely populated areas, primary care is centralized to community health centres and hospitals. Without a primary healthcare provider, people use walk-in clinics or emergency departments instead (Hay et al., 2010).

Young women in Ontario mostly arrange to have their first pelvic exams in an outpatient primary care clinic. Pelvic exams occur in a clinical exam room.

These rooms are fluorescent lit, with or without windows. The bright painted walls are usually decorated with public health advertisements and program promotions. Inside, there is usually a desk with a computer and printer, beside a chair or two for patients. The healthcare provider sits in a wheeled office chair or stool.

Most exam rooms feature a counter, sink, cupboards and drawers. On top of the counter there may be colourful baskets of condoms, and tall glass jars of cotton balls and tongue depressors. Papers, glass ampoules, and packaged syringes may also be scattered on these counters, perhaps a sign of a busy day. In the best maintained rooms, the sinks are shiny and clean, reflecting the light, imbuing a sense of propriety.

The Exam Table

Exam rooms are fitted with an exam table, which sits about waist-high, with drawers on the side and at the foot of the table. These drawers hold drapes and gowns, and oven mitts to fit over the retractable metal foot stirrups. Some clinics use cloth gowns, while others disposable
ones, made of crepe paper with an inside layer of plastic. Below the stirrups are two drawers for
the healthcare provider's use. Here, one may find various size specula, named after their
designers: Sims, Graves, and Penderson. Some healthcare providers use metal specula, which are
sterilized after each use. Others use disposable plastic specula, which can be lit for better
visualization.

There is usually a step at the side of the table, which allows the woman to comfortably
place her body onto the stripe of white crunchy crepe paper, which covers the table. The less
costly paper will split under the pressure of a person's weight, while the more costly paper will
quietly wrinkle. On the ceiling above the exam table, one may find artwork, intended to offer
distraction during pelvic exams.

For pelvic exams, most often, a woman is asked to undress her bottom half, position
herself on the table, place her feet in the stirrups of the exam table, place the drape over her legs
and lie down to face the ceiling. She may be offered a pillow under her head. This position is
called the lithotomy: the patient lies down on her back, with her hips at forty-five-degree angles,
bending the knees at ninety-degree angles, with feet placed in stirrups (Bates et al., 2011).

Criticism of the lithotomy position is visible in the literature. Women describe the
lithotomy position as "disempowering, abusive and humiliating" (as cited by Bates et al., 2011,
p.652). Sandelowski states, "necessitating the lithotomy position in most cases, the use of the
vaginal speculum had literally and figuratively placed women on their backs and under
male/physician control" (2000, p.78). Some healthcare providers reject the lithotomy position
and allow patients to decide which position best supports them to feel in control (Bates et al.,
2011). However, for optimal inspection and palpation of external genitalia, the lithotomy
position remains somewhat routine (Bates et al., 2011; Carter et al., 2013; Jarvis, 2009).
It is usually in a room like this, in the lithotomy position, that a young woman has her first pelvic exam. I think of the many hours I spent stocking and organizing exam rooms during my work in primary care. I often felt a sense of satisfaction in setting up the rooms for a comfortable encounter. Now as an inquirer, I wonder how the layout and aesthetic of the exam room might influence a young woman's first pelvic exam experience.

**Looking Back, Looking Forward**

In this chapter, I reviewed the context of pelvic exams for young women in Ontario, using the Connelly and Clandinin’s commonplaces of experience. This included a brief history of pelvic exams (temporality), a review of the current relationships that women have with healthcare providers who administer pelvic exams (relationship), and the physical location where women's bodies are given first pelvic exams (place). This is the context that I and my co-participants consider in this Narrative Inquiry.

Before we continue along the thesis journey, I provide a guide for the chapters ahead. This thesis is laid out as follows: chapter two provides an initial literature review to explicate what current research tells us about first pelvic exams. Chapter three, the methodology, contains an overview of the research method (Narrative Inquiry), details of the study design, ethical considerations as well as standards for rigour and reflexivity. Chapter four, the first stage of analysis (personal justification) presents the stories of the co-participants, in a dialogue format with my own reflective interjections, as per Narrative Inquiry, demonstrating the relational aspect of storied experience. Chapter five documents my analysis process, identifying narrative
threads and patterns in co-participants’ stories in light of the inquiry puzzle. Chapter six reveals the second stage of Narrative Inquiry analysis (practical justification), where, using Critical Feminist Theory, I delve into the literature to deepen my understanding of identified narrative patterns. Chapter seven brings the newly developed knowledge together in light of the social justification (the third stage of Narrative Inquiry puzzle), explicating its social implications. Finally, chapter eight creatively re-presents the newly developed knowledge co-created in this inquiry, in form of a narrative. The thesis bookends with an epilogue on my journey through this inquiry.

As I approach the literature review, I wonder— as any inquirer does, Has anyone asked this question before? What is known about women's first pelvic exam experiences? What could be the implications of this inquiry, given the current landscape of literature on the subject? In the next chapter, I traverse the literature seeking answers to these questions.
Chapter Two: Literature Review

In preparation for this study, I consider what peer-reviewed and gray literature may have to teach me. In this chapter, I explore what other scholars have written on my phenomenon of interest, which is, women’s experience of their first pelvic exam. In order to investigate this topic, I wonder how first pelvic exams matter to the lives of women who have them. Do these procedures 'set the stage' for future experiences, or are they forgotten with the passing of time? If first pelvic exams are indeed important, what might the literature have to say about how women experience them?

In this chapter, I also present my literature search approach, and I synthesize the themes of what I learned from the literature review. Upon reflection on the emergent knowledge, I elucidate my research question, or as it is termed in Narrative Inquiry, my inquiry puzzle. I then discuss the imagined implications for this research study.

Literature Search Approach

The purpose of this study is to analyze women’s stories of their first pelvic exam experience. As such, the literature review focuses on the experiences of women who had their first pelvic exam when they were twenty-five years old or younger.

With this literature search, I looked for representations of pelvic exam experiences from women's perspectives, particularly their first pelvic exam. I remained open to any literature that described, portrayed or informed pelvic exams in a narrative or descriptive manner, particularly from the woman's perspective as the recipient of the exam. I included English language research and theoretical literature from the past thirty years. If a result did not discuss pelvic exam experiences in any way or add to my understanding of the first pelvic exam experience, that literature was excluded. I judged this by examining the title and the abstract of each result.
Although this inquiry focuses on the experiences of cis-gendered women, to gain a fulsome picture of the pelvic exam experience, I included literature on all gendered individuals' experiences of pelvic exams. With these parameters set, I began searching the literature.

**Searching the Literature**

Literature searches began in Fall 2018 and has been repeated iteratively until Winter 2020. ProQuest was mainly used to find peer-reviewed journal articles, theses, and dissertations. The reference lists of key articles were also reviewed for relevant sources, and Google Scholar was purposively searched to access scholarly articles and gray literature from reference lists.

Initially, CINAHL was searched using terms “youth” or “young people” or “adolescent” or “teen” or “young adult” and “gynecologic examination” or “physical examination”. This yielded only five results: none of which were relevant or informative to pelvic exam experiences. All five articles from this search were excluded.

In ProQuest, the terms “youth” and “pelvic examinations” after the year 1990 produced eighty-one results. I screened titles and abstracts of the articles for mention of young women's experiences of a first pelvic exam. From this search, sixty-one articles were excluded as they did not meet inclusion criteria. However, twenty articles were included.

Although the authors of the included twenty articles did not directly address women’s experiences of their first pelvic exam, each article informed the pelvic exam experience in some way. Such topics included patient education (Alexander & Guyer, 1993; Daley et al., 2004; Fiscus, Ford & Miller, 2004; Grimshaw-Mulcahy, 2008; Hobbs, 2000; Zacharyczuk et al., 2011), provider approach (Daley & Cromwell, 2002; Fawcett, 2007; Mansbach & Emans, 2001; Ricciardi, 2008; Schaeuble, Haglund & Vukovich, 2010; Woods, 1991), confidentiality (Pasternak, Hawkins & Schuman, 2019; Smith & Huber, 2018) and avoidance (Base-Smith,
As these subject areas were judged to be informative of the first pelvic exam experience, these articles were included in the synthesis.

In ProQuest, a second search using "Youth", "pelvic exams" and "narrative" yielded thirty-three results. Using the same inclusion criteria as above, thirty-one articles were excluded. The two included articles were an abstract from Amobi and Johnston (2017) which discusses pap test avoidance, and Ewing's (2008) phenomenological Master's thesis study on women's experiences of abnormal pap results. Ewing cites two sources (Kahn, Emans & Goodman, 2001; McKee, Fletcher & Schechter, 2006), which discuss youth attitudes and perceptions of pap testing. I included these in the synthesis. In sum, this search led to the inclusion of four articles in the synthesis.

I broadened my search, I searched for narrative research on the experience of pelvic exams at any age. Using ProQuest, I removed the term "youth", and searched "pelvic exams" and "narrative". This generated sixty results. Of this search, fifty-five results were excluded, as they did not describe, portray or inform pelvic exam experiences. Five articles (Harrison, 2016; Kebicz, 2001; Mookherjee et al., 2013; Potter et al., 2015; Thompson et al., 2018), discuss the context of education and communication about pelvic exams. As this context adds to my understanding of the experience of a first pelvic exam, these articles were included.

Finally, seeking exploration of the connection between religious beliefs and the experience of a first pelvic exam, I searched in ProQuest "religion" and "pelvic exam". This yielded one hundred and twelve results. To reduce this total, I selected only peer-reviewed content. This produced sixty-four results. Of these sixty-four results, sixty-one articles were excluded as they were judged not to inform the inquiry. Three articles informed the pelvic exam
experience and were thus included in the synthesis (Asthana & Labani, 2013; Avuvika et al., 2017; Ghebre et al., 2015).

In total across all the searches, I included thirty-two articles in the synthesis (Alexander & Guyer, 1993; Amobi & Johnston, 2017; Asthana & Labani, 2013; Avuvika et al., 2017; Base-Smith, 2006; Daley & Cromwell, 2002; Daley et al., 2004; Ewing, 2008; Fawcett, 2007; Fiscus, Ford & Miller, 2004; Ghebre et al., 2015; Grimshaw-Mulcahy, 2008; Harrison, 2016; Hicks-Burchwell, 2000; Hobbs, 2000; Kahn et al., 2001; Kebicz, 2001; Lee & Vang, 2010; Mansbach & Emans, 2001; McKee et al., 2006; Merrill, 2007; Mookherjee et al., 2013; Pasternak et al, 2019; Potter et al., 2015; Ricciardi, 2008; Schaeuble et al., 2010; Smith & Huber, 2018; Stevens, 1992; Taylor, 2003; Thompson et al., 2018; Woods, 1991; Zacharyczuk er al., 2011). I further included three pieces of gray literature (Boyman & Cronenberg, 1988; Drandic, 2020; Skloot, 2010), which add social context on pelvic exam portrayals.

The following literature synthesis includes thirty-five titles. This literature met the established inclusion criteria: Western English language research, theoretical and gray literature (including film) published in the past thirty years and describe, portray or inform women's pelvic exam experiences from their perspective.

**Literature Synthesis**

In this section, I present a synthesis of relevant literature to construct my emergent understanding of women’s first pelvic exam experience. Upon the review of the literature, five themes emerged, which will serve as the structure of the literature synthesis: avoidance, negative experiences, trusting relationships, a knowledge gap, and the first pelvic exam as a turning point in a woman's healthcare journey. In this synthesis, I elaborate on each theme to better understand the experience of a woman’s first pelvic exam.
Avoidance

Pelvic exams are a common source of anxiety for women of all ages (Alexander & Guyer, 1993; Amobi & Johnston, 2017; Harrison, 2016; Hicks-Burchwell, 2000; Lee & Vang, 2010; McKee et al., 2006; Nyblade et al., 2017; Taylor, 2003). Young women avoid primary care in general (McKee et al., 2006), and avoid pelvic exams in particular, due to concerns of pain, shame, awkwardness, embarrassment, lack of confidentiality, and concerns about the experience, from the uncertainty of abnormal results to the unknown (Bates, Carroll & Potter, 2011; Daley & Cromwell, 2002; Fawcett, 2007; Ferguson & Chor, 2018; Harrison, 2016; Hobbs, 2000; Mansbach & Emans, 2001; McKee et al., 2006; Pasternak et al., 2019; Smith & Huber, 2018; Taylor, 2003).

The literature shows that avoidance is even more common among overweight women (Base-Smith, 2006; Merrill, 2007) and members of the LGBTQ (lesbian, gay, bisexual, transgender and queer) community (Potter et al., 2015; Roller et al., 2015; Stevens, 1992). Although not the focus of this inquiry, I note there is little research on LGBTQ experiences of pelvic exams.

Firmly held religious and cultural beliefs, mistrust in the Western healthcare system, patriarchal values and cultural practices of modesty are barriers to cervical cancer screening (Asthana & Labani, 2013; Avuvika et al., 2017; Ghebre et al., 2015; Lee & Vang, 2010). Authors Lee and Vang (2010) found women in their study trivialized their health needs and avoided care.

Negative Experiences

When asked, women shared that their pelvic exam experiences caused them feelings of shame and embarrassment (Lee & Vang, 2010). A third of the women in Bryan and Chor's
(2018) investigation reported a negative first pelvic exam experience, some describing the experience as "less than ideal" (Daly & Cromwell, 2002, p.31). Young women in Taylor's (2003) master's thesis study report anxiety, vulnerability and a sense of invasion with pelvic exams. All fourteen participants described pelvic exams with adjectives denoting unpleasantness: "that dreadful thing" (Taylor, 2003, p.54) was "the price you pay" (p.56) for contraception. Individuals with non-conforming gender identities report that pelvic exams cause distressing gender dysphoria (Potter et al., 2015).

In her doctoral dissertation, Stevens (1992) used feminist ethnography and narrative analysis to examine adult lesbians’ experiences with health care. Stevens (1992) discussed the “compounded vulnerability” (p.vi) the women experienced as they recounted shaming, hostile, exclusionary, objectifying, aggressive and even abusive experiences. Disturbingly, five of the thirty-two women who told full narratives reported that they had been sexually abused by physicians while seeking care.

Negative experiences with pelvic exams have alarmingly been explored in popular culture and gray literature. With the #BreakTheSilence movement, maternal health advocate Daniela Drandic (2020) raises awareness on the culture of denying and stigmatizing pain control for gynecologic procedures, part of the protest against gynecologic violence in healthcare.

Canadian filmmaker David Cronenberg explored gynecologic violence in his 1988 fictional film, the psychological thriller Dead Ringers. In it, renowned twin gynecologists juggle patients and sexual partners in a downfall fueled by addiction, ending in violence. In one scene, the protagonist ridicules a woman's expression of pain during a pelvic exam. "This" he states, "is a solid gold mantle retractor. Solid gold. It's the best there is. This clinic's the best there is!" He reclines her body with vehemence, stating, "it couldn't possibly hurt". The woman apologizes
and silences as he re-inserts the surgical retractor in her vagina. Later, he defends himself to his twin, asserting "there's nothing the matter with the instrument. It's the body. The woman's body was all wrong."

*Dead Ringers* masterfully captures the aesthetic of power and male gaze in gynecology, with a sinister twist of corruption and abuse. Certainly, when compared with women's negative experiences in peer-reviewed literature, this portrayal seems conceivable (Gamble, 2017; Sandelowski, 2000; Stevens, 1992). Leaving interpretation up to the audience, Cronenberg credits the story of the lives of prominent twin gynecologists Stewart and Cyril Marcus, who were found together, dead by suicide in New York City in nineteen-seventy-five. The audience is left to wonder, *What is fiction, what is reality ... How close is fiction to reality?*

In the absence of other, realistic pelvic exam portrayals, as provided in healthcare literature, this film contributes to women's understanding of the pelvic exam as a torturous, violent experience. This perception is grounded in history, perpetuated by media, and used as information even to twenty-first century young women. Furthermore, such fictional portrayals invite young women to wonder what degree of pain and violence is simply inherent in a pelvic exam experience.

A more factual portrayal of negative pelvic exam experiences can be found with Skloot's critical biography *The Immortal Life of Henrietta Lacks* (2010). Henrietta Lacks was a Black woman who lived with undiagnosed cervical cancer long before she sought care. In 1951, she went to Johns Hopkins Hospital, a segregated hospital in Maryland, USA. She had a pelvic exam, and without her consent, her doctor took a sample of her cervical cancer cells and sent it to his colleague conducting cell research. Henrietta's advanced cervical cancer did not respond to treatment, and she died. Her cell sample, though, was grown and sold to research labs around the
world. Henrietta Lacks' cells live on as the famous 'HeLa' cells, which were used to develop the polio vaccine, cloning and gene mapping. Despite her non-consensual contribution to modern medical science, her family remains uncompensated.

Both peer-reviewed and gray literature indicate that while not seeking pelvic exams may pose risks, for some women, there is simply so much more to consider. This echoes the assertion made in peer-reviewed literature that for some young women, the proposed benefits of pelvic exams do not outweigh undesirable features of the exam (Hobbs, 2000; Kahn et al., 2001).

**Trusting Relationships**

Another major theme of the literature was women seeking accessible, respectful communication in a trusting relationship with their healthcare providers.

Young women identified lack of respect from the healthcare provider as the leading barrier to seeking primary care (Schaeuble et al., 2010). When it comes to pelvic exams, women value and expect dignity, respect, communication, and consent in a trusting relationship with their healthcare providers (Bryan & Chor, 2018; Daley et al., 2004; Hobbs, 2000; Ricciardi, 2008; Schaeuble et al., 2010; Taylor, 2003; Woods, 1991). Young women recommend fostering a trusting relationship and maintaining gentle, communicative pelvic exams (Hobbs, 2000). These women asked healthcare providers to “try to be nice” (Schaeuble et al., 2010, p. 206), and recognize their vulnerability.

In response to women's concerns about pelvic exams, healthcare providers are recommended to take a minimalist approach to pelvic exams (Harrison, 2016), use urinalysis for infection screening instead of swabbing via pelvic exams (Zacharyczuk et al., 2011), offer anaesthesia (Amobi & Johnston, 2017) or self-swab where conceivable (Amobi & Johnston, 2017), and delay the first pelvic exam if possible (Mansbach & Emans, 2001). During pelvic
exams, healthcare providers are encouraged to set up a plan for communicating consent, and to stop the exam at the woman’s request (Kebicz, 2011; Keller, 2019; Levi, 2008; McCarthy, 1997). Despite these recommendations, the negative experiences presented in the literature suggest this practice is not widespread.

Efforts toward healthcare provider education on pelvic exam technique are visible in the literature (Bates et al., 2011; Daley & Cromwell, 2002; Levi, 2008). In their systematic literature review of medical student assessment training, authors Mookherjee and colleagues (2013) found pelvic exam technique was the second most studied physical exam by medical students (Mookherjee et al., 2013). Curriculum cited in the review teaches anatomy and perception of pelvic exams. Some programs use gynecologic teaching associates, who use their bodies as teaching tools and provide feedback on observed pelvic exams (Mookherjee et al., 2013). Certified nurse-midwife and scholar Levi (2008) encourages healthcare providers to engage in the tradition of self-examination to practice pelvic exam technique.

The literature repeatedly shows that despite their training, healthcare providers are not confident in their communication and provision of first pelvic exams (Carter et al., 2013; McCarthy, 1997; Ragan, 1990; Ricciardi, 2008; Thoma, 2009). Further education is required on effective therapeutic communication during first pelvic exams (Ferguson & Chor, 2018), and a trauma-informed approach has been recommended (Amobi & Johnston, 2017).

Knowledge Gaps

Kahn and colleagues (2001) found young women do not participate in pelvic exams due to their beliefs about the experience, their understanding of the purpose of the exam, and inaccurate knowledge about abnormal results. Indeed, much research has shown that young women have misconceptions about the purpose of pelvic exams (Daley & Cromwell, 2002;
Hobbs, 2000; Kahn et al., 2001; McKee et al., 2006; Taylor, 2003; Thompson et al., 2018). The young women in Taylor's study in Newfoundland, Canada report family (especially mothers), peers and school as primary sources of information for sexual and reproductive health (Taylor, 2003). Messaging, such as "don’t come home pregnant" (Taylor, 2003, p.51), has them seeking contraception with healthcare providers, who will not prescribe without completing a pelvic exam.

Further to this, education certainly is a part of the solution. Healthcare providers are encouraged to share with young women their knowledge about the importance of pelvic exams (Daley & Cromwell, 2002; Grimshaw-Mulcahy, 2008; Hobbs, 2000; Mansbach & Emans, 2001). Public health also uses educational campaigns in this effort. Research clearly shows that respectful health education for young women improves access to contraception (Mansbach & Emans, 2001; Woods, 1991), sexually transmitted infection screening and care (Daley & Cromwell, 2002; Fiscus, Ford & Miller, 2004; Grimshaw-Mulcahy, 2008; Thompson et al., 2018; Zacharyczuk et al., 2011).

Regarding the experience of a first pelvic exam, literature shows young women report feeling emotionally and intellectually unprepared, with inadequate counselling from their healthcare provider (Daley & Cromwell, 2002). To support their patients, healthcare providers are encouraged to use models (McCarthy, 1997), describe the procedure step-by-step, show the equipment and provide updates throughout pelvic exams (Daley & Cromwell, 2002).

**A Turning Point**

The first pelvic exam experience is considered a turning point in how women seek future healthcare, their trust in healthcare providers, and meaningfully, their empowerment in sexual and reproductive health (Daley & Cromwell, 2002; Ferguson & Chor, 2018; Fiscus et al., 2004;
Stevens, 1992). The impact of the experience is mediated by a young woman’s comfort with her body and sexuality, past experiences with health care providers, and family values about health care (Ferguson & Chor, 2018).

Literature shows that positive first pelvic exam experience supported trust, familiarity and comfort in future health care contexts (Bryan & Chor, 2018). However, negative experiences were associated with emotional and cognitive dissonance, a lack of trust in health care providers, and increased avoidance, leading to significant lapses in seeking care (Bryan & Chor, 2018; Stevens, 1992; Taylor, 2003). This impact is underscored by the recommendation that healthcare providers ask women about their first pelvic exam experience before providing a pelvic exam (Daley & Cromwell, 2002).

**Gap in the Literature**

In 2008, Ricciardi stated there is limited research on first pelvic exam experiences. The above literature review demonstrates that this gap still stands. In all thirty-one included articles, the first pelvic exam experience was mostly described indirectly (Daley & Cromwell, 2002; Fiscus et al., 2004). When the experience was described directly by women, it was done so briefly (Bryan & Chor, 2018; Stevens, 1992; Taylor, 2003) and categorized as simply a positive, negative or neutral experience. What remains to be studied deeply in the literature is the experience itself from the woman’s perspective.

Despite the significance of this health event, I found no researcher intentionally asked women to tell the story of their first pelvic exam experience, and no narrative analysis of the experience from a woman’s perspective. Finally, I did not find any research wherein the author sought to deeply know how women experience their first pelvic exam. Given the established significant impact of first pelvic exam experiences, this warrants deeper qualitative exploration.
Based on the above, I seek to systematically investigate women’s experience of their first pelvic exam through their own stories, using Arts-Informed Narrative Inquiry qualitative research approach.

**Inquiry Puzzle:** How do women experience their first pelvic exam?

**Imagined Implications of this Narrative Inquiry**

With the significance of the phenomenon under investigation established, I now discuss the imagined implications of this study for healthcare practice, education, and research. This study is positioned to generate knowledge and a richer understanding of how women experience this vulnerable interaction with healthcare providers.

**Practice**

Storytelling is a powerful force in changing perception. The knowledge generated by this inquiry may inform policymakers in evaluating directives, best practice and clinical guidelines around pelvic exams. The narratives here presented will provide information for decision makers on the qualitative impact of current policies and practice, as told by the women who experience the phenomenon.

In practice, this inquiry has the potential to have profound personal and professional impact. The impact of Narrative Inquiry is measured, in part, by the reflexivity it inspires. “There are no neutral stories, and no neutral hearing of stories” (White, as cited by Brown & Augusta-Scott, 2007, p. ix). By inviting reflection on the narratives re-presented in this study, I provide an opportunity for practitioners to evaluate and align their values.

Such reflections in a practice setting open attentiveness to the stories of others, supporting humanness in caring and the application of trauma-informed care, and narrative
approaches in practice. Such settings for such reflections may be primary care clinics, community health centres, women's health settings, obstetrics, gynecology, and LGBTQ spaces.

**Education**

This study presents opportunities to integrate narratives and reflective practice into healthcare provider education. The narratives of this study may serve as a launching point for exploration, critical dialogue and reflection for healthcare provider students as they learn to provide health assessments and intimate care for their patients. Such use of the study's narratives may thus contribute toward the emergence of narrative pedagogy (Bowles, 2016).

The knowledge generated by this study could be used to fill a need established in the literature synthesis, for healthcare providers to be educated in trauma-informed therapeutic communication approaches when providing women’s first pelvic exams (Amobi & Johnston, 2017; Carter et al., 2013; Ferguson & Chor, 2018; McCarthy, 1997; Ragan, 1990; Ricciardi, 2008; Thoma, 2009).

This inquiry is poised to provide healthcare providers with knowledge on how to educate themselves and how to then educate and support women, build trusting relationships, and empower young women to continue to seek care throughout their lives.

**Research**

This research study begins to address a gap in literature: women's first pelvic exam experiences from their perspective. The experience, as told by women themselves, is yet to be explored in the literature. This study is intended to augment the visibility of this experience in the literature, prioritizes the voice of women, and increases the depth of knowledge on the quality of this experience from the perspective of young women. This inquiry underscores the
importance of portraying and interpreting experiences with integrity towards those who have experienced the phenomenon.

From a methodological stance, this study will contribute to the emergent use of Arts-Informed Narrative Inquiry in health research, advancing personal experience methods (Clandinin & Connelly, 1998) an interpretivist approach in health research. The inquiry adds to the growing use of arts-informed methods in health research and knowledge mobilization and validates the use of Narrative Reflective Process (Schwind, 2003, 2008) in health research.

The knowledge generated by this inquiry may set in motion new directions for research beyond the nursing discipline. These directions of inquiry may include person-centred care (McCormack & McCance, 2006), relational practice (Doane & Varcoe, 2007), self-determination in sexual and reproductive health, intersectional feminism, and the meaning of consent in the context of health surveillance. The implications to research are limited only by the depth of reflection, which the narrative inspires.

**Looking Back, Looking Forward**

In this chapter, I presented a synthesis of extant literature on the subject of women’s experiences with pelvic exam procedures, with a focus on first pelvic exam experiences. I identified that women’s experiences of their first pelvic exam as told from their own perspective is a gap in the research literature. Upon examining the literature and the gaps therein, I have come to elucidate my inquiry puzzle, which guides me forward.

Next, in the methodology chapter, I review my chosen method, Arts-Informed Narrative Inquiry. I also explicate the study design, as well as considerations for ethics, rigour and reflexivity.
Chapter Three: Methodology

In this chapter, I explicate why Arts-Informed Narrative Inquiry (Connelly & Clandinin, 2006; Schwind et al., 2014) is best suited to address the stated inquiry puzzle, namely, to explore women’s experiences of their first pelvic exam. I first outline the historical and theoretical foundations of Narrative Inquiry. Next, I describe the emergence of Arts-Informed Narrative Inquiry in nursing research. Further, I address the rigour and ethical considerations, followed by the study design. Finally, I explicate how the selected method informs my inquiry puzzle.

In my inquiry and writing, I follow the lead of Lindsay and Schwind (2016) by capitalizing Narrative Inquiry to denote it is the qualitative approach developed by Connelly and Clandinin (1990), and to thus differentiate it from other narrative approaches (Leggo, 2008; Riessman, 1993; Lieblich, Tuval-Mashiach, & Zilber, 1998).

A Brief History of Narrative Inquiry

Narrative Inquiry is a linguistic narrative research approach strongly influenced by John Dewey's philosophy of experience (1938). Dewey was an American pragmatist philosopher and educator; whose writings continue to impact the landscape of education to this day. In his ground-breaking book, Experience and Education (1938), Dewey outlined the philosophy of experience as consisting of two mutually informative principles: continuity and interaction of experience.

For Dewey (1938), the notion of continuity denotes that one's past life experiences inform one’s present and all future life experiences. According to Dewey, “what [one] has learned in the way of knowledge and skill in one situation becomes an instrument of understanding and dealing effectively with the situation which follows” (p.44). As experience exists in an active, connected flow, Dewey went on to observe that experience is not only continuous, but also exists in both personal and social situations. He called this the interaction of
experience. In both personal and social situations, there are internal and objective conditions (with self, others and the environment). Dewey emphasized that "continuity and interaction in their active union with each other provide the measure of the educative significance and value of an experience" (p. 44-45). Purposeful reflection on these situations and conditions contextualizes experience and creates opportunity for continuous meaningful learning and growth. In other words, to understand one’s experience, one must intentionally consider its context and what can be learned from it. Therefore, according to Dewey, for experience to be educative, a person must intentionally reflect on both its continuity and interaction.

Dewey’s focus on the educative power of contextualized, intentional reflection on experience captivated the field of education well past his death in 1952. He is widely credited as the philosophical originator of experiential learning. In 1938 he wrote that "the immediate and direct concern of the educator is then with the situations in which interaction takes place" (p.45). Dewey thus inspired scholars in education to reconsider the nature of learning, practice experiential pedagogy, and to generate new education theories.

One such scholar and educational expert was Joseph Schwab, who during the nineteen sixties, led curriculum reform in the United States. Schwab was inspired by Dewey's principles of continuity and interaction when he conceptualized the commonplaces of education: teacher, student, curriculum (subject matter) and milieus, (learning environment) (Connelly & Clandinin, 2006; Schwab, 1973). In agreement with Dewey, Schwab argued that, in order for an educational intervention to be successful, one must attend to the needs of the four commonplaces in equal priority. Using the commonplaces of education, educators attend to the context of place, curriculum and relationships (of student and teacher, both with themselves and with each other). The commonplaces of education applied Dewey's philosophy of experience into educational
practice. Schwab's work, therefore, helped achieve Dewey's vision: a focus on experience in education.

Having studied with Schwab in the nineteen eighties, Canadian education researcher, Michael Connelly, continued to build on Schwab’s and Dewey’s perspectives. Connelly was interested in deeply understanding experience and sought to create a research method congruent with Dewey’s philosophy of experience. Joined by Jean Clandinin, a colleague educator and researcher, Connelly developed Narrative Inquiry qualitative research approach in the early nineteen-nineties. (Connelly & Clandinin, 1990).

Connelly built on Schwab's commonplaces of education to create the *commonplaces of Narrative Inquiry*: place, sociality and temporality (2006), the indispensable theoretical framework of Narrative Inquiry. Alongside Clandinin in the years to come, Connelly developed Narrative Inquiry into an established qualitative research method (Clandinin & Connelly, 2000). Over the past two decades, Narrative Inquiry has been brought into the field of nursing by a number of Connelly’s graduate students (Chan, 2005; Lindsay, 2001; Schwind, 2003).

**The Foundations of Narrative Inquiry**

Clandinin and Connelly (2000) believe narrative is “the best way of representing and understanding experience” (p.18). In personal communication with Schwind (March 20, 2019), she explains:

> Experience is an ontological event. Through telling stories of that experience, we move it into an epistemological sphere. This is where we have the opportunity to engage in dialogue with ourselves, literature, and others to intentionally reflect on that experience, thus expanding our future ways of being, thinking and doing (praxis).
In other words, since experience is expressed through stories, those stories become a launching point into deeper inquiry and subsequent understanding of experience itself.

By using Narrative Inquiry, the inquirer and the co-participant co-construct the meaning of experiences. With this constructivist approach, the inquirer invites the “living, telling, re-telling and re-living” of experiences (Connelly & Clandinin, 2006, p.478). This is done by either broadly asking about an experience, allowing the story to emerge, or by living alongside the co-participant, as the experience unfolds.

Demonstrating the direct influence of Dewey and Schwab, Connelly and Clandinin (2006) emphasize that experience is understood not as a static event, but as a highly contextual phenomenon expressed with fluid narrative. As Dewey stated, an experience occurs in a physical place or a series of places, in relationship with self and with others over time. Thus, an experience is understood to have three dimensions or commonplaces: place, sociality and temporality (Connelly & Clandinin, 2006). In order to more fully understand an experience, it must, therefore, be examined through these contextual dimensions.

**The Commonplaces of Narrative Inquiry**

What sets Narrative Inquiry apart from other narrative research is that experience is analyzed simultaneously through the lens of the three commonplaces (place, sociality and temporality) of Narrative Inquiry (Connelly & Clandinin, 2006). Using the commonplaces, the theoretical lens of Narrative Inquiry, inquirers simultaneously analyze the three dimensions of experience in four directions: inwards and outwards (emotions, sensations, thoughts and observations); as well as forwards and backwards in time (Clandinin & Connelly, 2000).

Narrative Inquiry challenges inquirers to “think narratively, to attend to lives as lived narratively” (Clandinin & Connelly, 2000, p. 120). By reflecting in four directions using the
commonplaces of Narrative Inquiry, inquirers are able “to experience an experience” (p.50). Through this process, inquirers become “wakeful” (p.184) to the commonplaces of Narrative Inquiry, and the living stories around them.

**Levels of Justification**

In Narrative Inquiry, there are *three levels of justification*: personal, practical and social. These seek to answer, “to whom does it matter and how?” (Lindsay & Schwind, 2016, p.15). All three levels are discussed at both the outset (‘justification’ for undertaking the inquiry) and the analysis stage (ensuring experience is considered at all three levels of justification) of the inquiry (Clandinin & Connelly, 2000). The three levels of justification with the commonplaces of Narrative Inquiry guide the inquiry process.

**The Narrative Inquiry Process**

By moving through the three levels of justification, first at the outset of the inquiry, and then at the analysis stage, the inquirer is able to engage in the experience (phenomenon under study) and derive a deeper understanding of it. In other words, the inquirer attends to the personal, practical and social levels of justification while engaging in the inquiry process. The process is understood not to be linear, as the word ‘level’ might suggest. Rather, the justifications (at both the outset and the analysis stage) are mutually informative perspectives, which contribute to the co-constructed meaning of the experience, as the inquirer considers its three contextual dimensions (Lindsay & Schwind, 2016). The following are the milestones within a Narrative Inquiry process: three levels of justification at the outset; being in the field (data collection); three levels of justification at the analysis stage; and the re-presentation narrative.
Three Levels of Justification – Outset

At the outset of the inquiry, the personal justification presents in the form of a personal story of relevance: it reveals the inquirer’s reason for undertaking the inquiry. The practical justification takes the shape of current literature review, exploring what other scholars have said about the phenomenon of inquiry. The social justification more broadly considers the potential or imagined relevance of the inquiry to the greater society.

Being in the Field (Data Collection)

Data collection in Narrative Inquiry is referred to as the collection of field text. Alongside stories and observations, Clandinin and Connelly (2000) encourage the inclusion of artefacts of experience, such as photographs, journal entries, and drawings. The interpretive process of collecting field text is essential to develop a deeper, aesthetic understanding of a phenomenon (Connelly & Clandinin, 2006).

The meaning of any creative self-expression is co-constructed within the inquirer-co-participant relationship. When engaging with co-participants, inquirers seek to gain a greater understanding of the inquiry puzzle, and with that purpose, their narrative interview unfolds.

Noting perceptions and relevant experiences invites the inquirer to more deeply examine the experiences of co-participants. What underlying truths might these experiences reveal? How might a shift in the commonplaces (place, sociality and temporality) inform this experience? Asking further questions and considering potential solutions connects the experiences of the co-participants back to the levels of justification.

It is in this creative, interpretive, puzzling frame of mind where an inquirer engages with the levels of justification and the commonplaces of Narrative Inquiry to create interim text from field text. Interim text is highly reflexive, iterative, and, like field text, it may take many forms.
(letters, presentations, photographs, storied accounts of ideas). "There is no one bringing together of the field texts into research texts" (Clandinin & Connelly, 2000, p. 133). Interim text serves to bridge the transition from field text to research text, which is the final product, in this case, the written thesis itself.

Three Levels of Justification - Analysis

At the analysis stage of the study, the personal justification presents the stories of experience as told by the co-participant. Using co-participant’s words, fragments of told experiences are crafted by the inquirer into a story that has a beginning, middle and end; centred around the inquiry puzzle. Crafted stories of experience are confirmed with co-participants for accuracy and clarity. Once approved by the co-participant, the stories are often written in form of a dialogue, where the inquirer reflectively engages with the text of the co-participant’s story, looking for meaning, noting descriptions and observations and accordingly contributing their own relevant experiences and perceptions. During this level of justification, the voice of the co-participant is the strongest.

In the practical justification level, emergent narrative threads and patterns are identified and explored through extant literature. Narrative Inquiry has its own commonplaces of Narrative Inquiry as a theoretical framework, through which the told or lived stories of experience are examined and analyzed in light of the inquiry puzzle. However, depending on the identified narrative patterns, another theoretical framework may be considered, which could better inform the stated inquiry puzzle. Impact of the examined stories on the discipline is also considered.

Finally, the social justification level invites the inquirer to discuss why this study and its outcomes are important to the greater society. The inquirer expands the inquiry to the broader societal level by looking to answer the questions, “So what?” and “Who cares?”. Opening such
space for further reflection and potential implication for society at large sets up the stage for transferability of study outcomes, as well as for subsequent research considerations.

**Re-Presentation Narrative**

Once analysis of the told stories is complete, researchers create a narrative re-presentation of these stories. Narrative re-presentations are a re-construction of the experiences, as told through story, with the addition of knowledge from personal reflection (the personal level of justification), scholarly literature explored through a relevant theoretical lens (the practical level of justification), and discussion of the wider social implications of the inquiry (the social level of justification). The narrative re-presentation is the finishing piece of the inquiry. It embodies and brings together the developed knowledge cultivated by engaging in the commonplaces (the three-dimensional space of experience), along the three levels of justification (at the outset and at the analysis).

Narrative re-presentations appear in a wide variety of formats and styles, unique to each individual inquiry. Some inquirers choose to re-present narratives using linguistic form, such as poetry (Aksenchuk, S., 2020; Manankil-Rankin, 2015; Thavakugathasalingam, 2016) or letters to relevant social groups (Aksenchuk, K., 2013; Gough, 2019; Kwok, 2017; Sharma, 2015; Thavakugathasalingam, 2016). Inquirers may also create more abstract and metaphorical re-presentations, with original art such as paintings (Gaudite, 2015) and drawings (Walji, 2014), collage (Lindsay & Schwind, 2014) or digital narratives (Schwind, 2012). While making choices of form, inquirers consider the subject matter of the inquiry, the aesthetic nature of the told stories, the emergent threads and patterns of the told stories, the new knowledge gained through analysis, and the medium that speaks to the individual inquirer, and significantly, the audience that would benefit from learning of the inquiry outcomes.
Although inquiry and learning are life-long, research studies are not. The knowledge and the learning from one Narrative Inquiry study, crystallized in the narrative re-presentation, flows into the next experience for the inquirer, the co-participants, and the audience of the inquiry, which aligns well with Dewey's philosophy of experience. Inquirers themselves move on from the inquiry changed by the period of intense reflection on experience under investigation. With the re-presentation serving as a touchstone of the inquiry, inquirers bring new knowledge, perspectives, inspiration, and wonder to their next inquiry experience, which grows out of that initial inquiry. Gaudite (2015) beautifully depicted this dynamic and evolutionary process of Narrative Inquiry, when she, using the metaphor of mountain climbing, reached the peak of her current hike (inquiry puzzle), and from that vantage point consider other peaks to climb within the mountain range (potential program of study). And so, as Dewey stated, "the process goes on as long as life and learning continue" (1938, p. 44).

**Arts-Informed Narrative Inquiry**

Integrating arts in research has been a process over a century in the making. To elucidate this context, here follows a brief description of how Arts-Informed Narrative Inquiry emerged in health and nursing research.

Art, including narrative, is an undeniable force for expression and connection (Eaves, 2014; Lapum et al., 2016). At its core, art is a creative self-expression, which challenges understandings and assumptions, transcends boundaries and broadens the horizons of its audience (Eaves, 2014; Rossiter et al., 2008). Engaging with art is a highly contextual and co-interpretive process (Lapum et al., 2016), which supports plurality, reflexivity, sensemaking, personal development and story sharing (Eaves, 2014; Rossiter et al., 2008).
Arts-related approaches use art to explore, understand and present human experience (Savin-Bade & Wimpenny, 2014). This includes arts-inquiring pedagogy, arts-based inquiry, arts-informed inquiry, arts-informing inquiry, arts-engaging inquiry and arts-related evaluation (Savin-Bade & Wimpenny, 2014). Arts-informed research, the approach used in this inquiry, draws inspiration from art in eliciting and re-presenting research findings (Eaves, 2014). This differs from an arts-based approach, which is immersed in the craft of the art and serves as the basis of the study right from its conception (Eaves, 2014).

Arts-informed research offers creative ways to access difficult concepts and adds to the depth of meaning and expressed themes (Lapum et al., 2012; Lindsay & Schwind, 2016; Schwind et al., 2014). This approach to research honours the complexity and the ambiguity of life events, supporting the re-imagination of difficult experiences and their meanings. An arts-informed approach has been applied to data collection, analysis and mobilization of knowledge with meaningful effect (Lapum et al., 2012; Savin-Bade & Wimpenny, 2014).

Arts-informed research is philosophically informed by John Dewey’s Art as Experience (1958), Joseph Schwab (1960; 1973), and the work of Elliot Eisner (2006). During the same decade that Narrative Inquiry was being developed, arts-related research was also emerging. Schwab's notion of fluid inquiry became embodied as non-linguistic forms of artistic expression (i.e. visual, performance art) in research became more common (Savin-Bade & Wimpenny, 2014). Increasingly, scholars across disciplines have been embracing constructivist epistemology and postmodernism.

In 1993, Elliot Eisner established an arts-based research institute (Eisner, 2006; Savin-Bade & Wimpenny, 2014). Researchers gained confidence using arts-related approaches and noticed increased engagement in the inquiry process. As such, they called for further
development of techniques and theories to improve rigour in arts-informed and arts-based research approaches that are congruent with their selected theoretical underpinnings (Savin-Bade & Wimpenny, 2014).

By the 2010's, arts-related research emerged as a respected approach to research in many disciplines (Savin-Bade & Wimpenny, 2014). In nursing, the approach has been shown to improve empathy, holistic care approaches and relational care (Lapum et al., 2016).

**Arts-Informed Narrative Inquiry in Nursing**

In the landscape of this broader interdisciplinary shift in inquiry process, Arts-Informed Narrative Inquiry emerged within the nursing discipline. To better understand the context, a brief review of history serves to inform the present use of this method.

**Brief History of Patterns of Knowing in Nursing**

Florence Nightingale intended for nurses not to cure, but rather to "put the patient in the best condition for nature to act" (Nightingale, 1860/1969, p.133). Around the world, her nursing schools taught students holistic care practices using technical education, with an emphasis on observation, documentation and the organization of the knowledge gained from this process. Despite Nightingale's desire for nurses to develop and teach their knowledge distinct from medical science, by the early nineteen-hundreds, this ideal was lost (Chinn & Kramer, 2018).

Nursing schools were taken over by medicine and hospitals. Unstructured hospital apprenticeships became standard training, and higher education among nurses was discouraged (Chinn & Kramer, 2018). Nurses, mostly working-class women, were expected to be subservient and obedient. They were exploited for their free labour as students, only to find themselves jobless upon graduation (Chinn & Kramer, 2018).
In the cold-war era United States, the space race affected education in many disciplines (Connelly, 2013). For their part, nurses of this era were convinced by medicine to concentrate on post-positivist Western epistemology, especially empirical knowledge (Chinn & Kramer, 2018). Although nurses re-established themselves as educators of their own discipline in the early twentieth century, knowledge development in nursing continues to experience the impact of its history (Chinn & Kramer, 2018). Today, nurse scholars work to embrace a postmodern epistemology and de-centre empirical knowledge in the face of the other patterns of knowing: ethical, personal, and aesthetic (Carper, 1978; Watson, 1995), with Chinn & Kramer (2018) adding the emancipatory way of knowing at a later time.

**Narrative Inquiry and Patterns of Knowing**

Narrative Inquiry contributes to a constructivist epistemological shift in nursing. The knowledge developed by using Arts-Informed Narrative Inquiry is often personal, aesthetic, ethical and emancipatory in nature. This method acknowledges the equanimous co-construction of knowledge between inquirer and co-participant. The theoretical framework, the commonplaces of Narrative Inquiry, involves a pluralistic perspective to analysis. Arts-Informed Narrative Inquiry is a highly emergent method of interpretive, contextual, personal inquiry. The method further embraces interpretivism, while acknowledging the qualitative value of experience (Schwind, 2019). Arts-Informed Narrative Inquiry was pioneered in nursing research and education by Lindsay and Schwind (2014). This work was informed by Schwind’s (2003) arts-informed data collection approach, which she later termed Narrative Reflective Process (NRP) (Schwind, 2008). NRP includes storytelling, metaphor, drawing, creative writing, and reflective dialogue (Schwind, 2008, 2016, Schwind & Manankil-Rankin, 2020). The application of NRP in the work of some of Schwind’s graduate students demonstrates
the potential of Arts-Informed Narrative Inquiry to examine complex and emotionally difficult experiences (Aksenchuk, K., 2013; Aksenchuk, S., 2020; Gaudite, 2015; Kwok, 2017; Sharma, 2015; Thavakugathasalingam 2016; Walji, 2014).

There is a great opportunity for Arts-Informed Narrative Inquiry to support the co-creation of new knowledge on how women experience their first pelvic exam. The approach offers the ability to capture both the personal and the aesthetic patterns of knowing of this ontological event in narrative proximity with the women who have experienced it.

In the next segment of this chapter, I explicate the considerations for rigour and reflexivity in this inquiry.

**Rigour and Reflexivity in Arts-Informed Narrative Inquiry**

Rigorous Narrative Inquiry, according to Clandinin and Connelly (2000), meets five criteria: (a) explanatory, (b) invitational, (c) authentic, (d) adequate, and (e) plausible (p.185). Lindsay and Schwind (2016) discuss these criteria as follows: first, the entire process should have an *invitational* quality, inviting the reader into self-reflexivity and self-inquiry; second, the inquiry should be *explanatory*, written in such a way as to clearly explicate the phenomenon under investigation. *Authenticity* is maintained through iteratively consulting co-participants during data collection and analysis, ensuring the told stories are authentically represented. The fourth criterion, *adequacy*, refers to presenting sufficient detail about the told experiences to ensure *plausibility*, which means that logical conclusions flow from the exhaustive representation and analysis of the told stories of experience.

In my inquiry I demonstrate adequacy and plausibility through diligent analysis using the commonplaces of Narrative Inquiry at the three levels of justification. I return to co-participants and the literature repeatedly to ensure adequacy, authenticity and plausibility.
The value of a Narrative Inquiry is seen in the transferability of its outcomes, by the balanced, meaningful and deep self-reflection inspired in the inquirer, the co-participants, and the reader (Connelly & Clandinin, 2006). Reflexivity is essential to Narrative Inquiry and is threaded throughout the entire process. Engaging in this thorough process invites meaningful, authentic reflection leading to new understandings.

An arts-informed research approach augments reflexivity and wakefulness, which support a rigorous Narrative Inquiry study. In order to maintain reflexivity and wakefulness as an inquirer, I engage in journaling, creative reflective activities, academic supervision, daily mindfulness meditation, and mindful movement practices. Journals “portray the relational circumstances of the situation represented in the field text” (Clandinin & Connelly, 2000, p. 95) and support inwards reflection on thoughts, feelings and sensations regarding the experience. These journals are essential to the field text, and support movement between internal reflexivity and engagement with co-participants. Using journals, I am empowered to move in and out of the intimacy of co-participants’ stories and my relationships with the co-participants (Clandinin & Connelly, 2000).

Having established the parameters of a rigorous and reflexive inquiry, I next review the ethical considerations unique to this inquiry puzzle.

**Ethical Considerations in Arts-Informed Narrative Inquiry**

Arts-Informed Narrative Inquiry is deeply personal, with autobiographical implications (Lindsay & Schwind, 2016). This is true particularly in this inquiry, where the experience under investigation is intimate and vulnerable. The ethical implications of this inquiry puzzle bear careful consideration. Having received Ryerson University Research Ethics Board approval, the entire inquiry process was guided by relational ethics, specifically the framework laid out by
Jean Clandinin (2006): negotiation, respect, mutuality, and openness to multiple voices. With each co-participant I engaged in respectful negotiation regarding mutually convenient time and place to meet for our narrative interviews. I also supported each co-participant in sharing their stories of experience to the level of their comfort.

Given the arts-informed approach to this inquiry, I further look to two ethical considerations by Savin-Baden and Wimpenny’s (2014) for ethical arts-related research: ownership and reflexivity. Informed consent was obtained at the start of the inquiry and maintained throughout. I reviewed the consent form, written in clear language, with each co-participant, and answered any questions to ensure free and voluntary consent. Each co-participant consented to participate in the inquiry. I provided each co-participant a copy of the signed consent form.

Considering the sensitive topic of this inquiry, I met with the three-co-participants individually in a private room, thus providing them with privacy and upholding confidentiality. Each co-participant was invited to select a location for the storytelling interview at a mutually convenient and confidential place, at private office at Ryerson University, in a separate building from the co-participant's faculty to avoid participant identification. The first interview required a maximum of two hours of their time. Upon completion of the consent form, each co-participant was compensated for public transit and given a gift card.

Furthermore, due to the sensitive subject matter, I was attentive to the risks of exploring difficult experiences and the potential for the disclosure of trauma. I followed the guidelines established by Clark, Classen, Fourt and Shetty (2015) for trauma-informed care. I practiced reflexivity to avoid engaging in transference or countertransference with co-participants. In the consent form, I provided co-participants with accessible community mental health and primary
care resources for follow up. During the interviews, I prioritized respect, mutuality, and openness to multiple and conflicting meanings.

Throughout the interviews, I respected the right of co-participants to decline to answer any question or to withdraw their consent to participate in the inquiry without penalty. Each co-participant was informed that their decision to withdraw consent would not impact their compensation or their relationship with Ryerson University or the inquiry team. I notified co-participants that in the event they withdrew their consent, all prior information collected would be destroyed, and I would cease to collect any further information. No co-participants withdrew their consent.

Co-participant confidentiality has been strictly upheld. Personal information collected includes the co-participant’s name, phone number and email. Contact information, along with the consent form and original or scanned drawings (should co-participants opt not to retain their original drawing) were stored separately in a locked file folder in a secure home office. Three years from the date of consent, the consent forms, contact information and original drawings will be obscured and shredded.

The original audio-recordings of interviews, transcripts of interviews, scanned copies of the metaphor drawings and research data were stored separately on the Ryerson Shared Google Drive (according to Ryerson University guidelines), an encrypted server with two-factor authentication. All identifying information has been removed from this data. Co-participants were identified with a pseudonym and locations are fictionalized. Audio recordings were taken with a digital audio recording device and were listened to on private headphones in a secure location to limit risk of voice recognition. Once analysis of the stories was complete, the audio recordings were deleted. I ensured my journal writing and descriptive observations did not
identify the co-participants. My reflective journal was also stored in a locked cabinet in my home office and will be destroyed by shredding upon successful defense of this thesis.

After examining co-participant stories and metaphor drawings, I emailed co-participants an attachment of their respective crafted stories of experience and a scanned version of their metaphor drawings. I invited the co-participants to review their story for authenticity and accuracy, inviting them to provide any additions or deletions. Approximately one week after this email, I met with co-participants over the telephone to verify proposed meanings of the stories. This phone call required a maximum of thirty minutes of their time.

Finally, upon successful defense of this thesis, I will email co-participants with an electronic copy of the final product of my inquiry. Where appropriate, I will aim for open-access publication. I will preserve reflexivity, transparency and authenticity with rigour, upholding the integrity and honouring the experiences of co-participants throughout.

Having established the considerations for rigour, reflexivity and ethics for this inquiry, I now review the design for this inquiry.

**Study Design**

**Three Levels of Justification - Outset**

Reflecting on why I chose to study this particular phenomenon (personal justification), I told the story of my first pelvic exam. I employed a high degree of self-reflexivity to attend to my feelings, thoughts, tensions and personal experiences (Lindsay & Schwind, 2016). To support my reflexivity, I engaged in journaling and my own metaphor reflection (Schwind, 2016). My personal justification for this inquiry was textured by my perspective as a health care provider who has been on both sides of the speculum, as a nurse and a young woman receiving her first pelvic exam, separated by time.
In the practical justification, I presented a synthesis of the existing literature on the topic of women’s first pelvic exam experiences. The existing knowledge demonstrated a research gap that my Arts Informed Narrative Inquiry could inform: Women’s stories about their own experiences of receiving their first pelvic exam. For the social justification, I discussed the potential significance of the study for the greater society.

**Co-Participants**

For this inquiry I invited three cis-gendered women between the ages of 21 and 35. I advertised for co-participants at Ryerson University. With Ryerson Research Ethics Board approval, co-participants self-selected on a first-come-first-served basis to participate in this study. The co-participants were willing to tell their experience of their first pelvic exam through story and creative methods. I met with each co-participant individually to uphold their privacy and confidentiality. While I upheld confidentiality, co-participants embraced the autobiographical implications of the research (Lindsay & Schwind, 2016).

**Collecting Field Text**

With informed consent obtained, stories of experience were collected during audio recorded interviews, conducted at a mutually convenient, confidential setting. Co-participants were asked open-ended questions considering the four directions of inquiry: inwards, outwards, backwards and forwards. Questions such as “How did you come to book your first pelvic exam appointment?” and "How would you describe your experience of your first pelvic exam" opened the conversation, while extending and clarifying questions such as “What were you thinking about while lying on the examination table?” and "How did you feel after the exam? Can you expand on this?” were used to elucidate emergent narrative threads.
Co-participants also engaged in metaphor reflection, an adaptation of the Narrative Reflective Process, (Schwind, 2016) to create drawings, which for them represented their storied experiences. Meaning of the metaphor drawings was established by the co-participants themselves. I sought clarity of meaning with open-ended questions, such as, “Tell me how you came to choose this image to represent your experience”, “What is the mood of this image?” and “Is there a reason you chose this symbol/colour?” Co-participants’ metaphor drawings provided a platform for further conversation about their experiences, supporting their aesthetic understanding.

**Interim Text**

Following each interview, I manually transcribed the audio-recording to immerse myself in the field text. I journaled my reflective thoughts and feelings as I immersed myself in their stories and metaphor drawings, adding to field text while creating interim text.

After crafting the stories, I ensured co-creation of the meaning of these stories with co-participants. At the second interview, by telephone, I reviewed each written story with each co-participant individually. During this interview, I clarified the meanings to ensure the story was co-constructed and authentic to the co-participant’s experiences. Upon verification of meaning, I moved to the analysis stage of the Narrative Inquiry process.

**Three Levels of Justification - Analysis**

In the personal justification level of the analysis stage, I present the stories of experience and metaphor drawings interspersed with my own reflective thoughts, feelings and wonderings. I compare the metaphor drawings of co-participants with my own artistic representation of my experience to examine the intersections and uniqueness of our experiences. Voice of the co-participants carry this justification level.
In Narrative Inquiry, it is at the practical justification stage of analysis that theory enters the inquiry. As well as using Narrative Inquiry’s theoretical framework, the commonplaces of Narrative Inquiry, I use Critical Feminist Theory to deepen my understanding of the phenomenon under study. Reflecting on narrative threads and patterns found in the stories, I accordingly return to the literature to gain a deeper understanding of the told stories in light of the inquiry puzzle. I discuss the implications of the newly understood narrative patterns to the nursing discipline.

The final level of analysis, the social justification, situates the inquiry puzzle beyond the nursing discipline. Here, I answer the question, “Why does it matter to ask women about their experience of their first pelvic exam?” and “How does knowledge of the quality of this experience matter?” I discuss the importance of the inquiry in a broader social context. I invite reflection on the impact of this new understanding; imagining new possibilities for inter-professional and inter-disciplinary knowledge (Lindsay & Schwind, 2016). To express my emergent understanding of the inquiry puzzle, I create a visual re-presentation of the told and analyzed stories in form of a digital narrative (Lindsay & Schwind, 2016; Schwind, 2012). Finally, further directions for inquiry are discussed.

**Method Alignment with the Inquiry Puzzle**

Everyday experiences are told and re-told in the aesthetic of story. Stories of experience are a “portal through which a person enters the world, and by which his or her experience of the world is interpreted and made personally [and socially] meaningful” (Connelly & Clandinin, 2006, p.477). The practice of storytelling supports creation of new meaning (Clandinin, 2006).
In my inquiry puzzle, I seek to understand how women experience their first pelvic exam. Based on the extant literature, this inquiry offers something not yet done, presenting women’s stories of their first pelvic exam as told from their own perspective.

There is evidence that young women already use storytelling with peers to make meaning of their first pelvic exam experience (Taylor, 2003). Although stories tell of experience, they can be augmented by creative self-expression in the form of metaphoric reflection (Schwind, 2009, 2016). Hearing the told stories and using metaphoric reflection, augments personal and aesthetic knowledge of the phenomenon (Chinn & Kramer, 2018). Arts-Informed Narrative Inquiry offers a fuller, humanistic understanding of experience, which honours the person who experienced the phenomenon. For this reason, Arts-Informed Narrative Inquiry is best suited to explore how a woman experiences her first pelvic examination.

**Looking Back, Looking Forward**

In this chapter, I have explicated Narrative Inquiry and specifically, Arts-Informed Narrative Inquiry, qualitative research method that I use to study women’s experiences of their first pelvic exam. I also reviewed the rigour and reflexivity entailed in this inquiry. I outlined the study design and demonstrated the appropriateness of this method to address this particular phenomenon. In the next chapter, I present the personal justification level of analysis.
Chapter Four: Analysis: Personal Level of Justification

Introducing the Stories

In this chapter, I undertake the first step of narrative analysis: the personal level of justification. I begin by presenting each co-participant’s told experiences. I crafted fragments of their experiences into their respective stories that have a beginning, middle and end. Each co-participant reviewed and approved their own crafted story.

My reflexive engagement with their experiences is presented in the form of a dialogue. This demonstrates the relational (sociality) commonplace of experience (Connelly & Clandinin, 2006). Co-participants' voices are strongest in this chapter. Their respective voices are presented in their own words. I share each co-participant’s story in the chronological order in which I encountered them. As I engage with their stories, I share reflections on my movement backwards and forwards through time and space, demonstrating the commonplaces of temporality and place in Narrative Inquiry (Connelly & Clandinin, 2006).

I advertised for co-participants between the ages of 21 and 35 at the University. Consequently, each co-participant is a post-secondary student. The names that identify the co-participants are pseudonyms. I invited each co-participant to choose their own pseudonym, however, none chose to do so. Each asked me to choose their pseudonym, which I have done according to the onomastic meaning of each name, informed by their told stories: Andrea (strength), Celeste (heavenly) and Claire (clear and bright).

I offered each co-participant to choose a unique font that would represent their individual experiences. Celeste and Claire chose their own fonts (italicized Calibri and Raleway, respectively), while Andrea invited me to choose a font for her. For Andrea, I chose Helvetica, as
a tribute to the clarity, warmth and power of her voice. My own thoughts and reflections remain in Times New Roman, size 12.

Although, some of the upcoming experiences may be difficult to read, they are also difficult for young women to share, and to write. As we enter the space of these experiences through their stories, I invite you to take your time as you read the following twenty-eight pages of this chapter. Take care of yourself and please remember to appreciate the courage and strength of these young women.
Andrea

Andrea is the first to answer my advertisement. On the day we meet there is a strong wind chill in the air. The snowbanks along the sidewalk are frozen into sharp spikes.

I arrive early to the University to set up for our meeting. The room I reserved is small and clean, with a round table, four chairs and a tall frosted glass window. I arrange pencil crayons, paperwork, the digital recorder and glasses of water on the table. I am eager to begin; hearing Andrea’s story marks the beginning of a long-awaited step of my inquiry into women’s experiences of their first pelvic exam.

Figure Four


Note: by Emma MacGregor, 2020.
Meeting Andrea

Andrea greets me at the reception area with a big smile and gregarious speech. I feel her eagerness to be here, and I note that sometimes, to reduce tension, I too convey friendly excitement. Andrea’s mannerisms alert me to the power dynamic of our inquirer - co-participant relationship. I am reminded to act responsibly, so Andrea is safe and empowered to self-express.

Once settled in the room, I carefully review informed consent with Andrea, which she confirms and signs. I begin recording. Andrea removes her boots and sits cross-legged on her chair. She quickly and all at once, tells me her story. After a pause, I respectfully ask her to revisit the beginning, and share details to the level of her comfort, so that I can better understand her experience.

Mundane Footsteps

**Andrea:** For a while, my GP kept telling me I needed a pap test because of my age. I thought to myself, *I’m not that old. I’m only twenty-three. I am not worried about cervical cancer.* Friends told me, "Don't go, it's painful". My GP kept booking me appointments, and I just kept cancelling them, before the cancellation fee would apply.

**Emma:** Even though Ontario's cervical cancer screening guidelines start at twenty-one, age alone is not an indicator for a pelvic exam. I recall how women defer pelvic exams in order to "avoid danger" (Stevens, 1992, p.264), and in Andrea's case, pain. I reflect that sometimes non-compliance is an act of self-preservation, and as such gives the individual a sense of control.

**Andrea:** It wasn't until I wanted an IUD that I had my first pelvic exam. When I asked him for an IUD, he jumped at the chance to get the pap test done at the same time. He referred me to a doctor in his clinic. When he told me that it was a female doctor, I was relieved. I automatically assumed I would feel more comfortable than being around a man.
Emma: This preference is well documented in the literature. Yanikkerem et al.’s., (2009) large cross-sectional study found that 45.5% of women preferred a female healthcare provider involved in their obstetric and gynecologic care. Only 4.2% preferred a male healthcare provider, and the remainder (49.9%) expressed no preference.

Andrea: I wasn’t sure what to expect, but the cancellation fee was two hundred dollars, and I didn’t have that. I figured it would be an external exam at the most. Once inside the doctor’s small exam room, I got the sense she was in a rush. She explained the rationale for the pelvic exam, then asked me to undress. She didn’t leave the room. She just drew a curtain halfway, saying "I’m gonna see it anyways". I thought to myself, I am just a body, and this is part of her job.

Emma: With the large cancellation fee and a lack of procedural explanation, Andrea’s consent is compromised. Further, without Andrea’s privacy respected, her personhood and trust are objectified.

Andrea: As I was taking my pants off, I thought, Here we go again! I put my underwear on the exam table. I zoned out. My thoughts went back to other times I’ve taken my pants off in front of someone else. It brought me back to negative sexual experiences I’ve had in the past.

Emma: During a gynecologic skills course, I was alerted to be on the lookout for zoning out during pelvic exams. I’ve since observed it as a chaperone nurse in such exams. When considered from a trauma-informed perspective, Andrea’s behaviour may be considered a form of dissociation, a response that allows a person to compartmentalize a stressful event from the rest of their life experience. Dissociation helps by "temporarily making the situation tolerable" (Clark et al., 2015, p.25). In the long term, it can fragment one’s sense of self (Clark et al., 2015).
Andrea: "Hop on up" she said. The table felt cold on my back. My bare feet felt the metal stirrups. Despite a white cloth over me, there was a breeze down there. I felt very exposed. Lying facing the ceiling lights, I heard her voice: "OK, spread your legs". She wasn't telling me what she was going to do next. I was not a person. I was a vaginal area that she was trying to examine. My whole body was rigid and clenched, my toes arched upward. I know this doctor couldn't read my mind, but she should have tried to read my body. As a doctor, you should be able to see that I'm not coming that close to you: I'm not relaxed, I'm not comfortable here.

Emma: Sometimes a procedural focus of the healthcare provider is the sign of a novice practitioner, covering for a well-documented lack of confidence in providing first pelvic exams (Carter et al., 2013; McCarthy, 1997; Ragan, 1990; Ricciardi, 2008; Thoma, 2009). Regardless, this approach neglects Andrea's trust, ultimately reinforcing her sense of bodily disempowerment and exploitation.

Andrea: She just said, "Come closer, I need to put this in". Suddenly this rod was being shoved inside of me. I lost all control over what was happening. I was having this intense pain. I didn't have a way to stop it. I didn't know what to do. I retreated in my head. I heard myself say, "Ow, ow, ow!" She only kept on repeating, "Deep breaths! Inhale, exhale!". I thought, Whom is that helping? Give me a different solution! The doctor just carried on.

Emma: Being unable to control a painful pelvic exam thrusts the patient into a state of further powerlessness. This can be particularly terrifying for those who have been in similar situations without control in the past (Clark et al., 2015). In this context, generic comments, "Deep breaths", seem like patronizing placations.
Andrea: Just as I thought that she would ease up, she told me, "We have to keep going". I felt like I didn't have a choice. This was happening whether I wanted it to or not. The consent part wasn't even happening. We're in 2020 at this point: as a doctor, she should know what consent is.

Emma: As noted in the literature review, breaches in consent have major consequences on patient’s sense of trust, as well as their future health-seeking behaviour. Certainly, factors such as time, personal experience, or prejudice may impact the healthcare provider’s actions. However, there is no excuse for breaching consent at any time, and especially during pelvic exams.

Andrea: The pain was ridiculous, and time slowed down to make me feel like this was going on and on and on. The IUD went in with very intense pain. It hit something. "Deep breaths, deep breaths!" the doctor kept on repeating. I yelled, "Ow!". "Keep going, keep going!" she insisted.

I thought, *Could you maybe be a little more gentle? You’re also a woman!* It didn't feel like she was much of a person. I thought to myself, *I understand you’re seeing a hundred patients a day, but at the same time, take into consideration that I’m a person and you’re doing a very personal exam.*

At this point I thought, *Maybe, distraction will help.* I tried to talk to her about the weather, but she didn't engage. She didn't really care.

Finally, she withdrew the speculum, to say "OK, I'm gonna give you a belly rub". It wasn’t the motherly, friendly, soothing gesture I expected. It wasn’t helpful or comforting at all. I felt like a ball of dough she was forcefully rearranging. As if she was making sure the IUD was in; and she does ten of these a day. All I could think at this point was, *Please, stop touching me!*
Emma: It seems that Andrea’s sense of powerlessness has moved to a state of resignation and silence. Andrea's intelligence is demeaned, and her body disrespected, further dismissing and disempowering her.

Andrea: The doctor abruptly let me know it was time for me to get up and get dressed. She returned to her bubble: at the computer, typing. Once again, I was left to dress behind the half-closed curtain. She gave me a list of expected symptoms and a follow-up appointment. When I told her I was in pain, she told me to take some Ibuprofen. Honestly, for the amount of pain I was in, Ibuprofen would have been about as effective as a Skittle.

Emma: Introducing foreign objects into the uterus causes pressure and pain, which may be excruciating. Again, this healthcare provider seems to give a rote response, diminishing Andrea’s experience of pain, objectifying her body and dismissing her personhood. I also note the doctor does not address Andrea by her name at any time throughout the entire procedure, as if she were simply an “IUD insertion”.

I wonder how this healthcare provider protects herself from vicarious trauma. I ponder more broadly about all healthcare providers, How does witnessing suffering impact their humanity?

Andrea: Walking out of the clinic, the friendly receptionist asked if I was OK. She comforted me and empathized with my pain. She was a bright sunny day compared to what I'd just experienced. With my hand on the door to leave the building, I felt so relieved.

By the time I got home, my relief moved into intense loneliness. I went through this really invasive kind of day and didn't really have anyone to talk to about how it went, or how I was feeling.

The whole experience was destabilizing, dehumanizing, unnerving, painful and just so uncomfortable. It brought me back to negative sexual experiences I've had in the past,
and made me feel, yet again, like I was being treated not like a person, but like a vagina. The whole thing was someone else's priority that needed to be done. My feelings didn't matter, my feelings were not being considered. I wasn't treated like a person, and it brought me back to all the other times I wasn't treated like a person. Since this experience, I have anxiety when I go see my GP. When I'm there, I zone out.

Emma: I can't help but validate her experience. I feel empathy, as Andrea again expresses her desire to be seen and valued as a whole person, a human being who is simply seeking healthcare. I agree with Clark and colleagues (2015) that "disempowerment […] can make it difficult to enter a relationship, even a therapeutic relationship with a healthcare professional" (p.31). I recognize the disempowerment that results from this kind of experience. I feel a deep sense ofsadness for Andrea.

**Engaging in Metaphor Reflection**

Once Andrea has told the whole of her story, I pause the audio recording and we take a short break. As Andrea steps out, I notice we are past half of our prescheduled time. When Andrea returns, I notify her of our timing. Andrea is agreeable to finish the interview and confirms her availability. I resume recording and we continue.

I invite Andrea to envision her told experience as a metaphor. She tells me about her choice and picks up the gray pencil crayon. She draws circles of small figures in various bright colours. She draws at a firm, steady pace, as she talks about relationships. I watch her draw and listen to her, offering brief, supportive murmurs of validation as she shares.

Over time, I watch Andrea create a thick, colourful circle of figures, surrounding an open white space. In time, she pauses to appraise her work, then announces her work is done. I invite Andrea to sign her artwork, to claim it as her own. She enthusiastically does so, and together we move into exploring the deeper meaning behind her drawing, which she later names *Gray*. 

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Figure Five


Note: by Andrea, 2020.
Andrea’s Interpretation of her Metaphor

**Andrea:** I love the calm and quiet of fresh snow. There’s something so pretty and romantic about it. It’s peaceful and tranquil, and there’s usually no people around. But when snow has been stepped in, it means it’s a busier, loud street. It feels like this mundane, nine-to-five, everyday reality. The footsteps symbolize we’re here again. That doctor’s exam felt like one more stupid mundane thing I had to do; another moment where the circle was closing in a bit more and I didn’t have a choice. I thought I could trust this person, that I was going somewhere safe, where I would be comfortable, not in pain. The way she shoved that speculum in there, felt like I was another person, another patient, another girl you’re having sex with. Another instance of being a nameless, faceless person in this revolving door of a system. This person that I could trust, she didn’t seem to care at all. I felt like I was being let down – again!

I understand that going to the doctor’s isn’t going to be a "ten out of ten" experience, but at least try! You’re going into someone’s vaginal area, take a minute to be a person. That’s all it takes, just be a person, don’t be a robot!

The colours represent that I’m trying to make sure that I am bright, fun, positive, and happy. (Pointing to colourful footsteps) This is every time I laugh, or every time I put my hand up in class.

I keep using different colours or shoes, hoping it'll change how I'm looking at something. But internally, it doesn’t feel orange, purple, or green. It doesn’t feel black either, that I am completely lost or angry. A blur of trying to be happy blends into the same colour – gray. (Andrea blurs her vision) You unblur your eyes, and it focuses more. Sometimes you can see where it starts. But when you blur your eyes, you don’t know where it starts or ends. It looks brighter, more confusing. That’s how it feels right now.
I keep walking in the same place, doing the same things, stuck in the same oppressive system. No matter how much you try to brighten it up, it feels like where we started. This is one big confusing string of yarn that I'm trying to untangle, but it's just not working.

When Andrea finishes, I pause to respect the significance of what she has shared. I invite Andrea to title her work beside her signature. Andrea thanks me for this activity, and we both acknowledge the depth of meaning we were able to reach together. I thank Andrea for her time, and for sharing her meaningful experience with me. I remind her of our follow-up phone call in two weeks, to which she affably agrees. We exchange good-byes, and I watch her exit.

I return to my seat. I am moved. I am angry. But, I smile. Her resilience and perseverance inspire me. I think to myself, *This is exactly why I am doing this thesis!* I pack up my belongings and close the door to the room, knowing I will return here to meet my next co-participant.

As I make my way downstairs, a comment Andrea made earlier comes to my mind. She expressed empathy for the people in Asia currently on lockdown due to a novel coronavirus. I think of our small, fragile planet – I am keenly aware that it takes only one flight for this virus to arrive here, to this continent. I ponder the odds.

Walking away from the building, I notice again the snowbanks along the sidewalk. I wonder what I would do if I were on lockdown. A hawk soars over the nearby roof, reminding me that I am nature, and the city is a mirage.

**Reflecting on Andrea’s Story**

As I make my way home, I reflect on my encounter with Andrea. I acknowledge Andrea's experience as valid and significant. Andrea is not alone in her desire for a basic courtesy and human connection during the first pelvic exam experience, or any therapeutic interaction, for that matter (Scheauble et al., 2010). Andrea repeatedly emphasizes her need for safety, while offering explanations for her healthcare provider’s dismissal of her humanity and betrayal of her trust that
she experienced during her first pelvic exam. For Andrea, this may be informed, not only by this experience, but by past sexual experiences. Dismissal is often internalized, then integrated into the social role of a young woman in a patriarchal society; and it is perpetuated through hegemony. In this way, her storytelling style indeed resembles Gray.

I consider how Andrea describes the impact of her first pelvic exam experience, as she tells me about her sense of anxiety and zoning out at future appointments. I feel the magnitude of her struggle. I wonder how I can better support patients like Andrea when I resume my role as a healthcare provider.
Celeste

Celeste is the second co-participant to contact me about participating in the study. After exchanging emails to find a suitable time, I am looking forward to our meeting. As this is my second interview, I feel slightly more confident than before. I decide to walk to the University, taking shortcuts to avoid the crowds. I look into the windows of the bustling shops as I go. Restaurant television screens project messages about the novel coronavirus. The nurse in me wonders if this is something to be concerned about. It is a brisk, sunny afternoon, and I determine not to let the news bother me today.

I smile as I return to the same room where I held my first narrative interview with Andrea. I wonder what I will learn today from Celeste. I set up the materials and glasses of water. I take a moment to sit in silence, allowing the day's distractions to fade. I go to the reception area, where Celeste arrives right on time.

Meeting Celeste

Celeste settles into a seat across the round table from me. I carefully review the consent form with her. She indicates she has already read it, but I continue to review the form to ensure she has no unanswered questions. Celeste signs the consent form and I tuck it away into my study folder. With her permission, I start recording our meeting.

Celeste holds her hands to her abdomen as she begins. She speaks in a low volume, with breathy laughter and rising intonation. I lean in and listen carefully.

Blind Trust

**Celeste:** Oral contraceptives weren't working for me, and I wanted to try a non-hormonal option. So, I asked my family doctor for an alternative contraception method and she suggested a copper IUD. She referred me to an OBGYN, (Obstetrician-Gynecologist) who
was a part of their health care practice, and who would insert the IUD. My family doctor told me to take Advil beforehand. I am not overly thrilled with hospitals, so it was a huge relief when I discovered that the ambulatory care section was at the front of the hospital.

**Emma:** Celeste's lack of enthusiasm for hospitals is very common and can often prevent women from accessing healthcare (Ashraf et al., 2016; Ashwin, 2016). To overcome it, a college career advice article (Concorde College, 2019) recommends doctors "treat patients like a human instead of a number" ("Enhancing the Fearful Patient's Experience", para. 1) and support them to feel in control. Interestingly, I struggled to find scholarly articles on the subject of hospital aversion and women’s access to healthcare. I note to myself that this is something that warrants further exploration in a subsequent study.

**Celeste:** My boyfriend at the time drove me to my appointment. I checked in and waited in the waiting room until the nurse called my name and led me through multiple hallways. Finally, I found myself in a giant triage room with a few beds behind curtains. Here, at one of the beds, I met a team of three or four healthcare providers, one of which happened to be a former neighbour. As we exchanged greetings, I remembered her saying she worked at the hospital. I never knew where in the hospital she worked.

**Emma:** According to the literature review, and thinking back to Andrea's story, confidentiality is a top concern for young women seeking sexual and reproductive care (Pasternak, Hawkins & Schuman, 2019; Smith & Huber, 2018).

**Celeste:** The clinicians introduced themselves, and then explained the procedure. They passed me a cover and told me to undress from the waist down. They left the curtained area and I removed my pants and underwear. I put the cover, a crunchy dentist bib material, over my knees and laid down. At this point, I was kind of nervous, but I assumed
they knew what they were doing. I just did what they said. I thought to myself, "I have to get this done. I am too young for children".

Emma: I note with relief that unlike Andrea, Celeste was given privacy to undress. Yet, Celeste seems to unequivocally trust in the healthcare providers’ skills and credentials. As blind trust is not based on merit, it can sometimes be abused. I think of the young women in Taylor's thesis (2003), who were led to believe they had to consent to a pelvic exam before they could obtain oral contraception.

Celeste: I heard the doctor on the other side of the curtain ask if I'm good. I said "yes", and three people shuffled in. There was a nurse at my head, another person at my side to pass the doctor equipment, and the doctor at my feet.

I was a little relieved to see my neighbour didn't stay for the procedure. It was a little awkward to see her, but our families aren't close, so I was not worried about my privacy. It could have been worse. It could have been a different neighbour.

The doctor showed me the speculum and told me "you're going to feel pressure and cold". When she put it in, my muscles contracted a bit, so I felt some pressure, and cold from the lubricant.

Celeste shrugs as she tells her story and reflects, "They've gotta open you up somehow".

Next, the doctor showed me the IUD. It was all folded up, and she told me they would insert it into my uterus where it would unfold. She told me to sit still for this part. The team distracted me with conversation and reassured me. I suddenly felt like I had to fart, and I kept thinking, "don't fart, don't fart", while talking with the nurse. The doctor told
me she was cutting the strings of the IUD, and then she removed the speculum. "All done!"

they told me. They all left the curtained area, and I noticed I didn't have to fart anymore.

Emma: Similar to Andrea, Celeste seems to disconnect from her body as she continues to unquestioningly trust the healthcare providers to decide how they will examine 'it'.

I recall how differently women consider chaperones: a source of comfort (Bates, Carroll & Potter, 2011), voyeurs (Potter et al., 2015) or complicit in their objectification (Sandelowski, 2000). I think of Mulvey's male gaze (1975), a feminist theory that reveals how women see themselves represented as objects, and, through hegemony, they then engage in self-objectification (Calogero, 2004). I wonder how young women's objectification in first pelvic exams might be further compounded by the medical gaze (Foucault, 1973).

Celeste: I still don't like hospitals, and I wanted to get out of there, so I quickly re-dressed.

Outside the curtain, the doctor gave me a follow-up appointment, and I was told to have protected sex until then. I left the giant room and went back through the maze, feeling a little discomfort in my abdomen, but glad the experience was over. I had dinner afterwards with my boyfriend, feeling a return to regular life with this task complete.

After my first pelvic exam, I didn't need to worry what the experience would be like anymore, and with the IUD I didn't have to worry about getting pregnant. It was done!

Now everything else seems like a whole lot less in comparison.

Emma: Celeste's absolute trust in her healthcare providers seems to have given her a positive experience. I think back on Andrea's experience of passively following directions, while internally protesting. I am left wondering how unqualified trust in the skills and knowledge of the healthcare providers, authority figures within the healthcare system, informs subsequent healthcare interactions of young women.
Engaging in Metaphor Reflection

Celeste tells the story of her first pelvic exam experience in a remarkably chronological order, from start to end. We revisit some moments together, for clarification on my part. When Celeste is satisfied with her story as complete, we shift our focus to the metaphor reflection. I introduce the activity, offering explanations and rationale where appropriate. Celeste considers her choice carefully, thinking quietly to herself.

After some time, Celeste chooses a bright yellow pencil crayon. She draws a large circle, colouring it in. She then draws two circles in pencil inside, then a large, toothy grin. Celeste expresses dissatisfaction with the drawing. She fervently erases the teeth, and they fade on the page. I offer Celeste another try at the drawing, and she accepts. With a fresh piece of paper, Celeste uses the same yellow pencil crayon to quickly draw a circle and colour it in. With the pencil, she draws two dots and an upward half-circle. She puts down the pencil, announcing her completion with a succinct "There!" We pause in silence a moment, and she promptly begins to tell me what she has drawn.
Happy (satisfied) Emoji

Figure Six


Note: by Celeste, 2020.
Celeste's Interpretation of her Metaphor

**Celeste:** *I chose the happy emoji, because when you see one, it represents being inviting and overall positive. It's yellow because that is the colour of the emoji, but it also represents, like other bright colours, being positive. Dark colours represent being negative, sad or gloomy. The doctors and everyone were welcoming and approachable, and I had a positive experience.*

*When they ask you to rate your overall experience from a happy emoji to a sad or angry emoji, I would choose this one to represent it.*

Celeste describes her metaphor with the same straight-forward logic she uses in her story. She draws on the healthcare providers' expressions to represent and ordinally measure her experience. Celeste titles her metaphor, *Happy (satisfied) Emoji.* I thank Celeste for sharing her experience with me. I clarify our follow up plan, and she departs.

It's a mild afternoon, and the sunset reflects off the fresh snowfall from last night. I remember Andrea's metaphor, and send good thoughts her way. I decide to take the streetcar home, choosing warmth over my growing preference to avoid crowds. Nearing my home, I see the evening lights flickering and my mind momentarily turns to my third co-participant, Claire. I wonder what her story will reveal.

**Reflecting on Celeste's Story**

As I reflect on Celeste's story, a disturbing children's hymn from my childhood plays in my mind, like a broken record:

> Obedience is the very best way to show that you believe.  
> Doing exactly what you're told to do (sic), doing it happily.  
> Action is the key: do it immediately; joy you will receive.  
> Obedience is the very best way to show that you believe.  

*(Greene & Greene, 1977, stanza 1)*

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The unsettling words of the refrain repeat in my mind. I make the connection between blind trust and obedience. Certainly, blind trust allows for task completion, but it also inherently reinforces disempowerment and a sense of resignation, which I sensed as Celeste shared her story.

Although a different experience, I am aware how Andrea’s outwardly passive compliance during her first pelvic exam, also reflects that similar sense of resignation. Both stories seem to suggest obedience in the presence of power and the authority figures, the healthcare providers. However, instead of Andrea's anxiety in future healthcare interactions, Celeste expresses a sense of preparedness, that the worst is over. I feel unsettled as I ponder how we as healthcare providers may inadvertently undermine young women’s power and voice.
Claire

Claire is the third young woman to email me about participating in my inquiry. I am eager to meet her, but on the day of our meeting, I am distracted. All week, my phone has been lit up with notifications about North American cases of novel coronavirus. I think back to Andrea's empathetic comment for people on lockdown in Asia. Today, for the first time, I feel a sense of unease for the future health of this continent.

I do my best to remain in the present moment and behave prudently. With my nursing knowledge of infection control precautions, I consider what I can do for my meeting with Claire. Along with the pencil crayons and paperwork, I place a small bottle of hand sanitizer on the table.

Meeting Claire

Claire is early for our meeting and is waiting outside the meeting room. I am surprised, as I met Andrea and Celeste in the reception area. After we greet each other and she identifies herself, I pause in a moment of self-consciousness: she must have seen me setting up. I am glad this humanizes my researcher role. We laugh at my surprise.

I welcome her with a big smile into the meeting room, and together we settle into our seats. She listens patiently as I review in detail the consent form with her, ensuring she clearly understands all its points. Claire is mostly silent until I press 'record' and we begin our interview.

It is What it is

Claire: I asked my sisters, "Can I just see a gynecologist?" I was having pain with sex. "Go see your GP" (General Practitioner), they said, "but, since you're twenty-one, she's gonna want to do a pap" (Papanicolaou test). "Oh great", I said sarcastically. I find medical situations awkward at the best of times. They told
me, "It's generally uncomfortable, but it's probably gonna be worse for you". I thought to myself, Just FML (f*** my life), but I gotta do it.

**Emma:** While dyspareunia (pain with intercourse) clinically indicates the need for a pelvic exam, Claire, similarly to Andrea, expects to be pressured to have a pelvic exam, just because she meets the age requirement. Like Celeste and Andrea, Claire too seems to communicate a sense of resignation about the imminent visit to her doctor.

**Claire:** I'd heard stories from friends. Some had dismissive male doctors, some had doctors who were like aunts to them. For me, I'm glad my doctor is a woman. I'm always more comfortable around women in authority, because they can relate to me. My GP will know what I'm going through in general: she herself probably had a pap smear! And besides, she is a calming, motherly type of person, and easy to talk to.

**Emma:** Like Andrea, Claire is relieved to have a female healthcare provider. I notice that Claire likens some healthcare providers to aunts and describes her doctor as 'motherly'. I recall Andrea's description of her 'belly rub' as un-motherly. Even Celeste had a female healthcare provider who was a former neighbour. Beyond the literal sense, a maternal relationship is caring and nurturing. In a therapeutic context, one might expect a maternal healthcare provider to be respectful and understanding. When Andrea's female healthcare provider is neither, for Andrea, the betrayal made her healthcare provider comparable to a robot. I ponder what a matriarchal healthcare system might look like.

**Claire:** First, I had to call to book the appointment. I don't like talking on the phone to strangers. My mom used to do this for me. When the receptionist
asked my general reason for the appointment, I said "a referral to gyne" (gynecologist). She gave me an appointment for two weeks later.

**Emma:** I know from my nursing experience in primary care that young people are often reluctant to call to book appointments over the phone. There was no scholarly literature that explores a connection between reluctance to call to make an appointment and young women's access to health care. This is another point of interest for me to pursue in subsequent research.

**Claire:** I was early for my appointment. As I walked down the hall, I prepared myself for a potentially awkward situation at the small reception area. I opened the door and was happy to see there were only two people waiting: I was not crowded. The receptionist was busy with paperwork, and it seemed I was inconveniencing her by checking me in. I sat and was glad when my GP brought me in right at my appointment time. Now I could get this over with, instead of making scenarios up in my mind.

**Emma:** The healthcare provider's effective time management seems to positively support Claire’s sense of control, trust and comfort. I note that Claire was also early for our meeting.

**Claire:** We sat in her small exam room and I shared my concerns. She didn't make me feel like I was over-reacting; rather that I knew my own body and I was not making it up. She shared reasons for the pain I was having and gave me a gynecology referral. Then she said what I knew was coming: "While you're here, we should do a pap test". She explained the rationale and added that it might be really uncomfortable and hurt. I was prepared for this. I thought of my grandmother who had cancer. I said "OK".
Emma: Despite Claire's positive description of her relationship with her doctor, it seems Claire still felt a sense of relief not to have been dismissed. I reflect on how difficult it is to overcome internalized socially accepted dismissal of women’s concerns, especially of our bodies. I pause to appreciate that Claire considers her ancestors in her decision to consent to her first pelvic exam.

Claire: She asked me to undress my lower body, sit on the bed and put my feet in the stirrups. She gave me a blue disposable drape for my legs and left the room. I did as she asked and noticed reddish oven mitts on the stirrups. Strange, I thought. I laid flat and gazed at the ceiling tiles.

I heard a knock at the door. With my permission, she re-entered the room. She showed me the equipment as she explained the rationale for each. She again warned me it would probably hurt, but that she would use lube, and that taking deep breaths would help. Anticipating pain, I squeezed my hands together at my chest and felt my heart racing. She counted down: "Ok, on 3… 2… 1…"

Emma: I recall how oven mitts are used to cushion and warm the feet from the otherwise cold stirrups. With this silent gesture, along with the explanation, Claire is supported by the doctor to be comfortable and empowered about the imminent pelvic exam.

Claire: Right away, I felt pain. I jumped and twitched a bit as I braced myself. I was clenching, and yet trying to remain calm. She kept talking, explaining that she would now take swabs. It was nice that she explained what she was doing to my body in language I could understand; and I liked the background noise of her talking. Silence would have only increased my anxiety. I felt a weird
feeling, like a Q-tip scraping inside me. It was uncomfortable. Then she did the cervical swab, which felt like a rugburn twisting inside me. The whole time, she kept talking to me about what she was doing and asking if I was OK. *I hope it's over soon.* I thought to myself. She told me she was going to remove the speculum. I felt another sudden instant of pain. It was over.

**Emma:** It seems Claire's pain, which may be related to her underlying concern of dyspareunia, is mitigated by the compassionate and respectful actions of the doctor. I note that Claire refers to her body as *'me'*, suggesting that, unlike Andrea and Celeste, she did not zone out or disconnect from her body during her first pelvic exam. Instead, Claire refers to the procedure as *'it'*. 

**Claire:** "How was that?" she asked me. We both knew the answer, but I defaulted to politeness: "Oh, it wasn't that bad!" She didn't show it on her face, but I knew she didn't believe me. It was nice of her to acknowledge the fact that it was uncomfortable. But really, I didn't want to discuss it. It is what it is! I had to do it to make sure I was healthy. What was the point of discussing it further?

**Emma:** I consider how women are socialized to be deferential to authority from a young age, and, as a result, often mask their true feelings or accept discomfort as a normal state of affairs for women. I think of Celeste's smiling emoji, and Andrea's outward acceptance of the instruction, while internally protesting. It seems as if suffering is an expected part of a woman’s life. Claire minimizes her pain and inadvertently objectifies her experience. I wonder if in so doing, Claire and the doctor are enacting the *medical paternalism* (Ayodele, 2016, p.57) inherent in the larger healthcare system, symbolized by the power inequality, the speculum, the age requirement for a
pap, and the clinical indication for a pelvic exam for dyspareunia (American College of Obstetricians and Gynecologists, 2018).

**Claire:** She slipped out of the room so I could get dressed again. I put my clothes on and sat in the chair by the window. The doctor joined me and explained when I could expect the results. She asked if there was anything else for today, and I said no. With that, she opened the door, and followed me out. I said goodbye and felt a sense of relief. That definitely could have been worse!

**Emma:** Claire's healthcare provider seems to be unhurried, and focused on establishing authentic, mutual trust and respect with her. I think of Andrea's story, and I wish for her to find a healthcare provider who would be similarly professional and caring. As a nurse, I still wonder, how healthcare providers could be educated to support their patients, especially young women, in being seen and heard with respect.

**Engaging in Metaphor Reflection**

I introduce the metaphor reflection to Claire, and without much explanation, she asks if she can begin. I invite her to the materials, and she immediately draws a large grey rectangle. She then draws two smaller purple rectangles at the top, inside the grey rectangle, and colours them in. Next, she draws a large blue rectangle inside the grey rectangle, and colours this in. Then, she draws a person lying flat on the blue rectangle with a flat mouth, hands to abdomen. Finally, Claire draws a brown cat beside the person, with a speech bubble reading “MEOW”, and motion lines around the cat’s body.

She does not hesitate at all throughout her drawing, and when she puts down the pencil crayon, she asks if this will work. I smile, and let her know the decision is hers, and if she feels
she is finished then we can proceed. She agrees, and I ask her what she has drawn. She laughs and tells me that she has drawn her cat.
Figure Seven


Note: by Claire, 2020.
Claire's Interpretation of her Metaphor

_Claire_: Whenever I'm having period cramps, or if I don't feel good, my cat always jumps on my lap, purrs and sleeps on me. It makes me feel better. Even if he can't change the fact that I'm in discomfort, he acknowledges the fact that I'm not happy and he does what he can to make me feel better. My doctor knew this was not gonna be a good experience for me. She couldn't change that fact, but she still tried to mitigate how painful, uncomfortable or awkward the situation was. Pap smears are definitely a situation that can easily be traumatizing. And if she hadn't taken the time to do all the things she did, it easily could have been. That reminds me of when my cat tries his best.

I notice that instead of feeling outrage when I heard Andrea’s story, or unease with Celeste’s account, I have a sense of joy when Claire finishes her story. I invite her to title her work, and I smile in quiet appreciation of her positive experience. I also recognize with chagrin that a positive experience should be considered standard, not an exception. I am the eternal optimist, always pushing for what could be better. With Claire's permission, we close the meeting.

From the University, I leave for my weekly volunteer shift at a nearby children's centre, feeling excited for what I have learned, and looking forward to playing with the children. As I walk, I pass through a low-income neighbourhood of my city, and notice people accessing community supports. I think about how supports in one's life make the struggles more bearable.
Reflecting on Claire's Story

Although healthy relationships should not be rare, and struggles in life should be few, I recognize this is often not the reality. Claire's experience of her first pelvic exam left her with a sense of relief and growing trust with her healthcare provider, further solidifying her understanding of their relationship as maternal. I think about Andrea, Celeste and Claire's connections between female healthcare providers, their families and communities. I think about the women in my life, in my community, and I reflect that positive female relationships include healthcare providers too. I remind myself to express gratitude to the supportive women in my life tonight.

It's Tuesday afternoon. By Friday, my city goes into a pandemic lockdown. Yet, I continue to dismiss signs of the impending threat closing in around me, much the same way Andrea, Celeste and Claire dismissed their body's signals of physical or emotional pain and discomfort.

Looking Back, Looking Forward

As I mark the end of this important step of my thesis journey, I pause to express gratitude to the co-participants whose stories have deeply enlightened my inquiry puzzle. With their guidance, they have given me clues and directions to pursue in order to more deeply understand how women may experience their first pelvic exams. Having heard their experiences, I prepare to move more deeply into the analysis process. Before I can begin the practical justification of analysis, I engage in creating the interim text. In the next chapter, I explicate my process of crafting the stories, exploring the prominent narrative threads, followed by identifying the
emergent narrative patterns that connect Andrea’s, Celeste’s and Claire's accounts in relation to the inquiry puzzle.
Chapter 5: Interim Text

When someone tells a story, they spin you a yarn, as the expression goes. Although this idiom may have dismissive connotations, in this inquiry, I receive the stories with respect. As Andrea likened her experience to "one big confusing string of yarn", I work to understand her yarn and those of her co-participants. In order to do so, I must deconstruct the told stories and examine what is unraveled.

In this chapter, I document my process of moving from field text to research text. Clandinin and Connelly advise that "there is no one bringing together of field texts into research texts" (2000, p.133). Embracing this, I immersed myself in various creative techniques to identify the narrative threads and the emerging narrative patterns (Clandinin & Connelly, 2000) of the told stories. To demonstrate resonances among my co-participants’ experiences with the intent to co-create personal knowing, I included reflective thoughts on my own lived experience of undergoing my first pelvic exam, which I shared in the Prologue. As I engaged more deeply with Andrea’s, Celeste’s and Claire's stories and metaphors, I was adjusting to the new world around me. I found myself living narratively, "trying to make sense of life as lived" (Clandinin & Connelly, 2000, p.78) in the midst of this inquiry and the heavy cloud of the pandemic.

The Process

First, I preserved Andrea, Celeste and Claire's told experiences by manually transcribing the audio recordings of each narrative interview. I noted "narrative expressions" (Clandinin & Connelly, 2000, p. 79), such as breaths and gestures, as well as my own thoughts and reflections. I used a transcription pedal to immerse my body in the rhythm and cadence of their voices. Then, I listened to the audio recordings on headphones. I wrote events, quotes and sensations onto
sticky notes, and arranged them on my office floor. I moved the sticky notes into chronological order for each shared account, creating three stories with a beginning, middle and end.

**Figure Eight**

*Andrea, Celeste and Claire's Story Arrangements, 2020.*

Next, I asked myself, *In light of my inquiry puzzle, what words seem to repeat through their respective stories?* In Narrative Inquiry, these recurring words are referred to as narrative threads. I took different colours of yarn and assigned each to represent a narrative thread. I taped each yarn to sticky notes where the narrative thread emerged in each story. I then journaled notes about the movement of the yarn. Later, these reflections served to support my understanding of how narrative threads coalesce to become emergent narrative patterns.

**Figure Nine**

*Journaling Narrative Threads and Narrative Patterns, 2020.*
Andrea

This process revealed three narrative threads in Andrea's story. The first was *feminine, protective energy*. This narrative thread was prominent in both a positive and negative light. It was most evident when Andrea was first "relieved" to have a female healthcare provider, only to later feel she was "let down – again!". The narrative thread continued in her encounter with the "friendly" receptionist who "empathized" with Andrea as she left. I noted that the yarn representing this narrative thread did not interact with the others.

The second narrative thread, *paternalistic healthcare system*, appeared at the beginning of her story and moved in broad strokes throughout Andrea's story. I noticed that it is closely interwoven with the third narrative thread, *past negative sexual experiences*. The yarn for this narrative thread emerged when Andrea described being asked to undress with her doctor still in the room, which brought her "back to negative sexual experiences I've had in the past". Following this, the yarn remained highly visible throughout her story, ending with her reflective description of the experience overall as "destabilizing, dehumanizing, unnerving, painful and just so uncomfortable". Both the second and the third yarn strands connected multiple times to Andrea's description of feeling objectified. All three yams zigzagged in sharp spikes across the floor, each connecting in some way to her sense of not feeling safe.
Engaging in the same process with Celeste's story, I first identified *building resilience through experience*. The yarn that represented this narrative thread began when she sought out her pelvic exam, however, it was not visible during her pelvic exam. Rather, it was most prominent when Celeste reflected on the experience as one that supported her in the future to not "worry what the experience would be like anymore". The first narrative thread emerged alongside the second: *unequivocal trust in healthcare providers*. The yarn for this narrative thread connected in wide strokes throughout her story, especially when she recalled lying on the table before the exam began: "I was kind of nervous, but I assumed they knew what they were doing. I just did what they said. ". It concluded when Celeste declared the pelvic exam as "done!".

Finally, *facing discomfort*, the third narrative thread, was represented by yarn that criss-crossed throughout her story, closely following the second yarn. This narrative thread first appeared when Celeste spoke to her lack of being "overly thrilled" with hospitals, expressing her nervousness and need to "get this done". Later, it resurfaced when Celeste was "glad the experience was over", and reflected that, "everything else seems like a whole lot less in comparison". By the end of Celeste's story, each yarn found a natural conclusion.
In Claire's story, the first narrative thread to appear was *positive female relationships*. This yarn started when she went to her sisters for advice. As she explained to me, she is "always more comfortable around women in authority". It is further apparent as she portrayed her "calming, motherly" healthcare provider. Though less apparent during her actual pelvic exam, this yarn carried through to the story's conclusion, as Claire described her supports at home.

The second narrative thread in Claire's story was *power and control in her hands*. The yarn of this narrative thread was heavily scaffolded throughout her story and most clearly connected to moments when Claire "was prepared for this" experience, and when she made empowered choices about her body and health. Following closely alongside, I found *duality of experience*. This final narrative thread became apparent when Claire spoke about her perceptions of apprehension and acceptance, discomfort and comfort as co-existent. It carried through as she reflected on her experience, recognizing "that definitely could have been worse!"

**Story Confirmation and Immersion**

I photographed each arrangement and wrote a draft of each story of experience. I sent the crafted stories to their respective owners, Andrea, Celeste and Claire, and asked them to review for accuracy. After two weeks, I connected with each co-participant over the phone. Small adjustments were made for clarity, and each co-participant gave me permission to move forward with her story. In the meantime, I moved each story arrangement to my office walls. The stories
coloured my space, as I further immersed myself in my co-participants’ experiences. The yarns entangled, as did their voices. In this way, I was able to embody their experiences, and as Clandinin and Connelly would say, to "experience an experience" (2000, p.50).

**Figure Ten**

*Yarns Entangled, 2020.*

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**Discerning Emergent Narrative Patterns**

Having immersed myself in my co-participants’ told experiences, I sought to discern the emergent narrative patterns as they came forth from the narrative threads. To do this, I created a concept map. I first recognized that the narrative threads *feminine, nurturing protection* (Andrea's story) and *positive female relationships* (Claire's story) were expressions of similar ideas. As Manankil-Rankin describes, when narrative inquirers move from field text to research text (2016), they identify resonance and reverberance across experiences. I applied this frame of mind to other narrative threads and observed more concepts, such as obedience and resignation conveyed as a *paternalistic healthcare system* (Andrea's story), *unequivocal trust in healthcare providers* and *facing discomfort* (Celeste's story).
Maintaining this perspective, I then noticed that these concepts had a degree of connection and resonance within and across each story. When I pulled these resonant threads together, I was able to see the narrative patterns. On the map, I circled each emergent narrative pattern in corresponding colours. Then, I named each colour: objectification, resignation, hope, trust, gaze and voice. To verify these, I returned to the stories. With the inquiry in hand and at the forefront of my thinking, I used colourful markers, to underline each emergent narrative pattern within each story. Expressions of each were evident in all three stories.

Figure Eleven


Objectification

In the context of the stories, I understood objectification as the dissociation and disconnection of oneself from one's body. Andrea's healthcare provider did not leave the room while she undressed, and never addressed Andrea by her name. She disrespected Andrea's privacy and personhood, and Andrea marked this by zoning out of the experience. Andrea goes on to anticipate this in future care, expressing a sense of anxiety and zoning out in pursuant visits to her healthcare providers.
Both Celeste and Claire were encouraged by their healthcare providers to engage in
distraction from bodily sensations during their pelvic exams. Although this was an effective
strategy for pain management for both, I noticed when Celeste reflected on her experience, she
said: "They've gotta open you up somehow", seemingly referring to herself as an object. Claire
and her healthcare provider also seem to subtly reference this, conceding "It is what it is".

Resignation

I came to perceive resignation as a combination of hesitation, discomfort, awkwardness
and, ultimately, a resolution to undergo the first pelvic exam, no matter the consequence.
Andrea’s and Celeste's first pelvic exams were required to obtain their choice in birth control
(IUD). After successfully avoiding cancellation fees in the past, Andrea expressed her sense of
resignation through her statement, "this is happening whether I want it to or not". Before her
pelvic exam, Celeste told herself "I have to get this done. I am too young for children". For her
part, Claire expected to be asked to consent to a pelvic exam in order to investigate her
symptoms and, possibly, to obtain the gynecology referral. After expressing her frustration, she
stated "I gotta do it".

Hope

Within this narrative pattern, I included expressions of hope for a positive maternal
experience, as well as for understanding, empathy and respect. Both Andrea and Claire
connected their hope for a positive experience with having a female healthcare provider.
Celeste's hope for a positive experience was related to the setting of the experience, stating "it
was a huge relief when I discovered that the ambulatory care section was at the front of the
hospital".
When Andrea reached out to her healthcare provider for distraction from pain, she expressed hope for empathetic encounter. Instead, she was dismissed. In Gray, Andrea's footsteps persistently try and find a way out of an "oppressive system", perhaps hinting at her own sense of resilience.

**Trust**

Trust appeared in the stories as a sense of shared confidence in relationship with self and with others, a measure of their sense of safety in the care of the other. Andrea wanted to be able to trust her healthcare provider but was "let down" in this. Andrea carries mistrust into the future, describing her sense of anxiety with future healthcare visits. Celeste expressed blind trust in her healthcare providers, as she "just did what they said". Looking forward, Celeste said "now everything else seems like a whole lot less in comparison". It seems Celeste expects to find it easier to continue to engage in blind trust in future healthcare encounters.

Claire is the only co-participant to imply that her first pelvic exam occurred in the context of a trusting, "calming, motherly" relationship. The explanations and distraction that she was offered during her pelvic exam build on this foundation. In the end, Claire acknowledged "that definitely could have been worse". She seems to anticipate a continuation of this kind of therapeutic relationship into the future.

**Gaze**

I came to understand gaze as the power-based viewing of Andrea’s, Celeste’s and Claire's bodies by healthcare providers during their first pelvic exam experiences. Andrea responded by zoning out to a lack of privacy as she undressed. Although Celeste had a team observing her first pelvic exam, their view of her body was limited, and she was offered distraction. Despite this, Celeste focused on controlling her body in their presence, suggesting her awareness of their
observation. Finally, Claire described herself gazing at the ceiling during her first pelvic exam, while her healthcare provider provided information and distraction.

**Voice**

I recognize voice as one's honest expression of one's experience, either verbally or non-verbally. In her story, Andrea stated that she wanted her healthcare provider to "read my body". She exclaimed her pain, but was otherwise silent, and internally protested the pain and indignity she experienced. Celeste used her voice to seek care, yet she did not verbally express her lack of enthusiasm or physical discomfort during her pelvic exam.

Finally, Claire was hesitant to call her clinic to book her appointment, but in so doing was able to access care. Her healthcare provider listened and respected Claire as the expert on her body. Even still, as her pain was acknowledged after her first pelvic exam, Claire "defaulted to politeness", not seeing the benefit of being truthful.

Surveying the above six emergent narrative patterns, I further reflected on the interactions of each in light of my inquiry puzzle. I found that each story contained a unique cascade of emergent narrative patterns. When I examined the cascade of each story, I noticed shared meanings that could be included under two larger emergent narrative patterns: trust and voice.

I understand trust to be shared confidence and sense of safety in partnership with oneself or another. I observed how trust was influenced by the context of hope, objectification and gaze. Thus, I come to see that the first emergent narrative pattern, trust, encapsulates these three narrative patterns. I further see voice as the honest expression of oneself, informed by the narrative patterns objectification, resignation and gaze. I then recognize that the second emergent narrative pattern, voice, captures these three narrative patterns.
Taken together, trust and voice became focal narrative patterns by which I sought to understand this inquiry puzzle. Thus, I wonder, *How do the narrative patterns of voice and trust inform women's first pelvic exam experiences?*

**Looking Back, Looking Forward**

I look back on all I have done to immerse myself and understand the experiences of the three women, Andrea, Celeste and Clair, and how these inform my inquiry puzzle. I have worked to pull apart, disentangle, examine and discern the narrative threads and narrative patterns of their respective experiences. Ahead lies the next level of analysis. In the *practical justification,* I expand my knowledge and thus my understanding by delving deeper into the scholarly literature. I use the framework of the three commonplaces of Narrative Inquiry (Connelly & Clandinin, 2006), along with the lens of Critical Feminist Theory, to investigate how voice and trust inform women's first pelvic exam experiences, and the possible impact these may have on their subsequent health seeking practices.
Chapter Six: Practical Justification

In this chapter, I begin a fulsome analysis of the two identified narrative threads: trust and voice. First, I outline the historical and theoretical underpinnings of Critical Feminist Theory. This includes an overview of the history of the feminist movement, the theoretical perspectives, which emerged out of this social movement, and finally, the present-day interpretations of feminism and feminist theory. I explicate the alignment of the Narrative Inquiry (Connelly & Clandinin, 2006) theoretical framework: commonplaces of experience (temporality, sociality and place), with the theoretical lens of Critical Feminist Theory, as related to the inquiry puzzle. Following, I use the framework of commonplaces to structure the analysis, as I examine each of the two narrative patterns using the Critical Feminist Theory lens. I delve extensively into scholarly literature to gain a deeper understanding, and broader knowledge of how trust and voice relate to women's first pelvic exam experiences.

Critical Feminist Theory: Historical and Theoretical Background

Critical Feminist Theory is a broad theoretical perspective, which generally posits that (a) women's experiences are valuable, central, normal, and that they are portals by which to open new ways of knowing, (b) gender is a basic organizing principle by which gender-based differences are exaggerated where women are devalued and exploited, (c) gender relations must be analyzed through a socio-historical lens, (d) hegemonic ideologies of class, gender, and sexuality contribute to the oppression of women, and finally, (e) social change is essential to support equality of women (Osмонde & Thorne, 2009). Critical Feminist Theory emerged from the socio-political contexts of the feminist movement, Marxism and Critical Social Theory. In order to understand the influence of these movements and philosophies, I provide a brief overview of each.
The Feminist Movement

The feminism movement began in the late eighteenth century, with a focus on women's legal rights to education, suffrage and equality (Osmonde & Thorne, 2009; Ridarsky, 2012). Woolstonecraft, an early leader of the movement, advocated for women to "strengthen the female mind by enlarging it, and there will be an end to blind obedience" (1792, p.24). Following this, in the second wave of feminism (between nineteen-sixty and eighty), feminist scholars developed and applied three main branches of Critical Feminist Theory: Liberal, Radical and Socialist Feminism. Finally, the third wave of feminism emerged into the new millennium, in part due to the rise of Black feminism in the nineteen eighties (Snyder-Hall, 2010; Evans, 2015). Critical Feminist Theory of this era is pluralistic and inclusive, (Ferguson, 2010), including Intersectional Feminism (Crenshaw, 1989), Post-Colonial feminism (Hall, 1996), and Radical Social Feminism (Evans, 2015), proving de Beauvoire's famous statement that "one is not born, but rather becomes, a woman" (1949/2010, p.330).

Marxism and Critical Social Theory

Feminists were inspired by Marxism and Critical Social Theory as developed by scholars of the Frankfurt School. Exiled from Germany in 1932, these scholars used Marxist politics and Freudian psychoanalysis to understand and prevent the horrors of fascism (Chinn & Kramer, 2018). They challenged capitalism, media, and nationalism, inspiring a resurgence of Marxism in the West (Chinn & Kramer, 2018). Feminists identified theoretical alignment with Marxism and Critical Social Theory for its focus on oppression and the voice of the oppressed (Osmonde & Thorne, 2009). Due to this association, Critical Feminist Theory and feminism at large were not widely accepted in North America during the Cold War era (Chinn & Kramer, 2018).
Nurses of this time were mostly non-feminists. Critical Feminist Theory appeared in the nursing discipline when Wilma Scott Heide (1973) implored nurses to think independently and "ask different questions, in different ways, and from different perspectives" (p.827). In this context, in nineteen ninety-five, Jill White proposed a new pattern of knowledge be added to the discipline: socio-political knowing (Chinn & Kramer, 2018). Thirteen years later, emancipatory knowing was added to the praxis of knowledge development in nursing (Chinn & Kramer, 2018).

**Theoretical Alignment with Inquiry Puzzle**

Feminist scholars have long used narrative methods to develop knowledge from experience (Christensen & Jensen, 2012; Osmonde & Thorne, 2009), and to "ask 'new' questions that place women's lives and those of other marginalized groups at the center of social inquiry" (Hesse-Biber, 2012, p.3-5). This Arts-Informed Narrative Inquiry puzzle is no exception, asking a new question of women, inviting the inquirer and the audience to listen and to reflect alongside their lived and told stories. Further, Critical Feminist Theory supports the intention of Narrative Inquiry to investigate women’s experiences as a launching point to deepen understanding and broaden knowledge about women’s lives. In the context of nursing knowledge, my use of Critical Feminist Theory in this inquiry opens critical reflection to develop emancipatory knowing, along with personal and aesthetic knowing (Chinn & Kramer, 2018) on how trust and voice impact women's first pelvic exam experiences, as well as their subsequent healthcare seeking practices.

Trust and voice both develop over time, within relationships and in particular places. As such, the commonplaces of Narrative Inquiry (Clandinin & Connelly, 2006) create a framework for understanding these narrative patterns. In the following two sections, I address each narrative pattern, and the relevant narrative threads, which are identified in italicized font. I analyze
forwards and backwards in time, in young women's relationships with self and others, and the internal and external environments wherein these narrative patterns reside. Using the Critical Feminist Theory lens, I examine each narrative pattern through the theoretical framework of the commonplaces of Narrative Inquiry, to reveal how young women's trust and voice during first pelvic exam is informed by the context of gender, race and power between women and their healthcare providers.

**Trust**

As I stated in the previous chapter, I understand trust in this inquiry as shared confidence and safety in a caring relationship between self and other. This narrative pattern is uniquely apparent in each of the told experiences. Andrea anticipated *feminine, protective energy*, and a "more comfortable" experience with a female healthcare provider. Instead, she was met with a *paternalistic healthcare system*, where her privacy and dignity were dismissed, reminding her of past negative sexual experiences, establishing continuing mistrust.

Celeste faced discomfort in seeking out her first pelvic exam. Despite being nervous, she expressed *unequivocal trust in healthcare providers*. She was treated with respect during her first pelvic exam, and so she was able to complete "this task". Her understanding of trust in healthcare providers helps her *build resilience through experience* for future. Finally, Claire's *positive female relationships* included her healthcare provider. Although she anticipated her first pelvic exam to be painful and awkward, her privacy and autonomy were respected. Claire exercised *power and control in her hands*. This allowed for her pain and comfort to co-exist, the *duality of experience*, as portrayed by her metaphor drawing, *Cats make everything better*. Claire described how her beloved cat gave his warmth and presence to help ease her discomfort, reminding her of how her healthcare provider also tried her best to make Claire comfortable during her pelvic
exam. This understanding sheds light on how Claire might expect her healthcare providers to respect her going forward.

In the process of analyzing the narrative threads and narrative patterns, I notice that each co-participant seemed to be aware of the risk for a paternalistic experience. This is apparent as they hoped for feminine, protective energy, and they expressed a sense of resignation to the experience they lived. Co-participants' trust grew only when they were treated with respect by their healthcare providers. However, it is important to note that historical medical paternalism, still present in today’s healthcare encounters, detracts from young women’s trust in their healthcare providers. This observation informs my understanding of the significance of trust in therapeutic relationships, and especially during women’s first pelvic exam. Thus, trust in this context is comprised of mutual respect as demonstrated through shared power and a woman's sense of safety.

In order to further deepen my understanding of trust within therapeutic relationships specific to women’s experience with their first pelvic exam, I consulted scholarly literature. I first created a concept map to help me synthesize the relevant research on the subject matter.

**Figure Twelve**

*Trust Concept Map, 2020.*

Temporality of Trust: A History of (Dis)Respect

In order to investigate the context of trust, I first explore the temporality of trust between young women and their healthcare providers (particularly physicians and nurses), meandering backwards and forwards over roughly the past one hundred and fifty years. Women's trust in healthcare providers takes time to build (Borba et al., 2012; Coles et al., 2015; Zhang et al., 2017), and develops through inductive reasoning on past experience (McLeod & Sherwin, 2000). Although this was their first pelvic exam, all three women were reluctant to undergo this experience. Andrea expected it to be "painful", based on the experiences of her friends. Claire found "medical situations awkward at the best of times", and her sisters warned her it would be "uncomfortable […] probably worse for you". Nevertheless, each young woman was able to overcome their reluctance, and book their first pelvic exam.

Historically, patients were explicitly told how they were to trust healthcare providers. The first American Medical Association Ethical Code states that "obedience of a patient to the prescriptions of his [sic] physician should be prompt and implicit" (1847, p.96). This statement directly informed the power-laden relationship between patients and their healthcare providers. The use of masculine pronouns in the Code emphasizes further the point of women being subjugated and excluded in society. Since male patients were expected to subordinate to their physicians, this statement implies that the expectation to unquestioningly obey healthcare providers was even more pronounced for women. When examined from a Critical Feminist Theory perspective, this code edified medical paternalism (Ayodele, 2016), systemically entrenched dominance over women, and informed widespread disrespect for women's experiences, knowledge and autonomy. The impact of this Code lives on more than one hundred
and fifty years later, as made apparent in Celeste's story, "I was kind of nervous, but I assumed they knew what they were doing. I just did what they said". Thankfully for Celeste, she was respected, but her statement suggests a sense of resignation of her body and perhaps of her personhood to the authority of her healthcare providers.

Submissiveness can be functional to a point. Celeste's blind trust allowed her to attain contraception and feel a sense of task completion. However, especially when rewarded, one moment of submission can easily become a pattern of acquiescence. Young women may anticipate that in order to receive care in the future, they will be required to submit themselves to the authority of others again. Celeste suggests this in her statement that she now feels "everything else seems like a whole lot less in comparison". Thus, women's first pelvic exam experiences can also be an establishment of submission for future interactions with healthcare providers.

Historically speaking, acquiescing to medical paternalism has been detrimental, even deadly for some women (Poirier, 1983). This was particularly notable during the late nineteenth century, when (mostly male at the time) physicians actively practiced eugenic beliefs that women's brain weight, skull size and shape made them physically and emotionally inferior to men (Poirier, 1983). The combination of deeply erroneous, sexist beliefs and a lack of accurate scientific knowledge caused healthcare providers to disregard women's dignity. Coupled with the expectation of total obedience to the physician, young women were left

\[\text{Figure Thirteen}\]
\[Du\ toucher,\ la\ femme\ debout,\ 1882.\]

\[\text{Note: From Nouvelles\ demonstrations\ d'accouchements,\ by\ Maygrier,\ 1882,\ Paris,\ France.\ In\ the\ public\ domain.}\]
with very little power and even less voice within these power-imbalanced relationships (Poirier, 1983). Pelvic exams at this time were depicted in Maygrier's gynecologic textbook, Nouvelles Démonstrations d'Accouchements (1882).

While young women at this time may have hoped to trust healthcare providers when seeking care, they were suspected of feigning illness to skirt domestic duties (Poirier, 1983). "Hysteria" (Poirier, 1983, p.17), the catch-all diagnosis for mentally unwell women, became "neuresthesia" (Poirier, 1983, p.17). To treat it, Dr. Weir Mitchell introduced the infamous Rest Cure in eighteen seventy-three (Poirier, 1983): a combination of rest, seclusion, food, massage and electricity (to prevent muscular atrophy). Pursuant to the Ethical Code (AMA, 1847), healthcare providers expected and even enforced women's obedience to this Cure. When women did not follow these orders, they were force-fed and in extreme cases, even whipped (Poirier, 1983). Due to missed diagnoses, some women perished under the Rest Cure (Poirier, 1983).

Famous survivors of the Rest Cure are Charlotte Perkins Gilman and Virginia Woolf. Gilman drew on her experience of the Rest Cure in her famous short story, The Yellow Wall Paper (1892/1899). In it, Gilman’s “narrator” describes her infantilization, mistrust, and descent into psychosis after being put on the Cure. Her physician husband said that her sense of emotional unwell "is a false and foolish fancy. Can you not trust me as a physician when I tell you so?" (Gilman, 1899, p.32). This is reminiscent of the "gaslighting effect" of dismissal, term coined by playwright Patrick Hamilton to describe the process of psychological manipulation, to cause one to mistrust their own judgement (Atwood & Seifer, 2007; Van et al., 1944/2004). Gilman's story tells of a patriarchal society where husband is an extension of the physician, both of whom a woman is expected to trust beyond her own sense of reason.
Unlike Gilman's mistrust, Woolf expressed a more nuanced view, saying of the Rest Cure in a letter: "I've no doubt it will be damnable […] but I also imagine the delights of being sane again. He says he won't insist on complete isolation, so I suppose I shant [sic] be as badly off as I was before." (Woolf, V., 1888-1912, Woolf to Bell p.428). In this way, it seems women accepted a certain amount of indignity in order to receive care and to improve their health state. I am reminded of Claire's reflection that "it is what it is". These expressions of trust seem to be borne of a socially constructed sense of powerlessness.

Young women's first pelvic exam experiences are deeply informed by the historical context of women's oppression in the healthcare system governed by medical paternalism. All three co-participants communicated this sense of resignation and compliance: Andrea, outwardly complied, while feeling disrespected, Celeste simply gave herself over to the experience, and Claire stated, "but I gotta do it".

While physicians applied their ethical code, nurses continued to rely on the Nightingale Pledge (Gretter, 1893), which states in part that "with loyalty will I endeavour to aid the physician in his work and devote myself to the welfare of those committed to my care" (Fowler, 1984, p.379). Into the twentieth century, Nursing Ethics for Hospital and Private Use (Robb, 1901) and later, Beulah Crawford's How and What to Teach in Nursing Ethics advised nurses "To the patient's welfare all else must be sub-ordinated" (1929, p.213), including "her zeal to please her instructors, supervisors, and doctors, and to be popular with her co-workers" (p.213). This message suggests advocating for patients, which was intended to establish trust. However, Crawford undermines this when simultaneously recommending "Acceptance of authority, - so lacking in many of the youth of today, obedience, deference" (p.212), and "judgment in the use of the tongue" (p.212).
As evident, instead of building trust, nurses were taught to uphold patient welfare at the discretion of the physician. Any trust that could be established between young women and the healthcare providers at this time would have been entirely conditional on obedience to the physician. This places nurses, young women themselves, in role of enforcers of hegemonic gender roles, male oppression and white supremacy in service of medical paternalism. Thus, nurses of this era enacted horizontal violence, particularly towards young women.

The shift away from enshrined medical paternalism in healthcare is an ongoing process. Thanks to the social action of the feminist movement, more women began to enter the field of medicine and other traditionally male professions (Osmonde & Thorne, 2009; Poirier, 1983). Eventually the nursing discipline, emerging from the control of medicine, developed its own ethical code. In 2015, The American Nurses Association Code of Ethics describes building trusting relationships as a nursing obligation. The Canadian Nurses Association's Code of Ethics (2017) describes building trust with patients "as the foundation of meaningful communication" (p.8). The most recent American Medical Association Code of Ethics (2016) declares trust as the foundation of a physician-patient relationship, based on mutual, informed consent. As Andrea stated, "it's 2020 at this point. As a doctor, she should know what consent is". It seems that, despite these advances, in clinical practice medical paternalism is still evident.

As manifested throughout history, in the literature and in the stories of experience, a sense of respect from healthcare providers is pivotal in women's experience of trust, particularly informing future pelvic exams (Bradbury-Jones et al., 2015; Coles et al., 2015; Oscarsson et al., 2007). The literature shows that mistrust causes women to underutilize healthcare services (Borba et al., 2012) and lower their expectations for their ability to trust healthcare providers in the future (Bradbury-Jones et al., 2015). Additionally, Andrea's response to her "dehumanizing"
experience was permeated with a sense of anxiety and a feeling of "zoning out", which similarly impacted her future appointments. A sense of mutual respect with healthcare providers informed Celeste's choice to defer to their authority and gave Claire the strength to manage her pain.

Young women being treated with basic human respect supports the development of a trusting relationship over time (Alexander, 2001; Borba et al., 2012; Leslie & Lonneman, 2016; Zhang et al., 2017). This suggests that the trust, which develops between young women and their healthcare providers during first pelvic exams also informs young women's trust in social relationships, including intimate partners (Leslie & Lonneman, 2016).

Young women experience their first pelvic exam as a temporal shift in trust. As women continue to seek care after the first pelvic exam, continuity (temporality) of experience is demonstrated and supports the need to establish women's trust when engaging in early therapeutic relationships (Borba et al., 2012; Leslie & Lonneman, 2016). In the next section, I examine the sociality (relationships) of trust between young women and healthcare providers.

Sociality of Trust: Sharing Power

The sociality dimension of experience refers to relationships with self and others. In this inquiry, it is within the context of therapeutic encounters, such as recounted by the three co-participants. Feminists have long argued women cannot ask their oppressors for liberation (Osmonde & Thorne, 2009). Similarly, I acknowledge that young women cannot simply ask healthcare providers for a trusting relationship and expect it to happen. Women's trust in healthcare providers, especially during first pelvic exams, exists in the context of medical paternalism and unjust power dynamics (McLeod & Sherwin, 2000). In the stories of experience, each woman's sense of power is informed by her perception of her own ability to exercise autonomy and control over her experience. How this power is expressed within a therapeutic
relationship significantly influences the sense of trust a woman may experience in the moment, as well as in future healthcare encounters.

Andrea desired contraception and wanted to avoid the two-hundred-dollar cancellation fee. From the very beginning, her consent was influenced by the threat of punishment, the cancellation fee. This compromised Andrea's autonomy, and was expressed in her perceived lack of control over the experience: "I felt like I didn't have a choice. This was happening whether I wanted it to or not". In order to develop genuine trust with young women, it is essential for healthcare providers to empower them to take control of their experience (Bradbury-Jones et al., 2015; Coles et al., 2015; Oscarsson et al., 2007).

Claire's healthcare provider promoted her autonomy by providing information and preparing her for the experience. As Claire said, "it was nice that she explained what she was doing to my body in language I could understand". This simple show of respect, sharing knowledge, supported Claire to feel comforted through pain, and fostered a sense of trust in their relationship. Fulsome explanations in healthcare offer an opportunity for partnership between healthcare providers and patients. This promotes patient autonomy, confidence and a sense of trust in the therapeutic relationship.

Gaps in knowledge have major implications on women’s autonomy and ability to trust healthcare providers (Bradbury-Jones et al., 2015; Coles et al., 2015; Hoffkling et al., 2017; Johnson, Harwood & Nguyen, 2015; McLeod & Sherwin, 2000). In some situations, when healthcare providers counsel young women, they, the providers, decide what information is shared or left out (McLeod & Sherwin, 2000). As seen with Andrea's "belly rub", overly reductive or infantilizing explanations also interfere with genuine respect, and autonomy. Instead of asking Andrea for consent for an abdominal palpation, her healthcare provider usurped
Andrea’s right to informed consent and dismissed her intelligence all at once. By withholding knowledge, healthcare providers interfere with patient’s autonomy, once again exemplifying paternalism.

Healthcare providers may also lack knowledge about their patients’ relevant personal and medical histories, which could augment trust in therapeutic relationships (Coles et al., 2015; Wadsworth, Krahe & Searing, 2019). As Martino and colleagues describe a case study of a woman experiencing intimate partner violence, they emphasize that this context is "more than just an issue of compliance" with care (2005, p.509). None of the co-participants mentioned that they were asked if they had any history of trauma. Without this knowledge, healthcare providers may inadvertently provide negative pelvic exam experiences, resulting in mistrust (Hinden et al., 2015; Cadman et al., 2012; Wadsworth, Krahe & Searing, 2019). Feminists have long advocated for society to seek out women's experiences, and in the literature, healthcare providers are implored to use a trauma-informed care approach and to routinely ask about history of trauma using non-judgemental language (Coles et al., 2015; Leeners et al., 2007; Steele, Yan & Wang, 2013; Wadsworth, Krahe & Searing, 2019).

In other cases, lack of knowledge may occur out of honest absence of information due to gaps in research, itself an expression of systemic paternalism (McLeod & Sherwin, 2000). A clear example of this is the widespread gender bias in large scale clinical trials (Weber, 1994). This context reinforces the message that women's experiences do not matter, and that instead of using knowledge to inform their choices, women should continue to defer their autonomy to healthcare providers (McLeod & Sherwin, 2000). As a result, young women often prefer female healthcare providers, believing the healthcare provider's personal knowledge of their life experience as a woman would provide greater understanding and respect towards female
patients, making a trusting relationship more likely. This is noted in Andrea’s and Claire’s narrative threads of feminine, nurturing protection and positive female relationships, respectively. Claire expressed that "My GP will know what I'm going through in general: she herself probably had a pap smear!". Claire's healthcare provider indeed treated her with respect, and so Claire was able to trust her. But when Andrea's trust in her female healthcare provider was broken, "it didn't seem like she was much of a person", but a "robot". It appears that gender of the healthcare provider does not guarantee young women will have a trusting relationship with them. Medical paternalism can be enacted by women, too. What matters more than gender is the transformation of a healthcare provider's knowledge of their personal life experience into active empathy in their therapeutic relationships with young women.

After a "dehumanizing" healthcare experience, where personhood is dismissed, as it was for Andrea, women cannot easily change their belief in the trustworthiness of others, especially their healthcare providers (Alexander, 2001; Henry, Ekeroma & Filoche, 2020; Johnson, Harwood & Nguyen, 2015). The dismissal Andrea experienced from her healthcare provider informed her ability to trust herself to find a way out of the "oppressive system" she portrayed with her metaphor reflection, Gray, where she felt she was stuck walking in endless circles.

When Claire shares her experience of dyspareunia with her healthcare provider, the opposite occurs: "She didn't make me feel like I was over-reacting; rather that I knew my own body and I was not making it up". There was a palpable sense of relief in Claire’s words of just being believed, which informed her sense of being able to rely on healthcare providers in the future. Without trustworthy healthcare providers, many women must advocate for themselves during vulnerable therapeutic situations (Alexander, 2001; Henry, Ekeroma & Filoche, 2020; Johnson, Harwood & Nguyen, 2015).
McLeod and Sherwin (2000) argue that in order to self-advocate for autonomy, women must develop self-trust. This is done through women's social environments, which allow the opportunity to build decision-making skills and be supported and encouraged by others (McLeod & Sherwin, 2000). I recall how Claire consulted with her sisters for encouragement and support prior to her first pelvic exam, and how this informed her understanding of trust to be a form of positive female relationships, inclusive of her physician. Women need to trust their capacity to choose effectively, their ability to act on decisions made, and trust the judgements that underlie their choices (McLeod & Sherwin, 2000). This was also evident in Celeste's story as she sought out her first pelvic exam based on her informed choice of contraception.

McLeod and Sherwin (2000) go on to state that paternalism deprives young women of the opportunity to develop skills in autonomy, informing their sense of self-worth, self-trust, and their own decision-making capacity. From my professional experience and from scholarly literature, healthcare providers are strongly encouraged to foster women's capacity for autonomy during pelvic exams by not practicing relational paternalism, as this experience impacts their very sense of personhood (McLeod & Sherwin, 2000). Yet, Andrea's vivid description of being "a nameless, faceless person in this revolving door of a system" suggests otherwise.

Place of Trust: Comfort and Safety

Florence Nightingale was one of the first to identify the importance of the place of healing (Zborowsky & Kreitzer, 2009). Her focus on nature, location and building design fit into modern understandings of architecture, design, safety, ergonomics and human factor science (Zborowsky & Kreitzer, 2009). Current design researchers have shown that well-designed physical spaces support a sense of safety and healing (Ulrich et al., 2008). Thus, the setting of first pelvic exams likewise informs a young women's sense of comfort and safety, and her ability
to trust healthcare providers. In this section, I examine the environments that support young women's trust in healthcare providers during first pelvic exams.

Celeste’s first pelvic exam occurred in a hospital outpatient clinic. She expressed "huge relief" that she was "at the front of the hospital", explaining her personal dislike of hospital environments. One literature review hospital design (Ulrich et al., 2008) examined the impact of noise, lighting, nature, art, layout, and ventilation on various outcomes. Specific to patient experience, studies found that exposure to loud, unpredictable noise, and insufficient lighting caused healthcare providers to be distracted, which was connected to increased risk for medical errors (Ulrich et al., 2008). An increased risk of errors, coupled with disruptive noises, informs a patient's sense of safety, and thus their ability to trust in their healthcare providers.

After checking in to her appointment, Celeste is led down "multiple hallways" to a "giant triage room with a few beds behind curtains". Triage rooms are usually quite sterile, with bare white walls and equipment on display (Rito et al., 2016). Rito and colleagues observed patients became visibly upset when they entered these rooms. Celeste's sense of vulnerability in the space is perceptible as she describes covering herself with "crunchy dentist bib material" while her team of providers wait behind the curtain.

In their quasi-experimental study, Rito and colleagues (2016) painted the walls of a procedure room lavender and green, displayed artistic representations of nature, placed artificial plants, light diffusers with images and played relaxing music. Researchers found patient anxiety was much lower when they were treated in the renovated room. The researchers emphasize that renovations need to focus on places where patients are the most vulnerable (Rito et al., 2016).

Despite the lack of these interventions, Celeste felt safe to trust her healthcare providers in her setting. Celeste described her pelvic exam experience as positive, drawing Happy
(satisfied) Emoji to represent her experience. Even so, after her exam, Celeste still "wanted to get out of there" and described her exit from the disorienting "maze", suggesting a feeling of being set free. Given the literature on hospital settings, I realize how deeply Celeste's comfort in her experience was influenced by the aesthetic of her environment.

Most young women, like Andrea and Claire, have their first pelvic exam in outpatient primary care settings. Research on primary care spaces is still emergent (Alexander, 2001; Lasslo, 2019; Rice, Ingram & Mizan, 2008). However, women in Alexander's dissertation shared that their trust in their primary care provider started in the parking lot, "you walk into the place right past all their fancy dancy cars, it really tells you what is important" (2001, p.107).

Claire did not expect to be comfortable in "the small reception area" of her clinic, and felt that she was "inconveniencing" the receptionist by checking in. These observations imply that Claire sensed her comfort was not a priority in this space. This is echoed in the literature, as other women recommended comfortable chairs, reading materials, and painted walls in the waiting room (Alexander, 2001). Despite this perception, Claire was "glad" when she was seen by her healthcare provider on time. Other women agree this is a sign of respect (Alexander, 2001). Claire's experience suggests that an uncomfortable waiting room experience does not preclude a women's sense of trust when they are treated with respect by healthcare providers.

Both Andrea and Claire described their exam rooms as small, and both had painful experiences. Claire, on the other hand mentioned sitting by a window in the exam room. To understand this, I look to the study by Ulrich (1984), which placed matched post-surgical patients in identical hospital rooms, one with a large window overlooking nature, the other without. The patients placed in the room with a view had better outcomes and required far fewer
pain medications. In light of this evidence, I recognize that Andrea’s and Claire's experiences of pain may have been informed by the presence (or lack) of a window.

While lying on the exam table, Andrea described facing the ceiling lights, feeling "very exposed.” Her description of the lights suggests a sense of vulnerability under the healthcare provider's gaze in a sterile, utilitarian room. Other women in the literature have recommended the use of less harsh lighting to improve pelvic exam experiences (Lasslo, 2019). Thus, exam room lighting also informs a woman's sense of emotional safety during pelvic exams.

In her story, Claire commented that she "gazed at the ceiling tiles" during her exam, perhaps searching for a distraction to augment her painful experience. Art can be a source of visual distraction from pain. Art featuring representational images of nature were generally the most preferred by patients, with abstract art being the least preferred (Ulrich et al., 2008). Further, the more immersive the art, the better for patients' pain management and distraction. Studies cited by Ulrich and colleagues (2018) show that images projected onto ceilings with relaxing audio accompaniment improved patient's comfort during colonoscopies (Lee et al., 2004), bronchoscopies (Diette et al., 2003), gastric procedures (Kozarek et al., 1997) and chemotherapy (Schneider et al., 2004). It stands to reason that such an immersive display would also serve to improve women’s comfort during first pelvic exams. However, in this inquiry none of the co-participants mentioned art in the place of their first pelvic exam. This could be considered a missed opportunity to enhance women's sense of safety and trust during their pelvic exams.

Women's experiences of the physical space inform their interpretation of how healthcare providers respect their comfort and safety. These observations directly inform how women anticipate they can trust their healthcare providers. However, Andrea's sole empathetic encounter
was from the receptionist, after she left the exam room. Andrea evokes the image of "a bright sunny day" to describe this interaction, suggesting that to be respected enough to be seen is more important than the quality of the place.

Listening to women's experiences can inform the environment of care, where implicit values are creatively supported. A setting that is comfortable, both emotionally and physically, allows trust to flourish in therapeutic relationships (Coles et al., 2015). Therapeutic environment (as explicated by nursing codes) includes the physical, emotional, spiritual and mental environment, as well as other patterns, which are yet unknown (Zborowsky & Kreitzer, 2009). Women experience their first pelvic exam in a state of vulnerability. Physical place can augment or emphasize this. Either is a choice made by healthcare providers, in a reflection of their inherent values and beliefs about women, and how these are enacted within the therapeutic relationship.

**Reflecting on the Narrative Pattern of Trust**

The understanding of trust between women and healthcare providers has evolved over history, laden by the context of male dominance and violence against women. It is not until relatively recently that genuine trust and informed consent have come to hold the focus it now does. Even still, a culture of trust and consent in healthcare is still in its infancy. The historical context of medical paternalism and nurses' enforcement of obedience to patriarchy (hegemony) is sadly still alive today. Centuries of healthcare providers practicing by ethical codes that do not mention trust within therapeutic relationships, leaves young women on their own.

Claire herself acknowledged that "pap smears are definitely situations that can easily be traumatizing". This is especially true when pelvic exams are conducted without respect and building of trust (Cadman et al., 2012; Hinden et al., 2015; Martino et al., 2005; Wadsworth, Krahe & Searing, 2019). For some women, pelvic exams are reminders of past sexual assault or
violence that they may have experienced. Therefore, in addition to knowing a woman’s personal history, to further support a positive first pelvic exam experience and build trust, healthcare providers may offer guided mindful practices, deep breathing exercises, grounding and centering during pelvic exams (Clark et al., 2015; Dole, 1996).

I recall how pelvic exams were avoided by healthcare professionals before the advent of the speculum, and the modern use of chaperones to avoid litigation. I reflect that all these interventions centre the comfort of the healthcare provider, instead of the young women in their care. One male medical student's observation in a Canadian peer-reviewed journal states "please hear out the guy on the other side of the speculum—I detest this procedure more than you do" (Thoma, 2009, p.1112), missing the point of the power held by the healthcare professional, and the vulnerable position of the patient. Despite the progress made to respect the dignity of women, clearly some healthcare providers remain blind to the humanity and the ethics of their professional role.

In fact, none of the above interventions and observations focus on building trust and supporting women to improve their experiences of the pelvic exam. They are simply work arounds to attain women's compliance and cling to power, and to release themselves of accountability, as is the case with the young medical student.

As I reflect on the notion of trust within therapeutic relationships, I recall a recent personal experience that took place in an interprofessional setting. I was talking about my thesis. As I shared my inquiry puzzle, an older white male physician interrupted to inform me of his
perception that lately women are more sensitive than ever before, and so he was not sure how to provide pelvic exams. Silence ensued, and I offered my observations on possible ways of building trust within therapeutic relationships with young women.

I struggled with frustration as I interpreted his comment. I tried to communicate that viewing patients as partners in care allows for a balance of power and control within the relationship, supporting the notion of dignity. He closed his eyes and shrugged. The conversation moved on.

Looking back, I recognize that, regretfully, his perception is not uncommon, even in the twenty-first century. However, such comments still indicate an interest in positive change. In this moment, my colleague opened space for a critical, meaningful reflection on the nature of trust. I think of the Leonard Cohen lyrics "There is a crack in everything. That's how the light gets in" (1992). In this moment, my colleague showed a crack in his beliefs and perceptions. I hope I was able to direct some light into it.

Closely related to trust is the narrative pattern voice. Next, I examine voice in the context of therapeutic relationships, specifically young women’s experiences of first pelvic exams.
Voice

As stated in Chapter Five, I define voice as honest verbal or non-verbal expression of one's experience. Voice emerged as a narrative pattern in the stories of experience, being informed by the early emergent narrative patterns of objectification, resignation and gaze. To understand how women experience voice in their first pelvic exams, I continue to use Critical Feminist Theory along the commonplaces of Narrative Inquiry (Clandinin & Connelly, 2006). Andrea engaged mostly with her non-verbal or inner voice during her experience. When her healthcare provider's actions reminded Andrea of past negative sexual experiences, she wished the healthcare provider would "read my body". The dismissal of Andrea's voice led Andrea to feel that, in the eyes of her healthcare provider, she "was not a person", but "a vaginal area". This interpretation reinforced Andrea's understanding of a paternalistic healthcare system and disrupted her sense of trust in feminine, protective energy.

Celeste's exchanges with her healthcare providers helped her to face discomfort during her pelvic exam. Celeste's use of voice, informed by her unequivocal trust in healthcare providers, seems to have helped her to build resilience through experience. Claire relied on positive female relationships to ensure her voice was heard and she was able to experience power and control in her hands. The "background noise" of Claire's healthcare provider's voice allowed Claire to embrace the duality of experience and have a positive experience despite the pain. Even still, after the exam, Claire denied having discomfort to her healthcare provider.

Reflecting on the narrative threads and narrative patterns, I recognize that young women sometimes expressed resignation to objectification of the medical gaze (Foucault, 1973) with silence. In order to capture this communication, I come to understand that both silence and body language are included within the narrative pattern of voice. I also note that creative self-
expression, in which the three co-participants engaged, is another form of voice. It is for this reason that I offer my arts-informed perspective alongside the Critical Feminist Theory and the Narrative Inquiry commonplaces.

To deepen my understanding, I again return to scholarly literature. Being a visual and kinesthetic learner, I create a concept map to synthesize the relevant findings I uncover as they pertain to voice.

**Figure Fourteen**

*Voice Concept Map, 2020.*

![Concept Map](image)


**Temporality of Voice: A History of Disregard**

In this section, I begin by examining women's use of voice backwards and forwards across roughly the last one hundred and fifty years. In the latter half of the nineteenth century, young women were expected to understate their discomfort and not disturb others (Loscar, 2018; Reckitt et al., 2019). In this way, young women were still expected to behave like children: "seen and not heard". The impact of this historical adage is apparent in modern day, when Claire perceived herself as an "inconvenience" to the receptionist at the clinic. In Gilman's *The Yellow*
Wall Paper, her "narrator" writes how her husband dismisses her concerns by calling her a "blessed little goose" (1899, p.12) and "little girl" (p.30). I think of how Andrea's healthcare provider referred to the abdominal palpation as a "belly rub", inviting Andrea to anticipate a motherly interaction. Instead, Andrea experienced paternalism from her healthcare provider. In either case, Andrea was seen as a child, instead of the adult woman she is. In this way, I come to understand that the context of infantilization is still very much alive during women's pelvic exam experiences.

In the nineteenth century, women were further told that talking about their experiences would be a waste of time, invite suspicion or disdain, and in certain company, even danger. Considering the comparative recency of witch hunts, women at the time knew that public opinion could shift against them, with severe consequences. It was in this context that women learned that given the risks, it was safer to be silent.

Regardless, women still found ways to express themselves. One such method was with creative self-expression. Art was touted as a quiet, solitary activity that did not disturb others (Reckitt et al., 2019), and women were encouraged to practice art as part of their portfolio of "feminine accomplishments" (Reckitt et al., 2019, p.16). Creative abilities were considered to be domestically valuable: embroidery, music and painting enriched the home. However, it was also through creative self-expression that many women expressed their experiences, desires and thoughts. When women's-only art schools began to open in Europe in the eighteen forties, women honed their craft to express themselves in new ways (Reckitt et al., 2019). Still, the male-dominated art world was critical of their work as irrelevant or frivolous (Reckitt et al., 2019).

Despite this, women continued to express themselves, and eventually, they began to use art to portray their experiences with healthcare. One such example is Frida Khalo's depiction of
her miscarriage at Detroit's Henry Ford Hospital (1932). Khalo used heavy symbolism to communicate her sense of vulnerability, loneliness and helplessness, as she sheds a single tear while laying naked in a pool of her own blood. Her use of industrial imagery and materials suggests a sense of objectification she may have experienced during her time in hospital. She is far away from her home in Mexico City, and the usual vibrant colours of her work are muted by gray, brown and blue tones, indicating her sense of identity and culture were also dismissed in this experience.

**Figure Fifteen**

*Henry Ford Hospital, 1932.*

*Note:* by Frida Khalo, 1932, Dolores Olmedo Museum, Mexico City. Copyright by Khalo Estate.

Women have always found a way to share their experiences, and feminists of the twentieth century brought women together to do just that. A literary example of this emerged in nineteen seventy-three, when feminist activists and scholars published *Our Bodies, Ourselves*. The book was a reclamation of bodily knowledge alongside women's perceived need "to evaluate
the institutions that are supposed to meet our health needs – the hospitals, clinics, doctors, medical schools, nursing schools [...]. The experience of learning just how little control we had over our lives and bodies" (Boston Women's Health Book Collective, 1973, p.3). Through sharing their experiences, women exposed and reflected on the inherent sexist values and beliefs, which were still held by many healthcare providers all these decades later. However, as feminist scholar Carol Gilligan argued one decade later, women's voices were still not valued or sought out, and even actively excluded (1982).

Gilligan further emphasized that it was not enough just to simply hear women, but that the act of listening to women's experiences with respect invited the act of caring. In other words, listening to women is only made meaningful when the healthcare provider then demonstrates that they respect women's experiences by actively upholding their dignity, supporting and caring for women (Alexander, 2001; Loscar, 2018; Perry et al., 2015; Reeves, 2018). When Claire communicated her symptoms of dyspareunia, her healthcare provider listened to her, believed her, shared information and provided resources. Thus, as Gilligan predicted, the act of being actively cared for helped Claire to feel respected and to have power and control in her hands during her pelvic exam. Claire was treated as a whole person, not just "a vaginal area", as Andrea experienced the same procedure.

The modern era feminist movement has encouraged women to be increasingly vocal about their experiences, and compassionate people are starting to listen with respect and action. As demonstrated by the #metoo movement, women's experiences are increasingly being respected, and used to hold people to account. Despite this progress, when women speak up, others still threaten their credibility, welfare, personal safety, emotional wellbeing, and their very right to speak of their experiences. Furthermore, when a public figure is exonerated for violence
against women, other women fear that their own experiences will not be considered credible, even to healthcare providers (Reeves, 2018).

In their relationships with healthcare providers, women fear being judged, blamed, facing prejudice or even violence (Alexander, 2001; Clark et al., 2015; Reeves, 2018). This indicates that public events and trials also inform women's experiences of voice during their pelvic exams. This may explain why, even with an empathetic healthcare provider, Claire expressed relief when she was believed without further inquisition.

Today, women continue to use art to communicate their experiences, including those of pelvic exams. A recent exhibition at Arizona State University, *10 Artists, 2000 Speculums* (2018) presents the works of ten artists as they share their experiences with pelvic exams, focusing on the speculum. One artist, Cydnei Mallory, created an interpretive sculpture to honour Anarcha Wescott, Betsey Harris, Lucy Zimmerman and other Black enslaved women for their part in the creation of the speculum (2018). Another artist, Jen Urso, asked women "what do you remember about your first gynecologic exam?", drawing their responses with pen and paper (2018). Such exhibitions seek to challenge the stigma women still feel when communicating their experiences, and these events invite audiences to listen.

Likewise, women in the literature also ask healthcare providers to take time to listen to women and explain pelvic exams procedure to them (Alexander, 2001; Chipiro-Mupepi, 2001). As soon as Andrea entered the exam room, she "got the sense [her healthcare provider] was in a rush". Andrea's healthcare provider provided the rationale for the pelvic exam and then promptly asked Andrea to undress. Both expressions seem to indicate a rushed encounter, and Andrea immediately recognized the dehumanizing effects of this approach: "I am just a body, and this is part of her job". Such hurried therapeutic encounters, especially during first pelvic exams, further
communicate to the young women the value of their personhood, and thus a sense of safety within the healthcare system.

**Sociality of Voice: Respect in Relation**

Respectful communication is the cornerstone of therapeutic relationships. In this section, I examine Andrea’s, Celeste’s and Claire's experiences of voice within such relationships, with their respective healthcare providers, others, and themselves, as they relate to their first pelvic exam.

Celeste shared her contraception experience and consulted with her healthcare provider about it. Not only did her healthcare provider respectfully listen to her, but she provided the resource Celeste needed to access her choice in birth control. Furthermore, both Celeste and Claire's healthcare providers asked for their consent to enter the curtained area (Celeste) or to do the pelvic exam itself (Claire). In Andrea's story, she reflected on the absence of consent in her experience, noting that "as a doctor, she should know what consent is". Luckily, Andrea understood the importance of consent, and recognized its absence in her experience. However, Andrea's reflection leads me to realize that when a healthcare provider disregards a women's consent, this may inform a young woman's internal beliefs about the significance of consent (Reeves, 2018). Reflecting on this, I come to understand that women's experiences of consent during first pelvic exam experiences informs how they go on to anticipate autonomy in other relationships, including intimate partnerships.

A key part of listening to women is respecting what women say. During her pelvic exam, Andrea's expressions of pain were dismissed when her healthcare provider repeatedly told her "we have to keep going", while she "just carried on" with the procedure. Healthcare providers' widespread dismissal of women's pain is still problem in healthcare (Alexander, 2001; Loscar, 2018). Neglect of pain causes unnecessary agony for women (Loscar, 2018), insufficient
evaluation of symptoms (Alexander, 2001), resulting in women's sense of being dehumanized (Alexander, 2001), experiencing mistrust in healthcare providers (Hattori-Uchima, 2012; Chipiro-Mupepi, 2001; Reeves, 2018).

After her pelvic exam was over, Andrea again told her healthcare provider that she was in pain. Andrea was simply told to "take some Ibuprofen", which Andrea knew to be inadequate for the amount of pain she was feeling. From professional experience, I know that IUDs can be inserted incorrectly, and can perforate the uterus, causing severe pain. Without proper and timely interventions, such an event could cause significant damage. Instead of recognizing Andrea's pain as meaningful, the healthcare provider did not show concern, or act with empathy towards Andrea. This informed Andrea's sense of comfort and safety in this therapeutic relationship. Furthermore, Andrea's experience of being dismissed by her healthcare provider reinforced her perception that her personhood was not valued, and her voice was powerless to change that.

When women come to believe that their voice is not heard, after repeated attempts, they often decide to remain silent (Loscar, 2018). This was evident in Claire's story when she judged that her healthcare provider could not change the nature of the pelvic exam, so instead of talking about the pain she experienced, she decided to default to "politeness". I recognize that Claire's decision also connects to Celeste's expression "they've gotta open you up somehow" and Andrea's narrative thread, a paternalistic healthcare system.

Instead of perpetuating young women's sense of resignation, healthcare providers can empower young women by respectfully and empathetically explaining the pelvic exam procedure (Alexander, 2001; Leeners et al., 2007). While she was lying on the table, Andrea shared that her healthcare provider "wasn't telling me what she was going to do next". This caused Andrea to feel anxious and afraid that she "lost all control over what was happening" as
soon as the speculum was inserted. This compromised her feelings of safety. The literature shows that healthcare providers' explanations go a long way towards equalizing power in therapeutic relationships, and supporting women to feel safe (Alexander, 2001; Chipiro-Mupepi, 2001; Hattori-Uchima, 2012; Reeves, 2018).

Andrea's experience stands in stark contrast to Celeste's healthcare providers, who "introduced themselves and explained the procedure". In response, Celeste "assumed they knew what they were doing", expressing her unequivocal trust in healthcare providers. The healthcare providers continued to explain the procedure throughout her pelvic exam, and Celeste went on to reflect that her healthcare providers were "welcoming and approachable". Celeste further embodied this perception in her metaphoric image of a bright yellow Happy (satisfied) Emoji. Similarly, Claire's healthcare provider explained the pelvic exam procedure before and during her pelvic exam, supporting her to have power and control in her hands. Claire said, "it was nice to be explained what she was doing to my body in language I could understand". Together, the co-participants' experiences indicate that clear, consistent communication allows young women to feel welcome and safe to express themselves during their pelvic exams.

Such communication from healthcare provider's also supports young women to manage pain and discomfort during pelvic exams. Celeste said her team "distracted me with conversation and reassured me". Likewise, during her pelvic exam, Claire shared that she "liked the background noise of her [healthcare provider] talking. Silence would have only increased my anxiety". Unfortunately, Claire's statement seemed to be true for Andrea. When Andrea tried to distract herself from her pain during the pelvic exam by starting a conversation with her healthcare provider, she stated that her healthcare provider "didn't engage. She didn't really care". The healthcare provider's silence throughout Andrea's pelvic exam exacerbated her feelings of
being dehumanized, increasing her anxiety about future healthcare interactions. This leads me to understand that a healthcare provider's silence during pelvic exams can inform a young woman's sense of self-worth, dignity and even pain (Reeves, 2018).

Beyond healthcare providers, many other women (Alexander, 2001), like Andrea and Claire seek the reassurance of peers before their pelvic exam. Andrea's friends told her "don't go, it's painful", and so she was rightfully hesitant to attend the appointments booked for her. Likewise, Claire's sisters told her that pelvic exams are "generally uncomfortable" but would likely be worse for her. Together, Andrea’s and Claire's stories suggest that young women's conversations with female peers inform their expectations and self-talk during first pelvic exams.

Women are willing to accept that pelvic exams are uncomfortable, and can be painful (Alexander, 2001). As Celeste put it, "they've gotta open you up somehow". After her painful pelvic exam experience, Claire said that her healthcare provider "couldn't change" that her pelvic exam was going to be painful. Therefore, when Claire reflected that her healthcare provider tried her best, she felt cared for. Claire related this to being soothed by her pet, in her metaphoric depiction, *Cats make everything better*, saying "even if he can't change the fact that I'm in discomfort [...] he does what he can to make me feel better". When healthcare providers actively empathize with women during their pelvic exam experiences, they are made to feel valued and respected. This allows the first pelvic exam experience, as awkward or painful as it may inherently be, to still be a positive one. Thus, I come to understand that it is not pain that makes a pelvic exam experience negative – it's the absence of respect.

When women recognize that their personhood is not respected by healthcare providers, women respond with anger and indignation (Alexander, 2001; Reeves, 2018). When Andrea reflected on her experience, she said "I understand you're seeing a hundred patients a day, but at
the same time, take into consideration that I'm a person”. This suggests that although Andrea could imagine the context of her healthcare provider's behaviour, she could not condone it. Other women in the literature pray for healthcare providers to increase their self knowledge and support women's autonomy, saying they don't want to perpetuate disrespect (Alexander, 2001). These reflections lead me to acknowledge that some women try to make sense of dismissive pelvic exam experiences by seeing the experience from the healthcare provider’s perspective. In this way, their own empathy and understanding of personhood, deepens their personal values of respect for the dignity of self and of others.

As Andrea herself acknowledged, the context of a dismissive experience is not an excuse to treat women with disrespect. Experiences of being dismissed by healthcare providers cause women to feel isolated (Reeves, 2018). This is true for Andrea. She felt "intense loneliness" after her first pelvic exam, stating that afterwards she "didn't really have anyone to talk to about how it went, or how I was feeling". Celeste, who had a respectful encounter, was able to "return to regular life", and shared a casual social dinner after her first pelvic exam. This leads me to appreciate that respectful experiences of first pelvic exams also inform young women's sense of connection in social relationships.

**Place of Voice: Safety and Privacy**

Finally, as women's voices are understood over time and through relationships, voice is also understood in relation to physical and technological space. In this section, I investigate places of first pelvic exams to understand the influence on voice.

For many women, their experience of voice with pelvic exams begins when they book the appointment (Alexander, 2001). Andrea's healthcare provider made a number of pap test appointments, which Andrea repeatedly cancelled. It was not until Andrea wanted an IUD that
she was willing to undergo a pelvic exam. Andrea was not sure what to expect but decided to attend the appointment in order to avoid a two-hundred-dollar cancellation fee. The pressure of booking her pelvic exam left Andrea feeling resigned, saying that "the whole thing was someone else's priority that needed to be done". Andrea’s experience suggests that women's autonomy during a first pelvic exam is often informed by clinic policy and booking procedures.

Claire described the dread she felt to use the telephone to book her appointment but was able to overcome this discomfort in order to access care. Claire is certainly not alone in feeling avoidant of phone conversations. Yet, as noted in Chapter Four, research on the impact of this on young women's access to care is not apparent in the literature. From professional experience, I know that the use of online booking or short message service (SMS) makes it easier for young women to book appointments or communicate with their healthcare providers. Although none of the co-participants mentioned such a service, this could be considered a missed opportunity for the healthcare system to make it easier for young women to book their pelvic exams.

I appreciate the amount of effort that Andrea went through to cancel her many prior appointments. For Claire, the phone call was yet another thing she had to motivate herself to do. The booking procedures in each clinic seemed to inform both Andrea's and Claire's initial sense of comfort about their pelvic exam. Thus, I come to understand that telephone-only booking practices impact young women's confidence and comfort in seeking out their first pelvic exam.

In terms of bio-physical space, voice starts in the mind as a thought, and emerges from the mouth, in concert with the vocal cords, breath and diaphragm. When Andrea was first laying on the exam table, she said "lying facing the ceiling lights, I heard her voice". Andrea seemed to describe her healthcare provider's voice as disembodied. I observe that as young women listen to their healthcare provider's voice, they are able to discern if that healthcare provider is connected
with their own personhood in the moment. All Andrea asked in the end was for her healthcare provider to "just be a person, don't be a robot!", expressing how important the presence of her healthcare provider’s personhood was to her sense of respect and dignity.

When her healthcare provider inserted the speculum into Andrea's body, Andrea "zoned out" and "retreated" into her head. Such an act may be understood as the process of dissociation, which occurs as a defense mechanism when a person is overwhelmed by an unbearable situation. Dissociation compartmentalizes the event so "the whole psyche does not have to experience it in its entirety" (Clark et al., 2015, p.74). While zoned out, Andrea described moving to an internal place of safety within herself. I also note that she described how she "heard [herself] say “ow, ow, ow”, suggesting her own sense of disembodiment. In this state, a person may feel like they are in "slow motion" (Clark et al., 2015). Andrea said, "time slowed down to make me feel like this was going on and on and on". Thus, Andrea's sense of presence during the pelvic exam impacted not only her sense of time, but her overall experience of the therapeutic encounter.

Zoning out was a protective act for Andrea. Just as Celeste's unequivocal trust in healthcare providers allowed her to complete her first pelvic exam, Andrea's retreat to her mind allowed her to put an end to the pelvic exam more quickly, and with less perceived damage to her sense of safety. Despite its benefits, dissociation disrupts a person's sense of wholeness. Further, it may become an "ingrained" (Clark et al., 2015, p.75) response to similar experiences in the future. Andrea spoke to this, as she described "zoning out" when she returned to her clinic for future appointments.

Clark and colleagues (2015) state that "when an individual dissociates it is essential to help them reconnect to the present moment" (p.76). This supports the person to regulate their emotional state, regain control over the experience, and feel that they are safe. Andrea's
healthcare provider did not even recognize that Andrea was no longer fully present. This informed Andrea's feeling that she was being "let down – again!", calling back to past negative sexual experiences. These observations lead me to understand that healthcare providers' mental and emotional presence during first pelvic exams informs young women's sense of mental and emotional presence in their bodies both in the present and in the future therapeutic encounters. Andrea's internal voice defends her body throughout her pelvic exam experience, until by the end, all she could think was "Please stop touching me!". Andrea's connection between mind and body in her pelvic exam experience informs my understanding that bodily respect is essential to help the patient maintain their voice and a sense of safety. Without this, women may retreat to an internal place of safety: the mind.

Each co-participant engaged in active internal dialogue with themselves during their first pelvic exam. In the stories, and as noted in Chapter Five, I observed that each co-participant expressed resignation in order to undergo their first pelvic exam. Other women in the literature describe summoning courage to seek healthcare services (Alexander, 2001). In lieu of accurate information from her healthcare provider, Andrea told herself her pelvic exam would be "an external exam at the most" and thus kept her appointment to avoid the cancellation fee. While on the exam table, Celeste told herself "I have to get this done", reminding herself that she does not want to get pregnant. Claire accepted that her pelvic exam would likely be painful, and reassured herself that her healthcare provider, as a woman herself, would understand her. These observations indicate that young women engage in self-talk to express resignation, to convince themselves of the necessity of pelvic exams, and to reassure themselves of their safety in the care of their healthcare providers within the healthcare examination rooms.
The physical space exterior to the body informs voice as well. Private spaces allow women to feel safe to express themselves (Alexander, 2001). Celeste was not "overly thrilled" with hospitals and felt "huge relief" when she learned that the clinic she was referred to was "at the front of the hospital". As previously mentioned, she had her first pelvic exam in a large triage room "with a few beds behind curtains". Triage rooms usually have hard-surface flooring, creating an acoustic space. I note that I am not sure if those beds were empty, or if people were in them. Certainly, if the curtains were drawn, Celeste herself would not have known.

Research has shown that use of curtains instead of walls impairs auditory privacy for patients (Ulrich et al., 2008). This lack of privacy has significant consequences. For example, curtains have stopped women from disclosing domestic violence to their healthcare providers (Reeves, 2018). I can recall from my own professional experience the efforts that patients would take to silence me at their bedside, pointing to the curtain to imply their awareness of the person on the other side.

I note that in Celeste's experience, she mostly described the voices of her healthcare providers. Except for her "yes", expressing her consent for them to come to her side of the curtain, she otherwise did not mention vocalizing aloud during her experience. Her voice was mostly internal, in private thoughts. By examining the physical place of her experience, I come to understand that perhaps Celeste did not feel completely assured of her privacy. I wonder if she had been in a walled room, how her use of voice might have changed.

To investigate the influence of walls and curtains on a first pelvic exam experience, I again look to Andrea's story. Her first pelvic exam occurred in a small, walled room with a curtain. When given the opportunity to provide Andrea the assuring privacy of walls as she undressed, Andrea's healthcare provider opted for a half-drawn curtain, while herself remaining
in the room. These observations lead me to conclude that the reason this curtain was installed at all was for the benefit of saving time for the healthcare provider and not the privacy of the patient.

Given that Andrea observed that her healthcare provider seemed to be "in a rush", this may be indicative of the culture of the practice overall. Unfortunately, this choice undermined Andrea's experience of being respected. In fact, it appears that Andrea did not perceive that the walls of her exam room protected her privacy. Instead, they protected that of the healthcare provider. Within these walls, Andrea was alone with a person who did not show her respect, and who disregarded her pain and her voice. Considered from this perspective, it makes sense that Andrea wanted to exclaim her pain out loud. Perhaps the kind receptionist in the waiting room heard her and was moved to show compassion towards Andrea afterward the procedure.

**Reflecting on the Narrative Pattern of Voice**

I note that voice is an expression of one's self. Voice and personhood are inextricable. In demonstration of how far we have yet to come as a society, many women are still made to feel that their voice is not valued, respected, and not acted upon. Women are still told to prioritize the comfort of others at the expense of their own comfort and dignity.

With this in mind, many women in therapeutic relationships seemingly voluntarily remain silent through hegemony, which facilitates women's continued experience of being powered over by others. Yet even in silence, voice exists as thoughts and body language, and creative self-expression. Therefore, one cannot "give" voice any more than one can "give" personhood. Likewise, there are no "voiceless" persons, only those who do not listen.
In order to hear women's voices, healthcare providers must slow down and listen. Healthcare providers must then demonstrate that they respect women through their actions. When women are respected as persons with dignity, their voices are empowered. Furthermore, engaging respectfully with women also allows healthcare providers to respect themselves as whole persons. The knowledge of Andrea’s, Celeste’s and Claire's experiences is just the beginning of what can be learned by respectfully listening, honouring and upholding women's voices.

**Reflecting on Narrative Patterns Trust and Voice Together**

When I look back at the stories of Andrea, Celeste and Claire, I consider how their experiences are reflected in the narrative patterns trust and voice, which are closely entwined and mutually informing. In a moment of pause, I step back and look at the narrative patterns from a larger perspective.

When I reflect on trust and voice overall, I now understand how trust grows from a foundation of respect, and from which emerges voice. Without respect, genuine trust cannot grow, and thus voice suffers. I recognize that without respect, obedience, or blind trust may develop. This form of trust negates the necessity for thought and self-agency, and it silences voice. As I reflect further, I realize how dangerous this can be. Women rely on their internal voice to help them make sense of their experiences, judge the safety of their surroundings and feel like a whole person. Andrea felt a disconnect from her healthcare provider, yet she never
stopped talking to herself to make sense of what was happening and to validate her right to be seen as a person. I feel myself cheering Andrea on for her inner strength and resolve.

Even in the context of respect and the growing, genuine trust of the healthcare providers, it can be difficult for young women to exercise their voice. Claire was seen and respected as a whole person, but in the end, she still silenced herself when she and her healthcare provider together seemed to acknowledge that "it is what it is". In that moment, I mark the source of women's silencing: paternalism.

Women sense that they are not safe in the presence of paternalism. To protect their safety, women move their voices from physical, external spaces, to internal spaces, to their minds, and eventually to a vanishing point beyond my current understanding. Given what I have learned, I see that women are right to move their voices to protected places, until they feel safe to bring them forth. Outward silence is how many women are able to survive until they can speak their truth.

When I think about what healthcare providers can do to help support trust and voice, I recognize that it's a violation of personhood to simply ask women to speak up in unsafe situations. Instead, healthcare providers need to enrich the environment of care with respect, so that women can feel comfortable enough to allow themselves to speak. Environment is informed by physical space, yet it is much more than that. The trusting relationship, based on genuine respect, is the place where women's voices can thrive.

As I wrote this chapter, I sometimes thought to myself with exasperation, *None of this is new information!* Then I realized that I felt this way because most women, including myself, already innately know how they experience respect during their pelvic exams, as embodied by trust and voice. Women share this knowledge with their friends and sisters, as Andrea and Claire
demonstrated. Women have been doing this for generations to protect themselves and each other. This leads me to reflect that people themselves are sources of knowledge, as expressed through their experiences.

Narrative inquirers draw knowledge and meaning out of experience and bring it to light for further examination and deeper understanding. I recognize that the commonplaces of Narrative Inquiry have been extremely helpful for examining these experiences. I would not have been able to identify all these patterns of experience without this theoretical framework. Nor would I have been able to recognize paternalism and the context of women's experiences so thoroughly without the Critical Feminist Theory perspective. I consider myself fortunate that I have had the opportunity to learn about these theories and take the time to engage in this inquiry. In so doing, I have been able to more deeply understand the embodied knowledge that young women carry within them.

**Looking Back, Looking Forward**

I pause and feel my breath in my own body. I think about how the voices in this inquiry will go on to inform new experiences in new spaces. By the use of my voice, how can I invite others to listen to the voices of Andrea, Celeste and Claire?

In the next chapter, I look to new spaces beyond healthcare as I examine the *social justification* of this analysis process. In a space of reflection, I ask myself: "So what?" and "Who cares?". These prompts may seem blunt, but the responses are seemingly limitless. I invite you to join me as we consider the possibilities borne out of these young women’s stories.
Chapter Seven: Social Justification

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.
(Margaret Mead)

In this chapter, I explicate the possible implications of this inquiry for society at large. I answer the questions "So what?" and "Who cares?" about women's experiences of their first pelvic exams. I structure these implications in terms of their relevance to practice, education, and research from an interprofessional perspective for all healthcare providers. As we move through this chapter, I invite you, dear reader, to consider how women's first pelvic exam experiences may matter to you as a person and/or in your professional practice.

Implications for Interprofessional Healthcare Practice

I was drawn to this inquiry puzzle through my clinical practice as a Registered Nurse in primary care. Thus, I believe the implications of this inquiry are visible in primary care practice, and in other places where pelvic exams occur, especially with young women.

This inquiry attends to the importance of autonomy in women's access to care. This begins with giving young women options to book their own appointments using online or SMS services, instead of doing it for them or expecting them to use the telephone. This inquiry also demonstrates the importance of not imposing hefty cancellation fees as a punitive measure, preventing women’s autonomy. Seeing patients on time, whenever possible, communicates respect for their personhood.

Through this inquiry, I came to appreciate the significance of the clinic space, particularly the examination room. Features such as windows, painted walls, soft lighting, "domestic style" furniture, art featuring representational images of nature and projected light displays on ceilings are supportive to women's sense of comfort and safety.
Reflecting on the told stories, I have come to recognize the significance of taking the time to listen to female patients with empathy and respect, hearing their stories and believing them. Furthermore, asking patients about possible history of trauma using non-judgemental language is essential, especially prior to pelvic exams. Women are supported by explanations of the procedure, both before and during the pelvic exam. Additionally, healthcare providers need to be fully present with their patients, so that if women become emotionally “zoned out” during a pelvic exam, they can appropriately support them to become grounded again. This could be done respectfully with empathy, offering guidance on mindful breathing and guided imagery, for example.

This inquiry reveals how, unfortunately, women's personhood in the twenty-first century is still dismissed by many healthcare providers. This can be avoided by listening to women's experiences, acknowledging their pain, and respecting their privacy. Most of all, as this inquiry demonstrates, healthcare providers must attentively listen to their patients, believe them and act with respect in the therapeutic relationships.

As the literature review and analysis in this inquiry demonstrates, many healthcare providers and other members of the team still require a deeper understanding of how to enact respect in therapeutic relationships, especially towards women. Creative reflective practice is one such valuable resource to support this effort, as the approach supports an individual to access and reflect on their personal and professional values and beliefs, developing personal and aesthetic knowledge (Chinn & Kramer, 2018).

Facilitated experiential workshops can guide healthcare teams in creative reflective practice. Such workshops provide active learning through experiential mindful practice that include mindful self-compassion, metaphor reflection and creative self-expression (Schwind,
2008, 2016, Schwind & Manankil-Rankin, 2020). Such workshops should be routinely offered in practice settings, on paid time, and inclusive of all members of the team, including administration. Some healthcare providers may require theoretical background on these concepts, based on current research. These should be provided through asynchronous online workshops to support flexibility and accessibility to such offerings.

Such an inclusive approach would sustain widespread reflection on values and beliefs in healthcare practice, strengthening an interdisciplinary understanding of therapeutic relationships, compassion, empathy and respect for persons more broadly. The knowledge gained from these creative reflective workshops should then be integrated into organizational norms so that the knowledge can be meaningfully enacted in everyday practice. Integration of empathy and respect, as developed through experiential creative reflection, would further empower healthcare providers to support patients during vulnerable medical procedures, like pelvic exams. Furthermore, the knowledge of such resources for self-compassion may encourage healthcare providers to recommend similarly supportive community resources for patients.

In terms of practice, it is important to acknowledge that healthcare policies also inform care experiences. Although three women’s stories of experience with their first pelvic exam may not alone change the existing policies, they are most certainly critical pieces of information to inform such processes. Hearing and acknowledging how women experience medical procedures from their perspectives, enriches the research that builds needed support for policy changes. In particular, this inquiry invites reflection on public health promotion of cervical cancer screening, personalized reminders, advertisements and education campaigns. How we choose and enact healthcare policies should be considered from the patient's perspective, and this inquiry offers an opportunity to do so.
Furthermore, this inquiry invites re-consideration of the impact of service incentive programs and fee-for-service payment models on women's autonomy, particularly in their pelvic exam experiences. Review of healthcare payment schedules may also deepen understanding of how respect, money and time are communicated in therapeutic relationships. Such a humanistic approach to healthcare practice and policy would ultimately support all persons to feel cared for in a safe and respectful environment.

The healthcare providers' attentiveness and commitment to the person in their care is essential to a dignified, respectful encounter. Reinforcing the importance of the relational space in practice would establish an intention of partnership between healthcare providers and patients. Such an intention would be supportive of person-centred care from an interprofessional perspective, in congruence with relational practice approach (Doane & Varcoe, 2007), person-centred care (McCormack & McCance, 2006) and narrative medicine (Charon, 2008).

**Implications for Interprofessional Healthcare Education**

This inquiry also informs healthcare education. Using narrative pedagogy (Bowles, 2016), the experiences presented in this inquiry may inform how students learn health assessment, particularly of women. Theoretical courses need to include research that encourages deeper understanding of women’s issues and perspectives, and especially the value of empathy, trust and voice, as well as the underlying concept that connects them all: respect. Furthermore, as in practice, this inquiry supports the integration of trauma-informed approaches, creative reflective practice such as metaphor reflection and creative self-expression, including mindful practices, into undergraduate healthcare education programs. These approaches would prepare future interprofessional healthcare providers to develop narrative competence in education, becoming empathetic and compassionate towards themselves and others.
This inquiry may also inform gynecologic skills courses offered as continued education opportunities for healthcare providers. Some existing programs use gynecologic teaching assistants, who use their own bodies as teaching tools for learners. The experiences presented in this inquiry may inform simulations of first pelvic exam experiences in such learning settings (MacGregor, 2019). Finally, this inquiry may offer information that supports the integration of mindful practices into educational programs for healthcare providers, to support their ability to stay present with their patients, develop their empathy and thus strengthen their therapeutic relationships even during times of stress.

**Implications for Interprofessional Healthcare Research**

As demonstrated in the literature review and through the told stories, further research is needed on women’s health issues. This inquiry identifies the context of white supremacy and eugenics in healthcare, and the need for more research on Black women's experiences of pelvic exams to bring this focus to light. Additionally, I recognize that transgender, non-binary and gender diverse persons also experience first pelvic exams. Their experiences are similarly underrepresented in research, and future research might further develop new understanding of the first pelvic exam experience from this perspective.

This inquiry also identifies the internal movement of voice, an emergent concept that would benefit from deeper understanding through further research. More research is needed to understand how women access healthcare services, and especially the young women, who seem to prefer text-based technology over the traditional telephone. Additionally, as demonstrated in the analysis, more research would shed light on the effect of the physical care environment on patient experience, particularly with regards to windows, walls, lighting, furniture, curtains and
art. And importantly, further research is required on how women’s experiences of pain are minimized or altogether dismissed by healthcare providers, even in this modern-day context.

This inquiry adds to the legacy of Critical Feminist Theory in nursing research (Ashley, 1975; Heide, 1973; Roberts, 1983), and adds to the growing body of research on the use of Arts-Informed Narrative Inquiry (Lindsay & Schwind, 2014) and Narrative Reflective Process (Schwind, 2008, 2016, Schwind & Manankil-Rankin, 2020) to develop emancipatory, aesthetic and personal patterns of knowing (Chinn & Kramer, 2018). I identify further theoretical resonance within nursing, through person-centred care (McCormack & McCance, 2006) and relational practice theoretical framework (Doane & Varcoe, 2007).

Engaging in this Narrative Inquiry has also ignited my own passion and interest as an emergent researcher. I hope to continue to develop aesthetic, personal and emancipatory knowledge on women’s healthcare experiences, in order to advance the quality of therapeutic relationships in the spirit of empathy and respect towards personhood. My future work may make use of creative reflective practices and participatory action research on healthcare providers’ values and beliefs in primary care. I further envision future research using grounded theory to develop a theoretical framework for developing therapeutic relationships, specifically with women. Through this inquiry, I recognize that I have identified my area of research interest in women’s health, specific to respectful therapeutic relationships.

**Beyond Healthcare**

Healthcare spaces are increasingly built and renovated with the patient experience in mind. This inquiry draws attention to the significance of windows, walls, lighting, furniture, curtains and art on a patient's sense of comfort and safety. Such implications may be particularly relevant to disciplines such as interior design, architecture, and industrial engineering.
Furthermore, as the health design discipline seeks to enhance person-centred healthcare, this inquiry may provide the narrative context, which can inform their relationships with patients in collaborative co-design sessions that aim to inform change. Further, this inquiry may be relevant to the biomedical engineering discipline, as novel instrumentation develops with an acknowledgement of the historical context of many medical instruments, and a shift towards a more compassionate approach to care.

This inquiry is relevant to women, feminists, activists, healthcare providers, policymakers, health designers, scientists, teachers, learners, politicians, civil servants, and ultimately, in fact, to all human beings. No matter our discipline, education, or identity, when we work "in the service of humanity", respectfully and empathetically listening to experience will always be relevant (personal communication, J. K. Schwind, May 4, 2019). In contemplating these linkages, I realize that the interdisciplinary implications of this inquiry are limited only by my current understanding.

**Looking Back, Looking Forward**

I pause and listen to the sounds outside my window. The street below buzzes with voices, and I think of all the people who have informed my inquiry. I think of all the voices that have yet to be heard, and in this, I recognize that my inquiry is never truly done. As long as I remain curious and listen to my voice and to that of others, I will always be moved to inquire.

Ahead in the next chapter, I return to Andrea's, Celeste's and Claire's experiences, and draw on my own voice to consider what I have learned and what message I can share with my healthcare provider colleagues. As I reconstruct the narrative of the told stories, I consider how best to re-present these experiences and invite reflection and action in healthcare spaces, in new
ways. Join me, dear reader, as we move into the final chapter of this inquiry: *re-presentation of narrative.*
Chapter Eight: Re-Presentation Narrative

Having deconstructed the told stories, examined them using scholarly research and literature, in this chapter, I reconstruct the stories with new understanding to create the narrative of three women’s experiences of their first pelvic exam. In this inquiry, I recognize how the use of yarn helped me to identify nine narrative threads, and six emergent narrative patterns, which further helped me recognize the two key narrative patterns: trust and voice (Chapter Five).

Throughout this inquiry journey, I knit a scarf with this same yarn, allowing my hands to be busy as my mind continues to reflect. As I knit, I enter the flow of the experience. My mind wanders to Andrea's, Celeste's and Claire's voices. I think about my own voice and feel a tightness in my throat. As a healthcare provider myself, I feel compelled to share what I have learned with my healthcare provider colleagues. I know silence is no longer an option.

A Letter to My Healthcare Provider Colleagues

Dear Colleagues,

It is now more than two hundred and twenty-five years since Mary Woolstonecraft first wrote of the vindication of women's rights. Despite incremental social change, current literature, as well as my own research demonstrate that healthcare providers are still not listening, believing, or respecting women when they speak about their experiences.

Early in my research, I discovered the disturbing history of the treatment of women during pelvic exams. I learned about Anarcha Wescott, Betsey Harris, Lucy Zimmerman and Henrietta Lacks. Our disciplines have enacted and have been complicit in violence in the name of white supremacy, eugenics, and paternalism. You, like me, may not be completely
surprised. This history, sadly, lives on through the speculum we use today in the name of healthcare science.

As part of my inquiry, I met three young women, who sat with me to tell me their stories of their first pelvic exam. They told me how they can tell when we are in a rush, when we are not mentally present, and when we are on autopilot. Worse still, they told me of the damage these actions have on their sense of safety, bringing up past experiences of trauma and causing further damage. I know we can do better.

As healthcare providers, we may see pelvic exams as a matter of routine, but it's not so for young women receiving these assessments. These young women told me how during first pelvic exam, they came to understand whether or not we respect them. They told me how this affects their ability to trust us, their ability to speak up and use their voices. Most importantly they told me that how we relate to them affects their very sense of personhood.

Their first pelvic exam experience affects not just their view of healthcare, but also their subsequent social relationships. By disrespecting them, we reinforce violence against them.

I understand what it feels like when pressures seem too much, and when we are challenged most to stay present with people in our care. We can use our voices to change this by advocating for respect and empathy for the people we care for.

I believe that we need to remember why we became healthcare providers in the first place. What were our values then? What are our values now? Look within, especially at what makes us uncomfortable. Where do we still harbour a desire for power over others?

You are not alone. We can learn together, using research and theoretical frameworks to structure our progress. We can engage in collaborative creative reflective practices, exploring our values and beliefs through conversations. We can develop our ability to stay empathetic in the present moment by engaging in regular mindful practices. There are many resources for us to do this work, if only we care enough to use them.

Ultimately, women are no longer waiting for change to arrive. As healthcare providers, we need to move with decisive action to break the cycle of violence against women. This begins first and foremost, within.
Young women expect us to protect them, and to keep them safe. This means to respect them, to hear them and to believe them. To do this, we have work together. It will be difficult, but we owe this to them, and to ourselves.

Respectfully,

Emma

**Looking Back, Looking Forward**

After sharing my voice, I reflect on how women in the literature described praying for healthcare providers to develop their self-knowledge. I am amazed that even in the face of violence and dismissal, they did not wish to perpetuate disrespect (Alexander, 2001). I recognized that in order to see the change I wish to achieve I must follow their example and not allow indignation to overtake my sense of empathy and compassion.

I continue to knit and look ahead to what lies ahead for me on this path of inquiry. I approach the final chapter of this inquiry journey with a sense of bittersweet joy. I have learned so much, yet there is so much still to do. Still, onwards!
Epilogue

*It took me quite a long time to develop a voice,*
*And now that I have it, I am not going to be silent.*
(Madeleine Albright)

I have written this thesis in the context of a global pandemic, and the isolation and uncertainty of a year unlike any other I have experienced. What I have learned through this process is that life can change quickly, without notice. The entire world ground to a halt by a single-cell organism. While the virus is a veritable threat to our lives, I cannot help but lament that society does not move as quickly to change violent systems of oppression. Instead, women have been left with incremental change over centuries, and expected to celebrate our achievements in a male-dominated world where we are still paid eighty-two cents for every man's dollar.

As I write this, Associate Justice of the American Supreme Court, and feminist icon Ruth Bader Ginsburg died. Her political stance on defending women's bodily autonomy in the highest court in America protected countless women against laws that would threaten women's autonomy. Her advocacy for women's equality and belief that "Women belong in all places where decisions are made" inspired modern feminists. We bought RBG pens and T-shirts, fiercely defending her personal strength as a guardian of our own vulnerability. Without her, the legal future for many women's bodily autonomy is unknown.

As we grieve the loss of this figure on a social level, I also anticipate the loss of a family matriarch, my grandmother. A deeply determined woman, she overcame childhood polio, and went on to start her own business with a partial university degree at the age of thirty. She travelled the world and shared her independence and determination, always encouraging me to
push myself to be my best. Her absence will mark a shift to the next generation of matriarchs in my family.

As I think of the younger women in my life, I reminisce of what I needed when I was their age. I needed help to understand that I always deserved respect, unconditionally. That trust did not mean obey, and I should develop beliefs and values for myself. With the support of key figures in my life, I am learning to use my voice more and more. I recognize this is what I can do for other young women.

I look back to the prologue and revisit my depiction of myself as an oyster at the bottom of the sea. At the outset of this inquiry I thought of myself as being safe there, in my oyster shell. But given what I have learned on this inquiry journey, I now understand there is no safer place for me than on the surface, sailing my own boat. Time has come for women to live in a society where respect and trusting relationships are the norm, and where we are free to express ourselves. In my role as a healthcare professional, who is also a woman, I must use my voice to advocate for women’s issues, especially within the healthcare system. I want to "be a good ancestor". Not only to family, but to the next generation of humanity.

I hope that with this thesis I have left a mark of reflection for what young women need from healthcare providers, and from the world. We are not just bodies, reproductive organs or objects for procedures. Women's trust and voice are essential to our liberation, to our personhood and to our survival as a species.

It is important to note that this work is only just beginning. This inquiry may end here, but the implications and my understanding of these experiences is ongoing and will continue to inform my work going forward. As I finish knitting my scarf, I come to understand the yarn to represent sisterhood, our ancestors, and the broader community of women. I reflect that we are
all connected together like the yarn. When we show disrespect, even unintentionally, to one another, we tear the yarn that unites us. But, when we act with respect to one another, we allow the yarn to stay whole, so that we may co-create something new. I know I will carry Andrea's, Celeste's, and Claire's experiences with me as I move forward in my career and life.

As I close this inquiry, the pandemic continues. Every morning, news alerts notify me of record-breaking case numbers. We are in the "second wave”. A term which would have been meaningless a year ago is now a part of my everyday vocabulary, and of billions of others on this planet. The threat is real but living with it has become less intense. I take precautions and prepare for the winter ahead. I am still uncertain about the future. Yet somehow, it feels different now. The waves of anxiety I once felt are farther apart, and more manageable.

I have come to see how uncertainty is a part of life, and in some ways, constant. I no longer think of myself as a closed oyster in the dark, as I did in the beginning of this inquiry. Rather I have come to the surface of the sea, in broad daylight, to navigate my own ship. I recognize that I have the freedom and awareness to know that I can navigate uncertainty. At the helm, I recognize in an empowered voice, the world is my oyster!
Figure Seventeen


Appendix A:

Advertisement

INVITATION TO RESEARCH PARTICIPANTS
Women’s Experiences of their First Pelvic Exam: An Arts-Informed Narrative Inquiry

☑ Are you a cis-gendered woman (assigned female gender at birth, presently identifying as a woman) between the ages of 21 – 35?
☑ Have you ever had a pelvic exam?
☑ Are you interested in sharing the story of your first pelvic exam experience for research purposes?

If you answered ‘yes’ to all the above questions, you are eligible to volunteer in this study.

Background
Pelvic exams are a common source of anxiety for women. They are often delayed and avoided. The first pelvic exam experience affects subsequent trust and access to health care. Unfortunately, research depicting a woman’s experience of her first pelvic exam from the woman’s perspective is limited.

If you choose to participate in this study, you will be invited to tell the story of your first pelvic exam and create a drawing to represent your experience.

Participation is confidential and will involve one private face-to-face meeting with me (max. 2 hours) at Ryerson University, followed by one phone call (max. 30 minutes). Both interviews will be audio-recorded. In appreciation of your time, you will receive a $25 Indigo gift card and reimbursement for your public transportation for the interview.

This study seeks three participants. If you are interested in participating in this study, or would like more information, please contact me, the primary researcher:
Emma MacGregor  emacgreg@ryerson.ca

This study is being conducted in partial requirements for my Master of Nursing degree. The supervisor of this thesis is Dr. Jasna Schwind. This research study has been reviewed and approved by the Ryerson University Research Ethics Board [2019-360].
Dear Potential Participant,

Thank you for expressing interest in this research study. My name is Emma MacGregor. I am a graduate student at Ryerson University in the Master of Nursing program.

This thesis study is titled: Women’s Experiences of their First Pelvic Exam: An Arts-Informed Narrative Inquiry.

This research is being done as part of my Master of Nursing degree requirement. My supervisor’s name is Dr. Jasna Schwind, at Ryerson University. The focus of this study is women's experiences of their first pelvic exam. To participate, you need to be a cis-gendered
woman (assigned female gender at birth, presently identifying as a woman), between the ages of 21-35, who has had a pelvic exam, and who is willing to talk about your first pelvic exam experience for research purposes. This study requires three participants.

Participating in the study is completely voluntary and confidential. Participation involves one face-to-face meeting (maximum 2 hours), followed by one phone call (maximum 30 minutes). Both interviews will be audio-recorded.

If you volunteer to participate, you will be invited to a private face-to-face meeting with me at a mutually convenient location, at Ryerson University. At this meeting, you will be invited to tell the story of your first pelvic exam and create a drawing. This interview will take up to two hours of your time. It will be audio-recorded and your metaphor drawing will be scanned. If you would like the original drawing returned to you, I will make a copy of the drawing at the end of our first interview and provide you with the original. In appreciation of your time, you will receive a $25 gift card to Indigo bookstore and reimbursement for your public transit travel to the face-to-face meeting.

Two weeks later, I will contact you by email with a scanned version of your metaphor drawing and an attachment of the story of your experience of your first pelvic exam. You will be invited to review the document for accuracy and offer any further comment (additions or deletions) on the story. Over email, we will arrange a time and date for our second meeting (to be conducted over the telephone) in the following week, where you will have an opportunity to provide feedback on the story of your experience.

The purpose of this telephone meeting is for you to verify whether or not I captured your story accurately. At this time you will have the opportunity to add any further information, if you
like, as well as remove any information you wish deleted. This brief telephone meeting will take a maximum of thirty minutes of your time.

The research has been reviewed and approved by the Ryerson University Research Ethics Board (file number 2019-360). To support your informed choice in potentially participating, I have attached here the consent form for you to review. If you are interested in more information about the study or would like to volunteer, please reply to this email.

Warm regards,

Emma MacGregor
CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Title: Women’s Experiences of their First Pelvic Exam: An Arts-Informed Narrative Inquiry

Principal Investigator: Emma MacGregor, RN, BScN, MN(c)
Master of Nursing Student
Ryerson University
Email: emacgreg@ryerson.ca

Thesis Supervisor: Dr. Jasna K. Schwind, RN, PhD
Associate Professor
Ryerson University
Tel: 416-979-5000 ext. 556321
Email: jschwind@ryerson.ca

Dear Potential Participant:

You are being asked to take part in a research study. This research study is being conducted by me, Emma MacGregor, as part of my Master of Nursing thesis degree requirement.

Please read the information provided in this form. This form contains details about the study, including risks and benefits, should you decide to participate.

Take as much time as you need to make your decision about participating in the study. Please ask me or my thesis supervisor (Dr. Schwind) to explain anything that you do not understand. Either I or my supervisor will answer all your questions before you decide to sign the consent form.

Participation in this study is completely voluntary. You can choose to withdraw at any time without penalty.

Background and Purpose of this Study:

Women have long consented to pelvic exams by their health care providers for various reasons. In Ontario, women begin pelvic exams for cervical cancer screening (‘pap’ tests) at age 21. Some women have their first pelvic exam younger than age 21. The first pelvic exam is often a source of anxiety. Many young women frequently delay or avoid their first pelvic exam.
A young woman’s first pelvic exam experience affects her trust in health care providers and subsequent access to health services. Thus, the quality of the first pelvic exam experience is important. Yet, many women describe their first pelvic exam negatively. Research that depicts a woman’s experience of her first pelvic exam from her perspective is still very limited. The purpose of this study is to invite women to tell their story of their first pelvic exam experience, which would be analyzed using the Arts-Informed Narrative Inquiry qualitative research approach. This study seeks three cis-gendered women aged 21 – 35 who are willing to share their story of their first pelvic exam experience. (Here cis-gendered women are defined as individuals who currently identify as women, who were assigned female gender at birth).

**Study Design:**

You will be asked to share your story of your first pelvic exam experience. This will occur over two meetings, described below. Upon completion of the consent form, before the start of the first interview, you will be compensated with a $25 gift card from Indigo.

**Study Meetings and Procedures:**

**Meeting #1: Face-to-face interview with creative self-expression activity**

This will be audio-recorded and transcribed. This is expected to require maximum 2 hours of your time. This will occur at a location of your choosing, at a mutually convenient and confidential setting, at Ryerson University. You would be compensated for your travel there via public transit.

You will be invited to share the story of your first pelvic exam. The following questions may be asked to guide the storytelling process:

This interview will begin to unfold by asking:

1. How did you come to book your first pelvic exam appointment?

Depending on how the interview unfolds, prompts may be used to invite you to share your experience. An example of such prompts include:

1. How would you describe your experience of your first pelvic exam?
2. What were you thinking about while lying on the examination table?
3. How did you feel after the exam? Can you expand on this?

You will then be invited to select, draw and describe a metaphor or symbolic image that best represents for you your first pelvic exam experience. Your artistic ability is not in question, rather your creative self-expression is intended to allow you another way to tell your story. The following questions may be asked to guide your descriptive process:

1. Tell me how you came to choose this image to represent your experience.
2. What is the mood of this image?
3. Is there a reason you chose this symbol? Colour?

Your metaphor image drawing will be scanned to be used in the study and subsequent publications and presentations. A scanned version of the metaphor drawing will be emailed to you. If you would like the original drawing returned to you, I will make a copy of the drawing at the end of our first interview and provide you with the original.

**Email Exchange**

Approximately 2 weeks after the face-to-face meeting (our first meeting), I will contact you by email with your metaphor drawing and an attachment of the story of your experience of your first pelvic exam. You will be invited to review the document for accuracy and offer any further comment (additions or deletions) on the story. Over email, we will arrange a time and date for our second meeting (to be conducted over the telephone) in the following week, where you will have an opportunity to provide feedback on the story of your experience.

**Meeting #2: Telephone Meeting**

According to our mutually agreed upon time and date, approximately 1 week after your response to the sent email, I will call you for our second meeting. This will be conducted by telephone, audio-recorded and transcribed. This telephone call meeting is expected to require approximately 30 minutes of your time.

The purpose of the telephone meeting is to provide you with an opportunity for any further information, as well as to receive your approval that the story accurately represents your experience of your first pelvic exam. I will ask the following questions:

1. What do you think of the story that I emailed you?
2. Is it an accurate representation of your experience?
3. Did I miss any details which you would like included in this story? Is there anything that you would like to have deleted in this story?

**Benefits Related to Participating in the Study:**

You may or may not experience direct benefits from participating in the study. It is possible through telling of your story that you may develop a novel perspective on the experience and your relationships with health care providers.

This study uniquely asks women for their perspective on care experiences, something not otherwise documented in literature. This study will contribute to healthcare students’ and healthcare providers' knowledge of person-centred care, especially for young women.

This study also contributes to the use of Arts-Informed Narrative Inquiry in health research. This method demonstrates the value of stories and creative-self expression in generating knowledge.
Participating in this study may contribute to your sense of accomplishment and your personal contribution to health practice, education and research.

Potential Risks Related to Participating in this Study:

There are no physical risks to participating in this study.

However, sharing the details of this sensitive experience may cause difficult emotions to arise. As you tell your story, you may feel emotionally uncomfortable. If this occurs, you may refuse to answer any questions or stop the interview altogether at any time without penalty. Should difficult emotions arise, as the principal investigator, I will ask for your consent to provide you with information about existing resources, such as the following community mental health services.

- **Hard Feelings** - 416-792-4393
  - Low-cost counselling for a maximum of 12 sessions.
- **Women's Health in Women's Hands** - 416-593-7655
  - OHIP covered individual counselling for a maximum of 15 weeks
  - Also provides primary care resources
- **Stella's Place (for young adults up to 29)** - 416-461-2345
  - OHIP covered walk-in counselling

**Duty to Report**

In the event you disclose that a healthcare provider sexually abused you, as a Registered Nurse, I am professionally obligated to report it to that healthcare provider’s regulatory college. Sexual abuse is defined in this context as:

- physical sexual relations with a client;
- touching, in a sexual manner, the client's genitals, anus, breast or buttocks
- touching a client in a sexual manner
- behaving in a sexual manner with a client; and/or
- making remarks of a sexual nature to a client

(College of Nurses of Ontario, 2018)

You have the right to remain unnamed in the report. If you voluntarily choose, you can consent in writing to have your name included in the report.

**Confidentiality:**

If you consent to participate in this study, as the principal investigator, I will only collect the personal identifying information needed for the study, which includes:

- Name
- Contact Telephone Number
- Contact Email Address
• Postal address (if you wish to have your original drawing returned to you)

Personal Identifying Information
There is a minimal risk for personal information being revealed in this study. All information is confidential and only I and my thesis supervisor (Dr. Schwind), will be allowed to access the study records for the purposes of ensuring the collected information is correct and the laws and guidelines are adhered to.

Identifying information collected (i.e.: the consent form and contact information) as well as your original drawings (should you opt not to receive this by post) will be stored separately in a locked filing cabinet in a secure research environment at Ryerson University. Three years from the consent date, the consent form, your contact information and your original drawing will be obscured with a black marker and destroyed by shredding.

For our interview, we will meet in a location separate from your school or department in the university, so you will not be visibly identifiable as a participant in the study. When listening to the audio-recording of the interview, I will use headphones in my private office to limit voice recognition. For our telephone interview, I will be in a private office.

All identifying information will be removed from the audio recordings, transcripts of the interviews, scanned and original drawings, my reflective journal and research data. You will be identified with a pseudonym, and there will be no identifying descriptions of your appearance or voice. All mentioned places will be fictionalized.

The audio recordings of the interviews, transcripts of the interviews, scanned drawings and the research data will be stored separately on an encrypted Ryerson University server with two-factor authentication. Once data analysis is complete (approximately around July 2020), I will destroy the audio recordings of the interviews. My reflective journal will be stored in a locked cabinet at my home office, and will be destroyed upon successful defense of the thesis (approximately November 2020). To allow for sufficient analysis, the rest of the data (transcripts of the interviews, scanned drawings and research data) will be destroyed three years after the date of consent.

Once I complete this thesis study and successfully defend it (approximately November 2020), I will share an electronic copy of the document with you to your email address.

There will be some study information that will be disseminated outside of Ryerson University, for example at conference or educational presentations, and publications. I will publish study findings and may conduct secondary analysis for practice journals. I will also create a digital narrative, a 4-5 minute video, synthesizing the experiences and metaphor drawings shared in this study. I will use excerpts of your stories and the metaphoric drawings in this digital narrative. I will present this digital narrative in educational settings such as women’s health conferences.

The digital narrative, as well as any publications, reports or presentations that may arise from this study will not include any physical description of you or your voice, your actual name, telephone number, email or original audio recordings.
Voluntary Participation:

Your participation in this study is voluntary. You may decide not to be in this study, or you may decide to be in the study now and change your mind later. Your decision not to participate will not affect your relationships with the researchers or with Ryerson University, either now or in the future.

Withdrawal from the Study:

You can stop your participation in the study for any reason, at any time. If you decline to answer particular questions or stop your participation in the study altogether, this will not affect your relationships with the researchers or Ryerson University either now or in the future. At any point, if you decide to withdraw your consent to participate in the study, you will keep the gift card. If you decide to withdraw your consent to participate in the study, the information collected will be destroyed. There will be no new information collected without your consent.

Costs and Reimbursement:

You will not have to pay for transportation (via public transit) or any of the activities or supplies involved in the study. You will be provided a $25 gift card for Indigo as a thank you for your time upon completion of the consent form. If you decide to withdraw your consent to participate in the study after that first meeting, you will keep the gift card.

Questions about the Study:

If you have any questions, concerns or would like to speak to the study team for any reason, please contact me, Emma MacGregor at emacgreg@ryerson.ca or my thesis supervisor, Dr. J. K. Schwind at jschwind@ryerson.ca or 416-979-5000 ext. 556321.

Ryerson University Research Ethics Board (REB) is a group of people who oversee the ethical conduct of research studies. They are not a part of the study team. They have reviewed this study (file number: 2019-306). If you have any questions about your rights as a research participant or have concerns about this study, contact the Chairs of the Ryerson University REB. Everything you discuss with the Ryerson University REB will be kept confidential. You can contact Ryerson University REB at 416-979-5042 or rebchair@ryerson.ca.
Participant Agreement

Dear Participant,
Your signature below indicates that this study, titled “Women’s Experiences of their First Pelvic Exam: An Arts-Informed Narrative Inquiry” conducted by Emma MacGregor as supervised by Dr. J. K. Schwind both of Ryerson University, has been sufficiently explained to you and any questions you had, have been answered to your satisfaction. You are aware you may leave the study at any time without any penalty to you. You agree to the use of your information as described in this form. You agree to voluntarily take part in this study. You have been given a copy of this entire agreement document. You have been told you are not giving up any legal rights by signing this agreement.

_______________________________ ____________________        __________
Study Participant’s Name (printed)  Signature   Date

Artistic self-expression (i.e.: artwork and writing)
By signing below, you agree to have your artwork and writing photo-copied/electronically scanned for data analysis and subsequent study dissemination. You agree to have a copy of your artwork and writing displayed publicly by the research team, without being directly identified with your actual name.

_______________________________ ____________________        __________
Study Participant’s Name (printed)  Signature   Date

Audio recording
By signing below, you agree to be audio-recorded during the first and second meetings discussing the story of your first pelvic exam experience. None of the identifying names or attributes will be included in future publications.

_______________________________ ____________________        __________
Study Participant’s Name (printed)  Signature   Date
Contact Information

By signing below, you agree for your contact information to be collected and retained for the purposes of emailing you a copy of your drawing and story, for contacting you for the telephone meeting, and for emailing you a copy of the final research study document.

__________________________________________  ____________________
Email Address     Phone number

__________________________________________
Study Participant’s Name (printed)    Signature   Date
Appendix D

Interview Guide

INTERVIEW GUIDE

Women's Experiences of Their First Pelvic Exam: Arts-Informed Narrative Inquiry

Face-to-face meeting

Narrative Inquiry is a highly relational and emergent research method (Clandinin & Connelly, 2000). As such, this interview will begin to unfold with the following open-ended question:

4. How did you come to book your first pelvic exam appointment?

Depending on the participant’s response, further clarifying prompts may be used to further elucidate the inquiry puzzle. Below is an example of the possible prompts that may be used during the interview.

2. How would you describe your experience of your first pelvic exam?

5. What were you thinking about while lying on the examination table?

6. How did you feel after the exam? Can you expand on this?

Next, co-participants will engage in metaphor reflection (Schwind, 2008, 2016) to create drawings, which represent their experiences for them. Meaning of the metaphor drawings will be established by the co-participants. To introduce this next portion of the interview, I will state the following:

At this time, I invite you to select, draw and describe a metaphor or symbolic image that best represents for you your first pelvic exam experience. The purpose of engaging in metaphor drawings is to provide a different way to express the experience you have just described. Your
artistic ability is not under examination, rather your creative self-expression is intended to allow you another way to tell your story. Using the supplies provided, I invite you now to create an image that best represents for you your experience. It can be anything you like, as long as it is meaningful to you.

Co-participants’ metaphor drawings will provide a platform for further conversation about their experience and support an aesthetic understanding of their experiences. Regarding their drawings, I will seek clarity of meaning with open-ended questions, such as:

1. Tell me how you came to choose this image to represent your experience
2. What is the mood of this image?
3. Is there a reason you chose this symbol/colour?

I will conclude the first interview by thanking the co-participant for her time. If she would like the original drawing returned to her, I will make a copy of the drawing and provide her with the original.

I will remind her of the following: Approximately 2 weeks after this meeting, I will contact you by email with your metaphor drawing and an attachment of the story of your experience of your first pelvic exam. You will be invited to review the document for accuracy and offer any further comment (additions or deletions) on the story. Over email, we will arrange a time and date for our second meeting (to be conducted over the telephone) in the following week, where you will have an opportunity to provide feedback on the story of your experience.

**Telephone meeting**

After greeting my co-participant and confirming her consent to audio record the phone call, I will begin the audio recording.
Thank you for meeting with me over the phone to review the story of your experience. The purpose of this interview is to confirm that the story I have written is accurate to your experience, and to seek feedback on any points of clarity, additions or deletions to the story.

4. What do you think of the story that I emailed you?

5. Is it an accurate representation of your experience?

6. Did I miss any details which you would like included in this story? Is there anything that you would like to have deleted in this story?

Upon conclusion of the conversation, which will unfold through the above questions, I will remind the co-participant of the next steps in the study. Namely, that I will work with my supervisor to engage in the analysis process of the research method I am using to gain a deeper understanding of my research question. I will remind co-participants to expect an email with the final thesis document upon successful defense, approximately November 2020. I will express my gratitude to the co-participant for their invaluable participation in the study.
Dear Participant,

Thank you for being a part of my research study titled: Women’s Experiences of their First Pelvic Exam: An Arts-Informed Narrative Inquiry. This study has been reviewed by the Ryerson University Research Ethics Board (file number 2019-360).

Following our interview, I have composed the story of your experience in the attached document. At this point, I invite you to review the document for accuracy and offer any further comment (additions or deletions) on the story.

You will also find attached the scanned version of your metaphor drawing.
At this point, I invite you to a second audio-recorded interview over the telephone, where you will have an opportunity to provide feedback on the story of your experience. The purpose of this telephone meeting is for you to verify whether or not I captured your story accurately. At this time you will have the opportunity to add any further information, if you like, as well as remove any information you wish deleted. This brief telephone meeting will take a maximum of thirty minutes of your time.

Please let me know a date and time next week which is convenient for you to conduct this telephone interview.

Warm regards,

Emma MacGregor
Appendix F

Research Ethics Board Approval

To: Emma MacGregor
Nursing
Re: REB 2019-360: Women's Experiences of their First Pelvic Exams - An Arts-Informed Narrative Inquiry
Date: December 12, 2019

Dear Emma MacGregor,

The review of your protocol REB File REB 2019-360 is now complete. The project has been approved for a one year period. Please note that before proceeding with your project, compliance with other required University approvals/certifications, institutional requirements, or governmental authorizations may be required.

This approval may be extended after one year upon request. Please be advised that if the project is not renewed, approval will expire and no more research involving humans may take place. If this is a funded project, access to research funds may also be affected.

Please note that REB approval policies require that you adhere strictly to the protocol as last reviewed by the REB and that any modifications must be approved by the Board before they can be implemented. Adverse or unexpected events must be reported to the REB as soon as possible with an indication from the Principal Investigator as to how, in the view of the Principal Investigator, these events affect the continuation of the protocol.

Finally, if research subjects are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research.

Please quote your REB file number (REB 2019-360) on future correspondence.

Congratulations and best of luck in conducting your research.

Dr. Asher Alkoby, LL.B., LL.M., S.J.D.,
Chair, Ryerson University Research Ethics Board
(416)979-5000 ext. 2491
alkoby@ryerson.ca
rebechair@ryerson.ca
http://www.ryerson.ca/research
The Following protocol attachments have been reviewed and approved.

- Advertisement - December 1.docx (submitted on: 01 Dec 2019)
- Email to participants two weeks following first interview - December 2.docx (submitted on: 02 Dec 2019)
- Comments to Chair - REB revisions - December 2.docx (submitted on: 02 Dec 2019)
- Interview Guide - December 11.docx (submitted on: 11 Dec 2019)
- Recruitment Email - December 11.docx (submitted on: 11 Dec 2019)
- Consent Form - December 11.docx (submitted on: 11 Dec 2019)

If any changes are made to the attached document throughout the course of the research, an amendment MUST be submitted to, and subsequently approved by the REB.
Appendix G

Reproduction Agreement for Image of J. Marion Sims: Gynecologic Surgeon

APPLICATION FOR PERMISSION TO REPRODUCE OBJECTS
IN THE COLLECTION OF THE
MICHIGAN MEDICINE, UNIVERSITY OF MICHIGAN

INSTRUCTIONS: Please read the stipulations governing the reproduction of object(s) from the Collection of the University of Michigan Museum of Art on the reverse of this document, sign, and return to the Registrar’s Office. A countersigned copy will be emailed to you for your records.

Requestor: Emma MacGregor, emacgregor@ryerson.ca
Institution:
Address:

 applies for permission to reproduce the following object(s):

Object(s): UMHS.30
Artist/Maker: Robert Thom
Title: J. Marion Sims: Gynecologic Surgeon, from “The History of Medicine”
Date: circa 1952
Medium: oil on canvas
Dimensions: 4 ft. 8 13/16 in. x 4 ft. 6 in. (144.15 x 116.84 cm)
Credit Line: From the collection of Michigan Medicine, University of Michigan

for reproduction in:
Title: N/A
Author/Editor: Emma MacGregor
Publisher: N/A
Date of Publication: N/A
Type of Publication: Research
Print Run: N/A
Rights Requested: Research purposes only. No dissemination without additional permission.

The applicant agrees that this permission shall be subject to the conditions listed on the reverse of this form.

[Signature]
September 18, 2020

Applicant’s Signature
Date

Permission to reproduce the material listed above, in compliance with the conditions stated, is granted.

Signature for UMMA
9/18/2020
Date
CONDITIONS GOVERNING THE REPRODUCTION OF OBJECTS IN THE COLLECTION OF THE UNIVERSITY OF MICHIGAN MUSEUM OF ART

1. Permission is granted for only one usage in one publication, one edition, and in one language. Additional language editions and subsequent revised new editions will be considered upon request.

2. Documentation and credit line as specified by the museum must appear either directly under the reproduction, on the page facing, or on the reverse.

3. All reproductions must be made only with materials supplied by the museum.

4. The reproduction must be full-tone black and white or full color and may not be reproduced on colored stock. Nothing may be superimposed on the reproduction.

5. Each object must be reproduced in its entirety and the reproduction may not be bled off the page or cropped in any way. A specific detail must be approved in advance by the museum.

6. If requested, one color proof must be submitted before production so that the museum can compare it with the original works of art and make any necessary color corrections.

7. All color transparencies, if provided, remain the property of the museum and must be sent back after use.

8. Duplicate transparencies may not be made from original transparencies.

9. Special permission is required if the reproduction is to appear as a bookcover/dust jacket, calendar, or individual reproduction. In such cases, an additional fee is payable. The final layout must be submitted before production for approval by the museum.

10. The museum assumes no responsibility for any royalties or fees claimed by the artist or on his behalf.

11. The publisher is to provide the Office of the Registrar of the museum with one copy of the publication in which the reproduction appears. Please send publication to the attention of the Registrar's Office at the address listed below.

12. All reproduction fees are payable upon receipt of invoice.

13. It is the responsibility of the applicant to obtain permission from the holder of copyright when reproducing objects that are copyrighted.

All communications regarding rights and reproduction should be addressed to:

Registrar's Office, Rights & Reproductions
University of Michigan Museum of Art
525 S. State Street
Ann Arbor, MI 48109
Appendix H:

Fair Use Evaluation for du Toucher la Femme Debout

Fair Use Evaluation Documentation

Compiled using the Fair Dealing Evaluator [cc] 2008 Michael Brewer & the Office for Information Technology Policy, Modified for Canada by the Copyright Advisory Office at Queen's University https://library.queensu.ca/copyright/

Name: Emma MacGregor
Job Title: Registered Nurse/Master's thesis student
Institution: Ryerson University
Title of Work Used: Du toucher, la femme debout
Copyright Holder: Antoine Chazal (designer) and Forrestier (engraver)
Publication Status: Published
Publisher:
Place of Publication: Paris, France
Publication Year: 1882
Description of Work: still image of illustration of pelvic exam from the french medical textbook by author Maygrier, Jacques-Pierre, "nouvelles demonstrations d'accouchements"
Date of Evaluation: September 17, 2020
Date of Intended Use: September 17, 2020

Describe the **Purpose** of Your Intended Reproduction:

I intend to use a copy of this still image to explicate the historical context of pelvic exams prior to the advent of the speculum. This is strictly for the purposes of my master's thesis study.

![Scale of Fairness](image)

Page 1

173
Describe the **Character** of Your Intended Reproduction:

- Reproduction is clearly defined and is restricted in scope (limited duration, not iterative, restricted access, etc.).
- Reproduction is one-time, or is only occasional or spontaneous.

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<th>Unfair</th>
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Describe the **Amount** of Your Intended Use in Relation to the Copyrighted Work as a Whole:

- Only limited and reasonable portions will be reproduced.
- Only the amount required to achieve the stated, socially-beneficial purpose or objective will be used (be that research, private study, criticism etc.).
- If the entire work is to be reproduced, it is clear that no less than the entire work will achieve the stated purpose of the use (e.g. use of a photograph, a short poem, an article, etc.).

The image is only reproduced once in the thesis, for research purposes.

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Describe any possible **Alternatives** that you could use in place of Reproduction:

- Only limited and reasonable portions will be reproduced.
- Only the amount required to achieve the stated, socially-beneficial purpose or objective will be used (be that research, private study, criticism etc.).
- If the entire work is to be reproduced, it is clear that no less than the entire work will achieve the stated purpose of the use (e.g. use of a photograph, a short poem, an article, etc.).

The image is only reproduced once in the thesis, for research purposes.

| Fair | | | | | | | Unfair |
Describe the **Nature** of Your Intended Reproduction:

- [x] Work to be used has been previously PUBLISHED
- [x] Original work was not created and/or has not been marketed for the stated purpose of the proposed reproduction

![Fair-Unfair Scale]

Describe the **Effect** of Your Intended Use on the Potential Market or Value of the Copyrighted Work:

- [x] The work is NOT currently under commercial exploitation (out of print, no licensing available, etc.)
- [x] A market for the work as it will be used is absent or is negligible & use of the work will have little or no negative impact on its value or potential value
- [x] Use of the work minimizes the potential for unauthorized use that could impact its value (i.e. steps are taken to ensure the content is not used outside of the stated purpose or audience)

The image is also in the public domain (due to publication date)

![Fair-Unfair Scale]

The Average "**Fairness Level,"** Based on Your Rating of Each of the 6 Factors, Is:

[see tool disclaimer for important clarifying information]

![Fair-Unfair Scale]
**Other Important Criteria:**

Bibliothèque Nationale Française (BNF) states this image is in the public domain
https://gallica.bnf.fr/ark:/12148/btv1b21000641.planchecontact1f1

Based on the information and justification I have provided above, I, Emma MacGregor, am asserting this use is FAIR under Section 29 of the Canadian Copyright Act.

Signature: 

Date of Signature: September 17, 2020

*Disclaimer: This document is intended to help you collect, organize & archive the information you might need to support your fair use evaluation. It is not a source of legal advice or assistance. The results are only as good as the input you have provided by are intended to suggest next steps, and not to provide a final judgment. It is recommended that you share this evaluation with a copyright specialist before proceeding with your intended use.*
Appendix I

Fair Use Evaluation for Henry Ford Hospital

Fair Use Evaluation Documentation

Compiled using the Fair Dealing Evaluator [pc] 2008 Michael Brewer & the Office for Information Technology Policy. Modified for Canada by the Copyright Advisory Office at Queen's University https://library.queensu.ca/copyright/

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Job Title</td>
<td>Registered Nurse/Master's thesis student</td>
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<td>Institution</td>
<td>Ryerson University</td>
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<td>Title of Work Used</td>
<td>Henry Ford Hospital</td>
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<td>Copyright Holder</td>
<td>Frida Khalo</td>
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<tr>
<td>Publication Status</td>
<td>Published</td>
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<tr>
<td>Publisher</td>
<td>Dolores Olmedo Museum</td>
</tr>
<tr>
<td>Place of Publication</td>
<td>Mexico City, Mexico</td>
</tr>
<tr>
<td>Publication Year</td>
<td>1932</td>
</tr>
<tr>
<td>Description of Work</td>
<td>Painting depicting Khalo's experience of a miscarriage at Detroit's Henry Ford Hospital. She lies in a bed in the centre of the piece with six symbolic figures connected to her body, a view of Detroit in the background.</td>
</tr>
<tr>
<td>Date of Evaluation</td>
<td>September 26, 2020</td>
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<tr>
<td>Date of Intended Use</td>
<td>September 26, 2020</td>
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Describe the **Purpose** of Your Intended Reproduction:

[1] Reproduction is for the purpose of "research, private study, education, satire, or parody" This image is used in an unpublished thesis for the purpose of demonstrating women's use of art to describe their pelvic exam and healthcare experiences from a historical perspective.
Describe the **Character** of Your Intended Reproduction:

- [x] Reproduction is clearly defined and is restricted in scope (limited duration, not iterative, restricted access, etc.)
- [x] Reproduction is one-time, or is only occasional or spontaneous

I use the image in the analysis section of my thesis, only once. It is fully cited to the author.

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Describe the **Amount** of Your Intended Use in Relation to the Copyrighted Work as a Whole:

- [x] Only limited and reasonable portions will be reproduced
- [x] Only the amount required to achieve the stated, socially-beneficial purpose or objective will be used (be that research, private study, criticism etc.)
- [x] If the entire work is to be reproduced, it is clear that no less than the entire work will achieve the stated purpose of the use (e.g. use of a photograph, a short poem, an article, etc.)

I require use of the full image in order to present Khalo's depiction in full. It is only for the use of research purposes.

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Describe any possible **Alternatives** that you could use in place of Reproduction:

- [x] Only limited and reasonable portions will be reproduced
- [x] Only the amount required to achieve the stated, socially-beneficial purpose or objective will be used (be that research, private study, criticism etc.)
- [x] If the entire work is to be reproduced, it is clear that no less than the entire work will achieve the stated purpose of the use (e.g. use of a photograph, a short poem, an article, etc.)

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Describe the **Nature** of Your Intended Reproduction:

[++] Work to be used has been previously PUBLISHED
[++] Work to be used is UNPUBLISHED, but its reproduction with acknowledgement could lead to a wider public dissemination of the work
[+] Original work was not created and/or has not been marketed for the stated purpose of the proposed reproduction

This thesis will not be published, however it will be put online. Khalo's work (1932) has been published previously, and used in other online sources.

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Describe the **Effect** of Your Intended Use on the Potential Market or Value of the Copyrighted Work:

[++] The work is NOT currently under commercial exploitation (out of print, no licensing available, etc.)
[++] A market for the work as it will be used is absent or is negligible & use of the work will have little or no negative impact on its value or potential value
[++] Use of the work minimizes the potential for unauthorized use that could impact its value (i.e. steps are taken to ensure the content is not used outside of the stated purpose or audience)
[++] Use of the work has the potential to create or improve the market for the work

Use of this work may introduce new audiences to Khalo's work, for which licensing rights are available through the Dolores Olmedo Museum in Mexico City, Mexico.

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The Average "Fairness Level," Based on Your Rating of Each of the 6 Factors, is:

[see tool disclaimer for important clarifying information]:

Fair  ☑  ☐  ☐  ☐  ☐  ☐  Unfair

Based on the information and justification I have provided above, I, Emma MacGregor, am asserting this use is FAIR under Section 29 of the Canadian Copyright Act.

Signature:  

Date of Signature:  September 26, 2020

*Disclaimer: This document is intended to help you collect, organize & archive the information you might need to support your fair use evaluation. It is not a source of legal advice or assistance. The results are only as good as the input you have provided by are intended to suggest next steps, and not to provide a final judgment. It is recommended that you share this evaluation with a copyright specialist before proceeding with your intended use.
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