PROFESSIONAL RATIONALITY AND THE EMOTIONAL LABOR OF GENDERED CARING IN NURSING

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ABSTRACT

This dissertation offers an understanding of how the emotional labor of caring by female nurses is manifested, and whether this has changed from what has previously been described in the literature. A hybrid of Hochschild’s (1983) theory of emotional labor is used with concepts from symbolic interactionist and critical theory to guide this inquiry. From this lens, relevant concepts affecting emotional labor are considered in order to examine how the organization of work roles for nurses enable or constrain their ability to manifest a caring presence. As the healthcare delivery system and nurses’ roles have changed dramatically over the past century, looking at how nurses’ caring is configured into their work identity is useful for tracking changes in identity and career expectations. This work is important because there is some indication that market driven approaches focusing more on manipulating the perception of caring and quality care, are displacing the opportunities for caring by nurses. First, I review key terms essential to the study, particularly caring and emotional labor and then use theory and a review of literature on emotional labor through the lens of caring and gender. The specific research questions addressed in this research, from the qualitative data of female registered nurses (RN) are: ‘what is caring, how is it learned, what gets in the way of it and what facilities it?’ Finally
a thematic analysis of interview data is interpreted from a critical theory, symbolic interactionist and late capitalism perspective, with regard to the discourse of caring by nurses.

Keywords: emotional labor, dissonance, caring, nursing, emotional regulation
DEDICATION

A dissertation is an undertaking that influences the lives of many others. One of my many reasons for undertaking this work focused on my desire to demonstrate striving for success in life despite obstacles. I dedicate this dissertation to my nieces and nephews as a symbol of how important it is to learn to harness the value of feelings and thinking as they journey through their life.

To: Weber Marret, Jake Hogan, Elizabeth Weber, Justin Hogan, Sean Hogan, Chryslee Hogan, Chandler Hogan, and Casyn Hogan: May you always remember that you need your head and your heart to fully live as human.

And I also dedicate this work to my parents, Thomas Hogan who lived to see me complete this dissertation and to my not so long ago departed mother, Eddie Mae Hogan; and to my not so long ago departed sister, Rebecca Weber; and to my living siblings, Barbara Bruce and David Hogan.
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Table of Contents

ABSTRACT ............................................................................................................................... iii

LIST OF TABLES .................................................................................................................... xvi

LIST OF FIGURES .................................................................................................................. xviii

CHAPTER ONE ......................................................................................................................... 1

INTRODUCTION ...................................................................................................................... 1

Statement of the Problem ......................................................................................................... 1

What is Caring? ......................................................................................................................... 3

Benefits Accrued from Caring ................................................................................................. 4

Expectations for Caring ........................................................................................................... 6

Caring as an Undervalued Unrecognized Part of Economic and Family Life ............ 7

Changes in the Practice of Caring ......................................................................................... 9

Gender Influences in Nursing .............................................................................................. 11

Changes in Nursing Education and Scope of Practice Introducing the Hierarchy. 12

Dissatisfaction in Nursing ..................................................................................................... 14

Structural Constraints on Caring .......................................................................................... 15
Theoretical Summary Statement ................................................................. 77

Relevance to Nursing: The Gendered Nature of Nursing ................................ 78

CHAPTER THREE ...................................................................................... 83

Chapter Overview .................................................................................. 83

Defining Caring .................................................................................... 84

Gaut’s Philosophic Concept Analysis of Caring ......................................... 84

Swanson’s Literary Analysis of Caring .................................................... 86

Additional Studies of Caring ................................................................ 93

How Patients Define Caring .................................................................. 98

Benefits Derived from Caring ................................................................. 100

CHANGES IN THE PRACTICE OF CARING ........................................ 101

NURSING EDUCATION ............................................................................ 106

Gender Differences in Caring ............................................................... 110

A Gendered Division of Labor ............................................................... 118

EMOTIONAL LABOR OF CARING ....................................................... 125

Incongruence and Dissonance in Nursing Work ..................................... 137

Marketing Caring and Selling Emotional Labor for Score Cards .............. 138

Imposing a New Layer of Emotion Labor: Simulated Caring to Lessen Perceptions of a Lack of Caring ............................................................... 140

Consequences of Emotional Labor on Employee Wellbeing .................. 143
CHAPTER SIX ..................................................................................................................322

DISCUSSION AND CONCLUSIONS ............................................................................322

Chapter Overview ........................................................................................................... 322

Summary Evaluation of the Research Purpose and Findings ..................................... 322

Summary of Theory and Research Relevance to Discussion ..................................... 325

Caring-Confusion, the Transmutation of Caring ......................................................... 326

Caring Conflicts: Emotional Dissonance and Compounded Emotional Labor ......... 334

Regulating Emotion Arising from Interference with Caring ...................................... 340

Surface Acting and Deep Acting ................................................................................. 340

Emotional Labor’s Effects on Personal Relationships, Feelings of Exhaustion, and Emotion as a Signaling Function Related to Survival .......... 348

Exploiting Caring .......................................................................................................... 352

Conclusions and Recommendations for Future Actions and Studies ..................... 355

Final Remarks ................................................................................................................ 365

References ..................................................................................................................... 370

APPENDIX A ................................................................................................................. 476

UNIVERSITY OF ALABAMA AT BIRMINGHAM ....................................................... 476
CURRENT INSTITUTIONAL REVIEW BOARD APPROVAL ........476

APPENDIX B .................................................................................478

POSSIBLE INTERVIEW QUESTIONS FOR NURSES .........................478
LIST OF TABLES

Table 2.1 Definition of Terms relevant to critical theory ........................................ 33
Table 2.2 Summary of Perspective on which Critical Theory Perspectives Converge .. 34
Table 2.3 Symbolic Interactionism Principles ................................................................. 51
Table 2.4 Dramaturgical Concepts relevant to Emotional Labor ................................. 53
Table 2.5 Definition of Terms Relevant to Hochschild’s Theory of Emotional Labor .. 58
Table 2.6 Central Aspects of Hochschild’s Theory of Emotional Labor ..................... 60
Table 2.7 Examples of Emotional Labor Techniques used in Nursing Jobs .................. 64
Table 2.8 Potential Problems Arising from Emotional Labor in a Service Economy ..... 68
Table 3.1 Meta-analytic Studies of Caring and Categories of Caring Studies ............... 86
Table 3.2 Levels of Caring Studies by Study Focus from Swanson’s Analysis ................. 92
Table 3.3 Watson’s Ten Caritas Processes ........................................................................ 95
Table 3.4 Five Dimensions of Caring derived from Watson’s Caritas Processes ............ 96
Table 3.5 Summary of Implementation Outcomes for the Watson Caring Model ......... 97
Table 3.6 Examples of Conditions and Diseases associated with Work Stress .......... 149
Table 4.1 List of Personal Reflection Questions to ask During Data Analysis .............. 189
Table 5.1 Screening Results .......................................................................................... 193
Table 5.2 Demographic Characteristics of Nurse Participants .................................... 196
Table 5.3 Marital Status of Participants at Time of Interviews .................................... 198
Table 5.4 Educational Characteristics of Staff Nurse .................................................. 199

Participants at the Time of Interview ......................................................................... 199
Table 5.5 Ages of Participants ........................................................................................................ 200
Table 5.6 Racial Ethnic Reporting Status of Participants ......................................................... 200
Table 6.1 Summaries of Themes from Results ............................................................................. 324
Table 6.2 Emotional Labor Strategies Used by Nurses to Manage Caring Interference 346
Table 6.3 Set One of Conclusions and Recommendations Regarding Caring ....................... 356
Table 6.4 Set Two of Conclusions and Recommendations Regarding Workplace Stress,
   Emotional Labor and Health Risks ......................................................................................... 357
Table 6.5 Set Three of Conclusions and Recommendations .................................................. 358
   Regarding Exploitation of Caring ......................................................................................... 358
Table 6.6 Set Four of Conclusions and Recommendations .................................................... 359
   Regarding Emotional Labor Strategies .............................................................................. 359
Table 6.7 Set Five of Conclusions and Recommendations .................................................... 360
   Regarding Barriers to Caring ............................................................................................. 360
LIST OF FIGURES

Figure 2.1 Simplified Model of Emotional Labor of Caring........................................... 33
Figure 5.1 Four Main Themes from Nurses interviews on Caring................................. 201
Figure 5.2 Subthemes for Natural Caring, Caring as Part of Self-identity...................... 202
Figure 5.3 Theme Two: Accelerated Caring and Associated Subtheme ....................... 240
Figure 5.4 Subthemes for Flexible Caring................................................................. 280
Figure 5.6 Subthemes for Institutional Caring, Caring defined by others .................... 300
CHAPTER ONE

INTRODUCTION

*The most exhausting thing in life is being insincere.*
Anne Morrow Lindbergh

Statement of the Problem

An internet based newspaper in the United Kingdom reads, “Why have nurses stopped CARING? An investigation into the crisis hit [National Health System] NHS” (Coward 2013). In this news story, and in similar stories from other countries (Broder 2013; Bronstein and Griffin 2014), patients, families, and nurses reveal their personal horrors about witnessing unsafe care, serious errors, wrongful death, falls, and in some cases, outright abuse. In one case, patients were reported to have drunk water from a vase of flowers after being unable to summon someone to respond to their thirst (Reeves, Ross, and Harris 2014). How can this be? Are hospitals not supposed to be places of caring where one goes and trusts they will be cared for when needed?

A nurse administrator responded to this story that she had to let the staff know that caring and compassion were part of their job expectations and that this would be remedied (Coward 2013). The nurses, especially the older nurses, say this is but a small part of the problem; they describe a work culture on nursing units these days completely
unlike the one in which they trained. The nurses say that the focus of care today is on documenting checklists of stringent expectations related to reimbursement and accreditations with little time to care for patients directly. This is not the first time in our world history where we have paused and asked, “How could this have happened?” And now we ask again, how can this be happening?

Contrasting these stories are stories about compassion, caring, and altruism (Bronstein and Griffin 2014; Watson 2002). Hospitals showcase their caring nursing staff in advertisements for employment and when marketing patient care services. Caring nurses are understood to be important to patients and their families (Davis 2005; Messner 1993) and some hospitals are adopting caring theories along with returning the caring in nursing (Kostovitch and Clementi 2014; Watson 2002). Again, a question arises, are we embracing caring as a necessary inclusion in our healthcare system or are we abandoning it in the name of scientific progress, efficiency and bottom-line dollar figures?

Through various periods of a person’s lifespan, human beings sometimes need the caring assistance of their fellow human beings – sometimes just for a helping hand and sometimes for our very survival (Glenn 2010a; Kittay 2013[1999]). During these moments of being vulnerable, we hope the person who responds to our needs is a caring person (Scott, Aiken, Mechanic and Moravesik 1995; Al-Kandari and Thomas 2008; Brunero, Lamont and Coates 2010; Ceci 2004; Coughlan 2006; Douglas 2010) who can anticipate the needs we may be unable to express and who does so in a way that encourages a feeling of safety and respect.

Although most people agree caring is necessary (Bowlby1953; 1973; Fine 2006; Kittay 2013[1999]; Leininger, 1991; Mayeroff 1990 [1972]; Watson 2002), it is not
always prioritized for inclusion when considering the bare essentials for societal functioning (Cancian and Oliker 2000; England, Budig, and Folbre 2002; England 2005; Folbre 2002; Glenn 2010a and 2010b; Harrington-Meyer 2000). Part of the problem with care and caring is that it is often done in the shadows of other more highly-esteemed economic activities such as when one cares for an elderly family member while others in the family continue with their career progression. Aside from, and contributing to its invisibility, the definitions of “caring” can be nebulous, making it difficult to capture the essence and value of caring. I will consider some of these definitions in the literature review and theory section, and also will address them briefly here.

What is Caring?

Despite the many ways caring gets defined, it is still not entirely clear how caring differs from similar concepts like kindness, empathy, and compassion (Schantz 2007). Even so, scholars generally agree that caring is recognizable to people when they see it (Finfgeld-Connett 2008; Sargent 2012), and especially, when it is absent. Most dictionaries define “caring” in terms of action emanating from kindness and concern for another person (Stevensen 2010). This definition can be problematic in that it raises as many questions as it answers. Does favorable intent toward another suffice as an act of caring? Who decides if the behavior is caring? Does characterizing someone’s action as caring depend on the outcome of those actions? Do both the caring person and recipient of caring have to agree that the action was caring or helpful? Is it only the motive that counts?
Clarifying definitions of caring can be complicated and the answers deeply philosophical. For the purposes of this research, I chose the general definition of caring as “displaying kindness and concern for others” (Stevensen 2010: 204). Beyond this guidepost, the answers to how caring is defined will come from the participants in the research undertaken for this project. Participants’ meanings and descriptions of how they enact a caring presence, or caring identity, are discussed in the results section, where some of the meanings converge with definitions previously offered by scholars of caring.

Scholarly definitions of caring can also be problematic, especially for researchers. Watson (2008b) and others in nursing (Larson 1984; Lea and Deary 1999; Lea, Watson, and Deary 1998; Wolf 1986), have developed tools for measuring and defining caring, based on agreed upon behaviors and attitudes toward the patient. We know caring when we see it, when we experience it, and we especially know it by its absence. It is that missing ingredient in a highly vulnerable moment which might have made a difference in how someone experienced vulnerability. Over time, these memories may fade and caring may be minimized if it were not present, but for those who experience caring at these moments, they usually report it was transformative for them (Higgins 2001).

Benefits Accrued from Caring

At its most fundamental level, caring is necessary for survival (Bowlby 1953); it is also beneficial for physical health and emotional well-being (Leininger 1991). Patients who experience the staff as caring tend to have lower blood pressures (Butler, Lee, and Gross 2009; Gross and Levinson 1997; Light, Grewen, and Amico 2005), slower
progression of cancer (Gross 1989), faster healing times after surgery (Gouin and Kiecolt-Glaser 2011; Weinman, Ebrecht, Scott, Walburn, and Dyson 2008), quicker discharges (Gittell 2000), and fewer complications (Lelorain, Brédart, Dolbeault, and Sultan 2012; Street, Makoul, and Epstein 2009).

From initial diagnosis to follow-up of treatment progress, all that occurs in caring for a patient depends on the patient feeling comfortable enough to share their concerns and intimate life details with the care provider (Clair 2015; Coulter 2011). Patients who feel the care and compassion of caregivers are much more likely to understand and comply with their treatment regimen (Clair 2015; Scott et al. 1995: 78-80). This means there is evidence that caring is not just an optional add-on to the menu of care in a hospital; it is essential for delivering effective care (Lelorain, Brédart, Dolbeault, and Sultan 2012; Street, Makoul, and Epstein 2009).

Caring is especially important when a person is vulnerable because of illness or significant life changes (Leininger 1991; Watson 2002). Trusting one’s caregiver can facilitate the patient’s feeling of safety. This sense of safety that can be experienced during such periods of vulnerability can be demonstrated from a patient’s emotive recall of the experience.

*Going back to ICU, I made numerous trips for MRIs and so forth. I think I had either 3 or 4 preop, and a registered nurse went and stood beside me throughout the procedure for every one and almost insisted, and I’m glad she did, that I take some medication by about the third one, to settle me down a little bit because it was frightening. And she stood right outside, I mean I could see her. I could see my feet out there, and I could see my nurse, and she was right there. And sometimes she would tap me and say, ’It’s okay” and it was really nice. And she herself escorted me from the unit to*
MRI and back to the unit, one on one ... her presence, I knew that she knew how I felt and I thought that she would be my advocate. That she would pick up if some sort of immediate intervention were needed. It was a real security blanket ... it was continuity. She knew all about me ... She was my nurse; she was the one who suggested that she give me a sedative before the third one. She communicated things for me.

Shattell, Hogan, and Thomas 2005: 164

Patients who are under the influence of pain medications, who are without family members present, who speak a different language from the staff, or who have a terminal illness exemplify the many possible ways that illness can leave a person feeling dependent and vulnerable (Mattox 2010). It is this vulnerability of patients and the unequal status relationships in caregiver relationships with patients that make professional ethics violations such egregious offenses (ANA 2015); therefore, all professions given the right to practice are simultaneously charged with an expectation of caring and respecting those they serve (Freidson 1970; Parsons 1937).

Expectations for Caring

The American Nurses’ Associations Standards and Scope of Practice for Nurses state their expectation that nurses will be caring in their manner with patients (ANA 2010: 11-45). Likewise, hospital management and nurses both realize that the public expects their staff to be caring, especially nurses. Caring nursing staff is one of the main considerations patients have when completing patient satisfaction surveys (Bowling, Rowe, and McKee 2013).
Nurses have always included caring in their definitions of nursing (Reverby 1987). Even as technology has grown in importance to a nurse’s job, nurses still considered caring a central part of their responsibility (Alasad 2002; Cooper 1993). Caring is so ingrained in nurses that some nurses see caring as sacred (Leininger 1991; Watson 2002) and as being tied to their personal as well as professional ethics (Von Dietze and Orb 2000; Noddings 1984; Schoenhofer 2002). Caring is also seen as developing within a relationship, requiring time to get to know a patient well enough to demonstrate the trust and competence that are foundational to caring (Finfgeld-Connett 2008; McCance, McKenna, and Boore 1997; Peplau 1952). Most nurses see caring as a commitment to another person’s growth and healing (Mayeroff 1990 [1972]; Leininger 1991; Watson 2002) which requires putting the needs of the patient above one’s own needs (Sargent 2012; Watson 2002). The nurse who does not care risks negative evaluation by their patients and of their peers (Altmiller 2012; Savage and Favret 2006). Reverby (1987) sums up the problem of caring when she explicates the dilemma for nurses: they are expected to be caring by the same society that does not value caring.

Caring as an Undervalued Unrecognized Part of Economic and Family Life

On a societal level, some scholars suggest that caregiving is devalued because it is predominately done by females (England, Budding, and Folbre 2002; Reverby 1987). Since caregiving arose from undervalued female roles in the family, and nursing has also been devalued, some suggest this intertwined identity – nurse and female – has
contributed to the undervaluing and low pay of caregiving compared to other occupations (Eisler 1995; 2002; 2007; 2014).

In the Canadian healthcare system (and other countries are following suit), streamlining care shifts the burden of providing all but highly technical care back onto the family or community (Rankin and Campbell 2009). This often means, as Glenn (2010b) asserts in the title one of her books, that females are often *Forced to Care*. Increasingly, people find themselves having to care for others in their immediate or extended family as patients are discharged when less intensive care can be provided in a less expensive setting. Sometimes, the family is left to assume the caregiving role without compensation. An argument has been raised by scholars that the lack of economic value attributed to the care and nurturing necessary for a healthy and functional society fails to acknowledge the value of caregivers’ contribution to society (Eisler 1995; 2014; England, Budding, and Folbre 2002; Glenn 2010a; Harrington-Meyer 2000).

Changes have begun to be examined and suggestions made, but for now, the problem remains one of personal character and commitment as to one’s willingness to make a commitment to care. Like most social change, the observable changes are small, gradual, sometimes undetectable, and sometimes reverting back to their original state of affairs, even if the actors, props and stage generate an appearance of change having occurred. For example, nurses call themselves professionals and say they have autonomy (ANA 2010). The rule-orientation and constraints imposed on their practice by others does not fit with this asserted change.

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1 Although nurses’ pay may be unsatisfactory and incommensurate with responsibilities, their pay tends to be an exception to the lower pay of most caregivers.
Changes in the Practice of Caring

What is a nurse today? Once known as “angels of mercy” (Lagana 2001: 19) for their compassionate servitude to the sick and injured, nurses also have been called battle-axes for their unyielding enforcement of bureaucratic rules in hospitals and nursing care homes. Sometimes nurses have been called sex kittens, objects of desire for the handsome physician or the lonely patient. Nursing has been called woman’s work, God’s calling, a duty to country and mankind, a way out of poverty, a path for the well-to-do upper class woman interested in pursuing a respectable career (although sometimes only until marriage), and a means of financial support for the spinster or non-traditionalist woman disinclined to marry (Kalisch and Kalisch 1987; Darbyshire and Gordon 2005).

Nursing was a way to make a living for many, a way out of poverty, and an opportunity to do what was otherwise deemed unacceptable for women (Kalisch and Kalisch 1987; Porter, 1992a and b; Reverby, 1987; Valentine, 1996).

But what are nurses today? Are they still the nurturing, service-oriented icons of relief and compassionate caring to the patient dependent on their care? Examining the varied and changing images of nursing against sociopolitical changes affecting the practice of nursing, two representative images persist: nurses are female and nurses are caring (Adams and Nelson 2009; Gordon 2005). The nurse as a caring female is so ingrained in our psyches that it requires focused effort to erase it.

From the beginnings of nursing, it was viewed as a vocation suited for females (D’Antonio 2010; Davies 1980; Nutting and Dock 1907). Caring was a requirement for entering into nursing (Jasmine 2009; Sherwood 1995; Wilde 1997). Skills could be taught
in nursing school and on the patient care units, but unless the nurse’s natural caring
tendency could guide their actions in providing the required care, there was little chance
the nurse would be able to sustain the expected image of a nurse. How caring was shown
sometimes varied with the nurse’s personality, but patients and nurses came to
understand these variations through the developing relationship between patient and
nurse over the course of the patient’s care (Peplau 1952).

As technology entered into the care requirements of nurses, the faster pace and
greater intensity of care led nurses to seek ways to maintain their relationship and caring
focus with patients (Buckner and Buckner 2011). Despite the machinery and instruments
creating physical distance between nurses and their patients, nurses and patients still
thought caring was the foundation of a nurse’s work (Berg and Danielson 2007).
Technology is expensive and as healthcare costs rose, third-party reimbursement and
coverage issues escalated, and patients were admitted only for the most urgent physical
conditions (Adams and Nelson 2009). Even then, their care trajectory was fast-paced and
intensively focused on readiness for discharge to less expensive care. That care might
transfer to rehabilitation facilities, home care agencies, outpatient clinics or perhaps the
family members would have to learn how to provide the needed care. Because of the
intensity of care, nurses often were busy with immediate physical care and had less time
for psychosocial care. Patients often comment in studies about the hospital environment
that the nurses were so busy, they hated to bother them (Shattell, Hogan, and Thomas
2005).

With no time to show caring alongside rising demand for quality scores (Pearcey
2010), administrators use checklists, team talks, and predetermined scripts to ensure
caring occurs in this fast-paced environment (Bryman 2004; Francoeur 2004). There is some indication in the gender literature (Ollilainen and Calasanti 2007) that using family metaphors in team-talks encourage female workers to perform emotional labor and perpetuate the gender hierarchy of workplaces. Nurses acknowledge they do not have time to show caring to patients; sometimes they cannot even complete required and ordered physical care, though they report longing to be able to do the little things they do not have time for anymore (Pearcey 2010). There are differences, however, in how male and female nurses manage the display of caring (Robinson et al. 2014).

Gender Influences in Nursing

There is some indication that gender stereotypes are becoming less entrenched in nursing (McDonald 2013; Thompson, Glenn, and Vertein 2011) and that nursing is attracting fewer traditional female types (Clow, Ricciardelli, and Bartfay 2015; Fettig and Friesen 2014). Some scholars think this may be because nursing and nursing education has become more focused on technology and science (Sandelowski 1999). Nursing also is aggressively recruiting males (Clow, Ricciardelli, and Bartfay 2015) and nontraditional students (Fernandez, Salamonson, and Griffiths 2012).

In contrast, studies showing the enduring image of the nurse as caring and feminine still attract predominately female students (Eley, Eley, Bertello, and Rogers-Clark 2012). While some studies suggest nursing students are more androgynous (Thompson, Glenn, and Vertein 2011), others suggest males and females are more alike on feminine traits (Loughrey 2008), especially caring and nurturing. This is not surprising since gender socialization places the burden of expressing oneself as a caring, nurturing
person on females (Chodorow 1995 [1978]; Radsma 1994), but also clearly depicts the masculine role as more esteemed (Kimmel 2000). Nursing might easily become a repository for females who are adhering to traditional role prescriptions, however, the recruitment of males (Clow, Ricciardelli, and Bartfay 2015) and nontraditional students (Fernandez, Salamonson, and Griffiths 2012) suggest efforts are being made to present nursing as more gender neutral. Males who attend nursing programs still report gender stereotypes (Dyck, Oliffe, Phinney, and Garrett 2009; Meadus and Twomey 2011) and having to struggle with mixed messages regarding their gender role adherence in an all-feminine occupation.

Some people suggest that males in nursing experience advantages (McMurry 2011; Williams 2012) such as faster career progression and higher salaries. Also, males are not held accountable for expressive demonstrations of caring to the same extent as female nurses (Rose and Bruce 1995). However, there are indications in that the norms for demonstrating caring may be shifting away from the emotionally expressive demonstrations of caring typically associated with female-caring (Bartfay, Bartfay, Clow, and Wu 2010; Cottingham, Erickson, and Diefendorff 2014). This suggests outward displays of caring may be becoming more normative in nursing practice and nursing education.

Changes in Nursing Education and Scope of Practice Introducing the Hierarchy

Another change in the nursing workforce has to do with the hierarchy of nurses. While the protracted issue of entry into nursing-practice has remained in the background and is periodically resurrected, the baccalaureate prepared nurse has become the
highbrow of the registered nurses (Smith 2008). With hospital diploma nurses nearly nonexistent, college-based associate and baccalaureate programs are the only options for becoming a nurse, with the baccalaureate degree preferred. Expanding career options for nurses away from bedside care has created new job titles, credentials, and advanced education (Gershon et al. 2007; Hamington 2010; Heide 1973; Porter 1992a and b; Ward 2010) that has generated a hierarchal arrangement of nursing and medical work (West, Barron, Dowsett, and Newton 1999) that has been termed “constituting of the classes” (Charles-Jones, Latimer, and May 2003). Sometimes these new roles are implemented quickly with minimal time to negotiate role responsibilities with other nurses and medical staff (American Nurses Association [ANA] 2012; Miller and Holm 2011). These circumstances can invite conflicts, and because the positions often raise the nurses’ salary and status over that of staff nurses, these expanded roles can generate hierarchies within nursing adding to occupational tensions and resentments (Hogan 2012) and transforming the discourse of caring into one of efficiency and effectiveness (Charles-Jones, Latimer, and May 2003).

Some scholars suggest that when nursing education moved from the traditional hospital based training programs into the university setting, the kind of nurses attracted to nursing changed (Clifford 1995; Jones 2007; Woodward 1997). With nursing roles outside of the traditional hospital staff nurse, entering students of nursing sometimes come into nursing school with the stated intent of becoming a nurse practitioner or nurse anesthetist (Shindul-Rothschild, Berry, and Long-Middleton 1996). Aside from generating nursing hierarchies, the addition of alternative nursing career paths during a projected nursing shortage compounds the crisis (Duvall and Andrews 2010; Fox and
Abrahamson 2009). Baccalaureate programs can become recruiting grounds to channel matriculating nurses straight into doctoral programs in nursing in hopes of creating a pipeline of new faculty to replace retiring faculty (AACN 2011), but may further marginalize staff nurses at the bedside (Cummings, Fraser, and Tarlier 2003; MacKusick, Issac, and Minick 2010). Providing direct patient care often times is seen only as a necessary step on a more preferred path in nursing.

A number of scholars have noted that over the years, the division of labor in nursing has placed the registered nurse further away from working on the patient’s body (Charles-Jones, Latimer, and May 2003; Lawler 1991; Twigg 2006) by delegating these duties to patient care assistants. Distancing from the body also occurs through the use of technology, placing machines, tubes, and monitoring gadgets between the nurse and the patients. These things change the relationship between nurse and patient, making the foundation for caring less emergent from a relationship that develops out of mutual trust and respect (Abel and Nelson 1990). Bodily care has been characterized as dirty work (Emerson and Pollner 1976) with the degree to which one can remain distant from it being an indication of one’s relative status in the healthcare hierarchy.

Dissatisfaction in Nursing

Dissatisfaction of nurses is also at an alarmingly high level with many nurses making plans to leave nursing altogether (Buerhaus 2008; Aiken et al. 2002). Being surrounded by more experienced but dissatisfied nurses makes it more difficult for new nurses to adapt to their roles. This initial negative experience can set the stage for an early retreat from nursing for new nurses.
Nurses are not dissatisfied that the work is too difficult or demanding. Rather, it is that no matter how hard they work, nurses report being unable to complete their job according to their own professional ethical standards (Dunn 2012; Tufte, Clausen, and Nabe-Nielsen 2012). When nurses who were attracted to nursing because of a desire to be caring with patients encounter a lack of caring opportunities, this unanticipated experience (Pellico, Brewer, and Kovner 2009) makes it difficult to retain these nurses at the bedside. This is counterproductive to efforts to increase the supply of nurses to offset the ongoing shortage of nurses (Djukic, Pellico, Kovner, and Brewer 2011; Khokher, Bourgeault, and Sainsaulieu 2009; Kramer 1974; Walsh 2009).

Dissatisfaction in nursing becomes an open exit door through which experienced and increasing numbers of new nurses pass (Morrow 2009). There is concern about who will be left at the bedside to care for patients. Sometimes the difficulties with the nurse being able to show caring has to do with the organization (Goodrich 2012; Jones 2007; Lea, Watson, and Deary 1998; Scott et al. 1995) or some aspect of the greater social structure in which hospitals operate.

*Structural Constraints on Caring*

How and whether a nurse can show caring depends on the structure and context of the work environment (Goodrich 2012; Jones 2007; Lea, Watson, and Deary 1998; Scott et al. 1995). There has been some suggestion that nurses currently are more focused on instrumental or task oriented kinds of caring (Bradley and Falk-Rafael 2011) as opposed to emotionally expressive caring.

As managed care has been implemented, hospitals have had to focus their gaze on the financial bottom-line and measured outcomes (Adams and Nelson 2009). This
means the traditional oversight provided by a nurse on a patient care unit is quickly transferred to less expensive outpatient facilities and home care. Sometimes patient discharge criteria are met before the regulatory requirements for admission assessments have been completed, creating an impossible bind between rules and expectations.

Dr. Naomi Weisstein (2006), hospitalized many times for life threatening complications from chronic fatigue syndrome, ponders this focus on dollars.

*Why are hospitals such nightmares? Partially for economic reasons. Even at the "best hospitals," managed care has done its depredations in the name of "efficiency" and profit. They fired so many nurses in the quest for dollars that now there's a critical nursing shortage. The nurses who remain are so unconscionably overworked and stressed out, it's hard for them to be pleasant. It's also hard for them to stay on the job, contributing to a further reduction in staff.*

Weisstein 2006: 216

Instead of worrying about sentiments of staff, patient’s sometimes say that at the end of the day, the fact that they survived was what mattered the most to them (Shattell, Hogan, and Thomas 2005). Expressing relief for just surviving misses that opportunity to experience a caring presence during difficult moments.

The reaction of nurses to the structural constraints on caring varies. Some nurses appear to be resilient (Jackson, Firtko, and Edenborough 2007; Skovholt and Trotter-Mathison 2011), but it is not clear if this is a function of extreme loyalty, social support systems, or financial well-being independent of their nursing employment. These resilient nurses are the exception; more nurses have problems related to their experience of emotional intensity and ethical conflicts in the workplace (Aiken, et al. 2002; Buerhaus 2008). Specific terms appear in the literature to capture this dilemma of caring in nursing:

Some scholars suggest that nurses who are dissatisfied with their hospital work environment may be dissatisfied because of how work conditions constrain their expression of caring (Aiken, et al. 2002; Buerhaus 2008). Documentation requirements have grown while time with patients has diminished, leaving nurses wondering about the integrity of what they are charting (Rudge 2011).

Most nurses acknowledge that it is somewhat difficult to maintain a caring manner for the length of a 12-hour shift. However, many nurses report they like 12-hour shifts (Geiger-Brown and Trinkoff 2010), in terms of having fewer days to work. Unfortunately, they find the 12-hour shifts to be draining and requiring a prolonged recovery time (Rogers, Hwang, Scott, Aiken, and Dinges 2004). There is ample evidence that 12-hour shifts add to a number of safety issues for the patient and nurse, yet these shifts remain commonplace in hospitals (Rogers, Hwang, Scott, Aiken, and Dinges 2004).

An added issue in nursing work unpleasantries is the increasing occurrence of workplace bullying. Interestingly, much of the bullying comes from fellow nurses, patient care assistants, and sometimes patients (Hutchinson, Vickers, Jackson, and Wilkes 2006). While physicians may still engage in some workplace bullying, this is much less than in years past (Hodson, Roscigno, and Lopez 2006). The common explanation for the
increase in workplace bullying is to call it” horizontal violence” (Roberts, Demarco, and Griffin 2009) and attribute it to oppressive group behaviors of nurses). Other scholars argue that this explanation minimizes the organizational context which perpetuates the conditions affecting nurses’ work (Hutchinson et al. 2006).

These conditions leave little time for the nurse to focus on being caring (Bone 2002; Pearcey 2010), even though it remains an expected part of their work identity (Amendolair 2007; American Nurses Association [ANA]; Daniels 2004:183; Hallam 2000; Watson 2008). Nurses perceive that a breach in their contract with the organization has occurred when they are unable to provide good care (McCabe and Sambrook 2013).

However, others say that perhaps nurses never really have been caring (Fletcher 1997). After all, nurses also have been described as some of the most judgmental healthcare workers with regard to patient lifestyle, stereotyped views of marginalized persons (Harling 2014; Higgins, Van der Riet, Slater, and Peek 2007; Soderhamn, Lindencrona, and Gustavsson 2001), and conservative attitudes toward other people’s value choices (Chiang 2014). Perhaps, the caring was just part of an image that is missed in a nostalgic way; perhaps, nursing like other areas of society has changed and become less caring (Staden 1998; Williams 1992).

Marketing Caring

Lacking time for the little things that demonstrate caring to patients such as discussing the patient’s day-to-day lives and learning how that impacts their illness (Pearcey 2010), nurses are expected to follow scripts that are supposed to help create the perception that patients have been well cared for. These scripts are guaranteed by customer experience management (CEM) experts to improve patient satisfaction scores
(Bryman 2004; Francoeur 2004; Hallett, Madsen, Bateman, and Bradshaw 2012; van Maanen 1991). Knowledgeable patients expect to participate in their care (Hafferty and Light 1995). With this in mind, a CEM expert states:

*Therefore, the challenge for the marketer is primarily to build the perception of delivering great health care*

(george 2008:181).

*Scripts for caring.* The market-approach calls for nurses to portray choreographed actions, words and phrases in all interactions with their patients (Bradshaw 2009; Ritzer 1993). Doing so transforms an interpersonal function into a simulated performance of caring (Baudrillard 1994). Visual signs, cues, and scripts reproduce the feeling of being cared for when time is lacking to develop the relationships between nurses and patients needed to enact genuine caring. However, healthcare delivered according to principles of marketing looks different from healthcare based on improving health status.

Marketing principles focus on the patient’s experience and perception of having received good care. Throughout the hospital, staff communicates consistent messages: ‘*We just want you to know we are here for you*’ or ‘*Is there anything you need, I have time?*’ (National Nurses United 2010; Tholis and Kozlowski 2012; Vest and Gamm 2009). These key phrases, visual cues and written information appear in the corridors and hallways of the hospital mirroring the questions asked in patient satisfaction surveys. The patient is being primed for filling out patient satisfaction survey when they are discharged. When the patient completes this survey, they are presumably inclined to endorse familiar items and phrases. Agencies such as Medicare use such patient
satisfaction instruments as the Hospital Consumer Assessment of Health Provider and Systems (HCAHPS) and base their payment on good scores, a third of which comes from the patient’s experience of satisfaction (Guadagnino 2012; Sellers 2013).

Loss of the real – simulating caring. These CEM tools – scripts and key phrases – are seen as insincere by many nurses. Some nurses say these market-based methods fail to address patient’s medical and nursing needs and also violate the trust between the nurse and their patient. (Amendolair 2007; Begat, Ellefsen, and Severinsson 2005; Corley 2002; Dunn 2012; Geiger 2012; Kalvemark et al. 2004; National Nurses United 2010; Pearcey 2010; Tufte 2013; Ulrich et al. 2007).

The focus on documentation to compliance requirements creates appearance of good care for insurers, credentialing and certifying bodies, and for the public image of the hospital and its staff (Geiger 2012; Rudge 2011). The added requirements and performances detract from the nurse’s time to do other nursing care and imply a trust issue with the staff’s professionalism as noted in the comment below:

“It's no longer enough to turn out the lights and close the door so patients can have an environment conducive to a good night’s sleep. Now nurses must add the phrase, “I am closing the door and turning out the lights to keep the hospital quiet at night,” so patients have a mental cue implanted when they encounter a related HCAHPS question”

Geiger 2012: 11
Some nursing scholars argue this marketplace orientation in nursing is detrimental to nursing’s’ continued legitimacy (Austin 2011). Emotional labor scholars (Wharton 2009) note that scripts, such as those used in marketplace approaches to good patient care scores, are generally used for employees unable to appreciate the complexity of the job’s emotional requirements or employees lacking emotional competence.

The Work of Emotional Labor

Regardless of where caring comes from in a nurse, whether it is feminine or gender neutral (Fejes and Haake 2013), when it is absent from expression by members of an occupation whose identity is built around caring (Houtsonen and Wärvik 2009; Kirpal 2004; Mezey and Fagin 2001), incongruity is to be expected. Nurses’ work involves many incongruities and these incongruities will be described in the theory and review of literature section as cognitive (Festinger 1957) and emotional dissonance (Hochschild 1983), terms reflecting the feelings generated by incongruence at the level of thoughts, behaviors, attitudes, or feelings.

An example of emotional labor done would be feeling contempt for a patient who is an alcoholic but having an ethical obligation to treat all patients with respect. Thus, the nurse would have to regulate feelings and values in a way that allowed the ethical obligation to be realized. Mismatched feelings and thoughts are extremely uncomfortable and is the essence of what happens in emotional labor (Gray 1999; Hochschild 1983; Smith 1991; 1992; Smith and Gray 2001; Theodosius 2008) when nurses have to display feelings that do not fit the situation in which they are working. The severity of discomfort
guarantees an effort to regulate the feelings, usually by one’s beliefs, behaviors, attitude, or emotions (Festinger 1957; Butler, Lee, and Gross 2009; Hochschild 1983) to fit the situation when it cannot be evaded. The emotional labor of nursing has been a job requirement expected by nurses (Lachman 2012) in order to present a caring nonjudgmental manner to their patients. With this understanding, nurses usually try to moderate their responses to maintain a professional and caring appearance congruent with their ethical standards of practice even when dealing with patients who are rude, critical, or demanding. Obviously, maintaining a caring presence requires a certain amount of emotional labor effort (Gray 1999; Henderson 2001; Smith 1991; 1992; Smith and Gray 2001; Theodosius 2008). The effort varies depending on the particular personal reactivity of the nurse, which is why nurses are encouraged to engage in personal growth and self-awareness as part of their professional development (Freshwater 2000). Nurses always have had to juggle emotions (Bolton 2001) to manage a myriad of patient and family situations such as avoiding letting patients detect any disgust or embarrassment over private topics around bodily function or appearance (Gimlin 2007).

A New Kind of Emotional Labor

It appears that today’s nurses have a different kind of emotional labor to perform. When nurses are uncomfortable performing the required emotional labor to achieve a caring presence with a client, this might be termed secondary emotional labor. In secondary emotional labor, the nurse experiences a second layer of emotional labor because of the ineffectiveness of one’s emotional labor effort.
But when nurses are having to engage in emotional labor because they are not able to perform the emotional labor of caring as they are ethically expected to do, and when the organization is prohibiting the emotional labor through structural constraints, this might be also be termed secondary emotional labor because it requires a second layer of emotional regulation to manage ones feelings.

When however, the organization imposes another level of emotional labor that conflicts with professional mandates and ethics, such as reciting required scripts that are contrary to what one is able to do, this might be termed tertiary emotional labor.

Nurses are finding they must suppress their caring in order to complete their work tasks (Bolton 2002; Lewis 2005). Because of their ethical commitment to care as a core value of nurses and central to both personal and professional identity, having to suppress the urge to be caring in order to instead be able to perform mandated tasks efficiently and quickly, conceivably could be one of the most difficult kinds of emotional dissonance for nurses (Coughlan 2006; de Raeve 2002; Hochschild 1983). It is this kind of labor that holds the greatest potential for dissonance in nurses. Based on emotional labor theory, there would be more discomfort when dissonance impinges on one’s identity and commitment (Abraham 1998; Brotheridge and Grandey 2002; Grandey 2000; Morris and Feldman 1996; Pugliesi 1999). There are however, also physical effects from the stress of emotional labor.
Physical and Emotional Effects of Nurses Work Environment

With an already stressed nursing staff functioning beyond the level of adequate resources, this kind of work stress is problematic to a nurse’s emotional and physical health (Chandola, Brunner, and Marmot 2006; DeVries, Glasper, and Detillion 2003; Ellenbogen, Schwartzman, Stewart, and Dominique-Walker 2002; Eller et al. 2009; Siegrest 1996; Van Vegchel, De Jonge, Meijer, and Jan Hamers 2001; Karasek and Theorell 1990; Van Vegchel, De Jonge, Bosma, and Schaufeli. 2005; Van Vegchel, De Jonge, and Landsbergis 2005). Demanding jobs in which the worker lacks the needed autonomy, control, and resources to perform their job successfully have been linked with serious health issues such as cardiovascular disease, diabetes, cholesterol, and metabolic syndrome (Amick et al.1998; Berkman, Buxton, Ertel, and Okechukwu 2010; Chandola, Brunner, and Marmot 2006; Dedert, Calhoun, Watkins, Sherwood, and Beckham 2010).

Emotional Effects

Nurses also have expressed concerns about their family life, self-care, and personal relationships (Agosti, Andersson, Ejlertsson, and Janlöv 2015). Nurses report being emotionally drained by their work (Simon, Kümmerling, and Hasselhorn 2004) and this affects their personal relationships and self-care ability. In fact, the incidence of depression (Letvak, Ruhm, and McCoy 2012) and post-traumatic stress disorders (Laposa, Alden, and Fullerton 2003) is higher among nurses than the general population.

There is also an issue of trust and safety looming as emerging threats to the nurse’s health comes into public view (Rushton and Broome 2015). This was evident in the recent concerns expressed by National Nurses United and local State Nursing
Associations about inadequate preparation of nurses and facilities for Ebola (McPherson 2014) and contagion issues. Such occurrences leave nurses feeling undervalued. In fact, some scholars suggest that all caregiving is devalued in society.

Significance of this Dissertation

The importance of this dissertation is sevenfold. First, caring is worthy of consideration because how we value or devalue caring impacts our survival as human beings (Benson 2011; Bowlby 1953; Champagne 2010; Harlow 1958, 1971; Lupton 2011). When caring is lacking, infants do not thrive (Harlow 1958; 1971; Champagne 2010; Schore 2001), children are predisposed to physical and psychological stress problems in adulthood (van der Kolk 2005), and the negative effects of stress are worsened in adults (Benson 2011; Bowlby 1973; Harlow 1958; Thoits 2011; Umberson and Montez 2010; van der Kolk and McFarlane 1996).

Secondly, holding nurses to an ethical mandate of caring and then interfering with that imperative to care by work designs that block control and resources is oppressive and potentially abusive (Adler and Borys 1996; Falk-Rafael and Betker 2012; Kirchhoff and Karlsson 2009; Shoqirat and Cameron 2012). Obscuring the restricted control nurses’ have over their work with conflicting rules, policies, and procedures while promoting rhetoric of autonomy and professionalism adds stress to nurses’ work (Folkman and Rankin 2010), and frames shortcomings in work performance as individual problems of nurses (Andrews, Karcz, and Rosenberg 2008; Beck 2009; Meyerson 1998; Hutchinson et al. 2006).
Third, an excessive focus on rationalized work processes and efficiency, as can occur in a managed care environment, is conducive to psychic numbing (Berlant 2008; Waitzkin 2000). The absence of time allotted for workers to reflect upon decisions and actions in such a high stress and fast paced environment, raises one’s vulnerability to manipulation (Bauman 1989), and leaves one insensitive to suffering (Bauman 1989; Berlant 2008; Bowden 2000; Sumner and Townsend-Rocchiccioli 2003; Waitzkin 2000). This potentially raises the likelihood of problems experienced by patients.

Fourth, this particular type of work−demanding, but with little control over outcomes−has been linked to serious mental and physical health problems for employees (Karasek et al. 2010). Cardiovascular problems have been linked to this particular type of job strain (Schnall, Landbergis, and Baker 2004).

Fifth, nurses, 92 percent of whom are female (Bureau of Labor Statistics [BLS] 2010), are said to be in short supply (Duvall and Andrews 2010; Fox and Abrahamson 2009; Grinspun 2003). Furthermore, surveys on the status of the United States nursing workforce revealed that 93 percent of nurses are dissatisfied with working conditions; some of them reporting being dissatisfied enough to be considering leaving nursing altogether (Buerhaus 2008). The continued recruitment of nurses into the profession without correcting issues pertaining to retention permits nursing to be a repository for inexperienced nurses without the benefit of mentorship and stability for responding to the economic and marketing shifts in healthcare design (Price 2009).

Sixth, hierarchies within nursing have developed as new roles, changed titles, preferred education, and certification credentials have been added. These hierarchies within nursing add to the existing subordination of nurses in the patriarchal structure of
healthcare, especially in hospitals (Ashley 1976; Fletcher 2006; Fletcher 2007; Harmer 2010; Jarrin 2007; Lemonidou and Pappathanassoglou 2004). Hierarchies, by definition, promote non-egalitarian relations which are incompatible with caring (Porter 1992 a and b; Gershon et al. 2007; Hamington 2010; Heide 1973; Ward 2010). Nurses’ ability to negotiate caring in their work will be constrained by the social and organizational ideologies perpetuating hierarchal relations (Dong and Temple 2011; Ehrenrich and English 2010; Sauer et al. 2007). Thus, it is important to raise the issues for consideration and reflection.

Seventh, sociologists have called for a reevaluation of the theoretical assumptions around dependency, care and caregiving (Bruhn and Rebach 2014; Drentea 2007; Eisler and Potter 2014; England, Budig, and Folbre 2002; Fine and Glenndinning 2005; Glenn 2010a and b; MacDonald and Merrill 2002; Oliker 2011; Thoits 1989). Gordon points out that as society undergoes change, so do emotions— including caring (1987:136).

All of this raises several questions that will be explored in this dissertation. If nursing continues to be 92 percent female, how has nursing been affected by changing gender roles? How do these traditionally female characteristics of nurses fit into a healthcare system that is increasingly driven by technology, bottom-lines and a market-based model for attracting customers? And what of the changing roles of nurses: can nurses still depict caring as it has been previously described by traditional female characteristics? If nurses still have a caring disposition, how do they manifest it in a day-to-day work environment that is increasingly controlled by demands to complete specific tasks and regulatory standards imposed by the multiple financial entities committed to the most efficient, least expensive bottom line outcomes?
The relevance of this inquiry about the emotional labor of caring is that nursing, a female-gendered, service-oriented job, has historically been associated with the subordination of females. The gendered nature of nursing is strongly supported by a tradition and societal expectation of submission to exploitation and oppression.

Specific Aims of this Dissertation

The aim of this dissertation is to reveal how nurses negotiate the caring function of their jobs in the acute care environment of hospitals, to discover practices that (intentionally or unintentionally) suppress caring by nurses or require displays of caring in the absence of genuine opportunity to demonstrate caring action, and to understand how nurses manage threats to their identity as good nurses (i.e. caring). In order to study this type of incongruence described by Hochschild (1983) as part of emotional labor, it is necessary to draw upon theories of the sociology of emotions and the sociology of work through the lens of emotional labor theory. The next chapter will review the theories related to caring in nurses’ work.
CHAPTER TWO
THEORETICAL FRAMEWORK

*Theory is an arbitrary structure that we impose on chaos to make it meaningful and predictable*

*John Whiting*

Overview of Chapter

Using several theoretical perspectives, I propose a model of how nurses use emotional labor to show caring. I use Hochschild’s (1983: 3-10) emotional labor theory, which, as she acknowledges, is derived from the symbolic interactionist perspective of Goffman’s dramaturgy theory and the critical theory perspective of Marxism theory. Both critical and symbolic interactionist theories share the aim of examining how language, symbols, and meaning can generate contradictions in a social system. The symbolic interactionist perspective captures the interactional features of relationships, social norms, roles, and identity, while the critical theory perspective expands the understanding of these concepts for examining how structural constraints, including ideologies, may promote or interfere with the emotional labor of caring.

Combining these two perspectives into the emotional labor theory of Hochschild (1983) becomes a useful theoretical lens for this study of how nurses are encouraged or inhibited in performing the emotional labor of caring in the market based healthcare
system. The specific critical theory of focus in this model is Marxist theory including early and neo-Marxism, and late capitalism theory. The symbolic interactionist theory used in this model is Goffman’s dramaturgy theory, which uses the metaphor of the theatrical stage to illuminate social processes shaping human behavior. The model proposes that the facets involved in performing emotional labor are understood by considering: (1) societal expectations of nurses to be caring, (2) nurses’ expectations of themselves as caring, (3) features of the hospital environment supporting or interfering with the nurses’ caring role, (4) nurses’ feelings of coherence or incongruence about fulfilling their caring role, (5) the nurses’ capacity to promote institutional goals, and (6) how adding institutional expectations for internal marketing to promote institutional goals may be obscured by a sense of incoherence in the nurses or enhanced by a sense of congruence. This presumes that nurses and society expect caring from nurses, and that while the emotional labor of caring may entail work, it is work that is congruent with role expectations.

On the other hand, when, the emotional labor required is generated by interference with the expected emotional labor of caring, the emotional labor performed by the nurse assumes an added burden. I introduce, and propose the term, “secondary emotional labor”, to refer to the added emotional strain experienced by nurses who have to suppress feelings of frustration and job estrangement so that these emotions do not get in the way of the successful performance of the emotional labor of caring that is expected by and of the nurse. The stress of “secondary emotional labor” is exacerbated by imposing scripted performances on nurses to create an appearance of caring. Because the expression of genuine caring has been constrained, the nurse is placed in a position of
performing simulated caring (Hogan 2013). This potentially represents a third layer of emotional labor (tertiary), conceptualized through emotional labor theory as a response to management’s efforts to counteract the effects of structural constraints interfering with role-congruent emotional labor of caring by nurses instead of the constraints being addressed.

Both of these theories, critical and symbolic interactionism, as foundational to emotional labor, will be reviewed before specifically discussing emotional labor. Following an overview of critical theory, I will discuss the Marxist concepts of commodification, false consciousness, exploitation, and alienation. I will then discuss late capitalism as a concept depicting the expansion of capitalism into increasing areas of the economy and personal lives, demonstrating how this impinges on the performance of emotional labor of caring by nurses in a market based hospital setting. Next I will discuss the principles of symbolic interactionism. I will shift to the more specific symbolic interactionist theory of Goffman addressing front and back-stage performances, scripts, roles, and props. Finally, I propose the hybrid emotional labor model, introducing the conceptual term of secondary emotional labor, applied to the performance of emotional labor in a market-based hospital setting. A simplified version of this model (see Figure 2.1) suggests how the concepts from these theories collectively contribute to an understanding of the emotional labor of caring in the nursing workplace.
Because hospitals have begun to adopt a market approach to healthcare services (Bowen and Schneider 1995), the critical theory perspective is helpful in understanding how to conceptualize emotional labor in this setting. An overview of critical theory aims and perspectives is presented next.
Critical Theory Perspective and Aims

Critical theory emerged out of the work of Karl Marx (Tyson 2006: 56). Although the various critical theory perspectives have shifted away from Marxist theory over the years, the enduring influence of early and neo-Marxist thinking remain helpful in understanding a society whose economy relies on a capitalist mode of production. Much of Hochschild’s (1983: 3) theory is based on Marxist concepts such as labor exploitation, commodification, alienation and false consciousness. Table 2.1 includes some of the terms and definitions pertaining to critical theory.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>ideology</td>
<td>The ways in which language, symbols and meanings are used to reproduce power relations for those who are in power</td>
</tr>
<tr>
<td>domination</td>
<td>Unequal power relations in which one group is able to restrict the freedom and choices of another group</td>
</tr>
<tr>
<td>emancipation</td>
<td>Realization of ideals of freedom and equality</td>
</tr>
<tr>
<td>democratic</td>
<td>Free and open communication</td>
</tr>
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Derived from Buchannan 2010

Theories categorized as critical theory share certain unifying principles (Fuchs 2009; Littlejohn 1992: 238). These areas of agreement are listed in Table 2.2. As noted in the table, the essence of critical theory is an obligation or commitment to critique society.
(Macey 2000). In so doing, critical theory seeks to uncover hidden, taken-for-granted aspects of the social structure that support and legitimize recurring injustices in society. Critical theory aims to address these recurring injustices by exposing social processes that limit democratic participation in society and replacing them with policies and practices that create a more equitable social structure (Hall 1999).

Table 2.2  Summary of Perspective on which Critical Theory Perspectives Converge

- a commitment to critiquing society (Tyson 2014)
- an assumption that phenomena are constructed in such a way as to reinforce existing dominant ideologies and power structures (Fuchs 2014).
- an examination of the historical development of social phenomenon for inequities that tend to get repeated insidiously (Freire 2006 [1973/1993])
- a deconstruction of these social processes to reveal the interconnected social and economic relations, including who benefits from these arrangements and who is omitted (Derrida 1993)
- a commitment to increasing opportunities for social justice and a more democratic equitable society (Hall 1999)

Critical theory assumes that social institutions are constructed in such a way as to reinforce existing dominant ideologies and power structures (Fuchs 2014). Critical theories articulate explain how dominant ideologies are reinforced by persons in power, privileging particular groups of people and oppressing others. These ideologies tend to be self-perpetuating, often including built-in mechanisms to avert resistance (Pike 2010). Understanding the hierarchal structures of hospitals, its various roles, positions, and
dominant ideologies (Conrad 1992; Greer 1984; Hafferty and Light 1995; Strauss, Fagerhaugh, Suczek, and Wiener 1985; Zola 1972) is aided by the critical theory lens.

Critical theory is interested in questioning the status quo and facilitating transparency needed for people’s informed participation in legitimating the social system. Lacking transparency, people may find it difficult to navigate the intertwined rationalizations of firmly established social systems. This may contribute to accepting at face value whatever assumptions are set forth. For instance, a belief held by many people is that others are responsible for their own distress (Garland 2014). In this line of thinking, a patient who makes poor choices is responsible for the consequences. This belief omits consideration of the constraints on peoples’ lives such as social class, race, and gender, reinforcing the idea that individual choice is a chief determinant of people’s lives (Satcher 2010).

Similarly, many people assume that if a nurse is dissatisfied in their job, the solution lies in changing some individual attribute of the nurse (Anderson and Webster 2001; Burgess, Irvine, and Wallymahmed 2010; Moody and Pesut 2006). However, a job can be structured in such a way that logical-appearing solutions are constrained by nontransparent processes, resulting in the ineffectiveness of any seemingly logical action by the nurse. For example, a nurse may contact the nursing supervisor to explain why a patient discharge cannot transpire within the preferred policy-driven time frame. In so doing, the nurse further delays the discharge and generates a cascade of events in the system, which results in pressures being exerted back onto the nursing unit to discharge patients even more quickly. Thus, illuminating any of these nontransparent processes and contradictions could be useful for conceptualizing recurring and persistent problems in
nursing. For example, it can facilitate examining how problems such as the nursing shortage, powerlessness, lack of control over work processes, and oppression (Aiken 1990; Corwin 1961; Hall 1999; Hayes et al. 2012) impinge on or are affected by, performing the emotional labor of caring. In the next section, early Marxist theory is discussed for the purpose of revealing how Hochschild’s emotional labor theory incorporates Marxist theory to account for emotional labor within the capitalist mode of production.

**Early Marxist Theory**

Marx argued for a theory that sought to change the world, rather than to merely understand it (Smith and Cuckson 2002). While critical theory has departed from classic Marxist thinking, the basic underpinnings of Marxism continue to be informative about capitalism, labor processes, and economics. Many contemporary critical theories have their roots in classical and neo-Marxist theory (Fuchs 2014; Best and Kellner 1991; Tyson 2006). These Marxist-based theories have been useful for understanding some of the contradictions in a capitalistic healthcare system (Waitzkin 2000; Yuill 2005).

Many critiques of the United States healthcare system pertain to alienated workers, impersonal interactions, and excessive focus on efficiency and tasks (Waitzkin 2000). Marxist theory posits economic motives to be the chief explanatory mechanism for explaining how people negotiate relationships and come to share a common set of cultural assumptions and values (Coser 1977: 45; Marx 2007 [1867]) that are supportive of the dominant class (Bourdieu and Wacquant 1992; Coser 1977). For example, while

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2 Opposing views have addressed how a capitalist approach to healthcare solves the problems inherent in access and quality (Hyman 2007).
nurses may perceive themselves as opposing the hierarchal intrusion of medical control on nursing practice, they may be unable to see that this very opposition fuels nursing hierarchies created by new roles such as nurse practitioner and clinical nurse leaders. This hierarchy generated by the nursing profession places staff nurses at the bottom of the nursing status order, a position potentially similar to the one from which they sought escape (Hogan 2012).

Marx articulated how dominant classes control the division of labor by owning the means of production and rendering laborers dependent on participating in this mode of production for their own sustenance. By creating new supplies of wants through expanding available commodities, the capitalist market maintains a supply of laborers in need of meeting their own living needs, and sometimes also seeking the enticements created by these new desires (Marx, Moore, Aveling, and Engels 2012[1906]). The ongoing supply of new nurses, for example, is assured as nursing students are fast-tracked through accelerated curriculums while older nurses become alienated from their work, physically or emotionally incapable of meeting the constantly changing demands and add-on responsibilities. Efficiency means more work and fewer staff. In a market-based healthcare system striving to meet quality and customer satisfaction mandates for reimbursement, nurses and their emotions can be viewed as commodities.

Commodification

According to Marx, a commodity can be anything possessing qualities that satisfy a human need (Marx 1906: 125). An object, experience, or person is commodified when it comes to be valued only as an entity of exchange in an economic relationship, devoid
of its human value and relations (Marx 1906: 185). Commodification removes the human value of the laborer from their work by transforming labor into an object or service produced or provided by many workers. Sometimes, a worker’s job can be reduced to the effective performance of a role prescribed by the employer. The worker’s participation is fragmented and the end product of their labor is removed from the value of an exchange the worker can negotiate with others. Transforming the human relationship value of exchange into an economic relationship of exchange was referred to by Marx as commodity fetishism (Lukacs 1971: 84; Marx 1906: 83).

In the healthcare system, the nurse might be perceived as a commodity to hospital administration. Regardless of the unique characteristics or background of the nurse, as a commodity the nurse may be counted only as a standard work unit in an equation yielding an appropriated number of staff for a given unit at a particular time of day or night. When it comes to the end result of a patient care stay, it is the nurses’ ability to regulate the outward appearance of their emotions that matters most for generating the quality and satisfied customer scores essential to the hospital’s receipt of their third party payments. As a commodified product or provider of service, only the end results matter. The fruits of an employee’s labor have to be maximized if profits and the ongoing accumulation of capital are to support continued progress and growth (Marx 1906).

Exploitation of Labor

The capitalist mode of production depends on extracting more labor from a worker than it costs the owner of production to provide the goods, services, or experiences. This particular aspect of Marxist theory is Marx’s (1906) explanation for predicting a class revolution that would return a more equitable division of the profits. In
extracting maximum value from the laborer, work can be organized efficiently for the greatest profit. For the employer to make a profit, the employees’ labor must exceed what they are paid. In the case of healthcare and other human services, the workers’ caring ethic may be exploited by an employer who depends on the employee to do the caring work, notwithstanding the employer’s failure to allocate the time for doing so (Bone 2002; Scheid 2003; Weeks 2007). The overall contribution of an employee to the employer’s profits may be lost in the formulaic calculation of employee wages. Separated from all the underpinnings that facilitate comprehending the full experience of one’s labor and its subsequent effects after it is sold, a worker may feel alienated from their work (Woods 2006: 3).

Alienation

Alienation was referred to by Marx as the disassociation between a worker’s efforts and the end product. To Marx, alienation meant more than simply being detached. Alienation was a result of the waged labor in a capitalist mode of production which enslaved the worker by chaining them to the necessity of working for those who owned and controlled production. Worse, the efficient organization of work geared toward generating a profit, left the worker without the opportunity to find self-expression and pride in their work. Marx saw waged work as the most alienating type of labor. Marx further saw that waged labor in a capitalist mode of production depends on extracting more from the laborer than they are paid so that profits can be made with which to accumulate capital for further growth and enterprising pursuits. This leads to a self-perpetuating cycle in which the owners of capital become wealthier while their progress and technological advances tend to diminish the value of the laborer.
Marx saw alienation as having a domino effect in that once the cards begin to fall, all other aspects of human relation are affected, eventually leading to people’s estrangement from each other (Marx 1844: 72-77; Walliman 1981). In an assembly line, where each does their assigned part, the whole process may never be fully experienced by any one employee. The use implications of a product, its effects on lives beyond the factory, and the amount of total profit obtained by the company for this work, are rarely directly experienced by the laborer (Marx 1912: 567).

Additionally, the laborer often is lured into the wants and desires produced by the capitalist mode of production, locking them in more fully with each successive acquisition of goods and services produced by the system (Harvey 2014: 187; Kellner 1984: 83). One’s own labor comes to be perceived as external to the self (Woods 2006: 7), often occurring gradually and insidiously such that the worker is blinded to the fact that it is by their own actions and implicit consent that this system works (Burawoy 1979).

When an employee experiences only part of the process, it is easy to attribute blame to someone else if the end product fails. Alternatively, some workers may claim responsibility for the end product when they were responsible for a small portion of the total product. When it comes to one’s labor however, alienation keeps the worker blind to their own skill, contribution, and value. This is where “false consciousness” (Lukacs 1971 [1920]) becomes a tool of the dominant class, knowingly or unknowingly, for maintaining the status quo.
False Consciousness

The worker’s lack of awareness of their participation in the processes that contribute to their subservient role in a capitalist society is what Marxist scholars refer to as false consciousness. False consciousness is comprised of all the subtle and hidden ways that oppressed people are influenced to participate unknowingly in their oppression. While Marx made many references to the process defined as “false consciousness”, the term stems from the work of neo-Marxist theorists (Lukacs 1971 [1920]).

In its ability to control labor, the dominant or ruling class can also control ideology by influencing the institutions that shape the cultural assumptions about what rules and norms are needed to preserve the social order that keeps their positions intact (Harvey 2014: 102). Since the dominant class can exert influences in areas where the working class lacks control, ideology can be experienced as normative, obscuring awareness of its underlying function of maintaining the dominant social order (Woods 2006: 243).

Marx identified classes as groups of people who shared a similar position with regard to ownership of property and wealth. He recognized the similarity of values, beliefs, and world views that members of a class adhered to and mutually reinforced (Marx 1867: 516). This is similar to Bourdieu’s (1990: 52) concept of habitus which is defined by Bourdieu as a set of dispositions that become internalized as a result of lifelong experience, especially in childhood, and which serves as an internal compass against which to evaluate and interpret one’s encounters in the world thereafter (Bourdieu 1990: 52). The ways of being and socialized norms to which one becomes habituated maintain the status quo, particularly benefiting those in the ruling or dominant class. Silent assent and cooperation are a main purpose of ideologies (Kellner 2004: 243). If the
system of the dominant class depended on having classes that failed to see their participation in their oppression, the path for emancipation was the awareness that could begin to emerge as class consciousness.

Class consciousness

Marx believed that working class individuals could end their own exploitation by joining together as a unified group. While most workers have false consciousness, what would free them is awareness of the power in their solidarity or class consciousness. Therefore, something has to happen to raise the workers awareness of their conditions (Marx 1867: 536). As such, the attainment of class consciousness is not an event occurring at a single point in time, but rather a process evolving over time and reaching a tipping point, after which cohesive action could potentially occur.

An example of a problem being perpetuated and hidden from awareness: hidden racism. The lack of awareness of modern racism is apparent to others, but not to the racist. Van Dijk (2006) says that modern forms of racism are less readily apparent to people, because they are couched in politically correct terms. Residuals of racism can be detected in the politically correct phrases stated with such subtlety as to make questioning them seem to be an overreaction. For example, one may speak in favor of equal rights and nondiscrimination, even as they make reference to those people (van Dijk 1993: 143). This is an example of how critical theory views phenomenon as taken for granted because they are spoken with conviction even though onlookers may be able to see the contradictions. In the next section, I will discuss extensions of Marxist theory.
Beyond Marxist theory

In postmodernist films and literature, there is increasing recognition of a turn toward an intrusion into personhood, a dismantling of identities, an intermingling of person and machine, and a blending of reality and fantasy (Baudrillard 1994; Harraway 1991). Some of these theories are extensions or reactions to Marxist theory (Littlejohn and Foss 2008). Scholarly discussions of a changed depiction of society, one moving away, in one sense or another, from the period in which reason and logic reigned are the common threads of contemporary Marxist thought.

When expanding Marxist thought beyond economics and the capitalist mode of production, several terms are offered by scholars to explain the observed changes in the representation of the economic, personal, and social order. These terms share in common an understanding that something is different about the current times as compared to the times when industry and factories was the mainstay (Heaphy 2007; Jameson 1991). Giddens (1993) refers to a period as late modernity while Jameson (1991) writes about late capitalism. Baudrillard (1994) is associated with postmodern ideas, and an emphasis on the progression into a world of reproductions, images, and signs as the simulation, simulacrum, and hyper-real creations. Bauman (2000) uses the term liquid modernity to capture the transformative nature of what traditionally has been considered real and tangible. He says capitalism, having permeated all areas of life, even commodifying human emotion, has left people without the ability to feel, to care or to experience anything beyond the confines of rules, procedures, labels and categories. Burawoy (1979;
2012) echoes this concern about capitalism transferring the private life of feelings into the public sphere, thereby fracturing personhood.

There are a number of theorists commenting on, and hypothesizing about the emergence of a very different world which questions reality, denies singular identity, and reveres multiplicity and diversity (Baudrillard 1994; Bauman 2000; Deleuze and Guttari 1983 [1972]; Derrida 1974 [1967]; Lyotard 1984). Jameson’s (1981) theory of late capitalism extends Marxist theory about capitalism and is discussed next for its contributions to understanding the commodification of emotion in a market-based healthcare environment.

Late Capitalism

In his critique of what has been called postmodernism, Jameson (1991) refutes the idea that postmodernism is a shift away from modernity. He says instead that what many are calling postmodernism is but a new form and phase of capitalism, one that logically follows from capitalism’s drive to commodify everything and accumulate increasing amounts of capital.

Jameson (1991) sees the commodification of all aspects of life as the ultimate endpoint of capitalism, the commodification of commodities. In the late stage of capitalism, the new object of desire becomes this fascination with commodifying. There is also a fascination with endless possibilities and variations and the idea that singularity, reality, and fixed truths are nonexistent. In late capitalism, even that which is normally considered personal and private is turned into a possible commodity.
Rather than operating by rules of logic, science, production, and reason, Jameson says postmodernism is a reaction against them. To Jameson, postmodernism is the end or later stages of capitalism before it perhaps self-destructs. This is fitting with the idea that thought structures, notoriously resistant to change, begin to demonstrate signs that the time has arrived for a new paradigm (Kuhn 2012 [1962]). One such sign is when applying old solutions fail to achieve the expected results (Watzlawick, Weakland, and Fisch 1974).

Jameson’s use of Baudrillard’s concepts. Jameson (1991) began his theorizing as a Marxist, writing about the perils of a consumer society and the increasing monopoly of capitalism. Theory about late capitalism also has been applied to the healthcare setting (Fox 1991; Gray 1999; Herdman 2004; McNamara 2009). Specifically, there has been concern about how signs and symbols increasingly are used in healthcare to simulate the effects, felt experiences, and perceptions of good health and good healthcare (Adams and Nelson 2009; Weissten 2006). The market based healthcare environment uses signs and images to suggest outcomes that cannot be seen objectively in the patient. Checklists, electronic records, and compliance statements in official organizational documents suffice as evidence in an environment that has moved from the bedside care to the technology of a virtual world (Eiser 2013).

Jameson applied Baudrillard’s (1994), concepts of the simulacrum in his theory about late capitalism. Simulation refers to imitation, reproduction, or making of copies through digital technologies. Baudrillard says that as this process of reproduction continues to be embraced, someone creates an image that appears as a reproduction of
something, but in fact misrepresents itself as a copy, lacking a reference back to reality. The widespread acceptance of copies reproduced from and tangible sources makes it easy to assume that what is presented as a reproduction is in fact, something that is itself original in the context of a different. Baudrillard refers to this misrepresentation of tangible reality, which is assumed to be a reproduction of reality, as the *simulacrum*.

The simulacrum exists only in the world of media and technology, and not in the world we have known as reality. This changed reality, the *simulacrum*, is dis-associated from reality, representing a fundamental change in the foundation on which human beings have established relationships to each other, to nature, and to technology. As it becomes daunting to distinguish reality from simulations and simulacrums, Baudrillard (1998: 190) suggested the end of *transcendence*\(^3\). The structure formerly defining reality is collapsed, Baudrillard warned, in his writings, that this dis-association of reality from reproductions of reality the end of the human.

Baudrillard was concerned about how society had transformed the *use value* (Marx 1848) of commodities into *sign value* (Baudrillard 1994), with consumers constantly seeking out objects to signify prestige, status, and class. According to Baudrillard, this was an unfortunate state of development when people in society are more concerned with perception, signs, and images than substantive, tangible goods and services. Baudrillard saw this surrender to signs as far worse than the alienation accompanying the exploitation of physical labor. To Baudrillard, surrendering to a life of signs was a state of total alienation in which the human side of living is less valued, and reality is easily manipulated.

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\(^3\) Baudrillard borrowed the term “transcendence” from Herbert Marcuse (1964) in the *One Dimensional Man*. 
When images and signs are manipulated without any substantive and enduring referent, it gives rise to an order of commodity marketing that goes beyond influencing opinion. There is the risk that the reality defined for us by the dominant class may be imperceptible to class consciousness.

To conclude this section on critical theory and move into discussing symbolic interactionism, it is useful to consider that both symbolic interactionism and critical theory recognize how social processes become hidden from awareness such that their origins and meaning are taken for granted. Symbolic interactionism also adds to the understanding of the emotional labor of caring through theories related to roles, norms and identity, the generation of meaning between people, and the importance of a sense of coherence in daily living. In the next section, I articulate how symbolic interactionism is relevant to emotional labor.

SYMBOLIC INTERACTIONIST THEORY

Symbolic interactionism is a useful theoretical framework for research on the emotional labor of caring by nurses because caring occurs in the context of an interpersonal relationship between a patient, a nurse, coworkers, other healthcare professionals, and sometimes the patients’ family and friends. These interactions are the microprocesses of social institutions and manifestation of the roles, norms, and institutional culture are developed and maintained over time. I begin by providing a brief overview of the antecedents of symbolic interactionist thinking and then shift to discussing a specific symbolic interactionist theory – Goffman’s dramaturgy theory – which is part of Hochschild’s foundation for emotional labor theory.
A Succession of Scholars and their Students: Cooley, Mead, and Blumer

Cooley’s (1907) enduring contribution to symbolic interactionist theory was the concepts of the *looking glass self*. It was Cooley’s observation of interactive processes between self and society that led him to conceive of the *looking glass self* and develop a theory of how human beings develop a sense of self by seeing themselves through the eyes of others. The notion of the self that emerges out of relationships with others was a turning point in the development of ideas about self and social influence. It represents a shift from the self as bio-psychological entity to the self as a social being emerging out of us and developing through a process in which individuals reflect views back and forth and anticipate one another’s responses (Cooley 1907; Peplau 1952; Sullivan 1953).

Cooley’s student George Mead continued his teacher’s work on developing an interactionist view of self and society. Like Cooley, Mead (1934) was intrigued with human beings’ capacity to pause, reflect upon, and reconsider their response(s) from their own and the perspective of others. Mead’s theory viewed the mind, the self, and society as developing in stages of socialization during which the individual comes to understand the various roles, norms, and meanings characteristic of his or her social world. The ability of human beings to use language, symbols, and thought enabled them to learn the various roles occupied by others. Mead saw this role play and socialization process as key to the development of an understanding of what it is like to be another person, in another role, or under differing circumstances.

This ability to envision how people fit together with each other and with the collectivity of selves in society, was referred to by Mead as the *Generalized Other* (1934: 90 and 152). Reaching this stage of comprehending the self in relation to society was a
crucial development that extended beyond Cooley’s concept of the *looking glass self*. Mead also set the stage for understanding theories such as emotional labor in By conceiving how the mind emerged as a social construct and developed out of the back and forth exchanges of social interaction in which individuals anticipates others’ reactions and adjusted to align with others’ perceived expectations (Mead 1934: 82).

Mead set the stage for understanding theories such as emotional labor.

Mead strongly believed in human beings as active agents in creating and altering meaning. However, he also understood how meaning could become routinized. Despite this human tendency toward habituated ways of thinking, Mead took exception with scholars failing to credit people as actively participating in their worlds. Subsequent theorists in symbolic interactionism (Blumer 1969), continue to find this point of personal agency, and the creation of meaning, as central to the theory.

Mead’s student Herbert Blumer (1969) emphasized that human society was a construct, all aspects of which depend on social actors (1969: 85). Like many contemporary theorists (Archer 2007; Bourdieu 1992; Giddens 1993) who reference the reflexive nature of human social interaction, Blumer’s principles included the understanding that people neither simply fit themselves into the social structure that exists nor merely react to a structure that exists apart from them. Rather, people are active negotiators, generators, and re-shapers of meaning.

Symbolic interactionism also makes use of social constructivism, the idea that all meaning is made by human beings. In their account of social constructionism, Berger and Luckman (1966) point out that we create categories for people and objects, and thereafter we think of them from the perspective of the category to which we have assigned them.
The point of categorizing anything encountered in human experience is, according to Berger and Luckman (1966), to reduce the need to reassess it on each encounter. However to a certain extent, this process necessarily blinds to the unique attributes that cannot fit into a broad category. Serving the dual purpose of decreasing stimuli, and permitting some prediction of what to expect, categorizations allow us to anticipate exchanges with others, and have a measure of consistency. This process is called institutionalization and once this reality gets solidified, it becomes difficult, though not impossible, to change.

The notion of role expectations involves certain behaviors and patterns that are associated with a specific social role (Berger and Luckmann 1966: 68). As roles become institutionalized, they are characterized by their assumed nature such that they take on a life of their own, apart from those who occupy the roles at any given time (Berger and Luckmann 1966: 55).

Research using symbolic interactionist theory focuses on many of the concepts important to this research on emotional labor, particularly the way people interact through symbols, words, gestures, rules, and roles, and how these, in turn, affect the feelings that people experience as "natural" (Cahill 1986; Denzin 1984; Franks 2003). In studies of emotions, symbolic interactionists explore how individuals use agency to align their feelings with the role expectations others have of them. Emotion plays a large role in how individuals sustain and promote certain actions and patterns, while excluding others (Thoits 1989; Turner 2009).

Several basic principles and underlying assumptions about symbolic interactionism were identified by Blumer and are listed in Table 2.3. As described above,
a central premise of symbolic interactionism is that meaning and reality are co-created through the process of social interaction. Outside of these co-created meanings and realities, there is no meaning or reality.

Table 2.3 Symbolic Interactionism Principles

1.) Human beings react to things based on the meaning they have assigned to them.
2.) Things do not have any meaning outside of that constructed by people in interaction with each other.
3.) Meaning is jointly determined through people in repeated interactions through a process of reification.
4.) Reification occurs when people elevate the status of a thing into something they both agree is reality.
5.) The concept of a self and a society exist only in the context of interaction.
6.) It is through established meanings and agreed upon symbols and language that understanding and meaning are constituted.

Erving Goffman’s theory of dramaturgy is a symbolic interactionist theory focused on day-to-day routine interactions is. Dramaturgy theorizes that people manage interactions with others to create certain impressions, adjusting their behavior to align their performance with expectations. This theory is relevant to Hochschild’s emotional labor theory and is discussed next.
Goffman’s Dramaturgical Theory

Goffman’s (1959) microsociological approach, commonly referred to as *dramaturgical sociology*, offers insights about how we manage impressions during everyday interactions with other people. As a symbolic interactionist theory, dramaturgy uses the metaphor of theatre, stage, actors, props and scripts, to reveal the way each of us presents our self-image to others in a way that preserves our own and each other’s face. Goffman’s theory reminds us of the mutually cooperative nature of interpersonal relationships. In order for any of us to proceed in knowing what to expect from others, it is necessary that we agree to accept and respect each other’s self-presentation. This represents the orderly nature of interaction. Table 2.4 contains terms important to Goffman’s theory of dramaturgy.
Table 2.4  Dramaturgical Concepts relevant to Emotional Labor

<table>
<thead>
<tr>
<th>Actors</th>
<th>Service provider</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audience</td>
<td>Customers</td>
<td>Usually the patient and their family members or significant others, coworkers &amp; members of management</td>
</tr>
<tr>
<td>Performance</td>
<td>Behavioral interaction with the customer</td>
<td>Greetings, explanations, comments made while giving physical care; conveying caring and concern with the patient’s emotions, avoiding and suppressing negative feelings or expressions</td>
</tr>
<tr>
<td>Setting</td>
<td>Environment in which the service takes place</td>
<td>Hospital, particularly the nursing unit and patients room</td>
</tr>
<tr>
<td>Backstage</td>
<td>The actions done away from the customer in preparation for the performance and the actions done after the performance to relieve lingering tensions from or about the performance.</td>
<td>Nursing station, nurses lounge, cafeteria, at home</td>
</tr>
<tr>
<td>Frontstage</td>
<td>The part of the performance that happens with the customer present.</td>
<td>In patient’s room or in direct face-to-face contact with the patient or family or over the intercom</td>
</tr>
<tr>
<td>Script</td>
<td>Specific expectations for the interaction and its outcome</td>
<td>Sense of safety and trust, feeling cared for, receiving positive patient satisfaction scores</td>
</tr>
</tbody>
</table>

Because Goffman (1959) applied dramaturgical theory to observations about everyday life, as people went about their daily routines and rituals, this theory is useful
for translating seemingly minor interchanges into a foundation for all that occurs in society. Goffman (1959) observed unspoken norms and expectations being played out as people engaged in rituals and routines of interaction. As indicated in Table 2.3 on the principles of symbolic interactionism, these routines and rituals become the elements of social structure referred to as gender, status, class, norms, roles, and the like.

Goffman’s theory suggests our daily lives are like performing to an audience. People may not experience themselves as performers, however, because when socialization has been effective, properly enacted performances feel natural. When a performance fails to support socially defined roles and norms, it likely will be considered unacceptable. Some allowances can be made for errors, but corrective action is usually expected if one’s performance is out of line with the expected role or identity.

Goffman’s dramaturgical theory supports both role and identity theory in this regard. Individual actors create and maintain their identities by framing social settings with the appropriate props and scripts (Goffman 1959; Schlenker 1980). Like theatrical performances, a performance in interpersonal interactions is enacted to make a favorable impression. In a hospital, when the nurse enters the room with a piece of equipment, the intention of the nurse has been framed by the presence of the equipment. If the patient has just called the nurses’ desk complaining of pain, the nurse entering the patient’s room may be perceived as uncaring if the equipment being rolled into the room is unrelated to remedying pain. Assuming the nurse is there to address the patient’s comfort, but there are four other sick patients also needing the nurses attention, the nurse will need to be aware of, and skilled at managing the conflicting feelings, or risk coming across as uncaring or brusque.
When people are unskilled at hiding their emotions, their feelings may leak out, unintentionally creating an unfavorable impression. This is referred to as being out of face (1967: 5). Being out of face can occur when one must participate in a performance unexpectedly or when one lacks the necessary skills for the expected performance. Being out of face can also occur when one's feelings or values are incongruent with what one is trying to portray.

A certain amount of tension usually accompanies performances to the intended audience which typically dissipates as the performance reaches completion. This is called frontstage performance and evokes a certain amount of anxiety because it is imbued with expectations about the necessary elements and manner of performance. Once the frontstage performance is over, there may be a period of a backstage performance, where one can relax and even dissipate anxiety by making sarcastic or joking comments about the performance itself, or its requirements. For instance, a nurse may be warm and cheerful when answering a summons from a patient’s room. After the cheery interaction, the nurse may complain about how frequently patients are calling for extra things during their shift.

Such is the flow of events between people in interpersonal interactions as they create and sustain, collectively agreed upon roles and social institutions. Interactions are intended to run smoothly, be somewhat predictable, orderly, and cooperative between actors. In this way, Goffman’s dramaturgical theory supports the basic tenets of symbolic interactionism about the creation of shared meaning through interaction. Dramaturgy also fits well with theories of emotional labor, as noted by Hochschild, where there is an
expected performance or management of one’s own or others emotion for an intended effect.

Hochschild blended critical and symbolic interactionist theories in developing her theory of emotional labor. Hybrid theories have been advocated by other theorists in formulating their conceptions of contemporary phenomena, especially to incorporate the relevant power relations that are addressed less readily by symbolic interactionism (Denzin 2001; Weeks 2007).

ARLIE HOCHSCHILD’S THEORETICAL CONCEPT OF EMOTIONAL LABOR

Arlie Hochschild (1983) coined the term *emotional labor* (1983: 7) to describe a customer service orientation required in the present-day economy of service-based jobs. As previously defined (Hochschild 1983: 7), emotional labor is the process by which workers are expected to manage their feelings in accordance with organizationally defined rules and guidelines. Everyone engages in managing emotions, but terminology and rules differ based on its purpose and context.

Hochschild differentiated terms based on where and why the emotion work was being performed, when it is done in private or personal relationships, it is called *emotion work* (Hochschild 1983: 7n). Recently, more attention has been paid to the role of emotion work in spousal and relationship partnerships (Thomeer, Reczek, and Umberson 2015; Umberson, Thomeer, and Lodge 2015). When it is done while working for a wage, it is called *emotional labor* (Hochschild 1983: 7n). When an employee’s emotional expression is dictated by the employer, beyond mere compliance with social norms of public behavior, the employee’s emotions are a commodity. C. Wright Mills (1951: 181)
called this the *personality market*, describing the process by which personality attributes were made into commodities to be purchased as part of a service or enticement to a purchase.

All jobs require a certain amount of emotional labor, even if it is performed just to manage office civility with coworkers, supervisors, and customers. However, when an employee’s emotions become the central feature of the job, the employee’s emotions have become the commodity for the business. Usually, this occurs in service-industry jobs where customer satisfaction is the employee’s main priority. Regulation of emotion for a desired effect, usually defined by the employer, is the job requirement. Even when a tangible product is being sold, the service experience is supposed to meet a targeted need or desire held by the customer. This is deemed necessary for competition in this service-market

Service employees must learn or already be skilled in managing emotion. As a reflection of the company’s image, an employee’s dress, personality, emotions, and energies are part of what is being sold in the customer service experience (Hochschild 1983: 103). In her original study with airline stewardesses, Hochschild participated in the training of airline stewardesses and observed them learning to align their emotional presentation with the image the airlines wished to convey to customers (Hochschild 1983: 98). Most anticipated situations were discussed and considered during training with the overall consistent message to the stewardesses that what mattered was the customers’ experience. The stewardess had to demonstrate poise, friendlessness, and helpfulness in responding to demanding and inconsiderate regardless of how it impinged on the
stewardess’s sense of self, respect, or fairness (Hochschild 1983: 110). The table that follows (Table 2.5) includes terms relevant to a discussion of emotional labor theory.

Table 2.5  Definition of Terms Relevant to Hochschild’s Theory of Emotional Labor

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional labor</td>
<td>the process by which workers are expected to manage their feelings in accordance with organizationally defined rules and guidelines (Hochschild 1983: 7).</td>
</tr>
<tr>
<td>Types of emotional labor:</td>
<td></td>
</tr>
<tr>
<td>a. surface acting</td>
<td>a. deceiving others about what one is feeling internally by continuing to feel the feeling that is present and making an external display of feelings to fit an alternate presentation of emotion (Hochschild 2012: 36)</td>
</tr>
<tr>
<td>b. deep acting</td>
<td>b. attempting to internally change our feelings by aligning our perceptions with them</td>
</tr>
<tr>
<td>Emotional Regulation</td>
<td>the processes by which we influence which emotions we have, when we have them, and how we experience and express them (Gross 1998: 272).</td>
</tr>
<tr>
<td>Emotive Dissonance</td>
<td>occurs when a person simultaneously encounters conflicting attitudes, behaviors or feelings contradict other attitudes or behaviors. (Festinger 1957: 31)</td>
</tr>
<tr>
<td>Emotion work</td>
<td>“the act of trying to change in degree or quality, an emotion or feeling” (Hochschild 1979: 571).</td>
</tr>
<tr>
<td>Caring</td>
<td>The display of kindness and concern for others (Stevensen 2010: 204).</td>
</tr>
</tbody>
</table>

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4 Hochschild used the term emotion management rather than regulation.
Main Aspects of Hochschild’s Emotional Labor Theory.

There are several central aspects of Hochschild’s thesis about emotional labor (Hochschild 1983: 3-6). Fundamental to understanding emotional labor is conceiving that human beings’ emotions are used as an instrument of labor. Employees are required to manipulate their personal emotions as part of their job. Similar to the Marxist notion of a person’s body being used in physical labor and therefore under control of the employer, emotional labor places the employee’s emotions under the control and discretion of the employer. This distances the employee away from the direct experience of outcomes that can be directly attributed to the worker’s effort. As with Marxist thought about the exploitation of the working classes’ physical labor, Hochschild expressed concern that emotional labor also represented exploitation especially since jobs requiring sustained emotional labor were commonly lower paid, lower status, gendered jobs (Hochschild 1983: 171).

Hochschild (1983: 12) understood that emotions were subject to manipulation in personal and business relationships. To some extent, this kind of emotional work is expected in performing any role with others. Hochschild acknowledged that emotion was manipulated as part of entertainment, and in personal help such as psychotherapy. However, for Hochschild, an important consideration was whether the person had choice and control over their own emotions.

Aside from concerns pertaining to gender and status features of emotional labor exploitation, Hochschild (1983: 17) considered feelings to be as important to our awareness as are the senses of sight, touch, smell, taste, or hearing (Hochschild 1983: 229). Emotions convey important information and play a role in societal function. This
can be observed in the role of feelings in acts of war, sports, and public ceremonies.

Thus, while emotions are private and personal, they are subject to feeling rules learned during socialization and in the exchange rules of society for social functioning and order. The control and engineering of emotion by large corporations crossed a line into personhood that was of concern Hochschild (1983: 20). These are detailed in Table 2.6 and summarized below.

Table 2.6 Central Aspects of Hochschild’s Theory of Emotional Labor

1. Emotions are a biological signal with an evolutionary function which protects the species and individuals from danger by enabling them to monitor the external and internal environment and identify incongruences that may signal danger or safety.

2. While emotions are private and personal, they reflect the larger social and cultural environment in which a person lives and interacts.

3. During socialization, individuals learn what they are supposed to feel in which situations and at what level of intensity. These norms about feeling are called feeling rules in emotional labor theory (Hochschild 1983: 56).

4. Males and females are socialized to experience feelings differently such that females are more emotionally expressive and expected to perform the emotion work in relationships and employment situations (Hochschild 1983: 163).

5. Females are more likely to be employed in service related jobs that require the performance of emotional labor (Hochschild 1983: 171).

6. Jobs requiring emotional labor tend to be lower status positions (Hochschild 1983: 171).

Emotion Regulation

A number of theorists have contributed to the scholarly discourse on emotions and their regulation. Unlike other theorists (Grandey 2000) that focus on intra-psychic
mechanisms of emotional response, Hochschild’s theory of emotional labor places emotion regulation into a sociological perspective. Hochschild simplified her typology of emotion management into two broad categories: surface acting and deep acting.

Hochschild’s typology of emotion regulation: surface acting and deep acting.
According to Hochschild, regulating emotion can be done at two levels: surface acting and deep acting. In surface acting (Hochschild 2012: 36), a person alters the public display of their felt emotion, while their inner feeling remains unchanged. Because this creates a state of inner and outer discord between feelings, a person usually feels uncomfortable and may also feel insincere.

When engaged in surface acting, a person’s feelings remain unchanged, but what they show in facial expression, nonverbal gestures, and vocal tone expresses another feeling, the one preferred for the customer interaction. A person who is effective at hiding their emotions may find surface acting easy to do, even if it leaves them feeling somewhat insincere. For people with more transparent emotions, surface acting can be difficult. Covering up emotion requires extra effort and may be disagreeable and disconcerting. Extreme feelings of discomfort arise when something does not align with our existing beliefs, morals or attitudes. The discomfort experienced when a person is faced with competing emotions, as previously noted, is referred to as emotive dissonance (1983: 90).

Hochschild’s notion of emotional dissonance is derived from Festinger’s theory of cognitive dissonance (Festinger 1957; Festinger and Carlsmith 1959). As an intolerable state of mind, dissonance and lack of coherence motivate a person to seek resolution. The
motive for modifying behavior partly stems from the need for a sense of coherence (Byers 2011: 42) as described in the section on Festinger’s (1957) cognitive dissonance theory.

Sometimes surface acting is insufficient to manage emotions. This is true especially when a repetitive need for surface acting becomes a source of strain. In these cases, it is more beneficial to the employee to find a way to alter their internal feelings through the use of deep acting strategies. When a person engages in the effort to change their felt emotion and not just the way it appears to others, this is referred to as deep acting (Hochschild 2012: 37). While deep acting is expected to be less distressing for employees, it may require greater effort to achieve (Grandey 2003; Hochschild 1983: 136).

Hochschild identified techniques used by actors to invoke emotions, especially when deep acting is required. For example, one such technique used by actors and actresses is termed exhortation and involves inducing or preventing a feeling by convincing one’s self of something that will fit the appropriate feelings. A person also might use the imagination and manipulate emotion less directly (Hochschild 1983: 40) by evoking certain memories or refocusing on something that generate the desired emotions. The use of props is another way that emotional expression can be altered by setting up expectations for particular emotions to be elicited as called for by whatever the props represent symbolically. This aspect of emotional labor theory is derived from Goffman’s (1959) dramaturgy theory.

If an employee is unsuccessful in changing how they feel inside, their external display of emotion will remain uncomfortable and may worsen. If an employee cannot
comply with job expectations to present a particular customer service image, this magnifies their discomfort. For example, if a patient in a hospital and the hospital administration expect nurses to show a caring manner, but nurses are busy with urgent and competing medical matters, the nurse may not be able to display the expected caring. Some of the ways nurses have coped with these conflicting feelings are listed in Table 2.7.
### TABLE 2.7 Examples of Emotional Labor Techniques used in Nursing Jobs

<table>
<thead>
<tr>
<th>Walsh (2009): Nurses actively suppressed frustrations with administration about issues pertaining to work resources or conditions in order to give good care.</th>
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<tr>
<td>Walsh (2009): Nurses had to avoid demonstrating a caring manner to prevent flirtation by male prisoners. This allowed the nurses to avoid crossing professional boundaries and maintain the ethic of providing proper treatment for injuries or medical conditions.</td>
</tr>
<tr>
<td>Walsh (2009) Nurses had to work to hide feelings of disgust when dealing with an inmate who had committed a particularly heinous crime. Attending clinical supervision meetings helped nurses resolve feelings pertaining to judgments about criminal acts while maintaining their ethic of providing good care.</td>
</tr>
<tr>
<td>Huynh, Alderson, and Thompson (2009) Nurses had difficulty turning off feelings of frustration about work conditions so they could feel caring toward patients they believed they should have. Many of the nurses coped by making plans to leave the job.</td>
</tr>
<tr>
<td>Spitzer (2004) To cope with stress related to work organization issues, nurses avoided patients they expected to be difficult based on their behavior or stereotypes about the patient.</td>
</tr>
<tr>
<td>Lopez (2006) Work was organized in such a way as to foster and encourage staff to take time to deal with frustrating behaviors of geriatric patients such as insults, name calling, and other negative and uncooperative behaviors.</td>
</tr>
<tr>
<td>Lopez (2006) Patient care facilities required staff to follow scripts in dealing with specific behavior issues or complaints. (These employees were unhappy and felt less sincere).</td>
</tr>
</tbody>
</table>

Regulating emotion also can occur in other ways. Some of these have been described by psychologists of cognition, motivation, and emotion (Brehm and Brehm 1981, Grandey 2000, Gross and Levinson 1997; Lazarus and Folkman 1984; Muraven and Baumeister 2000) and organizational researchers (Abraham 1999; Bulan, Erickson, and Wharton 1997; Fineman 1993; Hopp, Rohrman, Zapf, and Hodapp 2010; Mentis, Reddy, and Rosson 2010; Morris and Feldman 1996; Rafaeli and Sutton. 1987).
Cognitive strategies are the most often mentioned techniques to modify emotional states and will be discussed briefly with regard to the strategies of surface and deep acting.

**Cognitive strategies for emotion management.** One of the most commonly described ways to resolve dissonance is by altering one's thoughts so they better align with feelings and behavior as suggested by Lazarus and subsequent cognitive theorists (Jarcho, Berkman, and Lieberman 2011). This is called a cognitive strategy. Lazarus and Folkman (1984) distinguished emotion regulation on the basis of whether a person was capable of altering the problem with their problem-solving abilities, thus their term *problem-based coping*, or if they had to resort to altering their emotions, termed this *emotion-based coping*.

According to Lazarus and Folkman (1984), emotion-based coping is used when a person does not feel they can remedy the situation through some action they might take. Barring an apparent solution, one might try regulating the feeling associated with the problem through one's own control over emotion or they might consider other ways to think about the problem that will generate a less uncomfortable emotional response. Hochschild's surface and deep acting encompasses these emotion-based coping strategies.

Gross (1989) offered a typology of emotion regulation based on which aspect of the emotion process was affected by the regulation strategy. The least effective strategy, according to Gross, is called a *response focused* strategy because it focuses on the efforts to modify an emotional response that has already been triggered. This would correspond
to surface acting and fits with Hochschild’s (1983) and other scholars (Grandey 2000) observations that surface acting retains the sense of dissonance related discomfort.

Like Lazarus and Folkman (1984), Gross suggested cognitive strategies were more effective for regulating emotion and he offered the term *antecedent focused emotion* regulation strategies to address emotion regulation done in anticipation of an emotional response. Several of these strategies involve decisions about whether and where to place oneself relative to the anticipated situation. One of Gross’s strategies, attentional deployment—pertains to how one thinks about a situation or focuses one’s attention. While Gross’s strategies have some relevance here, Hochschild’s typology is more useful for considering emotion regulation from a sociological perspective because it focuses less on the intra-psychic mechanisms employed and more on the extent to which one alters their self and their emotion in interactions.

Problematic Aspects of Emotional Labor Performance

An underlying assumption Hochschild makes about the performance of emotional labor is that emotions are a product of evolutionary adaptation. As biological signals providing warnings and feedback to people about their relation to others and their environment, Hochschild conjectured that altering these mechanisms likely would pose problems. What triggers particular emotions and their intensity varies with the person’s biological make-up, personal life experiences, acquired values and beliefs, and social and cultural life-world. Therefore, emotions may be considered an important part of who a person is and an important tool people have for navigating and understanding the self in relation to the world (Hochschild 1983: 7). While it is common for individuals to alter
their emotions, it is not being directly imposed on them and it is not done for someone else’s profit. When an employer starts expecting employees to alter their own experience of emotion, a new realm of exploitation has been entered.

Exploiting emotion to use in securing a company profit in exchange for a subsistence wage to an employee who performs the emotional labor pierces personhood in a way that extends beyond physical exertion (Hochschild 1983: 7). Whether this is offensive or not to a person, it is an ethics and values question that can inform a scholarly inquiry, particularly one asked from a critical theory perspective.

A main criticism of Hochschild’s theory (Brook 2009a; Brook 2009b) has been the failure to fully develop the concepts with sufficient depth to generate hypotheses and theory testing. Along these lines, Hochschild offers several areas for examination when considering the potential effects of an economy using emotional labor as its primary commodity. These are summarized and discussed after Table 2.8 below.
Table 2.8 Potential Problems Arising from Emotional Labor in a Service Economy

<table>
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<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Disruption of a Biological Safety-Survival Mechanism</td>
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<tr>
<td>2.</td>
<td>Loss of Personal Control over Emotions and Emotion Regulation</td>
</tr>
<tr>
<td>3.</td>
<td>Interference with Ethical Decision Making Capacity</td>
</tr>
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<td>4.</td>
<td>Exacerbation of Gender Inequality</td>
</tr>
<tr>
<td>5.</td>
<td>Perpetuation of Inequalities in Hierarchies</td>
</tr>
<tr>
<td>6.</td>
<td>Changing the Foundation of Interpersonal Relationships</td>
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<tr>
<td>7.</td>
<td>Disruption of Social Bonds</td>
</tr>
<tr>
<td>8.</td>
<td>Interference with Personal Identity</td>
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<td>9.</td>
<td>Interference with Self Control</td>
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*Disruption of a Biological Safety-Survival Mechanism*

Hochschild (1983: 17) refers to evolutionary theorists such as Darwin, who suggest that emotions are a biological signal arising within a person and serving as cues about a person’s relationship to the external world. Emotions serve as prompts about the presence or absence of safety. They are also an indicator of how internal values, beliefs, and attitudes resonate with external people and events.

If emotions are manipulated and altered to suit occupational demands, Hochschild reasoned this may generate problems related to a distorting of emotion’s signaling function (Hochschild 1983: 28). Emotions that naturally function to warn people of danger and the degree of complementarity and conflict in a situation may become so distorted as to lose the capacity to serve as reliable indicators for a person about their
relationship to their environment. Perhaps most disturbing to Hochschild was possible interference with a person’s capacity to recognize danger since this emotional trigger is hard-wired into our nervous system and behavioral repertoire from years of evolutionary adaptation. Many people studying emotion emphasize its importance to our very physical survival, our personal safety, our capacity for intimate relationships and as a barometer for ethical decision making (Darwin 1872; Ekman 1994; 2003; Wharton 2009).

Hochschild also viewed personal control over emotion as an issue of concern.

**Loss of Personal Control over Emotions and Emotion Regulation**

Although Hochschild sees emotion as private, she also acknowledges the strong influence of cultural values and societal norms. Through socialization, people learn what to feel and how much feeling is appropriate to feel and express, referred to by Hochschild (1983) as feeling rules (56). The process of manipulating emotion disrupts the connection between one’s inner and outer world (Hochschild 1983: 223), the primary means by which a person senses his or her self in relation to things and other people in the world. For Hochschild, it is one thing to choose to manage one’s emotions, but quite another for a company to do so. Hochschild was concerned that surrendering one’s emotions for a paycheck ultimately could manifest problems that may carry into other relationships.

**Interference with Ethical Decision Making Capacity**

Several scholars’ link moral and ethical decision making to emotion (Cameron and Payne 2011; Damasio 1994; De Sousa 1987; Gordon 1987; Hutcherson and Gross 2011; Kalvemark et al. 2004; Lazarus 1991; Noddings 1984; Ulrich et al. 2007)
suggesting that ethical and moral decision making is impaired by an absence of emotion. Thus, the potential occupational hazard for jobs high in emotional labor requirements is that a person can lose touch with their feelings over time, potentially affecting their ability to accurately gauge ethical dilemmas. Gender scholars (Gilligan 1988; Okin 1989; Tronto 1993) have addressed the male-female differences in ethical decision making and the use of emotion. There are also other potential concerns regarding emotional labor and reinforcing inequality.

Exacerbation of Gender Inequality

Gender socialization affects how feeling rules are conveyed. This can be observed in the division of labor in jobs. On the other hand, in terms of freedom of emotional expression, most organizations have followed a masculine norm in the work setting (Acker 1990; Fineman 1993). When emotions arise within the work setting, especially if they are unrelated to a service related job (Husso and Hirvonen 2012), females usually are expected to manage them, in much the same ways as they manage emotions in the home (Berlant 2008).

Hochschild had concerns about how emotional labor mirrored gender inequity in society (Hochschild 1983: 163). Since jobs high in emotional labor, more likely are performed by females (Hochschild 2012: 245), this could exacerbate gender inequity. Like housework, family caregiving, and coordinating the activities of multiple others, emotional labor often is taken for granted, unrecognized and uncompensated (Hochschild 2012: 170). In addition, emotional labor jobs tend to have lower status adding to the existing problem of females’ occupying lower status jobs (Hochschild 1983: 153). There
are yet added effects related to the emotion hierarchy that can generate problems for emotional labor employees.

**Perpetuation of Inequalities in Hierarchies**

There is a status hierarchy with regard to emotional labor jobs. Generally emotional labor jobs are lower status positions and even if training is required, it is still considered a job requiring minimal skills. Some scholars (MacDonald and Sirianni 1996: 15) have argued that service jobs make personal characteristics of its workers more important to the nature of the work than any other type job situation.

All jobs involve a certain amount of emotional labor, but when it is the sole function of the job, the position tends to be lower status and lower paid. Kemper (1984) maintains that status and power are essential to addressing emotions and identity because having a higher status is protective from the negative effects of emotions because others show deference to the emotions of the higher status person while the higher status person does not have to attend to the emotions of others. The effects of emotional labor also can carry into intimate and personal relationships.

**Changing the Foundation of Interpersonal Relationships**

As managing emotion for a wage becomes commonplace, it could change the nature of relationships based on trustfulness and trustworthiness. While some degree of withholding or distortion occurs in the Goffman sense of performativity between people, when emotional labor becomes an occupation, the potential exists for altering norms about how relationships are established and negotiated outside of a work setting. **Authenticity** has been considered foundational to relationships by a number of other
theorists\(^5\) (Gillath, Sesko, Shaver, and Chun 2010; Rogers 1951; Salmela and Maye 2009), but some scholars dispute the existence of an authentic self (Straub 2014). If personal relationships are altered, there is bound to be an effect on social relations on a larger scale.

**Disruption of Social Bonds**

Durkheim (1961; Fisher and Chon 1989) saw a role for emotions in the creation of social solidarity. The internal regulation of emotions as learned through socialization is one way social order occurs. Scheff (2003) identified shame as the master emotion in controlling human behavior from a moral perspective, while Goffman identified embarrassment as the core emotion for maintaining social order.

Hochschild maintained that because we use emotions to create, maintain and preserve social bonds, changing the foundation of relationships could change the nature of social relationships overall and disrupt the bonds important for a sense of social solidarity and order.

**Interference with Personal Identity**

Being the recipient of negative feelings is not the only problem associated with emotional labor. Another possible problem associated with performing emotional labor is that it requires selling a very personal and private aspect of one’s self and aligning this self with organizational expectations. Since the self can be transformed on demand, Hochschild (1983: 7) was concerned that this process could change personal identity, as well as how well one can trust what one thinks they knows of oneself.

\(^5\) The concept for authenticity has been challenged by scholars as problematic in that it implies there is a single fixed static self that represents the subjectivity of a person and this is unfitting with current thinking about identity. See *Authenticity: Studies on a Critical Concept* (2014) edited by Julia Straub.
Several theorists (Serpe and Stryker 2011; Tajfel and Turner 1986) have addressed the issue of people’s multiple roles and identities and the associated factors evoking one identity over another. For example, there may be times that one’s identity as a caring nurse is evoked while at other times, the loyal hospital employee may be made relevant by the organization. Hochschild says emotions are connected to validating one’s identity through reflecting how one’s internal perceptions match the external world. Being perceived as not caring or being prevented from enacting caring would be seen unfavorably by peers and patients (Fitzgerald, and Weidner 1995; Price 2009; Sokola 2013).

If work conditions change in a way that work no longer supports one’s preferred identity, this could have implications for retaining nurses. If caring no longer serves the goals of patient care, nurses may find ways to comply marginally, while avoiding situations that arouse conflicting emotion. In addition, having to comply with mandated emotional regulation could create problems for other areas of personal self-control.

**Interference with Self Control**

Another way emotional labor could affect identity is the potential for job performance activities to encroach on other parts of one’s life. For example, nurses must focus exclusively and intensely on the patients’ needs in the hospital setting. While nurses may be inclined to suppress their own needs and focus on others’ rather than self, it is possible for the day-to-day enactment of the caring to become an ingrained pattern impinging upon one’s personal relationships as well (Owens, Robinson and Smith-Lovin 2010; Serpe and Stryker 2011). Hochschild had concern that emotional labor could
change a person and how they relate to others in their private lives. A pattern of persistent self-care neglect has been suggested to be present in nurses (Sabo 2006).

Summary of Theoretical Hybrid Model for Emotional Labor

Hochschild (1983) acknowledged her theory was partly derived from Goffman’s (1959) symbolic interactionist theory of dramaturgy. As previously discussed, dramaturgy emphasizes the theatrical-like performances in everyday social life which vary depending on whether the “actor” is front or back stage. Backstage performances offer an opportunity to relax and be one’s true self. Hochschild also identifies emotional labor theory as intersecting with Marxist ideology with regard to labor exploitation. Weeks (2007) broadened the critical theory aspects of Hochschild’s work by recognizing of the influence of culture, social structure, and power on the identities and roles available to people. Further, the encroachment of capitalism into all areas of human life, as noted in theories of late capitalism (Berardi 2009; Harvey 1990; Jameson 1991) has added to the expansion of work in our daily lives.

Symbolic interactionists and critical theorists both suggest that social structures are so embedded that we maintain them out of comfort and familiarity. This is true even when in the face of resistance. Change occurs very slowly as the familiar is at least predictable. Symbolic interactionists typically recognize that in order for change to occur, the routines and assumed order of things must be examined. It is in this respect that symbolic interactionism is congruent with a critical theory. To resist the status quo, especially in situations of oppressive conditions or misuse of power, the routines and
taken for granted assumptions by which we live, must be exposed and reflected upon. Only then, can new choices be made or a commitment to re-enforce what was previously unnoticed.

Convergence of Theories on the Modern Hospital Marketplace

Contemporary hospitals display the service they provide to meet the wants and needs of patients through visual media and advertising. As postmodern theorists of late capitalism predicted, these images sell (McNamara 2009). The product or service may be no more than a replica of a service, an image or an experience evoking a particular feeling. Absent of tangible referents, such deceptions of reality were referred to by Baudrillard (1994) as “simulations”, simulacrums” and “hyper-real” creations.

Once designed as dull, sterile, neatly organized spaces, referred to by their function as patient wards, hospitals now are carefully designed facilities with modern architecture adorning both the interior and exterior of the hospital. Attractive amenities abound such as healing gardens, art displays, gift shops, fresh flowers and perhaps a farmers market. From greeters at information desks to physicians preparing to perform surgery, the service excellence slogans posted in the halls are echoed by each employee, often in the exact words, “we are here for you.”

An abundance of documents and iconic representations are on display mirroring the accrediting agencies’ published standards and requirements. Image is vital in a market-driven healthcare system. No matter what you actually see, what is real is what is written in those documents and recorded in the survey reports. Above all else, documentation by nurses must reflect quality care in accordance with written standards of
Evidence based practice (EBP), digitized patient care records and positive care experiences quoted from patient satisfaction surveys, place the subjectivities of patients outside of this simulated world of care while simultaneously seeking to rescue patients from its inhuman and detached character (Smith 1998; 1991; 1992).

EBP replaces the intuitive expertise of physicians and nurses whose years of dedicated experience and practice traditionally informed clinical care. If knowledge or treatment cannot be supported with reason and backed by controlled scientific studies, it is not made available for patient care (Denzin 2009; Denzin, Lincoln, and Giardina 2006). Holmes, Murray, Perron, and Rail (2006) refer to EBP as a form of micro-fascism because it restricts certain kinds of knowledge while privileging others. Is practice, favoring the efficiency and rationalized approach, reproduces a gendered way of being, one that is clearly masculine and one that reproduces patriarchal ideology.

Juxtaposed with a highly regulated, rationalized approach to care, there is a proliferation of discourse(s) about caring and emotion in healthcare (Watson 2008). Nurses and other hospital staff are taught how to display behaviors, gestures and words that mimic a caring professional service attitude (Hsu et al. 2011; Snow and Yanovitch 2009). These artificially constructed, positive-thinking customer-service sales pitches’ move healthcare into the era of simulation (hyper-real).

In the postmodern healthcare environment (Bendelow 2010; Gustavo 2010; Jameson 1991; 2010; Watson 2010), increasingly it becomes difficult to distinguish the real from the hyperreal, the authentic from the copy, and the genuine caring from the
enacted performance of organizational scripts focusing more on service satisfaction than on the provision of health.

The increasing rhetoric of care and excellence which exists to promote, but effectively inhibits, authentic events grounded in real experiences are shaped by rules, policies, documents – discourses – all of which consort to generate an experience for patient care that has been said to be quite removed from the actual experiences. As Cooley said, many years ago, “To have human value, the inner word and inner experience that interprets it must go together (1926: 65).”

Theoretical Summary Statement

The theories of Marxist ideology, Symbolic Interactionism, Critical Theory, and Hochschild’s emotional labor fit well with the basic tenets of postmodernism and the characteristic economic system of late capitalism. This theoretical framework underpins the focus of this dissertation to understand how caring is manifested in the modern hospital marketplace. A consideration of the emotional labor associated with caring by nurses leads to an examination of literature relevant to nurses’ work, its gendered nature and how some of the barriers to caring may perpetuate dominant ideologies which subordinate nurses and their caring work.

This theory can be applied readily to the expectations of nurses in their work. The gendered aspects of nursing are found in the normative expectations for nurses to exhibit caring behavior, to listen and to express feelings with patients. What this theory adds to the understanding of a phenomenon such as caring in nursing is how caring is manifested
in the current work environment of nurses, what influences it, how nurses cope with aspects of the work environment that produce incongruence in the nurse. This offers some understanding of why nurses burn out, experience trauma vicariously, become morally bankrupt, cynical or chronically angry as described in the literature (Thomas 2004).

**Relevance to Nursing: The Gendered Nature of Nursing**

At one time, nurses independently were hired for their expertise in care-giving. Nurses who gained experienced caring for others during sickness and dying were trusted to be caregivers in the homes of the sick or dying. Nurses rarely consulted physicians (Reverby 1987). This independence changed when nurses moved their work into the hospital setting. As micro-social institutions, hospitals reestablished the order of patriarchy. Nurses were subservient to physicians (Muff 1988; Reverby 1987) and to hospital administrators. Even the position of nursing supervisor was established to ensure nursing duties were aligned with administrative aims.

Increasingly, nurses grew determined to control their own work, pursuing a professional status similar to physicians (Porter 1992; Reverby 1987; Seago 2006). This eventually placed nursing in universities and created yet another conflict in ideas, particularly about nursing’s identity. Although overlapping areas of mutual interests existed between the professionalization of nursing and the women’s movement quest for gender equality, a collaborative convergence of effort never occurred (Group and Roberts 2001; Malka 2007). Nursing maintained a measure of distance from the women's
movement, and the women's movement did not perceive nursing’s goals as consistently compatible with their vision of gender equality.

However, both the process of the professionalization of nursing the pursuit of equality by the women’s movement resulted in a false sense of occupational equality. Public privileges were offset by less obvious mechanisms of controlling women such as double duty at work and home as well as a persistent experience of struggling to be heard and taken seriously (Belenky et al. 1996; Hochschild 1997). These parallels between nursing and the women’s movement will be integrated into a theoretical model that demonstrates the ongoing relevance of classical sociological theory in late capitalism and the need for a paradigm shift in sociology and in all science serving the wellbeing of human beings.

It is almost impossible to consider nursing without considering gender. The word nurse reflexively brings to mind female, woman and perhaps - mother. These terms are so embedded in our minds that it is difficult to rethink these long held constructions of what a nurse is, what a nurse does and what a nurse represents (Schultreiss 2001). Because women historically have performed caregiving roles in families (Lorber 1994; Chafetz 1999; Rosenberg 1995); it is easy to see how women might transition into caregiving roles outside the home (Robinson, Bottorff, Pesut, Oliffe, and Tomlinson 2014). The deep-rooted ties between the concepts of woman and nurse are exemplified in analogies which suggest the two roles are interchangeable. For instance, it has been said that every mother is a natural born nurse (Nightingale 1992[1859]; Nutting and Dock 1907; Reverby 1987) and that the skills required of a nurse are the same as those required for being a good woman (Nightingale 1992[1859]: v) or mother (Maher and Saugeres 2007).
These assumptive statements are part of the discourse that maintains images of nurses as female (Budrys 2011; Kalisch and Kalisch 1987; Jinks and Bradley 2004). Also, we do not say “female nurse” though we do say “male nurse”, drawing attention to male nurses as non-normative.

The interrelated histories of nursing and women have been a subject of fascination by many scholars who see mirror images of one in the other (Ashley 1976; Duffy 2005; Fletcher 2007; Heide 1973). Structured after the idealized role for a woman, nursing has remained a strongly gendered occupation - both in numbers of females and in expected role behaviors (Ashley 1976; Fletcher 2007; Group and Roberts 2001; Heide 1973; Porter 1992). In fact, 92 percent of nurses are women (Bureau of Labor Statistics 2010). Compared to other traditionally female professions, nursing has attracted the lowest percentage of males with only 8 percent males in nursing compared to social work which is 14 percent male and teaching which is 20 percent male. Though seldom highlighted and sometimes not even acknowledged, nurses have not always been women. At one time, males were the only nurses (O'Lynn and Tranbarger 2006; Trossman 2003). For instance, in the early Christian era, it was mostly men that took care of the sick and injured helping patients walk, giving massages and baths, cooking and serving meals and making beds. During medieval times, a special group of knights were responsible for the care of the injured. The assumption that nurses always have been women is clearly inaccurate as are some of the other recorded histories of nursing (Davies 1980; D’Antonio 2010; Group and Roberts 2001; Lerner 2005 [1979]). Likewise, nurses were not subservient to physicians. These misconceptions will not be detailed in this dissertation. The point of drawing attention to them is that when taken-for-granted
assumptions are examined, it becomes apparent how discourse is altered to favor dominant groups (Boyd and Waymer 2011). Because such discourse is so easily accepted, sex role socialization is effective, enduring and invisible (Eliot 2011) as discussed next.

*The Congruence between Gender and Nursing Socialization – Deference, Obedience, Service, Nurturance and Passivity.*

From an early age, girls are socialized to be attentive and sensitive to the needs of others (Daiski 2004; Kimmel 2000; Stockard 2006); this is also the focus of socialization to become a “good nurse” (Benner, Tanner, and Chesla 2009; Davies 1995; Group and Roberts 2001). Typical norms for female gender socialization include rewards for being giving and deferring to others, making the needs of males more important, expressing feelings, being gentle and less physically active, staying close to parents and home rather than seeking independence and taking initiative, focusing on home and family as priority, viewing career as secondary, avoiding the expression of anger, taking responsibility for the feelings and mistakes of others, striving to maintain harmonious relationships especially on the home front, avoiding boastfulness or self-promotion, being fearful and passive to name a few (Bem 1981). Some research has suggested that males and females belong to different emotional and communicative cultures, valuing different responses to emotional distress (Tannen 1990; Wood and Inman 1993). While this has been reviewed and refuted by others (MacGeorge et al. 2004), there is evidence that women are better at supportive communication skills and are more apt to engage in these behaviors. Both women and nurses are expected to maintain relationship harmony in their homes and in their jobs. They do this by being attentive to the relational components in their day-to-day
activities (Abbot, Wallace, and Tyler 2005; Kimmel 2000). While these characteristics are conducive to performing jobs in service to others, they also are the same types of characteristics present in other oppressed groups that favor the needs of dominant groups or persons (Allport 1954; Adorno 1950; Montagu 1946: 1992). Deference and submissiveness have been created by dichotomizing of gender roles between women and men and between physicians and nurses.
CHAPTER THREE
REVIEW OF LITERATURE

Chapter Overview

This literature review begins by examining studies that designate caring as central to defining nursing. In this chapter, I begin with a review of studies that attempted to unify how caring in nursing was defined. I follow with several meta-analyses, in which researchers combined their own caring research with those already existing. Then, I consider changes in the practice and teaching of caring over the last century. Evidence for gendered associations of nursing are then reviewed, focusing on how caring perceptions and displays varied by nurse and patient gender. The purpose of including gender differences is to reveal that the differences faced by male and female nurses would generate different experiences of emotional labor, and differences in the kind of emotional labor required.

Then, I turn to emotional labor literature, particularly focusing on studies of Hochschild’s theory, and how status, gender, roles, norms, identity, organizational, societal, and other structural characteristics influence emotional labor performance and its consequences. The shift toward market-based healthcare is reviewed for how it is
transforming the organizational discourse about the emotional labor of caring to one of customer satisfaction.

Defining Caring

Efforts to define caring for research, and scholarly clarity, revealed existing definitions lacked sufficient depth to be useful (Morse, Solberg, Neander, Bottoroff, and Johnson 1990; Morse, Botoroff, Neander, and Solberg 1991). Researchers cautioned other caring researchers about the need for better conceptual clarity before attempting to do further research, using the definitions available at that time (Morse, et al. 1991). Some researchers took the existing literature on caring in nursing, and synthesized it with their own research on caring; these studies are discussed next.

Gaut’s Philosophic Concept Analysis of Caring

Gaut (1993), a scholar of nurse caring, examined caring definitions in the nursing literature. She applied an established guided inquiry instrument (see Kerr and Soltis 1974) to caring definitions in the literature, producing three necessary and sufficient conditions for caring by nurses (1993: 322): (1) the knowledge necessary for recognizing a caring need, (2) the skills necessary for responding to the identified caring need, and (3) evaluation of nurses’ caring action based on its effect as reported by the patient’s, rather than the nurse’s opinion of its effect. Gaut suggested this definition clarified caring as an
action rather than a disposition; further, this action was deemed caring by the person on whom it was directed as opposed to the actor’s judgment of their action.

This definition of caring found it was insufficient to merely be thought of as a caring person, or decide one’s actions were caring. It was also inadequate to deem one’s action was caring based on the nurse’s positive feelings. Gaut’s necessary and sufficient conditions for caring were consistent with existing philosophical analyses of caring (Mayeroff 1990 [1972]; Noddings 1984) and with several other studies examining nurses’ caring (Jasmine 2009; Sherwood 1995). Another meta-analysis of nurse caring is reviewed following Table 3.1 below.
Table 3.1 Meta-analytic Studies of Caring and Categories of Caring Studies

<table>
<thead>
<tr>
<th>Authors of study</th>
<th>Focus or description of study</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morris, Solberg, Neander and</td>
<td>How caring is defined</td>
<td>The following range of definitions are too broad to synthesize meaningfully</td>
</tr>
<tr>
<td>Johnson</td>
<td>in the nursing literature.</td>
<td>as a guide for research:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Human quality</td>
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<td></td>
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<td>- Moral quality</td>
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<td></td>
<td></td>
<td>- Affect</td>
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<td></td>
<td></td>
<td>- Interpersonal relationship</td>
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<tr>
<td></td>
<td></td>
<td>- Intervention</td>
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<tr>
<td>Gaut</td>
<td>Concept analysis of caring,</td>
<td>Caring requires action as follows:</td>
</tr>
<tr>
<td></td>
<td>the necessary and sufficient</td>
<td>- Knowledge of a caring need</td>
</tr>
<tr>
<td></td>
<td>conditions for caring to be</td>
<td>- Capable of meeting the caring need</td>
</tr>
<tr>
<td></td>
<td>defined as caring.</td>
<td>- Evaluation is based on the other person’s welfare</td>
</tr>
</tbody>
</table>

Swanson’s Literary Analysis of Caring

Swanson (1999), a caring researcher, integrated her research on women who had experienced miscarriages with her meta-analysis of existing research categories identified in the nursing literature on caring. Unlike Gaut’s conceptual analysis for definitions of caring, Swanson categorized available studies on caring in nursing into five (5) levels, as follows: (1) studies defining caring traits; (2) studies addressing the values and beliefs underlying caring; (3) studies of conditions affecting caring; (4) studies describing specific caring actions; (5) studies detailing the consequences of caring. Each of these levels is discussed below.
Swanson's Level One Studies: The Traits of a Caring Nurse

In Swanson’s (1999: 34) analysis, level one studies addressed the caring traits of nurses. A total of twenty-one (21) studies spanning a decade (1986-1996), with seven hundred and eighteen (n=718) participants, the majority of whom were nurses or nursing students, were identified. Swanson concluded from these studies that a caring nurse was compassionate, empathic, knowledgeable, confident, and reflective.

Of these twenty one (21) studies, two (2) studies demonstrated a relationship between empathy and maturational readiness of the nurse (Benner 1984); therefore suggesting the nurse’s ability to display empathy depended on the nurse possessing a certain degree of emotional and physical maturity. One of these studies was a comprehensive longitudinal study, examining the nurses’ development of expertise over the course of their career (Benner 1984). The researcher described nurses’ career trajectory in progressive stages from inexperienced novice nurse to expert nurse.

According to the researcher, new nurses prioritized learning technical skills to become safe when using these skills. While developing technical skills, new nurses were less focused on interpersonal aspects of care, although they did maintain an awareness of the need to be caring toward patients. The findings of the researcher, studying nurses’ development of expertise over time, were that only expert nurses consistently displayed caring. Expert nurses were nurses able to simultaneously perform complex technical procedures, deal with multiple stressors in the work environment, and maintain a caring presence to others. These studies suggested caring was not a static trait, however, Swanson’s next level of caring studies suggested stable underlying beliefs about caring.
Swanson’s Level Two Studies: Underlying Values and Beliefs about Caring

Swanson’s level two studies focused on values and beliefs consistent with caring. Particular beliefs found to be foundational for caring by nurses were as follows: (1) people are unique human beings; (2) the nurse’s personal and professional identity includes being caring and empathic; (3) relationships can make a difference in people’s lives (Kahn and Steeves 1988). From eighteen qualitative studies (n=18), with over five-hundred nurses (n=500), the underlying value system that defined nurses’ actions as caring included the following: (1) the nurse had a sense of commitment and obligation to patient needs; (2) the nurse felt compelled to do the right thing, despite interfering circumstances or conditions (Swanson 1999). In one of these studies, nurses ranked characteristics of the ideal nurse, and then evaluated themselves based on these characteristics (Morrison and Burnard 1989; Morrison 1991). Out of a possible score between 0-48, with 48 representing the ideal nurse, nurses’ self-ratings were a mean score of 10.96 (\(\bar{x}=10.96\)), suggesting a large gap in nurses’ realizing their own stated ideals for caring. A large discrepancy between ideal and actual characteristics raised questions about the usefulness of maintaining such high ideals for caring, but was consistent with other studies suggesting a similar gap between nurses’ ideals and practice (Allen 2007; Kramer 1974; Pellico, Brewer, and Kovner 2009; Törnvall, Wilhelmsson, and Wahren 2004; Tufte 2013; von Krogh and Naden 2011). Swanson’s (1999) level three studies suggested nurses’ ability to display caring to patients varied by conditions in the nurse’s work environment.
Swanson’s Level Three Studies

Swanson’s (1999) level three studies addressed the multifarious conditions constraining and enhancing nurse caring. For example, when a nurse or their family member had previously been ill and experienced caring by a nurse, they were more demonstrative in showing caring to their patients (Donoghue 1993). Nurses identified it was difficult to show caring to disagreeable patients (Forrest 1989), and easier to show caring to patients who were determined to get better (Peteet, et al. 1992). This was consistent with subsequent studies suggesting nurses engaged in emotional labor to maintain a caring appearance under difficult circumstances (Bolton 2001).

Fourteen (n=14) of the level three studies reviewed by Swanson (1999), showed the amount of time given to patients by nurses depended on the patient’s documented needs for supportive care. Other variables influencing the amount of time nurses spent with patients were: (1) likeability of the patient; (2) the patient’s attitude toward their illness and recovery; (3) the patient’s personal appearance; (4) the patient’s communication style.

Level three studies also included organizational constraints and facilitators of caring by nurses. Of particular significance were Ray’s studies (1984, 1989) demonstrating strong support for the hypothesis that nurse caring varied based on the organizational definition of the nursing role in that institution. Factors affecting nurse caring, according to Ray, were role and personnel-related demands of the nurse, availability of resources, including technologies available to support the nurse in caring for patients, and the specific worksite conditions on the unit or in the particular hospital. The significance of the organizations’ role in determining whether nurses had sufficient
resources and control over work processes to be able to show caring was also found in a large multi-site study (Aiken 2001; 2002; 2003; 2010).

Administrative and supervisory support was found to be an essential facilitator of nurses’ caring (Quinn, et al. 2003; Smith 1992). Nurses’ were more able to display a caring manner with patients’ and colleagues when they felt they had available mentors in the workplace, and when leadership supported their efforts to take care of patients. Swanson showed nurses tended to engage in specific actions when showing caring.

**Swanson’s Level Four Studies**

Swanson’s level four studies included studies identifying specific caring actions of the nurse such as: (1) listening to the patient; (2) allowing the patient to express their feelings; (3) using touch to comfort patients. Several studies used quantitative measures of caring through the use of caring measurement scales considered to be valid measures of caring by nurse researchers\(^6\); Overall, these studies suggested that specific manifestations of nurse caring actions varied by context, but in most cases, any caring action by the nurse required the nurse knew a patient well enough to make relevant judgments about their needs. This was similar to findings from other studies about the importance of nurses individualizing their actions to meet the patient’s individualized needs (Ford 1981; Gaut 1993; Halldórsdóttir and Hamrin 1997; Larson 1984; Lea, Watson, and Deary 1998; Staden 1998; Wolf 1986). The last level of Swanson’s studies

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\(^6\) Some of the scales used in these studies were the Caring Behavior Inventory (Wolf 1986), the CARE-Q Inventory (Larson 1984; 1986; 1987), Caring Behavior Assessment (Cronin and Harrison 1984), and Supportive Nurse Behaviors Checklist (Gardner and Wheeler 1981; 1987).
focused on the effects caring had on patient health outcomes, satisfaction with care, nurse job satisfaction, and hospital fiscal outcomes.

Swanson’s Level Five Studies

Swanson’s (1999) level five studies synthesized the consequences (outcomes) of caring, although these studies were few in number. Of these studies, they tended to focus on the following: (1) a patient having a caring nurse; (2) a nursing student having a caring instructor; (3) nurses having caring supervisors, administrators, or both. Recipients of caring actions reported a sense of enhanced well-being. More specifically, having a caring encounter with their nurse (or instructor or supervisor) was associated with a greater sense of self efficacy, a positive improvement in mood, and a sense of satisfaction with the caring encounter (Swanson 1999). Swanson summarized this finding thematically as freeing up a person’s inner strengths and healing potential.

Swanson (1999) also included studies identifying uncaring actions such as those actions that left patients (or nursing students or nurses) feeling humiliated (Beck 1992 and b, 1993; Haldorsdottir 1990, 1991, 2008; Montgomery 1993; Riemen 1986), feeling out of control, afraid, hopeless, or alienated (Hall 1999; Shattell, Hogan, and Thomas 2005; Thomas 2004). Uncaring nursing-unit atmospheres were associated with nurses becoming robot-like (just going through the motions), depressed, and hardened (Swanson 1999: 53). Table 3.2 below summarizes the focus of these studies by the levels discussed.
<table>
<thead>
<tr>
<th>Study Levels</th>
<th>Summary of Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: Characteristics associated with caring nurses</td>
<td>Five traits are considered important to nurse caring:</td>
</tr>
<tr>
<td></td>
<td>• compassion</td>
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<tr>
<td></td>
<td>• empathy</td>
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<tr>
<td></td>
<td>• knowledgeable</td>
</tr>
<tr>
<td></td>
<td>• confident</td>
</tr>
<tr>
<td></td>
<td>• reflective</td>
</tr>
<tr>
<td>Level 2: Values /Beliefs</td>
<td>Three underlying beliefs are associated with caring nurses:</td>
</tr>
<tr>
<td></td>
<td>• people are unique human beings</td>
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<td></td>
<td>• personal, professional identity includes empathy</td>
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<td></td>
<td>• believes relationships can make a difference</td>
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<tr>
<td>Level 3: Conditions affecting ability to show caring</td>
<td>Two aspects about the personal experience of a nurse associated with nurses’ caring:</td>
</tr>
<tr>
<td></td>
<td>• appraisal &amp; experience</td>
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<tr>
<td></td>
<td>• prior caring experiences</td>
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<td></td>
<td>Five aspects of the organizational environment affecting nurse caring:</td>
</tr>
<tr>
<td></td>
<td>• role demands</td>
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<td></td>
<td>• personnel-related demands</td>
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<tr>
<td></td>
<td>• availability of resources</td>
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<tr>
<td></td>
<td>• specific worksite conditions</td>
</tr>
<tr>
<td></td>
<td>• presence &amp; availability of administrative/supervisory support</td>
</tr>
<tr>
<td>Level 4: Specific actions</td>
<td>Four actions considered essential to the nurses caring:</td>
</tr>
<tr>
<td></td>
<td>• listening</td>
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<tr>
<td></td>
<td>• expressing feelings</td>
</tr>
<tr>
<td></td>
<td>• touching</td>
</tr>
<tr>
<td></td>
<td>• knowing them well</td>
</tr>
<tr>
<td>Level five: Consequences</td>
<td>Two specific patient populations especially sensitive to caring by nurse:</td>
</tr>
<tr>
<td></td>
<td>• younger patients</td>
</tr>
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<td></td>
<td>• patients in pain</td>
</tr>
</tbody>
</table>

Overall favorable effects of caring was a freeing up a person’s inner strengths and healing potential (greater self efficacy, positive mood, & satisfaction with care)
In summary of Swanson’s findings, caring was neither a uniform nor static quality existing in a nurse. Rather, it depended on maturity, personal and professional experience, the presence of coworker and supervisor support, and an organization that facilitated caring. Actions considered to be caring were consistent, mainly interpersonal in nature, and these were associated with a stable set of beliefs about human beings, and personal dignity. Aside from studies using caring measuring instruments, cited in Swanson’s meta-analysis, subsequent studies of this kind were relevant to this study of emotional labor of caring by nurses, and are discussed next.

Additional Studies of Caring.

A number of studies (Austin 2011; Bassett 2002; Boykin and Schoenhofer 2001; Gustafsson and Fagerberg 2004; Freshwater 2000; Kong 2008; Pauly and James 2005; Pearcey 2010) revealed caring was consistently tied to a nurses’ professional and usually, personal identity. These studies suggested a caring identity was especially strong in newer nurses. Many studies differentiated between technical and interpersonal caring actions, respectively defining them as instrumental and expressive caring\(^7\) (Boumans, Berkhout, and Landeweerd 2005; Chen 1990; Clifford 1995; Murphy, Jones, Edwards, James and Mayer 2009; Woodward 1997).

Instrumental caring activities were defined as bathing, administering medications, and providing comfort (Watson 2006: 51). Expressive care (Watson 2006: 51) involved

\(^7\) Several nursing scholars of caring distinguish between instrumental and expressive caring (Leininger, Watson, and Swanson, for example ); however, the one clear origin of this phraseology was Parsons (1937) in his theory of social action
giving emotional support, and listening, as patients discussed their feelings and concerns.

In the next section, I will discuss the caring measures from a widespread theoretical approach that has been applied to patient care in national and international healthcare systems (Cara 2003; Smith 2004; Suliman 2009).

Watson’s Caring (Caritas) Processes

Jean Watson (2008b), a caring theorist, and founder of the Watson Caring Science Institute, encouraged a return of caring campaign by implementing her caring model in national and international healthcare systems (DiNapoli, Nelson, Turkel, and Watson 2010; Nelson 2006; Persky, Nelson, Watson, and Bent 2008). Watson developed caring or caritas processes to guide a caring based approach to clinical care of patients and to educate nursing students in caring. These processes are included in Table 3.3. In table 3.4 five dimensions of caring, derived from an exploratory factor analysis of nurse caring behaviors based on the Watson caring model are listed and include: (1) respectful deference to the other; (2) assurance of human presence; (3) positive connectedness; (4) professional knowledge and skill; (5) attention to other’s experience (Wolf, Giardino, Osborne, and Ambrose 1994).
Table 3.3 Watson’s Ten Caritas Processes

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Embrace altruistic values and practice loving kindness with self and others.</td>
</tr>
<tr>
<td>2.</td>
<td>Instill faith and hope and honor others.</td>
</tr>
<tr>
<td>3.</td>
<td>Be sensitive to self and others by nurturing individual beliefs and practices.</td>
</tr>
<tr>
<td>4.</td>
<td>Develop helping – trusting- caring relationships.</td>
</tr>
<tr>
<td>5.</td>
<td>Promote and accept positive and negative feelings as you authentically listen to another’s story.</td>
</tr>
<tr>
<td>6.</td>
<td>Use creative scientific problem-solving methods for caring decision making.</td>
</tr>
<tr>
<td>7.</td>
<td>Share teaching and learning that addresses the individual needs and comprehension styles.</td>
</tr>
<tr>
<td>8.</td>
<td>Create a healing environment for the physical and spiritual self which respects human dignity.</td>
</tr>
<tr>
<td>9.</td>
<td>Assist with basic physical, emotional, and spiritual human needs.</td>
</tr>
<tr>
<td>10.</td>
<td>Open to mystery and allow miracles to enter.</td>
</tr>
</tbody>
</table>

Compiled from Watsons webpage @ [http://watsoncaringscience.org/](http://watsoncaringscience.org/)
Table 3.4 Five Dimensions of Caring derived from Watson’s Caritas Processes

1. respectful deference to the other
2. assurance of human presence
3. positive connectedness
4. professional knowledge and skill
5. attention to other’s experience

Watson encouraged research to test and possibly modify her caring approach in nursing. Some of these studies validated caring measurement scales based on Watson’s caritas processes (Carter, Nelson, Sievers, Dukek, Pipe, and Holland 2008; Sitzman 2007; Smith 2004). Many of the studies focused on implementing the Watson caring model in educational and healthcare systems. Both qualitative and quantitative studies have yielded favorable responses from participants; nurses, in particular, often reported feeling invigorated and renewed as a result of the implementation of Watson’s caritas processes in their workplace (Schroeder and Maeve 1992). Other findings are summarized in Table 3.5 below.
Table 3.5 Summary of Implementation Outcomes for the Watson Caring Model

- family and significant others have described needs consistent with Watson’s carative factors which reflect humanistic values and the preservation of dignity and wholeness in approaching end of life care with a loved one

- patients described the importance of sensitivity, acceptance, dignity, and the caring presence of the nurse as important to their well-being and recovery

- Researchers found a significant cost savings following the implementation of nurse-patient partnerships based on Watson's caritas processes.

- Nurses with the highest scores for caring were most affected by their relationship with patients, but also reported being the most frustrated with their work environment when it did not support nurse caring.

Some researchers criticized Watson’s (caring) caritas processes research as being too esoteric to yield measurable research (Barker and Reynolds 1994; Paley 2000; 2002, 2014; Sourial 1997; Walker 1996). These critics also acknowledged Watson’s model is based on existential phenomenology, and more interested in the subjectivity of meaning from participants, than any tangible static measure. In the next part of the literature review, I look more specifically at how patients define caring and whether this is compatible with how nurses in practice define caring.
How Patients Define Caring

Mayer (1987) was one of the first researchers to find differences in how nurses and patients viewed caring. Mayer (1987) and others (Apesoa-Varano 2007; Findlay, Findlay, and Stewart 2009; Gaut 1993; Halldórsdóttir and Hamrin 1996; 1997; Papastavrou et al. 2012; Törnvall, Wilhelmsson, and Wahren 2004; von Krogh and Naden 2011; Swanson 1999) found nurses focused on interpersonal skills such as listening, and providing emotional support as most important for caring. Patients’ main concerns had to do with the nurse’s responsiveness to their needs and the nurse’s technical know-how (Bassett 2002; Larson 1984; Papastavrou, et al. 2012).

Studies suggested patients wanted nurses who were competent in performing technical skills, and who knew when to call the physician (Bassett 2002; Berg and Danielson 2007; Lundgren, and Berg 2011). Patients also wanted nurses who responded promptly to their requests, and were sensitive enough to anticipate their needs, rather than only responding when they asked for something.

Caring, as seen by the patient is important for higher patient satisfaction scores (Bowling, Rowe, and McKee 2013). Nurses say they see caring as important, and that they are dissatisfied with their expression of caring, but they find patient satisfaction scores being unrepresentative of what happens in the patient care environment (Apesoa-Varano 2007; Findlay, Findlay, and Stewart 2009; Gaut 1993; Halldórsdóttir and Hamrin 1996; 1997; Swanson 1999). Other studies help to clarify the appearance of this wide divide about caring and know-how.
Patients and Nurse Agree That Caring Means Being Attentive

Nurses and patients agreed on some aspects of caring. Three (3) found patients
and nurses both agreed a caring nurse attended to patient needs, conveyed a sense of
safety, concern, and well-being for the patient, and had positive regard for the patient as a
human being studies (Larson 1984; Wolf 1986; Wolf, Giardino, Osborne, and Ambrose
1994). Other found interpersonal relationships between nurses and patients were
important, to both patients and nurses studies (Finch 2008; Halldórsdóttir and Hamrin
1996; 1997).

Patients saw nurses as caring when they smiled, acted like they liked their jobs,
did things without having to be asked, made an effort to interact with them, were genuine,
and showed an appropriate sense of humor (Finch, Mort, Mair, and May 2008). Caring
nurses were experienced by patients as partners helping them face their illness, and
empowering them to recover (Halldórsdóttir and Hamrin 1996; 1997). Even if patients
wanted nurses who knew how to handle equipment, and perform procedures safely, an
uncaring nurse cancelled the patient’s positive regard for technical competence
(Sharman, McLaren, Cohen, and Ostry 2008; Wysong and Driver 2009).

Patients Find Uncaring Nurses to Be Discouraging to Their Well-Being

Uncaring nurses generated disempowering feelings, fostered anxiety, and left
patients feeling disconnected, discouraged, and hopeless (Halldórsdóttir 1996;
Halldórsdóttir and Hamrin 1997). Uncaring nurses were minimally present physically and
emotionally, often in a hurry, gruff in their manner, and treated patients as if they were an
object on which to perform a task. Rules were more important to uncaring nurses than
were patient or family needs (Riemen 1986). This fits with Halldorsdottir (2008)
conception of a relationship typology, in which she described the bioacidic relationship as belittling and disempowering to patients, and leaving them feeling hopeless. Halldorsdottir also identified positive benefits derived from caring.

Benefits Derived from Caring

The importance of caring, dating back to Bowlby’s (1973) observations that a consistent caregiver early in life was essential to forming interpersonal attachments, has continued to receive focus from most academic scholars (Ainsworth 1969; Bowlby 1973). Findings have ranged from the universality with which caring was seen as important across cultures (Leininger 1981), to biological and evolutionary pre-dispositions to empathic behavior (Batson 1998; Damasio 2010), to the impact of caring on healing by moderating biological markers of stress and disease (Zender and Olshansky 2012), and the sustainability of life through caring for our environment (Robinson 1993), to name a few.

Leininger (1991), a nursing theorist and cultural anthropologist, promoted caring as the essence of nursing practice, and challenged nurses to generate scholarship supporting a caring paradigm for nursing and society. Most of the studies by nurses in this manuscript were presented at the International Association for Human Caring, with whom Leininger was associated, as one of the institutes’ initial founders (IAHC 2015).

A caring nurse has been linked with facilitating patients’ use of coping skills (Latham 1996), lowering blood pressure measurements (Cosley, McCoy, Saslow, and Epel 2010), reducing recovery time from surgery (Glasper and DeVries 2005), improving patient’s remission rates from cancer (Engebretson, Peterson, and Frenke 2014; Butow et
al. 2013), and providing a sense of coherence and mastery, in otherwise stressful situations (Antonovsky 1993; Eriksson and Lindström 2005). Patient health outcomes (Aiken, et al. 2001; 2002), patient satisfaction (Amendolair 2007; Palese et al. 2011), institutional financial outcomes (Ray 1989; Ray and Turkel 2000; 2001; 2003; 2004), and nurse job satisfaction, have been associated with nurses displaying a caring manner (Aiken 2001; 2002; 2010; Dunn 2012; Lopez 2006; Scott et al. 1995). Beyond the individual caring aspects of a nurse, Halldorsdottir (2008) synthesized caring relationship typologies from her research, characterizing one end of the continuum as toxic relationships that belittle, disempower, and leave patients feeling hopeless, to the other end of the continuum, where relationships fostered respect, encouraged recovery, generated healing, and was described as a loving energy between participants in a relationship. Caring and how it has changed over time will be reviewed next.

CHANGES IN THE PRACTICE OF CARING

Before Christianity, the sick and injured were viewed as a burden, a threat, and were isolated, sometimes being left to die (Ferngren 2009). Widespread ideas of compassion, and suffering for another, came to be seen as socially expected actions among civilized people, only after Christianity.

An analysis of recent changes in the practice of caring by nurses was found to include written descriptions of caring from the time of Florence Nightingale (1992[1859]), the founder of modern nursing (Gaut 1993). During Nightingale’s time in the 1800’s, nursing was portrayed as the authoritative and dutiful implementation of specified tasks and duties. This orientation of caring as tasks continued into the 1950’s.
During part of the 1950’s, caring still mostly focused on tasks (Como 2007: 37; Reverby 1987: 58; Roberts 1925: 737; Smith, Turkel, and Wolf 2012) as opposed to sentiments, but these ideas were shifting toward caring as a trait of the nurse (McPhetridge 1968; Traynor 1996). Caring by nurses, after the 1950’s was depicted as a respectful negotiation with the patient about their needs for care. Three societal influences, occurring around the same time these shifts in views on caring began to appear in the literature, were: (1) a focus on interpersonal relationships; (2) a focus on understanding the influence of groups; (3) burgeoning advances in medical knowledge, and technology. These societal shifts will be discussed next.

The Increasing Interest in Interpersonal Relationships and Human Relations Training

Several philosophers and social scientists in the 1950s through the early 1970s highlighted relationships between people as important to well-being (Buber and Smith 2000[1958]; Erickson 1950; Mayeroff 1990 [1972]; Jourard 1964; Rogers 1951). For example, Carl Rogers (1957) was known for his psychotherapy approach emphasizing warmth, genuineness, and empathy as essential ingredients for any helping relationship. Many studies were done on these traits in helpers, and how these traits facilitated healthy relationships (Shapiro, Krauss and Truax 1969). Also during that decade, nursing theorist, Hildegard Peplau (1952) published her theory of interpersonal relations in nursing.

Hildegard Peplau (1952) defined the interpersonal relationship between nurse and patient as central to all of patient care. Peplau emphasized that caring emerged out of the

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8 Caring has been speculated (Como 2007) to be more of an action than a feeling because of the influence ideologies of the Age of Reason (Paine 1794) such as the preferential valuation of thought and logic over passions and feeling.
nurse-patient relationship, such that actions done by the nurse on behalf of the patient, were those which the patient was unable to manage on their own. According to Peplau, a helpful relationship was one that facilitated moving the patient toward their maximum functioning potential. The nurse’s primary tool for helping patients was the nurses’ skilled use of interpersonal competencies, and this could be applied across any patient care setting. The focus on interpersonal relationships, positioned the nurse as skilled facilitator of patient recovery, doing for their patient, only what they were unable to do for themselves. This shifted the caring relationship out of the mode of authoritative ministering of care, deemed to be needed by the nurse or physician, toward a collaborative agreement between the nurse and patient. The relationship between the patient and nurse was but one part of a larger social system operating around, and influencing the care of the patient. The influence of a work group and the social atmosphere on a nursing unit will be considered next through an examination of group dynamics studies.

Understanding how people influence each other and the dynamics among members of groups. The nursing unit and the relationships between coworkers, and other members of the patients’ treatment team, were part of the social environment in which hospitalized patients recovered (Murray 1990). Following World War II, studies facilitating cooperation, teamwork, and understanding others (Klein 2009) were a strong focus of research groups, and think tanks in the United States, and across the world.

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9 This relationship between nurse and patient would be constrained by any orders of the physician which the nurse would be required to follow; however, the nurse also may negotiate this care with the physician.
The Tavistock Institute for the Study of Intergroup Relations was one such organization.

Many studies done by the Tavistock Institute were published in an anthology of its early years of existence (Trist and Murray 1990; Murray and Trist 1993; Trist and Murray 1997). Two classic studies on hospitals provide examples of the research conducted (Klagsburn 1970; Menzies 1960). The first study (Menzies 1960), a case study of a hospital nursing service’s effectiveness in conveying caring, continues to be referred to in the training of professionals about group dynamics, and interpersonal relationships (Aram and Sher 2010). The researcher found that nurses’ organized their work around routines and checklists, shielding them from emotionally engaging with patients, and prevented them from conveying caring. After the nurses’ repeatedly failed in their efforts to alter these routines, that the nurses themselves agreed were problematic, the researcher concluded that if nurses became caring, they would also become more vulnerable to the pain and suffering they saw in their patients’ lives. The study revealed how logically-appearing solutions were resisted because of less readily apparent purposes served by maintaining the status quo.

Another study illustrated how group dynamics in an oncology nursing unit differentially affected the recovery of patients receiving a standardized chemotherapy treatment regimen (Klagsburn 1970). The study found the quality of relationships between patients and nurses, and between staff, on oncology units, affected the patient’s response to treatment, and the kind of recovery they experienced. This research is still used when training people in the social aspects of cancer care, as a way to discourage staff from allowing distancing from their patients, and to instead encourage self-
reflection, and self-awareness necessary for nurturing their caring capacity (Katz and Johnson 2006).

*Nursing’s Efforts to Professionalize And its Unintended Effects.*

Another influence on the changes seen in caring by nurses was the effort to professionalize nursing (Angrist 1965; Batey and Lewis 1982; Porter 1992; Sakuda et al. 1957; Turkoski 1995). Nursing leaders advocated for increasing the educational level of nurses (Davis and Burnard 1992; Zungolo 1968), expanding nursing roles and titles (Schmitt 1968), and enlarging the scope of nursing practice (Merton 1962; Rogers 1966). Gaining professional status was deemed essential, by nursing leaders, for diminishing patriarchal dominance by physicians and hospital administrators over nursing (Ashley 1976; Carter 1994; Falk-Rafael 1996; Nelson 1997).

Acquiring professional status meant relocating the site and nature of nursing education, to the university setting (Allen 2007; Ashley 1975; Doering 1992; Melchior 2004). This also served an emerging need for nurses to be better trained in science and technology, to accommodate advances in medical care. Nurses and physicians had mixed feelings about which responsibilities nursing would assume (Knaus et al. 1997; Dunn 1997; Henderson 1980; Keogh 1997; Schlotfeldt 1965; Tye and Ross 2000; Weiss 1983; Woods 1999). The tradeoff for nurses’ gaining expertise, greater responsibility, and autonomy, was spending less time in non-technical (interpersonal) care activities at the patient’s bedside.

A dualism between emotional caring, and knowledge-based caring emerged as a basis for debate about which of these would characterize the practice of the university-
educated nurse, as opposed to the nurse with a diploma awarded by a hospital-affiliated nursing school (Davies 1995). The changes in education of nurses will be discussed next, in concluding the discussion about the changes in the practice of caring.

**NURSING EDUCATION**

*Instrumental and Expressive Caring, University or Diploma Educated, Caring or Competent and other Dualisms in Nursing*

Nursing education accommodated advances in medicine knowledge by moving into university settings, providing an impetus for a conflict of dichotomous thought about nursing, based on educational background of the nurse (Aiken 2014). For example, a large study linked better patient outcomes of surgical patients to a higher proportion of baccalaureate prepared nurses (Aiken et al. 2003). The researchers speculated that baccalaureate nurses had better critical thinking skills, problem-solving ability, and were better at communicating, all of which affected early recognition and intervention of problems in patients recovering from surgery. Another study suggested only experience level, and not the educational level of the nurse, affected patient care outcomes (Blegen, Vaughn, and Goode 2001). The relevance of this argument is not in the answer to whether nurses should pursue baccalaureate degrees or be similarly educated for entry into practice. The important point is the onset of an enduring conflict amongst nurses regarding assumptions about caring levels and competence levels.

Parsons’ (1951) theory of social action, distinguished between *instrumental* (technical or detached) and *expressive* (interpersonal or emotional) dimensions of relationships. These dichotomies have since been used to designate the orientation of
individuals in interacting with others (Parsons and Bales 1955). Performing tasks in a detached, unemotional manner, is the instrumental dimension of relationships. For example, if a nurse comes into a patient’s room and changes the patient’s wound dressing, speaking only in regards to the task at hand, this is an instrumental or task-oriented function. When the nature of an interaction with a patient is focused on feelings, and reactions to care issues, this is the expressive or feeling-dimension of interpersonal relationships. For example, the nurse coming to the patient’s room to discuss, and explore potential barriers to the patient’s continued recovery at home, would be considered an expressive function.

When it comes to caring dichotomies in nursing, older nurses suggested younger nurses were lacking in the expressive dimensions of caring (Clifford 1995; Jones 2007; Sokola 2013; Staden 1998; Woodward 1997). Newer nurses said older nurses only did the minimum of required tasks (instrumental), and they did them without a caring manner (Staden 1998; Wiggins 1997; Williams 1992). Some scholars considered caring to have been absent from nursing for some time (Allen 2007; Tufte 2013), while others disagreed, and suggested instead, that any observed decreases in caring among new nurses, was a function of the changes in educational practices which deemphasized caring, and emphasized science and technology (Apesoa-Varano 2007; Todres, Galvin, and Holloway 2009).

One study confirmed that university-based education focused more on scientific reasoning and technology (Papastavrou et al. 2012). The study also found that patients and nurses rated knowledge and skill as more important than caring (Bassett 2002; Larson 1984; Papastavrou, et al. 2012). Similar to other studies about patient perceptions
of caring, the patients and nurses in this study still indicated a caring manner was important. Other scholars suggested the science-based focus in nursing curriculums attracted a different kind of student from the more traditional caring and feminine student, common in years past (Clifford 1995; Jones 2007; Sokola 2013; Woodward 1997). There was some evidence to support that nontraditional students, such as those in accelerated, second-degree nursing programs, were less likely to report caring, and a desire to help others, as their reason for becoming nurses (McNiesh 2011; Raines and Sipes 2007).

The literature does not support the idea that nursing curriculums omit caring (Ford 1990; Sokola 2013; Ward, Cody, Schaal, and Hojat 2012). It does support that nursing educators generally assume a person choosing to become a nurse will be a caring person (O’Brien, Mooney, and Glacken 2008; Raines and Sipes 2007), that most entering nursing students are motivated by a desire to care for others (O’Brien, Mooney, and Glacken, 2008; Raines and Sipes 2007), that entering nursing students score high on caring traits (Fitzgerald and Weidner, Heidemarie 1995; Price 2009; Sokola 2013), and that educators can enhance, but cannot teach caring ability if it is not already present (Eley, Eley, Bertello, and Rogers-Clark 2012).

Nursing students often report family or personal experiences that they believe made them a more caring person; however, the only experience found by research to be sufficient to affect one’s capacity to care was that of having been a patient (Sokola 2013). There was some suggestion that experiences in one’s family background placed some people in a position to feel most natural, when focused on the needs of others as opposed to one’s own needs (Donnaghue 1993; Huppatz 2012; Eley, Eley, Bertello, and Rogers-
Clark 2012). Nurses’ personalities have been studied in the past, describing them as good problem-solvers and caretakers, with tendencies to subordinate their own needs to those of others (Jain and Lall 1996). Nurses were also described as attentive to detail, trustworthy, compliant with rules, and as having a strong dislike of change. This is consistent with findings (O’Brien, Mooney, and Glacken 2008; Raines and Sipes 2007; Thompson, Glenn, and Vertein 2011) suggesting nurses’ have a habitus (Bourdieu and Wacquant 1992), an enduring predisposition toward certain values and ways of relating to the world, predisposing them to certain orientations and capacities in their social world. This would fit with faculty expectations that nurses come to nurse with a caring disposition (O’Brien, Mooney, and Glacken 2008; Raines and Sipes 2007).

There is also evidence that caring diminishes, rather than becomes enhanced, as students’ progress through their nursing education program (Thistlethwaite 2011; Ward, Cody, Schaal, and Hojat 2012), and as they become practicing nurses (Kramer 1974; MacIntosh 2003; Mlinar 2010; Price 2009). The reduction in caring of practicing nurses was especially true, when organizational support was not available for dealing with feelings associated with the intensity of caregiving (Price 2009; Ray 1989).

Even as measures of caring decreased in nurses, they still said caring was important in nursing (Price 2009). A study was actually prompted by nursing faculty becoming intrigued by the intensity with which a group of nursing students expressed being offended by a speech in which a nursing leader indicated that modern-day nurses’ work consisted of actions more important than caring (Rhodes, Morris, and Lazenby 2011). The faculty conducted in-depth interviews and surveys of these students, and found caring to be deeply ingrained in the students’ views of nursing, to the degree that
many indicated they would not remain in nursing if caring was lost. Even though research suggested nurse caring varied as nurses developed competence and expertise (Benner, Hooper-Kyriakidis and Stannard 2011; Benner, Tanner, and Chelsea 2009), other scholars have also shown nurses and nursing students, had strong feelings about a caring identity for nurses (Fitzgerald, and Weidner 1995; Price 2009; Sokola 2013).

Some scholars offered a more integrated view of the nurse as being a technical expert, scientifically knowledgeable, and a caring, compassionate, altruistic person all in one role, even if some are more salient or demonstrable at different times over the course of one’s career (Benner 1984). Other nursing scholars advocated dispensing with the dualisms which separate the unity of nurses (McConnell 1998; Paley 2000, 2002, 2014; Rhodes, Morris, and Lazenby 2011; Vince 2002; Watson 2002). With regard to dualisms, another dualism in nursing is the separation of nursing labor by gender, often along the instrumental (males), and expressive (females) dimensions, which will now be reviewed.

Gender Differences in Caring

*Nursing: A Segregated Occupation*

Although a recent study of the nursing workforce found the percentage of males entering nursing had increased from 2.7 percent in the 1970’s to 9.6 percent in 2011, the highest representation of males in nursing can be found in nursing anesthesia at 41 percent (Landivar 2013). The smallest percentage of males in nursing was in staff nursing positions. Males occupied staff nurse positions in less traditionally feminine areas such as critical care, and emergency departments (American Men’s Nurses Association in California 2012). Despite efforts to attract males into nursing, scholars continue to
describe nursing as the most sex-segregated occupation in healthcare, suggesting strongly
gendered expectations in nursing (Evans 2004; Henttonen, LaPointe, Pesonen, and
Vanhala 2013).

*Nurse Gender Stereotypes in Education and Practice*

Both female and male nurses define the feminine aspects of their job such as
taking care of others, expressing emotions, being an attentive listener, and showing
compassion, as essential for being a good nurse (McDonald 2013: 567). Studies of factors
attracting nurses into nursing showed that male nursing students had higher empathy
scores than females upon entering nursing school, suggesting males in nursing may have
a higher propensity for caring. This contrasted with the general population of females and
males, where females usually had higher measures of empathy (Penprase, Oakley,
Ternes, and Driscoll 2014). In nursing, it was usually females who spent more of their
time feeling responsible for managing emotional aspects of patient care (Gray 2009).
Males viewed this aspect of their work as less important than did females (Cho, Jung, and
Jang 2010).

Other studies suggested male nursing students felt pressured to comply with
traditional masculine roles and behaviors, that demonstrated their physical strength and
assertive leadership (Abrahamsen 2004; Dyck, Oliffe, Phinney, and Garrett 2009; Kada
2010; Keogh and O’Lynn 2007). It was also noted that men tended to view aggression as
an act of imposing control, whereas women saw it as “losing control” (Alexander, Allen,
Brooks, Cole, and Campbell 2004). There is support in the literature for males having a
strong propensity to construct their identities around images of masculinity, such that
adhering to the male as the stronger sex, leads males to put themselves at risk, by being
more likely to engage in demonstrations of strength (Courtenay 2000a and b). Male nurses often reported feeling discouraged from showing caring and sensitivity (Husso and Hirvonen 2012; Keogh and O’Lynn 2007; Wang et al. 2011) and other times, male nurses were reported to distance themselves from caring activities (Simpson 2011).

In recruiting males into nursing, the more feminine aspects of nursing were purposefully deflected in recruitment strategies as a way to attract males (Cottingham, Erickson, and Diefendorff 2014). Male and female nurses both expressed opinions against hyper-masculinized images on recruitment materials, and favored more gender neutral images (Landivar 2013; Wilson 2005). This separation of tasks and associated images, of nurses by gender, was consistent with studies in which students reported a strong awareness of being expected to conform to narrowly defined behaviors congruent with gender stereotypes (Paterson, Osborne, and Gregory 2005). These expectations were found by students to be inconsistent with the faculty and employer rhetoric of diversity, inclusiveness, and cultural sensitivity (Paterson, Osborne, and Gregory 2005).

Studies of student experiences in nursing school have described oppressive, uncaring, and overly rigid approaches for some students (Hall 1999; Hodson, Roscigno, and Lopez. 2006), but male nursing students reported unique disadvantages (O’Lynn and Tranbarger 2006). These problems for males will be discussed next.

Exclusion and Discrimination Experiences of Male Nursing Students

Males leave nursing faster than their female counterparts (Hsu, Chen, Yu, and Lou 2010; McLaughlin, Muldoon, and Moutray 2010; O’Lynn and Tranbarger 2006; Williams 2011; Wilson 2005). Some studies suggest males did not cope with the stress in nursing as well as females (Kada 2010; Laal and Aliramaie 2010). Other scholars
suggested it was the exclusionary and discriminatory practices, that were challenging male nurses’ coping capacities (Evans 2004a; Brown, Nolan, and Crawford 2000). For example, male nurses reported being less included in the friendship, and informal networks of nurses (Williams 1988). While this is partly preferred by male nurses, it is still experienced as pressure to not become involved in informal social talk at work. Male nurses reported added pressure to talk about male hobbies with male physicians, which sometimes generated conflicts, suggesting special privilege to their female nurse coworkers. In general, males tended to view workplace relationships in terms of access to resources, and accomplishing work objectives (Morrison 2009). Males were not usually bothered by lack of socialization, unless it restricted their access to resources required on the job. When males occupy jobs high in expectations for expressive caring, studies have found this to be more stressful for males (Evans and Steptoe 2002).

The opposite was true for females with regard to an absence of opportunities for expressive functioning in their work (Morrison 2009). In the absence of opportunities to interact with coworkers, and receive social support from somewhere, females experienced greater stress. However, in Simon and Nath’s (2004) study of the General Social Survey, little difference was found in the frequency of experienced emotion between males, and females, suggesting such differences to be exaggerated. Lively (2006) on the other hand, found that there were clear differences in patterns of emotion regulation between males and females. Males tended to redirect to alternate emotion states more quickly, whereas females took longer to cycle to other emotion states.

The ultimate exclusion for males, may be the way they are banned or discouraged from, careers in traditionally feminine patient care areas, such as labor and delivery,
postpartum, and nurseries (Biletchi 2013; Lindsay 2008).¹⁰ Males in nursing school are also minimized by males’ contributions to the history of nursing being omitted, and focusing exclusively on the feminization of nursing (O’Lynn and Tranberger 2006), a practice found to be detrimental to recruitment and retention of males in nursing (Evans 2004). Perhaps more bothersome than non-inclusion of the history of males in nursing are labeling stereotypes that marginalize male nurses (Williams 2006: 122-123).

*Marginalizing stereotypes.* The gay, and effeminate stereotype of male nurses, was the most common stereotype experienced (Allison, Beggan, and Clements 2004; Harding 2007). This stereotype was followed by several others including the suggestion that males were not as caring as the female nurses (Hsu, Chen, Yu, and Lou 2010). There were also stereotypes that male nurses could not get into medical school, and that male nurses could not succeed in typically masculine jobs (Hodes 2005: 31; Williams 2006: 122-123).

Male nurses and nursing students also experienced being perceived by others as a potential problem to female patients, and young children, adding to patents’ fear of exploitation (Anthony 2004). Male nurses, for example, reported reluctance about using touch as an expression of caring (Fisher 2009), partly because of their own fears of being seen as sexually inappropriate with female patients (Harding and Perkins 2008), as well as misinterpretations of touch that may occur with male patients (Huppatz 2012). Research indicated more complaints are filed against male than female nurses regarding inappropriate touching behavior or relational indiscretions (Chiarella and Adrian 2014),

¹⁰ While efforts have been made to address this as a discriminatory practice, the Supreme Court has been lenient in allowing hospitals to segregate certain jobs based on consumer preference (Kacezynski 2003).
even though studies suggest all nurses needed to be more discriminate about assuming it was acceptable to touch patients as a reassuring, supportive gesture or as a way of developing rapport (O'Lynn and Krautscheid 2011).

On the other hand, female nurses were more commonly sexualized by male patients, and this was suggested to perhaps be related to the sexualized images of female nurses in pornography, and general media (Ferns and Chojnacka 2005; Kalisch and Kalisch 1987; Pomfret 2000). In addition, female nurses were often expected to be deferential, rather than assertive, especially in relating to physicians, although this varied based on the gender of the physician. Female nurses were often assumed to be looking for a husband, incapable of finding a husband, or just doing a job expected of females (Zelek and Phillips 2003).

Economic Advantages and Disadvantages by Gender

There was also an assumption that the higher salaries of male nurses were due to masculine competitiveness, and that male nurses were treated better by administration, and physicians (Budig 2002; Williams 1992). While there was some evidence of differential entry of males into administrative positions, and evidence of higher salaries, this was not as magnified in the United States as it was in countries where there were more males in nursing (Wilson 2005). Studies showed male nurses were particularly drawn to the long term job stability, and adequate salary offered by a nursing career. Females were often drawn to the flexibility of the jobs, the opportunity to help others, and the ability to work part-time, as family situations changed (Whittock, Edwards, and Robinson 2002). Females, more than males, took advantage of family-friendly work
policies to engage in caregiving, a pattern found to disadvantage females economically (England, Budig, and Folbre 2002).

A common assumption was that female part-time employees were less committed to their work, and more engaged in family relationships (Lane 2000); however, other research indicated this was unfounded (Whittock, Edwards, and Robinson 2002), and that regardless of full or part-time work status, females were more likely to be juggling domestic responsibilities at home, including caregiving. The gender pay difference in nursing was found to possibly be related to a female mindset of being uncomfortable with advancement and recognition, and with females being less comfortable being competitive (Lane and Piercy 2003). There was also evidence of stronger consequences, such as backlash, for females violating gender role stereotypes (Rudman and Phelaan 2008), something which further contributed to difficulties with advancing oneself economically (Davies, Spencer, Quinn, and Gerhardstein 2002; Tracey and Nicholl 2007).

Female nurses often did not receive credit for the emotion work they performed, which was often done without calling attention to it, as being legitimate work (Guy and Newman 2004). Studies finding males were generally drawn to masculine-congruent nursing work such as surgery, intensive care or emergency rooms (Penprase, Oakley, Ternes, and Driscoll 2014; Simpson 2011; Williams 1992) were similar to findings that males tended to be more focused on technical skills and tasks (Ekstrom 2001; Husso and Hirvonen 2012); this suggested a differential orientation to caring behaviors, as is discussed next.
Manifesting Gendered Caring.

Male and female nurses differed in how they viewed caring behaviors. Male nurses usually viewed caring as promptness, and skill in completing care duties (Benbasset and Baumal 2004; Gazzanigga Halpern; Ekstrom 2001; Husso and Hirvonen 2012). This coincided with what patients said they preferred as characteristic of the caring nurse (Mayer 1987; Papastavrou et al. 2012). Female nurses usually saw caring as an emotional show of concern (Benbasset and Baumal 2004; Ekstrom 2001; Husso and Hirvonen 2012), and as noted above, patients preferred nurses who demonstrated knowledge, and skill in caring for them (Mayer 1987; Papastavrou, et al. 2012). On the other hand, other studies indicated an uncaring nurse diminished the value of their skills to the patient (Sharman et al. 2008; Wysong and Driver 2009).

Female and male nurses both reported engaging in interpersonal demonstrations of caring, although female nurses attributed greater importance to expressive caring than male nurses (Bradley and Falk-Rafael 2011; Batson 1998; Rajacich et al. 2013; Sprecher, Fehr, and Zimmerman 2007). Some studies suggested these differences corresponded to gender role norms (Biletchki 2013). In the next section, the differences in patient perceptions of caring based on gender will be discussed.

Manifestations of Caring Based on Gender of the Patient

Patients ranked the technical and emotional aspects of care differently based on their gender, and the gender of the nurse (Foss 2002). Studies suggested female patients preferred expressive demonstrations of caring from nurses, while male patients were more concerned with timeliness, consistency, and competence of nurses. In general,
studies revealed most patients preferred female nurses, but younger females, in particular, had a stronger preference for female nurses (Chur-Hansen 2002; Ekstrom 1999). When a patient wanted to discuss something emotionally sensitive (Chur-Hansen 2002; Hoekstra et al. 2012), patients preferred a nurse of their same gender. There was a tendency to call on males for activities associated with masculinity (Evans 2004) such as heavy lifting. Next, the gendered division of labor will be discussed further.

A Gendered Division of Labor

The kind of gendered division of labor that occurred among men and women in nursing resulted in unequal distribution of work (Evans 2004b). Masculinity in nursing was as a double-edged sword in that male nurses were expected to do more of the heavy lifting, and deal with aggression from patients and visitors; yet, males were also aware of the male nurse stereotype of being too male to be caring and gentle (Evans 2004b), and of the stereotypes that a male nurse might be sexually exploitative or gay (Huppatz 2012). Female nurses, on the other hand, tended to get called on for tasks related to bodily exposure (Lawler 1991), and other studies supported this tendency for patients to be more tolerant of females than males, for performing intimate work on their body (Fisher 2009). Females were also more often called on to discuss personal issues with patients and had to deal with stereotypes of female nurses as handmaidens, a stimulus for sexual fantasies, or being smart or compassionate (Hertenstein and Keltner 2011; Husso and Hirvonen 2012), but rarely both (Jinks and Bradley 2004).

Caring done by female nurses in hospital settings was often taken for granted and devalued as non-work (Gray 2009; 2012; Kosny and MacEachen 2010; Lynch, Baker,
Nurses were observed in the previously mentioned study about hospice nurses, telling patients they needed to get back to work, after providing emotional comfort to patients, thereby discounting emotional support as a non-work or extra activity (James 1989). Minimization of nurses work was also suggested by nursing care being subsumed under room and board on hospital bills to patients, while procedures, and consultations done by physicians and other occupations, were itemized as legitimately billable services (Welton and Harris 2007).

Longitudinal employment data found the pay of both males and females carework jobs was less than for comparable occupations (England, Budig, and Folbre 2002) in, even after controlling for variables typically yielding higher wages such as education, and experience (Acker 1990; O’Shaughnessy 2014). Researchers have suggested carework gets devalued because it involves dealing with the undesirability of bodily functions (McMurray 2012; Simpson, Slutskaya, Lewis, and Höpfl 2012; Simpson, Slutskaya, and Hughes 2012; Twigg et al. 2011), and unwelcomed dependency on others in a culture of individualism (Lynch, Baker, and Lyons 2009).

Policy changes about compensating paid and unpaid carework were suggested based on findings that negotiating carework in families, and on jobs, generates disadvantages for the careworker (Cohen and Huffman 2003; England 2005; Folbre 2002; Glass 1990; McMurray et al. 2000; Ridgeway 2011). There is some indication from research that gender segregation in occupations may be related to underlying values about altruism, and female roles in the family (Konrad et al. 2000). The predominance of females in nurses suggested females may be more inclined to select more traditionally
female jobs conducive to maintaining their family responsibilities (Weisgram, Dinella, and Fulcher 2011).

Supposedly, traditionally female sex roles, and the gendered division of labor has shifted in nursing, such that nursing attracts a more nontraditional student (Keepnews, Brewer, Kovner, and Shin 2010; Simpson 2011); however, an equal number of studies revealed the female stereotypical associations and gendered labor division still occur (Dyck, Oliffe, Phinney, and Garrett 2009; Evans 2002). Females also have gender related expectations influencing their entry into nursing as is discussed next.

Female Gender Stereotype Pressures and Sanctions for Entering Nursing

The gender subordinate status of females (Kanter 1977) added pressure for females to conform to the female stereotype generating fears of backlash from male and female colleagues, if they were not sufficiently nice, and warm (Glick and Fiske 1999). Job evaluations, and job advertisements, were also constructed in stereotypical ways using gendered language such as flexible work schedule, and supportive and caring person (Born and Taris 2010). Other research showed that nursing is so strongly female-gendered; any effect of job advertisement wording on males or females perceiving the advertisement as seeking a male or female applicant was overridden (Gaucher, Friesen, and Kay 2011). While networking is assumed to expand job opportunities, this was not seen in a study which showed females using informal networks for job searches were more likely to find traditionally female jobs (Drentea 1998; Fernandez and Sosa 2005). This contributed to occupational segregation, although there has been some concern
about data looking at pre-hiring decisions from post-hiring data (Fernandez and Sosa 2005).

A number of studies found female nurses strongly identified with the female gender roles (Huppatz 2012; Kada 2010; Ruchti 2012). Studies indicated that female nurses who violated traditional female gender stereotypes tended to receive strong sanctions from others, and risked losing social support (Kada 2012). Female nurses endorsing feminine qualities less strongly were often the same ones reporting they were coaxed into nursing by someone else. Females in general, have been found to emphasize their relational qualities over task-related competence, especially when around people with sexist attitudes (Barreto, Ellemers, Piebinga, and Moya 2010; Glick and Fiske 1996; Rudman and Glick 2001). While not entirely without sexism, nursing has been found to be more gender neutral in other countries, but in the United States, many females are still attracted to nursing, based on traditional roles for females (Hollup 2014).

Nursing as Doing Femininity

Studies examining reasons for entering nursing (Boughn 2003; Hemsley-Brown and Foskett 1999; Miers, Rickaby, and Pollard 2007) revealed that some nurses acknowledged coming into nursing by chance, because they were unsure of what they wanted to do, and did not really see a lot of occupational choices available for women. This was especially true if they wanted a family (England 2010). Females entering nursing for reasons other than to help others emphasized caring qualities to others, indicating they knew this was what was expected (Ruchti 2012); they avoided making responses related to coming into nursing for financial stability or because they were
unsure what they wanted to do; several nurses in the study indicated they definitely would have pursued other career interests, if their family finances had been better.

Some of these female nurses indicated that they came from a family with several nurses or families who had strong views about gender roles; they reported being strongly encouraged to consider nursing (Mooney, Glacken, and O’Brien 2008; Ruchti 2012). Many females in nursing were married to or partnered with males in highly gendered occupations such as law enforcement, mechanics, and engineering, further supporting the gendered nature of nursing (Huppatz 2012). However, a recent study (Hayman and Rasmussen 2013) of males and females in various careers did not suggest this gender difference regarding their values about work and family-life balance. Males were equally interested in more flexible family friendly work lives.

Research showed females have historically been drawn to nursing (Budrys 2011) as one of few acceptable occupations for women, and in the past century, it has remained true that females were drawn more to female occupations, especially those in which they had an opportunity to help others (Neilson and Jones 2012; Price 2009; Price, McGillis Hall, and Peter. 2013). Even as nursing educators socialized students toward professionalism, emphasizing the scientific and technical basis of nursing, the female association with nursing remained strong (Apesoa-Varano 2007), as is discussed next.

*Primed for femininity.* Social psychological studies demonstrated that activating gender stereotypes resulted in gender disadvantages (Davies, Spencer, Quinn, and Gerhardstein 2002; Steele and Aronson 1995; Steele, Spencer, and Aronson 2002; White and White 2006). For example, it continues to be rare for females to choose a major in
the science, technology, engineering, and mathematics majors. When females pursued this career path, they often dropped out before completing the program, and spoke of an enormous sense of derailment in their academic, and career trajectories (Sadler, Sonnert, Hazari and Tai 2012; Yost 2012). Females, and males as employees, know that expectations for them vary by their gender.

*Different expectations for caring based on your gender.* Studies showed supervisors also had different expectations for how males and females, showed caring behaviors in their work (Gray 2009; Husso and Hirvonen 2012). Male and female nurses were both expected to be technically competent in their work. Female nurses were held to a greater expectation for performing emotion work while this was trivialized for male nurses (Husso and Hirvonen 2012). A long history of associating females with emotionality in western culture (Jackson and Sturkenboom 2000) has continued to be present in several scholarly works (Harrington-Meyer 2000; MacDonald and Merrill 2002) about careworker’s experiences of constantly walking a line, between performing a service for money, and just doing what comes natural for women (Graham 1983: 16). As previously noted, male nursing students who demonstrated sensitivity risked being called gay, and being misinterpreted when their work required touch (Allison and Beggan 2004; Harding 2007). Female patients showed a preference for relational demonstrations of caring, while male patients paid closer attention to the timeliness, and consistency with which tasks were performed, suggesting attention to the gendered expectations of the nurse (Foss 2002).
Are gender differences in caring behavior learned or ingrained? According to some researchers, females’ propensity for nurturing, empathy, and caring, are a function of evolutionary adaptation related to the hormone oxytocin, which is released during labor and breastfeeding (Davenport and Hall 2011; Taylor et al. 2000). High levels of oxytocin have been associated with eliciting social engagement as measured and observed through imaging studies of brain activity (Weisman, Zagoory-Sharon, and Feldman 2012). Other research documented male and female neurohormonal differences, particularly evident in their stress responses (McEwen and Lasley 2004). Thus, biological sex differences in brain neurochemistry are clearly present, and provide some support to the idea that male and female differences may be related to evolutionary survival adaptations (Baron-Cohen 2004; Feingold 1994; Simpson 2009; Bourke, Harrell, and Neigh 2012; Tomova, von Dawans, Heinrichs, Silani, and Lamm 2014). There was also support for the social constructivist position that observed differences in caring, and emotional behaviors among males, and females is related to gender socialization, and gendered role performance (Acker 1990; 2000; 2006; Butler 1990; 1993; Chaplin, Cole, and Zahn-Waxler 2005; Zahn-Waxler 2000; Kessler and McKenna 1978). The relationship between gendered nature of emotional work of caring is discussed next.

11 For a discussion of the tend and befriend hypothesis, see Taylor et al., 2000
12 The nature vs. nurture debate is particularly interesting from the perspective of trauma research, which shows biological changes to occur in response to trauma and stress. For a discussion of these perspectives, see van der Kolk 1987
EMOTIONAL LABOR OF CARING

Emotion Hierarchies

Hochschild’s (1983) initial study and subsequent scholarly work about emotional labor suggested emotional labor expectations were greatest for lower status employees and females (Hochschild 1997; 2003; 2012; Hochschild and Ehrenreich 2002). Several researchers had similar findings about emotional labor job demands differing based on gender and status distinctions (Findlay, Findlay, and Stewart 2009; Khokher, Bourgeault, and Sainsaulieu 2009). Studies also suggested a narrow range of acceptable emotion expression in the workplace, based on gender and status distinctions (Sloan 2004; Soares 2003). These gender and status differences for emotional labor are discussed next.

The occupational status hierarchy of emotional labor. Researchers found patients and staff expected nurses to be caring when interacting with patients (James 1989; Khokher, Bourgeault, and Sainsaulieu 2009; Wharton 2009); this was seldom enforced for other employees (Martínez-Íñigo et al. 2007). Patients and staff exhibited tolerance for emotionally detached physicians, especially male physicians’, but were intolerant of uncaring nurses (Lovell, Lee, and Brotheridge 2009).

When nurses migrated to other countries to meet caregiving shortages, researchers found many migrant nurses being exploited, most often by minimizing the nurses’ educational preparation and insisting on placing them in lower status jobs which had high emotional labor demands (Salami and Nelson 2014). Migrant nurses agreed to perform these jobs for a finite time period, as part of an international careworker program; however, the time was often extended due to bureaucratic obstacles to the nurse securing
other employment. Migrant nurses in similar programs also were affected by lengthy periods of unpracticed professional skills, making these nurses less attractive candidates in future career endeavors, and decreasing their income earning potential (Batnitzky and McDowell 2011).

Global deskilling by using of migrant care workers to meet care work, and other needs, of more affluent persons in other countries was found to obscure the far-reaching impact of women’s desperation to get out of poverty (Ehrenrich and Hochschild 2002). As migrant domestic workers went to destination countries for employment, their own domestic and care needs were left behind to be managed in the most affordable manner, creating a cycle of poverty that has begun to reach directly across countries in its effects on families and children. Also contributing to the invisibility of these practices was that workers mostly worked in private homes. Such occurrences barely captured media, political, or activist attention, according to the researchers (Hochschild and Ehrenrich 2002).

Studies of deskilling of nurses have been suggested as reflecting a trend toward reiterating the naturalness of gender based skills (O’Brien 2007). Examples of deskilling were heard in reports from nurses that they felt like a waitress without the tips, and with extra duties that were quite distasteful (Herdman 1992). Other studies show nurses’ work is constantly interrupted (Rogers’s et al. 2004), and involves a level of multitasking that is inconsistent with how human attention, concentration, and memory are designed to work (Richard and Gross 2000). One study documented eight-six (86) different work activities during an eight hour shift for nurses (Tucker and Spear 2004. Frequent interruptions also impacted the nurses’ capacity to engage in successful emotional labor.
Interruptions in workflow due to work system failures also occurred 8.6 times per hour over the course of an hour shift (Bégat and Severinson 2001; Fletcher 2006). Greater emotional demands on nurses reduced the time nurses spent with minority patients (Debesay, Harsløf, Rechel, and Vike 2014; Spitzer 2004). Researchers found nurses prioritized their time limitations by focusing on patients with the most readily apparent needs, as opposed to patients whose needs took more time to identify. Information processing heuristics served as mental shortcuts to reduce effort and demand during times of work overload (Shah and Oppenheimer 2008). Heuristics have been found to be automatically invoked under constraints of time or similar pressures (Chaiken 1980; Giner-Sorolla and Chaiken 1997). Emotional labor responsibilities also vary by a hierarchy of gendered tasks, as discussed next.

*The gendered hierarchy of emotional labor.* Females dominate lower status jobs with high emotional labor demands (Hochschild 1983; Leidner 1991; Lively 2008). Job strain studies suggested lower status jobs were made more demanding by employers’ dictating how job demands were to be met (Karasek and Theorell 1990; Siegrest 1996). These jobs were associated with greater risks to mental and physical health (Rosenström, Hintsanen, and Kivimäki 2011; Schnall, Landsbergis, and Baker 1994), which progressively worsened each incremental step lower in the job status hierarchy (Marmot et al. 1991; Bobak et al. 2000).

Females were more likely to be segregated in jobs capitalizing on emotional labor skills, especially jobs mimicking gendered expectations for females to be caring and deferential (Azmat and Petrongolo 2014; Reskin, McBrier, and Kmec 1999). Jobs
occupied by females, more often required emotional labor than jobs occupied by males (Guy and Newman 2004; Wharton 2009). For example, researchers found supervisors had higher expectations for female nurses, than for male nurses, to perform emotional labor (Cottingham, Erickson, and Diefendorff 2014; Findlay, Findlay, and Stewart 2009; Gray 2009; Husso and Hirvonen 2012; Khokher, Bourgeault, and Sainsaulieu 2009). In one study, males were more often called on to do heavy lifting, respond to angry, potentially aggressive patient situations, and troubleshoot equipment functions (Evans 2004); Female nurses were more often called on to offer comfort, emotional support, or help diffuse anxiety in patients or family members. Studies also suggested female nurses who violated feminine or caring stereotypes, were more likely to experience some form of backlash in the workplace by coworkers, patients, or supervisors (Kada 2012; Rudman and Glick 2001). Female paralegals, moreso than their male counterparts were expected to display a caring orientation towards clients and attorneys and were usually seen as incompetent when they failed to comply with this expectation (Pierce 1995). This differential expectation for emotional labor as a female trait has also been observed in higher status jobs (Ecklund, Howard, Lincoln, and Tansey 2012). Other researchers have had similar findings about emotional labor expectations varying based on the gender of the employee, but generally it was females having the highest expectations for emotional labor work (Sutton and Rafaeli 1988). While females in jobs such as nursing, waitressing, or flight attendants are expected to be caring, nurturing, and cheerful in their work, males in jobs such as police work (Martin 1999) or bill collectors (Sutton 1991) are expected to display more aggression and firmness in their work.
Studies showed that females were expected to be positive in their emotional presentation, and to suppress negative feelings, especially anger (Soares 2003; Sloan 2004; 2012), and especially if they were female nurses (Kada 2012). Suppressing negative feelings has been shown consistently to have negative effects on physical health indicators, particularly increased stress responses, as measured by blood pressure, and heart rate (Richards and Gross 2000; 2006; Gross and Levenson 1997; Gross 2006). Suppressing negative emotion also affected perceptions of receptivity to social contact, quality of relatedness between people (Gross and John 2003), and impaired memory, concentration, and attention (Richards and Gross 2000).

Females were more often the recipient of negative emotions, particularly anger from males higher in the workplace hierarchy (Korczynski 2003; Leidner 1993; 1999; Soares 2003). Insomuch as emotional labor has been associated with female-role functions (Hochschild 1983; Wharton 2009), it has been often assumed (Brody and Hall 2008) that females, who were assumed to be more emotional (Kret and deGelder 2012), would be better at performing emotional labor (Scott and Barnes 2011). Studies (Scott and Barnes 2011) found females had an easier time putting on a fake smile, and were often seen as more approachable. Research does not support that females experience more emotion; only that they are more expressive and aware of their emotion (Barrett, Robin, Pietromonaco, and Eyssell 1998; Brody and Hall 2008; Chaplin, Cole, and Zahn-Waxler 2005; Zahn-Waxler 2000; Eagly 2013; Leidner 1993; Morris and Feldman 1997; Scott and Barnes 2011).

Studies showed females often had emotional labor demands at home, which added to work-home conflict (Leineweber, Baltzer, Hanson, and Westerlund 2013). Nurses who
were caregivers of family members or friends during their off time from work had a particularly difficult time with emotional labor demands and were at risk for a variety of physical and psychological problems. Most of these cases of double duty caregiving were females (Cannuscio et al. 2002); however, males have been found to take on caregiving roles within their families, more often than in the past (Wolff and Kasper 2006).

Females tended to do poorly when they were asked to mask feelings, as occurs in surface acting where the employee fakes the required emotion while their actual feelings remain unchanged (Diefendorf and Richard 2003; Grandey 2003; Johnson and Spector 2007). Females were more often asked to manage situations requiring surface acting based on an assumption they were more skilled at pacifying people’s feelings. A female employee who was considered to be open and flexible, received a disproportionate amount of emotional labor management tasks, compared to males with these same traits (Williams, Blair-Loy, and Berdahl 2013). Males were more likely to suppress their feelings (Simon and Nath 2004) and were more often called on to manage situations involving anger or aggression as intensifying anger (Scott and Barnes 2011; Moran, Diefendorff, and Greguras 2013).

Females doing emotion work were more affected by the associated distress of emotional labor (Sloan 2012), and this was modified by having opportunities for social support from their coworkers or supportive managers for dealing with work related distress (Schneider and Bowen 1995). When nurses’ work is constantly interrupted (Rogers et al. 2004), and involves a level of multitasking that is inconsistent with how human attention, concentration, and memory are designed to work (Richard and Gross 2000).
Adding to the distress of emotional labor for females were the greater demands on their time, including greater demands to take care of the emotions of others (Gove 1972; Gove and Tudor 1973; Montgomery, Panagopolou, de Wildt, and Meenks 2006), more family caregiving duties (Harrington-Meyer 2000), the second shift (Fuwa 2004; Hochschild and Machung 1990) they faced at the end of their work-day, and work-family conflict (Offer and Schneider 2011). These cumulative stresses have also been suggested to account for females’ greater experience of negative emotions (Simon 2002; Williams and Umberson 2004). There were also indications in other studies that personality characteristics present in nurses, as discussed below, may increase their subordinate status in hierarchies, and risk being given added work assignments (Farnsworth and Thomas 1992; Reyome and Ward 2007).

Emotional labor generated by personal feelings, experiences or characteristics of nurses. There is some evidence that individuals drawn to careers in nursing may posses traits or acquire certain characteristics through years of practicing as a nurse (Davenport and Hall 2011; Farnsworth and Thomas 1992; Yousef and El-Houfey 2014), which might increase their vulnerability to exploitation (Hare 1998; Hutchinson et al. 2006; Koonin and Green 2007; Reyome and Ward 2007). For example, researchers found nurses have come to view vulnerability as an attribute that enhances their caring ability (Davenport and Hall 2011; Eley, Eley, Bertello, and Rogers-Clark 2012; Jain and Lall 1996). This same attribute—vulnerability, increases the risk of being exploited (Hare 1998). Some nursing education programs and nursing groups worked with nursing students through a program of exercises intended to facilitate their ability to identify appropriate and
inappropriate helpfulness, focusing on identification of personal and professional boundary development as part of this experiential learning. A distinction made in these efforts to differentiate a kind of caring that comes from within an individual, and which helps each party grow personally, as opposed to one which cares under directives or false motives individuals focus too much on the needs of others, such that they place themselves or others at risk (De Waal 2008). In a study of nurses working in prisons, it was vulnerability that enabled nurses to see past criminal actions, and to be caring and sensitive when providing care to prisoners (Walsh 2009). On the other hand, being vulnerable was a possible way to manipulate nurses, a potentially dangerous problem in prison settings.

*Emotional labor generated by relieving the burden of other healthcare workers.*

The hierarchy of emotional labor in the hospital work culture was found to place nurses at a disadvantage in their interactions with patients (Khokher et al. 2009). In one study, for example, nurses more often reported (Khoker et al. 2009) unpleasant interactions with patients about events that occurred between patients and other healthcare professionals. It was usually the nurses who heard patient’s complaints, anger, lingering anxieties, and negative emotions about their care; when other worker’s left the unit, nurses were always present. Physicians in this study reported the most favorable interactions with patients. This heightened burden of emotional labor for the nursing staff was found in other studies as well (Sloan 2004; Soares 2003), thereby highlighting the downward position in the hierarchy for those who work closest with the patient and most directly with the patient’s body (Gimlin 2007; Twigg et al. 2011).
Nurses have reported a common occurrence of physicians, as well as other healthcare occupational groups, asking nurses to justify their intentions and actions, which felt like an assumed privilege over the position of nurses (McGibbon, Parrot, and Gallop 2010; Ruchti 2012). A privileged freedom of expression for physicians, and to some extent for other healthcare workers has been found in other studies as well (Khoker et al. 2009; Martinez-Ingio et al. 2007). Nurses reported that they took for granted that they needed to acquiesce to the busy schedule of physicians (Khoker et al. 2009; McGibbon, Parrot, and Gallop 2010), and they also anticipated they would be interrupted when they were in the middle of important procedures and conversations (Bégat and Severinson 2001; Fletcher 2006; Tucker and Spear 2004). While interruptions were sometimes necessary, they delayed nurses’ completion of tasks (Monk, Trafton, and Boehm-Davis 2008), increased their vulnerability to making errors (Westbrook et al. 2010), and generated feelings of frustration and helplessness in managing their work (Redding and Robinson 2009), for which they were often reprimanded (Bailey and Konstan 2006; Semmer et al. 2010). Many of these work problems were related to the way in which nurses’ jobs were designed, some examples of which follow next.

_Emotionally labor generated by organizational priorities on rules, routines, and checklists_. This hierarchal and bureaucratic impeding of patient care by nurses was illustrated in a study of the emotional labor of hospice nurses by Niki James’ (1989; 1992), a faculty and researcher of emotional labor. Hospice nurses seeing patients in the community followed their patients’ into the hospital in order to provide continuity and assist with advocating for the patient’s end of life wishes. James found that the hospice
nurses were unable to maintain the hospice care philosophy once the patient was admitted to the hospital. Hospice care, which prioritized the changing and emerging emotional and comfort needs of patients and their family was found by James to be contrary to the hospital’s priority for efficiency through routines and inflexible checklists. This placed hospice nurses in the position of expending their emotional labor on factors interfering with the emotional labor of caring, rather than being able to accommodate the less predictable needs arising as the patient and their family face end of life moments. This threat to the hospice philosophy of care has been observed in other studies also (Ward and Gordon 2006-2007).

James (1989) reported that the emotional labor of caring was devalued in the hospital setting and overridden by physical tasks and routines, even when the checklists were irrelevant to the patient’s care needs. James also reported having overheard hospital staff nurses offering brief emotional support to patients or family members, and then apologetically telling their patients they had to get back to work, thereby implying they viewed emotional support apart from their work in providing physical care and status-monitoring of the patient. James concluded that nursing work was organized in such a way as to disadvantage their capacity to enact the emotional labor of caring. The orientation to tasks was similar to the Menzies (1960) study previously mentioned, which found checklists and routines to be primary in nurses work.

*Other organizational constraints on nurses’ performing emotional labor of caring.* An emotional labor researcher studied problems arising from impossible to meet expectations for emotional labor in a social service agency (Coop 1998). In the study,
social-service employees were charged with assisting developmentally disabled clients to become employable. When the clients were deemed by workers to be ready for job placement, the only available jobs were too monotonous and boring for the client’s developmental levels. Despite this mismatch, staff were expected to promote these jobs to clients with a positive attitude. Borrowing from the term emotional deviance, (Thoits 1989) used by emotion sociologists (Thoits 2011), the researcher adopted the term occupational emotional deviance (Coop 1998) to describe an employee’s failure to meet expectations for emotional labor in situations where failure was a result of incongruence between expected performance and job design. The work expectation for maintaining a positive atmosphere of compassionate caring, despite a negative work environment unconducive to caring, has also observed in other studies (Rafaeli and Sutton 1987).

Studies have shown that even as nursing workload intensity increased, staffing patterns were changed such that registered nurses time shifted to administrative and supervisory tasks, removing them from physical care at the bedside to overseeing care by unlicensed personnel (Aiken, et, al 2002; Morrow 2009; Pellico, Brewer, and Kovner 2009). These patterns in which the number of registered nurses was reduced have been associated with a rising pattern of dissatisfaction in nursing, and a less safe environment for patients (Aiken et al. 2002).

Under work intensification efforts, nurses reported that they were unable to convey a caring manner (Manojlovich and DeCicco 2007; Valentine, Greller, and Richtermeyer 2006), and perhaps, more importantly, nurses said they were sometimes unable to complete required care tasks, and carry out physicians’ orders (Bolton 2001; Bone 2002; Weir and Waddington 2008). Another pattern aimed at efficiency, the
electronic medical record, was found to focus nurses’ charting on medically oriented procedures, while minimizing or excluding psychosocial care (Törnvall, Wilhelmsson, and Wahren 2004; von Krogh and Naden 2011).

A similarly constraining feature on nurse caring was found in a study of nursing homes where administrators generated rules, regulations, and routines regulating every moment of care (Ulsperger and Knottnerus 2008). Administrators attested to its value in achieving efficiency from employees. Good nursing care in the organization was defined by nurses’ complying with rules, routines and efficiency. When they did so, nurses saw themselves as good caregivers, even though they stated some of the rules interfered with conveying caring. Dominated by rules and routines, the researchers found the nurses in a position of overseeing care efficiency by unlicensed care assistants. Lacking sufficient time for full oversight, the nurses relied on the unlicensed care assistants to achieve the end results in any manner they selected; it was the end results that mattered in producing evidence of having complied with prescribed rules and routines, and which was the basis for employee evaluations.

These kinds of views of emotional labor in nursing are different from those with an exclusive focus on service industry jobs (Andrews, Karcz, and Rosenberg 2006; Brotheridge and Lee 2003; Cote 2005; Diefendorff and Gosserand 2003; Diestel and Schmidt 2011; Grandey, Fisk, and Steiner 2005; Gross 1998; 2002; Judge, Woolf, and Hurst 2009; Lewig and Dollard 2003; Liu, Prati, Perrew, and Ferris 2008; Morris and Feldman 1996; Totterdell and Holman 2003; Zapf and Holz 2006). In many service jobs, employees consider emotional labor to be a strain but they may actually enjoy the performance they are asked to enact in the name of providing a good customer
experience. Studies show that nurses actually enjoy the emotional labor of caring and expect to perform this kind of emotion work in nursing, albeit to differing degrees depending on the particular type of unit selected for employment (Brotheridge and Grandey 2002; Hawthorn and Yurkovitch 1994). As care actions and care goals become incongruent, nurses begin to experience increasing amounts of dissonance in their work.

Incongruence and Dissonance in Nursing Work

When nurses lacked the necessary resources to deal with job demands, they reported difficulty suppressing emotions related to their lack of success (Martínez-Íñigo et al. 2007). It was more difficult for nurses to demonstrate a caring manner when staffing was insufficient; however, expectations for caring remained regardless of staffing problems (Mentis, Reddy, and Rosson 2010; Hamilton 2011).

Most studies of emotional labor showed that employees experienced less distress when they were able to agree with the emotional labor they were expected to display. When unable, as noted by Hochschild (1983), employees often engaged in surface acting, which tended to be associated with more dissonance since the incongruent emotion remained despite the display of an expected emotion that was different from ones internal feeling. Deep acting, on the other hand, generated less dissonance (Ashforth and Humphrey 1993); when successful, deep aching meant the employee had found a way to align themselves with the expected emotions. When the employee and the job expectations for emotional labor matched, there was less effort required.

On the other hand, when the emotional display expectations were different, the level of dissonance generated by surface acting was such that the employee found it
intolerable, and therefore motivated to engage in an emotion management strategy to produce the required display (Gross 1989). This may involve leaving the job, avoiding aspects of the job, or redefining one’s job or one’s self in relation to the job, but the change necessitated effort, after which dissonance was reduced. One exception was that deep acting was not successful when role conflict was severe enough to attack the individual’s core values (Abraham 1999: 451).

A leading healthcare systems researcher urged remedial action be taken, after identifying in a multinational study, that systemic problems impaired nurses’ ability to practice in an ethical manner (Aiken et al. 2012). The researchers indicated that in their study, when patient satisfaction scores were low and complaints were high, the problems were, in most cases, related to poor work design, somewhere within the organization. Despite these and similar findings (Aiken et al. 2012; Armstrong and Laschinger 2006), the dominant advertising rhetoric in many hospitals was one of caring and compassionate staff (Findlay, Findlay, and Stewart 2009). Marketing and patient satisfaction issues are discussed next.

Marketing Caring and Selling Emotional Labor for Score Cards

Since patient satisfaction scores are a necessity for hospital reimbursement, conditions constraining good nursing care have made it increasingly difficult to affect patients perceptions of good nursing care (Aiken et al. 2001; 2002; Brooks, Lasater, Sloane, and Kutney-Lee 2014; Lundgren and Segesten 2001; Hall, Pedersen, and Fairley 2010; Rogers et al. 2004). Therefore, some hospitals have implemented nursing models of caring such as the Watson caring model and the caritas processes previously discussed

Alternatively, some hospitals invested in training to teach employees, including nurses and physicians, techniques guaranteed to improve patient satisfaction scores (Schneider and Bowen 1995; Hsu et al. 2011; Rafaeli and Sutton 1987; 1989; Snow and Yanovitch 2009). The nature of these programs is such that staff are required to follow pre-written scripts, use key phrases, and buzz words that are carefully selected by management consultants to emulate a caring manner. This training does appear to improve patient satisfaction scores, and perceptions of good care, but nurses often report feeling insincere, and like they have been used to help get a good scorecard for the hospital (Amendolair 2007; Begat, Ellefsen, and Severinsson 2005; Corley 2002; Dunn 2012; Geiger 2012; Kalvemark et al. 2004; National Nurses United 2010; Pearcey 2010; Tufte 2013; Ulrich et al. 2007). Scholars warn that the fast-paced, outcome-driven focus on economic efficiency is inconsistent with the pause, reflection, and evaluation of ones actions that is necessary for adhering to ethical care (Ulrich et al. 2007; Cameron and Payne 2012).

Market schemes have been shown to use distracting and perceptual cues to achieve desired marketing influences (Leys 2011). Marketing influence has been identified as most effective when able to stimulate changes at the level of emotion. The subtle manipulation of perception without calling attention to the influence has been shown to be an effective way to prime people into possibly favoring a particular choice (Nolan, Schultz, Cialdini, Goldstein, and Griskevicius 2008). One of the main ways to
avoid influence in groups, and through advertising, is having time to think, reflect, and process events and emotions, as is discussed next.

**Imposing a New Layer of Emotion Labor: Simulated Caring to Lessen Perceptions of a Lack of Caring**

Studies of hospital marketing initiatives, whereby staff were expected to engage in emotional labor by projecting a prescribed image of the hospital to patients and the public, found nurses’ were more committed when they felt these initiatives improved patient care (Schneider and Bowen 1995; Iliopoulos and Constantinos-Vasilios 2011; Rafaeli and Sutton 1987; 1989). Researchers studying emotional labor in nonhospital job settings found employees were strongly pressured to prioritize the parts of their work role that promoted the organization’s image, above any other part of their job (Ashforth and Tomiuk 2000). Bassett (2002) revealed clear differences in the constraints based on areas of specialty of a nurses work unit, the kind of work environment, and the degree to which emotional labor was required.

Both Bolton (2000; 2001) and Theodosius distinguish between a kind of emotional labor that is palatable to nurses in which the aim is making the patient feel better, rather than generating revenues (Bone 2002) or improving customer service scores. The requirement for emotional labor became problematic for nurses, when the required display of a hospital image conflicted with their experience of the hospital or with their moral sense of what constituted good care (Weir and Waddington 2008). For example, nurses fielding healthcare questions at a call center job had difficulty with their
supervisory directives to be cordial, but to avoid being emotionally supportive in order to become more efficient at handling a larger volume of calls (Weir and Waddington 2008).

In similar studies, researchers concluded that efforts to rationalize the process-oriented nature of nursing work were inherently dehumanizing (Cohen 2011). Prior studies have also shown it to be difficult to standardize the process-oriented nature of nursing work into imposed sequential, orderly and predictable routines (Benner, Hooper-Kyriakidis, and Stannard 2011), even though nurses themselves have acknowledged their (Menzies 1960; Ulsperger and Knottnerus 2008). When nurses’ experience marketing schemes appeared as merely raise their workload for higher scorecards for the hospital, they become resistant to these pressures (Bone 2002). As nurses complained about the focus on scores over care, some hospitals required staff to attend customer relations classes, or adopted hospital-wide management training programs through consulting firms that specialized in improving hospital satisfaction scores (Scheid 2003).

Learning how to appear caring, when time to devote to caring relationships was lacking, was generally offensive to nurses, although some nurses became willing adherents to this method of seeking organizational loyalty, as was shown in prior studies in which the institutionally defined definitions of good care were eventually adopted by the nurses (Ulsperger and Knottnerus 2008). Generally, nurses’ perceived being forced to fake caring, as a breach in their contract with the organization to provide good care (McCabe and Sambrook 2013). Studies show hospitals hold nurses accountable for targeted outcomes as named on various scorecards for hospital care quality reports, while nurses’ object to the defocusing of patient health outcomes on scorecards (Ballou and Landreneau 2010; Cropley 2012; Stanowski 2009). Staff nurses sometimes became less
trusting of management who were incentivized by securing their nurses’ compliance with these quality initiatives prioritizing cost control and quality scores above care (Doolin 2003).

Scholars have pointed out the ludicrous nature of these satisfaction scores, as missing opportunities to address real sources of dissatisfaction, which are usually related to threats to the patients’ personal identity or integrity (Coyle 1999). While many of these customer-satisfaction initiatives have reported enhanced patient and staff satisfaction scores, Vest and Gamm (2009) found the quality of research to be superficial and premature in conclusions.

The complexities of nursing work have been shown to be of a magnitude that specialized and focused attention is needed to defray the possible negative effects of intense emotions associated with events in the clinical settings of today’s hospital environment (Corley 2002; Figley 1995; Kalvemark et al. 2004; Malasch 2003; Malasch and Leitner 2008; McCann and Pearlman 1990; Stamm 1995; Ulrich et al. 2007). Researchers have found nurses’ work increasingly incongruent, and requiring nurse’s to work against a multitude of dissonant feelings in their work settings (Hunyh, Alderson, and Thompson 2008; Walsh 2009). Dissonance in nursing has generally focused on dealing with competing demands and ethical dilemmas (Coughlan 2006; de Raeve 2002; Kalvemark et al. 2004; Lopez 2006; Malloch 2001; Robinson and Demaree 2007; Scheid 2008; Weinberg 2003; Ulrich et al. 2007).

These studies suggest that emotional labor in nursing arises from two main sources: being expected to manufacture a caring image and having to suppress feelings arising from conflicting demands alongside limited resources. It is this first type that is
more typical of what a nurse expects to encounter in their work with patients. In the next section, some of the effects of emotional dissonance, the motivator for emotional labor are reviewed.

Consequences of Emotional Labor on Employee Wellbeing

Psychosocial Effects of Emotional Labor Demands

Erickson and Wharton (1997) found that workers having to display emotions contrary to how they authentically feel can experience a multitude of negative psychological states. Studies examining work stress in nursing show a relationship between work stress and physical and psychological symptoms (Allesøe, Hundrup, Thomsen and Osler. 2010; Brotheridge and Grandey 2002; Meigs, Hu, Li, Rifai, and Manson 2004). Several studies specifically found emotional labor demands of nurses’ jobs, when the nurse’s display requirements were different from their actual feelings, had a small, but significant relationship with burnout (Bakker and Hueven 2006; Erickson and Grove 2008). Another study found a relationship between job stress and depressive symptoms in medical –surgical nurses from three hospitals; however, it was unclear whether the specific measures were part of emotional labor requirements in the job (Walsh 2009). Many of the complaints and frustrations reported by nurses were unrelated to taking care of patients, but were mostly about the way their jobs were structured that interfered with patient care (Aiken et al. 2002; Buerhaus 2008). The problem of interruptions is discussed below.
Interruptions. A frequent complaint of nurses is being interrupted during tasks. Two researchers studying nurses work processes on their patient units in two large hospitals found nurses were interrupted an average of ten (10) interruptions per hour; in one of the hospitals, an interruption occurred on average every four and a half minutes (Kalisch and Aebersold 2010). Besides interruptions, 34 percent of the time, nurses were multi-tasking and there was slightly more than one error per hour. In several cases, nurses were interrupted while they were responding to another interruption. Interruptions and the continuous reprioritization of work activity, due to competing demands on the nurses’ time, led to noncompletion of tasks. In addition to interruptions, researchers have identified as many as 86 different kinds of work activities over the course of a nurse’s shift (Rogers et al. 2004). Studies examining the effects of interruptions, inhibition, and exerting self-control reveal consistently that multitasking and having to exert self-control without adequate recovery or reflection time, interferes with successful task completion and concentration (Muraven and Baumeister 2000; Wegner 1994).

In four other studies, tasks were left undone, incomplete or done with error (Beaudoin and Edgar 2003; Lundgren and Segesten 2001; Hall, Pedersen, and Fairley 2010; Rogers et al. 2004). As the concern about patient care errors has gained national attention, increasing attention has been paid to these research findings (Manojlovich and DeCicco 2007; Valentine et al. 2006). While non-interruption cues such as a subtle red line in the nurses work zone (Anthony, Wiencek, Bauer, Daly, and Anthony 2010) did help to decrease interruptions and reduce errors, more obvious cues such as red vests or signs that indicated the nurse was not to be disturbed led to an increase in interruptions (Relihan, O'Brien, O'Hara, and Silke 2010), and left onlookers appalled and feeling the
nurses were uncaring. Despite a need for some action to address medication administration errors, and interruptions, the overall effectiveness of the intervention strategies with *Do Not Disturb Zones* was found to be insufficient in a meta-analysis of ten (10) studies on this intervention (Raban and Westbrook 2014).

Besides interruptions, nurses face problems in their work environment with lack of resources and support. In their study of work flow processes, Tucker and Spear (2004) found that there was an average of 8.4 interruptions per eight hours of a nurse’s work shift in work flow due to system failures, or insufficient resources. Other studies of workflow and work processes have found these impediments to be accepted by nurses as part of the daily routine in their work, despite the obvious interference with completing patient care, and the kind of message that system induced derailment sends to the nurse regarding the value of their work (Ebright, Patterson, Chalko, and Render 2003).

There is a long tradition of research on the adverse effects of interruption on attention, decision making, memory (Gross 1998; Boehm-Davis and Remington 2009), motivation and mood (Becker and Leinenger 2011). Interruption contributes to frustration, a sense of helplessness and a depressed mood (Bailey and Konstan 2006; Jacobshagen 1990). These kinds of frustrations in work can sometimes generate a sense of helplessness, sometimes leading to the phenomenon of *learned helplessness* (Hiroto and Seligman 1975; Miller and Seligman 1975), where people eventually withdraw effort and give up on success even when circumstances change.

Another phenomenon that may be more likely in situations such as trying to provide good patient care, but lacking support and resources to do so, was becoming fixated on the unattainable goal, and continuing to measure oneself against this
unattainable goal (Gunia, Sivanathan, and Galinsky 2009; Weicke and Sutcliffe 2011). This phenomenon has been termed *vicarious entrapment* (Gunia, Sivanathan, and Galinsky 2009). Thus, effort and frustration persists in a cyclic fashion affecting the emotions and decision making of the affected person(s). These kinds of dissonant experiences can affect health and well-being immediately and over time, as discussed next.

*Physical Effects of Suppressing Negative Emotion: Cardiovascular Concerns*

Work stress, including emotional dissonance in jobs where expectations and ethics collide, has been demonstrated to begin a cascade of inflammatory processes disrupting body-systems such as lesions of the endothelium of blood vessels thereby raising risks of cardiovascular and metabolic disease (Meigs, Hu, Li, Rifai, and Manson 2004; McEwen and Lasley 2004; Rozanski, Alan, Blumenthal, Davidson, Saab, and Kubzansky 2005), metabolic syndrome, and insulin resistance leading to risk of diabetes (Dedert, *et al.* 2010), autonomic nervous system dysfunction (Gross 1998) manifesting in physical symptoms, and physical or mental diseases. A leading researcher of motivation and emotional regulation has repeatedly demonstrated a predictable rise in sympathetic nervous system activation of the cardiovascular system, and there is evidence from other studies that the responses are sustained beyond the immediate activating stressor (Campbell-Sills *et al.* 2006; Gross and Levenson 1997; Gross 1998; Gross 2006).

Emotional labor researchers found that females had greater difficulty when they were experiencing negative emotional states, and had to first suppress this state in order to display expected positive emotions (Erickson and Wharton 1997; Erickson and Grove 2008; Schaubroeck and Jones 2000). This dissonance, between negative affect and
expectations to display a positive affect was associated in two studies with feelings of emotional distress, and a high number of physical complaints (Schaubroeck and Jones 2000; van Vegchel et al. 2001).

Several other researchers conducted a double blind experiment to determine the differences in physiological stress responses, when participants suppressed negative emotion, faked positive emotion, and responded genuinely (Hopp, Rohrmann, Zapf, and Hodapp 2010). The greatest stress response occurred when negative feelings had to be suppressed in order to manufacture positive feelings. This is similar to findings from the above mentioned studies (Gross and Levenson 1997; Schaubroeck and Jones 2000; van Vegchel et al. 2001). When these results were further analyzed by gender, when females had to fake, their stronger systolic blood pressure responses increased more than when males faked emotion (Hopp et al. 2010).

Negative emotion was so consistently associated with negative health and psychological disorder that some researchers named a personality category for individuals prone to experiencing mostly negative emotion, the Type D personality. This personality category is characterized by persistent negativity and social avoidance related to a constant fear of criticism or being perceived as inadequate (Sher 2005). There has been research support (Sher 2005) for an association between the Type D personality, and a seven-fold increase in the risk for cardiovascular disease. Opinions differ as to the mechanisms by which this personality type were relevant to the this cardiovascular finding; however, suppressing negative feelings (Gross 1998), and lack of social support (Bradley and Cartwright 2002; Morrison 2009), have been the two most consistently linked aspects linking affective state to negative health outcomes, including
cardiovascular disease (Mauss, Cook, and Gross 2007). In addition, the Nurses’ Health Study data, an all-female sample of registered nurses, revealed an association between depression, and the incidence of sudden cardiac death in nurses. Even after controlling for the usual cardiovascular risk factors (smoking, diet, activity level, weight, family history and cholesterol), this risk persisted. The risk was even greater for nurses who took antidepressant medication (Whang et al. 2009).

An emerging pattern of health risks, particularly cardiovascular risks (Rosenström, Hintsanen, and Kivimäki 2011; Schnall, Landsbergis, and Baker 1994; Slopen et al. 2012; Karasek and Theorell 1990), were associated specifically with a kind of job stress in which expectation and demand were high, but control and discretion over work was low (Amick et al.1998; Berkman et al. 2010; McEwen and Lasley 2004). A list of some of these studies is provided below in Table 3.6. And is not an exhaustive, but a representative list, mainly from the Nurses’ Health Study. This kind of job was associated with a high degree of dissonance, which necessarily requires controlled or automatic coping strategies to dissipate some of the tension associated with high levels of dissonance.

The evidence for work stress and cardiovascular events, and metabolic syndrome, reached a level of concern prompting the Einstein Institute for Heart and Vascular Health, in Philadelphia, to issue a call for physicians to pay attention to the psychosocial stressors of their patients, especially employment stressors (Figueredo 2009). In the next section, studies about the effects of organizational, managerial, and coworker support on the nurses’ capacity for caring will be reviewed.
Table 3.6 Examples of Conditions and Diseases associated with Work Stress

<table>
<thead>
<tr>
<th>Condition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Brown, James, Nordloh and Jones, 2003</td>
</tr>
<tr>
<td></td>
<td>Goldstein, Shapiro, Chicz-DeMet, and Guthrie 1999</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>Allesøe, Hundrup, Thomsen, and Olser, 2010</td>
</tr>
<tr>
<td></td>
<td>Karasek, et al. 2010</td>
</tr>
<tr>
<td></td>
<td>Kawachi, et al. 1995</td>
</tr>
<tr>
<td></td>
<td>Lee, Colditz, Berkman and Kawachi. 2002</td>
</tr>
<tr>
<td></td>
<td>Rozanski, et al. 2005</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Jolivet, et al. 2010</td>
</tr>
<tr>
<td>Depression</td>
<td>Erickson and Wharton 1997</td>
</tr>
<tr>
<td></td>
<td>Jolivet, et al. 2010</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>Kroenke, et al. 2007</td>
</tr>
<tr>
<td>Metabolic Syndrome</td>
<td>Chandola, Brunner, and Marmot 2006</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Hu, et al. 2004</td>
</tr>
<tr>
<td></td>
<td>Kroenke et al. 2007</td>
</tr>
</tbody>
</table>

The Importance of Time for Reflection, Feedback, Social Support, Coworker Support and Managerial, Administrative Support

The embedded patterns perpetuating ineffective caring by nurses and other organizations analyses of hospital environments have shown that in the absence of support or feedback, it was difficult to institute and maintain any change in ineffective patterns of work (Jaques 1955; Menzies 1960; Obholzer, and Roberts 1994). On the one hand, a pattern of avoiding and shielding oneself from feelings continues to be observed among medical and other health practitioners such that the emotions expected toward
vulnerable patients get redirected into rationalizations and distancing behaviors (Emerson 1970; Leif and Fox 1963; Smith and Kleinman 1989). On the other hand, systems erect barriers to effective workflow, making the manifestation of caring difficult (Aiken et al. 2012; Armstrong and Laschinger 2006). Studies have shown a need for ongoing reflection, feedback, and support to facilitate maintenance of awareness necessary to keep stereotypes, and defense mechanisms from interfering with the kind of professional goals consistent with one’s identity and ethical values (Harling 2014; Steele and Aronson 1998; Lynch, Baker, and Lyons 2009; Steele, Spencer, and Aronson 2002; Spitzer 2004; Walsh 2009).

There is evidence that interventions could reduce this problem (Barclay and Skarlicki 2009; Epstein, Sloan, and Marx 2005; Pennebaker and Bealls 1986). Controlled experiments in which subjects are asked to write about stressful experiences have shown improvement in feelings of wellbeing, and even a decrease in heart rate of participants, a physiological indicator more conducive to enacting caring behaviors (Buczynski and Porges 2013). Studies of improving work environments suggest staff benefit from engagement with others able to facilitate desired workplace changes through feedback and support (Akerjordet and Severinsson 2007; Begat, Ellefsen, and Severinsson 2005; Begat and Severinsson 2006; Freshwater 2004; Gershon et al. 2007; Goodrich 2012; Menzies 1960; Schluter, Winch, Holzhauser, and Henderson 2008; Shattell, Hogan, and Thomas 2005).

Emotional labor researcher, Pam Smith (2008), found customer-service requirements for nurses to smile, and convey compassion under work conditions competing with effective completion of necessary care by nurses, were ineffective in
promoting caring. Smith recommended a more supportive environment in which nurses were able to manage and process emotions in a manner conducive to maintaining caring and compassion. Other researchers also recommended teaching nurses emotional labor skills in nursing education, and providing opportunities in practice that allow nursing staff to reflecting on, and process the emotions arising in the workplace (Bolton’s 2002; Freshwater 2000; Gray 2009; Söderlund, Norberg, and Hansebo 2012; Smith and Gray 2009).

Leading emotional labor researchers found employees have different capacities for using internal and external resources to manage emotional labor (Abraham 1998; Andrews, Karcz, and Rosenberg 2008; Ashforth and Tomiuk 2000; Brotheridge and Grandey 2002; Brotheridge and Lee 2007; Grandey 2000; Jahanvash 2009; Martínez-Íñigo et al. 2007; Morris and Feldman 1996; Pugliesi 1999; Wharton 2009), and ineffective emotion management has been shown (Abraham 1999; Brotheridge and Lee 2007; Malasch and Leitner 2008) to be related to the degree of emotional burnout experienced by workers. Thus, nurses who managed their feelings in ways that fit with their personal identity as caring persons were generally more satisfied with their jobs, and their patients were generally more satisfied with the nurses (Amendolair 2012; Begat et al. 2005; Jolivet et al. 2010; Burtson and Stichler 2010).

An example of how nurses use emotional labor to facilitate their caring through self-awareness and reflection was present in the study of nurses working with prison inmates (Walsh 2009). Many of these prisoners had committed horrendous acts that led to feelings of revulsion by nurses. Nurses reported struggling to manage their feelings so that they could provide quality and nonjudgmental care. The researcher noted that nurses
dealt with these kinds of feelings on a daily basis and generally understood this kind of emotional labor to be a part of their role as caring persons. For prisoners showing a proclivity towards manipulation, nurses had to consider how to provide quality care without leaving themselves vulnerable to manipulation or danger. Nurses in this study reported having experienced themselves as powerless inside an institution of rules, regulations and procedures. The nurses found ways to reconnect with their role as patient care advocates, and managed their concerns with supervisors, administrators, and coworkers in a way that felt ethical and reinvigorating.

The opportunity to participate in clinical supervision Begat and colleagues (2005) meetings where they could share feelings lowered nurses’ stress levels, added to their sense of coherence about their work and improved their sense of being supported by the hospital in their work. Henderson’s (2001) and Ruchti’s (2012) studies’ both emphasized the importance of organizational assistance to nurses for learning to manage the intensity of emotion in their work. This support to nursing staff in managing work related emotions as a facilitator of a caring environment was also found in Lopez’s (2006) study in nursing home settings. Lopez found striking differences in three nursing home facilities with regard to emotional expressivity and time spent with residents that seemed to be a function of the established norms for acceptable behavior set by administration and supervisors. The nursing home facility that was especially attentive to providing support to employees’ emotional honesty about dealing with difficult residents was noted by Lopez (2006) as facilitating a positive working environment in which nurses could realize their caring goals with patients by deflecting inherent tensions of incongruent emotions (Martínez-Íñigo et al. 2007). When staffing was insufficient, it was more
difficult for nurses to demonstrate a caring manner. On the other hand, knowing other staff was available to assist with managing work demands offset the stress of being expected to show a caring manner.

Much of the interpersonal dimensions of caring have been found to occur on the job in interactions with supportive coworkers and supervisors (Smith 2009). In general, nurses benefited from having time available for these kinds of informal work discussions (Hall 2007). The importance of interaction was also found in a study of job dissatisfaction and emotional labor requirements (Bradley and Cartwright 2002). Regardless of how difficult the work environment was, the nurses who felt supported by coworkers and nurse managers felt a sense of satisfaction in doing the right thing for patients.

A main positive aspect of work for nurses is the people with whom the nurses work, including the nurse manager (Hall 2007). When nurses feel as if they are misrepresenting themselves or the institution, they have generally found organizational requirements to perform emotional unpalatable and it added to their job dissatisfaction. When administration supported work practices that incorporated time and expectations for caring, it was more likely to occur (Lopez 2006).

Smith (2009) and others (Finfgeld-Connett 2008; Goodrich 2012; Landa and Lopez-Zafra 2010; Lilius et al. 2008; Mentis, Phillips, and Meissen 2010; Mentis, Reddy and Rosson 2010; Schofield, Green and Creed 2008; Savage 2004; Scott et al. 1995; van Vegchel et al. 2001; Wilding 2008) have begun to focus on emotional labor as the need for nurses to have time and space to manage their emotions in order to be effective with patients (Freshwater 2000). The review of literature relevant to this dissertation will now
be summarized and synthesized into the theoretical and methodological framework proposed in this study.

**Summary of Literature Review**

This literature review revealed a consistent pattern of changes in healthcare. These changes were especially apparent in the hospital setting. Fewer resources, greater demands, and increased work intensity were some of the constraints competing with nurses’ ability to show caring. A growing list of routines and a shorter length of patient stay interfered with nurses being able to develop relationships with patients conducive to individualized caring (Pearcey 2010). These changes in how nurses were able to relate to patients alongside a heavier and more intense workload, over which they had little control, has resulted in dissatisfaction among nurses (Aiken et al. 2001; 2002; 2004; 2010).

Emotional labor researchers such as Grandey (2000), and Allan, Barber, and Mazhindu (2003) suggest that nurses are expected to engage in more emotional labor in hospital work as part of facilitating satisfaction from patients. Healthcare researchers such as Bowling, Rowe, and McKee (2013) also suggest there are increased emotional labor demands of employees in healthcare because of the marketing and reimbursement incentives for hospitals.

Emotional labor researchers in nursing (Gray 2009; James 1989; Smith 1993; Theodosius 2008) suggest there is less time available for emotion work and greater dissatisfaction among nurses (Aiken 2001, 2002, 2008; Begat, Ellefsen, and Severinsson 2005; Kramer 1974; Malasch 2003). This pattern of worker dissatisfaction, higher
demands accompanied by less control over work has been linked to health problems, especially cardiovascular events (Amick et al. 1998; Cheng et al. 2000; Chandola, Brunner, and Marmot 2006; Theorell 2009). There are also indications from research that attention, informed decision-making, and the ability to execute patient care goals are compromised by the frequent interruptions and unplanned events occurring on nursing units (Cameron and Payne 2011; Chaiken 1980; Darley and Latane 1968; Koonin and Greene 2007; Muraven and Baumeister 2000; Robinson and Demaree 2007; Ward and Gordon 2006; Weick and Sutcliffe 2011). This suggests that the requirements and enactment of emotional labor may have changed.

The kind of emotional labor experienced by nurses has typically been the management of emotions and reactions to un-pleasantries in patient care that can be embarrassing or disempowering to patients. How nurses accomplish emotional labor of caring in a more intense care environment in the absence of time and resources to support caring is sparingly covered in the literature. This gap is widened by the changes in reimbursement stipulations that are tied to patient satisfaction ratings. Hospitals have implemented different kinds of strategies that require employees to follow scripts intended to convey caring and concern to patients. These scripts are developed so that the patients might be more inclined to endorse favorable satisfaction ratings (Vest and Gamm 2009).

The literature, particularly in the United States has not addressed how nurses use the emotional labor of caring to manage the changed demands and shorter patient stays in the present-day hospital care environment. The review of literature in this manuscript supports the research questions identified below.
Research Questions and Specific Aims of this Dissertation

This dissertation begins with the following research questions while acknowledging that qualitative inquiry sometimes redirects the researcher to other areas of questioning as understanding of processes unfold (Denzin and Lincoln 2005). This dissertation will address the following questions:

1. *How do hospital registered nurses manifest caring in the present day work environment of hospitals?*

2. *How can emotional labor as a critical symbolic interactionist theory (Hochschild’s emotional labor theory) explain the expression of caring in hospital staff nursing?*
CHAPTER FOUR
METHODOLOGY

Chapter Overview

This chapter provides an overview of the methodology of qualitative research and semi-structured interviews. The specific manner by which these qualitative techniques were applied in this study is detailed in this chapter. I also integrate principles and guidelines with these details to show protection of research integrity, and participant privacy and well-being. Finally, I discuss the processes used to convey the nurses’ voice in communicating and analyzing results as closely as possible. I begin with an overview of how qualitative methods fit the study’s purpose.

Definition and Description of Qualitative Methodology

Qualitative methodology yields narrative data from a participants’ experience of their world (Denzin and Lincoln 2005). Some sociological scholars say qualitative research methodology is the only way to retain the essence of knowledge generated by personal experiences (Blumer 1956: 683; Denzin and Lincoln 2008: 14; Marvasti 2004:
Understanding human beings in their own worlds requires techniques that can be flexibly applied to opportunities that emerge unexpectedly and help illuminate the concepts being studied (Charmaz 2006; Denzin and Lincoln 2005).

Of the qualitative techniques available, all involve entering the world of the participant in some way (Flick 2009: 58). Other commonalities are shared assumptions about knowledge and reality, and the researcher’s role, as discussed next.

Knowledge Production, Reality, the Role of the Researcher

Qualitative research, especially from an interpretive or interactionist perspective, suggests knowledge occurs when actions of people are interpreted (Denzin and Lincoln 2005: 27; Denzin 2009; Hammersley 2009). Knowledge is seen as continually evolving; new knowledge occurs as new aspects of the world come into focus (Flick 2009: 58). Stemming from this assumption, reality is whatever human beings in interaction co-create. Apart from this, reality is a nonentity. In other words, reality is how people make sense of things, as discussed in the symbolic interactionist and constructionist perspectives in the theory chapter.

Going a step further, the qualitative researcher is an active and essential part of knowledge production and reality. The researcher brings their past experiences, and ways of being in the world to the research relationship (Flick 2009: 16; Silverman 2006). When the researcher and participants interact, they produce a particular version of reality as they negotiate meanings through their interaction. All of these aspects of qualitative methodology fit with the theoretical basis of this study as discussed below.
In the theory section of this manuscript, I reviewed the relationship between symbolic interactionism, critical theory, and emotional labor as it pertained to the research question for this study; how do registered nurses manifest caring in the present-day work environment of hospitals? This research question arose out of emotional labor theory, which I suggested is a hybrid of symbolic interactionism and critical theory. Qualitative methodology fits this theoretical framework and this research question in that data required for constructing themes from the nurses experiences of caring can be generated through qualitative techniques.

Analyzing qualitative research produces richly detailed narratives often referred to as *thick description* (Geertz 1973: 5-10). Thick description offers readers a view of the participants’ experience from the environment in which the phenomena exists and derives meaning. Thick description in qualitative research can come from interviews, journaling done by researchers or participants, field notes acquired from direct or participant observation, and any other of the available techniques common to qualitative research.

What unifies qualitative research technique is its goal to make the voices and experiences of individual participants available for others’ understanding (Denzin and Lincoln 2005; Harvey 1990). The technique chosen for this study was in-depth semi-structured interviews of nurses, which is discussed next.
In-depth Semi-structured Interviews as a Qualitative Research Method

In this study, data was gathered by in-depth, semi-structured interviews. The answer to the research question, *how do nurses manifest caring*, was expected to encompass nurse participants’ interrelated actions, feelings and thoughts about caring. Qualitative researchers say in-depth interviews can offer insights into a participant’s connections and relationships between events and experiences (Denzin and Lincoln 2005). Interviewing was considered a good strategy for giving participants in this study an opportunity to relate caring experiences from their work environment in their own words.

Whereas structured interviews follow orderly patterns of content-specific questions, semi-structured interviews allow researcher flexibility in the sequence of questions (Marvasti 2004). The participant is considered the expert during in-depth interviews (Mack et. al 2005). Indepth interviews allow the participant to take the lead in how they tell their story, thereby avoiding disrupting the participant’s recall and reconstruction of events and experiences (Mack et al. 2005; Marvasti 2004). Participants may also add insights to the topic of caring as they go outside the bounds of the question (Burgess 1988: 109; Mack et al. 2005: 3). Often times, the qualitative researcher finds at the end of the participant’s narrative, they have covered the questions planned by the researcher.

Experienced qualitative researchers usually comprehend the skill involved in giving full attention to the voice of the participant without interrupting the participant to insert their opinions about the subject being studied (Mack et al. 2004). The researcher seeks a balance between open sharing and ensuring the focus remains on the participant.
Mutual dialogs with the participant can facilitate openness and acceptance for the participant (King 2004: 11; Silverman 2006: 112)\textsuperscript{13}.

After the participant has shared freely, the researcher can request more detail if needed or seek clarification of answers already provided. Unanswered questions can be asked after the participant finishes their story.

In their field book guide for conducting qualitative research, the Family Health International Foundation (Mack et. al 2005: 29) suggests a main benefit of in-depth in-depth interviews as adding a face to human problems. Semi-structured interviews can relax the atmosphere such that interviews become somewhat conversational in nature (Marvasti 2004: 21). Qualitative researchers say participants and researchers often report interview experiences are mutually rewarding (Mack et. al 2005). For the participant, interviews can be a rare and refreshing opportunity to speak about important matters from their day-to-day life. Participants sometimes report feeling flattered that someone cared enough to listen to what they had to say (Mack et. al 2005: 30). Interviewers sometimes experience a sense of awe at being permitted into the intimate life-world of the participant (Mack et. al 2005: 30). In the next section, I will discuss how the participants were recruited for the study.

*Sampling and Recruitment Strategy*

I sought to conduct interviews with up to thirty female registered nurses working in medical-surgical units. The sampling strategy used was purposive sampling; the characteristics of participants that helped answer the research question were the targeted

\textsuperscript{13} This type of exchange is parallel to the exchange that is sometimes described by nurses as a caring moment (Watson 2002).
sample (Marvasti 2004). In qualitative research, it is the intent of the research and homogeneity of the sample that determines sample size (Marvasti 2004: 9). Some researchers specify a minimum of twenty to thirty interviews for field-based research (Creswell 2013). Guest, Bunce and Johnson (2006: 66) reported from their comprehensive review of methodology articles and methods textbooks that saturation typically occurred at twelve interviews, after which themes were repetitive. With regard to selection criteria, differences in nurses’ work experiences led to particular decisions about sample inclusion criteria as discussed below (Brooks and MacDonald 2000; Cleary, Meterko, Wright, and Zaslavsky 2014; Kalisch, Tschannen, Lee, and Friese 2011).

**Inclusion Criteria.** The criteria for participants in this study were as follows: (1) female registered nurses, (2) employed full time in staff nursing jobs in the hospital, (3) working during primarily day shift hours, (4) medical-surgical nurses, and (5) working at a hospital within a one hundred mile radius of Birmingham, Alabama.

**Exclusion Criteria.** Once the criteria for inclusion were met, participants were excluded after two messages had been left in an effort to contact them after their name was provided by a mutual colleague. A participant was also excluded if they cancelled an interview without responding to two follow-up calls or when they cancelled and rescheduled more than two schedules interviews without calling back for another time. Participants who were in a supervisory relationship with the referring colleague were also excluded.
Rationale for Including Only Female Registered Nurses. A decision was made to include only female registered nurses because of differences suggested in the literature about males and females experiencing work differently (Dyck, Oliffe, Phinney, and Garrett 2009). Nursing is also a strongly female gendered occupation (Gordon 2005; Porter 1992; Reverby 1987). Excluding minimized the complexity associated with advantages and disadvantages of males in female gendered occupations (Williams 1992; 1995).

Rationale for Including Only Full-Time Nurses. The literature suggested differences in commitment and distress levels between full-time as opposed to part-time nurses (Wetzel, Soloshy, and Gallagher 1990). The total hours qualifying for full-time employment vary from 24-40 hours per week (Wetzel, Soloshy, and Gallagher 1990). Part-time nurses may work similar hours but under different conditions with regard to fixed, recurring schedules and consistent coworker groups; thus part-time nurses were excluded.

Rationale for Including Only Staff Nurses. The staff nurse is central to providing direct care to patients (Hunt 2014). Other hospital-based nursing roles such as case management, information systems specialist, and educator are indirect patient-care jobs, and so were excluded. Nurses in management support positions were excluded unless they regularly cared for patients by taking an assignment roughly comparable to staff nurses without managerial duties.
Rationale for Targeting Medical-Surgical Nurses for the Sample. The targeted sample for this study was medical-surgical nurses. This group of nurses was selected for the study because new nurses are often advised to work a few years in medical-surgical nursing to acquire their generic nursing skills (Hunt 2014). Medical-surgical units offer nurses a broad array of experiences covering the gamut of common medical and surgical problems encountered during a nurses’ career, and thus facilitates a foundation for the future development of expert skills (Hunt 2014). The representative generic skills and knowledge in medical-surgical nurses (which all nurses are expected to possess at a minimal level) was the basis for selecting this group of nurses for this study.

Rationale for Including Hospitals within a 100 Mile Radius of Birmingham, Alabama. Hospitals differ based on their identified specializations, types of patients seen, and affiliation with a university or church; they also differ by ownership and profit orientation, third party interest stake-holders, and type of accreditation and certification status (Horwitz 2005). For instance, university-affiliated hospitals are considered distinctive environments, setting them apart from hospitals without a primary teaching mission. Including potential participants from a wider range outside the most accessible area allowed for greater diversity within an area reasonably accessible to the researcher.

The nurses’ manifestation of caring was expected to vary by hospital expectations. Thus, I tried to maximize variation in types of hospitals employing the nurse participants. Summarily, this study sought female registered nurses caring for patients during daytime hours. Demographic sample characteristics are discussed next.
Types of units employing nurses which were included and excluded. The types of units included as employment sites of potential nurse participants were characterized by patients admitted for care related to acute illnesses of a medical, surgical, cardiac, gastrointestinal, neurological or orthopedic nature. Nurses who currently worked in specialty care areas or pediatric settings were excluded. The medical surgical units varied by kinds of patients admitted, but were mostly characterized by a diverse range of patient problems requiring a broad range of generic nursing skills.

Some units are highly specialized or have patient care situations that encourage or discourage closer contact with patient by the nature of the patient problem. For instance, nurses working on intensive care units necessarily have a closer proximity and more intensive contact with their patients. Some research suggest this facilitates a unique caring bond between the patient and nurse (Kalisch, Lee, and Rochman 2010; Vouzavali et al. 2011). By selecting generic nurses on general medical-surgical units as participants, the associated caring experiences of nurses can be seen apart from specialty units which may encourage or discourage relationship closeness with patients. For example, emergency rooms tend to be intense, urgent, and short term; this might affect the bond with patients positively or negatively due to the intensity. Intensive care units, transplant units, and oncology units tend to encourage strong bonds with patients because of the heightened life-death issues (Thomson and Trocoquet 2013: 15).

Psychiatric units involve a different type of care than is required on general medical nursing units; therefore, nurses from psychiatric units were excluded from participation. Rehabilitation units, characterized by a longer length of stay and a focus on non-acute care problems and psychological adjustment were also excluded.
Labor and delivery, and postpartum nursing units were excluded because the nature of care being given for an event such as a birth – a medicalized normal life event – (Brodsky 2008) was assumed to be different than the nursing care of acutely ill patients on medical or surgical units. Working with children tends to be different because of the greater oversight by external regulatory agencies of the care of children, the complexity of parent-child-nurse relationships, and the inherent developmentally divergent ways of approaching children as opposed to adults (Bowden and Greenberg 2013: 3).

Caring differences in this study of medical-surgical staff nurses were assumed to perhaps less likely be due to the uniquenesses of the patient population and problems treated on the unit. In the next section, several other features considered important for selecting the specific sample for this study are addressed.

*Rationale for Targeting Primarily Day-Shift Nurses*. Nurses working primarily during day-time hours were sought for this study. This was deemed necessary because of a difference in the level of activity generated by the numbers of people present on a patient care unit on a day as opposed to night-time shifts. Daytime hours on a patient care unit have a larger variety and number of personnel and visitors with which to interact. Nurses, unlicensed nursing staff, and on-call physicians, are generally the only workers present during night shifts on patient care areas. Restricting participants to those working mostly daytime hours assured that nurse participants experienced a more similar work
environment in terms of the numbers of people and departments with whom they interact\textsuperscript{14}.

Sample Demographic Characteristics Important to This Study

The demographics collected from participants included age, sex, marital status, ethnicity, education and income level. If the participant was living with another person, and their income was considered part of the total household income, that information was also included. These participant characteristics were unrestricted with regard to inclusion and exclusion, but were noted on the demographic data sheet. Next, the recruitment strategy is discussed.

Recruitment of Participants

The proposed plan for recruitment was to request permission from nursing administrators to allow flyers advertising my study to be posted at their hospital; the flyers invited nurses to contact me directly if interested in participating in an interview on caring. The flyer specified the interview would occur outside of work hours at a location such as a coffee shop of their choice. In addition to posting flyers, I also planned to seek

\textsuperscript{14} This does not imply night shifts are not busy; to the contrary, they can be quite unexpectedly busy. A participant was included therefore if they work a traditional day shift (7AM-3 PM or 3-11 or 7AM-7PM or 7PM-7AM but not 11PM-7AM). The specific times of shifts varied, but the main part of the worked shift was preferred to occur during the daytime hours.
permission to advertise my study in a hospital-based communication such as a newsletter or email distribution. There was the added possibility of attending staff meetings with nurses to discuss my research. Lastly, I proposed contacting several nursing organizations for permission to advertise my study through their communication channels such as a newsletter.

Response to Initial Recruitment Efforts

A nurse executive colleague of mine, having suggested to me that my recruitment strategy would be ineffective, influenced my decision to initially send only eight letters from the list of 57 hospitals. The letters were sent out in January 2014. Of the eight letters I sent out, I received communications from several of the Chief Nursing Officers or their designee over the next two months that indeed the strategy was problematic. The problem had to do, as predicted by my nurse executive colleague, with heightened concerns for people’s privacy, and organizational concerns about their staff being solicited for research, over which the hospital lacked input. The nursing administrator at one hospital informed me their hospital had policies strictly prohibiting any recruitment of their nurses for research. Three other hospitals contacted me for more questions about my research. They seemed to be mostly interested in determining whether their hospital would be able to be identified by name when the research was completed. Upon clarifying these questions, the nursing administrators for two of the hospitals checked with the Chief Executive Officer for the hospital, and declined to allow in-house recruitment through attending meetings; however, they were agreeable to allowing the flyers to be posted. The
Chief Nursing Officers at these hospitals requested I send the flyers and agreed they would place them in the appropriate areas. At two of the eight hospitals contacted by letter, three nurse managers who heard about the study from their nurse administrator contacted me and asked questions about the study. They had posted the flyer on their units and wanted to be sure they could reach me if questions arose. They also indicated if I received IRB approval from their hospital, they would be happy for me to come to their units. One of the nursing administrators from this hospital called me back, and indicated that hospital IRB, Human Resources, and Risk Management would need to be involved if I did anything other than post the flyer. They were agreeable to assist me with this process if I desired. Another hospital indicated their hospital’s IRB approval was required even for placing flyers. The nursing administrator at the last of the eight hospitals I had contacted stated I could do a study through their hospital, but they wanted me to do something other than caring because that topic was, “old news (their words)”. This administrator went on to explain that they had implemented customer-service strategies which had improved their patient satisfaction scores. This particular hospital was also agreeable to my coming onto the premises to talk with staff about my study, but strongly recommended reconsideration of the topic. I thanked them for their help and indicated I would share my results with them. A similar pattern occurred when approaching nursing organizations with regard to concerns about serving as a conduit for recruitment of their members for researchers. One of these organizations initially agreed to allow me to post an ad for a substantial fee (>$500.00). However, they later recanted upon learning their organization recently

15 During the interviews, participants from some of these eight facilities indicated they had seen flyers.
adopted policies against active research recruitment of its members. In the end, they were agreeable to announcing a call for participants at their meetings, and to disseminating my findings upon conclusion of my research. The second organization had the same policy. The third organization was receptive, but voiced concerns about legal liability, agreeing to get back with me after consulting with their risk management, human resources, and organizational officers. This organization did not get back with me, and I did not pursue the matter further; however, I did notice they sent out a tweet message about my study. There were no participants screened from these avenues of recruitment.

Overall, I learned that individual hospital IRB approval was going to be necessary for each of these hospitals if I expected to proceed as planned above. Acquiring hospital approval at 57 hospitals was prohibited by the time line for this study. I decided to revise my recruitment strategy by submitting an amendment to the IRB at UAB seeking permission to recruit participants through nursing colleagues known to me from my own nursing career. This amended approach is discussed next.

\textit{Amended Recruitment Strategy – Referrals from Nursing Colleagues.}

Once the amendment was approved by the IRB at UAB, I began to contact individual nursing colleagues I knew personally, asking them if they could refer or recommend a nurse who met the inclusion criteria of full time, day shift, registered nurses, who worked with adults in medical surgical nursing, and who lived within a 100 mile radius of Birmingham, Alabama. I added the stipulation that referrals be from non-
supervisory or advising relationships to avoid any element of coercion\textsuperscript{16}. Overall, the amended strategy yielded 104 potential participants, as is discussed next.

*Participants yielded by recruitment through nursing colleagues.* Colleague contacts yielded a total of 102 potential participants. When a colleague gave me the name of a potential participant, I asked the colleague to first contact and advise the potential participant of my intent to call. Some colleagues gave potential participants my number for them to initiate contact with me. With each potential participant, I reviewed the screening criteria to determine if they met the inclusion criteria. As participants were screened, it became apparent that there were a number of participants eager and willing to participate, but who did not work in the patient care areas included for the study. There were also some individuals screened who worked part-time or were male nurses. For these participants, I thanked them and explained the reason for their particular work unit or gender being excluded.

Some participants who agreed for me to contact them did not call me back. I decided to make only one follow-up call unless the participant requested I call back. Several of the nurses agreed to participate but had busy schedules as a result of childcare, being in school, or having caregiving responsibilities for older or ill parents or family members. Other potential participants were unable to find suitable times, or things came up that prevented them from coming at the scheduled time. A few employees wanted me to interview them at their worksites, which was not acceptable based on the initial

\textsuperscript{16} There were participants from one hospital that had a standing incentive for their nurses’ progression in their career advancement which required the nurses participate in nursing research.
feedback from hospitals regarding their concerns about their staff participating in research without their hospital IRB approval.

In the occasional situation where a colleague did not follow through with letting people know I would call them, I reminded the colleague, but avoided contacting people without them knowing first to expect a call. Several colleagues offered to generate incentives to get someone they worked with to get participants, and I declined this avenue of contact. My intent was to add no further pressure onto nurses than already existed in their work and personal lives, and to only call if someone was apparently agreeable. I assumed that by not pressuring participants, I was more likely to solicit participants interested in the topic.

Eleven (11) of the 104 potential participants did not call back after messages were left for them about the study. After confirming with my colleague that they had told the person of my intent to call, I called one additional time. After receiving no response, I ceased contact. Three referrals agreed to participate, but cancelled twice and were left messages that they could recontact me if they were available, and no further contact was attempted. Three referrals declined to participate indicating they had concerns they may get in trouble because of HIPAA violations.

When participants met inclusion criteria and were agreeable to meet and allow me to record an interview with them, we agreed on a mutual time and a location of their preference. I suggested participants make the meeting place convenient for themselves and in most cases; the interviews took place in coffee shops as noted in the section describing the interviews. There was no remuneration for their participation except that I agreed to buy whatever beverage or food item they desired during the interview and also
encouraged the convenience of the participant with regard to time and location of the interview.

Institutional Review Board Approval and Ethical Considerations

The IRB at the University of Alabama at Birmingham approved the research study after submission of a proposal detailing the purpose and protocol for the study, and detailed information regarding protection of participants and respect for their well-being and understanding of the study and its risks. The components required for IRB approval are discussed next.

Informed Consent

Nurses who contacted me or that I contacted, upon referral from a colleague, were screened for inclusion criteria. The criteria included whether the nurses were registered nurses (RN’s), working full time, female, employed by one of the 57 hospitals identified in the inclusion criteria, whether they worked on a general medical-surgical unit, and their availability and willingness to participate in a one-two hour recorded interview. When the inclusion criteria were met, I explained study details including my purpose for doing the study, and how I planned to use the data for analysis and result reporting. Potential participants were given an opportunity to ask and have their questions answered. If the participant was still interested, an interview time was arranged at a location such as a coffee shop, which they were encouraged to select for their convenience and comfort.
On the day of the interview, the participant and I met at the coffee shop or similar location they selected. I arrived at the interview first and informed participants where I would be sitting, what I was wearing, and any identifying information about my appearance that might facilitate them easily finding me. Usually, the participant also shared identifying information about themselves such that I was able to greet them at the door and accompany them to the ordering counter allowing time to chat while they selected a beverage and food item from the coffee shop or other meeting location. After we were seated, I went over the study purpose again, discussed how I planned to use the results, gave participants a chance to ask questions, and addressed their questions. Participants were invited to ask any questions regarding me, my background, my educational program of study, personal or professional qualifications, or anything about the study itself. I went over the benefits and risks of participation, as is discussed next.

**Risks and Benefits of Participation**

Participants were informed of the possible risks and benefit of participating in the study as part of the informed consent process. The potential risk to their well-being was described as mainly being related to personal disclosure of information about their jobs or sometimes about their personal lives. I explained that discussion could elicit comfortable or uncomfortable feelings, and even bring up things about their job they may not have considered in the way they were being asked to discuss it during the interview. Participants were advised that talking and reflecting about their jobs might be a positive, negative, or a neutral event for them.
Asking participants’ to discuss intimate details about their working life required extra attention to research ethics, especially privacy, confidentiality, sensitivity to feelings, reactions, and level of comfort about the study. Because the participants were nurses, an occupation known to be intimately tied to their identity (Davies 1995; Fagermoen 1997; Hallam 2000), it was important to be sensitive to any undesirable effects of participating in interviews about caring in their work. The intimate nature of these data had the potential to result in the participant saying more about their work situations than they might ordinarily share. I was careful to reaffirm my commitment to protecting the sensitive nature of their disclosures to minimize the possibility of regretful disclosure (Lewis 2003: 68). When participants appeared uncomfortable or became emotional, I paused, asked if they needed to stop or take a break, and reminded them they did not have to discuss anything they did not wish to divulge.

Protecting Participants from Harm

Before beginning interviews, participants were informed of the possibility that private and personal information disclosed during interviews could be regretted afterwards (Lewis 2003: 68). A relaxed and casual interview, in particular can lead participants to share more than they expected to share (Lewis 2003). While talking, participants sometimes surprise themselves about having been unaware that some aspect of their life had been present in their thoughts and feelings. My experience as a board-certified psychiatric mental health nurse aided my ability to discern behaviors suggesting discomfort and to explore this with participants. Offering periodic summaries of interview content, reassurances of confidentiality, and showing concern for the
participants comfort were helpful in creating a comfortable environment for participants (Mack et al. 2005). Participants were assured that any concerns arising about their specific disclosures would be discussed and remedied to their satisfaction, including the option of withdrawing their interview data from the study.

An added concern related to disclosing highly personal information was that participants’ emotions and memories of former events might be triggered and result in unsettling feelings or thoughts about these events or their work environment (Marvasti 2004). Therefore, participants were advised of this when the study was being explained, as previously noted. A list of available counseling resources was available if needed. As an experienced psychiatric mental health nurse, this kind of concern was easily detected, enabling me to provide a supportive experience during emotional moments in the interview. During participant disclosures, I acknowledged my responsibility to respect the participants’ needs and wishes, and honor their privacy and anonymity.

Assuring privacy, anonymity and confidentiality. Safeguards for the privacy and anonymity of participants were provided by: (1) a private office space away from the participant’s work setting, (2) a pseudonym chosen by the participant at the time of the interview and by which the participant is referred to in data collection, analysis, and results, (3) a secure locked location at my private home office for informed consent forms with actual participant names, (4) a secure locked location at my private home office for linking actual participant names on the consent form to the data, (5) nondisclosure of the codebook or pseudonyms of participants except as required by the Institutional Review Board for purposes of compliance or monitoring mandates, (6) not discussing interview
data outside of the dissertation committee, (7) nondisclosure of whether someone had participated in the study, (8) a password protected digitalized recording of interviews maintained in a locked location at my home except when listened to for data analysis or transcription purposes, and (9) doing transcriptions rather than using an external person to the study.

Participants were also informed of how I would keep their recorded and transcribed data anonymous and confidential, including using their selected pseudonym in all references to their interview. With regard to privacy in the coffee shop or similar site, I acknowledged it was not entirely private. To maximize privacy, we sat away from others. Participants were asked to indicate any discomfort they began to feel related to encroachment of space by others in the shop. I also monitored their nonverbal behavior for fidgeting, silence, and distractibility. I indicated I would be remaining alert to whether anyone appeared to be trying to listen to us or showed interest in our presence, and only once did this become an issue when a homeless gentleman came and stood beside us; however, he left when we stopped talking. Participants were also reminded they were free to end the interview at any time without any explanation.

Participants were informed about the potential risk of someone else reading or hearing a presentation of the results, and possibly thinking the information sounded like someone they knew. I reminded participants that all data were de-identified, except by their selected pseudonym and that the possible hospitals from which participants could be employed were within a 100 mile radius of Birmingham, Alabama. In the next section, I will review the procedures for assuring that participants understood the risks and benefits of the study, as well as their right to withdraw consent, and how to do so.
The right to withdraw consent. Participants were informed that their participation was completely voluntary, would not be disclosed to anyone, including their employer, and that they would be able to withdraw their consent at any time before the study is officially completed with the Institutional Review Board of the University of Alabama at Birmingham. Participants were provided numbers on their copy of the consent form, including the Institutional review Board, and my email, and private phone numbers. Included in this information was that participants did not need to provide a reason for withdrawing, and there would be no consequences to them for withdrawing consent. An example of second thoughts about their interview was provided as lingering hesitation about what they said in the interviews and wishing they had not shared the information, or not wanting it to be included in the study. While one participant called back several times concerned about talking badly about their employer, her concerns were allayed and she remained in the study. Thus, there were no participants requesting to withdraw consent from the study.

The Interview Environment and Context: Setting the Atmosphere and Stage for the Interview.

The interviews were primarily conducted in coffee shops during the middle of the day while other people were also present presumably for social or business reasons. With two exceptions\(^\text{17}\), the interviews all occurred at a coffee shop. I was able to go early and obtain the table that was most isolated from the crowd so that the surroundings for our interviews were public, yet somewhat private.

\(^\text{17}\) One interview was conducted at a McDonald’s so the participant could bring her children and a relative to watch the kids while she interviewed. Another participant wanted to meet at a bookstore.
Taking Time to Reiterate the Informed Consent, Benefits, Risks, and Assurances of Confidentiality

In addition to explaining the study over the phone at the time of first contact and screening, I reviewed the purpose of the research as examining how nurses show caring. I explained the concept of emotional labor to participants, thereby setting the tone for implying a relationship between emotion and caring. I stated a possible benefit to the participant of this research was the opportunity to discuss things about their work life that they may ordinarily lack opportunity to share. I also explained that study results would be published and could potentially influence nursing leaders’ views about what it is like for nurses to care in the present-day health environment.

The risks related to being in a non-private location for the interview were reiterated. The possibility of having emotions elicited during the interview was also restated. The possibility of developing a new awareness about their work which may result in them thinking differently in a positive or a negative way was reviewed. I also mentioned they might be inclined to share more than they wished because of the relaxed nature of the interview and how they could contact me should they have second thoughts or be bothered or uncertain about their disclosure.

I discussed their selection of a pseudonym and my plan to keep consent forms separate from their interview data. I informed participants that I would also remove any identifying information they suggested or that I thought may identify their place of employment. For example, references to a religious mission-statement, which was commonly advertised on local television, were removed. The same titles were used for employees in referencing any of the 57 hospitals as opposed to using hospital-specific
titles that could identify the hospital’s identity. I also reviewed how I would protect their recorded interview by erasing their recording at the conclusion of the study. Participants were given the opportunity to ask questions, to clarify anything stated, and to request further information to facilitate their feeling more comfortable. This part of the process was done over a minimum of ten to fifteen minutes with an emphasis on going into details about how I respected their privacy, rights, and concerns. Interviews with participants began after informed consent was obtained, including permission to record and transcribe their interviews. The recordings were made digitally and stored on a memory card that was password protected and kept in a secure location at my home office. The interviews are discussed next.

*Developing Rapport and Establishing a Common Bond during Interviews*

I began the interviews by talking about myself as a nurse, why I was doing the study and how I became interested in medical sociology, thereby setting the context for revealing that I saw the sociological perspective as important for understanding problems affecting nursing. I allowed the conversation to be casual before beginning the first research question, making the interview more conversational in style, as is often the case with semi-structured interviews (Mack et al. 2005: 20). The participant and I often exchanged stories from nursing school or work with each other, both positive and negative, setting the stage for inviting either positive or negative experiences in the interview. I was careful to ascertain before beginning the interview as to any time

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18 Having been a nurse and also having validated through the interviews with participants that nurses frequently find themselves having to take shortcuts in their work which left them feeling uneasy, I wanted to be sure to convey I was committed to not doing that very thing with my procedures to protect them.
limitations. If these existed, one of us set an alarm to ensure any deadlines such as picking up children, getting to an appointment and the like, were remembered.

The Interview Questions

Once the informed consent and permission to record the interviews was obtained, I began the interview by turning on the recording and giving an overview of the interview questions. By giving the participant an overall schema of the kinds of questions I would be asking, this potentially allayed any anxieties about surprise questions; it also allowed participants to speak more flexibly about the topic of caring without having to worry about the order of questions or whether they were addressing something I needed to ask them.

Once I provided an overview, I restated the initial question, suggesting it as a starting point; this question was stated as a broad open-ended request for information about caring: “Tell me about caring in your work”. Participants were told they could start there and address whatever they felt was important. I indicated I would ask questions when I needed to clarify or steer them toward an unanswered question, but they otherwise could speak freely in any order, about any aspect of caring they saw as important. The other interview questions that were addressed included asking participants to describe what they had been taught about the importance of caring in nursing work, whether they viewed caring as a characteristic that could be taught, whether they saw themselves as caring, how they viewed caring in their work and how caring related to patient satisfaction. Participants were also asked how they believed they acquired caring skills and whether there were features of their work environment that interfered with or
enhanced their ability to demonstrate caring. If interference was named, further exploration of how participants coped with this interference was sought. Prompts were provided if a spontaneous response did not occur or if the participant requested examples. Lastly, participants were asked if their hospital provided training or had specific expectations regarding the demonstration of caring and how it pertained to patient satisfaction initiatives within their hospital.

Interviews concluded under the following conditions: (a) when the participant indicated they had said everything they could think of to say, (b) when all the questions had been addressed, (c) when their stated time limits had been met, or (d) when the participant had moved more toward a reflective state of thinking about what they had said. I usually asked, whenever one of these conditions existed, if the participant felt like they had covered everything they wanted to say. The one to two hour time frame was typical. I also stopped at one hour to check as to their willingness to continue talking, and to see if they needed anything, including a break.

At the conclusion of the interview, I restated the main points from the participants’ interview and verified whether any inaccuracies or misunderstandings were present. I thanked the participants for their time, reminded them of how their interview would be helpful, and reminded them of the contact numbers should they have follow-up questions, concerns, or complaints. I usually offered a final refreshment prior to their leaving and there was usually some post interview social talk as we both exited the place of the interview.
Transcription and Safe-Keeping of Interview Data

Immediately after the interview, I made field notes about the interview, how it went, lingering thoughts and impressions, and observations thought to be possibly relevant. Within twenty-four hours of each interview, I reviewed the digital recording by listening to it in its entirety. I made notes of any hard to hear or awkward parts of the interview. Once I was satisfied the interview was adequately recorded, I transcribed each interview verbatim, a process which took five to six hours for each one hour of interview recorded. The interviews were clear which made the process go more smoothly than I have experienced with taped as opposed to digital recordings.

After completing the transcription, I read the interview transcripts through to the end noting any areas that seemed problematic. I then listened to the entire interview again and read along on the transcript, stopping to make corrections if necessary. Once the interview transcription was completed, actual names were replaced with the participant’s pseudonym and the date, location and duration of the interview. Typed and transcribed interviews were placed with the demographic data sheet. In the next section, I will discuss the strategy used for data analysis.

\[\text{19} \] The consent form was locked separately in a file cabinet at my home office. On a single sheet locked in a file cabinet, separate from the consent forms, I had a list with the participants’ pseudonyms and their actual name. This was the only place and only way to link the participants name to the transcribed interview.
Analytic Strategy

Themed Category Analysis of Interview Data

The main way interview data are analyzed is through repeated listening to the recordings of each participant interview (O’Connel and Kowall 2008; Marvasti 2004). After having listened fully to each transcript, the goal of qualitative research analysis is to reduce the data into their most meaningful units (Marvasti 2004). Most qualitative researchers use coding strategies to analyze their data; although, there is much variation among researchers as to the specific procedure and degree of adherence to pre-defined rules for approaching the data. Charmaz (2006) uses a constructionist perspective to reveal how the data represents something about social interaction (Marvasti 2004). Since this study stems from theoretical underpinnings related to an interactionist perspective, Charmaz’s focus on interactional processes was followed in asking questions about the data such as looking for actions and social processes.

Charmaz (2006) is known for her grounded theory research and her own approach to constructing theory from research data emerging from social processes. While this study did not follow grounded theory principles, Charmaz’s mechanism for coding data was applied in generating the themes for this study. The first step is coding the data was to find what Blumer referred to as sensitizing concepts (Blumer 1969); these are a working tool to aid in analysis that begins to highlight certain theoretical concepts to acts as signposts in the linking of data into coherent themes. Charmaz suggests grasping the sensitizing concepts by asking what and how the concept helps to illuminate the data (Charmaz 2002: 684).
Keeping these sensitizing concepts in mind as possibly important to this data, *initial coding* (first level of coding), was approached, as suggested by Charmaz (2002) by quickly reviewing the interview data for themes. Marvasti (2004) notes this first level of coding to be somewhat like *free association* (Freud 2005 [1941]) in that whatever comes to mind while reading the data becomes part of the initial coding strategy. Thus, in my initial coding of interview data, I sought themes about what the data was communicating about caring. I read each interview for these conceptual coding categories. This was followed by (in-depth coding) focused coding.

I went through each interview to identify themed codes that could be grouped together to explain yet larger parts of the data while retaining its significance for the original coding. Once the themes were identified, I listed the themes and checked them against each interview transcript. In the even that data did not fit the identified theme, it was reconsidered by returning to the data to verify the fit of other data (Clark 2008: 308). Had this been a grounded theory study, this process would have continued until consistency was established. In this case, repeated efforts to rectify themes were made, but exceptions were noted if persistent.

I also discussed themes with an expert colleague to verify accuracy or a need to examine the data and themes. A single description was given to all passages in a coded category (Table 5.1 of the next chapter). I will now discuss the ways I attempted to increase the validity and reliability of the data collection and analysis process.
Strategies for Addressing Reliability and Validity in Data Collection

The terms reliability and validity were defined and generated for quantitative research methods. Marvasti (2004: 11-12) says that efforts at establishing rigor in qualitative research should be directed toward conceptual clarity rather than technical precision. According to Marvasti, the theoretical underpinnings of the research should be examined to see if it is consistent with the questions asked in interviews and the data analysis (Marvasti 2004: 31-32). Thus, theoretical consistency for symbolic interactionism should ask interview questions pertaining to how the participant defines the concept under study, and the conditions under which these meanings were generated.

Tracy (2010) suggests that qualitative research is best evaluated by the following criteria: (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence. These criteria depend on the transparency of the researcher’s decisions, consistency, and demonstrated ethics. Data analysis should address how knowledge was jointly produced between the researcher and participant (Marvasti 2004). Using the participants’ exact words offers assurances that the researcher is not speaking for the participant. This kind of transparency in research calls for reflexivity on the part of the researcher and minimization of researcher biases, as discussed next.

Researcher Reflexivity

Reflexivity of the researcher means the researcher is an active participant in the research process. While the researcher may have a list of questions to ask, they must be
able to modify plans based on the processes and answers that emerge as the participant and researcher interact (Marvasti 2004). Rather than being unplanned and impulsive, this reflexiveness allows the researcher to be part of the participant’s world. Paying close attention to the participants’ words, gestures, intonation, topics discussed and avoided, are all an important part of being actively present and responsive to the participant during the interview.

Accountability for one’s part in the research process requires self-reflection on the part of the researcher. This is done in a variety of ways by qualitative researchers. Sometimes it is referred to as transparency to reflect the making the role the researcher played in the production of knowledge as clear as possible so that others can decide whether bias was present or hidden (Seale 1999; Finlay 2002). My strategy for addressing bias is discussed below.

Minimizing Researcher Bias

The interview process and the content of the answers necessarily yielded subjective experiences or observations that provided the data for this study. This was as intentional as was the intention to analyze this subjective data with a respectful representation of the participants’ voice. The procedure I followed in order to maintain an unbiased view of the participant’s voice is as follows below.

The first thing I did was to keep a detailed account of my own feelings and thoughts about the research topic in a notebook. I wrote extensively about the topic as an exercise in putting my personal biases to the side. Some researchers call this *bracketing* or *empathic neutrality* (Gibbs 2008: 93) and it is commonly done in other qualitative
studies, especially phenomenological studies. These terms convey the researchers’ commitment to examining how their own personal experience could affect the analysis and conclusions of collected data. I also talked to colleagues about my thoughts and feelings regarding the study, and asked for feedback about areas of apparent bias, especially where I was unable to support my thinking with available evidence in the current literature. I generated a list of these biases and areas of vulnerability so as to heighten my awareness throughout the research process. After each interview, I recorded field notes with a summary statement of my thoughts about the interview and my impression of the participant’s overall message. Throughout the analysis of recorded interviews, I consulted my field notes, bracketing information, and list of vulnerable areas, and asked myself a list of self-generated questions as noted in Table 4.1
Table 4.1 List of Personal Reflection Questions to ask During Data Analysis

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Is what I am hearing in this interview the participant’s voice or my bias about (whatever relevant bias fit the transcript)</td>
</tr>
<tr>
<td>(2) What is my motivation for being drawn to this particular passage in the participant’s voice?</td>
</tr>
<tr>
<td>(3) What things about myself do I know that may have influenced the interview process and content of what was said by the interviewee?</td>
</tr>
<tr>
<td>(4) What things did I say in the interview that may have influenced what the participant said?</td>
</tr>
<tr>
<td>(5) What opinions did I cultivate about the participant during or after the interview that may have influenced my perception of their messages and meanings?</td>
</tr>
<tr>
<td>(6) What might someone listening in on the conversation have thought about the interview between me and the participant?</td>
</tr>
</tbody>
</table>

Other methodological procedures for making the research transparent. Another way the research was made trustworthy is that live recorded interviews were done rather than relying on recall. The recording was listened to a minimum of three full times: after the interview, during transcription, and in checking the data against the transcript. By doing my own transcription, I was able to become very familiar with the interview from the frequent relistening to passages and to the entirety of the transcript.

Face-to-face communication allowed clarification in the moment of any miscommunications that arose. At the conclusion of each interview, a summary statement repeated back to the participant allowed for correction of any errors or misunderstandings. The data for this study are theoretically available for independent
reviewers to examine directly (should an appropriate reason for doing so arise) (Miller and Brewer 2003: 50-51); however, such an occurrence would only arise in the event of some question raised to the IRB regarding this particular research as the data itself are protected.

Generalizability

Qualitative studies do not usually seek to generalize beyond the data to the larger population of interest. The inclusion of more than one setting and making the number of settings as representative as possible was aimed toward improving the likelihood that similar results might be obtained using similar samples. As repeat studies on a particular subject accumulate, a qualitative study can become a basis for comparative analysis among similar studies (Denzin and Lincoln 2005; Flick 2009; Marvasti 2004).

Summary of Methods Chapter

This chapter has provided an overview of the participants sought for this study, the procedures applied to ensure transparency of the research process, the way in which respect for participants was demonstrated, the acknowledgment of accepted principles of research ethics and the intended procedure for analyzing the data. In the next chapter, the results of participant data analysis are presented.
CHAPTER FIVE
RESULTS

Chapter Overview

These results are derived from analysis of twenty-seven (27) semi-structured interviews with registered nurses working mostly day-time shifts on medical surgical hospital units within a 100-mile radius of Birmingham, Alabama. The interviews were conducted for the purpose of exploring nurses’ experiences of the emotional labor of caring in order to: (1) define how nurse participants viewed caring in their current work environments, (2) determine nurse participants’ perceptions of the origins of caring for a nurse, (3) gain understanding of nurse participants’ perception of barriers and facilitators to the emotional labor of caring, (4) examine strategies used by nurses to show caring despite these barriers, (5) consider nurse participants perceptions of caring by male nurses, and (6) identify themes in the interviews from nurse participants’ experience of caring.

Demographic data were also collected on participants including: kind of hospital where the participant worked, chronological age, years of nursing experience, marital and family status, and type of educational preparation. Field notes of relevant auto-biographical data from my experiences in doing the research were also kept.

The results are presented in three sections. The first section provides a summary of participants screened and an overall description of the final sample. Section two
reveals four main themes from the nurses’ interviews on caring. The third section identifies the organizational constraints and facilitators of caring, as reported by nurse participants. The fourth section reveals how nurses used emotional labor to manage interference with caring. The results of screening from recruitment efforts and the final sample of twenty-seven nurses are presented first.

SECTION ONE: RESULTS OF PARTICIPANT SCREENING AND FINAL SAMPLE

Participants Not Meeting Screening Criteria

The results of screening are presented in Table 5.1 below. The number of potential participants screened and not included in the study was fifty-six: twenty-nine of these fifty-six referrals had never worked medical-surgical units; an additional six had worked in medical-surgical units in years past, but were presently working in home health nursing; three worked in medical nursing units, but had just completed nurse practitioner programs and were no longer working as staff nurses; four worked in medical-surgical units in a pediatric hospital setting; three were employed part-time or exclusively for night-shift; three had staff nursing jobs that were more managerial in nature; two were on extended family or medical leave; and one had been retired more than one year. Despite the request for female participants, five males were also referred.
Table 5.1 Screening Results

<table>
<thead>
<tr>
<th>Potential participants screened who did not meet inclusion criteria but worked in a hospital</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-medical-surgical unit</td>
<td>29</td>
</tr>
<tr>
<td>Non-staff nursing position in hospital</td>
<td>3</td>
</tr>
<tr>
<td>Employed in pediatric setting</td>
<td>4</td>
</tr>
<tr>
<td>Part-time or only 11pm-7am shift</td>
<td>3</td>
</tr>
<tr>
<td>Male nurse</td>
<td>5</td>
</tr>
<tr>
<td>More managerial type position</td>
<td>3</td>
</tr>
<tr>
<td>Out on extended leave (family reasons)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total # hospital-based potential participants not meeting inclusion criteria:</strong></td>
<td>49</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential participants not meeting inclusion criteria and not working in a hospital</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-hospital employment</td>
<td>6</td>
</tr>
<tr>
<td>Retired (for 2+ years)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total participants not meeting inclusion criteria</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of participants directly or indirectly declining</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response to calls or emails</td>
<td>12</td>
</tr>
<tr>
<td>Fear of being identified</td>
<td>1</td>
</tr>
<tr>
<td>Concerned about HIPAA violations</td>
<td>3</td>
</tr>
<tr>
<td>Cancelled &gt;3 scheduled interviews</td>
<td>3</td>
</tr>
<tr>
<td>Agreed to participate but did not follow up</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total participants directly or indirectly declining</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of participants from recruitment between January 2015-October 2015</th>
<th>27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of potential participants from referrals by a participant</td>
<td>2</td>
</tr>
<tr>
<td>Total number of potential participant contacts from professional colleagues</td>
<td>103</td>
</tr>
<tr>
<td><strong>Number of participants screened</strong></td>
<td><strong>105</strong></td>
</tr>
</tbody>
</table>
Participants Declining to Participate

Twenty-two potential participants were contacted and either directly or indirectly declined participation by lack of follow-through. Of these twenty-two, one potential participant expressed concern about her manager finding out about her participation. I was unsuccessful allaying her concerns and her participation was not pursued. Three potential participants expressed concerns about getting in trouble because of HIPPA violations\(^\text{20}\). Each of these potential participants indicated they had understood from their hospital training that participating in research outside of their hospital could be violating the Health Insurance Patient Portability Act (HIPPA). I was unable to allay their concerns by assuring them they would not be asked about patients and any general comments about providing patient care were confidential and anonymous (OCR HIPPA Privacy 2013[2002]). An additional twelve potential participants did not respond to messages or emails left on two separate occasions; these participants were not re-contacted once I ascertained they had been made aware to anticipate my call by the nursing colleague known to me and the participant. A total of twenty-seven potential participants agreed to participate in the study. These screening dispositions can be found in Table 5.1 above.

Final Sample of Study Participants

From January 2014 through October 2014, a total of twenty-seven participants completed interviews. Twenty-five of the final participants agreed to participate as a result of contact through a mutual colleague. Two additional participants were recruited from my presence at a hospital-based staff meeting for nurses. One participant was referred by another participant who had completed an interview. This is presented in Table 5.1 above.

As previously stated, the final sample for this study were twenty-seven full-time registered nurses working mostly day time hours on medical-surgical units of hospitals within a 100 mile radius of Birmingham, Alabama. The employing hospitals ranged from those with strong religious orientations, to private, for-profit hospitals, hospitals affiliated with medical centers, hospitals affiliated with educational institutions, and a rural community-based hospital. The greatest number of participants (n=13) worked in educational affiliated hospitals. All of the nurses held either Associates (ADN) or Bachelor’s Degrees in Nursing (BSN), and one was completing a Masters Degrees (MSN). Four participants were completing the masters’ portion of their Accelerated Masters in Nursing (AMN) programs for second-degree students. Table 5.2 below presents an overview of the demographics for study participants and are detailed in the section that follows.

---

21 Of the twenty-five who agreed to participate, twelve of them indicated they would not have participated if the interviews had been at their worksite.
Table 5.2 Demographic Characteristics of Nurse Participants

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Percentage/Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>10/27 = 37%</td>
</tr>
<tr>
<td>31-40</td>
<td>12/27 = 45%</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
</tr>
<tr>
<td>51-60</td>
<td>3 5/27 = 18%</td>
</tr>
<tr>
<td>61-70</td>
<td>1</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>21/27 = 77.8%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2/27 = 7.4%</td>
</tr>
<tr>
<td>African American</td>
<td>4/27 = 14.8%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>27/27 = 100%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>ADN</td>
<td>7/27 = 25.9%</td>
</tr>
<tr>
<td>BSN</td>
<td>15/27 = 55.6%</td>
</tr>
<tr>
<td>MSN</td>
<td>1/27 = 3.7%</td>
</tr>
<tr>
<td>AMN</td>
<td>4/27 = 14.8%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>11/27 = 40.8%</td>
</tr>
<tr>
<td>Married</td>
<td>14/27 = 51.8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1/27 = 3.7%</td>
</tr>
<tr>
<td>Widowed</td>
<td>0/27 = 0%</td>
</tr>
<tr>
<td>Partnered</td>
<td>1/27 = 3.7%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------</td>
</tr>
</tbody>
</table>

Sample Demographics

*Employment.* All of the twenty-seven participants worked 12-hour shifts\(^{22}\) in medical-surgical units in hospitals\(^{23}\). Most 12-hour shift positions required 36 hours per

\(^{22}\) Two participants worked shifts less 12-hours duration; both were over the age of fifty (50) and had made arrangements with their managers to work more flexibly

\(^{23}\) One of these 24 participants, one was working out a resignation notice before starting a new job in home health nursing. Three participants had recently left their jobs on medical-surgical units; one had been
week for full-time status; however two nurses worked weekend-only jobs which required 24 hours per week for full-time status at the nurses’ hospitals. Thus, all participants were full-time employees, though the actual hours they worked varied from 24-40 hours per week. All of the 12-hour shifts were 6:30 AM-7:00 PM. Nurses rotating to another shift usually worked 4 hours during the late evening or sometimes had to work a full 12 hour shift from 6:30 PM-7:00 AM.

Salaries. Nurses’ salaries ranged from greater than $30,000 to greater than $80,000 when considering their salary alone. Of the fourteen nurses with working spouses or in-home dependents contributing to the family income, six were the main source of income for their family. The highest salary reported was a nurse with 36 years of experience who had begun working night shift, which earns the nurse a shift-differential, which varies by hospital.

Marital status. Fourteen of the participants were married, one was recently divorced, eleven participants reported being single (two of these ten were engaged to be married within the year), and one was living with a life-partner. None of the participants were currently pregnant or undergoing adoption proceedings. Eight participants had children under the age of 18, and at home with them. One participant had an adult child still residing in their home and one of the participants who had a chronic disease with frequent flare-ups lived with her parents. Three participants currently had disabled or chronically ill parents, spouses or siblings living with them, and for whom the participant terminated from their position since the time of our initial contact, and was looking for another medical-surgical staff nursing job; the other two of these three participants had started case management positions.
was primary caregiver. An additional three participants had been primary caregivers during the past several years for now deceased family members (See Table 5.3 below).

Table 5.3 Marital Status of Participants at Time of Interviews

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>11/27</td>
<td>40.8%</td>
</tr>
<tr>
<td>Married</td>
<td>14/27</td>
<td>51.8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1/27</td>
<td>3.7%</td>
</tr>
<tr>
<td>Widowed</td>
<td>0/27</td>
<td>0%</td>
</tr>
<tr>
<td>Partnered</td>
<td>1/27</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Gender. Being female was an inclusion requirement for the study. All 27 participants reported their gender as female.

Education. Fifteen participants had graduated from baccalaureate nursing programs (BSN)\(^\text{24}\). Four participants reported BSN degrees, but were actually completing on-line coursework or clinical practicums for accelerated masters in nursing programs (AMN)\(^\text{25}\); thus, they were counted as AMN degrees since a BSN is not usually awarded, but they do take nursing licensure exams allowing them to work while finishing their masters’ degree coursework. Each of these four AMN degree nurses expected to graduate within four to eight months from the time of their interviews, at which time they would

\(^{24}\) Participants reporting having first received an associates degree or diploma in nursing were counted as baccalaureate graduates if they had since completed this degree.

\(^{25}\) Accelerated masters programs and similar names are fast-track opportunities to advance students through nursing fairly quickly when they already have baccalaureate degrees in another field. See (for example) Cangelosi, Pamela and Karen J. Whitt. 2005. "Accelerated Nursing Programs What Do We Know?" Nursing Education Perspectives 26 (2): 113-116.
be eligible to take nurse practitioner exams. In addition, one BSN graduate was also beginning a two-year master’s program (MSN) in nursing. Seven participants graduated from associate degree programs; one of these was enrolled in a BSN program (see Table 5.4 below).

<table>
<thead>
<tr>
<th>Education</th>
<th>ADN</th>
<th>7/27 = 25.9 %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BSN</td>
<td>15/27 = 55.6 %</td>
</tr>
<tr>
<td></td>
<td>MSN</td>
<td>1/27 = 3.7 %</td>
</tr>
<tr>
<td></td>
<td>AMN</td>
<td>4/27 = 14.8 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

**Age.** Participants ranged in age from 23-62 years, with a mean age of 34 years, and a median age of 31 years. The greatest number of participants was the 20-40 age range; ten of these were between 20-30 years old; twelve of the participants were between 31-40 years old; only one participant was in the 40-50 age range; five were greater than forty years of age (See Table 5.5 below).
Table 5.5 Ages of Participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>10/27</td>
<td>37%</td>
</tr>
<tr>
<td>31-40</td>
<td>12/27</td>
<td>45%</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>3</td>
<td>18%</td>
</tr>
<tr>
<td>61-70</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

\[ X = 34 \]
\[ Mdn = 31 \]

Race and ethnicity. Twenty-one participants reported their race/ethnicity as Caucasian-White, two as multi-racial, and four as African-American (See Table 5.6 below)

Table 5.6 Racial Ethic Reporting Status of Participants

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>21/27</td>
<td>77.8%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2/27</td>
<td>7.4%</td>
</tr>
<tr>
<td>African-American</td>
<td>4/27</td>
<td>14.8%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

In the next section, the nurses’ perspectives on caring and how they show it are discussed by the main themes emerging in the analysis of interview data.
In this section, I address how nurses defined caring, which includes examples from their work. First I provide participants’ interview excerpts that support four themes that emerged from the data: (1) natural caring, caring as part of self-identity, (2) accelerated caring, caring despite busyness, (3) flexible caring, caring that adjusts to the person and situation, and (4) institutional caring, caring defined by others. Integrated into these themes is how nurses addressed male and female differences in caring, their beliefs about the innate and learned origins of caring for nurses, the barriers and facilitators to their caring, and the emotional labor strategies they use to display or manage interference with caring. These themes are illustrated below in Figure 5.1.

**Figure 5.1 Four Main Themes from Nurses interviews on Caring**

As noted in the methods section of this manuscript, themes were derived from coding of the individual interviews. Each of the twenty-seven interviews was coded and these codes were synthesized into subthemes which were eventually subsumed under the four main themes identified above and in Figure 5.1.
In this section of the results, excerpts from participant interviews will be provided. These will be reported under the four main themes. I will separate the quoted material by the subthemes associated with each theme in order to facilitate transparency in how the themes were derived. Some of the codes applied to excerpted materials will also be named. Obviously all of the individual codes will not be included, but hopefully, enough are present to give coherence to the strategy used in deriving subthemes and themes. I will begin with natural caring and the four subthemes associated with this first theme, which are illustrated in Figure 5.2 below.

**Figure 5.2 Subthemes for Natural Caring, Caring as Part of Self-identity**

<table>
<thead>
<tr>
<th>Subtheme One</th>
<th>Subtheme Two</th>
<th>Subtheme Three</th>
<th>Subtheme Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring as an inherited trait</td>
<td>Caring as a learned trait</td>
<td>Caring as character</td>
<td>Caring as part of a social existence</td>
</tr>
</tbody>
</table>

**Theme One: Natural Caring, Caring as Part of Self-Identity**

*Overview of Theme One*

In this section, excerpts from nurse’s interviews are offered to support theme one: natural caring, caring as part of self-identity. The nurses’ interviews showed variation as to whether they thought caring was a learned or inherited trait, but they all agreed on one
thing; it was something a person either has or does not have. Many participants believed they were caring people from their birth; some said they had to learn how to express caring, but they believed caring was always present within them. Others thought anyone could become caring if they had caring role models or experiences with the suffering of others when they were growing up.

Alternatively, some nurse participants saw caring as a trait related to one’s propensity for being around others; they defined the quality of being drawn to people, enjoying learning about the lives of others, and hearing people’s stories as an indicative of their caring. Some of these nurses saw themselves as caring because they were natural talkers and could easily elicit conversation from others. Other participants saw caring as nothing more than good manners and common courtesy.

These responses were coded into four subthemes which were subsumed by the overarching theme of natural caring. The four subthemes as illustrated above in Figure 5.2 are: (1) caring as an inherited trait, (2) caring as something learned from life experiences, (3) caring as character, and (4) caring as a part of a social existence. Some of the participants’ statements supporting natural caring, caring as part of self-identity, will now be provided below, beginning with some of the interviews coded under the subtheme of caring as an inherited trait.

Theme One, Natural Caring; Subtheme One: Caring as an Inherited Trait

As alluded to previously, most participants believed caring was something a person either had or did not have. In particular, many nurses believed they had always
been caring, and that they likely were born that way. Thus, this subtheme of natural
caring includes excerpts from nurses’ interviews which support beliefs and views of
caring as a natural part of their identity as nurses. I will begin with a brief introduction
including some demographic facts about Katrina prior to providing quoted material from
her interview to support the theme of natural caring and its associated subtheme of caring
as an inherited trait.

I think I have always been caring. Katrina, RN, BSN is in her late forties, married,
has one teenage child living in their home, and has worked in a large academic medical
center for twenty years. Nursing is a second career for Katrina; her first career was in
business. Her husband is the main source of income in their family, and Katrina also
makes a significant financial contribution with her full time nursing work. Katrina left her
position as a medical surgical weekend nurse due to changes in leadership and
perceptions of unfairness; she was working in a case management position at the time of
the interview and looking for another full time staff nursing position in the same hospital.

Katrina shares her belief that she was always caring, even though she did not
know how to express caring before becoming a nurse.

I think I have always been caring; I don’t know that I have
always possessed that ability to convey caring as I do now.
I think it is because of my experiences in nursing that the
caring I already possessed was fostered. The experiences I
encountered brought it out of me.

As indicated in the demographic description for Katrina, nursing is her second career.
She spoke about how quickly she acclimated to changing careers from business to
nursing and remarked several times how she had never considered becoming a nurse until she was laid off from a business job and some of her coworkers suggested she go to nursing school.

While Katrina spoke confidently about her sensitivity to other people, she spoke as if slightly embarrassed when sharing her small indiscretion of receiving and keeping a gift from a patient.

*I still have my... very first present that was given to me by a patient – it was an angel (teary eyed). Just knowing that something I did made a difference for somebody – made a bad situation better... just knowing that when you are going through something that somebody cares that you are going through it.*

Katrina described her personality as driven, organized and compulsive about keeping things neat and orderly, making the significance of this gift greater in that she still had and still cherished this gift twenty years later. The next participant, Cabriole, also believed caring had always been part of her as a person.

*I've always cared.* Cabriole, RN, BSN is in her fifties, single, has no children, and has an adult sister and aging mother living with her, both of whom have chronic illnesses; one of them is disabled. Cabriole’s father also lived with them until the time of his death last year. Cabriole was her father’s primary caregiver up until his death. Cabriole has over thirty years’ experience in several different medical-surgical nursing units, mostly at the same hospital where she presently works. In Cabriole’s quotation below, she expresses strong feelings about caring and sees it as part of who she is as a person.
I’ve always cared. Oh yeah, I have always cared; I walked in the door caring. And I didn’t know anything...I mean, I really take to heart, ‘if you give a drink of water in my name, then you have done this unto me’, and I really take that seriously. And even if I am getting a dead body ready for the morgue, I find that to be a very spiritual thing...you know, a monumental thing has occurred, and this person has passed from this world to the next and their life was worth something. I take caring for the sick very seriously. I always did and I still do.

Cabriole spoke confidently, looking directly at me as she spoke these words about caring, leaving no doubt about her reverence for human life and the opportunity to be part of working with people who were sick. The next participant, Alice spoke about caring and nursing in a similar way, conveying that caring and working as a nurse was integral to her identity.

I’m a compassionate person. Alice RN, BSN is in her early twenties, is single and without dependents, works in a religious based nonprofit hospital, and has been a nurse for two and a half years. She has worked at her present job just over a year. She chose to work in an area that provided services to a lot of low-income patients. Alice sees herself as caring and makes the following observation about what she had hoped caring would be like when she became a nurse.

I guess caring and compassion kind of go hand in hand. That’s a lot of why I was interested in nursing’ I don’t know, ... I guess it’s just kind of part of who I am ... I mean it’s kind of what my job is, I think. I feel like it’s hard to separate nursing from caring...I think caring is partly why I became a nurse because I like to say I’m a compassionate person, in general...I guess. In my job, in my work, what I am trying to do is let the patients know that I really do care...
about them, that I want to love them, I guess, and make
them feel like they are someone and that they deserve care.

Much of Alice’s interview reflected the same uncertainty, indecision or confusion
that is present in this passage from her interview. She did not strike me as uncertain about
her beliefs, but she was hesitant about speaking negatively about her place of
employment. This is apparent below where she hesitated in answering questions about
whether there were things at her job that interfered with caring.

I guess it’s definitely different than I expected….yeah
different than I expected, maybe it’s hard to say exactly.
Um, I guess I imagined or envisioned having more time to
actually spend with the patient, to get to know them, to
maybe have more of a relationship I guess, with the. I don’t
know ...Now, since I am actually working, like anytime I’m
in someone’s room and I’m actually enjoying it, I am still
thinking the whole time of all the things I have to do...I am
making a list in my head but I want to really talk with my
patient...I feel sort of bad saying that, I mean I am not
saying it’s the hospital’s fault, like they don’t give enough
help because it’s a good hospital, but then I guess I am
saying that in a way cause it makes it really sort of hard,
maybe impossible to be able to have a relationship with
your patient. I don’t know, maybe.

Alice had an overall positive experience of her managers, coworkers, and nursing
school, but found the workload to be a barrier to caring. She said she felt bad saying that
and sometimes felt like it as her who just wasn’t good enough. This is similar to how
nurses in the literature reported seeing themselves as failures if they were unable to
sustain their caring with patients (Bone 2002; Scheid 2003; Weeks 2007). Another nurse
who believed she had always been caring was Susanna; she also enjoyed spending time
with patients as the favored part of her job.
True, true caring, you have to have a caring heart. Susanna, RN, BSN is in her twenties, is single, engaged, and has no dependents. She came to a large medical center for the opportunity to participate in an internship program prior to accepting a permanent patient care unit position. She has worked the same unit she selected two years ago.

... True, true caring, you have to have a caring heart, but I think you can have a caring presence if you are a good enough actor. I think I started out truly caring. I loved spending time with my patients, that’s more of what I enjoy about nursing. That’s why I picked this unit because the patients are not as sick and are recovering from surgery so there was more of an opportunity to interact with them.

Susanna said she saw a distinct shift in her feelings about caring shifting during the first year of her employment as a new nurse.

When I first started, my caring was like a natural energy; I would be like ‘Good Morning, I am gonna be taking care of you’. And then after a few months, at some point, it became like - I would stand outside and talk myself into going in the room with a smile. Then it became like, I don’t always even try to put on a face. I just try to walk in and be courteous and do my job...

Susanna started out getting a lot of positive feedback from patients and felt good about the caring she was able to display. She found this to be a rewarding aspect of her job that reaffirmed her career decision. Within that first year, Susanna began to understand that staying late was perceived by management as an indication of inefficiency.
I used to be a whole lot more caring in the beginning. I wasn’t as tired probably (giggle) and was more able to go above and beyond, but I was staying late (emphasis). I was supposed to leave at 7 and I might stay til 8 pretty much every night, finishing up charting. ... I was way more satisfied and the patients were more satisfied, and I liked that I was able to bring them some comfort, but I knew that I was also expected to leave on time and that me staying late was a cost to my unit, and it meant I wasn’t doing my job to the standard expected, so...

As the interview progressed toward the end, Susanna began to express sarcasm about being redirected from relating to patients to worrying about the financial well-being of the hospital. Throughout her interview, Susanna struggled with acknowledging limitations and barriers to caring. Her interview will be quoted from several times throughout this manuscript.

In this subtheme about caring being an inherited trait, participants’ had differing views about whether male nurses could have been born with a caring disposition. Most participants thought there were innate differences between males and females. Several of these participants who saw an innate difference between male and female caring will be highlighted before moving onto the next subtheme of natural caring.

_Men just naturally have fewer emotions._ Kelly, RN, ADN is in her late twenties, married, has two young children at home, and has been a nurse seven years. Kelly and her husband contribute approximately equally to their family income. Kelly worked in a hospital with a strong religious presence since graduating nursing school; she has since left this position for a case management job outside of the hospital. Kelly says she has always seen herself as having been a very caring nurse, and she knew some very caring
male nurses also. She acknowledged she had not had a lot of experience with male nurses, but she thought that men were naturally less caring, implying this was to be expected for a male. She did find exceptions, but generally thought male nurses were more task-focused and less emotion-focused in taking care of patients. This is consistent with the stereotyped views of male nurses (Paterson, Osborne, and Gregory 2005).

_I didn’t work with that many of them (male nurses) and I even trained one of them before I left, but I think...it’s just with any man in nursing, it’s like they have a job to do, but I think they just naturally have less emotions, and maybe some patients might interpret that as not compassionate or caring or something. I’ve seen some male nurses that are even more caring than female nurses and they do sit in there with some of the older ladies (loud laughter) and I mean some of those ladies were just tickled to death to have their young guy in there. There were some male nurses that were I think, ... lost in situations that would come up that required more of a caring response than some kind of medicine or technical skill. They would be like, ‘OH I don’t know how to handle that.’ ..._

While Kelly suggests overall that she thinks males may be less caring and emotional, she did acknowledge there were exceptions.

Another nurse also shared her thought that male nurses were quite different in showing caring. Sasha, RN, BSN is in her middle thirties, single, has no dependents, and is engaged to be married. Sasha has mostly worked in hospital settings since she graduated from nursing school fourteen years ago. She worked in a private, for-profit hospital for several years after graduating, and has spent most of her years working in an academic medical center on its hospital units. Sasha explored several other settings for a couple of years including clinics, diagnostic testing centers, home health, and hospice.
Sasha has been on her current unit one year, but has worked in very similar units at this facility in years past. She offers an example below of her observation that male and female nurses show caring very differently.

One is if a patient’s family member is really sick or they may be dying, you might have a male nurse, yeah he might be empathetic or he might sit up there and listen. Whereas if a woman is taking care of that patient and you’ve gotten close to that patient and the patient’s family member starts crying or getting upset, we might start, if we have been close, we might start exhibiting some tears. If a patient is dying, I think a woman is going to have been closer to them we might start to get close and we might start to exhibit tears; it’s just different, they are different, most definitely.

Cheryl also sees male and female nurses having innate differences. Cheryl, RN, ADN is in her fifties, and has worked as a medical-surgical nurse for thirty years. She is married, has adult children who live on their own, and she and her husband have been involved in the care of parents in recent years. Cheryl presently works full time, floating to any of several medical-surgical floors in a large hospital. She responds to my question about differences she perceives between caring exhibited by male and female nurses.

Definitely I think there is just a difference between men and women… You know, that’s why they are men and we are women. First of all, most male nurses don’t do med-surg to begin with. You know, they want something more acute like the emergency room or the intensive care units. Typically if you see them on a medical-surgical floor, they are either charge nurses or moving that way, but it doesn’t mean they aren’t caring—I know of one or two that are very very caring and really, really try to do right for the patient, I guess less emotional, but it doesn’t mean there aren’t women who aren’t unemotional…but they are just naturally different on the emotional side of it.
Perceiving the trait of caring as something one naturally has or does not have characterizes the collective sample of interview quotes in this subtheme of caring as an inherited trait. Some of the codes from this section included (a) being born caring, (b) I’ve always cared, (c) men just naturally have less emotion, (d) I am a compassionate person, (e) it’s something that you just have in you. While the participants focused mostly on having always been a caring person, they did not provide evidence of inheriting the trait of caring; however, the way these participants spoke about it reflected a clear belief that it was something they had from birth. The next subtheme of natural caring focuses on how experiences and education contributed to nurses learning to be caring.

*Theme One: Natural Caring [Caring as Part of Identity]; Subtheme Two: Caring as a Learned Trait.*

Most participants, including those who strongly believed they were born with the trait of being caring, also believed it was possible to learn to be more caring. Lacking an already present trait of caring, most participants thought learning to care was improbable. Few participants believed otherwise, although one participant acknowledged a very bad-tempered physician who became kind and humble after his wife went through a long illness with an unusual disease.

Several participants credited personal experiences, educational experiences, and significant role-models in their lives as having enhanced their caring ability. As participant Katrina said earlier, sometimes events can trigger and stimulate the caring that already resides within a person. In this subtheme, participants address learning
experiences affecting caring. Their quotes imply there usually needs to be a pre-existing trait onto which learning can be applied.

You couldn’t take the average Joe and teach them to be caring. Mary, RN, BSN is a married nurse with three children, who has worked mostly on one medical-surgical unit at the same hospital since graduating eleven years ago. During those eleven years, she left for two years to explore home health nursing. She felt it enriched her work with patients when she returned to the hospital on her same previously worked unit. She prides herself on being a multi-tasker and finding ways to remain connected to patients despite the busyness of patient care units.

I think a lot of caring is how you were raised and the mentality, whether it’s God given or in your soul; I don’t think it’s 100% taught- Of course, a lot of it is – some of it is, but I don’t think all of it is. I don’t think you could take the average Joe and say ‘this is how we want you to do patient care’. They most likely would not be able to do it. They’d be lost.

From her experience watching others Mary concludes nursing is not for everyone, nor can anyone just learn what is needed in a job that requires caring.

Mary also mentioned clinical instructors from nursing school who she remembered as being approachable and caring with students. These were memories that came to mind during difficult moments in work.

When we first started out in nursing school having clinicals with an instructor present, I was fortunate to have had a
clinician who was just awesome; nursing was in his heart; this is what he wanted to do and you could tell that. And I will never forget him saying ‘You are never above anything, just because you have that RN behind your name; you’re still able to go out there and wipe butts and change bedding and things like that. Don’t let that RN title behind your name get to you’.

Mary recalled instructors who brandished their professional titles in the absence of demonstrable skill. From her perspective, this lack of clinical experience with patients disqualified them as legitimate role models. While Mary felt positive about what she learned in school, her comments as to whether caring was taught in nursing school suggested minimal focus on caring.

To be honest I feel like school just kind of pushed so hard on the fundamentals of doing everything, more so than the caring. I don’t really remember it being a focus, maybe just assumed...Now I had some very caring clinical instructors that I still remember who taught me a lot about being caring, but they weren’t even regular instructors who worked at the school; they were just helping out because there were so many of us. I felt fortunate to have the ones who actually had worked in nursing and were still working in nursing.

Several of the nurses reflected on caring role models and said they thought about those role models years later whenever they experienced caring dilemmas.

I still remember things he taught me. Mabel, RN, BSN is single, in her thirties, has no children, and has worked on the same unit in an academic medical center since she graduated two years ago. She earns above $40,000 and is considering returning to school.
Mabel expressed similar feelings as the other participants did about encounters with caring clinical instructors in nursing school. She felt fortunate to have had the same instructor two terms in a row who taught her a lot about what it was really like to be a nurse; this contrasted sharply with teachers who accompanied them to clinical but were unable to teach from current real-life nursing experiences outside of the classroom setting.

*I feel like some of the best advice I got was nurses who actually worked. I had the same clinical instructor two terms in a row who was a nurse and we went to his unit and I feel like, there are still things that he taught me or taught us, that I remember—just because he was an actual nurse, like he did this everyday compared to those who taught it, just taught it. He just related to the patients in a down-to-earth and real way. I learned so much from him.*

*If you’re in your twenties and you don’t care about anything or anybody.* Shelia RN, AMN, graduated from the portion of her accelerated master’s program that allows her to work as a registered nurse while she is completing the masters’ portion of her program. She anticipated finishing her master’s degree and becoming a nurse practitioner within the next three months. Since finishing the basic nursing portion of her nursing program two years ago, Shelia has worked on the same unit. Shelia is married, has no children, and she and her husband, earn approximately equal incomes. She thinks a nurse always can improve on caring but that if it isn’t there by early adulthood, it is unlikely it can be acquired by learning.

*If you’re a new grad and you’re already in your 20’s and you don’t care about anybody or anything, it’s hard to teach somebody that. I think most people get into nursing*
because they care about something, you know - I don’t know many nurses who became a nurse, went to nursing school just because of the money …They may not all have come because they were especially caring people… But truly caring and caring about what you do, I don’t know that you can teach that. I think it’s kind of part of your personality, part of values, and part of how you were raised; there’s probably a million things that go into that and that we could talk about all day long but you can’t- it’s hard to teach someone to care.

*If you have suffered and hurt, you learn to be more compassionate.* Cabriole, whose interview excerpt was previously shared about her reverence in providing care to the sick, also thought it was hard to teach people to care.

*I think its gifts, you know that we are given and then it’s your upbringing and I think too, if you have hurt and suffered, then you really learn to be more compassionate… My father was very caring.*

Cabriole and others gave examples of students currently entering nursing who show no interest in learning about how to care for patients. She compares this to her own thirst for knowledge that continues today.

*A lot of these young nurses are on their phone, making plans for the weekend, talking about each other, and just show no interest in learning. I work circles around them, circles! I don’t expect them to know everything, they’re new, but I do expect them to want to know, at least to care, that they don’t know.*
In this subtheme about the learned aspects of caring, nurses talked about events and experiences in the work setting that interfere with learning caring. These barriers to learning were seen as especially detrimental to newer nurses seeking knowledge, role models and support. A learning barrier identified by experienced nurses was new nurses exhibiting comfort with their level of inexperience.

*It’s hard to learn anything when you don’t know what you’re doing.* Cheryl also shared thoughts about the newer nurses going straight into practitioner roles without gaining clinical expertise as staff nurses. In both of Cheryl’s examples, the concern focuses on a barrier to caring. Cheryl makes the point that the increased use of nurse practitioners, and especially the trend of encouraging new nurses into nurse practitioner programs has a trickle-down effect on what kind of learning environment is created for new nurses who are trying to learn to become technically proficient and how to be caring at the same time.

*It’s like these younger nurses just don’t know, I mean it really scares me and it scares me that we are spitting out all these nurse practitioners who have no hands on experience, and my boss just did a big eval that turned out that management thinks these nurse practitioners should be clinical experts, prior to being able to put in orders for doctors. ... It doesn’t help the nurses to do their jobs caring for patients... if we have to spend all our time worrying about whether someone is competent. All your caring goes to protecting, not helping the patient and then think about these new nurses who are trying to focus on learning themselves and they have to deal with inexperienced practitioners trying to give them orders.*

A new nurse’s desire to learn is present in the next excerpt from Nita’s interview.
I wanted to learn everything I could to be prepared for real-life nursing outside of school. Nita, RN, ADN has been out of her associate’s degree program for four years. She was working out her resignation notice at her hospital job at the time of her interview and planning to work in home health. Nita is single, has no dependents, and was making a salary greater than $60,000, a higher than usual salary. Nita was an exception to observations of young nurses being uncaring and unfocused on learning how to be more caring.

Nursing school itself was more about the book and not so much about the caring aspect. I was fortunate to have some great mentors from a special program outside of the school that taught me so much about how to be a compassionate and caring nurse, and best of all, they taught me how to survive...When I got out as a new nurse, I just sucked all of that knowledge in and I just became a sponge. I didn’t care about anything except becoming a good nurse. I said “I want to be humble and learn everything I can learn, I am going to observe and take advantage of everything. And I also prayed, I said, ‘Lord please put me with good nurses that are going to season me and prepare me for what I am going into, because nursing school and real life, are two different things to me.’

It’s something you learn. Nita states she thinks a person just has to already be a caring person, even though it could just be something someone learned by how they were raised.

I want to say probably when I was a child is when I learned it. It’s something you learn, caring is something you learn with growing up. I was the youngest of 3, and we always. I mean we always looked out after each other and that was just part of our family and so I think it was just a learning trait about your family.
Nita identified growing up in a family to be a source of learning to be caring. She thought it was something one could improve upon in nursing school, but was not something that could be taught in adulthood. Nita also shared how her caring was greatly enhanced by a nursing mentorship program she took advantage of from an organization external to her nursing school. The next nurse participant also discussed a learning experience in caring during nursing school.

*I learned in school that you can’t be caring if you don’t have that relationship with the patient.* Jennifer RN, BSN is married, has a toddler at home, and has been working in the same unit since graduating five years ago. Jennifer remembered an emphasis on developing a trusting relationship with patients from nursing school and talked often about how this was impressed upon her in school.

*They taught us to care in nursing school...It’s not just telling them you care; it’s an action thing; you have to show them you care by what you do and how you do it...They are not gonna listen to you if they don’t trust you and they are not gonna trust you if they don’t think you care...and if you don’t have that relationship with the patient, you are not gonna get to the caring.*

Jennifer emphasized she was unwilling to work in places that did not permit her to apply these principles to caring work; she said she has seen over and over that it is the only way you can really show caring. This was a strong learning experience for her that affected how she views her work as a nurse.
It’s just something that clicked when I was in school, I don’t know why but it made sense. If you can’t establish that trust and showing you care, then what is it you are doing? I am still at my job because even though it gets busier all the time and over the years, it’s that opportunity I still have to be able to show caring that is important to me.

In the next quotes, nurses identified experiences besides education and mentoring examples that they believed contributed to their present manner of caring.

*Learning to care for everybody else.* Jennifer also thought her life experiences contributed to her caring disposition. She indicated her mother was a nurse and it was not so much her mother’s direct influence that helped her become caring as it was her mother’s work schedule which left her responsible for the younger siblings.

*Learning to care for everybody else is what did it to me. I’m momma to a lot of people, my sisters’ are older now, but when they were kids, I was the one. It’s easy for me to do that, caring for everybody else...you know I learned to give my heart out so much, I didn’t know what else to do.*

Like Jennifer, Amy also experienced taking care of people from an early age. Amy, RN, BSN is in her mid-twenties, works in a nonprofit hospital, and is a graduate of an accelerated nursing program. Amy is married, has no dependents, and will soon graduate from a nurse practitioner program that was part of her accelerated nursing program. Amy works full-time weekends in a nonprofit hospital, and she and her husband contribute equally to the family income.
I think my upbringing kinda taught me to be caring. I'm the older sister; I’ve got a younger brother and they always said I was really caring with him. My friends always said I was caring too; I was like the mother of the group. I think my mom raised me that way, just to care. My mom is very caring; she was a kindergarten teacher so... I think I was taught to be caring from the time I was little. ..I wanted to be in the health professions cause there was nothing else I could see me doing, but I didn’t start out in nursing, I did something else but feel called to do it now.

I learned caring from my mother. Kelly, who was quoted earlier about her view on male nurses’ caring ability, believed her caring mostly came from within her family.

I know a lot of my kindness and caring came from my mom; she is very compassionate and kind, and I learned it watching her.

My mom taught me to be caring. Lindsey RN, ADN is in her early sixties, is married, has one adult child, and currently has no dependents living in their home. Lindsey was the primary caregiver for her elderly mother who lived with her before she died last year. Lindsey and her husband also cared for a disabled family member during that same time Lindsey is presently exploring retirement after working twenty-years in nursing. Prior to becoming a nurse, she spent almost twenty years in another non-medical career. Lindsey has been at her present job for five years, but has been a nurse for twenty years.

I learned it from my mother I said I don’t know if I can define it. It’s something that you have. It’s in you and you exhibit it to people and its part of your make up- what you are.
I learned caring from my mother and grandmother. Sarah, RN, AMN is presently completing the masters’ portion of her accelerated nurse practitioner degree. She has been working as a nurse for a year and a half, all in one location, a small community hospital. She floats between several medical units with fluctuating staffing needs. Sarah earns just over $40,000 in this position, slightly more than nurses of her years of experience. Sarah is single, has no children or dependents living with her.

I learned caring from my mom and my grandmother. They were caring, very caring...Some of the new nurses are very caring, but they can’t do it, it’s too much work... Guys do it differently like our techs; I don’t know about them, they’re just not emotional. They don’t look you in the eye; they’re rough. It’s hard to care with as many patients as they give you. You have to try your best.

Sarah’s interview will be quoted several times under subsequent themes as she had much to say about caring, nursing work, and ways to facilitate caring in nursing.

I learned to be caring just from being in and out of hospitals all the time with my grandmother. Mabel talked about watching and learning about caring from the nurses who cared for her grandmother many times over the course of her life.

My grandma was chronically sick and so you’re in and out of the hospitals and I guess for me, oncology nurses, they were very caring like they spent the time and those were the people I learned from. To me caring is giving patients that time, not just giving them their medicines, not just giving them their treatment but giving them that time to help process whatever is going on with them because that was what I always observed, the best nurses, that was what I always observed from them. For learning it, I mean probably just observation like in and out of the hospitals with my grandma we saw every spectrum of nursing. From the great ones who knew us every time we came in, broke
the rules for us or let us break the rules... you know, the ones who we could stay past visiting hours or bring in outside food or whatever because it wasn’t hurting her. And then to the ones who just came in and did the rote job; they did their jobs well; they just weren’t always as caring.

While some nurses learned from role models and some nurses learned from experiences through their formative years, most of the nurses said they did not experience nursing school as focusing on caring. Instead, most nurses remembered nursing school as being about acquiring technical skills and the science of bodily functioning.

School teaches you the technical stuff, not the caring. While Mabel and Mary shared positive learning experiences from clinical role models in nursing school, most participants thought nursing school was less focused on caring. Below, Amy makes this point about nursing school. She also says that because she was a caring person, it has been helpful that she selected a religious-based hospital that fosters her caring.

I don’t really think they talked about caring at all in nursing school. I mean they try to incorporate that into school but I don’t think they do. You just don’t know about it until you get out there ...What I’m thankful for is a hospital that has a religious background cause I have a religious background and that’s helped me with being able to incorporate God and the Bible in situations for caring. That helps, and it usually helps patients and families. And we also have a chaplain on call that can come but that’s a lot of caring...For me as a nurse, I think communication is the biggest way we can be caring, sometimes it’s trying to calm them down in bad situations and help them find hope and relief from suffering that a pill can’t fix.
Another nurse, Sasha, says she just always knew nurses were expected to care. She came from a family of nurses who reminded her of the importance of caring when taking care of a patient. Like other participants, Sasha did not see caring as a huge focus of nursing school. Sasha said caring was just assumed to be something nurses would have if they were presenting themselves to be a nurse.

*They (nursing school) might have had a lecture or something but I just knew. I come from a family of nurses so I knew what to expect...You have to already have that passion to help people, and to work with people and if you don’t already have that in you coming into nursing school, that’s not something that can be taught, that has to be something that’s already within you.*

Participants like Sasha, Amy, and Nita who acknowledged their nursing school’s minimal focus on caring, also saw it as a trait one was expected to already possess if they chose nursing. In this subtheme about learned experiences of caring, nurse participants identified gender socialization experiences as strongly influencing male nurse caring even if they were inclined naturally toward a caring disposition.

*It’s the stereotypical male persona that makes it hard for male nurses to be caring.* Katrina talked about male nurses as if the observed differences in caring were largely due to upbringing and stereotyping.

*I think that it’s easier for women. I don’t think that every man would be a good nurse, be good with the caring aspect I mean, maybe because of society and the way they were raised to not show emotions. I know it’s the way my husband was raised. His father passed away and it took*
him a good 8 years before he could lay his head on my shoulder and cry about it. And I see him say that to our kids too ‘Don’t be a cry baby’...I think some people feel that in order to care the way you would have to care as a male nurse, you might be perceived as showing weakness or God forbid, be gay oooo. I think men have to try harder just because of the stereotypical man persona you know, but I have worked with some excellent, excellent men and so I think that what you see with men who are nurses who are very caring, you are seeing the cream of the crop.

For me, it’s about having suffered myself. Mandolyn, RN, BSN, is in her early twenties, engaged, and has no dependents. Mandolyn has worked at an academic medical center since graduating one year ago, and earns a higher salary than most nurses with her years of experience. Mandolyn plans to enroll in, and complete a nurse practitioner program before marrying and moving out-of-state. In this interview excerpt, Mandolyn is responding to my question about the origins of her caring manner.

I got it from myself because I had to go through a very dark period in my life. I actually had depression when I was younger ...and I still have depression now, but the biggest part was back then ... I wanted to become a nurse and become somebody in the medical field, particularly psychology or psychiatry to help people who don’t have the strength to care for themselves ...I can be that little shoulder to stand on and help them get stronger and push through the darkness and become a better person because I had to do that for myself.

Similarly, other participants who had suffered with life-long or adulthood diagnosed illnesses themselves also felt this made them more sensitive as nurses.

Overall, a role for learning about caring was evident in each of these transcripts, with the caveat that there needed to be a foundational trait already present. Overall,
nurses did not see nursing school as the main place for learning caring; rather, they had personal or family experiences, or strong mentors that facilitated their developing caring abilities. Being the caretaker for family members or growing up around other caregivers set the stage for considering themselves as caring. In the next subtheme, participants who felt a strong link between caring and one’s character will be addressed.

**Theme One, Subtheme Three: Caring Comes From Your Character**

In this subtheme of natural caring, nurses share their views about the connection between caring and one’s ethical character. This subtheme is less lengthy, but was clearly important to the participants who related caring and character. Interviews that focused on doing the right thing, being able to be trusted to do the right thing and having a sense of right and wrong made up most of this subtheme. This link between caring and ethics was also important in the literature on caring (Corley 2002; Noddings 1984).

**Doing the right thing.** Cabriole, who was quoted previously in this section, defined caring in terms of adhering to a set of principles.

*I think caring is attention to detail, doing the right thing. Always doing the right thing. Just like the other day a nurse before me had left this patient with the end of the tubing exposed where we hook his IV up and disconnect it after the medicine runs in. Well that could have been a potential death sentence. So yes I was exhausted, yes I was under a time crunch, but I went and got new tubing and redid the whole thing. Caring is engaging them, finding out who they are, where they are from, their families, and chit-chatting and listening. Nurses really need to listen, observe and pay*
attention to the cues. That’s part of caring, and when you care, that’s what you do.

Cabriole integrates the caring and ethics with the source of knowing that is acquired by interacting with and relating to her patient. In this and previous quotations from Cabriole, her sincerity and caring manner is evident; it is nonetheless striking that her first words in defining caring echo the written words that hang in the hallways and corridors of her place of work as characteristics of their nurses, ‘always do the right thing.’

There were other participants who talked about the importance of doing the right thing if you are a caring nurse, but not all nurses using the word character were using it to refer to the sense of right and wrong; they used the word in a manner more consistent with personality; however, I never directly asked for a distinction during the interviews, leaving this uncertain and assumed.

It’s just my character. Sasha describes the development of caring as growing and becoming refined over the years, culminating in becoming a nurse who makes a difference for patients.

And I think it’s something that over the years you develop and as a new graduate you, well I think me personally, it’s just my character. But, you do start to find your way feeling comfortable in your role, and the years roll by and you develop values. You know you start you start to exhibit characteristics that make you that kind of nurse that makes a difference...
Sasha’s choice of words in her description of caring as part of her character include the word values; however, without further clarification, it cannot be known if Sasha was speaking of a set of values that served as guides to decisions made on behalf of the patient, or if she was speaking of skills she developed that fostered effective change in patient recovery. The totality of Sasha’s interview did have several references to her attention to principles of following rules, guidelines, policies, and professional standards; this makes it somewhat likely that she speaks beyond a personality trait in describing caring as her character.

Similarly, in a passage from Nita’s interview below, she looks for the words to say that caring may be an act for some people, but suggests a certain integrity and internal behavioral consistency is present when a person really cares.

*I mean they can try to tell you how they think you should greet someone or act toward someone or maybe their idea of “caring” for somebody because you can think of the word caring as something different, caring as a feeling vs. caring, actually caring for them, it can be just going through the motions. But I do think probably the actual feeling of it is just something that you have.*

*And ... seeing how a nurse actually talks to patients and the way they talk to other coworkers too will tell you about them and their real character.*

*The things you would do, regardless of anyone else around.* Ophelia RN, ADN is in her middle twenties, is married, and has one toddler at home. She has worked in a religious based hospital for almost four years. Ophelia works 12-hour shifts on weekends
only, and is considered full time by her hospital. She and her husband earn approximately equal salaries.

*Caring extends from here, from your heart, do you really want to be here; you know, is this really what you want to do; do you feel called to do this?: of course, spirituality comes into that too - plays a role. To me caring would be just like doing the things you would do, regardless of anyone else around or who’s watching, not watching – are you gonna do exactly what you know is right, you know; I guess integrity starts to plays a role in that too-how you treat somebody.*

Again, the use of the word character for me summons associations with morality, ethics, and guides for behavioral action, but I did not clarify this with the participant. Nita’s sentence suggests watching people’s actions to be indicative of who someone really is as opposed to an act being put on for a specific person such as a patient.

Lindsey also shared a similar sentiment about being able to discern whether a person is genuinely caring.

*It’s something that you have. It’s in you and you exhibit it to people and it’s part of your make up, what you are. And I think people know who cares and who doesn’t care. When you meet people and spend some time with them you know whether they are or not. You can’t fake it for long, maybe a quick interaction, but people know. You see it in their eyes.*

Lindsey and several nurses spoke about coworkers who put on a caring face to patients, but were uncaring in their actions toward patients not assigned to them other staff or to other staff. This inconsistency in demonstrating caring was seen by the nurses as faking
caring as opposed to being genuinely caring. Lindsey’s struggled to define caring but was confident about the trait of caring being one that shows itself to others if it is present. She was not exactly sure what she used to know whether someone was or was not caring, but felt it in her ‘gut’ whether someone was caring or not, implying an acquired skill of being intuitive or of picking up on cues of deception.

Cheryl talked about reporting a nurse who consistently was abrupt or harsh with patients. Her manager told her that as long as she did her job, they were not there to change employee personalities. Her response follows:

“That’s not a personality – it’s being rude and what I wanted to tell her is she was just about as rude as the nurse I reported... sometimes a family member will come to the nursing desk and everybody will just sit there charting, charting, charting, and I think that’s so wrong, so I look up and ask if I can help them and usually it’s asking for one of the nurses and I can hardly get that nurse’s attention from charting and it’s their patient needing them. The ones who care end up doing too much cause they won’t ignore someone needing something when they see it. And it’s just not right but if you report it and it falls on deaf ears, so I can’t ignore a patient. I always promised I would take care of patients as if it was my own family.

Sasha also talked about feeling she had to intervene when someone was not caring for their patients.

...I try to be cordial but when I see where it’s going and that they are not trying to care for their patient, and then I know that’s when I step up and be the patient advocate. They are not trying to be there for their patient and so I am going to go in and do it and then have a talk with them and then if that doesn’t do it, I am going to report it.
Mary also was quoted earlier about the ethical imperative to be kind to people who are vulnerable and needing help. Several other nurses gave examples of uncaring behaviors of nurses and expressed conflict about how this was handled by management.

People take advantage and nothing happens. Sarah also expressed frustration at reporting things and at being called in to work a lot because so many people take advantage of the fact that the hospital is so short-staffed they cannot afford to fire anyone.

There are no repercussions ... You don’t get fired I got called in to work Monday because two people called in on a floor. Did they get trouble? No ... and when you send emails about things people do that are a problem for patient care, nothing happens, maybe a conference, if that. ... At what point, I mean you can’t just start firing people because you’re already so short.

Several nurses had nearly identical words as Katrina regarding how they saw caring as an ability to remember the golden rule.

I think all of caring boils down to the golden rule. I am gonna treat you just like I would want you to treat me.... and while I am treating you, I am going to put myself and my needs to the side.
If you don’t do what you say you are going to do and treat people like they matter, nothing else matters. The trust the trust and if you don’t have that trust then it doesn’t matter what you do they are not going to perceive you as caring.
You have to be a person that keeps their word.

Faye and several other nurses also found it important to comment on the need for nurses to put their own needs off to the side when they are there caring for patients.
If I am having a bad day, I am not supposed to take that into the patient so they can see. That’s just common courtesy and professionalism and good character, the patients are there and your job is to help them today.

Overall, the nurses found it was important to do the right thing, but a few saw it as indistinguishable from caring. Some of the nurses defined caring in terms of manners and common courtesy.

*Its good manners.* Cabriole focused on treating people right by using your manners and being sincere.

But you know, honestly just good manners, and being sincere and conscientious and following through with what you say you are going to do is what a lot of it is. That’s what makes a difference to people and makes them feel good about their care.

April, RN, BSN is in her late forties; she lives with a life partner, and has a teenage child at home. Since graduating from nursing school nineteen years ago, April has worked several different units within the same hospital, and is looking forward to retiring in less than a decade.

I’m trying to make it a few more years if I can…Yesterday I cried with one of my patients family members and just while she cried, so I think that has a lot to do with caring and like I said, it’s hard to do that anymore You have so many patients to take care of and know what’s going on with them….My coworkers told me to grow a backbone.
That bothers me. If you can’t have caring, it’s time to get out.

April talked about wondering if she can continue to work in an environment that encourages the nurses to become hardened and to overlook the things that go on that are unfair to patients such as having nurses spread so thin, they may not even know each patients reason for being in the hospital, beyond a diagnostic label. She feels the customer orientation to patient care is problematic by fostering nurses as servants as opposed to caregivers.

Now it has changed and the patients and families get this image of nurses as being there to serve their every whim. The patient is your customer and the patients come in and it’s not exactly that they want you they want you to be caring, they expect things – a cup of coffee, and their family members there and ‘I want you to bring my family member a cup of coffee’ and its changed a good bit; of course, sometimes, it is hard when you walk in a patients’ room and the first thing they say is, ‘bring me a cup of coffee’ and so you are thinking, ‘that’s not what I am in nursing for’.

Somewhat like April, Mary expresses puzzlement over why uncaring people would even come into nursing, and how unethical it is to work with sick people who are vulnerable, and be anything but caring.

I just don’t understand it, why would you do that I mean there’s plenty of other places you could work where you would make more money so why come and be mean to people.
The last theme in this section has to do with participants who expressed a strong awareness of caring for others as one of the facts of life.

**Theme One, Natural Caring Subtheme Four: Caring as Part of a Social Existence**

In this subtheme of natural caring, participants talked about their perception that caring was something that could be assumed to be an important aspect of relating to other people. An inclination toward being sociable and enjoying talking with others and wanting to know people in their day to day lives was common among some of the participants. Several of these participants shared feelings about humanity and the common needs they anticipated people would have while they were in a hospital, away from their usual comforts, personal control, and support systems. For these particular participants, comments about people seemed independent of their job as nurses, giving the impression they might be the way they described with any person in any setting they encountered.

As with the previous subtheme, this one is shorter than the first two, and is included even though the comments were fewer in number. In this subtheme, caring as part of a social existence, participants spoke about caring and life in a manner that suggested they had a strong affinity for those experiences that all human beings share, particularly the need for caring, and the need to maintain some degree of personhood when situations arise and take us into surroundings without being able to bring our usual foundations for stability. This is not meant to imply these participants were any more
caring than others; only that there was a distinctive quality about these participants views about people and life, an understanding of shared experience common to all of us.

_I have always enjoyed people._ Kelly talked a lot about her openness to people and her ease in approaching people to deliver small acts of kindness and courtesy. She credits her mother’s deep compassion for other people which she observed growing up and she also remembers her mother talking to her about difficult times people had to go through.

_One of my favorite parts about nursing is the people I’ve met. I do think of myself as a very caring and compassionate person. One of the main reasons I went into nursing is cause I just like people. I like being around them and just talking to them and all the things you can learn from them I mean that’s probably one of my favorite parts about nursing is the people I’ve met. And I do enjoy taking care of people … To me, it’s just enjoying people and life._

_They’re just on fire about it and then …stuff happens to them and they just realize._

Kelly shared how sad it was for her to turn away from nursing, but was clear she did it in order to preserve her caring manner toward people. Her awareness of deficiencies in the hospital system of care that left her unable to provide the kind of care she believed people deserved and that she felt good about providing led to her decision to find an alternate type of position.

_I feel really bad for nurses, especially new nurses… I’m a pretty new nurse myself but even when I would train some of them, and I would see that fire when they’d first start and that’s what they want to do too just like I did. They want to do everything right and they’re just on fire about it and then …stuff happens to them and they just realize, man_
I don’t have time to do all this. I can’t even keep them safe let alone talk to them and be supportive... I think it’s the bottom line any more, that’s what administrators want. They try to tell you it’s about patient care but it’s not.

Like other participants, Kelly tried to offer alternate explanations for why hospitals were the way they were, and she did not want to talk negatively about anyone.

...sometimes at the end of the day, you stop and say how many times did that patient even see me. Do you think they even remembered that I was their nurse? But that’s just staffing issues ...that could be because it is such a pattern of being that busy that nobody wants to come on their off day; me having been one of them. You’re so tired from your shift; you sure as heck don’t want to do any extra. I hate to really sound like I am just so anti-hospital, but I had to get away from it for my own peace of mind plus I have a family and I needed to have some of me left for them at the end of a day.

I don’t understand people who don’t care. Cabriole talked about how she viewed caring as just a fact of life and did not understand people who did not care. She is the participant who spoke of finding spiritual renewal in merely offering a drink to one who was sick.

We all suffer and need help from time to time and it’s just part of living. People tell me I am so caring, but to me, it’s strange that everybody isn’t caring. Caring is essential to living together and it’s part of our God-given gifts to help each other. It’s about living in the world with other people, common courtesy, the golden rule, the things we all have to do to be respectful, you know.
It seems natural to get to know someone you are going to be taking care of.

Susanna talked about doing everyday things like going for a walk with a patient and the joy it gave her to make them feel less like a patient and more like a regular human being.

I mean like if I am going to be taking care of you, it seems natural to want to know about your life, about you as a person...Talking to people or helping them stroll around the hall after they have had a surgical procedure is something that makes us feel more human, like we are part of everyday life. That’s one of the reasons I selected that floor.

We all want to be treated as a person. Mary also spoke with an understanding of normalizing things for patients, remembering anyone could be in that position.

I think we all want to be treated as a person when we are sick and not like that difficult person bugging me in room ___ It could be anybody, your own mom, yourself, your child, and I can tell you if it was, my coworkers better be nice to them (laugh) and I better be nice of it was theirs but it’s something that can happen to any person so why not just be kind.

Why would you not be nice? Amy’s words were about the experience of living and the uncertainty of the time table for a life.

Nobody knows how much time they have so if you have an opportunity to be kind before someone leaves this world, then why not take that opportunity We are all gonna be there at one time or another.
For these participants, their words extended past nursing to humanity in general. Nursing was but one more way they expressed their respect for life and people. Throughout their interviews, the participants had things to say about their work and their working conditions. These comments set them apart from others who only focused on their work lives, the only thing they were directly asked about. These participants added another dimension of their caring as they shared something about their views on the process of life. The next section shifts to the second of the four main themes identified which is accelerated caring.

Theme Two: Accelerated Caring, Caring on the Run

*Overview of Theme Two: Accelerated Caring, Caring on the Run*

All of the nurses were acutely aware that getting through a shift required too many demands on their time for them to be able to sustain a caring manner, but they were determined to make the effort. Nurses engaged in a variety of strategies to show caring, even when they were extremely busy. They did things like take breaks, pray, hide in the bathroom a few minutes, and they especially engaged in a lot of self-talk. Nurses had their own mantras and self-talk strategies to spur them toward completing objectives, to remind them why they were there and to do whatever they could to remain focused on their preference to do things in a manner that made them feel like caring nurses, and make it to the end of their 12-hour shifts. This was similar to the flight attendants in Hochschild’s (1983) seminal study of emotional labor.

From this study of medical-surgical nurses, working in today’s hospital environment five types of patterns emerged about showing caring despite the busy-ness
of the unit. These patterns represent the subthemes for the theme of accelerated caring, caring on the run. In each of these subthemes, the nurses express how and whether they are able to convey caring when overburdened with care tasks.

These patterns ranged from the rare and well-staffed units were nurses routinely took only three patients, to the units where nurses had too many patients and were ready to call it quits. In the middle of these extremes were the representative comments from the greatest number of nurses. These were the nurses who were struggling to find some resolve between caring ideals and practical realities, and so far, their strategies had not worked.

The five patterns and corresponding subthemes for this second theme of accelerated caring, caring on the run are as follows: (1) You can still care, I was able to work it out, (2) I have it figured out for now. I can care some and I am satisfied with my work, (3) I am dancing as fast as I can and getting nowhere, (4) I have a duty to care, and nothing can get in the way of me meeting my duty, and (5) There’s nothing left to try; I am outta here. These subthemes were collectively defined under the overarching theme of accelerated caring as illustrated in Figure 5.3 below. Excerpts from individually coded interviews for this first theme of accelerated caring are presented under each of these subthemes.
Figure 5.3 Theme Two: Accelerated Caring and Associated Subtheme

<table>
<thead>
<tr>
<th>SubTheme One</th>
<th>SubTheme Two</th>
<th>SubTheme Three</th>
<th>Subtheme Four</th>
<th>Subtheme Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>• It’s working fine for me and I can still care</td>
<td>• I have it figured out for now.</td>
<td>• I am dancing as fast as I can</td>
<td>• I have a duty to care</td>
<td>• It's impossible to care; I'm outta here.</td>
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Theme Two, Accelerated Caring, Caring on the Run; Subtheme One: You Can Still Care; I Was Able To Work It Out.

Six of the nurses in this study readily indicated they had no problem being able to show their caring, even if they became overloaded with work tasks and changing priorities. For some of these nurses, their units were so well-staffed, there was adequate time to get back to their original purposes even if sidetracked by urgent priorities. These nurses considered themselves lucky. These nurses are discussed first.

Well-staffed units. Beth worked on a unit where she was never responsible for more than three patients at a time. She liked her job and looked forward to working. She was not particularly fond of the way her nurse manager ran the unit, and she was not especially close to her coworkers, but did think they all worked well together and helped each other when they really needed assistance. Beth liked her hospital and thought the nurse supervisors and administrator for the whole hospital were supportive of her as a nurse. She smiled as she talked about calling the nurse supervisor for any problems that arose and commented,
She’s like having a mama; she’s always there and always kind, no matter what you do to mess up as long as she feels like you’re telling the truth.

Beth worked 12-hour shifts only on the weekends and was considered a full-time nurse. She had no contact with the nurses from the weekdays and said she liked it that way.

I don’t like being around a lot of people. I like my patients and my workgroup, and I want everybody else to just let us do our work and leave us alone (smiling).

Just being able to be there. Beth spoke about the work she does with patients with enthusiasm. She named situations with patients that were positive caring experiences for her, and she assumed was also positive for the patient. Her most memorable caring experience was when she was able to be part of a male patient’s last few days of life.

This one patient – a guy, he passed away ... and he was really sick, and he didn’t have any family. And just being able to sit in there and talk with him was so wonderful to be able to do. To be able to be there for him at that time. You know at times it’s just being able to go in the room and sit with them... Talking to patients sometimes does better than anything you could do for them medically.

I feel so lucky to be able to get to know my patients. Beth indicated that on her unit, there were moments when things were hectic and she felt overloaded, but she almost never was unable to do something for a patient that she had wanted to do for them to make them feel well-cared for. She spoke of being lucky and not taking her job for granted.
I feel so lucky to be able to get to know my patients, to know why they are there and actually take care of them like I am supposed to. And I know it’s not that way everywhere. We have nurses waiting to come to our unit because of that. I almost feel guilty saying it. We have it so good because I know how it is most places, so I make good use of my chance to have a great job.

I might not know what’s going on in the chart, but at the end of the day, you’re gonna be glad I was your nurse. Ophelia also worked on a unit where she rarely had more than four patients. She experienced problems with some of her coworkers, and was frustrated by her manager’s lack of involvement in patient care problems on the unit. She said she found her greatest satisfaction in providing bedside comfort to patients.

Like I am ok at telemetry, IV’s and all that…book stuff, but I feel like I excel at the bedside...and I can make you feel really comfortable... I may not know exactly what’s going on in the chart and what the doctors are doing, but at the end of the day, you’re going to be glad I was your nurse and you’re gonna be saying that. That’s bold isn’t it?

I try to be with my patients as much as possible. I don’t care about the charts. Ophelia received a lot of compliments from patients and physicians about how she was always in a patient’s room, and never sitting at the desk. Ophelia says if she sits out at the desk with the other nurses, she finds herself thinking about the problems on the unit and how it could be improved with a better manager.

It’s better for me to be with the patients; that’s where I belong and what makes me love my job. I wish things were better I think how awesome it could be if it were run better, but I haven’t got time to think about that... I know how bad some nurses have it because I have friends who talk to me
and I just count my blessings and try to be with my patients as much as I can, and I don’t really care if my charts aren’t perfect. I do what I am supposed to do, I guess. I haven’t had any problems reported.

Staying focused. Despite the increased acuity and workload on her unit, Cabriole says you can still care by staying focused on the patient’s needs.

Of course, you can still care. You can always care. Things are busier, but if you keep your attention on what matters, you can care, sure you can... I have never stopped caring. I walked in the door caring, and I care no matter what else happens.

Cabriole remarked that she found younger nurses coming in and staying on their cell phones and socializing.

It’s not that they don’t know anything that bothers me; it’s that they act like they don’t care that they don’t know. I walked in the door caring and trying to learn everything I could as a brand new nurse because I wanted to be the best nurse I could be. Nursing is a very big job and you have to take it to heart.

It makes no difference whatsoever to me what the administrators are doing. Cabriole continues her conviction that caring can happen, and goes so far as to say she is able to detach from the administrative happenings in the hospital, and instead focuses on what she needs to do for patients.

...I am there to take care of the patients; to administer what needs to happen in their plan of care, to help them get better...Some people complain all day about what administration is doing but it makes no difference
whatever to me. The administrators can dance over there in their circles. I know what they are about. I am over here doing my thing. I just don’t even think twice about them. I know I am doing what I am supposed to be doing.

Cabriole conveys that attention to caring is a responsibility and commitment. She speaks with confidence about her caring ability and has little interest in the background politics of the hospital. Other nurses in the study made comments about their annoyance with social media and with cell phones at work, suggesting it interfered with the unit atmosphere.

*Multi-tasking.* Mary manages to find time to care on a unit where she regularly cares for five or six patients when scheduled during the week. On the weekends, she may have up to eleven patients, and often lacks support staff such as a unit secretary and care assistants. Mary says she likes her coworkers and likes her nursing boss okay, but finds the hospital administration to be unresponsive to patient care problems. Mary considers herself caring, and a strong advocate for patients. Although she is the main provider for her household, she says she never backs down from anyone if she feels something is unethical.

*Once you go down that road of being intimidated even though you know what is right and what needs to happen, you can never turn back. Call it morals, religion, good upbringing, bold or whatever, but I don’t back down to anyone when I know something’s wrong.*

Mary also prides herself on being a good multi-tasker, indicating she would otherwise never get the personal contact with patients that she desires.
I am a big multi-tasker I think it’s part of being a nurse ...so while I am in there charting or cleaning their room, I’m talking to them. And it doesn’t have to be related to their illness. It can be like –Oh where are you from? Oh you live out in the country, you like to go fishing – I like to go fishing and I think that little bit is what helps out and they remember that. If they ever come back, they are like ‘Hey, you’re the little fishing girl.’ ..

Everybody’s got a story to tell if you just give them an ear. Mary maintains her commitment to caring by imagining herself or a family member in the patient’s bed.

Reminding herself to view the patient as more than the task to be performed is evident in her avoidance of referring to the patient by the tasks being performed.

I try to tell new nurses …that patients know how busy you are. They can see. But I tell them to just try to have even a five-minute conversation and they will find something the two of them like and then just go from there...And I tell new nurses, ‘don’t look at them as a bandage and drain you need to do today’. There’s more to them than that...Caring can be a very small thing...Everybody’s got a story to tell if you just give them an ear. You know, sometimes that helps...Really caring for your patient makes the job enjoyable.

While there was some indication from Mary that she found it hard to find time to care, especially on the weekends when staffing was minimal, she stressed the importance of making the effort. For example, Mary says you may not have time to sit and explore social and personal concerns, but you can and should remain approachable. Mary indicated she had found a way to accept things as they are, rather than clinging to what she had envisioned about nursing;
Just stop and think about why you are supposed to be there. Amy’s comments highlight the importance of taking the time to address patients’ needs.

The first thing you’re doing when you’re going in a room is establishing that relationship for the day. And you’ve got a million things on your mind... ‘How am I gonna get all this done?’ Like yesterday, I had six patients and every one of them had something going on...That part is just hard, but what I do is I just have to stop and realize that the patient is important; they’re the most important thing right then and I am just gonna have to be a little late on a medicine...I may need to take a second to explain some things to them, and let them know what’s going on, and you know, you just have to let some of the things administration expects go if you want to do the right thing by your patients.

You might have to care faster. In this quote from Jennifer’s interview, she makes the point that a nurse who just walks in the patient’s room to do whatever task needs doing and then leaves is not showing caring.

I work with a lot of older patients on my floor who have a lot of chronic problems, especially arthritis...You can’t just walk in and do something and then leave. It doesn’t matter how busy you are, why in the world would they even want you to come back in their room?...And you may not have the same time to care you think you should, but you just have to figure out how to communicate your caring in the time you do have; otherwise, what’s the point? It’s just busy work.

Jennifer holds onto the importance of the relationship as essential for caring, even if it means figuring out how to achieve that connection in less time. She acknowledged this could be difficult, but suggested it was important enough to make the effort.
In the next subtheme, nurses found ways to be satisfied even though they had given up on their ideals for caring nurses. They did this by finding a way to be satisfied with the caring moments that occurred, however rare. Or they found a way to redefine caring so that it more accurately matched what they were able to do. Still others found something else about their work and made it their focus.

_theme two: accelerated caring, caring on the run; subtheme two:_

I have it figured out for now

There were nurses who accepted that they could not be the caring nurse they had once considered to the ideal nurse. Several of these nurses started out with nurse managers and coworkers who groomed them to adapt to the realities of the present-day care environment. From their first experiences in nursing, they learned strategies that enabled them to let go of caring as they had envisioned it in nursing. They found ways to be satisfied with their jobs and expressed feeling good about the work they did with patients. One nurse had several mentors while in nursing school that assisted her to anticipate some of the challenges she would face as a new nurse. The interesting thing about these nurses is that they were the small number who directly expressed satisfaction with their jobs even though they mostly identified themselves as caring and unable to care. As their interviews progressed, they began to relax their positive comments and express feelings of angst toward the hospital administration or the healthcare system. They became more emotionally expressive and animated, speaking louder and with more intensity. Each of these nurses disclosed near the ending of their interviews that if they thought they would have to stay in their jobs indefinitely, they would be unable to do so.
Each of these nurses was actively pursuing or thinking toward alternate careers that would offer more interpersonal contact with patients and greater control over their work.

Other nurses learned how to cope the hard way. They experienced the frustrations and changes in the care environment over their years of practicing as nurses or they were quickly oriented by experienced nurses that they had to forget about trying to be ‘the caring Florence Nightingale’.

_I have a great boss._ Anne, who formerly talked about herself as caring by being conscientious, expressed that she felt good about her work. She shared these feelings about her manager and coworkers.

_We have a really great unit manager and she’s really all business, but I respect that. She’s all about quality and our image and the whole of the hospital…Whenever we have staff meetings. She will read off the discharge phone calls they make to patients after they leave. That helps you feel motivated about trying._

_My manager and coworkers make all the difference in the world._ Shelia also felt supported by her manager and coworkers.

_I mean my job is hard – it is hard and I don’t always like it. And I don’t always have good days, but the big picture of it is… I like what I do and I work for good people in a good organization – that’s the big picture …it’s mentally hard, it’s physically hard, it’s emotionally hard. You know it’s hard in more ways than one, but my manager and coworkers make all the difference in the world._
It's more than just what you do. Providing something beyond the routines and tasks to be accomplished also was described by Lindsey as an example of things patients and families have said to her about her and her coworkers’ caring.

‘The other floor, they did everything they were supposed to do, but when they picked up his hand to check for a pulse, they just drop it, not gently like ya’ll did. And when they turn him, they just turn him; they don’t pat and touch and talk sweet like ya’ll do’. Not everybody does it like ya’ll and I see how much ya’ll cared here for us.

In Lindsey’s interview excerpt implies that caring while performing a task did not take extra time but was qualitatively different, as in the gentle letting down of the hand rather than dropping it, or engaging in talk while you perform a task quickly.

Caring is giving patients that time. In Mabel’s passage below, she was reflecting on her observations of good nursing care when she was a young person accompanying a grandparent to the hospital or physician’s office.

...To me, caring is giving patients that time, not just giving them their medicines, not just giving them their treatment, but giving them that time to help process whatever is going on with them, because that was what I always observed the best nurses do with us.

In Mabel’s interview, she identifies her image of caring by recalling the actions of those nurses who cared for her grandparent, thereby emphasizing an enduring impact of caring role models. She holds onto the importance of time spent with patients as essential to
demonstrating you are there for more than the routine of administering ordered treatments. This was also evident in Mary’s comments about caring.

*I felt like I was a better nurse and I got more compliments from patients when I only had three or four patients.* Amy also noticed that she was a much better nurse and had a much better attitude when she could pause and think about what she was doing.

*I feel like I can take the time if the assistants are busy and give my patient a bath. I can really focus in on them as a human being, not as somebody to run do something to against a time clock. I felt like I was a better nurse and I got more compliments from patients when I only had three or four patients. So see, we know the answers, we know what could help but we aren’t gonna do it. ‘We’re over budget.’*

Amy thought having time to do things directly with patients like giving a bath or attending to basic needs fostered improved relationships with patients and also helped facilitate relations with subordinate staff who were directly responsible for patients’ basic care and hygiene needs. Amy liked being able to work closely with the patient’s basic needs, saying it kept her in touch with the patient’s perspective.

There also were several nurses who planned to leave in the near future. None were planning to leave nursing altogether, but were seeking either advanced nursing roles such as nurse practitioner or they were seeking less stressful nursing positions. Nurses who could retire were eager to do so as soon as possible.
In the next subtheme, which constituted the largest group of nurses in the study, were the nurses who were still struggling with how to make their work situations more palatable. These nurses felt like they were sometimes just surviving.

*Theme Two, Accelerated Caring, Caring on the Run: Subtheme Three: I’m Dancing As Fast as I Can*

Some of these nurses vacillated between seeing the problems present and not present in their work. Several nurses who were still trying every possible way to manage their workload and show a caring manner showed an inclination toward self-blame for failing to achieve their ideals. These nurses repeatedly monitored their day-to-day work experiences for how they could become better nurses. Sometimes they wondered if a change of jobs or hospitals might be a better fit. These nurses were trying to make changes in themselves, their job environment, or the location in which they worked.

*They just come in and leave so fast.* Several nurses talked about the speed with which patients moved through the hospital system. One nurse who worked several different medical-surgical units as opposed to being assigned to one unit described this process well.

*On one floor, there is such a quick turnover, you may start out with five patients and end up with five different ones because they are just discharge, admit, discharge, admit, ...by the time you are just getting the required information on the patient, you get another patient and then this patient is leaving and you know you can’t keep up with somebody I used to love to just sit down at the bedside and just talk to*
my patients and say ‘What’s going on?’ and you just don’t have time to do that now, you don’t have time to do anything. I barely remember their names; let alone what’s going on with them…Now and then I get to still do that, and then I feel like I can breathe like a normal person. But it’s not anything I do to make it better, it’s just catching a break sometimes.

We just do the best we can and go on. Mary talked about being so busy she was unable to comply with times for ordered medications.

Sometimes I am still giving 2:00 medicines at almost 4:00… and when you are doing hourly rounding on 6 patients, that’s a lot…we just do the best we can and go on…

Obviously, developing rapport is a challenge in the situations described above. Sometimes, timing and people come together in such a way as to enable a more personal, caring connection.

Caring when overloaded. Sarah repeatedly talked about the importance of doing your best even when you are so overloaded that you cannot get to everything.

Caring is making people feel good, doing your best. Giving 100%, not just 50%. It don’t matter how busy you are, you can still be caring, at least cordial. Some people come to work and they walk in there and they are just like, ‘I can’t do this today’ and I am like, ‘Well you got 12 ½ hours ahead of you so you just need to go ahead and turn that attitude off… I am just like ‘You just don’t even need to be here’. If you can’t have a caring attitude while you’re here, well go home; it’s better for everybody.
*Just trying to survive.* Several of the nurses talked about having to decide to cut back on their caring because it was undoable. They found themselves having to choose between being the kind of nurse they had learned they were supposed to be, and the kind of nurse the hospital expected. Several interview passages from Susanna illustrate this theme of surviving under conditions of accelerated caring.

*That whole...I sacrificed, I gave.* Susanna spoke about how she struggles between sacrificing her own self-care and caring for patients. In this passage, she is speaking with sarcasm about some of the rhetoric of nursing that can be damaging to one’s well-being.

_I feel like so much of the American pride and the nursing pride is like saying to ourselves, ‘I worked so hard and I didn’t go to the bathroom and I didn’t take a lunch break’ and its somehow like a twisted part of psychology and, ‘I’m proud to be a nurse; I did those things so that I could care, I sacrificed, I gave,’_

*I had to survive.* Susanna does not think this is a good strategy because these kinds of thinking patterns promote unnecessarily self-sacrificial behaviors that add to the dissatisfaction in nursing. Soon after stating those words, Susanna began to recall how much more satisfied she was when she was doing nursing to her own standard of excellence as she had been taught to do and as she understood was part of being a nurse. She begins to question her decision to be more efficient and less caring.

_I think when I first started my job, fresh out of nursing school, I was able to sustain more caring...I was able to carry that presence out with my patients more successfully. I guess because I wasn’t as tired probably (giggle) and to I_
was motivated to go above and beyond, but I was staying late (emphasis). .. I was supposed to leave at 7 but I would stay til 8, pretty much every night, finishing up charting. At the end of the day, I was more satisfied and I feel like my patients were more satisfied, but I knew that I was also expected to leave on time and that me staying late is a cost to my unit...I also was not performing my job to the standard expected by the hospital so I had to survive and look around at other nurses and see how they did it....

I traded in what I enjoy in my job to work harder and meet the standards.

Susanna continues by identifying nurses who were not very caring but were very efficient and still deemed to be good nurses. She indicated she had adopted that style but as she talks about it, she begins to question how well that works for her and for her patients.

...But then, there’s that point that I noticed in myself, ‘I was way more satisfied with my job when I stayed late...because I enjoy being able to do something slower and to my standard of excellence. I liked to be able to perceive that my patients were happy; I received a lot more patient compliments when I stayed late ... They said I gave good care...Funny thing is, now I am working harder in a sense, because I am working faster... at the end of the day, I am still overextended .... So I traded in what I enjoy in my job to work harder and meet the standards that are expected of me. OK then

I worked so hard...and at the end of the day, they reported me for being rude. In her example, she speaks of a family complaining about the care of their family member who was quite ill and who occupied much of Susanna’s time that day. In her mind, she worked and focused on averting a crisis that may have resulted in the patient getting transferred to an intensive care unit. The patient’s family however, reported her for being rude and uncaring.
I had a patient this week that was pretty sick and I thought I had taken very good medical care of her, as far as following all the doctors’ orders, assessing her well, keeping the doctor updated on the changes in her condition, doing everything in a timely manner, getting her fever under control, doing all these things. But that family didn’t have much medical knowledge and at the end of the day, they complained about me for being what they perceived as rude because I was exhausted, working really hard on her, because I was concerned about her and I had had several other patients and didn’t have as much of my charm like “oh you know just carrying on a conversation…

Susanna’s patient was quite ill so the perceptions of whether Susanna was caring came from the family. Susanna expressed some ambivalence about her decision to focus on safe medical care as the priority.

Susanna indicated she had been indirectly made aware that her hospital valued nurses more who were not an added cost to their unit by overtime, such as the kind that occurs when a nurse has been so busy caring that they did not complete their tasks. Now, she gets out on time, but expends more energy and feels exhausted rather than tired but invigorated because her energies went toward following routines and standards that did not always make sense, sometimes got in the way of caring, and often required her to inhibit the urge to be more caring. She was meeting the standards of her hospital if she was not an added cost and if she completed the checklists of required activities that sometimes were not related to caring for her patient.

*Got to get off that clock.* Several nurses spoke of pressure to ‘get off the clock’, and were even expected to clock out before they returned to do charting if it was beyond the hours of their scheduled shift. Some nurses say their managers refer to nurses who
stay late all the time as a burden to their unit because of the overtime costs. Several nurses indicated they saved charting until last or they would never be able to spend any quality time with their patients. Nita describes this dilemma below.

_Every week I come back to work, there are new tasks added...More charting, more paperwork, less time, more duties, besides caring for patients. And they told us ‘OK you have to be off the clock by – 15 after the hour’. ’ They said they would only allow us a 2 hour grace period per pay period – every two weeks and you can only have two hours of overages and then they are gonna write you up because they assume you are riding the clock....They won’t come right out and say it, but they want you to clock out and then come back and finish your charting._

_I needed a break so bad I broke my arm. April talked about how she was so stressed with the pace of work that she welcomed an injury._

_To give you an example, things I have been through and I think God was kind of trying to help me out... but I think in some ways it was God going ‘she’s going to have to have a break even if it’s by having a break [broken arm]because I had come to my wit’s end and I was like ‘I’m through,’ because it was getting more and more difficult I was sick all the time – mentally, physically, everything and me having that break off from work...Mentally, physically personally, and all that stress what’s going on in nursing, it’s affecting the nurses and it needs to be addressed._

_I was lucky I had people prepare me for what to expect. Nita encountered an angry family who had become upset about a nurse who had preceded her. She was able to remain in the room and manage intense anger while calming the situation and attributed_
her ability to feeling confident in what she believes she should be doing and the patient’s right to make criticisms and requests. After speaking to the family, Nita had notified the patient representative to come and speak with the family. Afterwards, the patient representative spoke back to Nita about the encounter.

She just told me, Nita, they really really like you... They said you really cared and helped them understand’ and it made me feel good that they had confidence in me, just by what I said what I did for that woman in a few minutes time. I was so pleased and just thankful for the mentors I had that helped prepare me to be able to handle things like that.

We’re responsible for everything. One nurse talked about problems stemming from being too humble. By trying to be a teamplayer, nurses said they experienced conflicting feelings about having to defer their own work with patients to manage effects of other health workers omissions or errors. Given the level at which the nurses stayed busy, many said they found themselves increasingly resentful of being held accountable for others’ work responsibilities. As the employee always present on the unit, the nurses were the final checkpoint for ensuring all expected care was delivered. Several of the nurses spoke of their seemingly never-ending responsibilities.

That’s the thing, we are responsible for everything. That is something they don’t teach you in school. If housekeeping doesn’t clean it, you are expected to clean it; if dietary doesn’t bring their tray, or if they bring the wrong thing, they call the nurse. If respiratory therapy doesn’t come on time, you have to micromanage them. If the doctor puts in the wrong order, you’re supposed to catch it. Like we are responsible for making sure everybody else does their job,
and doing our job...It always falls back on us, somehow, it’s always our responsibility or our fault.

Faye described a similar sentiment when a called meeting for nurses with hospital administration had everyone wondering about the agenda. After fifteen or so minutes of stressing the importance of nurses to the well-being of the hospital, the administrator proceeded to talk about how the nurses needed to start monitoring tests that were ordered which may have been done in the past and therefore would be rejected by third-party payers, especially Medicare.

Well, when we see that one patient who has been here has been ordered 6 echo’s you know we are not going to get reimbursed’ Now What dummy doesn’t know you are not gonna get paid for all those multiple echo’s and repeat MRI’s?... and I asked my manager, ‘are we really expected to say ‘You can’t order another MRI on this patient to the doctor?’ ... And she said ‘Well yeah they want you to remind the doctors’ and I think that’s a little bit unfair.

Faye also cited another instance of being held accountable for the work of others, yet lacking formal authority in the hospital to do so. In the passage below from her interview, Faye is referring to the nursing assistants, medical assistants or care techs26.

It’s like their role is getting vital signs and that’s it; they don’t care if a patient is clean; they don’t care if a patient is turned; they don’t care if the patient is pulled up for supper or for breakfast...They get trained down in...

26 which go by various names at different hospitals and are called assistants as a uniform name to minimize identification with a particular hospital.
orientation and then send them up here but I feel like if they are supposed to be helping us with the patients, then they should be orienting with us and seeing how to do things and get used to being accountable to us for the patients. They think they don’t have to do what we ask them

*It’s just too much.* Susanna also talked about how the assistants tended to call in sick a lot on her unit and she believed it was related to how hard their floor was to work on.

*Every time I come to work and I am like already I give a lot here and then they say, Ok in addition to the patients you have, you need to choose one patient to do a bed bath on and do all your IV’s today and it’s just like, ‘It’s just too much’ that’s probably the phrase I hear my coworkers make most often, they say that the most; we like our patients, we like our coworkers, we like our manager, but it’s just too much.*

*I used to just skip lunch.* When the nurse needs help with a patient, Susanna says they are almost scarred to ask the assistant for help.

*They give us this vibe to the nurses like they are so overworked… like ‘We can’t help YOU’*. I wouldn’t ever ask them to do anything unless I absolutely had to. And I would do things that was their job that I could have asked them to …but they all kind of took on this attitude that they were always drowning and they wouldn’t help so I would go to my supervisor or manager and he would sort of go into this thing about how he can help me if I ever get in that situation again, and I am like, ‘really like I am gonna go get the manager to do something the assistant should do. I don’t think so, so he just sort of says the smooth it over thing and oh well…so I used to just skip my lunch and try to handle anything, but not anymore, I always take my break now.*
Nobody wants to be seen as a lazy nurse. Ophelia also had trouble with assistants offering some insight into how nurses’ self-consciousness about how they are viewed affects their delegation of duties.

Assistants and nurses butt heads all the time I wish there were a way around it but there’s really not. You just have to hope you get on their good side...We bow to them. I don’t even know why. I feel scared to ask them, can you please do this, if you have time...I don’t want them to label me as a bad nurse or a lazy nurse.

Ophelia indicated the assistants would talk about different nurses thinking they were too good to do the dirty work and so they all tended to overcompensate for that. But she finally just started telling them,

You signed up to be an assistant and you knew what the job was. Now that is the job I am asking you to do, go do it.

Sometimes the technology to help us slows us down. Susanna, who was cited above about being more fatigued when complying with institutional requirements, also talked about the expectations for immediate communication and carrying out medical orders that has occurred since her institution purchased portable computers to help them comply with efficiency requirements.

I wheel this humongous computer in the patient’s room, which slows me down...It’s like, here I am I’m human, Like I am gonna listen and I’m thinking, ‘now I like have this in my head it’s like this computer that reminds you that I am here to do my job and I have these meds to give you and if your bed’s dirty, maybe I’ll have to say like I’m gonna give
you these medications, I have a few others to give I'll see if the tech can do it but if not, I'll be back and it could be as long as an hour or two and I don’t like to do that.

Sometimes the things we are expected to do conflict with each other. Nurses were also slowed down by getting conflicting rules, orders, and directives. Nita talked about unrealistic expectations placing the nurses in contradictory positions with regard to their line of action.

The Chief Nursing Officer we had before was more thoughtful than the one we have now. The one we have now—she is the type that—her expectations are unrealistic, I think to myself. ‘you want me to do everything precise and correct, no mistakes, and my scan rate to be 100%, plus get off the clock on time, it’s not gonna happen...when you scan our bar codes, sometimes those bar codes don’t even work- So they expect me to take out the medicine, send it down to pharmacy, wait for the pharmacy to send me an actual bar code when I know the medicine and it matches what the patient has ordered—I am gonna click it, I am not fixing to wait for pharmacy to repackage it and get it back so I can have 100% scanning score. And then, I turn around and be in trouble for being late too plus it’s slowing me down going to my next patient which is slowing me down from getting off and so on.

Anne had a similar example to share about conflicting expectations in her job which was especially difficult when she was already pressed for time.

From the time the discharge paper is put in we have like one hour to discharge the patient and if we haven’t discharged the patient within an hour through tribal tracker reports our secretary has to explain why we haven’t and then we have to go through these mandatory education classes because we’re getting to many readmissions.
hospital-wide for pneumonia and chf. And all they can talk about is how many times they are supposed to hear this information so it’s just kind of like they are rushing us to get these people out. I mean we are being basically harassed every hour why isn’t the patient out why isn’t he leaving what’s the hold up and then on the other end they are like we are supposed to be educating and our admission rate is way too high. And it’s just like sometimes it seems like we are working in opposite direction.

Those little checklists…if we forgot one thing, we’ve failed at everything. Mabel also makes the point that even when expectations conflict with each other; this is omitted when patient surveys are interpreted. How busy the unit was on the day of a survey was also omitted when considering survey results.

The biggest complaint on our unit is probably that but while we feel empowered as nurses, by the time they get to you, they don’t always reflect on some of our surveys and now we got to focus on remembering to give you this on your discharge instructions and on this little notecard and if we don’t remember to give that to you then we’ve failed you for your entire visit. And I think it’s the competing factor, for the hospital, we want to focus on when we have a discharge order, we want to get that patient discharged as quickly as possible because there’s someone else waiting on that bed…As a hospital because someone else but then someone else says ‘you’ve gotta provide all this information to send them home which is fine I mean I understand that but they conflict with each other.

This subtheme of accelerated caring has captured the nurses’ beliefs that caring is about more than doing a job. Finding the time to spend with patients outside of the required tasks and making a connection is something the nurses continually strived to do.
In the next subtheme that is part of this accelerated caring theme, nurses maintain caring by being committed to caring as a duty.

Theme Two, Accelerated Caring, Caring on The Run; Subtheme Four: It’s my duty to care

Some nurses felt such a strong duty to their patients or to their belief that they were called to be a nurse that they ignored anything contrary to this ideal. These were the rarest group of nurses but they were strongly committed to remaining in nursing.

We need more nurses, that’s what we need. Sarah vacillated between talking about her commitment to caring and working hard for the patients and being aware of problems within nursing which make the job of caring undoable.

There’s no way I can keep six straight…if somebody calls and I am like, hang on a second, let me get my paper out… We need more nurses, that’s what we need. There’s no way with that many patients that you can care; you can’t do it. You just have to do your best, but it makes me mad to see so many who don’t even try… I think we have an obligation to the patient to do our best.

Oh who cares about all that stuff, I am there for the patients. Cabriole expressed feeling a strong obligation to be there for the patients and to ignore anything that got in the way of that.

I am there for one reason, to minister to the patient. That’s the only thing important and that’s what I focus on and nothing more and nothing less.
I feel as though I was called to do this so I am not going anywhere. Sasha described work related problems but in each instance, refocused on something positive.

I ain’t got time for all that. This is what I am supposed to be doing and I know patients need someone who cares so I am not going anywhere even though I do actually see things happening which I don’t necessarily like. I am not going to leave. Somebody had to be there for patients, and that’s me. That’s how I feel and maybe that’s because I was brought up in a family with a lot of nurses.

Sasha also said it was her sense of duty to patients that led her to become more assertive.

I just finally realized one day, I am not gonna let anybody run me off from what I feel like I need to be doing. Nursing is in me.

Sometimes you just gotta walk away. Mary knew her limits of stress and conflict tolerance and took a break so she could stay for the long run.

Um sometimes that’s what you have to do – walk away – keep your mouth shut and walk away cause you never really know what’s going on in their mind. You never know what’s going on in their mind...take a break, come back, and be compassionate. Cause 10 out of 10 sick people are not happy campers; you know and so don’t make it any worse on them.

We pull together as a team. Sasha knew her unit was too busy to allow her to get everything done and definitely got in the way of traditional caring expected of nurses.

I really love my coworkers because we pull together as a team....we’re helping each other; I’m like Ok I am at a stop
for a minute, you ok?, What do you need? And we all do that for each other.

Sasha’s indicated she still understands that despite she and her coworkers teamwork, the level of busyness is still a problem that needs to be addressed.

We see people at their worst. Shelia just tries to remember that if she feels bad because it’s busy, the patients and families who are vulnerable must feel even worse. They need her attention to be on them and not on the negatives on the unit.

A lot of times, you see people at their worst, all the time. That’s how I have thought about it. You know the patient in the bed is sick, they’re not at their best; they’re sick, they may be hurting. They’ve got a lot going on. They have a lot of stressors. And then you have family members who may be very stressed out about the situation and confused. And they may not understand really what’s going on.

I try to exhibit caring, regardless. Sasha focuses below on her perception that caring requires putting your own problems aside as you perform nursing tasks. She speaks about emotional clarity in one’s self as necessary for being able to notice and respond to the patient’s emotional needs.

Patients can tell if your heart is not really in it, if you go in and you’ve got a scowl on your face, and a rustle in the seat of your pants. You know they pick up on that. I try to exhibit caring, especially if I have had a bad day before I come into work, I do like meditation, I do try to pray about each situation and then leave it outside of the doors of where I work.
Patients don’t need my problems too. Trixie indicated she had never thought about leaving nursing, but had taken a few breaks.

This is what I love, and most of the time it does not get to me at all. But every now and then my own problems set in and if I can’t leave them at home, I take a mental health break cause patients don’t need my problems too. It’s what you have to do. They taught us that or they taught me that anyway when I was an LPN before I went back to school.

This subtheme about caring as a duty predominately was seen in the nurses who had such a strong sense of duty they made a conscious decision to stay despite the problems they encountered. In the next subtheme, nurses had little conflict about work because they had given up on caring.

Theme Two Accelerated Caring, Caring on the Run; Subtheme Five: It’s Not Possible, I’m Outta Here

When everyone is tied up and the patient needs to go, it makes you feel bad. Some of the nurses had come to the conclusion that caring was not possible. Most of these had made decisions to leave or were contemplating leaving. Amy found the degree of busyness on the unit made it hard to even attend to patient’s basic needs.

The patients are a lot sicker, so…you may have a patient who has all kinds of wounds, and you may be in that patients room 30 minutes to an hour doing a dressing change. And that means you still have four or five other patients that you haven’t seen because you’ve been in that
room so long [with the patient with all the wounds] and most of the patients on our unit can’t get up by themselves, and when they need to go to the bathroom and you are tied up, and so is everybody else, it makes you feel bad.

Routines and checklists don’t tell the story of how many staff you need. Several nurses spoke about competing priorities that resulted in the nurse’s attention being directed to more urgent care needs. Basic hygiene, comfort, and nutrition needs were trumped by more urgent needs. On some units, the nurses and care assistants sometimes were all tied up with other patients, so that no one was able to respond to the patients’ basic needs for using the bathroom, finding comfort in their beds, and being assisted with meals. On paper, these care tasks may look orderly and adequately covered by the number of personnel scheduled to staff the unit. In real-time, these tasks sometimes arise simultaneously rather than in sequential, predictable order. Time allotted for routines and checklists of tasks appear neat and complete when checked off, but do not convey the events as they unfolded on a unit when caring for patients. In addition, routines designed to fulfill requirements tied to reimbursement, leave no space for omissions or incomplete tasks. Mary talked about how staffing formulas cannot always predict the unit’s needs when things are busy and unanticipated. Shelia agrees that it was difficult to communicate complexity through staffing formulas.

Sometimes our patients are so complex that – and their family members and their psychosocial situations are so complex, I am not always able to do as much as I would want – sometimes tasks get in the way – you know at the end of the day I have a checklist of things I have to do. That’s why we’re here, is to get you better and I have tasks I have to perform. And it’s a balancing act between the
tasks you have to do and I feel like I have enough time to do enough, but I could do more…but who couldn’t?

People can become uncaring sometimes. Sometimes, nurses expressed being frustrated about being unable to show caring, and complete required physical tasks. A few of the nurses expressed feeling horrified by other employees’ uncaring actions. Ophelia described an uncaring action that occurred on her unit.

First thing that morning, this patient’s bed alarm went off. He wasn’t supposed to get out of bed because he was a fall risk, so we go running to his room. He tells us, ‘I need to use the bathroom.’ ... so we’re like ‘OK, let’s see what we can do. So we get him back in ... and he says again, ‘I gotta pee’ and I said to the person who was his nurse that day, ‘we’re gonna have to address this bathroom need like prompt’...But she [the patient’s nurse] says, ‘crazeee...hope I am not dealing with this all day.’ It was under her breath, but it was loud enough for like everybody to hear. I mean I could not get out of that room fast enough. I was on fire.

Nita also has seen nurses that were so busy that they failed to think about the impact of what they said in haste, and their comments were uncaring.

I have a male nurse friend ...and one day, he was helping me change a female patient, and she coughed. And he jumped back and said, ‘Ho, are you ok? And she did it again. [he told the patient], ’Next time I come in here, I am going to put on a mask cause I don’t want whatever you have getting it into my respiratory. ’He was so rude.
Other nurses also talked about different levels of rudeness observed by nurses or other staff. After repeatedly hearing complaints of rudeness from patients, Cheryl reported a coworker to their manager. She was surprised by her manager’s response.

She [manager] told me we were not there to change people’s personalities as long as she [the nurse who was reported as rude] was doing her job. And I said ‘Oh yeah we are, there is a certain way to talk to patients and families…’

Kelly also noticed some actions going beyond uncaring toward being punitive. She vividly recalled being a student and working with a nurse taking care of a female patient who had overdosed.

She was gonna have to give her some medicine; she could have given it to her through her NG tube, but she poured it out and made her swallow it so she would have to taste it. Like I remember that so vividly being in nursing school, I remember, it’s that like charcoal stuff, and she could’ve done it through the tube before she took the tube out, but she didn’t. It was almost like punishing her and that stuck with me.

I have considered leaving. There also were nurses who focused on leaving eventually as a way to cope with their jobs. Alice has started considering if another unit might match her personality and desire for caring interactions.

That is one thing I have thought about is going to a unit or somewhere different because …taking care of six patients, which we do, is very hard. Yeah I wish I could give them a lot a lot more time and care than I can because of time
constraints... some patients are much more critical than others and you know, we spend a lot more time with them, than some of the others that are not maybe as needy physically. They, I guess sort of get— neglected is not the word for it exactly, but they don’t get as much of your time.

You are never caught up. Sarah found the constant busyness to be overwhelming, offering little time to process what all was happening.

That’s all you have time to do, with all those patients and charting ... I just don’t know where the day goes...It’s hard to believe that with 12 hours, that’s all you can do but with six patients. And we are on the phone with doctors and the way they keep coming with all these computers, you’d think it’d make your life easier, but it doesn’t...And these orders are coming continuously and they are all saying like stat stat do this now, stat stat...so you have these orders all day. And so if you get any new patients, all you do is give meds and discharge and admit and as soon as you’re caught up, something else happens. A patient loses an IV or another patient does something else and then something else happens...

Sarah also said she was aware she would not be able to do her job much longer of it weren’t for knowing she would be moving on to be a nurse practitioner somewhere else.

You can tell the older nurses; and the ones who worked there longer that are overworked ...I wouldn’t let myself get like some of them. I would quit. I probably see myself being a little calloused but that’s alright... I see the light at the end of the tunnel...It takes a toll on you...like a lot of those people you see working at Wal-Mart, they might be nurses; it’s true. A lot of the people you see out in jobs like that. Don’t ever judge. I was somewhere the other day, oh I was at a doctor’s office and one of the nurses there said, ‘I had to take a break from nursing; I went and worked at Wal-Mart for like three years. I just couldn’t take it’, she said ‘there’s only so much caring you can do; only so much emotion you can give to a patient’.
April is looking forward to the day she will go ahead and retire.

*Things have changed a lot through the years in nursing; you don’t have the chance to spend the time with patients to care for them; I mean, you can care for them, but not to give them that extra special touch...You have so many patients to take care of and know what’s going on with them and so I don’t know, I have about had it; I am trying to figure a way to move on. You start getting grudges; I used to love my job. I used to love to take care of my patient. And now it has gotten to where, there are some days I just don’t know if I can go there. I don’t think I have it in me. I don’t think I can work 12 hours. Heck I am gonna be 50 before you know it. I can’t do this anymore.*

*I just want to be left alone after working.* Susanna began to consider how she would manage life when she gets married, saying that she is exhausted and mentally in a bad mood at the end of her three 12-hour shifts and it takes several days to recover.

*I tell my fiancé all the time, ‘you are probably at a disadvantage because just from my job, I am always like this much giving giving giving and then he comes to me and I am like, he has no idea. I just want to be left alone.*

*Never good enough.* Following this statement, Susanna thought about a male coworker she had that she thought may eventually leave, and she wonders if she might just have to do that as well.

*One of my coworkers was like ’I do my very best to be the very best nurse I possibly can and then for our manager to pull me in and say, You need to update your boards better...and you need to do your hourly round sheets, and you need to you need to... That totally demoralized him; he*
was like, ‘I have been working so hard to give the very best care’...

Susanna thought these kinds of things contribute to nurses leaving. Susanna, like Sasha found prayer to be a useful centering activity, particularly for coping with facing work that seems undoable.

I think it would be helpful sometimes I just use my little, OK I’m gonna go in the bathroom before I start and I just kind of sit there and I say, ‘OK we can do this’... It helps.

Sarah and other nurses talked about the lack of help from their managers when the unit was overwhelmingly busy. When this occurred, nurses resented nurses in positions that no longer cared directly for patients.

And the nurse managers (shakes head) just don’t know what they do. I just don’t know. I came in the other day and (name of unit) was struggling. I walk in and that nurse manager, her office is just right there by the big window. And she is just sitting and staring at her computer. I walk past her and everybody on (name of unit) is just desperate for help. Nobody’s had a break, they haven’t been to lunch. And she’s just sitting...

I think it would help a lot of the nurses got a lunch break. Sarah provides an example of how she sees a manager could help the nurses be better nurses given the constant work-pace.
I would first of all have a nurse that could come in everyday... I feel like that would improve everyone’s moods ... if everyone could get 30-45 minutes of lunch. And you would only have to pay someone on each floor for someone to come in three hours and relieve someone ... and you would only have to pay me three hours. That would cost hardly anything.

Jennifer, who was referenced in an earlier part of this section on caring when overloaded, talked about managing busyness by reframing the situation as acceptable and just the way things are and verbalizing good intentions.

Oh well, I guess that’s just how it has to be. In the next passage, Susanna shows ambivalence about the answer to the caring problem, restating managerial rhetoric about why things are as they are and why they cannot be changed.

I mean, the way, I don’t know, not without rewriting our system, like, um I don’t know, probably because I agree, most of our things are research based, and doing all these things leads to better care. I guess they are kind of new things we are implementing. You can’t do everything for that patient, I guess... Even what they expect of me, except like there are a few things that are redundant, like I guess I mean... like I don’t think, there is nothing I am doing in my day that I think is a waste of time. Charting in five different places, the same thing or something like that, but there’s the legal system and I don’t want to do that in the court, and so it seems like the climate of things, the way things just are, like ‘I don’t really know.”
Susanna questions her reasoning about work, and mostly returns to accepting the explanations and rationales she has been given or discerned for herself about why certain things are done as they are.

*Some days I feel like such a bad person.* Another nurse talked about how she sometimes experiences herself as a bad nurse when she fails to make caring connections with patients, even though she realizes those kinds of strong connections are not daily occurrences. Other times, the feelings of failure have to do with always knowing there was more that was needed or more she could have done.

*Some days, I’m ready to cry and I’m not a crying person.* I don’t cry but um <giggle> sometimes it’s just horrible. You feel bad about yourself because you feel like you are a terrible nurse, you know you didn’t do what you should have done, or could have done...you don’t connect with everybody and I think you can still show them compassion or caring... sometimes you do feel kind of like you’ve done your job well, but you just didn’t feel that connection with your patients.

*It makes you numb sometimes.* Jennifer feels numb after her day at work when it has been constant giving and responding to urgent issues.

*It makes you become numb to the rest of the world like that and I am sure it’s easier for other people but that’s just not my field. You have to - when you got to work, you have to kind of put your stuff aside ...It is; it’s very hard and sometimes when you think you are doing it but you are not; I got called out by a good friend this week so you, you have to watch yourself; you gotta take care of yourself before you take care of everybody else, I mean so...*
I saw so many hard things this week. Shelia talked about seeing so many hard things, being unable to process all her emotions. She understands she needs to inhibit her emotions in front of the patient, but finds she cannot even process them all at the end of her day.

So you really have to set it aside and so it builds up, and builds up and builds up, and it’s easier now that I’ve been at it for a while, but when I first started I had a hard time with that... it’s something that you just kind of develop I guess. And I probably, we probably all suppress things that we shouldn’t suppress... nobody really teaches you how to handle that in school... it’s something that you learn, but it’s totally overwhelming.

Shelia realizes she shuts down her emotions down and channels them elsewhere. She is satisfied with her job, her manager and her coworkers, but she knows she cannot continue in this type of nursing.

I mean if you let all that stuff just soak in and you don’t get rid of it, you really will just get to feeling just crazy... By the time I get home, I don’t want to talk done; by the time I got home yesterday, I could maybe count maybe 5 minutes that I sat down all day long... I mean it was like all day long, the whole 12 hours. Woke up this morning and my feet were killing me... I’ve got a really good support system and family and my new husband, that’s just nice. He cooks dinner I have dinner waiting on me... Sometimes I tell my husband, I don’t have a good reason for it, I don’t really know why but sometimes I just need to cry...... I don’t have a child ... but I think pets are the greatest thing you can have. They’re always happy to see you; You can do no wrong by them; they think you’re the most wonderful thing in the world, you know- How can that not be good for you to have somebody just run up to you when you walk in the door, just be like ‘Oh I am glad you’re here.
Support matters a lot. Mabel reveals how important processing intense emotions can be for one’s well-being.

I can still remember my worst day. It was during that first six months. ...I ended that day in tears. Horrible, horrible day! Not only did our shift leader come in and try to comfort me; our nurse manager called and she had him put me on the phone with her because I’d had a bad day and she wanted to talk it out with me...and for a couple of weeks afterwards, different people... would come up and ask me how I was doing and they were trying to make sure I was emotionally healthy to keep coming back to work. Because it was traumatic emotionally physically...I was choked by a patient and it was awful for me, and it was scary, and it was devastating for me.

The immediate support and response to emotional intensity of trauma for this nurse greatly decreased her trauma. She described how all the support on the job helped her. While Mabel had managed to cope and also said she loved her job, her main interest was in becoming a manger so she could influence how nurses were able to find time for caring for patients.

Some nurses just seem to be able to bring that calmness to a situation. Anne describes feeling a disconnection between where she is emotionally about caring by conscientiousness or compassion.

Um...definitely not where I want to be. I look around at other nurses, whether they work with me, or just nurses I know from other units, who to me— just seem like they are both competent, really great at what they do, and they are just able to bring calmness, whether it’s a code situation, or an emotionally needy patient, they just seem to handle it all, and at the same time, give really good care. I don’t feel
like I’m to that point but I do think I am so much better than when I first started out. ... I think I have definitely progressed in being caring but I am not where I would like to be.

Anne reveals that she is actually hoping to become more of a holistic practitioner so that she might be able to incorporate more of what she believes is important in caring for patients.

*I just try to balance and keep my sanity.* Sasha indicated that a lot of times she is so busy on her unit; she is unable to get to her patients in a manner that management and care standards dictate, and that she believes to be acceptable.

*I try not to lie about it I’ll just say we’re a little busy, we’ve had a lot of new patients to come in, but I don’t necessarily say we’re short staffed. I just let them know ...I am here to help, what is it that you need. I try to balance it by keeping my sanity all at the same time.*

*I’m not really that kind of nurse anyway, all sweetsy...* Anne talked about how she had tried to lower her expectations and most of the time is able to be accepting of how she did lower what she expected, but not always.

*I am not really gonna be that kind of nurse like who’s really affectionate to a patient and sits on the bed and holds their hand That’s not really my personality anyway...So I feel like as far as what prevents me from doing that to another person is like I don’t have time and feeling like you know it’s more important that I give out these twenty medicines to four different people than sitting down...*
Although Anne says she is not the traditional caring type and she likes her job, she plans to look into a holistic care practitioner career because she can have more time with patients and what’s really going on in their lives. This ambivalence was common in nurses who had figured out how to convince themselves their work conditions were acceptable. In Anne’s case, she did have the support of a great unit manager and helpful coworkers, but she still aspired to more interpersonal contact with patients. At least for the time being, she was finding it workable to not be ‘that kind of nurse.’

_Somebody needs to let people know…we can’t do this._ Susanna had lowered her expectations, but did not think patients, families, and managers had done so.

_We have some people who still think we should still be the nurse angel type role, but…the medical care just keeps expanding, taking up time._

_As long as I can, I am going to be caring._ April talked about how she knew she was leaving eventually, but in the meantime, she had no intention of lowering her standards for caring for patients.

_Somebody told me I needed to grow a backbone…because I was crying with a patient’s family member and of course my response was ‘the day I quit caring, is the day I need to get out’ and Laugh….. but that’s why I’m here and if I quit caring, well – I still care for my patients. I will leave when I quit caring …if not before hopefully_

In this theme of accelerated caring, the nurses who were most satisfied were those with good managers, good coworkers, and nurses who found a way to redefine their work
success and goals. Even these nurses, however, were making plans to leave their jobs for more interpersonally satisfying jobs.

Some nurses were appalled by uncaring actions of nurses and wondered how they had arrived to the point of being able to be so uncaring. Calling patients names aloud was unsettling and unthinkable to nurses who saw themselves as caring. Misusing one’s discretion as a nurse to cast judgment and inflict punitive consequences was outside the purview of the nurse, especially the caring nurse. Disregarding the patients’ needs and interpreting those needs in terms of how it affects the nurse at the moment was clearly seen as uncaring and as something that happens to nurses who allowed themselves to stop caring but stayed in their jobs rather than get help or move on. At the end of the day, regardless of what a nurse says or does, Sasha’s says both patients and other nurses know when a nurse is or is not caring. In the next major theme for this study, nurses talked about how they adjusted their level of caring based on patient needs and context of the unit or hospital they worked.

**Theme Three: Flexible Caring, Caring as Adjustable.**

**Overview of Theme Three: Flexible Caring**

Several of the nurses, as they struggled to figure out how to maintain a caring manner despite heavy workloads, realized that their own style of relating to others was not always suited to the needs of a diverse group of patients; thus, these nurses learned to adjust their caring styles to meet particular patients’ needs in a way that made sense to both of them. For instance, nurses attempted to adjust their caring to what the patient perceived as caring and to the age and developmental levels of patients. Most of the
nurses in this study found pre-defined approaches to care were antithetical to responding flexibly to patients’ varying needs. These nurses preferred to use guidelines as opposed to fixed routines to respond to the patient and situation. Sample passages from nurses interviews are provided below and grouped by the subthemes of the third main themes for this study, flexible caring. The subthemes are illustrated in Figure 5.4 below.

**Figure 5.4 Subthemes for Flexible Caring.**

<table>
<thead>
<tr>
<th>Subtheme 1</th>
<th>Subtheme 2</th>
<th>Subtheme 3</th>
<th>Subtheme 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>knowing your patient</td>
<td>awareness &amp; sensitivity</td>
<td>sometimes it’s what you don’t do...</td>
<td>Finding your own style of caring</td>
</tr>
</tbody>
</table>

**Theme Three: Flexible Caring, Subtheme One: Knowing Your Patient**

In this subtheme of flexible caring, nurse participants talked about the importance of understanding patients’ day-to-day lives so they tailor teaching about illness management to the patients’ unique living circumstances. Nurse participants indicated they were usually so busy with required routines that it diminished their sense of caring for the patient. Katrina felt she was particularly skilled at adjusting her caring to the patient as described below.

*You know as a child you are taught the golden rule – do unto others as you would have them do unto you, but everybody is so different. I don’t want to be treated the same way as everybody else does. For instance if I am sick and I am at home, I will be in my bedroom with the door*
shut. Check on me, make sure I am breathing and don’t need anything, but leave me alone when I’m sick. Not everybody is like that, so if I treat you like that, you are not going to feel cared for. Patients may perceive me as not caring and not a good nurse if I do for them what I would want, so – my caring is adjustable; it adjusts to that person. You become a good reader of people … even if you just met them.

You have to be attentive to cues. Katrina spoke of having strong intuition about people which she developed after years in nursing. She referred to this as her ‘nursing gut.’ Jennifer also describes her caring as needing to be adjusted based on the patients’ needs.

…So when I have a patient who is hurting, not hurting just because of what they’re there for – they may have a daughter who just found out she has lung cancer or a mother who just had lung cancer…or like recently I had an older female patient who lost her husband; they had been together fifty-something years. That’s definitely going to affect her and you may not know that if you don’t take time to develop some sort of relationship with that patient.

You can’t approach everybody the same way. Jennifer implies that without knowing the relevant concerns in a patient’s life, it becomes difficult to know how to approach and remedy a patient’s problem. Several participants offered examples of how standardized checklists prevented them from getting to know their patient as well as they might if they approached them as an individual. Jennifer pointed out that as a female nurse; she had to approach her male and female patients differently.

It’s the same goal of making everybody feel comfortable …but it’s how you make them feel comfortable. It’s
different for men and women... As a female nurse, you can’t show men the same caring in the same way you do to a woman; you have to approach it differently...With women, we are sensitive and we talk...show emotion and concern, maybe touch or pat, but with men, you just walk in and tell them what the bottom line is, and to them, that’s just as good as that hand pat or emotional talk with a woman.

Jennifer also used knowledge of developmental stages to approach patients of different age groups differently.

You have to approach them different. Just like I am not gonna tell a 3-year old straight up what to do; they’re three, their mind set is different; you are gonna hold them and love on them, and tell them that the blood pressure cuff is an air balloon, and that something that makes noise is a cricket. You’re gonna go to them at their level. You’re not gonna tell an 18-year old the same thing you tell an 84-year old in the same way.

Knowing what is unique about people rather than treating people as a routine.

Many of the nurses felt that establishing a relationship with the patient allowed them to get to know the patient as a person and better anticipate their needs. Susanna selected her work unit for that reason.

I decided to work on that floor because most of the patients were not so sick that they could not talk to you...a lot of what I needed to do with them after they had their surgery allowed me to talk and have interaction with them. I thought that was nice and allowed for caring. I think it makes people feel more human when you can talk with them and get to know them as people, know what is unique about them, rather than treating everyone by a routine.
Everyone is different in how they cope. Similarly, Shelia talked about how she understands when a patient may be expressing a fear that warrants her reassurance.

You have differences in family members – everybody takes that stress and these emotions and portrays that differently – you have some people that become angry; you have some people that they will watch your every move; they feel like they have lost so much control that they try to find something they can control – they’ll find something – you know I had a patient’s family member one time that pointed out a small spot in a ceiling tile. She was very upset about it-I mean very upset and she was adamant that we have maintenance to look at it you know (laugh) and I did.

Everybody does not need the same thing to feel cared about. Shelia talked also about patients having markedly different personalities, backgrounds, cultures, and correspondingly different needs.

I just think it’s how people portray their emotions at times... you go from room to room and in one room, you may go in there and the family may cuss you, they may talk down to you, they may look at everything you do, and then 5 minutes later, when you leave that room and you go to the next room...the patient needs to be turned - The family has already done it – you can’t do anything for them – ‘Would you like a cup of coffee? No absolutely not; I would not want you to have to go and get me a cup of coffee’ ... everybody does not need the same thing to feel cared about.

Showing caring varies person to person, but it’s not gender that makes it different. Shelia also felt there were variations in how all nurses displayed caring and she emphasized she did not think it was due to gender.
I mean they may be different in the way they approach things, but everyone is; but it’s not gender, its personality and the way they show they care, and the things they care more about may be different, but just from person to person – not gender.

Shelia talked about a male nurse who was highly efficient but gave no emotion to their patients. She emphasized there was a female story to match every male story, and thought gender was over-emphasized in nursing.

Don’t yell at old patients til they tell you they can’t hear. While several of the nurses felt developmental and age differences were covered well in nursing school, some nurses noted fine distinctions in learning about as opposed to typecasting people based on assumptions of differences. For instance, Ophelia was annoyed by an often observed practice on her unit; nurses’ automatically shouted at older patients.

We get a lot of 70 and 80 year old patients and sometimes we get 90 year old patients that are really vulnerable, and maintaining respect for them while they’re vulnerable like that, has a lot to do with how you care for them, and how you talk to them. Don’t just speak loudly because they’re older, you don’t know if they’re hard of hearing; you’re assuming something. Quite frankly, it can be offensive so until they say ‘baby I’m hard of hearing could you lean into my good ear’, then you can speak loudly or louder...It’s like putting a blanket over people even when they aren’t cold – same thing.

Where you work has a lot to do with how your job is. Nurses who worked at other than their present hospital usually also commented on differences in how the institution made it possible to care and differences in expectations for caring. The comparison from
one hospital to another often made the nurse grateful for their current job, even if there were problems. Below, Cheryl explains how she left a hospital after having worked for years in a larger medical center associated with an academic environment.

At (name of hospital) I went to the nurse manager...I said, 'I am just gonna tell you right now; I don’t think this is gonna be for me.' And she said, 'Oh please, stick it out and let’s just see', and I said 'I will'; It’s not the patients; to me, they are easy compared to where I worked, but it’s the mentality here about the doctor...I mean I really just felt like it was backwards ... you know where I came from, I provided nursing care to the patients, not checked up on what the doctor was supposed to be doing, not that I ignored what they were supposed to do, but I took care of patients, not doctors.

Cheryl cites an example of being expected to manage details that fell under the physician’s responsibility.

At this place, the nurse was responsible for everything, and the physician had no accountability...You know one day I had a patient screaming in pain and I finally got the physician on the phone and said 'Look he needs a pain pump or something' and he said 'OK, well order a pain pump’ click! And I said to the charge nurse, ok, I am not used to that, what drug, how much, and the charge nurse told me it was on a protocol to make it easier for the doctor. The work should be easy and you should really be able to spend time with your patients, but all your time is running shuttle for the doctor to make their life easier.

Cheryl’s ability to be caring toward patients had to be adjusted because of differences in how the hospital defined responsibilities. Cheryl left this job because she did not wish to adjust her idea about caring for patients even though it was tempting since it was within
minutes of her home, the pay was comparable to her previous job, and the patients were relatively uncomplicated. In the next subtheme of flexible caring, nurses talk about the importance of knowing oneself to be able to care for patients.

*Theme Three: Flexible Caring; Subtheme Two: Awareness and Sensitivity*

Awareness and sensitivity was a subtheme of flexible caring that had to do with nurses who adjusted their caring by self-reflection, pausing and reconsidering, journaling, or other forms of self-examination. Most of the nurses acknowledged having little time to reflect on interactions or actions and feelings affecting patient care. There were several nurses however who had made personal commitments on their own to reflect on their work with patients. Alice ruminated a lot about her work and her interactions with patients, but what she focused on was how her coworkers’ role modeling of caring behaviors prompted her to reconsider her own feelings and reactions to a patient.

*There are days when you can have personal stuff going on or tough patients or whatever, and when you see other nurses really caring for their patients or you see them come in your ‘difficult patients’ room, and see them interact with them in a caring way, you think, ‘Oh I need to readjust what I’m thinking and, see that person as somebody other than how I am seeing them right now.*

*You have to anticipate what some patients need.* Shelia revealed how she maintained awareness of the differences in her patients’ expression of needs. Responding only to requests made by patients would eliminate the quiet patient who asks for nothing.
In Shelia’s example below, she shows how it is important to take the time to notice patients who are less vocal about making their needs known.

*Sometimes we will have patients and they will let you know everything that they need, but then sometimes we’ll have patients and they won’t ask for a thing. You kind of have to say, ‘you know, you haven’t had anything to drink today, how about I get you this or how about I do this’ – you know things like that, anticipating their needs even when they don’t express things.*

By pausing to place oneself in the situation of the patient, Shelia can offer the patient what she might want or need. This suggests sensitivity beyond that of being sensitive to requests made of the nurse. This sensitivity allows Shelia to provide the kind of caring she believes to be important and is also what gives her so much emotion to process about what she experiences with patients.

*Nobody really teaches you that, how to deal with all these emotions.* Shelia expressed a need to learn how to express the many emotions that build up inside of her when dealing with patient situations, some of which were especially hard emotionally.

*Sometimes it’s hard for your mind to process [emotions] because you have to put up a front ... and so it builds up and builds up and builds up... nobody really teaches you how to handle that in school...how do I deal with my emotions when I leave this place, what do I do to channel those?*
Getting to talk with others about work, it’s just nice to hear that other people think what you are thinking. Lacking opportunity to process and express these emotions was something Shelia was at a loss to do; she acknowledged she probably suppressed many of those feelings. Shelia also talked about something her hospital offered to improve the multi-disciplinary imperative for better teamwork. She found it validated her emotional experiences as part of normal reactions to difficult situations.

We have something ... called ... (name of group), they do them once a month and it’s where we come, present a case, something that was really hard or difficult and then everybody kind of talks. …. there’s usually just a ton of people there...but you can raise your hand and speak. I have gone to them and I thought they were awesome. I have never actually spoken up and said anything; I never really felt compelled, but it’s just nice to hear people saying things you are thinking. I’m not the only one, so you don’t feel crazy.

You need to know your limits so you don’t end up working in the wrong place for you. Cheryl, who worked on several medical units throughout the hospital, started her career working in a longer term facility where people with severe injuries were rehabilitated. She decided to try a different area, but learned it was not a suitable match working with newborns and premature infants.

I remember people kept saying ‘isn’t that so depressing?’, cause I had worked with paralyzed patients and I said ‘To me seeing these babies go home to these awful situations is depressing to me’.
Cheryl’s comments illustrate the value of self-awareness in order to know one’s strengths and weaknesses in helping others.

_You have to keep your own problem separate._ Jennifer talked about how dealing with a patient or family’s emotions was sometimes overwhelming. She indicated when she had problems of her own, she had to exercise self-discipline and feedback from others to stay focused on the patients’ problems.

_You have to - when you got to work, you have to kind of put your stuff aside. My coworkers’ call me out and keep me reminded if I am a little off my usual self._

_I just have to have that alone time after work._ Several nurses talked about needing their alone time after work. Alicia described her need for peace and quiet after a shift.

_I will come home and I’ll sit down and I’ll go outside and sit down-I will say hello, but I have to have that alone time just to get my thoughts and break away._

Susanna did not want to talk at all, and often felt mad at the end of a shift. She and other participants expressed concern about how this affected their personal relationships. When scheduling an interview with Cabriole, she asked to postpone our meeting day until at least the third day after her three 12-hour shifts ended, “I don’t really even feel like putting clothes on til about that third day.” Beth, Amy, and Trixie all mentioned having nothing left for anyone, especially after three back-to-back shifts and described feeling numb, depleted, and empty.
Twelve hour shifts were the worst thing that ever happened to nursing. While most nurses enjoyed the benefit of having extra off days with 12-hour shifts, Cheryl and several other nurses acknowledged it was probably not the best thing for patient safety because the nurse became too fatigued to be attentive and sensitive to patient needs.

With these 12 hour shifts, I think you don’t have consistency and you don’t get to know patients. When we did 8 hours I had my same four patients five days a week and so I would know if a patient had her hair washed. After 8 hours, you are tired and it’s hard to keep caring. …I don’t ever see it going back. The institution saves on those benefits and young nurses love the flexibility and off time. I think it was the biggest mistake nursing ever made.

In a prior example, Susanna shared her experience about a patient she felt like she had been very caring toward through her diligence and focus on responding to their urgent care needs. Still, the family perceived her as rude.

I just came in working, changing out pain pumps, assessing. You know I was just very; I was just very ...I was focused. If I had just taken two or three minutes to do a formal introduction and say ‘I am open to any questions you may have today’, that would’ve helped ... I guess I didn’t explain anything to them because they were sitting quietly with their electronics.

In Susanna’s example, she was unaware of how her busyness impacted the family, and thought because she was working so hard, this would be understood by the family. She did understand some of this retrospectively but felt somewhat justified by the severity of the patient’s condition.
There were many examples of nurses displaying awareness of how patients may perceive their actions. Some of the nurses tried to address that upfront with patients despite being told by management to never tell a patient they were busy. Others were aware but did not feel there was a lot they could do about it. Some participants tried to be as friendly as they could and felt a commitment to always hide their emotions related to being overwhelmed or preoccupied. In the next subtheme, nurses discuss the importance of withholding action as sometimes necessary for manifesting caring.

Theme Three: Flexible Caring; Subtheme Three: Sometimes It’s What You Don’t Do

The third subtheme of the third theme for flexible caring is sometimes it’s as much what you do not do, as what you do. Nurse participants speak about thoughts and actions as part of decision making about showing caring to a patient. Rather than assuming all caring is niceness and kindness, the nurses’ show how caring sometimes required doing something uncomfortable or withholding something more comfortable.

I will help you, but I want the patient doing things for themselves. Mandolyn, a fairly new nurse, finds it is important to base nursing actions on their implications for a patient. She points out that she has learned from hard times in her own life that the most caring action is sometimes to not do something for a patient, especially if they are capable of doing it for themselves. She uses bathing patients as an example.

That’s my big thing...lot of the people I see in the hospital – when it comes to doing baths and things like that, the staff
want to do it themselves ... But, I like to say, especially if the patient is able, I want the patient doing it themselves, ‘here’s a washcloth, wash your face and I’ll help you’. Because caring isn’t doing something for somebody; caring is almost like the old saying, if you give a man a fish he eats for a day; if you teach a man to fish, he eats for a lifetime. So caring would be sometimes a little bit of tough love, giving them the tools because ... when you’re not there ... when they are alone, they can do it for themselves.

Mandolyn’s comments suggest she considers the underlying effect of helping actions as her criteria for deciding if an action is truly caring. Lindsey also shared an experience about a patient who refusing to cooperate with preventive treatment pertaining to a developing bedsore.

We had a patient whose skin was in such bad shape, it literally, it made me cry...We’d go to turn him, “We need to turn you; you can’t lay on your butt all the time, ‘No I’m good’, No we really need to turn you ... Oh I didn’t turn him because he refused. ...People nowadays don’t want to take responsibility for their actions; it’s always somebody else’s fault.

You have to help patients do what they don’t want to do. Cheryl also gave an example of needing to get patients out of bed after surgery as an action supporting their recovery.

Newer nurses don’t understand; everything is so overwhelming, they see it, but will just leave the patient laying there and I would be like ‘has this patient not been up?’ and they would be like ‘No, he didn’t feel like it’. Hello we are there to help the patient get better. Just because they say no doesn’t mean your work just got lighter; it got harder, you have to help them do what they do not want to do, and keep at it. The patient needed to get
up and be turned and you can be nice doing it, but it’s part of it.

In the final subtheme of flexible caring, nurses address how they find their comfort zone for levels of caring.

**Theme Three: Flexible Caring; Subtheme Four: Finding Your Own Way Of Caring**

In the final subtheme of the flexible caring are the words of nurses acknowledging how they had to develop their own unique way of caring that felt comfortable to them. I begin with Mary who continues to work in nursing despite her disappointment with the busy market-driven direction hospitals have taken.

...Our nurse manager was doing rounds and noticed the nurses were staring at the computer trying to figure out what they’re doing instead of talking to their patients. She knew that when the new program was starting, there were going to be some complications – patient satisfaction was gonna go down. So I suggested ‘why don’t we do what we have to do on the computer, push it out of the room and then stay with the patient a little bit longer and talk to them about whatever you need to talk to them about, just carry on a conversation for a couple of minutes and then that way they feel like ‘ok, you are not just nursing the chart’, you’re taking care of them as well.

Mary was able to make a suggestion to her manager that was being tried and was going well so far. Whenever possible, Mary tried to bring in the caring aspect to conversations with management about work. Throughout her interview, she was realistic about the limited time available for displays of caring. While she was not greatly
impressed by her manager, good coworkers and the commitment to always remember the patient as a person was in the forefront of each action she described.

If I can’t have time to be caring, could I at least have help to do all this other stuff I am overloaded with? The next participant, Susanna also shares how she has come to accept she is unable to show caring the way she would like, but holds out hope for the day she becomes efficient enough at the required tasks. She also wishes she will have time for the interpersonal aspects of patient care. However, Susanna has begun to consider that they may never occur. She concedes that if she is not going to have time for what she enjoys, it would be nice at least to have someone to help her when she was overwhelmed.

Most of what I want is, I would love a very efficient skilled nurse... on our floor. I would love to have someone, I could go to whose answer had to be ‘yes I will help you’. I would love that. Just someone to do just like even the stupidest thing for me, like go give that one pill... I just want to feel like, while I am there doing my job that I have the help, I need to do everything I need to do.

With time and experience, you can become that kind of nurse. Next, Sasha shares her vision of having become a caring nurse.

You keep doing what you know you are supposed to be doing for each patient and hold to your values, and after a while, slowly you realize you have become that kind of nurse who makes a difference.
Sasha came from a family of nurses and saw nursing as deeply embedded in her identity; while she saw problems in hospitals, she was committed to her nursing identity, to her organization, and to the rules. She maintained a positive attitude about the motives of the organization and the meaning of the different rules and routines. At the end of the day however, Sasha knew when something did not seem right. Until someone disrupts her loyalty, she continues on as the compliant, devoted, and dependable nurse who never forgets she is there for the patient. In her interview, she described situations where she spoke out when she witnessed wrongdoing, especially regarding a patient. She stood up for herself and coworkers whenever another person did something to undermine her satisfaction with work.

Women don’t stand up and try to advocate for ourselves, like the men do. Cheryl who formerly identified several differences between male and female nurses believes the best way to affect caring in nursing is through what male nurses seem to have more of—leadership and assertiveness.

...I mean honestly most of the men that I personally work with are very caring and usually they are very involved in the teaching and the committees and change...I think a lot of why nursing don’t change is because women don’t stand up and try to advocate for ourselves, like the men do.

I don’t want to be the nurse who isn’t remembered. Mabel shares her ideal of caring nurses as one who people remember.
I want to be the nurse who people remembered because that was it for me...the nurses we remembered were the nurses who did something...I always remember the really, really good and the really, really bad and I don’t want to be the forgotten one in the middle. I want to try to make an impression, a good one.

Mabel became a nurse after having had positive experiences with seeing her grandmother cared for by nurses who stood out in her mind. Since becoming a nurse, Mabel strives to be that nurse for others.

*It starts with being mindful of how people are perceiving things.* Catherine, who has previously talked about caring as good manners, again defines her caring by her manners and courtesy.

*It’s one of those things that I have sort of learned my own way. Not my own way of doing it, but getting to my comfort zone of how I show caring to people. Of course, it starts in school where they tell us about treating people with respect and being mindful of how others are going to perceive what you are doing and saying.*

Catherine thought the best way to show caring was by being respectful and polite and always deferring to the patient. As one who described herself as talking a lot, learning to think of how people will perceive her words has been a way to be more caring for Catherine.
Caring? I had to cut back on that. As pointed out previously, several participants found they had to make a choice about how caring they could be. Susanna had to cut back on doing more for patients than the institution required.

I was motivated to go above and beyond...but I knew that ...me staying late is a cost to my unit... so I had to survive and look around at other nurses and see how they did it...and I had to cut back on those things that weren’t absolutely necessary.

As a new nurse, I just felt chaotic inside and so I had to choose...I chose to be competent. Anne had to make a decision to be more of the conscientious nurse than the compassionate nurse.

I just remember getting out of school and thinking, ‘I can’t both be calm and caring, and plus be learning how to be a new nurse’. On the inside, I would just feel chaotic. ...so I kind of feel like I had to, at the very beginning, choose between, ‘do I want to be that really sweet caring nurse or that competent let’s get it done’ nurse?’ ... I am a very safe and careful nurse and that’s how I care.

We all suppress things we maybe shouldn’t. Shelia found she had to suppress feelings in order to be able to provide the level of caring her job allowed.

You can’t let your emotions interfere and that’s a really hard thing to do. And you can’t teach new nurses that. You can’t, because I remember when I was a brand new nurse, my thing was ‘I just want to make sure do everything I am supposed to do’ and then you have to worry about this whole emotional aspect...I know we all suppress things we maybe shouldn’t.
I’m okay with being a control freak about getting your medicines right...that’s how I care and I’m okay with that. Anne, who earlier stated she felt she had to choose between being conscientious and compassionate found it was more fitting to her personality to feel good about being efficient.

That’s how I honestly feel... There are times when I say ok I could’ve said something verbally or I could’ve taken a moment to do something extra and that would’ve just shown them that I did have time or that I did care, but I feel like overall the fact that I am really a control freak about getting your medicines to you at the right time right dose right route is showing I care...That’s more of my personality too and I think personality in nursing is not all cookie cutter not all sweetsy I think there’s a value to having all kinds of personalities in nursing and I have somewhat come to terms with the fact that I am not going to be that really really just sweetsy sugar coat nurse No that’s ok I am ok with that.

In ending with Anne’s quote, finding her own style of caring seemed important to her job satisfaction. In the last theme of institutional caring, Anne reveals her ultimate aim is a nursing position where she can have more of those caring moments and approaches to holistic care concepts as opposed to the caring defined by others.

Theme Four: Institutional Caring, Caring Defined By Others

Overview of Theme Four

Most of the nurses bemoaned a lack of time for showing caring. They often noted that they could have done more. Several nurses already experiencing stress about being
unable to find time to carry out all of the physician’s orders were particularly angry when workplace barriers persisted, yet hospital administration insisted on nurses’ using slogans, phrases, and routines designed to give patients the perception of having been well cared for.

Some participants defined caring in terms that appeared to reflect their own hospital’s mission statements, slogans, and messages, suggesting they had internalized these definitions as their own. There were participants who felt a sense of pride about being associated with their hospital’s projected image; they reported feeling invigorated about an opportunity to strive to manifest what the hospital represented. They felt their association with the hospital’s image may also imply something about their own identity as nurses. Some participants redefined themselves as caring by more realistic standards. They accepted the demands for compliance with externally defined standards for good care, and settled on being safe nurses who simply did not have time to be caring. These nurses resented being held to unrealistic standards by the public and the hospital, including historical images of nurses as angels of mercy.

As reported in the literature, nurses found fault with the strong customer-service orientation of hospitals. They saw this focus of care as safeguarding against acknowledging hospitals’ insufficient staffing and resources (Bradshaw 2009; Bryman 2004; Francoeur 2004; George 2008; Hallett et al. 2012; Ritzer 1993; van Maanen 1991). Nurses’ specific comments will be shared for the final theme of institutional caring, grouped by subthemes (illustrated in Figure 5.6 Below) beginning with caring by the rules.
Theme Four: Institutional Caring, Caring Defined by Others; Subtheme One: Caring by the Rules

Caring by the rules, a subtheme of institutional caring includes statements by participants who experience a sense of structure or alternatively, an uncomfortable stress from requirements for strict compliance with rules about patient care. While most nurse participants found rules served interests apart from good patient care, some participants saw rules as ensuring thoroughness and equality in delivering care. There were hospitals that rewarded nurses with flexibility in arranging their own schedules when they achieved the one-hundred percent mark for complying with rules. Compliance with rules was tracked through surveillance devices. Several nurses held onto the hope that if they reached the desired efficiency required by the hospital, they would then be able to do more of the things they enjoyed such as spending time with patients.

Some nurses saw the compliance with rules to be impossible because rules conflicted with each other. This was made worse as additional requirements were added to older ones that continued to be enforced. Nurses who saw rules used inconsistently to promote things other than good patient care were more frustrated about their compliance efforts. There were also nurses who felt the rules were an absolute impediment to their
ability to be caring with patients. Some nurses felt their managers insulated them from rules that got in the way of taking care of patients. Having a manager who was encouraging and empowering to the nurses’ contributed to the nurses’ satisfaction and loyalty. These nurses were still able to see the bigger picture of hospital care as too constraining to their visions of what nursing should be to support their retention over the long run. Some of these nurses were contemplating plans for eventually leaving, often to become a nurse practitioner hoping they could better control their patient care. Specific statements begin below to substantiate this subtheme of caring by the rules.

You have to think about it from the perspective of job security. Sasha supports the institutional rhetoric of her hospital by considering that the institution knows what’s best for its longevity and financial survival.

Well, you know if the patient is not satisfied with that particular institution, word of mouth travels fast...they tell one person and another person tells another person and pretty soon, you’re losing business. If you’re losing business to the point you have to make cuts back and positions have to be cut ...so you have to think about it from the perspective of job security.

I try to do whatever I am asked. Sasha believed it was important to do what was asked of her by her institution because she understood it was part of remaining employed. She described readjusting her own nursing goals to comply with these requirements.

I just prioritize what it is I need to do. If I have patients who need pain medicines, I try to get that, and if I need to hang blood, I try to get to that ... I try to put charting off
until the last thing...first I try to do anything that’s pressing right that moment. You just accept this is what’s required.

Sasha prefers interacting with her patients, but understands there are things she must do as priority. Sasha expressed a strong motivator in her work was her coworkers who boost each other’s morale.

_Just giving all my medicines is about all I can do._ In the next example of caring by the rules, Susanna describes how she looks forward to becoming more efficient at the rules and procedures, so she can have more interpersonal time with patients.

_Right now, it’s all I can do to get through my day and having given all my medications on time and get out on time ... cause like as a new nurse, I do need to do those things expected of me by the hospital. And then hopefully as I become more efficient...I can find a middle ground of doing more of the things I actually enjoy, which are the those moments with the patients or just asking questions ...like, 'What did you do for a living or like what’s your job?', do you have any grandkids?_

As Susanna continues thinking about work routines and rules, she begins arriving at a conclusion that perhaps it is merely wishful thinking that she will ever be freed up enough to spend time with patients as she desires.

As they implement more ...and more ...of these institutional protocols, it is harder and harder to see that happening. Like now we are doing bar code medication administration, which pegs us down to the times of our medication and interrupts our workflow. I am literally in the patient’s room at 9:53 quickly scanning everything so I can say I gave the medication on time
They just keep adding and taking nothing away. Alice arrives at a similar conclusion about being unable to do the kind of caring in nursing she had envisioned because of so many requirements.

There are a lot of little things that add up. Like the handwashing thing…my hands are overwashed…it’s just a little thing but I mean …there’s all these little things they keep up with and … if you have a high enough score, you get to maybe make your own schedule …

As observed previously with this and other participants, it was hard for participants to articulate a complaint against their institutions. Alice excused being treated like a child by management by rationalizing that nurses did actually need to wash their hands.

People get in trouble for petty things instead of things that I think should matter.

In the next example, Sarah is less liberal with making excuses but falls short of acknowledging her anger directly.

I see people get in trouble for little petty things, but when it’s something I think you should get in trouble for, you don’t. Like bad attitudes…you don’t get in trouble for that…and calling in too much, you don’t get in trouble for that…and not knowing what you’re doing in taking care of a patient, you don’t get in trouble there too much, maybe have a class…But like, ‘OH you forgot your badge today … ‘oh my God!’
It’s not all about care, it’s about money. In the next example, Kelly talks about having become fed up with the excuses made by administration that never really fixed patient care problems.

Administrators like to say it’s all about care... but it’s even harder to hear coming from somebody who doesn’t do it. People are always trying to start and implement things that they don’t have any experience in, ‘Now you gotta do this’ They keep putting more and more on the nurse, but it’s like they don’t realize putting more and more on them, you are taking away from what they can actually do with the patients. It’s like more responsibility keeps getting added...If we’re short staffed, we can be the assistant; no secretary, the nurse can do it.

Kelly is the nurse who left nursing for an indirect care position. She describes herself as very compassionate and loved her work, but just grew weary of the insincerity and the business focus of hospitals. The next example comes from Mabel who is very clear with her thoughts about patient care and administrative undertakings that undermine her ability to provide care.

People that don’t do what I do should not be making these decisions. Mabel has shared some very sincere and solid examples of being committed to her institution throughout her interview. Below, she briefly digresses from supporting her institution to make a clear statement about her work as a nurse.

I feel like these people make decisions about my job and what I should do in my job but they’ve never done my job and some of them may not even have a medical background so it’s hard for me to take them seriously...I understand it’s
important; it’s what I have to do, but if I could sit down with some of them, I would be like ‘Dude, come on’ (laugh) have you ever done this- do you know what I do?’

All that focus on little things will take away the caring. Mabel goes on to explicate how routines can undermine caring.

Some things they put in place like hourly rounds. they are good tools...but sometimes we get so bogged down with rules - it doesn’t matter if I provided the best care to the patient, that I was so patient when they cursed at me, and when their family members yelled,...or when I held their hand while they got some bad news...They may not focus on that, but they will focus on the least departure from the checklists. It makes me worry that all that focus on little things will take away the caring and things we need to do at the bedside.

People who question things get in trouble. Three participants indicated they had found that if people think you are self-confident and know what you are doing, you can pretty well expect to be sabotaged. For example, Sarah talks about how she avoids telling managers about employee problems unless they are severe.

... I try not to act smart. They throw you to the wolves when you’re smart...People who question things, the rules, how things are done, I just think they get in trouble. I tend not to question stuff; I tend to question things only with patients...Maybe just drop a little note to the educator.

Other participants thought caring meant doing whatever was needed on one’s unit, and other variations of being committed to one’s workplace. As reported in the literature by researchers such as James (1989) and Ray (1989), rules and bureaucracy are inherent
in efforts to transform the care of human beings into standardized efficient routines dependent on profit. In the next subtheme, caring by the hospital mission, participants focus on those things that brand them as an employee of a certain hospital.

Theme Four: Institutional Caring, Caring Defined By Others; Subtheme Two: Caring by the Mission

The second subtheme for institutional caring was caring by the mission. Caring by the mission extends beyond complying with rules. Participants’ responding in ways suggesting they have identified and internalized their hospital’s mission statement tended to make comments sounding more directed than the participants own words. In a couple of cases, the definitions sounded similar to actual advertisements I had seen for their employing hospital. I begin with an excerpt from Alice’s interview, the nurse who selected her hospital specifically because they served a lot of patients from a lower socioeconomic class.

It’s being a representative of your hospital. Alice indicated she selected both her school and the hospital she works for because of their reputation for being caring and having strong Christian values.

I knew what to expect, but I still picked it because I like what it is and what it represents, and who it serves. The same thing with my school, the reason I picked (name of school) was because of the lady that started it. She was known for her caring, and so that’s why I picked it, and … all our instructors were very caring. When you see that and experience that, it makes you want to be more like that.
Alice is not reciting the hospital mission; rather she acknowledges what it is and says it was the mission statement that attracted her to apply. Alice goes on to compare her hospital to the biblical values it espouses and how they mirror those values in treating the employees the same way they want employees to treat the patients.

_the higher up people, I don’t know what all their titles are, but you see them walking around the hospital a lot, and they do know your name and they say hello to you or check on you, and see how you’re doing; it’s not like you see them all the time, but people in general are very friendly. I mean that’s how they want the environment to be. For the most part, it is and that is a lot of what I really enjoy about it._

Alice feels good about the administrators knowing the names of employees. Another nurse in the study who worked at this same hospital, in a different unit, did not experience the friendliness and caring Alice reported. The other participant left the facility due to concerns about the unresponsiveness of immediate management to patient care problems on her unit.

_we get a lot of feedback about how we’re doing._ Anne speaks with pride about her hospital being known for its commitment to integrity and quality care. Most notable to her was her immediate supervisor. Anne knew of her nurse manager’s good reputation among nurses and expressed gratitude for having found this unit because it was vastly different from the first unit she worked at another hospital.

_we have a great unit manager and she’s all business. I respect that; she’s all about quality and our image to the
patients and within the hospital. She turned our unit around a lot even before I ever got there. When we have staff meetings, she always reads off the positive things patients say about us... I think just getting that feedback is so nice... This hospital is much more attentive to quality care than where I was before.

Anne had thought the hospital she initially worked had a good reputation, but she ended up questioning whether she really wanted to remain in nursing.

*I think moving from (former hospital) to (current hospital) made me a whole lot more aware of how I am treating the patients. I feel like there’s a higher level expectation of the kind of care you give at (current hospital). Now I feel bad about not speaking up when I was there, but I was new and everybody just acted like that’s how things were.*

Anne’s pride about her current hospital’s reputation was intensified by this comparison.

*It helps when the hospital shows they care about you.* Shelia, who has previously spoken positively about her nurse manager, also extended her positive feelings to the hospital as a whole.

*We have a lot of control at (name of hospital); we have a voice, and what we say matters and is usually heard. I think that helps, when the hospital shows us they care about what we do and what we have to work with.*

Shelia was very aware that not all nurses at her hospital had the positive work setting that she and her coworkers enjoyed. Even so, Shelia’s positive feelings about her unit transferred to the hospital as a whole.
For nurse’s week, they didn’t give us anything. Sasha, who has consistently been positive and optimistic even about surveillance of her movements and whether she spoke certain phrases, was somewhat transparent with her feelings about the institution’s foiled attempt to have a Happy Nurse’s Week celebration for the nurses.

They are supposed to be all about the nurses. For nurses’ week, they didn’t give us anything and I think like they had a food truck… downstairs and they were like ‘Bring your credit card’ and I was like, why am I gonna bring my credit card and this is nurses week.

Administration needs to pay attention to what the nurses say. While Sasha has maintained a polite manner whenever speaking about her hospital, she acknowledged a need for nurses to have a greater voice and to be listened to by upper management.

Overall I think the administrators do care, but I think they need to start listening to the nurses... and not just have big wigs sitting up there and trying to make decisions.

If it’s all about patients, why don’t I have what I need to care for them? A hospital’s laudable mission statement could also become an impetus for a negative view of the hospital by the nurses. Kelly had tried to maintain a positive attitude before leaving her hospital position, but found herself feeling deceived by upper management.

They say it’s all about patient care, but then they are not giving us what we need to be able to do that and especially in med-surg - either giving us too many patients or too much paperwork, those are the things I think that got in the
way of it. That’s more of what they were focused on is you know the bottom line and that’s not fair to the patients, you know.

Like Sasha, Kelly also was unimpressed with the sincerity of the message for nurses’ week when she recounted all the lunch bags, key chains, coffee cups, and similar items with the hospitals name on it.

They just want us to look alike and think alike so we won’t see what’s going on.

Another participant, Lindsey, also found some of the things the hospital touted in its mission statement were little more than an effort to control the nurses.

I don’t like the changes that are coming to nursing…they are trying to make us all think alike and look alike. That’s what they want…and they think we are too stupid to notice. If you do notice, oh you’re not a teamplayer.

Lindsey also had strong opinions about the activities of nursing and hospital administration.

These decisions the higher nursing administration make that nurses supposedly have input into, well how come it’s all of the managers and maybe three nurses for the whole hospital.

They don’t want the older nurses around, we know too much. Lindsey and a couple of other participants indicated they wondered if management wanted to get rid of older nurses.
I may not have a master’s degree or a doctorate or any kind of advanced degree, but I am not stupid. I just feel that nursing in the twenty years I have done it, has declined in autonomy... It’s pretty ridiculous what they think we will believe, I for one do not... I think they like the younger nurses, they don’t want the older ones around because we know too much.

Several participants used hospital-specific language to say how they cared, and called it their own definition. These comments generally began with the following:

At __________, we care by ________ and ______ and that’s how we show we care at ________. That’s the way I define caring too.

In the next subtheme of institutional caring, caring by scorecards and checklists will cover how the nurses reacted to the hospital and regulatory based requirements that dictated much of their actions.

Theme Four: Institutional Caring, Caring Defined by Others; Subtheme Three, Caring by Scorecards

The content of the interviews in this subtheme of institutional caring will pertain to nurses thoughts and feelings about how their care and caring are affected by hospital scorecards and an increasing reliance on a checklist of required activities to be completed to meet regulatory or fiscal demands. The first interview quoted is from Sarah, who has previously been mentioned in this manuscript as talking a lot about doing one’s best despite the limitations and impediments.
Sometimes they get it confused with a full-service spa. Sarah who has been consistently focused on having a good attitude becomes more vocal and sarcastic as she speaks about the market-driven consumer focus that is predominant in hospitals today.

Sometimes they get confused with a full-service spa weekend. Why not? They have a fountain, a bakery, a coffee shop, hardwood floors, all we need is a pool and a bar. A five-star resort, full-service call light; that’s what they think when they come here. The call light’s confused with room service... Naturally they would be confused.

Sarah speaks about her hospitals’ efforts to make caring visible by displaying signs, posters, sending email reminders to nurses, and showing films about caring. She says it’s better than staff not being caring at all, but she does not believe people working in nursing should require reminders; rather they should be supported by management to do what they came into nursing to do. She indicated the constant reminders were especially overwhelming to new graduates who come in new and fresh and soon leave because of feeling inadequate.

We have really good nurses; I have seen them come off orientation and they really want to care for their patients, they try to take time. You can’t be in there for an hour when you’ve got six patients. And they get off orientation and within a month, they are gone. They’re trying to learn how to be a nurse and they get all these classes on how to show patients you are caring, what to say... I am like they can’t do it; I can’t do it.

Everything is scores and satisfaction. Penelope has been described in previous sections on other caring themes. In this section, Penelope speaks about the way scores
impact management’s views of how well nurses are doing in the area of giving good care and being perceived as caring.

Everything now is just scores ... it’s all about how patients perceive you...I feel like we have a lot of patients who genuinely appreciate us. But they’re not surveying all the patients, they’re randomly sending out surveys and then, it’s the random few who send it back...but it’s usually the upset people who send surveys back.

Penelope suspects the negative feedback is a function of how the surveys are done and finds irritation with the focus on this as a measure of how well the staff provided care. She also describes being frustrated about her response time to patients’ call lights being monitored to decide how well she is doing her job.

Patients call the nurse for everything... ‘I just need to see my nurse.’ You go in the room, and maybe had to leave something pretty important you were doing to answer this light so you won’t get a negative mark for being too slow answering the light. You get in there and they say, ‘Can you get me the number to the Hilton’ or ‘my pillows kind of flat’

Several participants spoke about the response time for call-lights being closely monitored by management. In some hospitals, patients could call their nurses directly on phones that only worked in designated zones.

Sasha agrees that answering call lights is important and should be done promptly. She indicated she and her coworkers worked together to help answer call lights, but sometimes there were too many calls at one time. Several nurses complained that
management had unrealistic expectations about the call light response-time given the numbers of staff they permitted to work based on the census.

_The nurse is too busy; it’s a hard balance when you have one nurse and five or six really sick patients, and if they are all calling around the same time, it’s hard to show that caring. To me, it looks like we’re getting swamped._

_There are so many things they keep scores on. At the end of the day, it’s just like a really big report card._ Anne points out that with everything being expected at near one-hundred percent, it is very frustrating.

_There’s a call light going off every 10 minutes and I am sorry, you just can’t be there all the time..._ by having so many things that we are graded on and scored, it seems like they say they’re want us to be caring, but at the end of the day, it’s just like a really big report card.

Mary also talked about pressure on the nurses to achieve near perfect scores for everything on a list of required routines that had to be done regardless of how well it matched the patients’ needs.

_Because you are being pushed; constantly ... patient satisfaction, that’s what drives the hospital getting paid. They are harping on you; this has to be done, that has to be done, and it’s ongoing, never ending, and when can I take care of my patient please?_
In this day and age, you are caring more for your chart than your patient. Mary mocks the required phrases she is expected to recite to the patients and gives her conclusion about nursing today.

I guess I could say ‘in this day and age I feel like you are nursing your charts more than you are your patient...because you have core measures you’ve got to keep up with, you have all these scores and everything ...You’ve got to not only make sure that everything is correct so that Joint Commission is okay with it... your mind is more geared to that than to your patient.

They just keep adding to what we have to do, now the family is our patient too because we are family-centered. Many hospitals have also incorporated more family involvement and expectations that nurses be attentive to the families’ needs. Cheryl shares her thoughts about times this is an impediment.

That’s where I have the problem...we’ve moved into where the family is also our patient ...When the family is not doing the right things for the patient and they are overbearing and telling me how to do my job ‘Wait just a minute before you do that....blah blah blah... I understand family is important, but we are way too busy to keep adding to what we have to do.

First we get scolded for scores and then we pray. Amy shared how her manager was especially demoralizing to the nursing staff, starting their morning off with criticisms and ending in prayer.
I think the most shocking thing coming into nursing was scores... I don’t really even know what they all mean...first thing in the morning, 6:30 am. Our manager is in there telling us ‘I don’t know what ya’ll are doing but it isn’t right. This is wrong, it ain’t right’...then she’ll call you out by name and say what you did wrong in front of everyone...and then we have prayer, really we have prayer after that.

You can’t say it’s a staffing issue; oh she did not like that. Amy indicated her manager asked for suggestions about how to improve scores.

It’s just in the mornings you want to be encouraged and you don’t want to be told you’re doing everything wrong...She’ll be saying, Why are these scores low ... Well, if I’ve got 6 patients and the assistants have got 10, how are we gonna do better; we have all we can do...One day she was asking how can we improve and I said, ‘ Couldn’t we get more staff , maybe it’s a staffing issue’ and oh she did not like that.

Amy will be leaving during the year when she finishes school, but in the meantime, she and her coworkers stay because they like being in a religious-based hospital, they like their patients, and they enjoy working together.

Use your key phrases, they tell us. Many participants mentioned particular phrases they were required to use when they were interacting with their patients. Anne comments on the busyness of her job and the continuous pressure to get their satisfaction scores up.
They say ‘remember to use your key phrases’ like ‘for your privacy’, ‘for your pleasure’, ‘I have time’ (said in mocking the repeated phrase); we’re like literally kind of brainwashed to say these phrases.

When Anne said the word brainwashed, she sounded irritated or perhaps annoyed, and yet also surprised. Her next words made an attempt to repair the term brainwashed, but it soon turned to cultish.

...Maybe brainwashing is a little strong...But I mean like, that’s a good idea and it’s nice when we all have like a united front. (Pause)... but also it sounds a little... (cringing) almost a little cultish.

*They listen to see if we are using our key phrases.* Sasha indicated her charge nurse checked to see if the phrases were being used and they received a score based on their compliance.

‘Do you need to get up and go to the bathroom’, ‘is there anything else you need’, or we tell them’, ‘I will be back in an hour to round’, phrases like that, they want us to use. They have the nurse manager to come around and actually listen or the charge nurse for that shift will come in and listen to be sure we are using the phrases.

*I think you could put out a caring presence if you’re a good enough actor.* Most of the nurse participants thought that scripts and predefined phrases were insincere, some found them insulting, but a few thought it was, at least, a way to make those who were not naturally caring be attentive to others. For example, Susanna indicated it may not be sincere, but a person could be taught to act the part of a caring person.
I think anybody can learn to be caring or at least to learn to put on, to go through the motions to do what other people perceive as caring; even if it isn’t in your heart, you can have a caring presence. That wouldn’t be hard at all. True caring, you have to have a caring heart, but I think you can have a caring presence if you are a good enough actor.

You can’t automate caring. On the other hand, Penelope, Nita, and most participants thought pretending to be caring would be obvious to patients.

I think caring is that kind of thing that you just have to be born with, I don’t think you can automate someone to care. I feel like you have to actually be concerned.

In addition to scripts and prescribed phrases, nurses and other staff were sometimes given acronyms to remember the expected comments or actions.

That’s what it is AIDET, it’s something Acknowledge their presence or something. Introduce yourself, you can tell acronyms are not really helpful. I can’t remember what D is, you are supposed to give the like specific timing like you’re gonna explain what you are going to do that day and when you are going to be in and you are supposed to put in the rounds somewhere. You know I am going to come around every hour I never tell my patients that.

These scores make me want to jump off of this building. Several other nurses talked about how the focus on scores detracts from care. Anne found it frustrating that the targeted goal is always one-hundred percent on everything. Catherine was especially negative about the focus on scores.
The (marketing and patient satisfaction) group, they make me want to shoot myself in the head. Ever since I took this position, I have heard their name and patient satisfaction scores to the point that I want to jump off the top of this building.

They say it’s about caring, but everything else kind of gets in the way of that.

Kelly describes her about how this focus on scores and reimbursement led to her exit from her nursing position.

It was easy for me to care and look past hard things at work. I did not mind if there were certain types of things I would have to say and I was definitely conscientious about doing my job right...and being a patient advocate or carrying out the doctors’ orders or ... taking more time, but that was me caring about my patients...One of the reasons I say I am not doing it anymore, I feel bad sometimes that I left, I miss my patients, not being at the bedside anymore, but everything else kind of gets in the way of that ...they try to emphasize....It’s all about patient care’ Well what exactly does that mean to them ‘getting them in and out and making money’.

Sincerity and realness are much more satisfying. In this theme about caring by someone else’s definitions of caring, Cabriole espouses values and realness over performance.

But you know what though, honestly just good manners, and sincere caring will keep the scores up, and conscientiousness will keep the scores up, and following through with what you say you are going to do...Sincerity and realness is much more satisfying than following a bunch of scripts (laugh).
While nurses always have understood there were certain attitudinal, self-awareness type mental and emotional activities they had to engage in to promote the caring they desired, this was a labor they welcomed, for the most part. Having to engage in emotional regulation strategies however, to deal with the rising constraints, escalating workload, and impossible to meet expectations call for emotional labor to deal with the interference with caring (secondary emotional labor). As the nurse participants spoke about their work, their disappointments with lacking time to exhibit caring, some acknowledged intentional cognitive, emotional strategies they engaged in to manage their feelings so that they could have a more caring presence at work. On the other hand, there were some nurses with marked vacillation of awareness levels about the barriers to caring and the degree to which they bought into the managerial and marketing rhetoric to promote the hospitals image, an image which the nurses were held accountable for, yet had not control over.

Summary of Results Chapter

This chapter has provided the results by four main themes derived from the nurses interviews about the emotional labor of caring. The first theme of natural caring included participant quotations that supported their views of caring as something inherent in a person. Not all nurses thought it was inborn, but most did see caring as something that would be already acquired by adulthood with rare exceptions. The second theme accelerated caring described nurses’ management of caring under conditions of increased workload and how they struggled to maintain their identity as caring, how they became
frustrated with trying to care, or how they redefined their goals of carework to make conditions more acceptable. The third theme, flexible caring was about the ways nurses saw caring as something that could not be done by routine, but required knowledge, sensitivity, and an awareness of needs acquired through interaction with patients. The fourth theme, institutional caring was mainly about how hospitals wanted the nurses to portray themselves as nurses, but also included any externally imposed influence on one’s caring. In the next chapter, these results are reviewed from the theoretical perspective of Hochschild’s emotional labor theory and how this study adds to the existing literature on emotional labor by nurses.
CHAPTER SIX
DISCUSSION AND CONCLUSIONS

Chapter Overview

This chapter will synthesize the results reported in the preceding chapter. The purpose of this chapter is to evaluate the overall research process, review its findings, and consider their significance and implications. This will be done from the perspective of the current literature and theoretical perspective of Hochschild’s emotional labor theory. At the end of the discussion, I identify the specific strengths and limitations of the study and make conclusions and recommendations for future actions stemming from this research. I will begin by providing an overall evaluation of the research process.

Summary Evaluation of the Research Purpose and Findings

This research sought to determine how nurses viewed and displayed caring in their positions as staff nurses on medical surgical units of hospitals. It was also this study’s intention to understand how nurses perceived they acquired a caring disposition, to identify barriers and facilitators to caring, and to know some of the ways nurses managed the barriers to caring. Hochschild’s theory of emotional labor served as the framework from which the research questions were derived. The existing literature on emotional labor, the nurse’s work environment, and caring in nursing provided a
foundation from which to proceed in addressing these questions. To address these research aims, I conducted semi-structured interviews with medical-surgical nurses working at hospitals within a 100-mile radius of Birmingham, Alabama. Using qualitative methodology guidelines, I analyzed and extracted themes from twenty-seven nurses’ interview data.

The nurses’ views about caring and emotional labor in this study were represented in these themes, as shown in the summary of results in Table 6.1. I was able to identify subthemes and themes that will now be considered within the context of the existing literature previously reviewed and the theoretical perspective of Hochschild’s emotional labor theory.
### Table 6.1 Summaries of Themes from Results

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples</th>
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<tbody>
<tr>
<td>1. Natural Caring, caring as part of identity.</td>
<td>I think I have always been caring; I don’t know that I have always possessed that ability to convey caring as I do now. I think it is because of my experiences in nursing that the caring I already possessed was fostered. The experiences I encountered brought it out of me.</td>
</tr>
<tr>
<td>2. Accelerated Caring, caring despite busyness.</td>
<td>... You can’t just rush in and draw their blood and say OK well I’ll get to you when I can...You have to let them know you really are busy, but you really are going to come back, and then you have to come back. ...You have to find a way to show them you care in less time.</td>
</tr>
<tr>
<td>3. Flexible Caring, caring as adjustable to the person and context.</td>
<td>You know as a child you are taught the golden rule ... but everybody is so different. ... Patients may perceive me as not caring and not a good nurse if I do for them what I would want, so -- my caring is adjustable; it adjusts to that person.</td>
</tr>
<tr>
<td>4. Institutional Caring, caring as defined by others.</td>
<td>You have core measures you’ve got to keep up with...all these scores and everything that you’ve got to not only make sure that everything is correct...but your mind is more geared to that than to your patient... in this day and age I feel like you are nursing your charts more than you are your patient.</td>
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Summary of Theory and Research Relevance to Discussion

The findings from this study support the premise that emotional labor by nurses remains an important area for researchers, particularly as our healthcare system continues to be redefined. The trend toward healthcare agencies using market-based principles in achieving compliance with reimbursement incentives made emotional labor especially relevant to examining changes in how nurses use emotional labor in managing their caring functions as nurses.

Hochschild’s emotional labor theory gave excellent focus to the concepts important to this study of nurses’ caring emotional labor. Hochschild’s (1983) theory has already addressed the service-oriented work trend and its requirements for emotional labor from employees. In service jobs, such as nursing, employees are expected to manage their feelings in accordance with organizationally defined rules and guidelines when engaging in face-to-face interactions with customers (patients). Goffman’s dramaturgical metaphor of theatre captures the performance of roles in everyday interaction. Hochschild extends dramaturgical analysis to jobs where employees are expected to manage their outward displays of emotion as part of the customer experience (1983: 103).

Hochschild’s theory also includes concepts from Marxist thinking. Because the specific emotion rules of a job depend on the purpose and context of the organization and are subject to hierarchies of status and gender (1983: 17), Hochschild saw the potential for emotions to be exploited. Extending from this Marxist-based theoretical perspective, Hochschild anticipated alienation problems from exploitation of emotional labor. Bringing in concepts from late capitalism links Hochschild’s theory to a phase of work-
life in capitalism where human beings and their sense of personal identity are within the reach of commodification. This exploitation of human emotion may possibly surpass other undetected intrusions into personhood and relationships that have been called part of a false consciousness (Lukacs 1971 [1920]).

In this discussion that follows, I will relate the findings from this study to emotional labor theory and existing research. This discussion and summary will focus on three main points about the themes summarized above in Table 6.1. First, I will address how the nurses’ confusing examples of caring behaviors might suggest a transmutation of caring from relationship-based to brief and superficial interactions with patients. Second, I will consider how nurses’ workload intensity, job dissatisfaction, and experience of stress may be related to successful and unsuccessful emotional labor performed by nurses to reconcile their inability to show caring. Third, I will discuss how the progression of nurses’ interviews was characterized by increasing discovery and expression of feelings about their work environment and how this may relate to the exploitation of nurses’ caring labor. The discussion of these points begins with the nurses’ views about themselves as caring.

Caring-Confusion, the Transmutation of Caring

In this study, the nurses’ views and displays of caring had changed from how caring was described in the literature up until the late 1990s. I will suggest that the concept of caring has been transmuted (Hochschild 1983) from caring arising out of relationships developed between nurses and patients to spectacles of caring routines exhibited during superficial and time-limited interactions with patients. This study
revealed that the nurses’ views about caring and how they displayed caring have changed from the descriptions of caring appearing in the literature up until the late 1990s (Gaut 1993, Haldorsdottir 1990, 1991, 2008; Larson 1984; Lea and Deary 1999; Swanson 1999).

From the 1950s onward, the literature focused on nurse caring as a relational phenomenon commencing with the nurse’s ethical imperative to demonstrate caring to patients (Austin 2011; Bassett 2002; Boykin and Schoenhofer 2001; Gustafsson and Fagerberg 2004; Freshwater 2000; Kong 2008; Pauly and James 2005; Pearcey 2010). In this literature, nurses’ developed caring bonds by directing interactions with patients toward the development of a collaborative relationship that placed the patient’s needs as the central focus.

In this study, only a few nurses had time for the caring they envisioned was needed by patients. These nurses enjoyed excellent staffing or worked on units where the occasional patient’s hospital stay extended into weeks rather than days. Nurses’ were pleased to be able to know their patients, determine their actual needs apart from a checklist of routines, and have the time to meet those needs. This supports the meta-analyses by Swanson (1999) and Haldorsdottir (1990; 1991; 2008) which showed that caring required forming a relationship with the patient. The nurses who worked these well-staffed jobs felt privileged. Occasionally they felt guilty because they knew their jobs were rare and that other nurses coveted those jobs and other nurses had unfavorable work situations.

This relational trend as the basis for nurses’ caring largely was unsupported in this study. Instead, the nurses in this study talked about being unable to develop relationships
with patients. Time and other constraints in the hospital work environment interfered with nurses’ getting to know patients and hindered them from developing relationships with patients. Interactions with patients often were limited to those occurring during the performance of time-limited tasks related to the patient’s required medical care. Lacking opportunities for significant interactions suggested that for nurses the only shared meaning of caring between the patient and nurse would have to come from assumptions and stereotypes of nurses’ roles and patients’ roles, leaving little time to verify their relevance for each patient and each nurse. As a matter of convenience, control, and predictability, most interactions are based on a careful reading of scripted interactions that unfold according to previously established meanings. Meanings can change through engagement and negotiation, but unless conflict arises, most social interactions unfold in established and predictable sequences (Goffman 1959).

Cooley (1907), Goffman (1959), Hochschild (1983), Mead (1934), and Blumer (1969) each proposed in their development of a symbolic interactionist theory that much of what goes on between people was based on the meanings derived from past assumptions and shared understandings. These shared meanings and assumptions become the basis for predicting how people will behave which enables a smooth flow to the interaction ritual (Turner and Stets 2005: 69). Goffman’s explication of this ritualized performance between people provides an excellent way to conceptualize the enactment of roles between nurses and patients. Interactions between patients and nurses often follow pre-determined rules and sequences and have their own system of rules, limits, and meanings. Taking on roles becomes the basis for all interaction between people, and while these roles can be changed, some roles such as possessing a caring manner in the
nursing role are firmly entrenched in participants’ expectations of each other (Muff 1988). Goffman (1959) recognized that even when roles carry certain expectations that are somewhat predictable and anticipated, encounters can sometimes conflict with each other. When this occurs, and one’s view of their self and of their role fails to be confirmed in the interaction, the flow of smooth interaction is breached (Turner and Stets 2005: 106). The resulting emotional tensions prompt new behaviors or understandings to reestablish the order of interaction. This emotional tension arising out of conflict in an encounter might be similar in some ways to the tensions implied in Festinger’s (1957) concept of cognitive dissonance and Hochschild’s (1983) concept of emotional dissonance.

In this study, most of the nurse participants embraced role-expectations for nurses to be caring. Even as they acknowledged being unable to show caring, many persisted in trying. Some of the nurses stated they knew their current work environment did not permit the kind of time needed to show caring to patients, but they expressed feeling satisfied in their jobs because they had good managerial and coworker support. These nurses conveyed an unexpected intention toward the end of their interviews. These satisfied nurses, who had been positive about their work environments, had future career aspirations that they hoped would give them an opportunity to have time for interpersonal relationships with patients. This suggests that the relational and caring ideal lingered beneath whatever mechanism had occurred that facilitated these nurses reported job satisfaction.

The evidence that the nurse’s views of caring in this study were becoming *transmuted* (Hochschild 1983) was present in the confusing examples they gave as to
what constituted caring. On the one hand, some of the nurses said they viewed themselves as caring, but they described being too busy to spend time with patients. They suggested that patients can “just tell” if the nurse really cares even if the nurse lacks the time to show caring. Several of the nurses thought they probably conveyed the caring to their patients through their manner of performing tasks, small-talk, or a particular way they looked at or touched the patient. Hochschild (1983) based much of her emotional labor theory on Goffman’s (1959) performance metaphor. Goffman extensively studied the intricacies of everyday interaction between people and the nuances of their behavior, gestures, and expressions which became a reflexively-used tool for evaluating people’s intentions and framed the interactions for participants. Perhaps, nurses and patients did feel a connection and understanding of role expectations for caring when they gazed in each other’s eyes and read each other’s facial expressions and manner.

Some of the nurses said they viewed themselves as caring, but they offered examples of caring behavior that struck me as a distortion of caring. One nurse described herself as always having been compassionate and concerned about comforting other people. Yet, as she spoke about interacting with patients, she indicated she felt annoyed when she goes out of her way to be caring and the patient does not express appreciation. Another nurse described herself as caring, but indicated she was able to show caring by doing little things such as going out of her way to get a patient a drink of water when that task was assigned to someone else. Another nurse commented on one of her coworkers as being very caring and always willing to help anyone else’s patients whenever he was free. Yet, when she related a story about this nurse helping her with one of her patients, she said this nurse scolded one of her patients for coughing without covering up her
mouth. She also indicated the patient had no known infection and that this nurse was particular about germs and always said something about germs whenever he was around patients. There was an ethnic difference between nurse and patient in this example, and it is possible this difference could have been further illuminated had I asked for clarification about the nature and context of meanings influencing that interaction.

These examples sound like confused enactments of caring that depart from the former definitions and shared meanings of caring. As in the beginning of this manuscript, when a patient in a hospital resorts to drinking water from a flower vase (Reeves, Ross, and Harris 2014), having been unable to summon relief for their thirst, something has gone awry in the way caring is interpreted, particularly by nurses.

Some of the nurses verbalized a depth of understanding of the patient’s perspective. One nurse in particular, commented about patient experiences with words suggesting a keen understanding of some of the personal aspects of the patients’ life that affected his or her illness. Nurses like this seemed to retain an awareness of the patient as a person with a role other than that of patient. Even though these nurses said they wished they had been able to be more attentive to the patient’s needs, they talked about approaching each interaction with that patient with an awareness of their life situations and how they were affected by their illness.

Some of the nurses indicated they were unable to provide the level of caring they believed was important, but thought that being conscientious in their job kept the patient safe and should be considered caring under the circumstances of intense workloads. Most of the nurses had commented on the importance of the relationship between a patient and nurse, but several of these nurses said that the changes in healthcare made relationships
impossible and they had reconsidered whether the relationship that nursing textbooks always referred to was really important after all. This thought led them back to thinking about how nursing school really never focused on caring, but emphasized science and technical skills instead. This suggested that caring was just all-talk and it just could not be done anymore. Most nurses thought caring was something a person could not be taught anyway, and that caring was something a person was either born with or learned in childhood upbringing and experiences. Some of these nurses thought a person who was “truly caring” did not have to make an effort to be caring because it was just natural. Thus, for nurses who considered caring as part of their identity, it was likely less significant to them that nursing school did not focus on caring.

Other nurses were unsure that caring was anything beyond good manners, common courtesy, following the golden rule, and deferring to the needs and wishes of others. Some thought caring meant going above and beyond the call of duty, such that they would have always had to do more than was required. Most of the nurses verbalized feeling like their jobs never ended and there was always more that could be done. This reflection on caring and how it was manifested suggested a commonly-held belief among most of the nurses that caring implied doing more and giving more than required.

A few of the nurses made inferences about their self-worth and measured themselves by the ideal they had of the caring nurse. They were unsure how to separate their own legitimate needs for self-care from their commitment to patient needs. Some nurses were unsure if it was acceptable to decline to care sometimes and whether caring for someone could feel badly sometimes. A few nurses were angry about being held to impossible to meet expectations of the ideal nurse and thought the public needed to be
educated about how nursing had changed so they would not expect so much from nurses. Still others connected caring to morality and ethics or placating the needs and comfort of the patient.

What emerged across these varied responses of participants was that there were very few, perhaps two or three nurses, who could clearly articulate a definition of caring similar to those described in the literature. The caring definitions in the literature focused on a relationship with the patient that focused exclusively on the patient’s needs as opposed to how the nurse felt about their actions. Several, though not all of these nurses, were beginning to question the importance of having a personal connection with the patient. This suggests the ongoing importance of verifying patients’ changing perceptions of caring also.

While Goffman (1959) and Hochschild (1983) recognized the inherent performativity of encounters, the importance of shared meaning and acceptance of the performance is also important. In this study, many of the nurses did not have clear understandings about what constituted caring anymore. It was also clear that much of the nurses’ knowledge and views about caring were based more on stereotypes and role socialization than on an understanding of caring as a multi-faceted concept. As gender relations and roles have changed, it seems possible that some of these changes in nurse-caring may be related to changes in performances of gender so that the less typically feminine presentation by females is also less typical in the feminized occupation of nursing. Some of the conflicts experienced by nurses may be related to this transmutation of the concept of caring and of gender roles in nursing. Caring conflicts as a source of dissonance are addressed next.
Caring Conflicts: Emotional Dissonance and Compounded Emotional Labor

The findings in this study supported that nurses still valued relational caring but were aware they had to curtail their displays of caring to meet the hospital’s requirements for reimbursement. Nurses were closely monitored for their compliance with mandatory routines and completion of checklists that were tied to reimbursement rules and certification requirements. This routinization of care also was reported in the literature (Adams and Nelson 2009; Bégat, Ellefson, and Severinson 2007; Geiger 2012). The nurses’ caring ideals conflicted with this type of work experience.

With few exceptions, the nurses in this study found completing these required activities left little time to show caring to patients. Several nurses indicated they were sometimes not even able to carry out all of the physician’s orders due to heavy workloads. This was reported by nurses in other studies (Barker et al. 2002; Bone 2002; Manojlovich and DeCicco 2007; Weir and Waddington 2008; Valentine et al. 2006).

While nurses in this study needed to engage in emotional labor to manage stress related to workloads, the literature on emotion work in nursing addressed nurses’ emotional support of patient problems and how nurses managed reactions arising while delivering patient care (Bolton 2001; Gray 1999; Walsh 2009). These referenced studies were conducted in the United Kingdom, and two were in the late 1990s and early 2000s. This may account for the differences since the changes in healthcare are occurring rapidly, but the United States seems to lead the way in the capitalistic influence on healthcare.

A few nurses in this study mentioned having to suppress their feelings of sadness or frustration around patients. Several nurses commented on being pretty sure patients
were keenly aware that the nurses were busy and frustrated. Several nurses reported that patients tried to help them out by foregoing baths and other comfort or hygiene amenities. Surprisingly, only two of the four nurses who talked about this indicated this was unacceptable to them. One of the nurses who found it unacceptable also said if it were not for patients foregoing these care activities, she would have been unable to complete other priorities which were being monitored for compliance.

With rare exception, nurses in this study did not get to focus their emotion work with patients on facilitating patient comfort or dignity. Consistent with more recent research, nurses’ emotion work in this study was increasingly constrained by work conditions that were incompatible with displaying caring (Amendolair 2007; Berg and Danielson 2007). Like studies that showed nurse’s having to work against a multitude of dissonant feelings in their work settings (Coughlan 2006; de Raeve 2002; Huynh, Alderson, and Thompson 2008; Kalvemark et al. 2004; Lopez 2006; Malloch 2001; Robinson and Demaree 2007; Scheid 2008; Weinberg 2003; Ulrich et al. 2007), nurses in this study expended most of their emotion work on managing feelings of frustration with care routines, being interrupted during patient care tasks, being unable to provide required care because of an absence of resources, or being delayed in completing care routines due to malfunctioning scanning devices. Conflicting and competing demands produced high levels of discomfort in many of the nurses in this study which most of the nurses either found or were actively seeking ways to remedy.

An added source of dissonance for some of the nurses in this study that was also reported in the literature was the expectation for nurses to repeat phrases and pre-defined scripts intended to boost patient satisfaction scores (Hallett et al. 2012; National Nurses
While most nurses in this study were in favor of helping patients to feel well-cared-for, with few exceptions, they found the phrases to be awkward and insincere. Phrases like, “for your pleasure”, “for your privacy”, “I have time”, Do you want for anything?” were part of a rotating set of pre-scripted phraseology that employees were to repeat in interactions with patients. In some of the hospitals that I had toured, signs and posters adorned the hallway walls and hung from the ceilings in patient waiting areas, ‘Here at (name of hospital), we care.’

Nurses’ implicated several work factors as barriers to their ability to care: poor staffing, unrealistic expectations by hospital management, being held responsible for other employees work outcomes, and being expected to participate in activities intended to raise scores rather than improve care. The work expectation for maintaining a positive atmosphere of compassionate caring, despite a negative work environment not conducive to caring, was observed in other studies as well (Rafaeli and Allen 2007; Thomas 2004).

Hochschild (1983) talked about emotional dissonance, borrowing from Festinger’s (1957) concept of cognitive dissonance, in which extreme states of discomfort are generated by incongruence between thoughts, behaviors, and beliefs. Most of the participants in this study talked about feeling uncomfortable with the direction nursing care had taken. Several of the nurses who reported being satisfied with their jobs later indicated discomfort with conditions for providing patient care. While beginning the interviews expressing positive comments about their jobs, as the interviews progressed, they showed hesitation to speak negatively about their employers’ and eventually, near the end of their interviews were expressing anger about being expected to make the hospital look good when their own way of caring was not supported. This pattern of
anger in nurses about their work conditions and how they were treated in their jobs was reported in the literature as well (Thomas 2004).

According to dissonance theory, if a situation is unchangeable, the other options are to change one’s thoughts or feelings about the situation or remove oneself from the situation. The amount of dissonance experienced varies by personality features and the degree of congruence and control over the situation eliciting the dissonant experience (Festinger 1957). Dissonance theory predicts that performing emotional labor of caring is congruent with the nurse’s role and would therefore generate less dissonance. Because caring is tied to a nurse’s identity, performing emotional labor that conflicts with caring would produce greater dissonance. The more dissonance experienced, the stronger the motivation to change.

Hochschild (1983) limited her categorization of emotion management to surface acting and deep acting. With surface acting, a person makes an effort to suppress their feelings, but does not really change how they think about the situation. When doing so greatly conflicts with one’s own identity and beliefs, this can be difficult. The strategy least likely to leave one with feelings of dissonance, but is also more difficult to achieve, is deep acting in which the person works at changing one’s orientation to the feelings by immersing their thoughts in something likely to be congruent with the feeling expected to be on display. As an example of deep-acting, Hochschild (1983) referred to some of the techniques used by professional actors to generate states of emotion for a particular role in theatre performances. Thus, nurses in this study who did things like sit quietly in the bathroom until they acquired a calm and caring feeling were engaging in this deep-acting strategy. Similarly, nurses who became convinced they may not have a job if they did not
follow the required care routines and mandated scripts experienced less discomfort with routines and other interference with their ability to show caring.

Lazarus and Folkman (1984) delineated emotion regulation strategies in which a person had the capacity to alter the situation as *problem-based coping*. When it was necessary for a person to alter their emotions by changing their beliefs or thoughts, Lazarus and Folkman (1984) referred to this strategy as *emotion-based coping*. In this study, several nurses talked about male nurses being inclined to stand up for themselves and try to change some of the problems in nursing. Several nurses also identified that they liked having male nurses on their unit because male nurses were much better at remaining focused on solutions and letting emotions “roll off their backs.” These patterns correspond to typical gender socialization of males and females (Chodorow 1995 [1978]; Kimmel 2000).

Gender socialization styles also can be seen in typical emotion management strategies identified by emotion researcher James Gross. Gross (1998) made distinctions in emotion management based on whether a person was able to regulate their emotion by making choices that pre-determined what emotional experiences they were likely to experience. Obviously, self-selecting situations would enable some degree of control over what emotions might occur, but self-selection has also been identified as increasing the experience of undesirable or negative emotion based on familiarity and predictability of response. Some of the nurses in this study described themselves as being excessively polite, too easy to give-in, overly focused on the needs of others, and afraid of conflict. These are typical female socialized characteristics described in the gender literature (Chodorow 1995 [1978]; Radsma 2006). Staden (1998) found that nurses in her study of
emotional labor already were primed for focusing on the needs of others. Similarly other researchers find female socialization and nursing roles to be compatible (Benner, Tanner, and Chesla 2009; Davies 1995; Group and Roberts 2001). Thus it is possible that females who are attracted to nursing may be more inclined to this career path because they had been socialized for caring. Alternatively, highly sensitive nurses may be inclined to avoid working in places where undesirable emotions may be elicited. Childhood and early adult experiences with helping other people were described by several nurses in the study as contributing to their desire to become nurses. A few nurses talked about growing up with a lot of responsibility for caring for younger siblings or assisting with sick family members. One nurse was adamant that she was not like this until she became a nurse and found it hard to turn off, focusing only on others’ needs while neglecting her own.

Whether there has been a change in the normative “silent suffering” of caregivers toward tolerance of open discussion of the caregivers own self-care needs would be interesting to explore. There were at least eight nurses who presently or previously had caregiving responsibilities for parents, siblings, or other family members who needed care in their homes, but most nurses in the study described wanting to be left alone rather than continuing caregiving patterns in their personal relationships when they left work. Most of the nurses were attracted to nursing because they wanted to be caring toward patients. These nurses had varying degrees of dissonance and anger about being unable to realize their caring ideals.

The other strategy identified by Gross (1998) for managing dissonance was altering emotion after it had been elicited. This emotion regulation style was considered a response-based strategy and included cognitive strategies such as changing how one felt
or thought about situations. This meant doing things like lowering one’s expectations, rationalizing that their actions were acceptable, denying or ignoring evidence incongruent with their feelings, redefining goals, and similar strategies. These emotion regulation strategies employed by nurses to manage interference with caring will be discussed next. These strategies were detailed in Chapter 2 in Table 2.8.

Regulating Emotion Arising from Interference with Caring: Surface Acting and Deep Acting

Hochschild referred to surface-acting as emotional labor requiring less effort but potentially leaving employees with greater feelings of dissonance. Because the incongruent feeling present in the employee remains with surface-acting, despite their outward display of gestures and expressions of a contrary and required emotional display, there is an experience of dissonance. Likewise, when employees’ personality characteristics match the requirements of the emotional labor required in the job, there is less effort and less dissonance (Ashforth and Humphrey 1992). Nurses’ caring identity therefore resonates with emotional labor of caring. This was true in this study for the nurses who worked on well-staffed units and felt they could take time to show caring with their patients, even if work intensity increased to the point of overload at times. Few complaints or problems were identified by these nurses, although there were also few nurses in the study who worked jobs with this level of staffing. Those few nurses who did work in well-staffed units said the periods of work intensity they sometimes experienced were usually followed by periods that allowed them to regroup and recover.
Emotional labor research shows the most intense experience of dissonance occurs when emotional labor impinges on one’s identity and commitment (Abraham 1998; Brotheridge and Grandey 2002; Grandey 2000; Morris and Feldman 1996; Pugliesi 1999). On the other hand, nurses who had persistently high workloads with minimal time to reflect and regroup had to find ways to make work more tolerable. An added emotional labor burden had to be enacted to manage the ongoing feelings of stress related to their lack of time for caring. Hochschild (1983) referred to deep-acting as a kind of emotional labor requiring more effort because it required strategies that affect more than superficial appearances of emotions. Deep-acting required the employee to change thoughts, feelings, beliefs, or actions so that they better aligned with the incongruent feelings associated with work requirements. Nurses who expected themselves to be caring but were expected to follow monitored efficiency routines had to find ways to manage this threat to their identity as caring nurses. Having to suppress the urge to be caring was found in the literature to be one of the most difficult sources of work stress for nurses (Coughlan 2006; de Raeve 2002; Hochschild 1983). This experience of having expectations that were interfered with by the job design and administrative decisions was referred to in the literature as occupational emotional deviance (Copp 1998; Thoits 1989). I suggested earlier in this manuscript that this occupational emotional deviance required an added burden of emotional labor. I referred to this added emotional labor burden as secondary emotional labor to reflect the emotional labor required by interference with occupationally normed emotional labor. As a type of emotional labor managing the threat to occupational identity, this would generate a particularly high level of emotional and
cognitive dissonance requiring some action for relief to permit adequate functioning in the job.

Some nurses also talked about being required to engage in scripts when they were already constrained in demonstrating caring. This represented a larger threat to their identity as indicated by their expressions of these scripts being insincere and insulting to them as nurses. The requirement to engage in scripted interactions to improve customer service scores was not a direct focus in this study but suggests yet another layer of added emotional labor burden that may be useful to explore in another study.

In this study, strategies for managing interference with caring included leaving the job altogether, finding a way to agree with the situation responsible for the dissonance or other ways to decrease the feelings of dissonance so the nurse could manage job expectations. This often meant avoiding certain aspects of the job, redefining one’s job or looking at one’s self in a different way in relation to the job. Some strategies included deceiving oneself through denying and rationalizing one’s actions. This self-deception was one of the concerns Hochschild (1983) had about emotional labor jobs because engaging in self-deception had effects reaching beyond immediate job performance into other aspects of an employee’s life.

As previously noted, the nurses experienced enough sources of dissonance to warrant their engagement in these emotion regulation efforts. Some of the nurses were successful, some were struggling with trying out different strategies in hopes of finding the right one, and some had given up altogether. It is the group that was less successful with finding ways to maintain their identity as caring nurses who likely experienced the most ongoing feeling of dissonance. The nurses who were determined to find a way to
remain in nursing after investing time, money, and personal effort expressed a sense of being trapped in an ongoing cycle of effort and frustration to make themselves or work more like they thought it should be. This came across as angst about work and a lot of venting about frustration. The nurses who had found ways to be satisfied in their job by lowering their expectations, redefining their evaluation of their success in caring for patients, or receiving support from managers and coworkers expressed being tired and overwhelmed, but felt positive about their jobs. Even these satisfied nurses eventually revealed lingering undercurrents of angst about the work conditions in nursing, which had them in planning stages of alternate career paths. The only really calm and unstressed nurses were those who had made unregrettable decisions to leave or those who worked in well-staffed units.

An interesting finding in this study related to the nurses’ patterns of increasingly candid disclosures that occurred toward the end of the interviews. While comfort would be expected to increase as long as the interviewer and interviewee were comfortable with each other, in this situation, something else seemed to be occurring. Nurses exhibited reluctance to speak negatively about their employers, being careful not to blame the hospital or their managers, and offering excuses for why certain routines had to occur. In a couple of cases, nurses retracted negative comments made and apologized for being negative. Several nurses talked about having to keep quiet because pointing out problems or offering solutions such as better staffing were met by verbal repercussions that ended up making them feel badly or like they were labeled as troublemakers. One particular nurse had been mostly positive about her job, only mentioning a few problems without incriminating anyone, but felt badly about telling me. This pattern of retracting criticisms
and negative statements reminded me of my previous experience in working with recipients of abuse. This privacy concern and protection of the employers’ image struck me as going beyond HIPAA violation concerns, but I did not explore it in the interviews. In retrospect, this is an area that might be explored further since it is difficult to recover from overwhelming feelings if one feels constrained from expressing experiences.

Another increase in disclosure that was observed in this study had to do with the nurses who had said they were satisfied in their jobs. These nurses had spoken with enthusiasm about their manager, their coworkers, and their care of patients. The enthusiasm shifted to a matter-of-fact mention of their intention to leave their jobs within the next year or two. It was toward the end of their interviews that these nurses shifted from positive comments about work to acknowledging that while they had been able to find a way to make work a positive experience, it was not the way they wanted to work with patients. This was not true of satisfied nurses working on well-staffed units. To the contrary, these nurses were afraid to leave because they knew their work situation was a rare and desired situation. Five nurses who had reported being satisfied in their current work and who also reported great managers and coworkers indicated they would not be able to stay in staff nursing roles for much longer because of the toll it took on them emotionally. This was not fully explored, but emerged as the interviews ended or even after the recorder was stopped. In the literature, good managers and coworkers were cited as conditions which decreased dissonance, dissatisfaction, and intentions to leave jobs (Bakker and Heuven 2006; Bradley and Cartwright 2002; Morrison 2009). In this study, this end-of-interview disclosure suggested their positive coworker and manager relations.
only temporarily remedied dissonance and dissatisfaction for these five nurses, but did not prevent them for aspiring to leave eventually.

One other escalation of disclosure toward the end of the interview occurred by nurses who were trying very hard to change themselves or their work through the emotional regulation strategies named below. Some of these nurses began to express an awareness that they had been encouraged to see work problems as things they could change and that as a result of talking, they were unsure that was fair. One or two of these nurses expressed anger. This anger lingering just under the surface of nurses was observed in Thomas’s (2004) study of nurses and anger. The nurse who used journaling to cope with feelings indicated she had become aware of feeling angry about how nursing jobs had changed, and this had made her more determined to spend time with patients; however, she was unsure this was working well for her even though she was learning more about the sources of her feelings. This suggested the benefit of having time and opportunities for reflecting and expressing intense work-related feelings. Table 6.2 below reviews some of the strategies used by the nurses in this study to manage interference with caring.
<table>
<thead>
<tr>
<th>Reduced Experience of Dissonance</th>
<th>Ongoing Dissonance and Resisting Changes in Caring</th>
<th>Lower Level of Dissonance Letting Go of Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redirecting attention from administrative and other hospital based events</td>
<td>Buying into the rhetoric about being a burden to the unit</td>
<td>Believing it was impossible to be both caring and compassionate</td>
</tr>
<tr>
<td>Committing oneself to remain as part of their duty</td>
<td>Nurse attributing problems to something within themselves.</td>
<td>Convincing themselves that patients could just tell who was really caring</td>
</tr>
<tr>
<td>Leaving hospital nursing Buying into mission</td>
<td>Breaking or ignoring rules</td>
<td>Not important anymore, they don’t even teach it in school</td>
</tr>
<tr>
<td>Putting themselves in the patient’s shoes</td>
<td>Getting mad at patients for making so many requests</td>
<td>Convincing themselves that it did not matter because patients were not there that long anyway.</td>
</tr>
<tr>
<td>Multitasking and finding time to engage in small talk</td>
<td>Praying Meditating</td>
<td></td>
</tr>
<tr>
<td>Adopting a particular patient to care about</td>
<td>Overworking</td>
<td>Giving patients what they want</td>
</tr>
<tr>
<td>Keeping knowledge about the patient in mind</td>
<td>Accountability to coworker or friend</td>
<td>Patients need to do things for themselves</td>
</tr>
<tr>
<td>Journaling about work Returning to School</td>
<td></td>
<td>Taking a break</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working close with coworkers, building camaraderie</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convincing themselves caring is really just good manners, common courtesy, and the golden rule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deciding that being conscientious and safe is just as important as caring</td>
</tr>
</tbody>
</table>
Hochschild (1983) had worried that emotional labor may impinge on the identities and feeling states of employees in service jobs. This was supported by the experiences of the nurses in this study. Some of the nurses found a way to preserve their identities or renegotiate their expectations of themselves and their jobs. Hochschild’s concerns about faking emotion as compromising one’s own internal barometer for emotions was seen in the emotional numbness of many of the nurses, in their desire to avoid social contact after working, and perhaps in their ambivalence about their jobs. Whether to stay or go in their jobs, how much of one’s self to give in a job, and wanting to continue 12-hour shifts despite all the negatives were incongruent kinds of comments made by the nurses suggesting this ambivalence.

In the literature, there was reference to management expectations for nurses to be caring despite staffing and other job constraints interfering with caring (Mentis, Reddy, and Rosson 2010; Hamilton 2011). In this study, there were no indications that staff were expected to be caring. To the contrary, nurses talked about being reprimanded for taking too much time with patients. Nurses also talked about having so many other expectations from management that they had little time or energy to be caring. The intensity of the workload and for some nurses, the conflict about caring, was mentioned by several nurses who said they were so exhausted and numb when they left work they wanted to be left alone. This exhaustion, numbness, and desire to be left alone are discussed next as possible effects of emotional labor jobs.
Emotional Labor’s Effects on Personal Relationships, Feelings of Exhaustion, and Emotion as a Signaling Function Related to Survival

Hochschild’s had concerns about emotional labor affecting personal relationships and confusing the signaling function of emotion for the employee in emotional labor jobs. The experience of feeling overloaded was expressed by most nurses and most of them also expressed varying degrees of exhaustion and having nothing left to give after their shifts. One nurse talked about being so overwhelmed with emotion that she just felt like crying. A couple of the nurses had figured out that the amount of work required to put on a false face at work was directly related to how tired they felt at the end of the day. All but three of the nurses expressed feeling “all cared-out,” “completely done,” “nothing left to give,” “totally numb,” and “just wanting to be left alone.” This was not reported by the few nurses who worked on well-staffed units, but was still reported by the nurses who said they were satisfied in their jobs. The nurses who said they were able to ignore what administration and management wanted and focus their caring intentions on their work with patients also expressed being exhausted and disinterested in social contact after their shifts.

Hochschild had anticipated jobs high in emotional labor would generate problems with relationships and disrupt the survival and cuing function of emotion. This was supported in studies of emotionally demanding nursing jobs (Martínez-Íñigo, et al. 2007; Montgomery et al. 2006). The literature offered many examples of problems such as burnout (Malasch and Leitner 2008), compassion fatigue (Figley 1995), secondary traumatization (Stamm 1995), moral distress (Corley 2002; Kalvemark et al. 2004; Ulrich et al. 2007) that were associated with emotionally intense jobs, especially jobs involving
providing care and assisting people who were vulnerable from illness or other traumas. The nursing literature also described uncaring nurses who had become robot-like and calloused (Swanson 1999). None of the twenty-seven nurses I interviewed in this study struck me as cold, calloused or robot-like. The denial of emotion as a necessary strategy for dealing with very uncomfortable events, when not appropriately reflected upon, has been identified by scholars in nursing and the humanities as interfering with understanding and developing effective and ethical ways of making sound decisions (Benner 1994; Benner and Wrubel 1989; Morton-Cooper and Palmer 2000; Tolich 1993). Mismanaged feelings and the resulting distortion of one’s feelings have been suggested as detrimental to the work atmosphere and to also interfere with ethical decision-making (Benner 1984; Darwin 1872; Damasio 2010; Ekman 1994; 2003; Gazzaniga 2006; Harling 2014; Lynch, Baker, and Lyons 2009; Steele, Spencer, and Aronson 2002; Spitzer 2004; Walsh 2009).

While none of the nurses described stress of that severity, one nurse had become so emotionally depleted during one of her jobs that she welcomed a bone fracture, surgery, and physical therapy as a way to gather her sense of self again. Several nurses reported lying around their homes after three back-to-back 12-hour shifts with no desire to see anyone or do anything. Other nurses found the workload overwhelming physically, and especially emotionally. These nurses described having little emotion or caring left for others after their 12-hour shifts and they wanted to be left alone. Only one nurse indicated that she was completely able to separate her work from her life with her family when she was away from work. Another nurse said she sometimes felt like crying for no apparent reason, but knew it was all the feelings she suppressed at work.
Additional effects of suppressed emotion were impaired memory, concentration, and attention (Richards and Gross 2000). The effects of interruption and frustration related to expectations to achieve unattainable goals has also been shown to affect decision-making, and cognitive-emotional processing abilities (Gunia, Sivanathan, and Galinsky 2009; Weick and Sutcliffe 2011).

There was also literature showing these feelings of being overwhelmed and emotionally numb could be relieved by expressive activities such as journaling, time for reflection, and opportunities to talk about experiences (Freshwater 2000; Pennebaker and Graybeal 2001). An example of the positive effects of time for emotional processing was offered by Mabel, who was assaulted by a patient and immediately attended to by a supportive manager and coworkers. Mabel was able to return from this traumatic event in several days and attributed this to the ongoing support from coworkers, management, and friends. This suggested reflection time, opportunities for expressing and processing feelings, and receiving validation and caring from others was helpful. The nurse who attended the care conferences which allowed time to process emotions about patient care situations also reported a sense of relief from hearing others talk about feelings, even though she did not share her own feelings. There is support in the literature for this kind of expressive and confessional sharing which encourages a sense of coherence in those who engage in the practice of expressive reflective action (Freshwater 2000; Pennebaker and Graybeal 2001).

Often times, the need to suppress feelings in the workplace were seen by the nurses in this study as detrimental, but necessary to get through the shift and required tasks. Unprocessed emotions would seem particularly likely to also affect the care
environment and feelings of patients, as has been shown in a number of studies about the role of the unit atmosphere on patient recovery and staff satisfaction (Menzies 1960; Swanson 1999; Rafaeli and Sutton 1989). An excessive focus on rationalized work processes and efficiency, as can occur in a managed care environment, has been suggested to be conducive to psychic numbing just as expressive opportunity is conducive to processing emotions and gaining a sense of coherence (Berlant 2008; Waitzkin 2000; Bauman 1989; 2008; Bowden 2000; Sumner and Townsend-Rocchiccioli 2003).

An interesting but less-well explored observation about female nurses experiences and opinions about male nurses’ caring was that several nurses indicated benefiting from males presence of the unit as helping them learn how to manage emotions and how to be less emotionally reactive. The literature on gender differences in nursing suggested males tend to be less emotionally expressive and to show a quicker recovery from negative emotions (Eckstrom 1999; Hopp et al. 2006; Robinson and Demaree 2007).

In the next section, I will talk briefly about caring as an exploited commodity. This was less evident in this study, but some relationship to Marxist thinking about alienation, commodification, and labor exploitation of labor can be addressed before final remarks are made along with suggestions offered for the next steps emerging from this research endeavor.
Exploiting Caring

Hochschild (1983) suggested that the elements of emotional labor that pertain to the Marxist ideas about exploiting labor have to do with how employees feelings are subjected to rules of the organization, thereby commodifying emotions as a product and bringing a highly personal aspect of personhood under the control of the organization. Researchers studying emotional labor in nonhospital job settings found employees were strongly pressured to prioritize the parts of their work role that promoted the organization’s image, above any other part of their job (Ashforth and Tomiuk 2000). Adding nurses to hospital marketing plans through the use of scripted slogans, phrases and ritualized recitations of goals for the day served as perceptual cues directing nurses toward the targeted patient satisfaction areas needing a score boost. As in the literature, these tactics mostly were experienced as insincere and burdensome (Leys 2011).

According to the literature, nurses were more responsive and committed to marketing strategies with objectives and initiatives aiming for improving care and not just perceptions of care (Bowen and Schneider 1995; Chang and Chang 2009; Iliopoulos and Constantinos-Vasilios 2011; Rafaeli and Sutton 1987; 1989).

Several theorists of late capitalism and post-modern and post-structuralist thinking have theorized about how healthcare and caring have become big business under marketing influences of capitalism (Adams and Nelson 2009; Coughlan 2009; Herdman 2004; Jameson 1991; Staden 1998; Waitzkin 2000). These scholars find the capitalistic and marketing influences in healthcare to be incompatible with caring. As Hochschild (1983) suggested, and contrary to what symbolic interactionists theorize about human
interaction and the production of meaning, workers performing emotional labor lose the opportunity to interact based on their own experience of circumstances. Instead, emotional labor employees engage in interactions on the basis of expected conformity scripts and expected presentations of a particular image. Marx’s (2000 [1848]) alienation concept addressed the alienation of workers from their product, its productions, and the end-product.

Hochschild compared emotional labor exploitation to physical labor exploitation, but noted that Marx had not anticipated emotions becoming thing-like as he described in referring to the products of people’s physical labor. Employees were effectively alienated from their own labor by not being able to see the end-product and its implications. This kind of alienation might be similar to that experienced by people who surprisingly become perpetrators of abuse as a consequence of being alienated from the full view of the consequences of their actions or decisions made in isolation (Darley and Latane 1968; Milgram 1974; Zimbardo 2007). A diffusion of responsibility or distortion of the trajectory of one’s actions makes it much easier to alienate oneself from the unintended effects of action or inaction (Darley and Latane 1968).

As nurses in this study became alienated from their emotion and from their caring demonstrations, there was some preliminary indications of a pattern of distortion or transmutation of the feeling of caring. Nurses began to be more confused about what constituted caring, and how much it mattered. In rare cases, nurses engaged in rude and insensitive comments to or around patients. There were also occasions, though rare, in which nurses began to see it as acceptable to view giving a drink of water to a thirsty
patient as an act of caring because it fell out of the purview of their routine checklists for which they were directly accountable.

Just as caregiving scholars and economists have suggested that caregiving skills are often assumed, taken-for-granted, or perhaps omitted altogether (Cancian and Oliker 2000; England, Budig, and Folbre 2002; Glenn 2010a and b), time allotted to maintain caring in nurses work with patients also was omitted or taken-for-granted. To take the caring of nurses and displace it by tasks linked to efficient compliance with routines and tasks dependent on reimbursement is a clear manifestation of commodifying nurse caring. By obstructing a nurse caring and imposing institutionally scripted caring, the human aspect of patient caring is transformed into a market-based commodity tied to hospital profits. This deepening dependence on consumerist ideology that emerges in late capitalism displaces feelings such as caring from their own experiences of interaction. In symbolic interactionist theory the interaction is the basis for all meaning and understanding that occurs between people, including the maintained of social institutions. Rather than exchanging human emotion and understanding in reading the meanings, symbols, utterances, and gestures between people, market-based caring projects the image of the hospital into the views and opinions of patients and the public. If interpersonal identities and streamlining of interactions impede the development of these relationships on which social solidarity depends, a lingering question from this research concerns how all manifestations of caring will eventually be affected.

What conclusions can be drawn from this study about nurse caring and the barriers and facilitators to caring? These will be addressed next followed by a
consideration of the strengths and limitations of the study design, sample selection, and data analysis.

Conclusions and Recommendations for Future Actions and Studies

The conclusions and recommendations for this study follow in Tables 6.2-6.6 below. The conclusions in the tables are organized as sets of related conclusions that could be followed up by similar recommended actions. Immediately after the conclusions and recommendations will be a discussion of the strengths and weaknesses of this study design, sample selection and data analysis.
Table 6.3 Set One of Conclusions and Recommendations Regarding Caring

**Conclusions:**

*Caring is a scarce resource in today’s hospital environment.*

*Caring is moving toward a masculine definition of caring with increased focus on instrumental functions and efficiency.*

*Most nurses believed caring was already present before entering nursing school, and that nursing school focused more on technical skills, physiological functioning, and disease processes.*

*Many nurses fondly recalled caring experiences from their personal lives or caring role models. Instructors with current clinical expertise who were passionate about nursing were recalled most when nurses had workplace caring dilemmas.*

*Nurses are unclear about what caring is, what it means to patients, its purpose, and how it is manifested in thoughts, feelings, and actions.*

**Recommendations:**

*Nursing schools should incorporate the concept of caring throughout their curriculum, including the provision of repeated and supported opportunities for exploring, defining, and applying caring in their own development as caring nurses. Particular attention should be drawn to exploring motives for caring, and how caring behaviors are determined and experienced by patients so that nurses can be clearer about the interpretation of language about caring.*
### Table 6.4 Set Two of Conclusions and Recommendations Regarding Workplace Stress, Emotional Labor and Health Risks

**Conclusions:**

*Nurses’ jobs are sufficiently stressful and overwhelming to warrant concern for how it affects their physical and emotional well-being.*

*Nurses who perceived their nurse managers as supportive, as their advocates experienced their jobs more positively even though they identified some of the same stressors as nurses who were less satisfied.*

*Nurses who experienced their coworkers as supportive and interested in a teamwork approach felt more positive about their work, even if they had unresponsive managers.*

*Secondary emotional labor is the emotional labor engaged in to manage feelings generated by work-induced interference of caring. This kind of emotional labor produces greater dissonance for the nurse than emotional labor engaged in to match caring behaviors with a caring identity.*

**Recommendations:**

*Further studies about the specific kinds of stress related health effects of nursing work should be explored.*

*Managers should be informed of the significance of management support and coworker support to nurse satisfaction and unit atmosphere.*

*Nursing schools should address strategies for nurses to manage the current work conditions in nursing which are not conducive to caring. Hospitals, human resources departments and professional associations in nursing should be encouraged to explore feasible ways to provide relief to nurses from the continuous intensity of nursing work.*

*Case study research into specific ways managers and coworkers assist nurses to feel empowered and how they help nurses redefine their jobs in meaningful ways would be useful for management training.*
Table 6.5 Set Three of Conclusions and Recommendations Regarding Exploitation of Caring

**Conclusions:**

*Nurses tried to comply with administrative directives and institutional standards to meet external regulatory and fiscal demands. As nurses progressed in interviews, they became aware of incongruences in the rationales for some of these directives. They also began to consider negative effects on their capacity to care as they talked about some of administrations initiatives which left them feeling manipulated and deceived.*

*A few of the nurses defined caring by their institutional discourse, sometimes without even realizing they had repeated it almost verbatim.*

*A hospital initiatives for caring have begun to transition toward becoming a performance, one that speaks more to manipulating perceptions, minimizes the need for relating to the patient, and is focused more on becoming better at doing a safe job with multiple competing demands and complying with routines and checklists rather than individualized care.*

*Nurses were extremely uncomfortable speaking negatively about their employers as if they had a ‘no talk’ rule.*

**Recommendations:**

*Opportunities should be created or taken advantage of in nursing schools and professional nursing associations to promote public awareness of the social and psychological risks of changes in the caring focus of hospital care.*

*Nurses should be educated further regarding the effects of isolation, group influences, the role of emotions in ethical decision making, and how to maintain clarity about the ramifications of rules, orders, and decisions made in isolation from relevant features of the intended actions.*

*Action research in which nurses participate in identification of researchable problems regarding work conditions should be conducted to help nurses become aware of patterns of exploitation, and how to escape the entrapment of participating in and perpetuating their own exploitation.*
**Table 6.6 Set Four of Conclusions and Recommendations Regarding Emotional Labor Strategies**

**Conclusions**

*Nurses were engaged in a variety of emotional and cognitive strategies, some of which operated in an apparently automatic, unconscious way. The most often cited strategy was minimizing the negative aspects of work by finding a positive venue on which to focus such as a special patient, a competent, supportive manager, or an institutional reputation.*

*Nurses who were dissatisfied but still caring tried to make changes in themselves or their workplace and left only after giving up hope of things changing.*

*Some of these efforts to change feelings about work involved distorting the concept of caring by rationalizing the level of care provided to patients as acceptable. The extreme cases of caring distortions included actions such as viewing the registered nurse getting water for patients, helping them to the bathroom or working really hard as an action that should have been done by another employee and therefore was evidence of nurse caring.*

*Some nurses remain committed to the humanistic importance of nursing, refusing to give up the interpersonal dimensions of caring.*

**Recommendations:**

*Nurses should be apprised of the health risks of emotion suppression while also being taught about emotional labor and ways in which it can be helpful or harmful in the workplace.*

*Nurses should be given opportunities by nursing educators and employers to explore their caring with other nurses and how to manage barriers and promote the things that enhance their capacity to show caring.*

*Nurses who find ways to avoid dehumanizing patients amidst the many required tasks should be interviewed further in studies to facilitate the wider application of strategies that enable caring even when nurses are busy.*
Table 6.7 Set Five of Conclusions and Recommendations Regarding Barriers to Caring

**Conclusions:**

*The main barriers to caring identified by nurses were the workload, conflicting expectations, and requirements to deliver care through checklist and technologies intended to save time but often slowing down work flow.*

*Marketing techniques and the focus on patient satisfaction scores were viewed as insincere by most nurses and also as diminishing nursing judgment, nursing care, and nursing autonomy.*

**Recommendations:**

*Nurse managers should carefully review job responsibilities, reporting mechanisms, and lines of authority to ensure nurses are held accountable only for their own work. Nurses working under duress with inadequate staffing need clear lines for reporting these incidents and document any consequences.*

*Minimum staffing levels need to be established and endorsed by the nurses and patients through hospital boards and professional associations of nursing.*

*Nurses should document conflicting requirements and submit to management, state Boards of Nursing and Human Resources Departments for resolution.*

*Nurses need to be able to vote managers out of their positions for non-support of their work as nurses and mechanisms for doing so should be explored.*

*Patient satisfaction improvements efforts need to be driven by the nurses who are held accountable for the outcomes as opposed to being forced to participate in marketing initiatives to change perceptions and not conditions affecting patient satisfaction.*

While the above conclusions and recommendations have been considered carefully, there are certain strengths and limitations which need to be considered in interpreting the validity of the findings and logic of the recommendations.
Strengths and Limitations of the Study

Strengths. This study had several strengths that will be addressed first, followed by identification of known weaknesses. Foremost among the strengths of the study was the ability to focus only on the medical-surgical nurses which enabled a sample of nurses who more consistently represented aspects of work likely to be present in all nurses’ jobs. I chose medical-surgical nurses because they are multi-talented, having to keep up with several differing kinds of patients and having to apply knowledge from all areas of nursing, making them somewhat of a prototype nurse, in my opinion.

Another strength of the study was the wide range of participants from several hospitals within 100 miles of Birmingham. Alabama. This generated greater variation among participants while also making it easier to reassure participants, they would less easily be guessed as having been a participant based on a quotation or description was familiar to them or others. By avoiding a direct relationship with the hospital, it possibly enabled nurses to feel freer about disclosing aspects of their work life.

The use of semi-structured interviews allowed for a more conversational style to transpire such that participants were able to feel relaxed as they talked about their experience. The use of a public setting such as a coffee shop was also helpful in this same regard.

The relaxed nature of the interviews was helpful for allowing multiple viewpoints to be shared in the interviews. There were some interesting parallel processes occurring between myself and my participants that somewhat mirrored the process occurring between nurses and their patients when they are able to be caring. For instance, as I
approached each participant from initial meeting until the end of the interview, I was aware of how similar the feelings I experienced were similar to what the nurses described as what they desired in their approach to patients. I wanted to be caring and respectful to the nurses, and make sure they felt safe and supported.

The topic was timely in that the issues relevant to the discussion of emotional labor and caring were currently happening to them as changes were being considered and implemented in their hospitals. Changes in how care was provided and shown to patients were at the forefront of nurses’ concerns. Many nurses were stressed and were eager to have someone to talk to about these changes. My nursing background gained me instant rapport and eased my ability to comprehend systems issues and terminologies being discussed without having to spend time defining and clarifying common areas of shared knowledge. As I listened to the participants’ stories about their work with patients, and the degree to which they worked to meet their needs, I felt more of a resolve to do the same for my participants. A parallel between nurses’ sense of needing to be advocates for their patients existed within me for them.

The ethnicity, age, and experience levels of participants was another strength which allowed for a consideration of whether differences among particular categories of nurses required further investigation. The ability to have older and experienced nurses was especially beneficial as medical-surgical nurses are often younger and inexperienced. As pointed out by many participants, there was a tendency for new nurses to come into medical-surgical nursing and move on to specialty areas once they gain basic nursing skills from working medical-surgical units. Thus, having older and experienced nurses represented in the study was a positive.
The numbers of participants were adequate for reaching saturation of themes about caring definitions, interference with caring, and strategies for managing interference. There was insufficient variability and experience of these nurses’ experiences with male nurses to sufficiently comment on perceived gender differences in caring.

Limitations. A main limitation of the study was the volume of data collected. This might have been better managed if the research and interview questions were specified better and less open to topics which sometimes were unrelated directly to caring, but were of concern to participants. My rigid adherence to the requirement for participants to work day shift increased the length of the study and perhaps resulted in screening out potentially good participants who would have contributed another perspective to the research. Excluding males felt awkward and may have alienated some males who wanted to participate. Having a specific plan in place to address male nurse perspectives would have been helpful.

I also think some of the nurses must have elected to participate in the study because they had particular issues of concern to them of an immediate nature. This was apparent in several interviews and all of the participants except one or two were eager to talk about their work. As a researcher, I believe I allowed myself to become focused more on the interesting phenomenon of patient satisfaction initiatives rather than redirecting the inquiry to specific questions and examples about how the nurses dealt with the dilemma of caring interference or how the managers facilitated nurse caring behaviors.
As the nurses and I connected about caring, I was aware of how much qualitative research was like nurses work with patients—Nurses must be sensitive to their patients to be able to be their voice, and qualitative researchers must do listen and be sensitive to their participants to be their voice. There is always some risk of inaccuracy in these kinds of human translations.

A more careful analysis or case study of one or two particular hospitals may have provided a better in-depth understanding of the cumulative and shared concerns of several nurses within a system, which could then be used as a basis for comparison across hospitals and hospital types. The study only speaks to hospital nursing, and is of course, not generalizable to hospital nurses as a population. As with all studies using a convenience sample, this study cannot be generalized to the larger population of hospital nurses. This study only includes the perspective of the nurses and not the ancillary workers, managers, administrators, and other occupational groups. The manner in which the participants were selected also made it more likely that the nurses were participating because they had a desire to talk about their work. The possibility of obtaining similar results from a similar pool of nurses was present because participation came about through my own professional contacts. Before final remarks are made, I will make some summative comments about the salience of gender for this research about emotional labor.

This study had the undercurrents of gender without directly or fully addressing the social institution of gender. The salience of gender was present in the way females were drawn into nursing, the expectations they and others have of themselves for deference to others (which was sometimes confused with caring), and the emerging changes in how
nurses’ caring has shifted toward instrumental caring, which is more often associated with male nurses’ caring style (Ekstrom 1999).

Several times in this manuscript, the literature suggested that instrumental caring, done efficiently and with skill was actually preferred by patients, as long as the nurse was not overtly uncaring. Yet, hospitals pay consulting fees to require staff to simulate a caring manner in their interactions with patients. This suggests perhaps that patients were not happy with the caring displayed by nurses.

Final Remarks

One thing that became clear to me with increasing resolve as I conducted, analyzed, and wrote about this study, caring is important for us at many levels of involvement. Caring is important for individuals to be able to thrive and emerge from life’s difficulties. As participants in relationships, caring sustains our commitments to each other and solidifies our bonds to each other. As members of society, caring establishes the integrity in our decisions about coexisting equitably. Years of research on caring have shown human beings need for caring and nurturing, albeit to differing degrees at different times in their lives (Bowlby 1953; Harlow 1958).

Aside from the documented benefits to recovery from illness and injury (Antonovsky 1993; Engebretson, Peterson, and Frenkel 2014; Eriksson and Lindström 2005; Glasper and DeVries 2005; Turner 2013), caring is important to our healthcare system. As the nurses in this study expressed, time and resources for caring are often omitted from the line-items budget plans and established routines. This is documented in our economic system that hides the dollar and social values associated with caring and

The symbolic interactionist and critical theory elements of Hochschild’s emotional labor theory provides an excellent framework for examining the way our day-to-day interactions with each other in our system of healthcare. By providing a framework for caring work within the context of the capitalist mode of production, the nurses’ interview responses could be understood from the perspective of the nurses’ relationship to their work, and to the kinds of interactions they were able to have or not have as they were recreating the meaning of caring. Whether caring is sustained or redefined in our healthcare system will depend on those interactions happening routinely between participants in the healthcare system.

Nurses’ roles and how they play them out in their work with patients depends on the social rules and expectations about care, caring, and gender. All behavior is a performance in dramaturgy theory, so acting the part of the caring nurse is part of fulfilling one’s role in service of the patient’s role in meeting expectations stemming from assumption of the sick role (Parsons 1937). The caring nurse and the sick patient are social performances within a larger institutional context, but how these performances are acted out often reflect the changing values of society.

It is because social structures are created and maintained by individuals that this research is useful for nurses, nursing leaders and administrators, and nurse educators. There are a number of changes occurring simultaneously in the larger social world in which we all exist. The dissolution of the iconic caring-female-nurse and of rigid demarcations of gendered caring roles in nursing could represent one of the many
manifestations of shifts in society about caring and exploiting vulnerabilities as capitalism’s effects reach into more and more areas of our selves and relationships.

As we wrestle with decisions about how we will redefine ourselves in an increasingly diverse and changing social world, we may find routines and neatly packaged categories bring coherence to bombardment with confusing changes. Alternatively, we may find this reliance on routines shrinks the essence of our personhood and relations to each other much as the routines and checklists condensed the patient’s expression of needs to time-limited and pre-determined responses to needs that are assumed based on shortcutting the paths to knowing who this patient is and what they need based on their illness experience.

As we continue to discover a range of behaviors and variability across polar opposites of masculine and feminine characteristics, we are perhaps collapsing dichotomous views about gender which suggest females are caring and males are rational. Benner (1984) suggested the expert nurse was the nurse who could be both competent and caring, and this required using both sides of one’s being – intuition and logic. As we collapse these rigid demarcations of being, and open up new possibilities for behavior, thinking styles, and emotion in people, and in nurses, in particular, perhaps, we will find value in dissolving a concentration of caring in one gender – females, and one occupation – the female icon of the caring nurse.

The healthcare system changes may be converging to affect the phenomenon of caring for nurses, and caring by nurses. There is plenty of existing research supporting the need for those involved in jobs associated with emotional intensity to receive some kind of provisions within that job to bolster their capacity to process these emotions. How
we make these decisions will affect how the healthcare system transpires over time. The nurses in this study expressed being overloaded and burdened by their inability to be caring, and yet expected to follow a script to show caring defined by the hospital. Time and resources are needed for processing emotions and managing the stress that allows people to experience coherence in their work. This would mean bare-bones staffing is insufficient in supporting the safeguarding of nurses and their work. The question is not whether the human resources are useful or necessary, but whether we are willing to invest in them. Alternatively, we can continue on the current trajectory of exploiting the nurses caring by superimposing added requirements to their already never-ending duties. This path leads to emotional numbness and runs the risk of producing a mass of nurse employees who are insensitive to suffering by acclimation (Cameron and Payne 2011; Zimbardo 2007).

Hochschild (1983) asked the question about emotional labor, if feelings are guides to our own moral compass, then what does it mean to sell these feelings? The beginning of this study highlighted the United Kingdom’s healthcare system as uncaring. There have to be decisions made about how much caring we wish to allow time for, and to what degree we wish to concentrate it in the hands of nurses. As Hochschild (1983) anticipated, these effects of emotional labor reached into the personal lives of some nurses and robbed them of their capacity for intimacy and closeness.

Mestrovic (1997) was concerned about the consequences of post-emotionality for morality. He suggested that ethical living grounded in duty, rather than compassion was empty. In the sociology of emotions, emotions are central in establishing, sustaining, and
changing the links between the individual and the patterns of social life. To examine these links is the concern of sociology.

"To ask sociological questions, then, presupposes that one is interested in looking some distance beyond the commonly accepted or officially defined goals of human actions. It presupposes a certain awareness that human events have different levels of meaning, some of which are hidden from the consciousness of everyday life"

Berger 1963

Conceptually routines, stereotypes, control, and dualisms seem to overlap with the human desire for predictability and control over people and events. In our dualistic and busy society, we tend to change slowly and sometimes gravitate from one extreme to another whenever we experience unrest with the existing order. Maybe we will concentrate caring in another of our social institutions such as marriage, religion, another gender, or any number of other ways of rearranging an aspect of a social system to regenerate equilibrium. Perhaps we will diversify caring across human beings and allow everyone to enjoy some of the qualities of caring we have tried to contain and label as belonging to nurses or females. At this edge of chaos in healthcare is new order and possibilities, if we care.
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APPENDIX A

UNIVERSITY OF ALABAMA AT BIRMINGHAM
CURRENT INSTITUTIONAL REVIEW BOARD APPROVAL
UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The Assurance number is FWA00005960 and it expires on January 24, 2017. The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56.

Principal Investigator: HOGAN, BEVERLY K
Co-Investigator(s): 
Protocol Number: X130515001
Protocol Title: Emotional Labor and Gendered Caring by Nurses

The IRB reviewed and approved the above named project on 4/15/15. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received EXPEDITED review.

IRB Approval Date: 4/15/15
IRB Approval Issued: 5/4/15
IRB Approval No Longer Valid On: 5/4/10

Member - Institutional Review Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.
APPENDIX B

POSSIBLE INTERVIEW QUESTIONS FOR NURSES
“Tell me about caring in your work”.

“Describe what you have been taught about the importance of caring in nursing work as a student and as an employee”

“Talk about how you see yourself as caring”

“What are your thoughts about whether caring can be taught?”

Do you think people have to come into nursing with the quality of caring?”

“Discuss how you view caring in your work .....such as how it is important, what aspects are most important.”

“What are your employers’ expectations about caring?”

“Does your employee evaluation measure your caring and if so How”? 

“How do you see caring relating to satisfaction of patients?”

“What differences do you see between male and female nurses when it comes to showing caring?”

“How do you think you acquired caring skills?”

“Talk about features of their work environment that interfere with or enhance your ability to demonstrate caring.

“What methods have you used to get around barriers to being able to show yourself as a caring nurse?”