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Carrying: Parental Experience of the Hospital Transfer of Their Baby

Michael van Manen[1]

Abstract

Some hospital practices that are routine for hospital staff may carry unintended significance for patients and their families. The transfer of neonatal infants between hospitals and hospital environments is one such practice that may be covered by perfectly acceptable rules and regulations but that, at times, gives rise to unsuspected anxieties, pain, and worries in the parent. In this phenomenological study, I explored meaning aspects of the phenomenon transfer to reveal a lived experience of carrying—a carrying across from here to there; a carrying between changing places; a carrying contact of parent–child in-touchness that is enabled or compromised in this experience; a carrying with care; and a carrying as a search for place as home. The concluding recommendations speak to the need for understanding the experiences of hospitalized babies' parents, and speak to the tactful sensitivities required of the health care team during the transfer of child and family.

Keywords

infants, high-risk; lived experience; pediatrics; phenomenology; relationships, health care; relationships, parent-child; van Manen

Newborn infants who are born prematurely or who become ill after birth are admitted to a neonatal intensive care unit (NICU) for ongoing care. Care occurs across a spectrum of need depending on severity of illness from least intensive (Level I), to intermediate (Level II), to most intensive (Level III) neonatal units. Some procedures in neonatal health care are so routine and innocuous that they are scarcely granted much thought. The transfer of infants between hospital environments is one such common and daily practice. Limited numbers of beds and other rationed resources may necessitate transfer for appropriate allocation of care. Hospitals specialize in particular services such that a transfer may be necessary for consultation or surgery. Sometimes, transfer may allow infants to be closer to their families' homes, facilitating contact between parents and their children. As such, transfer may be part of a transitional change "on the way home" to a regional hospital, or it may be that the infant with ongoing long-term needs has "outgrown" the nursery. A transfer may involve a major move between geographically distanced hospitals, or a minor move, just down the hallway to a new unit. Distant or neighboring units may differ dramatically in acuity and care culture such that distance alone is only one feature in the manifold of experiences. In the end, it is common for premature or sick babies to spend weeks to months in various hospital units, with multiple transfers marking their journey along the way, before they are finally able to go home.

In the literature of pediatric care, the qualitative parental experience of having a child placed within the nursery has been explored from maternal and paternal perspectives, employing a plethora of qualitative methodologies including narrative, ethnography, grounded theory, phenomenology, qualitative description, and metasynthesis. The few publications that mention or address the specific experience of transfer have recognized that many parents find the transfer as a whole stressful, even when it is a sign of improvement in their child's health (Kolotylo, Parker, & Chapman, 1991; Kuhnly & Freston, 1993; Meyer, Mahan, & Schreiner, 1982; Page & Lunyk-Child, 1995). Even when transfer occurs between close spaces, to a next-door room, changes in personal space, the tone in the room, and the transfer itself may carry significant meaning to parents (Hall & Brinchmann, 2009). In general, insights from this literature tend to be curtailed by the

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summative nature of the studies, reducing the potential depth, richness, meaningfulness, and complexities of the portrayals of the parental experiences. It would seem that the exploration of the meaning structures of transitional subjective experiences themselves, such as hospital transfer, are well addressed by phenomenological studies as the particular and universal are held in tension (Briscoe & Woodgate, 2010; van Manen, 1990). Yet, specific phenomenological studies of the parental experiences of infant transfer in a system of highly regionalized and geographically distanced neonatal care do not appear in the literature.

Methodology

The aim of this study was to explore the phenomenon of hospital transfer from the perspectival experience of parents caring for their hospitalized child. In particular, the focus was on parents of premature or sick infants requiring hospitalization from the time of birth in a NICU. To maintain an open attitude to the subjective experiences of parents, the phenomenon of hospital transfer was taken broadly as a felt change in place either within or between hospitals. To explore this topic, a context-sensitive form of interpretive inquiry, a phenomenology of practice, was employed (van Manen, 1990, 2007).

As a human science research methodology, phenomenology of practice represents a blending of hermeneutic phenomenology with qualitative empirical methods. In hermeneutic phenomenology, the author aims to describe and interpret the lived world as experienced in everyday situations and relations. The concern is with the immediacy of human experience prior to meditative or theoretical reflection. The purpose of phenomenological inquiry is not to develop theory. Rather, the aim is to produce qualitative portrayals by means of a dynamic blending of interrelated heuristic activities involving explorative questioning of a particular phenomenon or event—in this case the parental experience of their infant's transfer.

A central feature of this phenomenology of practice is a reliance on qualitative empirical methods to gather a field of descriptive evidence, lived experience descriptions, from which underlying patterns and structures of meaning may be drawn. This gathering should not be seen as an isolated research practice; rather, gathering should be seen as woven into the explorative questioning of a particular phenomenon of interest. In this way, phenomenology of practice is a nonlinear form of research, as "data collection" (gathering) and "analyses" (reflective questioning) are performed concurrently. Phenomenological methodology is well suited to serve practitioners who, in their day-to-day practice, may be unaware of or insensitive to the depths and subtleties of other people's experiences as lived.

As a physician working in multiple neonatal intensive care units, I am continually confronted with the task of patient transfer. However, I tend to be removed from the pain, joy, grief, and relief experienced by parents. Therefore, in an effort to gain a more intimate understanding of the experience of transfer, parents were recruited for interview from four local hospital nurseries in a western province of Canada spanning the scope of acuity seen in neonatal intensive care (Levels I, II, and III). These interviews facilitated exploration of a particular, intimate field of descriptive evidence, as the entire research study was carried out alongside my ongoing conventional clinical practice in neonatal intensive care.

In total, I conducted in-depth interviews with 12 parents, 8 mothers and 4 fathers, who had their child transferred in and between hospital environments. I want to be clear that I am not using terms such as *sample* or *sampling procedure*. The goal of phenomenological research is neither to sample nor generalize to a population. Rather, the aim is simply to reveal, open, and explore a possible human experience. As Merleau-Ponty said, the objective of phenomenological description is "to bring back all the living relationships of experience, as the fisherman's net draws up from the depths of the ocean quivering fish and seaweed" (1962/1945, p. xvii). Respectfully, therefore, I provide only general background information to help to contextualize the findings of the study. I hope that by refraining from giving detailed demographic or ethnographic data (means, ranges, and so forth), I will avoid confusing the reader of the nature of phenomenological inquiry. As described elsewhere, sampling criteria (size, cross section, demographical information) are examples of empirical research criteria and should not be confused with phenomenological research method (Norlyk & Harder, 2010).

To be eligible for this study, a parent's child had to receive at least one interhospital transfer (between physically distinct hospitals). Although some of the families experienced numerous interhospital transfers, all experienced multiple intrahospital transfers (within hospital yet between care teams, units, and so forth). Some of the babies were admitted primarily for observation and monitoring, others for high levels of support including mechanical ventilation, cardiovascular medications, intravenous nutrition, and neonatal surgeries. Admitting diagnoses varied greatly, including yet not limited to those related to prematurity, congenital anomalies, and transitional problems. Parents ranged in age, ethnicity, education, and socioeconomic background. Most families had never been in the NICU prior to the admission of their child. Some had never even been to a tertiary center, as their children were referred from remote or rural outlying areas. Interviews took place after transfer, and were conducted for the purpose of exploring and gathering experiential

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material, stories, and anecdotes that speak to the phenomenon of transfer. Parents were interviewed one to three times for 30 to 90 minutes at a location of their choice. All interviews were audio-recorded, transcribed, and reviewed to ensure clarity of transcription. Parents described multiple hospital transfers that provided a wide breadth and a vast range of subtle varieties of experiences.

In keeping with this phenomenology of practice, reflective methods (including thematic, guided existential, linguistic, and exegetical reflection) were used to identify and reflect on variant and invariant meaning aspects of the transfer experience (van Manen, 1990, 2007). The eidos and eidetic themes refer to the unique, or the more invariant patterns of meaning of the experience of transfer. Phenomenological evidence is always tentative and always subject to yet another phenomenological exploration. Wholistic and line-by-line readings of transcripts were employed for thematic exploration of lived experience descriptions. Through guided existential reflection, fundamental lifeworld themes were used as heuristic guides for reflecting on the parental transfer experiences: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality). Linguistic reflection involved attentiveness to conceptual and etymological aspects of the etymology of transfer, and exegetical reflection involved the study of related and sometimes seemingly unrelated literary and phenomenological texts in search for new insights and perspectives.

Anecdotes were drawn from the interviews to assist the reader of the research to access the subjectivity of the experience of transfer. Anecdotes were constructed from the interview material by deleting extraneous, redundant, and identifying material to strengthen transcript stories into the direction of the phenomenon and its themes. Names of interviewed parents were replaced with pseudonyms. The anecdotes were crafted to attend to the subjective rather than objective aspects of experience. As such, no effort was made to verify whether a parent's account of an event was in keeping with the way things actually happened. In this way, although the anecdotes do not make claims to ethnographic or empirical validity, they aim to evoke iconic validity to arrive at plausible descriptions of possible human experiences. Follow-up interviews were held with parents when possible to revisit their experiences and explore certain meanings and significances of their experiential descriptions.

The process of writing of this text was also a key part of the research that involved finding language sensitive to the phenomenon—yet allowing the phenomenon to speak for itself, as it were. This textual process required continual writing and rewriting. Drafts of the text and presentations of narratives were reviewed with diverse groups of health care members (physicians, nurses, respiratory therapists, dieticians, social workers, and parents of children who had been cared for in the NICU) to ensure the phenomenological descriptions and anecdotes resonate with lived life, triggering instants of recognition and evoking immanent (subjectively felt) phenomenological evidence.

Situating Within the Phenomenological Tradition

The focus on lived experience is an application of the phenomenological concept of perception. Merleau-Ponty has shown that perception is not merely an event or state in the mind, sensory organs, or brain, but a function of a person's entire bodily relation to his or her environment (1962/1945). Prior even to having a perspective that we can call our own, we are already interlaced with the world—a world of sense and sensibility, touch and tangibility, seeing and being seen. It is through an understanding of this embodied being-in-the-world that ordinary and everyday perception takes place at a primary, corporeal, and prereflective level. For example, researchers such as Simms and van den Berg have shown how the child's developing corporeal being is closely entwined with the corporeality of the world (Simms, 2008; van den Berg, 1983/1961). The child's perception of the world in its fullest, most complex, and most subtle sense is the fact of its preconscious or prereflective act of existence. But this is also true of adults who are cognitively able to reflect and think about the way that we normally experience our world prereflectively.

A starting point of this study is that the neonatal setting provides a unique challenge to researchers who are interested in seeking out the implications and promises of the phenomenological literature on perception and embodiment. We need to attend to the question of how the infant's preconscious perceptual systems (hearing, sensing, smelling, and feeling) are subtly but complexly integrated into the physical environment in which the child is placed. Yet, at the same time, we need to gain a more differentiated understanding of how, at this prereflective level, the parents perceive their infant's situatedness and subjectiveness to the care and handling of medical personnel. For the purpose of this study, the neonatal unit is considered the center where the infant's perception of his or her world and the parents' perceptions of their relations to the child's embodied existence—as well as to the parents' own responsiveness and situatedness in this shared world—may be studied.

Ethical Issues

Permission to conduct this study was obtained from the university health ethics review board and appropriate

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health authorities. Strategies to diminish the possibility of participant identification included careful selection of anecdotal examples and alteration of specific information that might increase the likelihood of identification. To avoid conflict of interest between my roles as researcher and clinician, I neither enrolled nor interviewed families at a time when I was involved in their care. Other strategies were utilized to avoid coercion, such as limiting recruitment strategies to poster presentation and word of mouth. Furthermore, participating families had to initiate contact with the researcher. No incentives were offered for participation.

Findings

The inquiry into the phenomenon of transfer yielded thematic events around which the research text has been constructed and composed: carrying across, carrying between, carrying contact, carrying caringly, and carrying home. Each of these thematic events of the eidetic or unique meaning of transfer is presented from the perspectives of the parental experience of self, the parental experience of their child as other, and the parental experience of health care people as other other. In reading this phenomenological text, the reader may ask questions such as: What is a parental experience of their infant's transfer like? What modalities of carrying the child speak to the singular meaning (eidos) of transfer? How may the transfer of an infant be experienced by the parents in terms of various modalities of carrying? Are the themes of transfer properly captured by the following eventful descriptions: (a) how transfer is a carrying across from here to there and with or without parental presence; (b) how transfer is a carrying between changing places; (c) how transfer is a carrying contact of parent–child in-touchness that is enabled or compromised in this experience; (d) how transfer is a carrying with care; and (e) how transfer is experienced as a search for place as home?

Transfer as a Carrying Across

The experience of transfer is already alluded to in the etymology of the term *transfer*. Hospital transfer is a carrying across of the child from one place to another. The very word *transfer* means to bear, bring, carry (*ferre*); from one place to another, across (*trans*). A shared eidos of crossing emerges from reflection on the various stories of carrying by way of bassinette, ambulance, or airplane between places such as holding arms, incubator, or hospital unit. As researcher I could not help but be reminded of the ancient image of the mythical ferryman, Charon, who carried the traveler across treacherous waters to the safety of the shore opposite or carried the soul across to Hades.

A mother recalled trying to find her way across, to, and from the intensive care nursery in the first days:

> I remember walking down endless corridors and stopping at a chair, just sitting down crying, you know. Because I am just so overwhelmed with emotions, fear, terror, all that stuff about my child. Where did they take her? I can't remember, because I go up so many flights of stairs, and I turn so many corners. I gave birth to this child but I cannot find my way to her.

For the parent, who has to make his or her own way during the transfer, the crossing is not just a traversing of space to be reunited with their child. It is a crossing to an unknown different shore. The parent may be drawn into a searching path starting from a place of loss, the lost anticipations of the expected "normal" birth. And, it is also the crossing of the emotional space and existential abyss separating the parent from his or her child. Thus, the routine procedure of transfer of the infant can pull the parent into a complex state, mood, and set of events that are deeply emotional and, at heart, surprisingly difficult to probe, understand, and describe:

> I know he had to be moved, and that it was for the best. But still, it is terrifying that someone thinks it is a good idea to take your brand new baby and put him on an airplane without you, to take him to another city, and put him in a hospital, all by himself. We just had him and I so needed to be near him. I so needed to know he was all right.

> He was calm when I left, and was not crying when we got there. And the people who transported him had gone. So whether or not he was crying and in distress during this first day of his life, I will never know.

Even when the parent is unable to accompany the child during transfer, but is offered the option to go, it may provide a sense of comfort:

> It made me feel more relaxed, that the option was there, that I could ride with her. Just so I knew that, I don't know how to explain it, that I could still have that option. It is a weird feeling when someone says that you can't go with her. After all, this is my child! And I have to be there for her.

Perhaps the transfer becomes less suspect when knowing, "I could ride with her." The crossing becomes a bridge that I too can take, a drive that I too can make. It becomes accessibly less alienating.

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Yet, a child transferred across and away can leave a parent feeling left behind. A mother recalled the experience of cesarean section as she awaited her child's birth, catching only glimpses before he was taken away—she was left outside trying to look in:

> I was trying to look at the overhead light, because I could see a reflection in the glass, a reflection of him. So when they were taking him out, I could not obviously, yet still, I caught a glimmer of him. That was the only glimpse I got. Then, I was left alone, waiting and wondering. As I was recovering from the C-section, all I could keep thinking was I need to find some way to get to the NICU to be there, to see him.

As the newly born is taken across, the parent may be left without her or his new child. The first happenings—eyes opening, harsh cry, tenuous movements—are missed forever because of distance. Moments cannot be recreated. So, being transferred across may not merely refer to physical space; rather, it may be felt as an experiential, relational gap as the parent (the self) is separated from their child (the other). In this way, even when the reasons for transfer are medically sound and the measured distance small, the child is still away, and the parent feels the absence.

Sometimes, in the case of a transfer close in time to delivery, the family is further divided. When Josh and Heather's son Taylor was born extremely prematurely, Josh went back and forth, camera in hand, as Heather recovered from the cesarean section. Returning and returning, over and over again, there was a weighted responsibility of being across and having to travel back across as Josh tried to bridge the distance. The first time Josh returned to Heather, Taylor was doing well: "'Beautiful,' I said that he was absolutely beautiful. I was so relieved just letting it out." Subsequently, Taylor stopped breathing and things became difficult:

> I couldn't tell her. I couldn't take that to her. I was weak in the knees to tell her. I was trying to stay strong because Heather could not race back to see Taylor like I could. I was trying to wait for good stuff to happen, trying to stay strong, but things were taking forever. They had a hard time getting a breathing tube down. I think they tried three times. Then they could not get an umbilical line in, and worked on that for forever. Looking at him, there was nothing there. He was just lying there, lifeless, his limbs spread out. They continued to work on him. Then a nurse came and said, "She is asking for you." I kept trying to delay going back, just for a few more minutes, just so I could say everything was fine.

Another father, John, recalled a sense of relief, as his wife was medically stable to come across to the nursery—relief as the family had finally made it across together:

> I think the biggest thing was just having my wife there. Finally, she was not in another part of the hospital. Finally, I did not have to run back and forth between them. Finally, I could have my wife there and I could have Sebastian there, and everyone was just there together. Being separated, having him in the NICU and my wife in postpartum care, that was probably the hardest part.

Carrying across, splitting the family between places, leads to more than physical distance. Families can be thrust into a way of being of separateness. Being separated perhaps can be all the more intense for parents of twins, triplets, and other multiples if the babies too are spread between nurseries. Certainly the family away from home, with limited social supports, now separated, may be all the more alone.

Transfer as a Carrying Between

Children come from a primordial place of close contact, a place of interiority—the containing pressure of the uterine wall, the regular rhythm of heartbeat, and the conducted sound of the mother's voice. Even after a baby is born into the exterior world, he or she may remain calm to the impressions of the first (uterine) place. Within the embrace of mother, the child is brought back to remembrance of the interiority of inside life. We see babies calm when they are bundled in containment, as they lie skin-to-skin against their mother's chest, reacquainting to her warm touch, distinctive aroma, and recognizable sounds. In this way, we are witness to the primacy and primordiality of place. A place world that prior even to having a perspective we may experience as our own. Perception is bodily, the body is perspectival, and perspective emerges out of the very stuff of the world: "My body sees only because it takes part in the visible where it opens forth" (Merleau-Ponty, 1968/1964, pp. 153, 154).

Hospital transfer is always a change between places. If parents sense that their child has a shared place in the world with them, then it follows that a transfer into a hospital nursery may be a kind of existential severing for both parent and child—a dramatic change from a sphere of interiority to exteriority, from the cradled simplicity of parent holding child, to something altogether different. The child is carried between.

To the uninitiated, arriving into the highly technological medical environment of the NICU is a surreal journey that few are prepared for. As a baby is brought into the nursery, he or she is hooked up to a variety of machines.

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The baby is laid in a medical bassinette that resembles a space-aged automated greenhouse. Colored wires, silastic tubes, and adhesive tapes dress the baby to allow continuous monitoring and provision of medical support. Extra equipment, such as a mechanical ventilator or an infusion pump, is brought to the bedside. Multiple screens display information to measure and monitor the baby's condition and medical interventions. Periodically, broached alarms trigger warning lights and sounds. Nearby tables are covered with paraphernalia. Various health care professionals visit the bed, assessing both child and equipment, taking notes and chatting in medical lingo. Seeing their child after the transfer in the NICU may be profoundly unsettling and disconnecting for parents:

> Then, when I saw her again, she looked like a little stranger. And yet, she is my child. I was traumatized, as a father, to see my child hooked up to all of those things. She was lying there sort of with her arms and legs spread. There were probably six to eight pumps running, IV tubes going into her tiny limbs and body, and just all kinds of different machines with lit-up screens. She was lying there supine, on her back, as if crucified. I could not help but feel so very close to her, and achingly distant.

> I was totally disconnected. I could not pick him up, could not hold him. There was so much running everywhere. It was hard to just see him, to see what he looked like, features and stuff like that. The tubes running down his nose and mouth, lines running everywhere. He was swollen with the stuff. I was just trying to make him out. And he was so tucked in that little incubator. Like a little fragile cyborg who I did not dare touch for fear of disturbing any of the artifices attached to his body.

As the child is carried between, the NICU may be experienced as a radically different place. A child critically ill, touched by hurt and sickness, may evoke pain and distress in the parent. Moreover, relationally it is not just a child who is carried between; rather, it is this parent's singular "my child." Embodied in place and relation, the child may be affected in subtle ways as a transfer between may be both a change in place and a felt relational change in the child.

There is a certain indistinctive medical quality to the nursery hotel as each patient's spot is designed with the intention of uniformity and sameness, of housing the prototypical NICU infant. An empty unit marks individual spots only by number or letter, each vacancy undifferentiated, serving as a mirror image to another—a place of deidentifying commonness and conformity. We could even ask when a child is grounded in this place, how is the child unformed? Where the child was previously open to the world, still carried by the family, the child now is contained and cut off from the parents in a medical incubator, a "concealed box." The infant may be experienced as less approachable and more fragile to touch, a different baby in the isolette just from being there, even when the isolette and paraphernalia are only used for monitoring.

A parent may be sensitive to these felt changes in their child. Jean was born after what would be considered a routine pregnancy and delivery to most physicians. In fact, many would describe the birth as unremarkable. However, on closer look at Jean, her left hand appeared malformed. The neonatal team was called to the delivery room to assess, and after "10 or 15 minutes" with her parents, she was taken to the nursery "just to be safe." Although it was perhaps prudent, the family's first time together was cut short, "feeling like only mere minutes." Her father recalled,

> I went with Jean to the NICU, it was kind of a whirlwind . . . I almost felt in the way. She was in her little bassinette, incubator that they have, and I was kind of just standing there, out of place. And did not know what was going on. Like I should not be there.

In the NICU, Jean was placed in a standard isolette with monitor. No invasive procedures were performed or bloodwork drawn. She was simply brought into the unit for observation. Still, as the child was carried into the nursery, the father was left out of place, unable to pass between. Casey (1993) pointed out that the experience of being out of place is corporeal. Just so, the transfer is a bodily change from what is expected and recognizable in place to somewhere altogether out of place. The experience of interiority, the typical and familiar, has been taken away through transfer. As a mother remarked, "I felt robbed of my experience that I should have had."

A transfer between places is always an experience of a different place: sometimes subtle, other times obvious. The new place may carry the possibility of invasive procedures, surgeries, or other interventions. Alternatively, the new place may carry the promise of an improvement of health with discharge home on the horizon. Still, even when a transfer "should be a good thing," it may still be wrought with worrisome meaning for the parent and child. In this way, changing between places may be hard for the parent, and also for the child. The "new place" may be reflected in the parent's perspectival experience of self, and child as other. Moreover, the relation of parent and child is different in this new place, as technology may disturb a parent's experiencing of their child. For example, the neonatal monitor may mediate the mother's experience of her child—bother, discomfort, stress—as

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she watches the dips in measured oxygen saturation on the monitor screen:

> I felt kind of uncomfortable to do kangaroo care. There was no privacy. The few rocking chairs that they had were hard, and how long can you sit in that! It was like a big gym full of babies, too loud to have that quiet time you need with your own baby. Yeah, you can pull a curtain, but even then you are still sharing the space with others. I felt that the atmosphere was hard on my daughter as well. She was very noise sensitive, she would desat and desat in response to the place. Normally, she would never have required that much oxygen, but the place was irritating her. We never experienced a sense of personal place. We just shared some space.

Transfer may mark a change in bodily perception of self and other. With transfer, the parent's bodily anchorage in the world may change because the world itself, and therefore the parent-as-self changes. And, the parent's experience of the infant transfer may be a change in the felt spatial being of the child as other. The encounter with the other, the experience of the face to face, as Levinas (1969/1961) presented it, is seen as an encounter with what lies outside of self and within the realm of the spatial. Thus, place may be seen as a complex but unitary structure, encompassing the self and the other, both spatially located and embodied (Malpas, 1999). Carried between places, the parent-as-self and the child-as-other are changed.

Transfer as a Carrying Contact

Carrying the child, by whatever ambulant means, involves moments of presence, connectedness, and contact. Yet, these moments may also signify absence, disconnectedness, and loss or longing for contact. Contact in carrying is not only a matter of physical touch; contact has to do with factors of spatial and relational proximity between people and the sense of community and intimacy that may be at stake in hospital transfer.

There is a special weave of the parent–child bond as perception is entwined, interwoven in what Merleau-Ponty called the flesh of a common world (1968/1964). The connecting flesh is more than the bodily tissue of a corporeal body; rather, the flesh is the substancing matrix, the milieu, conditioning sense and sensibility, perceiver and perceived, self and other. A father and mother recalled moments of connectedness, the father first, at the beginning, and the mother second, at the end of hospitalization:

> Having him hold my finger was the best feeling ever. Obviously he had not been in my tummy, I hadn't felt him kick and stuff like that. So, when he clenched my finger—I can't even explain the feeling. Just like everything almost came right off, the weight on your shoulders. I knew then that he was a fighter, an amazing little boy. He had a wicked grip, very strong. It felt like the biggest hand in the world just grabbed my hand and shook it. Like someone just came in, and grasped my hand with all their weight and shook it . . . and yet, it was only my finger.

> For the whole nine months, I was Jack's only constant. My husband came as much as he could, but I was the only one who was there every day, and Jack was the only person I saw every day, so that creates a really neat bond. Everything else changes, where you sleep, the hospital food available that day, the friends that you make, your schedule, everything changes. Every time you make plans they change, so you can't rely on anything. The only constant that we had was each other.

In the context of neonatal care, the parent may be the only constant caregiver for a child; doctors change, nurses change, social workers change, and so forth. We could wonder about those children whose social situation is such that no parent or other constant is present in their life: Who is truly there in touch for such a child? Who is singularly present in contact worrying for that particular child? Yet, perhaps this question is for another study.

As a child is transferred by ambulance or plane to a different hospital, a parent may somehow feel a loss of contact, not just from his or her child, but also from a sense of dependability:

> As I was leaving town I could see the ambulance in the rear view mirror, with the lights on going to the airport, and I just thought—I have to get there. The things that were going through my mind were the sounds that my daughter was making. The mask on her face. It just tore me apart. I could not share these sensations with anyone . . . that is all I could think about was that sound. It was a sound of suffering like no one could do anything for her. It was her crying on that warming table with that mask, just this sad cry that was just like a "help me" little cry, just made me feel so completely useless as a parent.

Separated, decoupled, and unwoven, a parent may feel unglued; a bond just untangling that should have been tightly knit. Wanting to be with the child, and wanting to be there for the child, the parent may continue to hear the summoning cry. The parent may experience a deeply felt need that cannot be met. In the words of Levinas, responsibility is primordial:

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> The I is not simply conscious of this necessity to respond, as if it were a matter of an obligation or a duty about which a decision could be made; rather the I is, by its very position, responsibility through and through. (Levinas, 1996, p. 17)

When the responsibility cannot be exercised, the sense of felt contact with the child may turn ambiguous:

> I think the first night he was born, the nurses were like, "There is your baby." And it was just almost surreal, like, "Yeah, we have a baby." But the ambiguity started to sink in more as he was moved from place to place. I remember just speaking on the phone and being like, "My son is in the hospital," and as soon as I said that I was like, "I used 'my son' in a sentence. I must have a child." And yet, it seemed that I was not convinced of my own fatherhood.

Another father described the connection to his son, Ken. The child was transferred to the nursery while his mother remained an inpatient in the adjoining maternity hospital. With Ken in the NICU and the mother in postpartum, the father shuttled back and forth, straining to be "here" and "there," yet neither "there" nor "here." The routine transfer for observation in the NICU left father in limbo:

> I didn't feel the connection to Ken right away because it was like, I hardly got to know him. I don't know if it is a standard dad thing or what, but it was like, yeah that is my son. But, I don't really know him, and he has a team of people that are surrounding him and keeping an eye on him. But, I know my wife. I wanted to make sure everything was okay with her, and she needed to know what was going on with Ken. We were not thinking about ourselves at all.

Beneath our distinctiveness as individuated selves or persons, our experience of this vulnerable other may arrogate the experience of self. Consider the newborn baby, responsive to others even prior to gaining awareness of the self as an autonomous being. When we stroke a baby's cheek, he or she roots reflexively; in comparison, when we place an object in his or her mouth, the baby sucks eagerly. Of course, these primitive reflexes are not empty movements. Rather, the movements are intentional, directed in expectant relation to another, the mother. In this way, the mother and child are paired. The infant's body transcends the matter it is made of by having an intentionality that ties it to the body of the mother—complementing the mother who fits her perceptions into the visible folds of the infant's body (Simms, 2008, p. 15). A reading of Levinas may illuminate the fitting complexity and disparate asymmetry of the parent's experience of child: "I do not have my child; I am my child. Paternity is a relation with a stranger who while being Other . . . is me, a relation of the I with a self which yet is not me" (Levinas, 1969/1961, p. 277).

We see parents yearning for contact with their children. Parents reach for opportunities to touch and sooth their child through the portholes of infant incubators. Intravenous lines and monitoring wires are untangled and carefully handled so a baby may be taken out of an isolette to lie skin to skin against the mother's chest. Here, the mother holds the baby ever so delicately in comfort, despite the cumbersome medical technology—tubes, wires, breathing tube all cautiously secured in place. Although we see a pattern, each baby is a singularity, an individual child of a particular parent, resisting generalizing objectification. The experience of a hospital transfer is in this way not simply a "someone" being transferred but rather, for the parent, it is "my child" being transferred.

Rose's parents were waiting for her to be transferred from a small-town hospital to a tertiary care hospital. Her medical condition was critical. The hospital staff acknowledged that they were working beyond their experience with equipment ill fitted for the requirement at hand. Her parents recalled their daughter's condition on presentation:

> She looked awful. Never been so scared in my entire life. She was letting out constant cries that were sort of muzzled by the oversized oxygen mask that they had over her that was covering her mouth, nose, eyes, going up to her eyebrows . . . covering her whole face . . . cutting into her eyebrows. . . . I thought she was going to die . . . and no one mentioned anything.
>
> I just talked to her, told her that we loved her. I really thought we were going to lose her. I was afraid she was going to have a heart attack. I was so afraid that her heart was just going to give out. The waiting was torturous.

Clenched in gripping anxiety, Mom accompanied Rose in the airplane:

> I remember sitting in the plane and watching her through the glass, and praying that we were going to make it. I could see attendants looking at each other, talking to each other. Of course, I couldn't hear anything, and they were kind of making faces at each other and I was like—is it good or is it bad?— I could see that they were talking about what was going on with her and I could see both their facial

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> demeanors. I was probably overanalyzing every little facial expression that they were making. I just felt totally alone on the plane. I realized that she might be passing away any moment, utterly alone. I could not touch her and I could not talk to her.

Carrying out of reach, beyond touch, there may be a chasm between parent and child—decoupling distance. Despite this distance, the parent may reach for their child in caring worry, identifying connection. Parent and child are intertwined as self and other. Feeling isolated, clutched in anxiety, the other other, the transport team, may become an absent presence of carrying.

Transfer as a Carrying Caringly

In the carrying transfer of an infant, there is a holding and protective bearing that is already detected in the etymology of the term *carrying*. Certainly, carrying a child involves a modality of bearing that comprises a guarding and caring for. Beginning perhaps in pregnancy, the child is carried and contained caringly within the womb of the mother. Here, "life begins well, it begins enclosed, protected" (Bachelard, 1994/1958, p. 7). Yet birth reveals the child to an open world—a social world. Parents may be struck by their child as other, feeling the weight of responsibility as they hold him or her in their arms—first looks, mouthed yawns, and grasping touches. The child comes to be in the parent's social world. But, being in a social world also means that a child can be taken away by some third party, the other other:

> It's just one of those things, that when you are a mom and sending your baby over, it's not that you don't trust people to take care of her. I mean, it is the health care system, they should be okay, but you just want to be there. It's not like I could help her or that she could hear me through the isolette or anything. I don't know, it's just an irrepressible need to be there, to know she is being cared for and about.

The transfer of a baby requires a specialized team of people, including nurses, physicians, respiratory therapists, emergency medical service workers, and other health care professionals. One father described the experience of his daughter being electively carried by ambulance between hospitals for a consultation as the parents were left to follow behind the ambulance by car. The father recalled an unnamed woman who seemed responsible for taking his child to the receiving hospital:

> And so the ambulance people came and they swapped out their beds for the crib that they put him in. And one of the nurses, I think she was a nurse, I don't actually know, she may have been a resident or something, I don't know, she was in scrubs but everyone there is in scrubs, I met her for about twenty seconds from the NICU. Anyway, she took him, then he was gone.

The woman doing the transfer was experienced as a third, the other other. The third may be nameless in anonymity, generating hesitation and apprehension in the parent. However, the third person does not have to be felt as impersonal. A mother described her encounter with a nurse, David, after the birth of her extremely premature child, Julie. The baby required emergency transfer by helicopter after birth. The mother only saw her child briefly as the transport nurse scooped her away:

> The nurse, David, was really understanding of the circumstances, compassionate and stuff. He explained and went through everything. He assured me that Julie was in really good hands and I did feel comfortable with her going ahead. For the first week, I could not even look at David without crying. If he had not done what he did, Julie might not be here. David will always have a special place in our family.

Nurse David was doing more than moving a child; he was carrying her in his "good hands." Despite the critical condition of the baby, there was trust and confidence as the mother gave in to accepting the transfer. Yet letting go may be difficult. Another mother described her felt need for togetherness, presence, and protection:

> It would have been really hard for me not to stay with him during the transfer, because I would have thought, well, what if he is scared? He has never been in an ambulance, never been outside, never been to this place. What if we get stuck in traffic and are held up for an hour? And there is always the thought that if you are not present, the nurses will assume that you are not involved, and they will not treat him as well. They may say that the care is the same no matter what, but I think that being there does affect the care. I always felt like I needed to be there as much as I could be, to ensure that he was getting the best care, to make sure the nurses knew that I loved him, and was watching over him.

Carrying in care is more than providing medical care. Care also comes from a caring worry, experienced as an affliction, an ethical demand of parental responsibility (van Manen, 2002). Jian's mother described an experience of "being called" back to the hospital as her son was electively transferred between units:

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> The transfer was pushed back so they had to take Jian right around the same time that I had to leave for dinner. From home, I called the nurse to ask, "How is Jian doing?" I needed to know, but all she could tell me was, "He is doing good . . . he is sleeping . . . he is saturating fine." But that was not enough. I just wanted to know, how is he sleeping? What side is he laying on? Does he have a blanket? These are all the little mother things that a nurse could not tell me. I wanted to be sure in my mind that he was okay. So, my husband drove me back to the hospital. When I walked into the room, there was Jian sleeping. But I wanted to touch him. I wanted to feel him close. That night, I held Jian, sleeping in the chair, all through the night.

Coming back to the hospital, Jian's mother took him back. She held him in her arms in responsive responsibility. Only a "being there" in presence, what could not have been achieved by a distanced phone call, alleviated her motherly worries.

Transfer as a Carrying Home

Transfer always involves a motion in relation to place, and the spatial experience of place may profoundly impact the mood—(dis)comfort, (in)security, and so forth—and sense of well-being or ill-being that the parent experiences in relation to her or his child. When parents and child dwell in a place, something changes. Now, the space of the place may become familiar and homelike. A mother described the nursery as her daughter's first home:

> I call this place home, as silly as that may seem. But it is what you make of it. We can pull the curtain whenever we want, we can read, we can sit, and we can do whatever we need. This is the first home my child knows. Yeah, this little room is our home.

Almost surprisingly, with time, despite the intrusive technological complexity and superficial anonymity of hospital space, the medical nursery may acquire the atmosphere of dwelling, being at home: familiarity, connection, and sometimes stillness. Yet, the NICU may become more than a home place; it may become the family's home. An out-of-town mom recalled coming back to the nursery after a trip to her house home for the weekend:

> We are going on two and a half months here. This has become kinda like home. I went home for a few days, and it was all right . . . but then, when I came back I said, "Ahhh, I'm home again," because this is kinda like where real home is right now for me.

So, almost strangely, the parent can feel in place, at home, in a space that is altogether different from his or her regular house home, as they are afflicted with an almost an uncanny anxiety of not feeling at home in their true house home (Casey, 1993). We may wonder: How can parents ever feel at home in such a medical, technological place? Is this problematic? Is that what is or is not desired?

Embodied in place with his or her child, the parent may become accustomed to the communal rules and routines of the nursery. For example, the parent may feel at home while going through such familiar bodily practices of washing hands at the communal sink, keeping things tidy under the counter, and drawing up a chair to sit and care for their child. In this way, a parent may develop a familiar spatial and secure relational way of being in the NICU shared malleable space:

> I started breastfeeding and just had this really maternal connection with Tim, and wanted to stay here. So, I had my own room, a boarding room, and I really liked that, having the same place to go back to. I could listen to my radio, and I had my sewing machine there and I could work in the evenings, that kind of thing. There were other moms there so we would have supper together. It became our place. It filled a need that I had. It let me stay with Tim, and it gave us a sense of community.

The ability to be at home is perhaps essential to our nature as free beings, being in a place both of and for the self. Home permits an experience of passivity—a settling background to our day-to-day life, providing support and structure (Jacobson, 2009). The home may offer inner space for our inner life, "the house shelters daydreaming, the house protects the dreamer, the house allows one to dream in peace" (Bachelard, 1994/1958, p. 6). As much as they can, families may actively make the nursery their own. For example, just by drawing barriers around them, a mother and daughter can create the shell of a nesting place. Curtains may become walls, with the sliver of light shining through adjacent panels serving as windows. One mother compared two nursery spaces:

> The space there was just not homey compared to here. Here you have a little drawer to put stuff in, and you have a little shelf to put stuff on, and you can kind of make it home for whatever amount of time that you are here. There, they do not have that. There, the space is just an open wall, lined with all the babies.

Building by decorating and dressing a space is a sort of body outside our own, a second skin that opens room for bodily dwelling in place (Casey, 1997). Parents may settle in, and spread out their own bodily being into place.

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In other words, personalizing space by placing pictures, clutch toys, and other personal artifacts may be a felt productive activity through which parents may make a place for themselves in the nursery, a means of which their own dwelling is articulated. When as health care professionals we pull the curtain or open the door to walk into these spaces, we may feel the tension of intruding into a space no longer our own. We cross these inviolable self-enclosures that now may be felt as altogether private. We find ourselves peering between curtains like an ornithologist peering through bushes at an inhabited nest. A physician recalled in passing:

> I remember one night on call being asked to assess a baby. The curtains were closed so I knew the family was present. I peeked through the curtains to check if the mom was pumping, or if some other activity was going on that I should not interrupt. The mom was sitting in a chair beside her baby with one hand cradling the bassinette. She was watching her child sleep, deep in thought. I would have knocked on the curtains, if they had been doors, if I could have. Instead, I meekly said, "excuse me."

Transfer may illuminate the meaning and significance of place by exposing the creation of an abrupt displacement as the home nursery is left. Although the transfer may be a move to a place that feels in the end more or less positive than the earlier place, the transfer may still feel like a disruption. And so, the parents now find themselves out of place. If the new place is experienced as alien, then everything is measured against the familiarity of home. Little things become big things. A mother described her sense of moving from a "little corner that felt like home" to a new, different, open-area nursery, and then moving back "home" again:

> This is how I compare it: You are coming from like, a five-star, and going to a two-star. That is how I felt going over there. I understand that it is busy because it is surgical and all that kind of stuff, so it is obviously going to be different. But, it just did not seem as welcoming as it did here. It is almost like Las Vegas over there, lights and dings, and everybody is running all over, and I had a hard time just because this is the only place I have known. The way they do things over there is just so different from the way they do things over here.

As parents settle in place in the nursery, relationships develop. Parents can be seen watching out for each other and each other's children. The nursery may become "my child's neighborhood." Yet, with transfer, relations with staff and other parents may be broken or lost, again to be out of place:

> You get to know your neighbors. You need that companionship with the other mothers, to hear their stories, their experiences, to make it a little more comforting to you. So I was nervous in a way to know that, oh gosh, I have got to meet all new moms now.

The goal of care in the NICU is generally that eventually all children will be discharged to their house home. The journey home, though, may be marked by complications, some expected and others unforeseen. Sometimes transfer marks a change in the expectation of going home. As Sean's breathing difficulties persisted despite his evolving maturity, elective transfer was organized to a surgical NICU for a specialist airway examination:

> There, they were all preemies, and most just need to grow and learn to eat and then go home kind of thing. Whereas here, it is mainly surgical babies. Lots of them are heart babies; they need to have one to three surgeries. So you need to go through a big stressful surgery date and then wait for them to get better, and then wait again, and it is more uncertain in a way. There, everyone is scared when they have a preemie because it is more unexpected, but once you get over that, in general, lots of the babies just need time, time to eat and get stronger, those kinds of things. Here, it is more like the issues that they have are them, like you have a heart condition that follows you around for life. It is a different feeling. Coming here, I had to face that Sean was not going to just grow out of his problems and go home.

On this path of being carried home, transfer can leave a family in disarray and abandoned. As the future become more uncertain, Sean was transferred to a general pediatric floor bed to make room in the surgical NICU. To complicate matters, Sean became increasingly breathless, struggling with his breathing. A resident came to assess Sean, asking his mom, "Why are you here?"

> I said, "We came from the premature hospital and I would really like to go back there." And she said, "Normally we discharge from here," and that really made me stressed out, because I still thought we were going back to the premature hospital. I wanted to go back there. I had friends there that I had spent the whole spring with. Friends I was counting on seeing again, those kinds of things. And I felt like the doctors and nurses there were more in tune with my child's situation, like they knew who we were. When we came here, people did not know him, and I was worried about his care. Like, I know his medications got switched around. I know he was on caffeine at that time, and the dose was either halved

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> or doubled or something like that. Just this feeling like I needed to know everything so that someone did not make a mistake. We felt abandoned, like the doctors who knew us had just forgotten about us.

Coming back to familiar ground, with home on the horizon, may promise the return to a place of dwelling and belonging:

> I was so relieved and happy when we got back here. He had all his stuff in the bottom of his crib. He still had his spot in the room. It was a different spot, but it was the same room, with his same specialists that were following him before he left. I was so relieved just because I felt like this is where he has been taken care of. Here he is actually known.

> It was nice. It was like a weight off my shoulders. I did not have to worry about her like, is she going to be okay? Or, is she going to be taken care of? It was nice to come back. I felt more relaxed, I did not feel as tense, that I knew she was safer. Not that I was worried that she was not safe, but that I just did not have to worry, I guess.

In coming to a place of home, there may be a sense of passivity in place—relaxation, release, and relief. With a foundation of home, the future may again be revealed as free. The future may seem open and the journey out of the neonatal intensive care within reach.

Concluding Comments

The routine transfer of infants between hospital environments may be far from routine and innocuous from the family's perspectival experience. In this study, I explored the phenomenon of transfer to reveal a lived experience of carrying. The thematic events of carrying across, carrying between, carrying contact, carrying caringly, and carrying home speak to the eidetic meaning of transfer, and draw our attention to a relational ethics of care. In transfer, the carrier bears the responsibility to not only reach the destination, but also care for the carried while carrying. As such, for the parent, to have their child carried by another is to have their child cared for and cared about by another, even if only for a brief time.

In giving practical consideration to the phenomenon of transfer, perhaps the focus should be less on the physical distance between places, and rather on acknowledging that the experience of transfer relates to this felt carrying between lived places. As a lived experience, it is the perspectival, subjective experience of place that is considered. Place change, then, may also include the experience of changes in relations, routines, and so forth. Distance may be but a contextual feature of the transfer experience. From this perspective, a transfer just down the hallway may be a profoundly meaningful experience for parents. Even the experience of a new team of professionals taking over care of a child in the same physical space may dramatically alter a parent's experience of a place. Places may have embedded meanings—my child's first place, a place of loss, a painful place—such that leaving or coming to a place may have more to do with the existential experience of that place than its physicality. Transfer as a carrying experience between felt places speaks to the sensitivities and understandings required of the health care team that is responsible for both major and seemingly minor hospital transfers.

At a system level, we see the need for family-centered initiatives that support both child and parent, separate and together. When possible, a parent accompanying his or her child during transfer seems a natural way of being, rather than a parent traveling separate to find a way across to his or her child. Similarly, infrastructure development for hospital nurseries to provide not just a space for the child, but also a place for the family seems intuitive. Although mother–baby units and close-proximity boarding rooms are structural goals, the need for personal place is more fundamental. Prioritizing family–child space in the form of initiatives that truly bring parent and child together, such as kangaroo care where the child is laid skin-to-skin against the parent's chest, may help return the family to a pedagogically responsive way of being. The image of the child and parent together in touch starkly contrasts with the child as monitored, distanced away in an incubator. Neonatal intensive care admission and hospital transfer is a journey with which few families are familiar; thus, the offering of guided and virtual tours in the anticipation of admission and transfer may be appropriate for many families. Correspondingly, family-friendly informational materials to help make transparent and understandable the "routine" happenings of the neonatal intensive care may be valuable. Through sensitive practice we may help parents and their newly born to grow together as a family, to make a place for themselves in the nursery, and to cope with the changes inherent in their neonatal intensive care story.

At an individual family and professional level, an understanding of hospital transfer as an ethical responsibility of carrying speaks not so much to a change in specific procedure or hospital policy, but rather to a sensitivity of care. Members of the health care team need to relate to families not only as knowledgeable, skilled technicians, but also as thoughtful, tactful professionals. We must consider the complexities that make up the manifold of the experience of transfer in our being with families in both our routine and uncommon day-to-day practices as caring professionals. In this manner, before, during, and after transfer we continue to be responsible in a

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collaborative and supportive relationship with the families whose children have been entrusted to our care.

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