Chapter 1
Creating a caring discourse

LEARNING OBJECTIVES

By the end of this chapter you should have an understanding of:

1. What caring might mean to nurses and service users
2. How stories can be used as a focus for reflection
3. How our reflections can help us to create a caring discourse which will enable us to begin to unravel the complexity of caring
4. How key indicators, such as being available, using informal social exchange and ‘connecting’ with service users, can point us to ways in which we can improve our nursing practice

Introduction

In this chapter, we will introduce storytelling as a means of discovering what caring is all about. We will show how theories can be beneficial and exciting in helping us to shed light on our experience and that of service users and their families. Our discussions will lead to new meanings and understandings - in other words help us to create a caring discourse and add to the evidence base for your practice. From those discussions we will begin to identify caring indicators, to which we will add more in later chapters. We can use these to strengthen the way we care in practice.

We will discuss ways in which you, as a student nurse, can make a valuable contribution to the creation of a caring environment. We look closely at the notion of compassion in caring, the complexity of caring and the potency of nursing presence. We will consider ways in which we are able to ‘connect’ with patients and the long-lasting impact of emotional feelings. We will discuss how we can use and share stories as an important basis for reflection and to help us to identify key indicators of caring practice.
Caring at the heart of nursing

Do you see caring as at the very heart of what you do as a student nurse? It was probably the most important reason that brought you into the nursing profession in the first place. However, you may well think that your acts of caring are under pressure in a health care system which has increasing challenges and pressures. You are not alone in this. The Nursing and Midwifery Council (NMC) has recognised the need to respond to public and professional concerns by including care, compassion and communication amongst its Essential Skills Clusters (part of the Standards of Proficiency) which must be integrated into every pre-registration nursing programme (NMC, 2007). Approaches such as this help us to understand the expectations of our patients and clients, and to gain the skills and qualities needed to provide quality care. We still feel, however, that a deeper understanding about the nature of caring through an exploration of its many different aspects and presentations will assist us even further in achieving this, and this is the purpose of this book.

We have called this chapter ‘creating a caring discourse’ which is our way of summarising what we see as an exploration through storytelling of what caring really means to us as nurses and to our patients/clients and their families. We all tell each other stories about what we felt about various situations we have come across at work. In these stories we express our emotions, thoughts, knowledge, judgements, ideas and values. In other words, like us, after a hard day’s work, you probably have the need to go through your highs and lows and let off steam with someone you trust. It is these stories that make up a shared nursing discourse. The term discourse is used to describe the way particular groups of people talk about their shared experiences. For example think of the ways adolescents talk to each other, which is very different from the way they might talk to their parents! In our work, there is also patient/client discourse and medical discourse. In this book we are using stories from people who have been involved in providing or receiving care to help create a caring discourse. The stories will be used as triggers for our discussion and we will draw on academic and other literature to gain more insights and to broaden and deepen our understanding.

We are drawing on experience gained over a number of years during which we have been studying the subject of caring by collecting critical incidents from patients, students and registered nurses (written and verbal accounts of significant events in their professional careers). We have found that many aspects of caring are unrecognised by nurses themselves but accepted as expectations of the role, rather than as something special. These caring moments have occurred in busy and traumatic periods and also during ‘everyday’ situations. We have also found evidence of the importance of the ability to express caring behaviour, illustrated by the guilt and frustration nurses feel if opportunities to engage in meaningful relationships with patients and relatives are thwarted. Have you felt like this too?

How students can make a valuable contribution to the creation of a caring environment

In our rush to get through our everyday work, we may forget that it is in very simple ways that caring can be expressed. Have you thought about the contribution students can play? Let us consider a message sent by a relative to staff about the care her grandmother had received from Jo, a student nurse in her first placement.
Have you had a similar experience as a student nurse? If you have been singled out for a particular mention in a ‘thank you’ card or in verbal communication, have you considered why? Reflecting back will increase your ability to pinpoint what you did that was particularly valuable, so that you can use opportunities to repeat this in the future. You can increase your caring skills even more if you use academic knowledge in this reflection. This is what evidence-based practice is all about. Our discussion below will help us to demonstrate this by reflecting in more depth and exploring Jo’s contribution to the quality of Alice’s experience of care.

Using theory to understand practice

The caring behaviour of the student was recognised and appreciated by both Alice and her granddaughter. Jo, inexperienced and in her first placement, conveyed warmth and interest ensuring that both perceived they were important to her and that what they asked was of consequence. In short the student was sending out a powerful message – that she cared – and she did so by using her natural warm, informal communication skills which are an important part of social exchange. The contribution student nurses make to creating a caring environment is not a new discovery but can be found in studies of nursing practice, e.g. Morrison (1994: 91) noted that students were ‘singled out for their attentive care and devotion’ and thought their constant availability was particularly appreciated by the patients.

Student nurses have excellent opportunities in all branches of nursing to provide holistic care and make real efforts to listen to and attend to individual needs. It is sad that more experienced and qualified health care professionals may be so preoccupied with competing demands on their time and energy that they may not be so easily available for providing the kind of contact that service users and their carers seek. Although students are in a position where they can develop close relationships with patients and relatives, a difficulty is that because of their lack of nursing experience, they may not always know how to respond effectively in complex situations (Dowling, 2006).

Have you found yourself in this situation? It may be reassuring to know that other students have found this too and that, in spite of the situations in which you now feel out of your depth, you will gain confidence and become much more skilled over time. In the meantime however, don’t be afraid to tell your mentor or supervisor how you are feeling because he/she is there to help and guide you. Indeed, they will probably share with you their similar experiences as a student.

Case Study 1.1

‘From a relative’s point of view with absolutely no experience of hospitals I didn’t have a clue where to go for advice, who to ask for information or what jobs each person I came into contact with did. Jo was wonderful because she was approachable. I used to visit Gran twice a day and whenever Jo was around she would have a chat with Gran. The chat might just be, “Hello Alice. How are you today?” But she never walked by without saying something which meant that Gran and I got to know her. Although I knew that Jo was a student and as such had no authority I realised very quickly if I asked her something she would find out the answer and let me know as soon as possible. I felt that some of the more senior members of staff were too busy to deal with what they considered to be “trivial” questions. Jo treated my Gran the way she would treat her own Gran and nothing was too much trouble for her.’

Have you had a similar experience as a student nurse?
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Sadly, it could be that when opportunities for assessing and attending to individual needs arise, all grades of nursing staff fail to take them. For example there have been debates within the profession that some highly qualified nurses (and also some students) may be missing out on opportunities to engage in caring activities which may occur whilst providing intimate or fundamental care. It has been argued that core nursing tasks have been devalued (highlighted in the ‘Too posh to wash’ debate (Wright, 2004) and nurses have distanced themselves from these, focusing instead on high technological or management roles. Although organisational and economic pressures and skill mix decisions may have resulted in fewer opportunities for ‘hands-on’ care, it is reassuring that experienced nurses such as Freshwater and Biley (2005: 14) question the assumption that nurses think themselves too superior to undertake such tasks, saying that ‘... our own experiences as nurses on a variety of busy wards were quite the opposite. We enjoyed being able to escape to the patient; those hours spent behind the curtains managing ‘basic care’ provided the ideal opportunity to engage in what was for us central to nursing: the therapeutic relationship’.

The centrality of caring to nursing has been there since the profession was established but it seems to be the one thing that might be so easily lost, diluted or undervalued as other priorities take precedence.

Time to think back

+ What do you think?
+ Do you think you make the best of the opportunities when you help patients/clients with fundamental care needs?
+ Have you found that some patients felt able to talk about their fears and concerns when you have been providing what may be described as ‘everyday’ care?

Students and health care support workers are important resources. Valuable communication exchanges between patients and relatives and qualified staff may be affected by restricted opportunities, professional status and demanding role responsibilities. As we have seen in Jo’s story, patients and relatives may be anxious not to burden more senior staff with what may seem to them to be ‘less important’ matters so instead they may approach the student or support worker. The relationship Jo had with Alice and her granddaughter was helpful and supportive, benefiting from the opportunities they had to become familiar and comfortable with each other through the informal social exchanges that took place during their encounters. Ersser (1997) has described the value of ‘natural’ emotional exchanges. Students like you and Jo, often do see the worth of these forms of communication when they begin their careers and perceive these ‘natural’ emotional exchanges as an essential component of being able to ‘care’. Being able to help people is, for most, the main reason for coming into nursing in the first place and becoming ‘distant’ is what many say they are most fearful of (Smith, 2003).

An added problem is that the very nature of caring may not be understood, as we shall go on to examine in the rest of this book. Caring may be taken for granted as something that comes naturally, particularly for women, but its complexity (for example the emotional as well as the physical skills required), may be underestimated (Smith and Gray, 2001). Compassion is an integral part of this and if we are to give effective patient-centred care of the kind we would want the closest members of our families to receive; we need to look for ways in which this is demonstrated.
Looking more closely at the compassion in caring

Consider the following story to gain insight into how a patient might experience compassion from a student nurse. Harry, a 50-year-old businessman, described his hospital experience:

**Case Study 1.2**

‘I was in a medical ward after a heart attack. I’ve always felt in control of situations and hated being ill. I think I coped with this by making myself the life and soul of the ward. I’d chivvy up the other men and we’d have a laugh about what was happening to us like going to X-ray wearing backless nighties! When my family and friends came in we’d talk about football and what was going on ‘outside’. I talked to my wife about the tests and treatment and she spoke to the doctors and nurses. When she was there I did my best to make everything seem normal. One night I woke up and couldn’t get back to sleep again. Rashida, a student nurse, noticed I was awake and asked me if I wanted a cup of tea. When she brought it, she must have noticed something was wrong because she asked me how I felt and for some reason I started to cry. I couldn’t stop and I felt so stupid.

I said to her, “Everyone thinks I’m coping but I’m not!” She just sat and held my hand. I told her that I didn’t want my wife to know that I wasn’t really a strong person. It’s hard to know how long I wept but it seemed as if she sat with me for a long time and not only then but several nights after she would come and sit with me for a while when it was quiet in the ward and we’d talk about how I was overcoming some of the fears I had of dying and leaving my family. I’m very appreciative of all the care I had – you couldn’t fault the medical care I was given. I had full explanations of everything but when I look back I still remember that time in the middle of night and how much that student nurse’s presence meant to me.’

**To think about**

- Think about what we can learn from Harry’s story about the nature of presence as part of compassion.
- Think about a situation in your practice. Reflect on how your presence has helped someone who was frightened or anxious.

You might want record this within your ongoing assessment record/practice portfolio. Remember to use pseudonyms to protect patient confidentiality.

Harry’s story helps us to understand the importance of holistic care and shows that the emotional features of care are as important as the rest of the knowledge and skills required to care. It illustrates how important it is to be ‘available’ to give supportive care (not just technical care), and to have a ‘caring presence’. This is what can be described as showing compassion. It also demonstrates the opportunities for care which nurses working at night can have. Kirby and Slevin (1992: 73) cite Marcel who, writing in 1949, spoke of the nature of real presence:

‘The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seeks merely to offer me a temporary loan raised on his resource. For the one, I am a presence, for the other, I am an object.’
Harry did not feel he was treated as an object. We can infer this because Harry was able to tell the student nurse of his fears. Perhaps this was easier for him to do than to tell his wife because he would have been less worried about upsetting her. Rashida was able to show that she cared only because she spent time with Harry, held his hand and waited for him to talk but she also followed this up by being available on subsequent occasions. These may only have been for a few minutes but would have made Harry feel that his feelings continued to be seen as significant and he would have felt more comfortable with his disclosures.

Roach (2002: 28) has helped to deepen our understanding of the nature of human caring and describes caring as a natural capacity of human beings. She emphasises that it is ‘not an exceptional human quality, nor the response of an exceptional few. … It is the most common, authentic criterion of humanness.’ This is perhaps is why students, even with little professional experience, can be so good at it. Roach (2002: 71) reaches the conclusion that people use occupational roles to express their natural, and self-fulfilling, human capacity to care. She describes this as the core value since, ‘it inspires, directs and sustains nursing’s identity and the identity of all persons who choose professions of care.’

Rashida entered nursing with a really useful resource – the capacity to show compassion. The important issue to consider is how we use our ‘natural’ human capacity to care within our practice and also what may stand in the way of how we can develop and extend it. It may not be as straightforward as we may initially believe.

The complexity of providing care

Many nurses aim at becoming highly skilled in technical tasks and being able to engage in sophisticated interventions, whilst for others it is the ability to engage in more fundamental care which gives them greater career satisfaction. Allan (2001) points to the disagreements various authors have had on the type of caring which patients and nurses themselves value and the degree to which different forms of caring are thought to be effective. As a consequence of these disagreements, she points to the continuing debate between those who see the emotional component of caring as its most defining feature and those for whom the practical aspects are more important. It is interesting that Tarlier (2004) insists that this kind of debate about the relative importance of different caring skills has stopped productive discussion and, rather than helping, it has been at the expense of understanding the complex nature of nursing.

**To think about**

+ Think about your care of a particular person.
+ What caring skills were you using?
+ Do you think some were more important than others?

You will find your answer will be influenced by a variety of factors depending on the urgency of the situation, the most pressing needs of the patient/client or their families, and so on. Reflecting back on the situation, were there any other caring skills you wish you had used?

Did you find it difficult to say that one skill was more important than another? If you had asked your patient, would you have got the same answer? It is therefore also a question of who is making a judgement about what was important about the care. Patients or relatives may
have a very different perception of the situation. Even in life-threatening situations where rapid physical interventions are vital, communication skills between team members and with the patient are also essential. For us, the debate about the relative importance of each skill has limitations but uncovering the often hidden, caring dimensions within care delivery will help us more in our understanding of what effective, holistic caring is all about. In other words, we are searching for what puts the caring into care.

As a student nurse, you are likely to have been aware of the high emotional feelings that caring for someone can bring and have wondered whether you responded in the best way. Have you ever been left feeling uncomfortable, challenged and emotionally, as well as physically, drained? On the other hand, have there been times when you found your nursing experience very exciting and interesting and have gone home knowing that you have done a good job, perhaps that lives have been saved or improved and clients and relatives appear grateful. At these times you probably feel that all is right with your world! It is a wonderful feeling when you enjoy nursing and appreciate caring for others! Perhaps these highs and lows contribute to the excitement of nursing and make it one of the least boring jobs.

As we have discussed, to unravel the complexities of what we mean by caring practice, there is a need for a degree of reflectivity or time to mull things over. Over the past few decades much emphasis has been put on reflective practice within the context of holistic, individualised care often described as the ideology of nursing practice (ideas of what nursing is or should be). This kind of care brings with it many challenges. Each individual is unique and has distinctive physical, psychological, social and spiritual needs. For example, try to imagine a situation in which a young man called Jimmy Jones is admitted to an accident and emergency department (A+E) with a paracetamol overdose and a diagnosis of alcohol abuse. A holistic caring approach will consist not only of managing the serious life-threatening event but also of finding ways of providing ongoing help in such a manner that Jimmy feels recognised and valued as a human being in every interaction with health care professionals. This will need the integrated, thoughtful, patient and non-judgemental approach of an interdisciplinary team.

Nurses contribute to the care within an effective team. Faugier (2005: 19) suggests that ‘when the unified force of experience, intellect and passion come together within a skill like nursing, it transcends the ordinary as much as a Michelin chef or a Ryan Giggs goal’. So, whilst a magnificent goal in football or the production of an excellent meal is most likely to be the combination of experience, knowledge and practice, the use of intelligence and the application of skill, it also depends on motivation and enthusiasm. Good nursing care often calls for a complex mixture of ingredients. In Jimmy’s case, excellent holistic care requires the application of a range of knowledge (for example, amongst other things, the science of the human body, the psychology of dependency, legal aspects and ethical frameworks) and practice skills (assessments and interventions likely to overcome a life-threatening event, risk assessment and a range of longer-term interventions). But these alone do not make care complete. Knowledge and skills need an essence of caring applied in an artistic way such as through the use of self and self-awareness or creative responses to meet individual needs. We think that this sort of care is what people mean when they say that good nursing combines both art and science. This sort of care can create a feeling in the recipient that someone has gone that ‘extra mile for them’. It is what changes a good nurse into an exceptional nurse.

Dunlop (1986) describes caring as a public form of private love and this may well come close to the rewarding aspects which many nurses entering the profession say they hope to experience. It would seem however that special experiences of care, may not, in Faugier’s terms, be ‘sensational goals’ which may be dramatic and unexpected but instead be an integral part of an everyday experience in which patients needs are really met.
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The potency of nursing presence

We have already seen how the presence of both student nurses, Jo and Rashida, demonstrated caring communication and compassion and was a powerful or potent influence. There are times, however, which unfortunately we all come across, in the hustle and bustle of everyday practice, in which some caring aspects are missing. Consider the following story given to us by Julie, a relative, and think about why she was so upset. What did one nurse do which made all the difference?

Case Study 1.3

‘My mother was seriously ill and although we felt that the nursing staff were polite, they gave us minimal attention and information and we thought that they were not really wanting to listen to us. I guess that they might have believed that they were giving good enough care but to be honest, it wasn’t really good enough for us as they were not really available and seemed to be avoiding us. One evening when we were feeling particularly despondent, a bank nurse came into the room. She stood for a moment and then asked us how we were and how Mum was. It was the first time we felt that someone cared and really wanted to help. This gave us the opportunity to say what we were worried about – which was how Mum’s pain was being managed. The outcome was that within hours a Macmillan nurse came and Mum became pain free for the first time for days. Thank God for that nurse!’

From Julie’s story it seems that in general the nurses’ world of care was far removed from what Julie and her mother needed. The nurses focused on what they perceived as the pressing activities and may even have thought that they were giving good care or they were so immersed in the ward routine they weren’t thinking about individual patient needs. It is interesting that in telling her story, Julie saw as particularly significant the action of the bank nurse who ‘stood for a moment’. This nurse gave the impression of availability. She was summing up the situation and was in a state of readiness to listen. That simple act made all the difference in the implementation of effective care and it is this kind of action that we need to consider and extend. These examples are in line with Barker’s (2003: 9) suggestion that an important way of considering care is with an emphasis on ‘caution, attention to detail and sensitivity that is necessary when handling something precious’. He draws parallels with the work of an archaeologist who adopts a ‘care-ful’ strategy for unearthing and revealing a possible find, including sensitivity and attention to detail.

Actions may be unthinking if they are part of routinised procedures. The actor and playwright Alan Bennett (2005: 12) wrote about the impact on him of what he describes as ‘the casual cruelties that routine inflicts’ when visiting his mother who had just been admitted to a psychiatric unit. ‘She had on admission been bathed, her hair washed and left uncombed and uncurled, so that now it stood round her head in a mad halo, this straightaway drafting her into the realms of the demented. Yet the change was so dramatic, the obliteration of her usual self so utter and complete, that to restore her to even to an appearance of normality now seemed beyond hope. She was mad because she looked mad.’

These stories point to the danger of routines which dehumanise or of a chaotic rush of activity and preoccupation, both of which lead to loss of individuality and a danger that patients and their
relatives or friends feel they are overlooked or ignored. A nursing presence is likely to provide a potent caring indicator in that the nurse acknowledges the intrinsic worth of each individual.

**Time to think back**

So far we have uncovered indicators about what Alice, Harry and Julie saw as important aspects of caring and also what they saw as unhelpful. We can use these positive indicators as pointers or signposts to guide us on our journey in creating a caring discourse. For example, we saw that just being there and being emotionally available can significantly improve patients' and relatives' experience of care. You will uncover more indicators through reflections on more stories as you progress through the book and we will use these to gain a fuller picture of the components or dimensions of caring. Since reflection is such an important part of this process, we will spend a little time looking closely at how we can use stories for this purpose.

**Using stories to create a caring discourse**

Stories create vivid images which remain with us and help us to learn. We know from our own and others' experiences, that we repeatedly recall certain specific moments that have had an impact on us. You will have recounted these moments as stories, or anecdotes, to others because they are meaningful to you. In simplistic terms, we reflect back on our experiences. As Schon (1983) notes, this is ‘reflection on action’ and in your nursing programme you will be directed to using reflective models as a means of helping you to learn most from particular situations which have occurred in practice. Stories help us to look again at a situation and find new meanings and understandings. Our nursing students have found a quotation from a poem by T S Eliot (1963: 222) very useful in summarising the impact of new discovery within a familiar situation:

‘We shall not cease from exploration
   And the end of all our exploring
   Will be to arrive where we started
   And know the place for the first time.’

We can use stories as the means for furthering our journey of exploration into caring and because stories are an important part of everyday life – they form a vital way of communicating with and relating to each other. We hear stories every day in our workplace and they can have an important impact on our individual practice. What we learn from them may guide and influence us, in our ways of working and influence our beliefs, values and expectations. However, if we use these stories without reflecting on them, we may build up nursing myths, some of which may be helpful and some less so, e.g. the myth that nurses should not become emotionally involved.

By using stories as a focus for our reflection we can critically explore myths, beliefs and values and so increase our knowledge of caring by building up a caring discourse. It is important that we also include stories from those being ‘cared for’ as we will then be more knowledgeable about their perceptions of the caring process and so be in a better position to
learn from and transform nursing care. We have to be sure that the resulting discourse is one in
which questioning occurs and assumptions are challenged and one way of achieving this is
through shared, critical discussion.

Phillips and Benner (1994: vii) reiterate the importance of sharing caring narratives. ‘We
believe it is essential to recover the vision of what is possible in actual practices today.’ These
nursing academics think that through the knowledge gained by sharing actual experiences we
will able to have a greater impact on future policies and decisions about how care is provided.
This emphasises the importance of sharing and learning from experiences - so something we
may undertake on a daily basis can be turned into a truly learning exercise.

The best of circumstances offer conditions for learning, and reflections can be about happy
experiences and moments that have made us feel successful and competent. However, there
may also have been times when we are anxious, shocked, sad, angry, guilt ridden and fearful
when we have been greatly puzzled by our own and others’ responses, leaving us with
unanswered questions. As a student, you are likely to encounter a number of these moments in
nursing and you may tend to share these experiences with individuals who are important to
you, perhaps colleagues who understand you and with whom you feel safe. On the other hand,
there are times when you may have difficulty in discussing them for a variety of reasons. You
may think that others may judge your thoughts, questions, feelings or actions since in sharing
something personal we put ourselves at risk of judgement. Stories, therefore, have another
important feature which needs to be taken into consideration.

The way we tell and reflect on our stories depends on who is listening to us. As Mishler (1991)
says, any story is socially reconstructed and reflects the content and the expected audiences. A
case in point: your reflections as part of your educational course or in clinical supervision are
likely to take on a different form from ‘storytelling’ occurring with a colleague in an informal
setting. Whatever form it takes, however, we can learn from storytelling. Stories are linked with
our self-image, or ways in which we see ourselves. They help us consider the role we are ‘play-
ing’ in a particular location.

Smith (2003) suggests that storytelling, as part of the reflective process, can help nurses
test out possibilities for future behaviours and help refine and/or integrate ideas about various
concepts. She came to this conclusion by using the research method of narrative analysis,
which led her to focus on trying to discover the moral of the stories nurses told, as students
and as graduates, in other words, why they told particular stories in the first place. This
approach helps to identify significant phrases such as the one Julie used (‘she stood for a
moment . . .’), which are particularly important to the individual telling the story but can easily
be missed. Julie, whose mother needed pain relief, told the story because she wanted to convey
the way in which the bank nurse gave time to the family and picked up their distress. The
impact of changes in Alan Bennett’s mother’s appearance highlighted by the phrase ‘She was
mad because she looked mad’, emphasises the impact unthinking ‘routines’ can make, in this
case in reinforcing a stereotype. This approach points to the benefits to be gained from writing
down stories and looking at them in more depth.

We have found that using written stories from students and qualified nurses has helped us
over a number of years to understand practice better (Smith and Russell, 1991; Smith and
Russell, 1993). We used them in workshops where participants were able to compare their
hopes and fears with those of others and also they provided an opportunity for us all to gain
increasing awareness of what can inform and influence future nursing practice. We are increas-
ingly aware of the importance of also using stories from service users.
Sharing stories with others

Sharing stories can be very helpful, as was illustrated by Vicky, a newly qualified nurse, who brought the next incident to one of our reflective workshops. She wrote about an important and frequently questioned aspect, that of 'having emotions' when caring for patients. As you will see, Vicky ended her written account by wondering whether it is acceptable for a nurse to cry. She indicated that she had asked herself this question as a student but even years after it still remained an issue for her. Sharing it helped her understand the complexity of caring and why the question had remained with her for so many years. We think it is one you too may be asking yourself!

Case Study 1.4

'I was a newly qualified nurse and the consultant, the house officer and I approached an elderly gentleman, called Henry, who had been frequently admitted to the ward with heart failure. Henry seemed a warm-hearted man and had made an impression on me. The consultant said, "I am sorry we have come to the end of the line; we have talked about this before, your heart is not strong enough to recover this time." I was shocked as I had not realised his heart failure was so 'end stage' and that he was so poorly. The two doctors left and I looked at Henry who started crying. What should I do?

I sat on the bed next to him and began to sob too. Henry gave me a hug. He told me that he believed in God and that he wasn’t frightened of dying. I felt he was comforting me, but surely it should be the other way around? Eventually I left him. The senior nurse took me into the day room. He said it proved that I was human and that nurses have feelings. I did feel a little better, but felt that crying may not have been the best way of handling this situation. After all a nurse can’t cry; can she?'

This story illustrates the uniqueness of the encounters between patients and professionals. In this instance, nurse and patient shared an intense, close and significant moment. It seems that Vicky’s main focus is on finding a correct way of responding in the situation. Nurses should not cry! Nurses can cry! We think that the story illustrates the type of questions that nurses ask themselves but one to which they often fall short of finding a simple and satisfactory answer. It is difficult to articulate what is expected of a nurse, a ‘caring professional’. Could it be that there is no simplistic correct answer to this and other similar questions?

To think about

Write a brief story based on an incident from your practice which made an emotional impact on you:

- Just write as if you were telling the story to a trusted friend.
- Underline any phrases which you see as particularly significant.
- Think about why the story was important to you.
- Consider what you have learned and how this will affect your future practice.

You might like to keep this as part of your reflective learning diary or ongoing assessment record.
Using reflection to increase our understanding

By reflecting, or looking again at the story, we can see that this newly qualified staff nurse, in trying to make sense of the situation, is unlikely to find an ‘ultimate truth’. In other words there will not be one straightforward answer. This does not mean reflection is not helpful but that it helps us to come to terms with the nature of knowledge that is often incomplete and uncertain. Work by Carl Rogers (1978) might help us understand this. He suggested that there is no such thing as a static truth but instead truth is about a series of changing approximations – we make judgments based on our varied experiences and perhaps limited knowledge.

Different perceptions and views of the same events are illustrated by the clinical psychologist Pamela Stephenson, who is the wife of comedian Billy Connolly. Pamela writes about her husband’s disturbed, abusive and dreadfully poor childhood in Glasgow and notes how he survived and triumphed over this. In the introductory remarks in her book (Stephenson, 2001: 1), she recalls her emotional reaction relating to the tremendous effect these circumstances would have had on him, and notes Billy’s retort to her emotional response was, ‘Well, I didn’t come down the Clyde on a water biscuit’. Perhaps this story demonstrates that whatever events occur, traumatic or otherwise, there are different perceptions and understandings to be made about their impact and the influence. She pointedly says: ‘for every one life, there are a million observed realities, including several of the subject’s’, so talking this over may have made them both think again and see things in a new light.

In summary, to explore the story of Vicky’s response to Henry it is helpful to reflect by using a wide variety of perspectives and in doing so, try to gain a ‘best fit’ understanding of the situation at hand. ‘Factual’ answers (answers that can be claimed to be completely scientific, objective, accurate and applicable/transferable to all circumstances) may at times be difficult to find. Although clear evidence and rational explanations have a vital role in care situations and interventions, many aspects of practice cannot be easily explained by applying a theory which covers all aspects of unpredictable human situations. We can therefore, as an alternative, look for literature, perspectives or theories, in order to help illuminate, or shed light on, what Schon (1987) describes as the unpredictable and ‘swampy world of everyday practice’.

Nursing in the dark

An early but influential qualitative study by Melia (1987) revealed some very interesting ideas about what it is to be a nurse. Her study with student nurses concluded that they learned to ‘get the work done’, ‘learn the rules’, ‘nurse in the dark’ and ‘be professional’. Using her work can lead us to reflect on the similarities in the situation the newly qualified staff nurse found herself in, still wondering whether or not it was really all right to cry in front of a patient and speculating about what her work really should involve, trying to learn and/or remember the rules about being a professional.

This seems to be what is happening to Vicky. Whilst the incident is occurring she begins to ask herself what she should do next when Henry starts to cry. Sharing this incident with colleagues in a reflective session, helped her to see that she was almost unconsciously using good communication skills when she sat next to Henry to try to comfort, or reassure him. Someone suggested that she started to sob due to a ‘heavy personal attachment’ she had for Henry and another questioned whether this was a good thing to have. Others disagreed and asserted that, by crying openly in front of Henry, she showed him that she cared about him and this displayed a characteristic of a caring nurse.
Most of her colleagues at the workshop thought that showing emotions as part of a caring approach is beneficial and an aspect of a therapeutic approach to care (and in written reflections later were able to draw on references in the literature to back this up: e.g. Peplau, 1952; Leininger, 1978; Barber, 1991; Ersser, 1997; Dowling, 2006).

However, as you can see in the incident, at the time Vicky felt uneasy, as if she sensed these were not, as she saw them, the ‘rules’ of everyday professional practice. Despite being given a form of reassurance from a more senior nurse, she continued to feel that she might have handled her emotions in this situation in a different way. In the discussion group, her colleagues inferred from her final comment, ‘After all a nurse can’t cry; can she?’, that Vicky was not clear about the ‘rules’ in this situation. From their discussions they concluded that showing emotion is an important aspect of care but were aware that this could be overwhelming at times. Talking over the incident with colleagues and gaining perspectives from literature helped them become more aware of how common such emotions are. Freshwater (1999: 29) confirms the benefits of this approach, suggesting that reflection provides an important opportunity ‘for caring individuals to explore and confront their own caring beliefs and how these beliefs are executed in practice’.

We have seen the importance of reflection in increasing our understanding, so if you look for ways in which theory can help explain and analyse practice, it will not only help to ensure you meet the academic requirements of your course but more importantly it will become an integral part of your ongoing development as a nurse so that the quality of the care you provide is increased. It can also help you gain in confidence. Smith (2003) found that reflection helps students and qualified nurses to become more confident in their ability to react to changing circumstances, including the ways in which they demonstrate caring. We all have a tendency to become static and unadventurous by clinging to that which we feel safe and comfortable with and so may be reluctant to reflect. Such an approach can have dire consequences for us all since without learning from the past or the present, we cannot explain what nursing is all about and we may be prone to ritualistic and unthinking care so that good care is compromised and the ‘freedom’ to progress is lost. We may, for example, not be aware of the importance and impact of the way in which we ‘connect’ with patients.

### Time to think back

1. Have you ever felt out of your depth and overwhelmed in terms of your emotional response to situations?
2. Did you cover up your feelings or did you talk to someone else?
3. You wouldn’t be alone in feeling like this. One of the skills that you will learn is how to handle close relationships within professional boundaries. You may find that talking to your mentor/supervisor or someone you can trust, such as fellow student, will help. Others find that using a reflective diary helps to look again at the situation and see things in a new light, such as understanding why you felt so upset.

### Connecting with patients using emotional labour

Just like you, many nurses have meaningful moments with their patients during which time a very close connection is made which may have been quite emotional. Nursing theorists, such as Parse (1992), explain the importance of patient and nurse co-creating the unique human
experience of illness, within a relationship of ‘connectedness’. Smith (1992) captures the essence of this when she quotes a patient who praises the nurses who held her hand ‘both literally and metaphorically’. However, the closeness of some of our relationships with patients and their families can seem quite challenging.

Nurses have to learn to cope not only with the task in hand but also with the emotions that sometimes threaten to overwhelm them as practitioners. A number of authors, such as James (1989) and Smith (1992) use the phrase ‘the emotional labour of nursing’. The demands of emotional work can be equally as hard as physical and technical labour, but not so readily recognised and valued although it has a key role in the creation of a caring environment (Smith and Gray, 2001).

Smith (1992) drew on the work of the sociologist Hoschild, describing emotional labour as requiring ‘surface and deep acting’ which nurses learn to use when there is a gap between what they do and what they feel. Have you ever tried to cover up your feelings in practice? You may have made a determined effort to appear calm when a patient is angry or seems hostile or you may have overcome feelings when encountering distasteful smells? What you are doing then is surface acting in which you consciously change a facial expression to show a particular emotion that you want others to perceive. In deep acting we change the feelings inside us by, for example, conjuring up images, so that we show the feelings we want the other person to see. For example, we might imagine that it was our relative or friend we were caring for so that we then display more caring attitudes. Good actors are adept at intentionally manipulating thoughts, feelings and behaviour so the purpose of emotional labour and ‘acting’ is to produce an outward appearance which helps in the connectedness of the relationship.

Connecting with patients and being yourself

In something of a contrast to labouring with our emotions and ‘acting’ in response to these, another early study by Jourard (1971), is helpful to our deliberations. He asserted that nurses need to learn to ‘be themselves’ with patients. He said that genuineness and congruence (what is being portrayed by our actions corresponds to that which we feel internally), warmth and positive regard are important in demonstrating that we care for others. Jourard believes that nurses should find ways of expressing themselves and their emotional concerns – rather than hiding or denying them - and sums this up in his phrase ‘The Transparent Self’.

Self-awareness and the therapeutic use of self are identified as key requirements for effective interactions and connectedness. To see how this relates to practice, if you return to the incident with Henry who was given bad news, we think Vicky was showing her ‘transparent self’, her emotional concerns were not hidden or denied, but rather ‘congruent’ with her behaviour. She cared about him and she showed this, but was very concerned that this was not the right way to behave, perhaps wondering if it would have been better (that is, more therapeutic) for Henry, if she had laboured emotionally and in her terms ‘acted in a more professional’ manner. Probably the best answer would have come from asking Henry what his perspective of the situation was! However, we believe that this nurse was able to give Henry something very precious by caring for him in this transparent and congruent manner.

The nature of closeness or intimacy within the therapeutic nursing relationship and the ways in which this is managed will be an important aspect of our discussion in the following chapters. Another aspect which we will also return to later, concerns another interesting question that Vicky asks when she wonders if it is appropriate for Henry to offer some sort of comfort to her - the ‘professional’. It seems that she is expected to be the provider rather than the receiver for this relationship to be therapeutic.
Have you experienced something like this in your practice when you have been frustrated because you wanted to be able to give a ‘perfect’ response in an emotional situation? What we have learned is that we will rarely be satisfied with what response we give but the emotions engendered may stay with us for a long time.

The long-lasting impact of emotional feelings

Even if you have been in nursing a relatively short time, you can still probably remember the emotions you felt in your first days in practice? Some of these will probably stay with you for a long time. Sean, who gave us the following story, says he remembers an incident vividly, even though it occurred many years ago. He is now a university lecturer and says he relates this story to students who struggle with guilt feelings and unanswered questions when they cry in front of relatives. It helps us to explore further the impact of emotional feelings concerning patients to whom we particularly connect.

Case Study 1.5

‘My first post after qualifying was on a trauma intensive care unit. I was on duty one afternoon when John was admitted with severe head injuries following a road traffic accident. It soon became apparent that the injuries John had sustained were so serious he would not survive. His parents were informed of this and were obviously very upset at the news. I was allocated to look after John and his parents; they spent a lot of time at John’s bedside and we talked about his treatment. His mother also asked questions about my life and during the discussion we determined that I was only four days older than John. This somehow seemed to help his mother. The following day I was again allocated to care for John. His mother brought some photographs of him and showed them to me and talked of John – what he was like, his job and his friends. Over the next few days of caring for John I felt I got to know him very well through his mother.

A few days later I came on to the ward to discover that John had died. His parents came in and his mother put her arms around me and cried openly. The emotion was so intense that I also cried. We exchanged few words, as they weren’t really necessary. That night when I got home I lay on my bed and cried. I was really upset that John had died. Even though we had never spoken, the discussions I had with his mother made me feel that we had known each other all of our lives. My mother came into my bedroom and asked what was wrong and when I told her she said she could not understand how I could be so upset over someone I had never really known. I did know him, even if he did not know me.’

Sean says that he believes the incident taught him that it is important to ’be you’ and not try to hide emotions. Because he behaved in a congruent manner in that his feelings and behaviour matched and he did not try to ‘act the professional part’ (whatever that may actually be) he showed he cared about John and his parents. Sean thinks that this helped the parents, especially John’s mother, to grieve for their son. As for himself, Sean says:

‘I often wonder what John’s voice sounded like. I really felt I knew him, although I never even heard him speak. The fact that he was so close to me in age also had something to do with why his mother got close to me and I got close to John. It was as if I did know him.’
This raises an important question. Why is it that with some patients we feel as if ‘a button is pressed within us’ and we feel more linked into their lives, deaths, problems and issues? Fosbinder (1994) describes this as ‘clicking’ - an immediate rapport between patient and nurse - which facilitates the process of ‘getting to know you’ but can also lead to the uncovering of some deep emotions within us. Perhaps some situations may be more significant and even problematic for us because the situations somehow remind us of someone who has died or from whom we are now parted or we worry about losing someone close to us. It may also be that we become more aware of our own mortality. Reflecting back on such situations can lead us to a deeper understanding and acceptance of ourselves and others.

All these incidents, stories and scenarios are rich, potential learning experiences and are the beginning of our journey into the development of what we hope will be a useful caring discourse. This has already led us to raise many questions and explore some of the key issues such as:

+ The importance of understanding and developing the skills of caring for nurses and their impact on service users.
+ How stories can act as a focus for reflective discussion and for showing how theoretical perspectives can provide us with an evidence base for practice.
+ The identification of aspects which are sometimes overlooked or underestimated, for example the importance of ‘being there’, of a caring presence. These indicators can point us to ways in which we can improve our nursing practice.

We will build up a collection of such indicators at the end of each chapter. At the end of the book all these caring indicators will be used as indicative criteria for a framework of caring. This framework will help us to know more about the dimensions of a caring approach, integrating compassion, empathy, concern and kindness within a context of skilled, informed evidence-based nursing practice. In the next chapter we will continue our journey by considering what else goes on within a caring relationship by exploring what we receive from, as well as what we give to, caring relationships.

Look at the caring indicators. Use them as you think will be most beneficial, for example:

+ Apply them to your practice and note when you have done this.
+ Consider how your actions and reflections can help you towards attaining some of the outcomes and proficiencies set out in your nursing programme.
Caring indicators

1. A caring presence – being available for patient and family
2. Participating in informal social exchange
3. Listening and using non-verbal cues
4. Connecting to patients and significant others
5. Recognising significant rapport (e.g. ‘clicking’) and its effects on our responses
6. Willingness to enter into a reflective discourse in order to learn
7. Noticing effects of interactions
8. Responding and attending to detail in a ‘care-ful’ way
9. Labouring emotionally when required
10. Displaying authenticity
11. Not allowing routines or business to ‘blot out’ individual care

References

CHAPTER 1 CREATING A CARING DISCOURSE


