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Introduction

‘The little things’

In the introduction to my first book I described my experience of making beds with a student nurse soon after she was allocated to an elderly care hospital, and my memory of her being close to tears because she felt that the old people were being treated like sacks of potatoes – hauled out and in of bed at the beginning and end of their day with no control over their destiny. This was a defining moment in my search to understand how student nurses learned to care (Smith 1992). Other students talked more positively about their experiences of elderly care, discovering that it was ‘the little things’ that made the qualitative difference to patients’ lives – little things such as dressing in their own clothes, manicuring their nails, making sure their hearing aids worked and their glasses were clean. As one student put it, in the elderly ward, the functioning hearing aid was just as much a lifeline as the intravenous infusion to the postoperative patient on the acute surgical ward. On the elderly ward, the high-tech heroics were set aside and the little things became all important.

Over two decades later these elderly care wards have mostly disappeared and given way to residential nursing and care homes located primarily in the independent sector, as part of a general shift towards the commercialization of elderly care brought about by the 1990 NHS reforms. Student nurses in the 2010s now experience caring for elderly people in these settings both as part of their placements but also as off duty contract workers as a way to supplement their bursaries. Although the context has changed there is evidence to suggest that ‘the little things’ still matter.

From my own experiences as a young patient and as a student nurse I recalled that in acute wards, it was ‘the little things’ that made the qualitative difference, especially as to how I felt: the nursing assistant who, when I was a patient, broke hospital rules to bring me an Easter egg; the sister in the outpatient department who noticed me shivering in a wheelchair and tucked me up in a blanket; and my own nurse teacher who visited students on the wards and encouraged us to talk
about our patients as individuals rather than cases. I reflected that all these people had shown personal interest in me and made me feel safe and cared for in an environment that was otherwise threatening, rigid and hierarchical.

Twenty years later my experience of care was not as a patient but as a carer of two increasingly ailing and elderly parents for whom ‘the little things’ continued to make a difference as to how they felt. They told me how important it was that professionals treated them as equals with life histories that mattered. Other examples were not unlike my own memories, involving care and attention of physical needs, which in turn impacted emotional wellbeing. During a visit to my mother in a rehabilitation unit, she described how the night before she had felt very cold. One of the nurses had noticed and promptly wrapped a blanket around her and brought her a hot cup of tea. The little things were also dependent on the ability of the staff to step outside routines, as the following incident illustrates. During a period of hot sunny weather, I arrived at the unit to find my mother along with other residents sitting in their wheelchairs under the trees with the staff, chatting companionably and sipping fruit juice in the natural surroundings of the gardens, free from institutional constraints.

In a follow-up study to explore emotional labour and student nurse learning in the 2000s (Allan et al. 2008a) a third year student described noticing ‘the little things’ as a quality that not every nurse developed. She said: ‘you notice the little things and not everybody does’. Recalling an incident from her current ward experience she gave the following example:

One of the patients had his wedding anniversary yesterday, after being married 42 years. When his wife came in I wished her ‘happy anniversary’. She was pleased I remembered and she said it made a difference.

Another student described that making a difference to patients meant:

A lot of the little things and I quite like, definitely like chatting to patients and asking them if they’re alright, if they slept okay, have they got any worries?

Noticing the little things was also described by a practice educator as part of being a good mentor and necessary for developing positive relationships with students. She said:

I think the students value just being made welcome and little things like being shown where the off duty is and where they can put their coat and it’s the buddy side of it, yeah. They do appreciate that.

But these ‘little things’, or ‘gestures of caring’, are still difficult to capture and they slip by unnoticed in the daily routines and the hustle and bustle of institutional life. When a patient is there ‘for life’ then the absence of these ‘little things’
is stark evidence of the lack of care. The recognition of the ‘little things’ becomes more urgent as increasing numbers of older people are likely to spend their final years in institutions. For students the importance of the little things as evidence of good personal relationships both between themselves and their patients and in turn between their mentors and themselves has taken on a particular significance in the acute care setting, where patient throughput is high, and the combination of their supernumerary status and staff shift patterns may have lowered their integration within the ward team and feelings of continuity compared with the student apprentices in the first study, who constituted two-thirds of the workforce.

So why then when these things make such a difference to how people feel do we still refer to them as ‘little’? One explanation lies in the continued stereotyping of care as women’s ‘natural’ work, which keeps it invisible and undervalued and on the margins of high-tech medically defined work—the background context in which the caring and learning takes place.

The reproduction of gender stereotypes was no better demonstrated in the 1980s than in the public images and perceptions of nurses and nursing. Attitude surveys reveal, for example, that the public identify ‘alertness to the needs of others’ as the mark of both the good woman and the good nurse (Oakley 1984). These attitudes reflect the patriarchal nature of nursing’s origins, enshrined in the powerful image of Florence Nightingale. Nightingale continues to capture the imagination, as a recent biography, Florence Nightingale: The Woman and Her Legend (Bostridge 2008), testifies. Over the intervening decades Mary Seacole, a Jamaican-Scottish healer, herbalist and business woman, once shunned by Nightingale and the Victorian establishment has risen to prominence to take her rightful place in nursing history. When the first book was written her story was little known and in many ways epitomized the marginalization and devaluation that black nurses subsequently experienced (Alexander and Dewjee 1984, Smith 1987, Baxter 1988, Smith and Mackintosh 2007). Seacole, who was well established in Jamaica, regarded it her duty as a loyal citizen of the Empire to travel to London to offer her services as a nurse in the Crimea. Although her offer was rejected, she used her own means to travel to the war zone and care for injured and dying soldiers. She returned to the UK almost penniless, but a group of grateful soldiers organized a concert to raise funds for her. There are now portraits of Seacole in the National Portrait Gallery and the Royal College of Nursing in London which testify to the work undertaken by the Jamaican Nurses Association and the annual Black History month. Over the past thirty years this has highlighted the achievements of Seacole and other prominent members of the black community to reveal their hidden history.

In the early 1990s, when I wrote my first book, nurse recruitment posters conveyed the predominant image of nurses, usually white women, as carers rather than technicians, special people who make a difference. ‘Patients remember nurses’ one poster states; another shows a little girl in a nurse’s uniform holding
her bandaged teddy bear: ‘the best nurses have the essential qualifications before they go to school’. In other words, caring is portrayed as intuitive, instinctive, as something you’re born with by virtue of your gender.

Young white women were still most likely to appear in the recruitment posters, and although a variety of technical images were presented (such as nursing a patient in head traction or tapping into a computer), the central message was that nursing is about people and ensuring the welfare of patients and their families.

By the mid-1990s, Kitson (1996), who at the time was a prominent nurse educator and researcher at the Royal College of Nursing, described the need for the images to change:

The nurses of the future need new images to reconcile their technological skills with core values of caring and companionship.

A 1997 recruitment advertisement for general nursing had a ‘Casualty’7 like image of a pair of hands administering cardio-version therapy to the exposed chest of an unconscious patient. The caption read: ‘Too much voltage and he dies, not enough and he dies. Clear?’
Technological skills were apparent in this message, in line with Kitson’s recommendation, but not necessarily caring and companionship. Indeed the advert continued: ‘You’ll never forget the first time you bring someone back from the dead ... by punching a human heart back to life ... there’s no other feeling like it’.

The requirements for such a job were specified as ‘hard work, studying and decision-making’. In the corner of the picture, in small letters, the reader was asked ‘Nursing. Have you got what it takes?’ By focusing on the hands the advertisement was gender neutral, which suggested the importance of head and hand required in an emergency life-or-death situation, which took priority over the relational side to nursing, of care and companionship.

I detected another shift in the recruitment messages of the 2000s, which reflected nursing’s move into higher education from the hospital schools of nursing where students are supernumerary rather than part of the workforce and supported by bursaries rather than wages. A recruitment poster from a London university, which asked ‘At what price nursing?’ assured prospective students that on completion of their three-year nursing programme they could expect the dual benefit of a good starting salary (£20,000 in 2005) and a university qualification.

This message is very much in contrast to the recruitment poster of the early 1990s, which gave a mixed message in response to the question ‘Do the financial...
Illustration 1.3  Do the financial rewards match the emotional ones?

Note: This illustration is based on a DoH recruitment advertisement.

Source: Liz Ashton Hill. Reproduced with kind permission.
"Mummy said she had cancer. Daddy got very upset. The nurse made them both feel better."

A Macmillan Nurse helps care for people with cancer. We need your support to help her do even more. Send your donations to 15/19 Britten St, London SW3 3TZ.

Cancer Relief Macmillan Fund
Living with cancer

Illustration 1.4 Macmillan nurse with a smile
Source: Macmillan Cancer Support, formerly Cancer Relief Macmillan Fund. Reproduced with kind permission.
“It wasn’t the cancer patient who needed me; it was the relatives.

When I arrived at the house the patient was asleep upstairs. I was immediately concerned about his wife. She looked as if she hadn’t seen her bed for a week, which she probably hadn’t. Her daughter was just leaving as I arrived.

They were obviously very close, but I got the impression that the mother was still trying to protect the daughter, to shield her from what was happening. When we were alone, we talked. Just talked.

About families, and how quickly things change. Sometimes a cup of tea is the best medicine in the world.

People sometimes ask me how I can do this, nursing people who are terminally ill. But you only have to take the hand of someone who’s caring for a dying relative. Someone who’s really desperate to rest. You can almost feel the relief easing its way through. Then you know that it’s worthwhile.

Every night Marie Curie nurses stay in the homes of people with cancer. They bring relief to the patients. And comfort and support to the relatives and friends who are caring for them. Please help us to continue this work.

Illustration 1.5  Marie Curie nurse helps relatives

Source: Marie Curie Cancer Care. Reproduced with kind permission.
rewards match the emotional ones?’ The answer (unlike the 2005 poster which directly addressed the issue of material reward) reassured prospective students on the one hand that although they were unlikely to be attracted to the job for the money, they could expect emotional rewards as well as financial ones. The conclusion here was that the emotional rewards came as an extra for working in one of the most ‘emotionally satisfying careers’.

During the 1980s and early 1990s, when the first book was written, the cancer charities were prominent in promoting the nurse as a central feature of their services, with images of caring portrayed by holding, smiling nurses, who helped to ease the emotional pain of caring for a relative with cancer. One poster that advertised the nursing services of a cancer charity used a child’s drawing of a smiling nurse with the caption: ‘Mummy said she had cancer. Daddy got very upset. The nurse made them both feel better’.

An advertisement for the Marie Curie cancer charity showed three powerful images of a nurse comforting the distressed wife of a cancer patient. She was shown as performing the little things: holding, talking and preparing a cup of tea. The nurse seemingly performed these tasks effortlessly, with little demand on herself and for little material reward. Part of the wording read: ‘People sometimes ask me how I can do this, nursing people who are terminally ill. But you have only to take the hand of someone who’s caring for a dying relative. Someone who’s really desperate to rest. You can almost feel the relief easing its way through them. Then you know it’s worthwhile’.

These images suggest that when the first book was written the cancer charities were prominent in promoting the nurse as a central feature of their services with images of caring portrayed by holding, smiling nurses who helped to ease the emotional pain of caring for a relative with cancer. Over the past 20 years, this image has changed, as advances in cancer treatment has resulted in cancer being regarded, in many cases, as a long-term condition rather than a terminal illness. This is attributable, in no small measure, to the discoveries made about the role played by genetics, which makes it possible to find out whether a particular drug is likely to be effective based on the individual’s genetic make-up. The advances in treatment and long-term management of cancer are refiect of the strategic vision and direction of the charities.

For example, the Cancer Relief Macmillan Fund, now renamed Macmillan Cancer Support, presents a broad strategic vision which includes proactive fund raising involving the public, fighting inequality and changing lives. Funding nurses is the first of seven strategic statements. Giving time, supporting families and making coffee can be identified as the indicators of emotional labour as a function of the whole organization. For example, a recent advertisement read ‘Help with the Emotional Effects of Cancer’ – ‘We are Macmillan Cancer support’, which suggested the organization had become the embodiment of that support through a corporate form of emotional labour.
Furthermore, since the first book was published, the IT revolution has had a massive impact on how information is transmitted to the public by means of websites and databases, and in the case of Macmillan Cancer Support a variety of booklets can be downloaded free from their website (www.macmillan.org.uk). In the context of emotional labour, two titles caught my eye: ‘Hello and how are you?’ and ‘How are you feeling?’ In addition public posters strategically placed at bus stops asked anonymous patients and their carers ‘Are you tired of putting on a brave face?’ Words rather than images were conveying the message, but in the booklets there were many powerful images of care and concern, laughter and determination, sincerity and concentration not only on the part of the professional but also on the part of the person with cancer and their carer. In some of the images it was not always possible to distinguish among professional, carer or person with cancer, which may be part of the power of the message being transmitted, that ‘we are all in this together’.

Four areas were highlighted in the website of Marie Curie Cancer Care (www.mariecurie.org.uk): nursing, hospices, cancer research and palliative care research. Since the image in the first book was on the transmission of emotional labour by the nurse, I also focused on the section of the website demarcated as ‘Marie Curie Nurses: How can we help?’ The information given was that Marie Curie nurses and health care assistants (HCA) care for 50 per cent of people with cancer who die at home and also for people with other end-of-life conditions ‘every minute of every day’. Marie Curie Cancer Care continues to convey the message that their nurses support carers by allowing them ‘to rest knowing that their loved-one is in safe hands’ and support them ‘at what can be an emotional and stressful time’. The accompanying booklet that can be downloaded carries images of concerned, considered and smiling patients, their carers and uniformed professionals. The emotional tone of the text both in the booklet and on the website was one of supportive partnership, while at the same time giving the sense of drawing a discrete boundary between the organization and the individual in contrast to the much more encompassing message of Macmillan Cancer Support, which conveys empowerment and partnership. It may even be possible to ‘Be. Macmillan’ and for professionals and public alike to create their own materials and resources.

What is care?

In the 1980s and 1990s I asked what is care? My second question in the context of these powerful images of nurses as caring (smiling, holding, talking) women, making things better for others was how can it be defined to go beyond such images? A number of feminist sociologists attempted to answer this question (Stacey 1981, Graham 1983, Ungerson 1983a, 1983b, 1990). Graham, for
example, described caring as both labour and love, caring for and caring about, doing and feeling. She says: ‘everyday conversations about caring are ... conversations about feelings. When we talk about caring for someone we are talking about our emotions’ (Graham 1983, p. 15).

In general, caring relationships are those involving and defining women in both the public and private domain. Throughout the life-cycle women care for children, partners, relatives who are sick, handicapped or the elderly. They reproduce these caring activities in the public arena of work. But differences occur in the affective domain, where feelings of love, concern and empathy are in danger of being replaced by ‘social distance’ (Graham 1983).

Nicky James (1989), a nurse sociologist, who spent five months as a participant observer in a hospice, chooses to describe care as labour. She found that the demands of emotion work with the dying and their families could be as hard as physical and technical labour, but not so readily recognized and valued. James concludes that ‘the management of emotions has many of the connotations associated with labour as productive work but also the sense of labour as difficult, requiring effort and sometimes pain. It demands that the labourer gives something of themselves and not just a formulaic response’.

She describes how emotions such as grief, anger, loss, despair and frustration were painful to watch and awkward to respond to, particularly as they did not fit in with standard ideas of workplace skills. But they were anticipated and seen as appropriate responses in coming to terms with death. Sometimes, however, nurses would choose to concentrate on the physical aspects of the patient’s care in order to avoid difficult relationships. When this happened, the ‘love’ part of the work was lost (James 1986).

Arlie Hochschild (1983), an American sociologist, whose groundbreaking work was the inspiration for my doctoral research and first book, also makes conceptual links among care, feelings and emotions. In her study of flight attendants, Hochschild used the term ‘labour’ rather than ‘care’ to describe the emotional component of their work (smiling, friendly, kind, courteous) which was required as part of their job and had explicit monetary value both for themselves and the airline.

Hochschild defines emotional labour as ‘the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place’ (p. 7). She goes on to say that jobs which involve emotional labour share three characteristics:

1. Face-to-face or voice contact with the public.
2. They require the worker to produce an emotional state in another, e.g. gratitude, fear.
3. They allow the employer through training and supervision to exercise a degree of control over the emotional activities of the employees (p. 147).
Thus, according to Hochschild, emotional labour is the occupational equivalent of emotion work/management which is done in a private context. It is sold for a wage and has exchange value. Because jobs with high components of emotional labour are most likely to be female occupations, gender stereotypes and expectations are reproduced in the workplace. Whether emotional labour is undertaken in the workplace or as emotion work/management in the home, it is guided by what Hochschild calls ‘feeling rules’. Feeling rules are the scripts or moral stances that guide our action. They come from within us, the reaction of others and social conventions.

Emotion work/management/labour intervenes to shape our actions when there is a gap between what we actually feel and what we think we should feel. Take the feeling of ‘anger’, for example. ‘Perhaps women are not any less aggressive than men’, Flax, a feminist writer, suggests, ‘we may just express our aggression in different, culturally sanctioned (and partially disguised or denied) ways’ (1987). In order to express our feelings in ‘culturally sanctioned ways’, Hochschild suggests that there are two kinds of emotion work: surface and deep acting.

In surface acting, we consciously change our outer expression in order to make our inner feelings correspond to how we appear. Deep acting requires us to change our feelings from the inside, using a variety of methods such as imaging, verbal and physical prompting so that the feelings we want to feel show on our face. Both feeling rules and emotion work may be unconscious or semi-conscious. Subsequently, a number of scholars have put the emotional labour analysis of feeling rules, surface and deep acting within public and private care work under scrutiny. Hochschild also shifted her analysis to a focus on care, which she defined as ‘an emotional bond’ between carer and cared for as testified in the following citation:

Most care requires work so personal, so involved with feeling that we rarely imagine it to be work. But it would be naive to assume that giving care is completely ‘natural’ or effortless. Care is the result of many small subtle acts, conscious or not (cited from Ruddick 1989).

Hochschild has since suggested that the commercialization of care work in a globalized economy has resulted in a ‘care deficit’ articulated through four distinct models which she suggests ‘appear in public discourse on social policy and so provide a tool for decoding that discourse’ (2003, p. 218).11

The emotional labour of care

But is emotional labour as a concept the same as care? What are the similarities and differences and the inherent contradictions of treating emotional labour as a commodity? In the first book I applied the concept of emotional labour to nursing
because nurses are expected to be emotionally caring and display emotional styles similar to those of flight attendants.

I first experienced caring as labour during interviews with students and patients when the language that they used and the feelings that they expressed conveyed a sense of the sheer emotional work required to sustain the traditional image of smiling nurses, holding patients’ hands. During one such interview a student described the following incident:

I’ve had times when I’ve been with another nurse and we’ve been changing a patient’s bed and he’s shouted at her or been rude or something. Well the procedure goes on as if nothing has happened. And when we’ve finished she just drifts off. And I actually go after her and say ‘Are you alright? I would have been very unhappy if he’d said that to me’. I think it’s so important that we notice each other’s distress so that we don’t have to cry alone in a corner.

As this account demonstrates, nurses laboured emotionally not only for patients but also for each other. The ward sister was the key person who set the tone for the caring climate on her ward. As one student explained, ‘if sister cares then I don’t need to take the whole caring attitude of the whole ward on my shoulders’.

Bone (2009, p. 57), writing in the 2000s, talks about the changes in the US health care system where ‘cost containment, medical control and profit making’ have eclipsed ‘those types of work that prioritize interpersonal and psychosocial care’ and the negative effects these changes have had on nurses’ emotional labour. Bone differentiates between ‘instrumental’ emotional labour characteristic of flight attendants’ work and ‘therapeutic’ emotional labour, which is nurses’ preferred style. Bone concludes that under harsh market conditions, nurses are forced to alter the style of care they give so that patients are left with no other option than to learn to live without it. She attributes this state of affairs to the conversion of many health and human services into commodities, which in turn reduce the availability of both paid and unpaid carers with the capacity to care, resulting in a ‘care deficit’. In the context of the US, the results of harsh market conditions on health and human services are very obvious to Bone, but similar effects are becoming increasingly apparent in the UK and elsewhere.

Bolton’s theoretical developments of emotional labour over the past decade (Bolton 2000, 2001, Bolton and Boyd 2003) have made useful contributions to unravelling the complexity of emotions in health care in general and nursing in particular. Bolton proposes a typology of workplace emotions and a range of motivational factors at individual and organizational level.12 What particularly appealed to me in Bolton’s analysis was the idea of emotional labour as a gift given for ‘philanthropic’ reasons by the gynaecology nurses, reminiscent of the ‘gift relationship’ described by Titmuss in his classic study of blood transfusion.
The nurses described the use of humour in a therapeutic way, giving the patients the opportunity to have a laugh in an ‘emotionful place’ that was a ‘woman’s world’, while a ward sister recognized the central role of caring to nursing when she said, ‘The essential basis of nursing is caring. You can’t be a nurse if you don’t care’ (Bolton 2000, p. 583).

Theodosius (2006, 2008) claims that emotion management, although conceptually innovative in its time, has potentially limited the relational aspects of emotion, in particular the unconscious processes taking place during patient-nurse interaction. She also reveals that working with emotions is integral to the way in which nurses construct their personal identity which goes beyond external factors to the very reasons why they choose to do nursing in the first place such as ‘unconscious love’ (Theodosius 2006, p. 899).

Theodosius (2006) decided therefore to apply a methodology that recovered the unconscious emotions by applying an interactive and unconscious approach in the field working with patients, nurses and other health care professionals to capture hidden and invisible emotion processes using diaries, interviews and participant observation. Theodosius was concerned that the emotional labour research undertaken by Nicky James and myself, rather than exposing emotion work and making it visible, had resulted in marginalizing it and driving it underground. Rather I would argue that the time when we were first researching and writing about emotions and nursing, we hit a spot that revealed a hidden world of nursing and learning to be a nurse. Subsequently, emotional labour as a concept has become ‘normalized’, and part of the everyday language of nursing and care work is being incorporated into the current discourse of compassion and dignity.

Theodosius (2008) has extended the analysis of emotional labour to examine the nature of emotions that nurses feel and how they form a part of their social identity, which goes beyond the presentational symbolic forms expressed through the emotion management framework first inspired by Hochschild (1983). She demonstrates her approach through a series of powerful vignettes in which she sums up that ‘therapeutic’ emotional labour (which she distinguishes from ‘instrumental’ emotional labour) ‘is still an important component to nursing care, that is still central to the nursing identity and that society in the form of those nurses care for – still needs and believes in it’ (Theodosius 2008, p. 172). In these vignettes Theodosius deals with and describes complex and challenging situations where nurses are working at the extremes: from loving care to complaints; from trust and reciprocity with patients to feeling to be working at ‘half measures’ and being bullied by colleagues. This summary does not do justice to Theodosius’ in-depth analysis, but she highlights the essential nature of two-way relationships between nurses, patients and their carers which contribute to the emotional labour process.

Scholars in a number of countries other than the UK have shown increasing interest in the application of emotional labour to nursing. Bone’s (2009)
study is just one of several examples from the USA. In Japan a translation of ‘The Emotional Labour of Nursing’ appeared in 2001, and interest continues to grow. The translator, Professor Asako Takei, has since published her own study of emotional labour (Takei 2001), and a number of collaborations and exchange visits with scholars and practitioners in Japan have ensued including symposiums and a public lecture attracting 300 delegates (Ars Vivendi 2009, Smith 2010, Smith and Cowie 2010). The appeal of emotional labour in the Japanese context is that it gives a language to describe feelings and behaviours that are recognized by practitioners, educators and researchers but are not always permitted by professional mores and circumscribed by public demands and expectations. The connections and differences between emotional labour and the more recent concept of emotional intelligence have also been explored.

**Emotional labour and emotional intelligence**

Emotional intelligence was first described at length by Goleman (1995). Huy (1999) makes theoretical connections between emotional labour and emotional intelligence and suggests that particularly at times of change, the process can be facilitated by judicious attention to emotions (Huy 1999). He concludes that emotions are an integral part of adaptation and change, and emotionally intelligent individuals are able to recognize and use their own and others’ emotional states to solve problems. Huy identifies ‘hope as an attribute of emotional intelligence and implies a belief that one has both the will and the means to accomplish one’s goals. It buffers people against apathy and depression and strengthens their capacity to withstand defeat and persist in adversity’.

In the nursing literature, Freshwater and Stickley (2004) suggest that emotional intelligence and the capacity to care influence nursing behaviours and the delivery of care. Emotional intelligence is, they suggest, also linked to what students understand nursing to be and what student nurses learn to do as nurses. In relation to learning and socialization in nurse education, Akerjordet and Severinsson (2004) suggest that supervised learning in clinical practice for mental health students fosters emotional intelligence, responsibility, motivation and a deeper understanding of patient relationships and their identity and role as mental health nurses. Clouder (2005) has linked emotions and learning and suggests that concepts such as caring are particularly troublesome because the messiness of practice conflicts with the ideals students hold of caring; indeed they would like learning to care to be trouble free! But it is exactly this messiness where learning occurs and where emotions are a fruitful and creative part of learning (Allan et al. 2008b, pp. 550–1).
Nursing and care

But in what way do nursing leaders and educationalists conceptualize care, and do emotional labour and, more recently, emotional intelligence feature in this conceptualization? A look at the literature of the 1980s and 1990s showed an increasing emphasis on the emotional aspects of caring and its promotion as distinctly nursing work ever since the influential Briggs report of the early seventies (DHSS 1972).

Baroness Jean McFarlane, one of the UK’s first prominent nursing academics, in a keynote address to the Royal College of Nursing, maintained that the words ‘nursing’ and ‘caring’ have similar roots. She says: ‘Caring signifies a feeling of concern, of interest, of oversight, with a view to protection. Nursing means ... to nourish and cherish’ (McFarlane 1976, p. 189).

McFarlane wanted to see an end to the nurse as the doctor’s handmaiden and wanted to see the emergence of a new role in which caring was pre-eminent. By describing nursing in terms of ‘helping, assisting, serving, caring for’ patients, McFarlane was seeking to raise the status of so-called basic tasks to the level of unique nursing skills. In a subsequent paper, she provided a philosophy and work method called the nursing process, to do this (McFarlane 1977). The nursing process, regarded by many as an American import, promotes a people-orientated rather than a task-orientated approach to patients and raises the profile of emotional care at the same time that, as Hochschild notes, the growth of the service sector and ‘people jobs’ has made communication and encounter the central work relationship.

Changes in the structure and knowledge base of nurse education proposed by the United Kingdom Central Council’s Project 2000 (UKCC 1986) and innovations such as primary nursing described by Jane Salvage (1990) as part of the ‘new nursing’, built on the nursing process philosophy and work method to emphasize people-centred care rather than patients and disease.

From the perspectives of the early 1980s, it appeared that the nursing leadership failed to grapple with the conceptual complexity of defining care, especially in relation to its emotional components and demands. An important implication of raising the profile of emotional care can be seen in the light of research undertaken in a London hospital over 50 years ago by Isabel Menzies, a British psychoanalyst, which has now finally been taken on board as a definitive piece of research in the nursing literature. Brought in to investigate some of the reasons why students were leaving nursing, she believed that high anxiety levels were partly responsible. Menzies saw the task-orientated way in which nursing care was organized as a defence against that anxiety (Menzies 1960). She wrote:

The nursing service attempts to protect the nurse from the anxiety of her relation with the patient by splitting up her contacts with them. The total workload of a ward or
department is broken down into lists of tasks, each of which is allocated to a particular nurse.

In the light of Menzies’ findings, the nursing process, with its explicit commitment to the development of nurse–patient relationships, could be seen to put nurses at risk of increasing their anxiety by removing the protection provided by task-orientated care.

The nursing leadership of the seventies and eighties also failed to address why many nurses favoured high-tech, medically defined nursing. McFarlane, for example, believed that an early job analysis of hospital nursing by Goddard (1953), in which the physical, technical and affective aspects of nursing had been distinguished, emphasized the status of technical over physical and affective nursing. Fretwell (1982) more realistically points out that the distinction reflected the existing medical division of labour and hierarchy within nursing. McFarlane’s reaction was typical of the curious lack of feminist perspectives brought to bear on the position of nurses by its leaders. Issues such as the stereotyping of care as women’s ‘natural work’ (encapsulated by the recruitment posters) and the gender division of labour within the health service and the patriarchal power relations between doctors (predominantly men) and nurses (predominantly women) were not addressed in these official versions of nursing.\(^\text{16}\) The Politics of Nursing, written by Jane Salvage (1985), in which she addresses some of these fundamental issues, is an important departure from the traditional nursing texts.\(^\text{17}\)

Nurse leaders who were firmly grounded in academic scholarship, politics and higher education were interviewed in the follow-up study in order to get a sense of where the leadership for learning was coming from (Allan et al. 2008a). They were clear that nursing had to keep pace with educational, organizational and global changes, which over the intervening decades had resulted in the need to look at nursing and nursing students from different perspectives. One leader took the view that student nurse learning and leadership was implicitly at the forefront of the new NHS because changing workforce initiatives since 1997 demanded new ways of working and shared learning among professions (Melia 2006). On the one hand policy reforms had led to ‘the shaping of the nursing agenda by medical concerns, the main one being the desire for a (medical) consultant led service’ and the establishment of a diversity of roles and nurse-led services on the other. These reforms have not necessarily been accompanied by structural, organizational and educational changes required to change professional cultures and patient empowerment to meet the challenges of the new workforce. The gap in being able to educate the next generation of practitioners in these new roles is borne out by a former ward sister reflecting on her transition to clinical nurse specialist (Mann 1998) in which she observed that the emphasis on student nurse learning in her new role had diminished.
Another leader suggested that students ‘want to go as far as they can to work at the interface with medicine and push role boundary work to its limit’ requiring both educators and students to ‘think outside the box’ in order to meet these different aspirations and to pioneer different approaches and models of practice. Thinking differently assisted students to craft and create their own learning environment ‘wherever that happens to be’. The leader concluded that flexible and innovative approaches to learning and practice were necessary because the ‘temporal order of the delivery of care has changed as have the spaces in which it is delivered’. Finally, she challenged the interviewer’s assumption that the opportunities to think were constrained by the ward environment because, in her view, the role of the clinical leader was to encourage students to think dynamically in order to build their capacity to transcend boundaries, people and roles. She said:

There are people that you find it easier to think with and places where thinking is more legitimately recognised. But I think if you are curious, you’re just curious and you sort of express that regardless of where you happen to be, although it helps when the environment and the context and the culture are right for it.

The need to go beyond traditional boundaries and stereotypes to think outside the box was expressed by another leader who prioritized values-based nursing and ‘altruistic behaviour’ as ‘going beyond the job descriptions’:

I like to think that you should or could have qualities that go beyond just the job descriptions to achieve a fully rounded set of skills to deal with people in a comprehensive way.

The importance of passing on knowledge and clinical skills was highlighted by a third leader committed to fostering an ‘intergenerational approach’ to encourage alumni to mentor future students in a variety of educational settings whether in the classroom, specially designed clinical skills laboratories or the clinical areas which put caring at the core. Such an approach required skill mix models that built in ‘opportunities for qualified nurses to be deeply involved in care’ as well as dealing with their management responsibilities to deal with budgets, targets and other bureaucratic requirements.

**The body–mind dichotomy**

Concepts of care continue to be fraught with contrasts and contradictions and generate a range of questions. Is it labour or is it love? Is it natural or is it a skill? Is it about feelings or tasks? Does it come from the heart, the head or the hand? Is it guided by mind or body? Or can caring be seen as an integrated whole? In
response to this last question the nurse leaders whose views are reported above are clear that it should. One leader raised an additional question which arose from the ‘check box’ culture with its emphasis on clinical competences in which you get to the point that you only measure and have interest in the things you can tick, then what happens to qualities such as judgement and integrity? You can’t tick either of those because they’d take time to mature and it’s about how the practitioner feels about what they are doing and have the opportunity to reflect on their practice (my emphasis).

Because of the heightening awareness of the need for nurses to be able to be given emotional spaces to think and feel about their practice highlighted by these contemporary leaders, there have been some criticisms of Hochschild’s work which described emotional labour as a ‘technical fix’ and perpetuating the body–mind dichotomy, with its origins in positivism, western dualism and what Mary O’Brien calls ‘male-stream’ thought. Pat Benner, an American Professor of Nursing, applies a philosophical approach to the concept of care, which she says transcends the body–mind split and enables connection and concern between nurse and patient. Emotions are seen as the key to this connection because ‘they allow the person to be engaged or involved in the situation ... The alienated, detached view of emotions, as unruly bodily responses that must be controlled actually cuts the person off from being involved in the situation in a complete way’ (Benner and Wrubel 1989).

Views such as these represent a trend apparent in the 1980s among nurses in the USA and Europe to move to a more holistic approach to care and away from ‘a nation’s blind embrace of high tech medicine’ (Gordon 1988).

This trend towards holistic care has continued over the intervening decades with increasing attention to the role of emotions in nursing and caring. Three characteristics of this trend can be noted. The first characteristic illustrated by Theodosiu’s work is the role of the unconscious and psychoanalytic and psychodynamic approaches to emotions. Phenomenology and embodiment as characterized by Benner’s work continues to be acknowledged as important for nursing. The symbolic interactionist and Marxist stance of the cognitive approach to emotions characterized by Hochschild’s work has attracted increasing theoretical critiques, in particular the risk that emotions become normalized and thus marginalized which detracts from what is given ‘freely’ as part of who one is and what one is paid to do (McClure and Murphy 2007).

My own empirical work refutes this view as one that can encourage nurses and women to give over and above what they are supported to do both personally and professionally. The emotional labour analysis pays attention to the division of labour within the health service and the gendered nature of care and has been expanded by Hochschild to examine the notion of a ‘care deficit’, which goes beyond the individual to systems and processes and the wider society in which
nurses and others operate to reveal how care as a core value has become increasingly threatened and devalued.

**The politics of care**

As concerns for cost-effectiveness and efficiency sweep the British health service and budgets are finely tuned to respond to the purchaser–provider divide, the little things are in double danger. On the one hand, nurses working under increasing pressure will find even less time to do the little things for patients. On the other, the increase in monitoring and standard setting may focus more on quantitative measures rather than on qualities of care. At what price is care, since emotional care is not easily costed?

A 1990s recruitment poster gave a mixed message. On the one hand, it reassured prospective nurses that although they were unlikely to be attracted to the job for the money, they would be well paid for their skills. On the other hand, it emphasized that they could expect emotional rewards as well as financial ones. In other words, the emotional rewards came as an added bonus for working in one of the most emotionally satisfying professions (see illustration on p. 7).

It was interesting to speculate that at the time of writing the first book, there appeared to be a trend towards the privatization of the NHS and a fear that this would lead to the commercialization of nurses’ emotional labour in the private health industry. There were images already being used for advertising private health insurance in the early 1990s, which bore similarities to those used by the airline industry to attract customers in the days before low-budget, ‘no frills’ airlines. Like the recruitment posters and charity advertisements of the 1990s, the nurse in the private sector was also portrayed as the key carer, smiling and helpful to the patient and their family (see illustrations on above pages and below).

At the same time, a contradictory trend was emerging in the rapidly changing health service of the 1990s which tended to marginalize care even further from medically defined work. An example is a Guardian article at the time, which described an elderly care ward staffed by untrained carers (Brindle 1990). Nurse training was criticized for being too formal and nurses too wedded to routine to provide the ‘caring touch’ for elderly long-stay residents. The technical needs of the residents were provided by a visiting nurse who was described as doing the ‘tricky dressings’ and complicated medicines. The untrained carers on the other hand described themselves as ‘just making people happy’ which in a health service sensitive to cost efficiency and effectiveness, drove a sharp division between caring and technical requirements, potentially marginalizing the little things or caring gestures, from technical skills. By the 2000s the division between caring and technical nursing had become even more sharply defined.
By 2008, the health care assistant (HCA) had become firmly established on the lowest rung of the nursing hierarchy to deliver frontline care, drawing on existing precedents for unqualified nursing labour (the untrained carer, the nursing auxiliary or the student nurse) to support the work of registered nurses (Dewar and Macleod-Clark 1992, Thornley 2001). Project 2000 demanded the withdrawal of student nurses from the frontline workforce, where they had formerly given up to 75 per cent of direct patient care (Moores and Moult 1979), to become supernumerary with perceived benefits to their learning (UKCC 1985). The introduction of the NHS Plan (Department of Health 2000) lent further support to the establishment of HCAs as the main players in the delivery of frontline care. The Plan proposed increasing their numbers, expanding the role and allocating a dedicated training budget to facilitate their progression via the National Vocational Qualification (NVQ) scheme and initiatives to meet local workforce needs (Department of Health 2003a, 2003b). Even though the HCA might be trained to work at a relatively senior level in a prestigious speciality such as critical care, Johnson et al. (2004) found that the main aspiration of the role was still to ‘relieve qualified nurses from routine, if far from basic tasks and procedures’. According to one nurse

Illustration 1.6  A nurse in full dress uniform and frilly cap gives ‘individual attention’ to a patient paying for private hospital care

Note: This illustration is based on a private health insurance advert.
Source: Liz Ashton Hill. Reproduced with kind permission.
leader, organizing the division of labour in this way has created a dilemma for nursing because:

Students are no longer the workforce providing basic care; HCAs are doing this and students no longer seek to do basic care; they seek to instruct others to do it rather than have a lifetime of doing it. The role of the staff nurse is the management of care, administration, organization and communication outside the ward.

For another nurse leader, taking staff nurses away from direct patient care placed them in a contradictory situation with regards to the education of student nurses and their effective supervision, in that leaders of nursing needed to give care in order to know how to supervise it.

Dividing labour in this way coincides with the introduction of targets within the NHS, which has changed and focused the organization of health care so that there is speed up and an emphasis on rapid throughput within the acute sector and the management of chronic illness and personal and social care within community and primary care (Ross et al. 2009).

As if to counteract targets and subsequent speed up, a recent trend within the health service is to promote dignity and compassion (Smith 2008). This trend has taken on different perspectives in England and Scotland. In England, a compassion index, the first of several initiatives proposed in the NHS Review High Quality Care for All (Department of Health 2008), scores how compassionate nurses are towards patients. Components of compassion include indicator smiles, and by inference the emotional labour defined by Hochschild (1983) as ‘the induction or suppression of emotions to make others feel safe and cared for’, which is required to give empathetic care (Smith 2008). The compassion index also includes measures of good nutrition, hand washing and safety as key indicators of quality care.

In Scotland, a project to enhance ‘patient care by promoting compassionate nursing practice’ was set up and supported by a local businesswoman, the local Health Board and a local university (www.napier.ac.uk/fhssl/NMSC/compassionatecare). One of the key strands was to support the development of leadership skills to provide compassionate care in a range of care settings. Meeting with the senior nurses involved in the project revealed a high level of commitment to and enthusiasm for identifying and describing compassionate care through narratives triggered by emotional touch points (Bate and Robert 2007, Dewar et al. 2010). Capturing stories showed the impact emotions had on patients, carers and professionals and the positive and negative effects that enhanced or hindered compassion. A textbook for carers, students and practitioners of nursing and health visiting described compassion as ‘the key to rediscovering what lies at the heart of nursing practice’ that would assist readers develop their ‘patient-centred care skills’ (Chambers and Ryder 2009). It is clear from this discussion that within the politics of nursing and health care, a values approach has been adopted and
applied to policy, education and practice but without necessarily taking account of the potential emotional costs. Doctoral scholarship may offer opportunities to redress this balance.19

**Emotional labour costs**

As the following account from an interview with a student nurse in my first study testifies, patients and their families then, as now, valued and needed caring nurses. But these skills that Benner refers to as connection and involvement require both teaching and learning in order to protect the nurse and heal the patient.

I asked the student to describe any incidents that she had found particularly stressful during her training. She told me about her time on the paediatric ward when she became involved with a young child and her family.

There just happened to be a patient on the paediatric ward at the time, a little girl who had cancer and for some reason she took to me. And in a good way and in a bad way I think this was encouraged because she loathed being in hospital. She was six.

**Q. How good and bad?**

She had a lot of chemotherapy and she died in the end, but it was good I think because she took to me, her mother did and her family did. But bad because it all became a bit too much really.

**Q. In what way too much?**

Well stressful really. I didn’t say at work but I should have done. It was silly of me because there is a very highly esteemed teacher up there and I am sure she would have been very helpful now I think about it. But at the time you want to look as though you’re coping. I mean the trained staff are there but they all knew that this child had taken to me so much and I was obviously being very useful to her making hospital not quite perhaps so unbearable as it had been, but it was quite a strain. I think it was from her mother more than her. Obviously her mother was very anxious.

I'm surprised nobody actually said to me ‘are you managing, is it alright?’ I think they forget about that side of nursing. They think ‘Oh yeah, you’re a nurse, you can manage’. But you can’t really. I mean we’re still pretty young. Outwardly you might be managing, but you know I used to go home and cry my eyes out sometimes. It was dreadful. But I've found that at work well you’ve almost got to be, well people expect you to be happy and not cross. And you can’t be cross even though you feel like wringing someone’s neck! You’ve got to be reasonably under control and of course everybody suffers when you go home.
I think you learn to stop that, you learn to switch off and be different, forget about work when you go home, I mean you’ve got to.

Q. And do you think you learn that?
I think you do, but through trial and error.

First, the student recognizes the importance of giving emotional support to a child and her family and the need for ‘connection and involvement’. But she also describes how she was pulled down by her lack of skill in handling her involvement in the absence of trained staff, who recognized and supported the emotional cost of caring. She recognizes that, as a nurse, she is expected to be happy rather than cross and expected to manage and cope with extremes of feelings. As these expectations come from her seniors, she consequently expects them of herself.

Like Hochschild’s flight attendants, she must induce or suppress her own feelings, some would say subordinate them, to make others feel cared for and safe, irrespective of how she feels herself. She learns through ‘trial and error’ to ‘switch off’ and ‘forget about work’ when she goes home. But is this through surface acting to the point that she can no longer remain involved with patients other than at a superficial level, at risk of becoming detached and alienated? Or can she learn through experience and systematic training to recognize and use her feelings to remain therapeutically involved both for herself and the patient?

Hochschild’s findings suggest that she can. One group of flight attendants that she studied received intensive training in the use of deep and surface acting to manage their emotions in given situations. Older, more experienced workers were found to be particularly adept at deep acting which allowed them to distinguish between their ‘personal’ and ‘work’ selves, develop a ‘healthy’ estrangement between self and work role and prevent burn out.

The acting techniques employed by the flight attendants seem feasible for the duration of a flight, but nurses have to sustain emotional involvement for much longer periods. Often they develop their own emotional labour strategies, some of which are positive, but many of which evolve to protect them from a range of feelings: guilt, fear, failure and anger, to name a few.

Hochschild’s notions of deep and surface acting apply to nurses’ accounts of their presentation of self to the outside world?

Hochschild’s suggestion that we manage our emotions according to feeling rules represented, for me, a framework for interpreting the empirical reality I encountered through the students’ accounts and my own field observations. The students quoted above clearly appeared to be managing their feelings, whether it was to carry on as if nothing had happened when a patient had shouted or been rude to them, or to make a little girl’s stay in hospital not seem quite so unbearable, despite feeling personally upset by her condition.

An account from 1998 shows that student nurses continued to feel vulnerable to what can be interpreted as the emotional insensitivities of qualified staff. The
following vignette was brought to my attention by a colleague during a debriefing session following student placements. The vignette again concerned a student’s experience on a paediatric ward. The student had been very unhappy during her placement, and her colleagues had encouraged her to describe her experience to their lecturer. The student had become involved with a young patient, bringing her presents and kind words. The ward staff had criticized her for her involvement with this patient and suggested this was not a good way to begin her nursing career. Indeed there was even a suggestion that she may not be a suitable candidate to be a nurse at all.

The lecturer talked through the situation with the student and discovered that she had been hospitalized as a child herself. They agreed that her history could account for her need to care for the young patient because she was symbolically caring for her childhood self. The student was reassured that her reactions were quite ‘normal’ and that far from being unsuitable for a nursing career, her obvious sensitivity and empathy for the child were future qualities she could draw on. The incident also demonstrated the importance of skilled mentoring on the part of the lecturer to encourage and support the student’s emotional insights and subsequent capacity for emotional labour (Williams 1999).

A mature approach to supporting students to care for young patients in emotionally difficult situations is illustrated by the following account which was described by a concerned social worker. It also offers a more optimistic view of how students can be supported in the future.

A child branch nursing student at the end of her second year was asked to sit with a seriously ill boy suffering from cancer. His father was also sitting with him and was extremely distressed by his son’s obvious extreme pain. The student went to tell her mentor that she was concerned at the boy’s distress and wondered whether he could be given further analgesia. The mentor told her to ‘hang on in there’ that the pain the boy was experiencing was not unusual and would settle down with soothing words. This was not the case, and the boy’s father told the student that he was convinced something ‘different’ was happening. After two further conversations with her mentor, the student finally persuaded her to take the situation seriously. On investigating the cause of the boy’s distress, the mentor discovered that the extreme pain was indeed ‘different’ from prior symptoms and caused by a pathological fracture of the femur. Appropriate action was taken, and the student and the boy’s father dissolved into tears of relief that something was finally being done but concerned that a fracture had been discovered.

This was not the end of the story. Once appropriate action had been taken to relieve the boy’s pain, the mentor sat down with the student to discuss what had taken place. First of all she apologized for not having taken the student’s first report seriously and admitted that this was partly because she had been busy and preoccupied with another patient. She also reflected on the importance of her own need to actively listen to both frontline carers and relatives and take their
concerns seriously and immediately. When the student admitted she would rather not have cried in front of the patient and his father, the mentor comforted her and suggested that sometimes such obvious concern can be appreciated by patients and their relatives and friends. She also noted that if the mentor had taken heed of the student when she first reported her concern about the boy, then she may not have been reduced to public tears.

This account is heartening because it demonstrates the key role the mentor can play in supporting students to care and the ability of this particular mentor to be self critical. It also bears out one leader’s view that:

The qualified accountable nurse as mentor is much more important than the Ward Sister in showing that learning is done. They are responsible for their students’ learning.

However, the account also demonstrates the dual demands on mentors to deliver a service as well as teach and supervise students. As this mentor was well aware, teaching students was seen as taking second place to delivering patient care.

The patients in these accounts were the recipients of the students’ emotional labour who in turn were supported either by each other or their mentors. But what did patients expect of nurses and how did their expectations contribute to the feeling rules that shaped their relationships with them?

**Everybody’s ideal**

In 1984, when I asked patients to describe a ‘good’ nurse they were more likely to talk about attitudes and feelings rather than technical competence.

Forty-four different words or phrases were used by the patients to describe ‘ideal’ and ‘real’ nurses. Only six of these words or phrases referred to functional rather than to affective attributes. Coser (1962), who designed the original interview agenda (see: Companion website, Methodological Appendix I, Smith 1992), reported similar findings. Words used to describe nurses’ functional attributes included efficient, observant, alert and ‘capable of doing their job’. One patient combined both functional and affective attributes by expecting nurses to be ‘caring but efficient’. As we shall see in Chapter 5, ward sisters also distinguished between nurses’ functional and affective attributes. The caring (i.e. emotional) aspects of nursing were clearly seen as distinct but complementary to and underpinning the functional (i.e. efficient, observant, capable, alert) aspects.

Kindness, helpfulness and patience were the affective or caring aspects most frequently used to describe the City Hospital nurses. Nurses were said to keep patients happy by being cheerful, loving, considerate, friendly and understanding.
and made them feel at home. Talking, listening, showing interest and sympathy featured as examples of the ideal nurse. As one patient concluded:

A nurse has to be aware of the patient's condition and how to tackle it. She has to have a nursing manner which requires a lot of patience and forethought and to try and relieve pain and suffering not by medical means but by compassion.

This quotation is interesting because the patient has a clear view that a nursing manner requires patience, forethought and compassion to relieve pain and suffering, which are distinct from medical means.

In a contemporary study, service users with long-term physical or mental health conditions and their carers emphasized that good communication promoted positive feelings of being in control and being valued, and were at the top of their list when evaluating the quality of their care (Ross et al. 2009). As one respondent said speaking for others, 'if I know what is going on I feel more positive and in control', while another respondent was grateful to staff who showed 'the time or willingness to listen to my concerns'. When asked what would make care better one respondent said: 'putting people first' or 'treating patients as individuals' and 'with dignity'. Once more the little things emerged as important, and those professionals who 'went beyond their remit' and ensured that the little things don't 'get forgotten' were very much appreciated.

The nurse as emotional labourer

From the 1980s data it emerged that patients, like students, realized that nurses had to work emotionally on themselves in order to care for patients. This view of care as emotional labour suggests that, potentially, patients recognize that caring is more than just part of the package of women's work.

The following quotations offer some interesting perspectives on the nurse as emotional labourer.

The first patient, a young man in his thirties, was a trained laboratory technician. He had had a lot of hospital experience, both as a worker and patient, and had even been a student nurse for a brief period. His background and interests therefore gave him some interesting insights. He said:

As a nurse you are more at the beck and call of the public than in a supermarket. I tell the nurse don't forget you're only human. You see them when the patient keeps ringing the bell and they grimace to themselves. Then they go up to the patient all smiles.

Here he compared the nurse with another service sector worker, the supermarket assistant. The difference between the two, he believed, was that the nurse was more vulnerable to the demands of the public. He closely observed the reaction
of the nurse to the ‘demanding’ patient who kept on ringing his call bell for assistance. She grimaced, irritated that yet again she was being called. But she couldn’t show the patient she was irritated; so she transformed her grimace into smiles as she approached him. The patient who was recounting this story clearly recognized that this transformation cost ‘superhuman’ effort by reminding the nurses that they were only human.

The second patient was also in his thirties and had had multiple hospital admissions for a chronic condition. As I spoke to him he implied he had been hurt by getting too close to nurses in the past. He valued those nurses who made him feel at home, but he was also aware that ‘care can be dangerous if you are emotional about patients, you can’t let it affect you, it’s got to be platonic’. The view that being emotional was dangerous and that platonic care was preferable is interesting in the light of an analysis of emotional labour. The importance of making the patient feel that care is safe rather than dangerous again shows that managing emotions requires skill over and above ‘natural’ caring qualities, and is different from love.

Patients, like students, identified caring as the emotional side of nursing as being distinct but complementary to and underpinning the functional (efficient, observant, capable, alert) attributes of the ‘ideal’ nurse. Some patients recognized that nurses had to work emotionally on themselves (undertake emotional labour) in order to appear caring at all times. This observation is of immense importance, because it potentially recognizes that caring is more than just part of the package of women’s work and requires specialist learning to produce in others a sense of feeling cared for in a safe place.

In the 2000s the increase in the patient population with complex long-term conditions living at home and the changes in service provision to respond to their needs resulted in community staff feeling stressed and emotional and pushed to the limit by their perceptions that patient safety was being put at risk (Ross et al. 2009, Smith et al. 2009).

Hochschild (1989) also looked at work in the home by focusing on the emotional life of two job couples and the different strategies adopted by working parents for dividing domestic labour and gratitude in the home. She showed how gender ideologies may either reinforce or conflict with reality. Feeling rules came into play, which guided emotion work to produce a gender-specific strategy to cope with the conflict. Hochschild concluded that one of the most important costs to women is that society devalues the work of the home and sees women as inferior because they do devalued work. Professional care work undertaken in the home may be similarly devalued.

What then are the implications of these findings for nurses, given that nursing reproduces many of the traditional female roles and domestic tasks in the workplace? What is the fit between gender and occupational ideologies? Do conflicts arise and if so what feelings are generated? Do feeling rules come into play to
guide emotion work and produce strategies to cope with these conflicts? If so, how do they manifest themselves? And how does the gender dimension of care shaped by twenty-first century changes in service delivery continue to be an important factor in the emotional labour of nursing?

In the seven chapters that follow, I comment on my original 1980s research, re-examine some of these questions and ask others in relation to nurses as emotional labourers. I present new research data to address these questions as well as the key question: can nurses still care? The original material was used to construct a series of close-up portraits, nurses’ own accounts and reflections on the nature of nursing and caring. Each chapter progresses to examine the viability of emotional labour as a concept; nurses’ different emotional styles; the students’ training trajectories and how they learn to care; the role of the ward sister in setting the emotional tone; the legitimization of emotional labour and the forms it takes between both nurses and nurses on the one hand and nurses and patients on the other; the strategies nurses adopt both to keep in touch and protect themselves from their feelings. New theoretical perspectives and empirical data are drawn upon to interrogate the original data and offer new insights to student nurses’ experiences of learning nursing and caring.

Perspectives were offered in my first book on the content and structure of nurse training that was judged to be relevant to planning and implementing Project 2000. Since then the new ‘Fitness for Practice’ curriculum has been implemented following critiques of Project 2000, and new data that investigated contemporary students’ experience of learning in the current educational and clinical climate have been drawn upon (Allan et al. 2008a). The Nursing and Midwifery Council (NMC) has been in consultation with the nursing profession on current educational provision in order to revise the curriculum in readiness for the new graduate level programmes required for 2013 (NMC 2010a, 2010b). Furthermore, the political landscape is on the brink of change as the coalition government established in May 2010 draws up radical plans following a major spending review to cut back public sector investment. Traditionally, nursing has fared badly during economic downturns revealing the susceptibility of the female workforce to market forces.

In summary then, this second book focuses on nurses and nursing as portrayed through contemporary popular and professional rhetoric to re-examine the notion of emotional labour as a component of caring, how nurses care and learn to care and its effects on carers and the cared for. Since the publication of the first book in 1992, many other research studies have been undertaken which add new perspectives on the emotional labour analysis, and some of these studies have already been highlighted in this chapter. The external global, policy and educational changes that have taken place in the intervening years will also form part of the analysis in seeking to understand the changing contexts in which nurses work, learn and care.
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