Constrained compassion

An ethnography exploring compassion in the hospital ward setting

Donna Barnes

RN (Adult Branch), BA (Hons), PG Cert (Palliative care)

Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy

September 2017

Jointly supported by the School of Health Sciences and the Economic and Social Research Council [Grant number ES/J5001]

Abstract

A series of healthcare scandals over the last 15 years in the United Kingdom (UK) National Health Service (NHS) generated a vigorous public and professional debate. Within this debate, care failures were framed as a 'lack of compassion' and, specifically, a lack of compassion in contemporary nursing.

The healthcare policy response was to rapidly implement a values-based strategy that aimed to 'embed the principles of compassion and caring' (DoH, 2014) in healthcare staff. The strategy progressed, despite evidence suggesting that healthcare professionals valued compassionate care (Maben et al., 2007b, Newton et al., 2009, Glazer and Beehr, 2002). Significant changes were made to nursing recruitment, regulation and education, with the explicit intention of prioritising compassion. The research response to the NHS care standards debate has also focused predominantly on the values of NHS staff, and has inadequately represented the contextual contingencies of practice.

This study aimed to develop an empirically informed descriptive and explanatory understanding of compassion in a healthcare setting. The objectives were to examine the key elements of the phenomenon and how participants constructed

and enacted compassion. The study was a constructionist ethnographic design set in one NHS hospital ward. Participants included various staff groups, patients and relatives. Fieldwork lasted one year and included over 150 hours of participant observation, 70 informal interviews and 30 recorded interviews. Analysis involved thick description of ward life, and thematic, key-event and deviant-case analysis. Theories of compassion, psychological research and a sociological perspective were employed as analytic lenses. Themes included contextualised compassion, compromised compassion, receiving compassion, and the role of threat and safety.

I found compassion in the ward setting was constrained by a tangle of micro- and macro-level contingencies which shape the experience of giving, and receiving, compassionate care. The contingencies of the clinical context were frustrating to staff and patients and led to an inconsistent quality of care. All actors contributed to the dynamics of compassion on the ward. I found that staff valued compassion as an aspect of their care, and for some it was part of their identity and gave meaning to their work. Patients also valued compassionate care, felt comforted by it, and responded positively, which in turn was uplifting for staff. Unexpectedly, some patients struggled to recognise, trust or feel relieved from

compassionate care. I found that a sense of threat dominated the ward culture, which was evident in the language and practices of staff, and could inhibit their capacity to engage compassionately with others. However, when the organisation provided positive practical support, compassionate care often flourished.

This study contributes the notion of 'constrained compassion' as a descriptive and explanatory framework for understanding the phenomenon in the ward setting, and evidences that threat and safety, compromise and cost are inherent in its enactment. It demonstrates that theoretically-informed compassion research can be beneficial, and highlights the value of cross-disciplinary approaches to compassion scholarship. The study also demonstrates the strengths and limitations of process- and values-based theories of compassion and argues that conceptualising compassion as a context-dependent process can broaden the possibilities of future nursing research. In terms of policy, this study argues that healthcare strategies must take a broader, research-based approach. Furthermore, it recommends the urgent acknowledgement and investigation of the contextual barriers to care. Embedding positive, practical and pastoral staff support within organisations should be a priority. Rather than aiming for 'compassionate staff,' healthcare organisations may

benefit from making multidisciplinary efforts towards developing compassionate healthcare environments.

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Acknowledgements

I could not have completed this thesis, or indeed my PhD journey, without the loving support and understanding of my family and friends. My fabulous mum, Kate, has provided childcare, meals, a shopping and laundry service, and endless psychological support to keep me going when times were tough. My husband Paul and two little boys have been an essential escape from the stress of work. They have all sacrificed a great deal over these four years, and I see this thesis as a true Team L-B effort.

My supervisors Jane Seymour, Paul Crawford and Joanne Cooper have been positive and supportive throughout. I am particularly grateful for Jane's reading, editing and thoughtful comments, and for her care and encouragement. It was after an enlightening Master's module with Jane that I gained the confidence to apply for the PhD, and she was instrumental in me obtaining the scholarship. She has never shown any doubt that I would complete the course, even when I have been unconvinced! I must also acknowledge the expert help and generosity of Glenys Caswell, Mórna O'Connor and Louise Bramley, who made the process so much easier for me.

Lastly, I am indebted to all the participants who took the time and energy to support the study. The staff of Hazel ward in

particular were so open and welcoming despite the risks of taking part. I was constantly amazed by their commitment to the care of their patients and their relentless, exhausting hard work.

Abbreviations and acronyms

AHP Allied health professional

CFC Charter for Compassion

CQC Care Quality Commission

CCARE Centre for Compassion and Altruism Research and Education

DoH Department of Health

ED Emergency department

EOLC End-of-life care

HCA Healthcare assistant

HCP Healthcare professional

HEE Health Education England

LCCP Leadership in Compassionate Care Programme

Mid Staffordshire Mid Staffordshire NHS Foundation Trust

NHS National Health Service

NMC Nursing and Midwifery Council

NQN Newly qualified nurse

PPI Patient and Public Involvement

OT Occupational therapist

OHT Oakfield Hospitals Trust

PIS Participant information sheet

UoN University of Nottingham

VBR Values-based recruitment

Chapter one: Introduction

1.0 Introduction

In this thesis I present an ethnographic study that examines the experience of giving and receiving compassion in an acute NHS hospital ward. I also engage in a broader discussion about compassion as a social phenomenon, care in the NHS, and how these matters have intersected to shape discourses of nursing and care in hospitals.

International interest in the topic of compassion has flourished over the last decade, fuelled by concern about increasingly individualised and materialistic lifestyles and worsening global suffering (Armstrong, 2011, Youngson, 2012). Those with an interest in health have been keen to demonstrate how compassion can contribute to a more positive experience of giving and receiving care, particularly in terms of personal engagement, tolerating one's own and others' suffering, reducing anxiety, and increasing feelings of affiliation (Youngson, 2012, Cole-King and Gilbert, 2011, Maben et al., 2010, Dewar, 2011, West et al., 2017, Cornwell, 2012, Ballatt and Campling, 2011).

A series of healthcare scandals over the last 15 years in the National Health Service (NHS) publicised the issue of care standards and generated a vigorous nationwide debate. Within

this debate, care failures were framed as a 'lack of compassion' in healthcare and, more specifically, in contemporary nursing. Compassion was largely presented as an individual value or 'natural' attribute of nurses (Hutchison, 2016, Timmins and de Vries, 2014). The policy response was to initiate a values-based strategy, which aimed to improve care by ensuring that the 'right staff' have the 'right values' to provide compassionate care (DoH, 2013). While the growing global interest in compassion was perhaps influential in this framing of events, the political benefits of 'invoking compassion' are also recognised (Woodward, 2002). This is chiefly in terms of focusing attention on individual staff and away from the structural and organisational factors (Hewison and Sawbridge, 2016, Hutchison, 2016, Nairn, 2009). As well as obscuring the complex and multifactorial causes of poor care, the debate on compassion in healthcare has had other problematic outcomes. These include a narrow representation of the phenomenon of compassion, potentially ineffective remedial strategies to improve care and widespread blaming of nurses for systemic health service problems.

The thesis has a British and nursing focus as a result of the intense and distinctive debate on compassion and healthcare in this country (McCaffrey and McConnell, 2015). However, in the wider discussion I draw from the international, cross-

disciplinary body of work, particularly the compassion-specific research that has emerged from the organisational and psychological fields in the last 15 years. I also utilise several key perspectives from nursing scholarship and sociological theory. In combination, these divergent viewpoints help to illuminate the many dimensions of compassion in the healthcare context. I now set out my motivations for the study before concluding this introduction with an overview of the thesis structure.

1.1 Motivation for the research

I present my motivations for undertaking this doctoral study to help the reader understand how I am situated in relation to the project and how I have influenced its production. My nursing experience in the NHS is perhaps the strongest impetus for undertaking the study. Prior to the PhD, I had worked as a healthcare assistant (HCA) and then as a registered nurse, mainly in NHS inpatient hospital settings, for 20 years. I, alongside my colleagues, had experienced the frustration of trying to meet the needs of patients and families with what felt like ever-decreasing resources.

I practised in the years leading up to the appalling care failures at Mid Staffordshire NHS Foundation Trust (Mid Staffordshire), and the events surrounding this scandal

seemed to mark a turning point. In the wake of the Francis report (2013), frustrations about poor care were now directed at nurses. I found the tone of media reporting, the government proposals to 'rate' nurses' compassion and the accusations of overeducated nurses both confusing and upsetting. Suddenly it seemed as though everyone was talking about compassion, and people were either praising me and my colleagues for showing it, or complaining that we lacked it. During one shift, I received thanks from a patient for caring for her compassionately. Later that day I received a complaint that I had not shown compassion to a relative.

I began to feel unsure of my practice and reflected on the care I gave. I thought of when I had avoided eye contact with patients I knew wanted to speak to me, or when I had become frustrated over seemingly trivial requests. I also thought of when I had worked without a break, hugged and cried with bereaved families, and missed my children going to bed because I stayed late. I didn't know if I was a compassionate nurse who was sometimes overstretched, or an uncompassionate nurse who sometimes happened to do the right thing. I found that the literature on the topic was disappointingly vague, sometimes judgemental and often devoid of any relation to my working environment.

I undertook this study to gain personal clarity on an issue central to my working life and my everyday experience of giving care. Professionally, I wanted to untangle the factors that cast nursing and nurses as both the source of and the solution to the problem. Academically, I wished to understand the concept of compassion and its relation to nursing care. Lastly, by undertaking those examinations in a systematic way, I hoped to make an empirically evidenced nursing-based contribution to the compassion debate, in which nurses are much discussed but little heard.

1.2 Structure of the thesis

Chapter two: Literature review

In this chapter I situate the study within the wider discourse, literature and research. I set out the NHS care standards debate in detail, linking the policy and research to the interpretation that poor care equates to a lack of compassion. I also provide an outline of the main theories and concepts that inform the thesis. I then present a focused review of the UK nursing research on compassion and demonstrate how this shaped the design of the study and the research aim.

Chapter three: Methodology

Following on from the research aims and objectives, this chapter presents the methodological aspects of the study. I

show how the underpinning philosophy, theoretical framework, study design and methods cohere, and justify their appropriateness for the research aim. The healthcare setting and sensitive nature of the topic generated significant ethical issues, and I discuss how a reflexive and rigorous approach helped me to manage these. Lastly, I detail the design and methods to give a transparent account of my conduct and the research process overall.

Chapter four: Setting the scene

This is the first of four chapters in which I present the empirical data. Each one reveals a different aspect of the data, in a broad-to-narrow sequence. Chapter four 'sets the scene' for the subsequent chapters. Here, I give an ethnographic description of life on Hazel ward to illustrate the key aspects of the culture. In doing so, I introduce many of the main themes that contributed to the findings as a whole.

Chapter five: Contextualised compassion

In chapter five I describe the distinctive context of the ward, and how it was characterised by operational pressures, organisational demands, the presence of suffering and a sense of threat. These elements complicated, or constrained, the process of compassion. I use participants' words, vignettes

and scenarios to show how these elements impacted on relationships and practice on the ward.

Chapter six: Constructions of compassion

In this chapter I put forward the second major theme: 'compromised compassion'. Here I show how participants constructed compassion in their language and social practices. I focus in depth on two ways of understanding compassion: compassion as an intrinsic phenomenon, and as an extrinsic phenomenon. I set out the differences between these accounts as well as the common factor – that enacting compassion involves compromise.

Chapter seven: Receiving compassion

In chapter seven I set out the last major theme: 'receiving compassion'. In the nursing literature this aspect of compassion is rarely considered, and the implication is that the sufferer passively accepts compassionate care from the HCP. Here, I present six atypical case studies to suggest that receiving compassion is a complex process in itself. Additionally, I propose that the recipient's response to the expression of compassion may form a feedback loop that shapes future care interactions with HCPs.

Chapter eight: Discussion

Here I discuss the findings in relation to existing theory, research and policy. The chapter has three main sections: a statement of findings, a main body of detailed discussion, and a concluding section.

In the main discussion, I cover four key areas, beginning with staff well-being, suffering, and the role of threat. Then I consider receiving compassion. I show how understanding of this aspect aids understanding of compassion generally. I also suggest that threat plays a role in how we receive compassion from others. I follow this with a discussion of how participants constructed compassion. I focus on nursing accounts particularly and how their decision-making around care is heavily influenced at both a micro- and macro-level. I lastly demonstrate how the application of structuration theory illuminates the tangle of structural constraints that shape compassionate practice in the ward setting.

Chapter nine: Conclusions

In this concluding chapter I demonstrate how I have met my research aim, and how this thesis contributes to nursing and compassion scholarship. In doing so, I acknowledge the limitations and broader implications of the study, and present specific recommendations for research, theory and policy that arise from the findings.

Chapter two: A review of the literature

2.0 Introduction

The focus of this study was to explore how compassion takes place in an acute hospital ward setting. This focus necessitated a critical consideration of broader perspectives on compassion, care in the NHS and contemporary nursing. In this chapter, I situate the study within these wider perspectives, and set out the existing research in this area.

The chapter is divided into four sections. Firstly, I set out the NHS care standards debate and how it was a catalyst for the emergence of compassion as a national healthcare priority. Next, I present the results of my review of nursing research on compassion, which informed the focus and design of the study. I then set out the research aim and objectives, showing how they relate to my learning from the review. Lastly, I introduce the key perspectives and concepts that inform the thesis and show how they relate to the issues discussed here.

2.1 Situating the study

2.1.1 The global compassion movement

As noted in the introduction, international interest in how a compassionate approach can benefit healthcare has been growing, particularly over the last decade. A sense of

discomfort with aspects of contemporary life has contributed to the emergence of this 'compassion movement' (du Plooy, 2014). Many are concerned that social trends of consumerism, political polarisation and disconnection from community and nature are contributing to global suffering (Armstrong, 2011, Worline and Dutton, 2017). Compassion is suggested as a way of encouraging a sense of shared humanity and efforts to notice and address the suffering of others (Worline and Dutton, 2017).

There are several key contributors who were at the forefront of the compassion movement, although now there is some collaborative work between them. For example, in 2006 two organisational scholars, Peter Frost and Sally Maitlis, set up CompassionLab (Worline and Dutton, 2017). This was a research hub for those interested in examining how compassion could improve workplace practices and relationships (CompassionLab, 2017). Two years later, Stanford University in California separately launched the Centre for Compassion and Altruism Research and Education (CCARE) after a meeting between the Dalai Lama and Stanford scientists (CCARE, 2017). CCARE has supported the development of a large body of work, applying a multidisciplinary scientific effort to the understanding of the neural, mental and social bases of compassion and altruism. In

2009, Karen Armstrong, an author and former Catholic nun, initiated the Charter for Compassion (CFC). This international organisation is comprised of diverse groups from the arts, business, healthcare, science and religion, and works collaboratively 'to establish and sustain cultures of compassion' (CFC, 2017).

HCPs, troubled by the 'focus on disease rather than wellbeing … costs, and the corruption of healthcare by profit' (Youngson, 2012, p2), have been an important part of this movement (Shea et al., 2014, Hewison and Sawbridge, 2016, Gilbert, 2005, Blomberg et al., 2016). Robin Youngson, for example, is a New Zealand medic who founded the Hearts in Healthcare programme, an international group which aligns the bio-psychosocial model of medicine with the scientific study of compassion and positive psychology (Youngson, 2012).

Professor Paul Gilbert's work has connections with all these groups through his research and the Compassionate Mind Foundation that he established in 2006. Gilbert, a British psychologist, developed compassion-focused therapy. This is an approach rooted in evolutionary science, attachment theories, Buddhist psychology and neuroscience (Gilbert, 2005). The foundation is also a hub for international research and clinical teaching aimed at integrating compassion and

healthcare. I have drawn from his theories on compassion to inform both the study and the discussion of the findings.

2.1.2 The compassion debate and NHS care

It is likely that the international attention on compassion and healthcare had some influence on how the NHS care debate came to be framed as an issue of compassion. However, in this thesis I consider the topic from a UK nursing perspective specifically, as I am interested in its relation to the national debate about NHS care. The UK discourse on compassion is distinct from the international interest in several respects. I set these out now to highlight the key issues of the discourse that inform the thesis and study.

The compassion discourse in this country is linked to a series of scandals that took place in UK care homes and hospitals (Borgstrom and Walter, 2015). The most prominent of these were the inadequate care, poor treatment, abuse and avoidable deaths at Bristol Royal Infirmary, Winterbourne View private hospital for adults with intellectual disabilities, Morecambe Bay NHS Foundation Trust and Mid Staffordshire. Several public reports were released over a short period (e.g. Care Quality Commission, 2011, Health Service Ombudsman, 2011, the Patients' Association, 2011, Francis, 2013), which charted a range of problems leading to failures in care and

treatment. However, the dominant narrative that emerged from media, political and academic sources was that there was a 'lack of compassion' (Bradshaw, 2017, Crowther et al., 2013, Sinclair et al., 2016a). Some commentators were more specific, stating that this compassion deficit related to nurses and the nursing profession (Smajdor, 2012, Smith, 2012, Smith, 2013). The subsequent critique levelled at nursing was particularly harsh and personalised, and targeted nurses' values, education and clinical ability (Wilson, 2011, Adams, 2012, Borland, 2011, Darbyshire and McKenna, 2013, Campbell, 2013).

The policy response has reinforced the idea that staff values, and nurses' values in particular, are responsible for poor care and/or a lack of compassion in the NHS. The government has been accused of 'scapegoating' nurses for systemic failures in care (Smith, 2013, Gabriel, 2015). Contemporary nursing education has received the most criticism and has been charged with 'eroding' compassion by over-representing the clinical and technical aspects of care (Rosser, 2017, Straughair, 2012 a, Bradshaw, 2017, Darbyshire and McKenna, 2013).

Subsequent changes to nursing education and practice have focused on 're-endorsing' the primacy of compassion and care

(Straughair, 2012 a). Initiatives have included intentional rounding, a system where nurses must evidence that they have visited each patient every hour to offer care; one-year HCA experience to learn 'basic' caring skills; and an overhaul of the nursing education strategy (Hayter, 2013, Shuttleworth, 2013). The new education strategy brings compassion centre stage, and aims to ensure that students with the 'right' values are recruited, that they demonstrate 'values of compassion' throughout their training and practice, and that those who do not are dealt with 'robustly' (NMC, 2013, NMC, 2017). However, students and nurses continue to express uncertainty about what exactly compassion is, and what it looks like in practice (Barron et al., 2017, Dewar et al., 2013).

2.1.3 The values-based healthcare strategy

The Department of Health (DoH) implemented a values-based strategy for the NHS shortly after the publication of the Francis report (2013). The issue of staff values was also highlighted in other major healthcare reports of the same period, for example the Berwick review (2013) of patient safety, the Keogh review of hospital care and treatment (2013) and the Cavendish review of HCAs and support workers (2013). In these reports, the importance of caring values was emphasised alongside the need for practical, positive

organisational support for staff; safe staffing levels; and strategies to ensure staff well-being.

However, health policy has heavily focused on values. The explicit aim was to ensure that HCPs had the 'right values' (DoH, 2013) and to 'embed the principles of compassion and caring' in all staff (DoH, 2014). This values-based approach now informs all aspects of healthcare policy, so that the NHS can become a 'values-based culture' (NHS Confederation, 2017), and has been seen most prominently in changes to NHS recruitment, appraisal systems and leadership teaching.

Values-based recruitment (VBR) has been the cornerstone of the government response to the Francis report, and was introduced rapidly by Health Education England (HEE) (Miller, 2015). All NHS employees are now recruited on the basis that their individual values and behaviours align with the values of the NHS Constitution (HEE, 2016). However, there remains little empirical evidence that VBR can ensure applicants hold compassionate values or will demonstrate them in practice (Patterson et al., 2016). Conversely, at the time VBR was implemented, there was evidence to suggest that staff already held caring values and felt distressed when they were unable to enact them in practice (Maben et al., 2007a, Newton et al., 2009, Glazer and Beehr, 2002).

The policy focus on nursing and individual values infers several key assumptions: firstly, that nurses have the main responsibility to ensure the compassionate care of patients; secondly, that compassionate care is distinct from, and exclusive to, the clinical aspects of care; and, lastly, that the patient experience of compassionate care is dependent on the values of the HCP who 'delivers' it. This last point suggests an underpinning belief that compassion is an intrinsic quality: this is an idea that I examine throughout the thesis. I now situate the study within the existing literature on the topic.

2.1.4 Literature overview

There has been an explosion of publications on compassion in healthcare since around 2010, consisting of texts, empirical research, concept analyses and opinion pieces. Many of the authors reference events at Mid Staffordshire, the associated inquiries and the surrounding debate as a rationale for addressing the topic. A large proportion of these are UK based, demonstrating the intensity of the debate in this country (McCaffrey and McConnell, 2015). However, the body of work is predominantly descriptive, and there remains a need for applied empirical research which investigates and contextualises compassion in the clinical setting (Sinclair et al., 2016a, Curtis et al., 2017).

A noteworthy aspect of the literature is the effort to clarify or establish understanding of compassion in healthcare, or what it practically means for nursing (McCaffrey and McConnell, 2015, Sinclair et al., 2016a, Perez-Bret et al., 2016). Despite the volume of work aiming to do this, recent publications continue to note or address the lack of clarity (Maxwell, 2017, Barron et al., 2017, Ramage et al., 2017). Sinclair et al., (2016, p14) argue that much of the compassion research relies on 'preconceived theoretical definitions' of compassion that lack specificity, clinical applicability and conceptual validity.

To aid clarification and understanding of the concept, several authors separate out perceived constituent elements of compassion (Chambers and Ryder, 2009, Bray et al., 2014, Waugh et al., 2014, Brown et al., 2016). However, the resultant elements can be non-specific and disconnected from the construct of compassion. Chambers and Ryder (2009), for example, set out the elements as separate chapters in their text: empathy and sensitivity; dignity and respect; listening and responding; diversity and cultural competence; choice and priorities; and empowerment and advocacy. As McCaffrey and McConnell (2015) note, apart from empathy, the elements are more closely related to good nursing care than compassion specifically. Chambers and Ryder (2009) use the patient

perspective to powerfully underscore how a compassionate nursing approach can benefit patient care. However, within this text, there is less attention paid to the range of factors that complicates compassionate care in practice.

As well as Chambers and Ryder (2009), there are two other key texts in this body of work: *Providing Compassionate Healthcare: Challenges in Policy and Practice* (Shea et al., 2014) and *Compassion in Nursing: Theory, Evidence and Practice* (Hewison and Sawbridge, 2016). The former provides an extensive discussion around compassion in healthcare from a range of historical, organisational, nursing, conceptual, psychological and educational perspectives. The work of Hewison and Sawbridge (2016) is similarly expansive, including many of the same perspectives but with a specific nursing focus. Both texts are important additions to the topic of compassion in healthcare because they present wider sociopolitical influences alongside the benefits of a compassionate approach to healthcare. Furthermore, both underscore the need for organisations to practically and emotionally support staff to deliver such an approach, and give suggestions for doing so. Hewison and Sawbridge (2016) link compassionate care with the concept of emotional labour. They use this body of research to argue that organisations have a 'legal requirement' to support staff to manage the

emotional demands of compassionate care (Hewison and Sawbridge, 2016, p142).

2.1.4.1 Prominent themes in the literature

In addition to efforts to understand the concept of compassion, there are several other prominent themes in the wide body of work on compassion in healthcare. Most commonly there is a discussion about both the emotional and the action elements of compassion. This suggests a consensus of understanding that compassion goes beyond feeling, to incorporate some type of action to address suffering, even if that is the decision not to act (McCaffrey and McConnell, 2015, Sinclair et al., 2016a, Perez-Bret et al., 2016). Examples of action are supporting, helping, reassuring, giving care and giving treatment, while emotional aspects include empathy, sympathy, care, respect, and sometimes love. The notion of giving time is particularly common (Bramley and Matiti, 2014, Sinclair et al., 2016b).

It is also common for compassion to be described as relational or interpersonal. However, there is rarely any depiction of a process of exchange between HCP and patient. Instead, compassion appears as a unidirectional transaction, going from the HCP to the patient. This transactional depiction fits with the conceptualisation of compassion as an intrinsic value

or virtue, a conceptualisation which dominates the literature (Sinclair et al., 2016a, McCaffrey and McConnell, 2015). Less commonly, authors present compassion as a relational or social process that is influenced by both the setting and the skill of the HCP (Sinclair et al., 2016a, McCaffrey and McConnell, 2015). Other common themes include considerations of whether compassion can be taught and methods or interventions to achieve this, and explorations of barriers and facilitators (Strauss et al., 2016, McCaffrey and McConnell, 2015, Sinclair et al., 2016a, Perez-Bret et al., 2016, Burnell and Agan, 2013).

2.2.2 Search strategy

In narrative reviews there is no template for the strategy process, as their scope is dependent on the specific aim (Green et al., 2006, Coughlan and Cronin, 2016). However, they tend to have a broad scope, and therefore it is important to impose appropriate limits in order to make such reviews manageable (Kitson et al., 2014, Coughlan and Cronin, 2016). My search strategy (see box 1) was broad in order to meet the phase 1 aim of scoping the range of work on the topic. From those results I selected the empirical studies for phase 2, the narrative review.

Databases	Search terms	Limits
CINAHL plus with Full Text MEDLINE via ProQuest PsycINFO, via Ovid	Compassion OR Compassionate In Article Title	1. English language 2. Journal articles 3. Human subjects 4. June 2004-June 2017

Box 1 Search strategy and limits

I used three common healthcare databases: CINAHL, MEDLINE and PsycINFO. To determine what type of work was taking place on the topic, I included a variety of sources, such as empirical work, reviews and opinion pieces. I tried a variety of search terms that included popular synonyms for compassion (sympathy, empathy, care), but I retrieved unmanageable numbers of publications, and many did not focus on compassion itself. Therefore, I used 'compassion or compassionate' and again limited the keywords to the title, because other options were voluminous and often irrelevant. I set several parameters (English language, journal articles and human subject) and a time frame of June 2004–June 2017 to encompass the emergence of the care standards debate.

2.2 Review of UK nursing research on compassion

In this section I present the results of a literature review on the UK nursing compassion research. The review had two functions: firstly, to establish the scope of work on compassion generally (phase 1); and, secondly, to examine in detail the UK nursing research to inform the design and focus of the doctoral study (phase 2). I set out here the results of both phases before discussing the methodological issues, dominant themes, and gaps that I identified from the literature review.

2.2.1 Literature review methodology

This review was narrative in style. There are a range of literature review approaches, but all share the basic characteristics of collecting and evaluating the literature on a given subject (Coughlan and Cronin, 2016). The choice of approach depends on the review purpose and type of research being examined (Ferrari, 2015). A narrative review was appropriate for my aim of establishing the state of the extant research in order to situate and justify doctoral-level study (Coughlan and Cronin, 2016, Kitson et al., 2014). It was also appropriate for the inclusion of methodologically diverse studies (Kitson et al., 2014, Coughlan and Cronin, 2016).

A narrative review approach has previously been used to evaluate the compassion literature (Sinclair et al., 2016a), but

the approach is often criticised as being haphazard, subjective and unreliable for assessing evidence (Coughlan and Cronin, 2016, Green et al., 2006, Hammersley, 2001). However, my aim is not to assess evidence on a clinical intervention or technique, but rather to identify patterns, contradictions and gaps in the body of work.

2.2.3 Results

From the three databases I retrieved 2,383 results. After the removal of duplicates and an initial screen for relevance, 234 international publications of mixed sources on compassion remained. I organised these into categories, such as discipline, source, topic and country of origin, and used these studies to establish a basic overview of the work on the topic. Figure 1 shows this searching and organising process.

The figure also shows how I selected the narrative review studies from the 234 publications. I focused the review on UK nursing papers because of the distinctive nature of the compassion discourse and the public and policy response, as set out earlier. I also chose to focus on empirical research only in order to situate my own study within this existing work. Lastly, I excluded 26 studies that were primarily on compassion fatigue. These mainly quantitative studies had limited discussion of the concept of compassion and instead

were focused on incidence, prevalence, risk factors and impact (e.g. turnover rates, sickness rates) associated with compassion fatigue and/or the relationships between compassion fatigue and, for example, quality of life, burnout or compassion satisfaction.

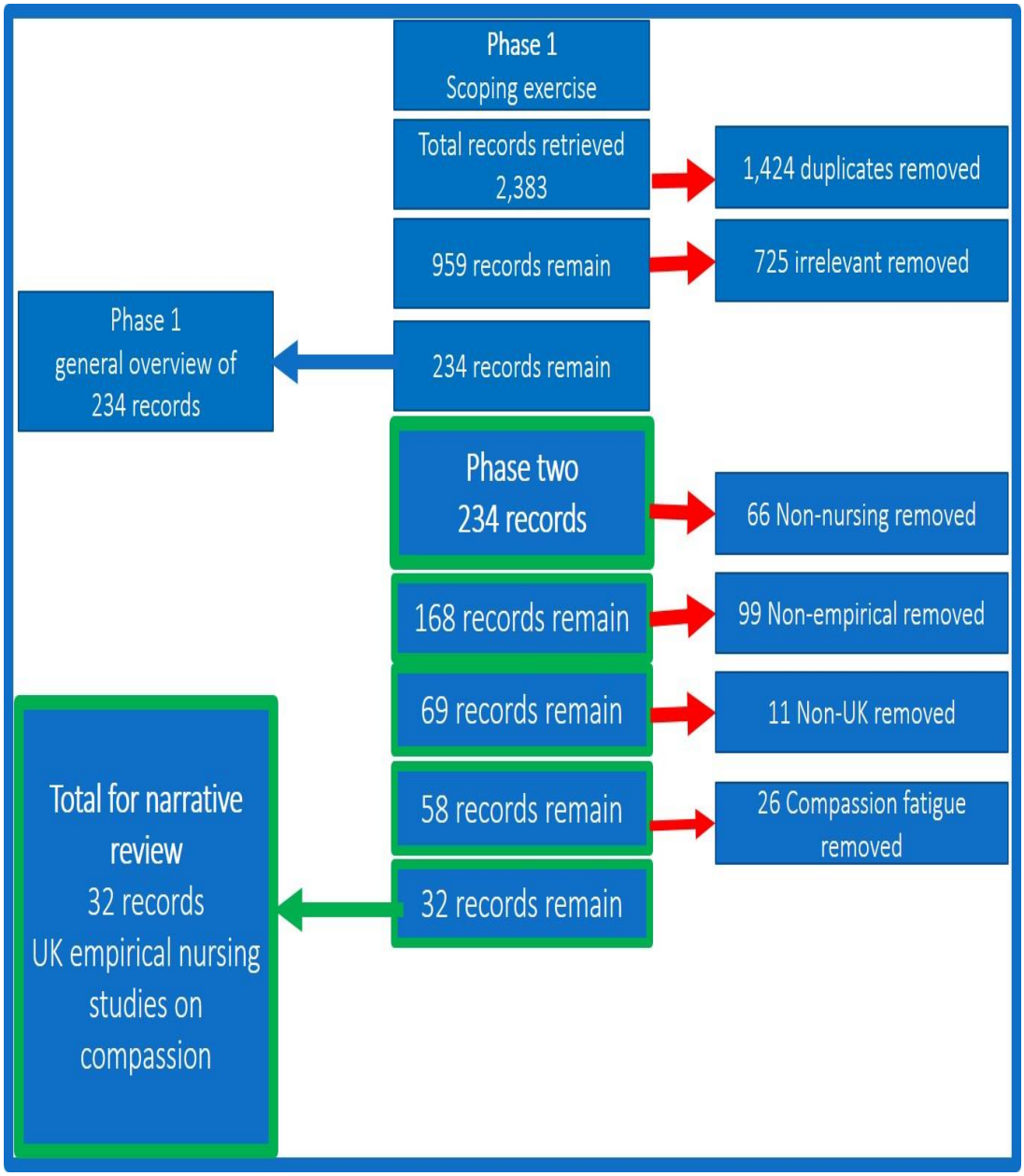


Figure 1 Search process and results

To ensure that no important studies were missing, I discussed the final selected papers with supervisors, conducted a Google Scholar search using the strategy and repeated the strategy periodically throughout the doctorate. Nevertheless, the limits I set for the search strategy inevitably missed some publications. However, based on peer review and knowledge of other reviews on compassion research, I am confident I have represented the research base sufficiently with regard to the aims of the study.

2.2.4 Overview

The 32 studies are all primary research which predominantly investigates compassion in relation to nursing, or in relation to healthcare but with nurses as the dominant group of participants. Ten of the studies relate to the Leadership in Compassionate Care Programme (LCCP). I briefly outline this programme now, because the research produced by the programme has contributed significantly to the body of knowledge on compassion in the UK.

The LCCP was a collaborative venture between Edinburgh Napier University and NHS Lothian (Dewar, 2011). It was a three-year research project that was initiated in response to a sense that some aspects of nursing care had been 'lost'

(Adamson et al., 2012). The LCCP therefore aimed to embed compassion and relationship-centred care within practice and education, and to share the knowledge with other organisations (Dewar et al., 2013). The programme took an action-orientated appreciative inquiry approach, and employed multiple qualitative and quantitative methods, such as collage, emotional touch points, surveys and stories (Smith et al., 2010, Dewar, 2011).

The appreciative inquiry design encourages a purposeful search for, and learning from, existing good practice (Dewar and Mackay, 2010). To this end, the research settings are 'beacon' wards, or clinical units identified as areas of good practice. However, a limitation of investigating only beacon wards is that it neglects the problems that affect care in more challenged settings, and a skewed picture of compassion may emerge. Nevertheless, Smith et al. (2010) stress that their study sites were ordinary units within NHS trusts and experienced the usual resource and care problems as other wards. Additionally, the appreciative approach that these studies take enables the authors to show that compassionate care does take place in ward setting and that it can flourish with practical organisational support.

Although the LCCP was nursing focused, study participants included a range of staff, patients and relatives. Therefore, rather than isolating nurses or patients, for example, much of the LCCP research incorporated the clinical unit as a whole. This does make it somewhat difficult to decipher the exact number of participants involved in each research activity when evaluating the LCCP studies. However, a positive effect is that the studies present compassionate care as a shared, rather than a nursing, responsibility. Furthermore, the collaborative research activities enhanced ward team relationships, as well as interactions with relatives (Dewar et al., 2010, Adamson and Dewar, 2015). Overall, the work of the LCCP makes a significant contribution to knowledge of compassionate care in the clinical setting. I explore more specific aspects of this contribution later in this review.

Appendix 1 summarises the 32 studies reviewed. Only two studies are quantitative, one using psychometric measurement scales (Durkin et al., 2016), and the other using a survey (Waugh et al., 2014). A qualitative approach and the use of interviews predominate, although many authors combine them with other methods. Dewar and Mackay (2010) note that a multi-method approach could better address the complexity and hidden nature of compassionate care. Qualitative interviews offer the advantage of a private space to discuss

sensitive care issues, while the semi-structured style allows participants to direct the topic to some extent. The qualitative design also allows the authors to present the data in a rich and emotional way, which enhances the power of the accounts and strengthens the overall argument.

Twenty-eight studies give a single perspective (24 were staff focused, 4 were patient focused), and the remaining studies have mixed participant groups. In terms of perspective, patients and relatives generally describe the experience of being a *recipient* of compassion, for example suggesting how staff could improve their care. Conversely, staff and student participants tend to describe the experience of expressing or enacting compassion and rarely depict themselves as recipients or sufferers.

Almost all studies present compassion as entirely beneficial for patients. Only one study (Brown et al., 2014) discusses negative associations, and this relates to staff using compassion in a coercive way, to manage patient behaviour or emotion. Numerous studies note that compassionate care can have negative effects for staff, however. This is described predominantly as compassion fatigue, and, less frequently, as emotional labour or cognitive dissonance. The dominant presence of compassion fatigue in these studies (Barron et al.,

2017, Ali and Terry, 2017, Durkin et al., 2016, Curtis et al., 2017, Crowther et al., 2013, Lloyd and Carson, 2011) reflects the general literature on the topic (Sinclair et al., 2017, Ledoux, 2015). This connection is made despite the fact that compassion fatigue is conceptually unrelated to the construct of compassion (Sinclair et al., 2017). However, in the review studies, compassion fatigue was presented as an inevitable 'cost' of compassionate care, an important assumption that is discussed in depth later in the thesis.

Lastly, it is noteworthy that few of the studies attend substantially to ethical issues or reflexivity. This is an important omission given the political and professional sensitivity of the topic, the vulnerability of the participants and the dual professional/researcher role of many of the authors. Dewar and Mackay (2010), Smith et al. (2010) and Bramley and Matiti (2014) are unusual for their mindfulness towards the emotional support of participants, including participants' need to feel 'safe', and the importance of taking a non-judgemental stance. I now detail the most relevant dominant themes and go on to show how they informed this study.

2.2.5 Defining compassion

Compassion is a complex, subjective and multifactorial concept, and consequently difficult to define (Schantz, 2007,

Goetz et al., 2010). In that regard it is important for researchers to set out how the phenomenon is understood and how that understanding has been informed. However, in the studies reviewed this is not always the case. Consequently, some lack coherence and/or support for the central argument.

In those studies that do define compassion, there is consensus on three particular elements: suffering, noticing suffering and acting to alleviate the suffering. This is consistent with wider scholarship on the topic, and the assertion that the 'action' component in particular is what distinguishes compassion from similar constructs (Blomberg et al., 2016, Gilbert, 2009, Avramchuck et al., 2013). In the review studies, there is often discussion about the confusion around the meaning of compassion and its conflation with similar concepts, such as sympathy and empathy (Dewar and Cook, 2014, Adamson and Dewar, 2014).

Although the element of suffering is recognised as an antecedent to compassion, it is rarely discussed in detail. This is problematic, because it is the personal engagement with suffering, distress, pain or grief that makes the enactment of compassion emotionally difficult and demanding (Gilbert, 2010, de Zulueta, 2015). However, Curtis (2013, 2014), Tierney et al. (2017b) and Brown et al. (2014) discuss the

relationship between suffering and compassion more substantively, and the depiction of compassionate care in these studies is perhaps more complex and rich as a result.

Some studies give no clear definition of compassion at all (Kneafsey et al., 2016, Waugh et al., 2014, Bray et al., 2014), while others use a basic dictionary definition (Curtis et al., 2012, Waugh and Donaldson, 2016). Dictionary descriptions are problematic, because they often incorporate pity. Pity infers judgement of the sufferer, or condescension, which influences the dynamic between the sufferer and the person expressing compassion, and how compassion is enacted (Goetz et al., 2010, Nussbaum, 1996).

Bray et al. (2014) do not provide a clear definition of compassion, and the overall validity of this quantitative study is consequently affected. The authors explored nurses' understanding of compassion using a two-part survey that asked participants to rank two sets of statements: statements that most closely matched their understanding of compassion, and statements that matched how compassion can best be demonstrated.

However, Bray et al. (2014) do not make clear how the statements relate to the construct of compassion. For example, 'treating patients as people' and 'being accessible'

are two of the given statements. They are clearly aspects of good practice, but their link to compassion is uncertain. The authors conclude that there was a 'high level' of consensus regarding the understanding and demonstration of compassion, but there is strong ambiguity regarding the phenomenon being measured (Bray et al., 2014).

Conversely, Dewar and Nolan (2013) offer a comprehensive discussion of the meaning of compassion that is rooted in both the wider compassion literature and the healthcare context. This discussion strongly coheres with, and supports, the model of compassion for clinical practice that the authors later present. Curtis (2014) also draws from the wider compassion literature, but uses it to develop a compound term of 'compassionate practice'. She argues that the term is more applicable to practice than some abstract definitions, and, again, this discussion supports the study findings. However in some of the LCCP studies, there is a tendency to use the compound terms 'person-centred compassionate care' (Adamson and Dewar, 2014) or 'relationship-centred compassionate care' (Dewar and Nolan, 2013). This means it is sometimes difficult for the reader to clearly distinguish between compassionate care and person-centred care in these studies.

Crawford et al. (2013), Brown et al. (2014) and Barron et al. (2017) all give strong explanations of how compassion is understood within their study, the literature in which that is rooted and how it relates to the study findings. This enhances the authors' subsequent discussion of their findings. For example, Brown et al. (2014) present an unusually complex picture of compassion in the healthcare setting. They show compassion as simultaneously positive and negative, a tool for care and coercion. Barron et al. (2017) present a similarly multifaceted picture. They describe a complex interrelationship between staff, patients and the wider organisation, so that compassion is both 'a driving force' for care and a source of frustration and guilt.

2.2.6 Neglect of clinical context

Another dominant pattern in the studies is the neglect of the clinical context and an emphasis on individual or interpersonal aspects of compassion. While the focus of research studies will always vary depending on the specific aim, those in this review are explicitly concerned with compassion *in healthcare*; therefore, it seems important to adequately represent the clinical context. Where the authors under-represent the clinical context, it can threaten the credibility of the research overall. Furthermore, many of the studies develop strategies or recommendations from the findings and claim them to be

suitable for HCPs to implement in clinical practice. It might therefore be expected that not only is the clinical setting accounted for, but HCP input is also included.

For example, Lloyd and Carson (2011) use an ethnomethodological approach to examine mental health service users and their carers' experience of compassion. The authors conclude that patients are not treated as equal partners within the health system, and this impacts negatively on their experience. It is important to understand the perceptions of service users and their experience of receiving care. However, the service-user experience is decontextualised from the care setting and from any sense of the HCP. This gives a picture of compassion as transactional, with the service user describing what they require from the HCP. Lloyd and Carson (2011) use these findings to produce a set of guidelines for mental health practice, but the exclusion of those implementing the guidelines and the care setting limits their applicability to practice.

Brown et al. (2016, p978) also produce a practice model, which aims to provide a 'clinically meaningful' strategy for compassionate care. Again, it was developed from service-user and carer data, and a rich set of findings depicting the problems faced by people with intellectual disabilities

accessing healthcare services. The model centres on liaison nurses acting as a 'bridge' between the patient, the family and the healthcare system. However, there was no nurse input into the model and the authors do not consider this to be a limitation.

In two further studies, the lack of contextual detail may overestimate the autonomy of staff in the practice setting. Bramley and Matiti (2014) and Crowther et al. (2013) both reference the challenging circumstances in which care is given. However, these circumstances are not incorporated into the discussion of the data.

One patient described asking for help and being told to 'wait their turn' because the nurses were with another patient (Bramley and Matiti, 2014). Another participant described the distress she felt when staff did not provide a side room for her dying father (Crowther et al., 2013). Crowther et al. (2013, p494) introduce the scenario as an act of 'unkindness' and 'lack of compassion', implying that the staff *chose* to withhold the side room. It seems reasonable to suggest that contextual factors such as workload, staffing and resources might have influenced staff behaviour in these scenarios. However, there is no critical consideration of the complex relationship between patient experience, staff behaviour and organisational

constraints, and of how these might shape perceptions of compassion.

Papadopoulos et al. (2015) and Waugh and Donaldson (2016) similarly fail to consider the dynamic interrelationship between patients, staff and the clinical setting. Both studies aim to encourage compassionate care from nursing students and both rarely refer to the clinical context. Instead, the focus is on developing students' knowledge of compassion and caring values. This assumes that knowledge and values will translate unproblematically into compassionate practice and that contextual factors are less significant.

Lastly, Kneafsey et al. (2016) represent the clinical context in more detail, noting how operational pressure and a 'production-line' culture can impede compassionate care. This study has a mixed staff, academic and service-user participant group and so incorporates a wide range of perspectives. The findings support the notion of contextual barriers to care, and the authors identify a prominent theme of the 'system taking over'. Despite this, their model only features behaviours and skills that the practitioner should enact to improve compassionate care and includes none of the contextual factors raised in the findings.

The absence or marginalisation of the contextual contingencies of clinical practice in these studies implies that staff values and behaviour are the most significant variables in the experience of compassionate care. In the next section I show that this individualistic perspective influences the recommendations arising from the research.

2.2.7 Recommendations

Many of the recommendations suggested by the review studies focus on what staff might individually do to improve care. While the responsibility of healthcare organisations to provide adequate staffing, resources and support is often mentioned, observations of this type are not as substantial as the staff-directed recommendations. Two implications arise from this: firstly, that HCPs are responsible for ensuring compassionate care of patients; and, secondly, that HCPs should develop ways of coping with the contextual barriers to care, rather than addressing the barriers themselves.

For example, the most dominant recommendations were related to the education of staff, and there were suggestions of specific techniques to do this (e.g. patient narratives, values-based teaching and communication skills). Support for VBR into nurse education was common, as was the suggestion

that experienced nurses should improve their role modelling to new or student nurses.

It was also proposed that staff should 'strive' to develop personal relationships with patients, spend more time with them, know them better, be more collaborative and utilise 'fleeting' displays of compassion when busy (Bramley and Matiti, 2014, Lloyd and Carson, 2011, Kneafsey et al., 2016, Crowther et al., 2013). However, there were no suggestions as to how staff might practically achieve these proposals. There was also a range of suggestions for strengthening HCPs' ability to 'positively adjust and thrive in environments of adversity … in order to uphold their ideals' (Curtis, 2012, p794). Ways to do this included developing personal resilience, moral courage and altruism, as well as using critical self-reflection (Bramley and Matiti, 2014, Papadopoulos et al., 2016, Bray et al., 2014, Curtis, 2014, Curtis et al., 2017, Curtis et al., 2012).

Two studies suggest self-compassion may have a role, though in diverse ways. Durkin et al.'s (2016) quantitative study measures the relationship between self-compassion, compassion satisfaction, compassion fatigue, burnout, compassion for others and well-being in a group of community nurses. The authors suggest that teaching the skills of self-compassion could potentially reduce the risk of developing

burnout. However, they primarily advocate self-compassion as a way of helping nurses cope with stress and the 'demands of their profession' so they can provide better care (Durkin et al., 2016, p113). Here, a concept that is focused on generating kindness for one's own suffering (Neff, 2003b) is used to encourage nurses to tolerate poor working conditions so they can better focus on others.

Conversely, McPherson et al. (2016) promote self-compassion as a way of caring for the self and relieving the work-related distress that their participants describe. The authors acknowledge that self-compassion may also improve capacity to care for others. Importantly, they describe how compassionate care requires healthcare organisations to 'enable and reward' the practice of self-compassion by staff. McPherson et al. (2016) also discuss the need for structural responses, such as improved staffing, increased time off and regular respite from the ward.

The other reviews that, like McPherson et al. (2016), incorporate the clinical setting more substantially tend to give a similarly broad range of recommendations (Brown et al., 2014, Crawford et al., 2013, Barron et al., 2017, Christiansen et al., 2015, Beardsmore and McSherry, 2017, Ali and Terry, 2017, Horsburgh and Ross, 2013). The work of Tierney et al.

(2016, 2017a, 2017b), for example, involves staff and student participants only, but because the analysis is well contextualised, a strong sense of the contribution of both patients and the clinical setting emerges. The recommendations offered in these studies represent all these aspects, including organisational leadership.

Crawford et al. (2013) and Brown et al. (2014) take a similar staff perspective, but the findings and discussion consider the patient standpoint and how the care interactions are influenced by the clinical culture. Recommendations are system-wide, and the authors explicitly state that although compassion can be considered an intrinsic quality, 'behaviours … are significantly influenced by the environments in which individuals are embedded' (Crawford et al., 2013, p725).

2.2.8 Review summary and gaps

In this section I have highlighted several methodological and thematic issues which predominated in the studies under review. These included the importance of a clear operational definition of compassion and how it relates to associated concepts, and the benefit of using multiple methods and multiple sources to illuminate the topic. It also appears that by focusing on compassion as an intrinsic quality, compassionate care can appear transactional rather than relational. Linked to

this, research which is decontextualised from the clinical setting can fail to account for the contextual contingencies that shape practice.

From this focused review and from a consideration of the wider healthcare literature and policy, I identified that compassion in the ward setting was inadequately represented. I found a need to examine the conceptual elements of compassion in a clinically contextualised way and in a way that represented the experience of both giving and receiving care. To do this, I would need to be explicit about my theoretical approach to compassion and reflexive about the influence of my nursing identity. I also identified that a multi-method, multi-perspective, longitudinal approach might avoid a narrow 'snapshot' of care and instead encourage a broader lens on how compassionate care unfolds in the everyday practices of the setting.

2.3 Research aim, objectives and significance

The aim of the study was to develop a descriptive and explanatory account of compassion in the hospital ward setting. The objectives were to examine the key elements, facilitators and inhibitors, and explore how actors in the setting constructed and enacted compassion.

The overall purpose of the study was to contribute empirical findings to compassion and nursing scholarship as well as the international, cross-disciplinary debate regarding compassion in healthcare settings. More specifically, I hoped to extend nursing theory and research on compassion by evidencing the limits and advantages of values-based and process theories of the concept. In terms of healthcare policy, I also hoped to demonstrate that a values-based approach is insufficient for improving compassionate care in clinical settings. I therefore aimed to contribute to the growing body of work that demonstrates the need to expand the policy focus from staff values to incorporate wider structural factors.

Before setting out how I designed the study to meet these aims and objectives, I first explicate the concepts and theoretical perspectives that are foundational to the study and the thesis overall.

2.4 Key concepts

2.4.1 Compassion

Compassion can be defined in various ways, reflecting its multiple and historical roots in a range of cultures, religions and disciplines (Davison and Williams, 2009, Schantz, 2007). It is considered an intuitive response, a fixed mental disposition, a practice (Brown et al., 2014), a vicarious

experience of distress, an emotion and a type of love (Goetz, 2004). Furthermore, related constructs such as empathy, sympathy and pity are often used interchangeably with compassion (Burnell, 2009, Schofield, 2012, Sinclair et al., 2017), while compound terms such as compassionate care, person-centred compassion and compassionate love add to the confusion (Dewar, 2011, Sprecher and Fehr, 2005).

This definitional variation creates challenges for scholarly work on compassion, and empirical research in particular (Goetz et al., 2010). It is therefore important to set out the operational definition for the study and the underpinning theoretical perspective. I use the following definition, which is a practical interpretation of the concept and is applicable to the healthcare setting:

> *[Compassion is] a sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it.*
>
> (Cole-King and Gilbert, 2011, p30)

It features the key elements of suffering, noticing and caring about that suffering, and acting in some way to alleviate it, which are consistently represented in the studies reviewed earlier, as well as in the wider cross-disciplinary literature (Chochinov, 2007, Lazarus, 1991, Goetz et al., 2010, Kanov et

al., 2004). Some sources consider other elements to be important. For example, an individual may make an appraisal relating to the deservedness of the sufferer, while some consider the element of motivation (acting to benefit self or another) to be crucial (Goetz et al., 2010, Cole-King and Gilbert, 2011, Crisp, 2008). However, these elements are less consistently cited.

For this study, a fourth element is important, although few authors note it as significant. This is receiving compassion, which relates to the response that compassion arouses in the individual. I say more about this element shortly. I also understand compassion as having three 'orientations', or as being able to 'flow' in multiple directions (Gilbert, 2010). This includes compassion from one person to another, but also compassion towards the self, and receiving compassion from another. Figure 2 depicts the conceptualisation of compassion that underpins the thesis. It shows all four elements as an interrelated process, as well as the three orientations. I now explain the concepts and theories associated with this conceptualisation, and why it is appropriate for this study.

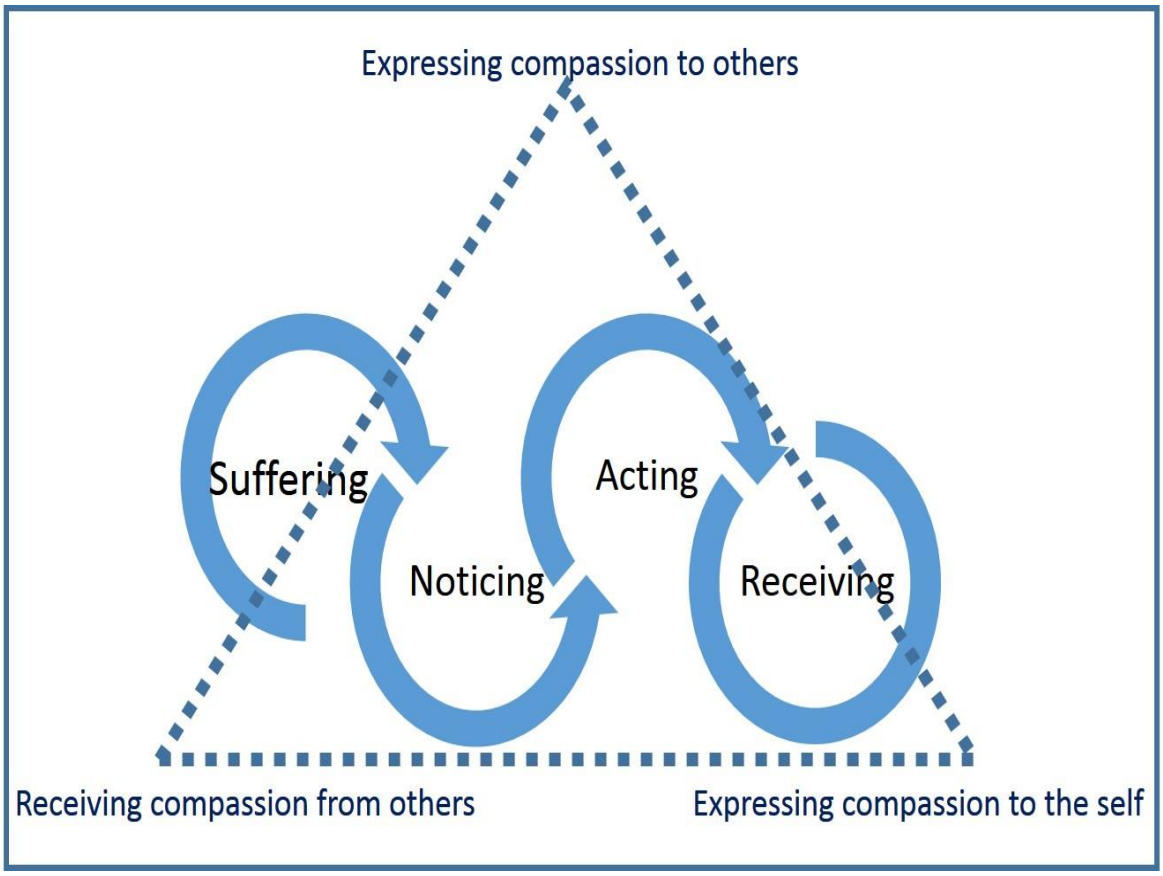


Figure 2 The four elements of the compassion process and its three orientations

2.4.1.1 Suffering

As noted, suffering is a critical antecedent for compassion. However, the term is problematic for research studies. It is infrequently used in lay contexts (Schantz, 2007, Goetz et al., 2010, Schofield, 2012) and in healthcare contexts is associated with crises and catastrophic events (Dewar, 2011). Wilkinson (2006, p1) argues that the medico-scientific interpretation of suffering in research often means that the 'everyday miseries' of life are neglected. His sociological

interpretation of suffering includes social isolation, estrangement, depression, humiliation, material deprivation and injustice, but he acknowledges that any attempt to give a comprehensive definition will always be inadequate (Wilkinson, 2005). Therefore, in order to capture the range of suffering that people experience in everyday life, I use a number of terms interchangeably with suffering, for example distress, grief, misery, anxiety and isolation. I also acknowledge that it can be physical, mental and/or emotional (Wilkinson, 2005, Hovey and Amir, 2013).

2.4.1.2 Noticing suffering

Noticing suffering should incorporate a feeling of concern to relieve it (Dutton et al., 2014, Kanov et al., 2004), and without either of these elements, a compassionate response is unlikely (Gilbert and Choden, 2013). This has particular relevance for healthcare settings, where HCPs have multiple responsibilities and roles, high workloads, and little support.

2.4.1.3 Action

The action element of compassion distinguishes it from the similar, emotion-based constructs of sympathy and empathy (Cole-King and Gilbert, 2011, von Dietze and Orb, 2000). Some argue that compassion has not occurred if there is no reduction in suffering (Burnell, 2009), but others maintain that

in some circumstances, withholding action may be compassionate (Dutton et al., 2014, Kanov et al., 2004). For this thesis I consider that a compassionate interaction incorporates behaviours that *intend* to improve the sufferer's experience, which includes deliberate inaction, and delegation of the response to another appropriate person. Delegation is particularly important in the healthcare setting, as staff frequently need to 'hand over' aspects of care to another suitable person.

2.4.1.4 Three orientations of compassion

As noted, the three interdependent orientations of compassion are: compassion expressed towards another; compassion expressed towards the self; and compassion received from others (Jazaieri et al., 2013, Gilbert et al., 2011). Self-compassion has received more attention in recent years, and nursing research is increasingly addressing the topic. Germer and Neff (2013) define self-compassion as compassion directed inwardly, and it is posited that a capacity for self-compassion can improve one's resilience and ability to cope with problems (Neff, 2003a). Self-compassion may also enhance an individual's capacity to extend compassion to others, and may buffer the negative effects of working with suffering (Neff, 2003a, Gilbert et al., 2011). However, it is not

uncommon for self-compassion to be viewed negatively, for example as an indulgence or weakness (Gilbert et al., 2011).

Receiving compassion from others is also perceived as weakness by some, and may trigger negative emotions (Gilbert et al., 2011). In the main, however, receiving compassion induces feelings of calm and well-being and can regulate negative emotions of fear and isolation (Gilbert et al., 2012). It is these positive effects that contribute to its value in healthcare. As noted, this orientation has received less attention, and it is often assumed that receiving compassion is a passive process of acceptance. Receiving compassion forms a major aspect of the study findings, and I discuss it in depth in later chapters.

2.4.1.5 Other terms used in the thesis

In the thesis I often use the compound term 'compassionate care' to refer to the result or effect of a compassionate interaction. For example, when a person notices suffering in another and acts to relieve it, I would describe it as compassionate care. During fieldwork and analysis, it was also necessary for me to distinguish between interactions that were necessary and functional, but were not 'compassionate' because they were not a response to suffering as such. These included dressing a simple wound, documenting care to ensure

continuity, assistance with personal care and explaining a clinical treatment. I use the term 'ordinary' or 'basic care' for these instances, which is far from ideal. However, it was difficult to find an appropriate term to distinguish care that was positive and beneficial, but not necessarily 'compassionate'.

Analysing care at this deep level exposed a 'side effect' of the compassion debate, which is that ordinary or basic care has become devalued in relation to compassionate care. Actions that help another or fulfil a need, and particularly those that take place away from the bedside, are commonly described using the somewhat pejorative term 'task'. Though these tasks may not require a deep emotional connection, they do require effort, competence and time, and they directly contribute to the clinical care, treatment, safety and recovery of the patient. I discuss this issue in detail in later chapters. Next I set out the theoretical perspectives that underpin the concepts discussed here and inform the thesis as a whole.

2.5 Theoretical perspectives

I have employed several cross-disciplinary theories throughout the thesis, either referring to them or directly applying them. A constructionist theoretical framework informs the research approach, and I discuss this at length in the methodology

chapter. I apply a sociological perspective to the findings - structuration theory - and introduce that in this section. I also use two compassion-specific theories throughout, and will introduce them now. It is important to note however that they are not referred to as theories or models in the wider scholarship. Through my engagement with the literature on the topic, I found that much of the work conceptualised compassion as either a personal value or quality, or as a context-dependent process. I therefore refer to them as value- or process-based theories in order to identify and differentiate the approach used in the literature or research. The approach to compassion that informs a piece of work, and indeed that fact that a particular conceptualisation of compassion is rarely acknowledged as such, are both of fundamental importance to this study. I elucidate these points more fully in the thesis.

2.5.1 Process-based theory of compassion

A process-based theory of compassion understands the phenomenon as a dynamic relational exchange, enacted between people and their social environment (Kanov et al., 2004, Jazaieri et al., 2013, Lilius et al., 2008, Gilbert, 2009, Crawford et al., 2013). This model is common in the organisational and psychological literature, and the following

quote from organisational researchers Kanov et al. (2004) clearly explains this perspective:

> *We regard compassion in organizations as processual and relational. It is common to think of it as an individual characteristic, and a given individual as being either 'compassionate' or 'uncompassionate' … In contrast, we conceptualize compassion as a dynamic process, or a set of subprocesses, that may be found both in individuals and collectivities. Building on Clark (1997), we identify these subprocesses as 'noticing', 'feeling', and 'responding', each contributing uniquely to the process of compassion. We argue that compassion and each of its subprocesses is relational in nature, occurring in and through interactions and connections between people.*
>
> (Kanov et al., 2004, p809)

Importantly, Kanov et al. (2004) differentiate their approach from an understanding of compassion as an individual characteristic. It is this conceptualisation that underpins a values-based theory of compassion.

2.5.2 Values-based theory of compassion

The assumption that compassion is an intrinsic quality or trait is common in the nursing and theological literature. The 'Good

Samaritan' parable provides a popular exemplar (Volkmann Simpson et al., 2014, Hem and Heggen, 2004, Sznaider, 1998). This conceptualisation presents compassion as a personal quality or 'gift' (Bolton, 2000, Way and Tracy, 2012) bestowed unidirectionally to the sufferer. It is a perspective that has dominated compassion research, and Fernando and Consedine (2014) argue that it has encouraged a monolithic focus on HCP characteristics.

2.5.3 Structuration theory

As noted above, I apply structuration theory (Giddens, 1984, Hardcastle et al., 2005, Stones, 2005) to illuminate aspects of the study findings. I fully demonstrate the application in the findings and discussion chapters, but outline it briefly here.

The notion of 'duality of structure' is the central concept of Giddens' theory and refers to the dynamic interrelationship between agency and social structures, so that they are understood as one 'thing' with two aspects (Craib, 2014, Hardcastle et al., 2005). From a research perspective, then, the focus is neither on individual experience nor on social structures, but rather on 'social practices across time and space' (Giddens, 1984, p2). Neither aspect is given primacy, although Giddens has argued that people are not 'puppets' controlled by social structures (Nairn, 2009). Instead,

individuals have 'reflexive capacity', or an awareness of the context of social life, which can be harnessed to understand 'how things are' and to contribute to that (Purkis, 1996). Through reflexivity, people observe, test and reflect upon their own and others' conduct, and this informs subsequent social interaction and practices (Foley et al., 2015). In this way, human action has the capacity to 'transform' social structures through 'skilled accomplishments' and knowledgeable interactions (Hinder and Greenhalgh, 2012, Stones, 2005). These interactions underpin social order and provide a sense of predictability or security about the world (Giddens, 1984).

However, it is argued that Giddens neglects the issue of power, and further that he overestimates the capacity for individual free will (den Hond et al., 2012, Hardcastle et al., 2005). Hinder and Greenhalgh (2012) argue that 'capacity' to act and make decisions about how to 'be' in the world implies a choice, and therefore the freedom to make that choice. However, as den Hond et al. (2012) note, Giddens ties power to the ability to know, access and draw from social structures; therefore, power is both fluid and context dependent.

Social structures are constituted by rules and resources, which include norms, language, political-economic institutions, technology and land (Hardcastle et al., 2005). All can be

thought of as ‘virtual properties’ that enable or constrain people’s actions and choices (Hinder and Greenhalgh, 2012, Hardcastle et al., 2005). These rules and resources are not independent entities, but are given meaning as individuals draw from, perpetuate, and shape them (Hardcastle et al., 2004). The changeable nature of social structures is important, as it implies that individual capacity to utilise them is also variable (Foley et al., 2015). This is central to my application of the theory, as it explicates how staff are at times enabled to give compassionate care, and at others inhibited.

O'Reilly (2015) criticises Giddens’ view of structure and agency as too ‘tangled’. However, it is precisely the complex enmeshment of the two that helped to explain my findings. The struggle experienced by staff as they enacted compassionate care in their everyday practice related to a tension between structure and agency, but not as two distinct phenomena. Instead, there was a dynamic interrelationship between them, as caring compassionately involved a continual push and pull between individual motivation and intent, and multiple structural constraints.

2.6 Conclusion

In this chapter I have situated the study on macro and micro levels. I have suggested that the study is shaped by events 'across time and space' (Giddens, 1984, p2), such as the global compassion movement, the problems in NHS care and sociopolitical perspectives on contemporary nursing.

I then reviewed the empirical nursing research on compassion to locate the study more specifically, and to show how I developed the study focus and design. I identified that there was a need to conduct a contextualised examination of compassion using an expansive, reflexive approach. I then set out the specific research aim and objectives before introducing the key perspectives and concepts that inform the thesis. The next chapter provides an account of the research design and process and the theoretical influences on these choices.

Chapter three: Methodology, design and methods

3.0 Introduction

The methodology of this study was a constructionist ethnographic approach, employing participant observation and interviews for data collection, and thematic analysis for the abductive analysis of the data. This was one approach to my research question, designed against a backdrop of diverse and evolving qualitative methodologies (Finlay, 2013). The diversity means that the possibilities for conducting research that requires an alternative to positivistic inquiry are numerous and exciting, but navigating the methodological choices can be confusing (for novice researchers). In this chapter I present the influences and rationale underpinning my methodological choices and the implications this has for the findings.

The chapter is structured in three sections. I begin with the philosophical and theoretical influences on the study and relate these to the research aim and design. Then, I outline three overlapping principles of qualitative research – ethics, reflexivity and quality – and show how they guided my research conduct. The topic and setting of the study raised numerous ethical issues, and I draw from fieldwork scenarios

to illustrate the challenges I encountered, and the role that reflexivity played in navigating them. Lastly, I detail the design and methods. I describe how I negotiated access, selection and boundaries for the study and demonstrate how the methods enabled me to address my aims, and to explore unanticipated elements of the topic.

I present the sections individually for clarity, but in practice these elements are inseparable (Holstein and Gubrium, 2008a). Mauthner and Doucet (2003) argue that a false distinction is made between the researcher, and the methods, methodology and epistemology they employ. They view the research process as an interrelated whole and argue that without a reflexive awareness of this, the personal, social and institutional context of the researcher is rendered invisible (Mauthner and Doucet, 2003, McCoy, 2014).

3.1 Methodology

Developing a critical account of methodological choices enables the researcher to appreciate the 'possibilities, conditions and limits' of their work (Brown et al., 2003, p20) while allowing readers to judge the quality of the study (Seale, 1999). Figure 3 given an overview of the methodological aspects in relation to the study aim.

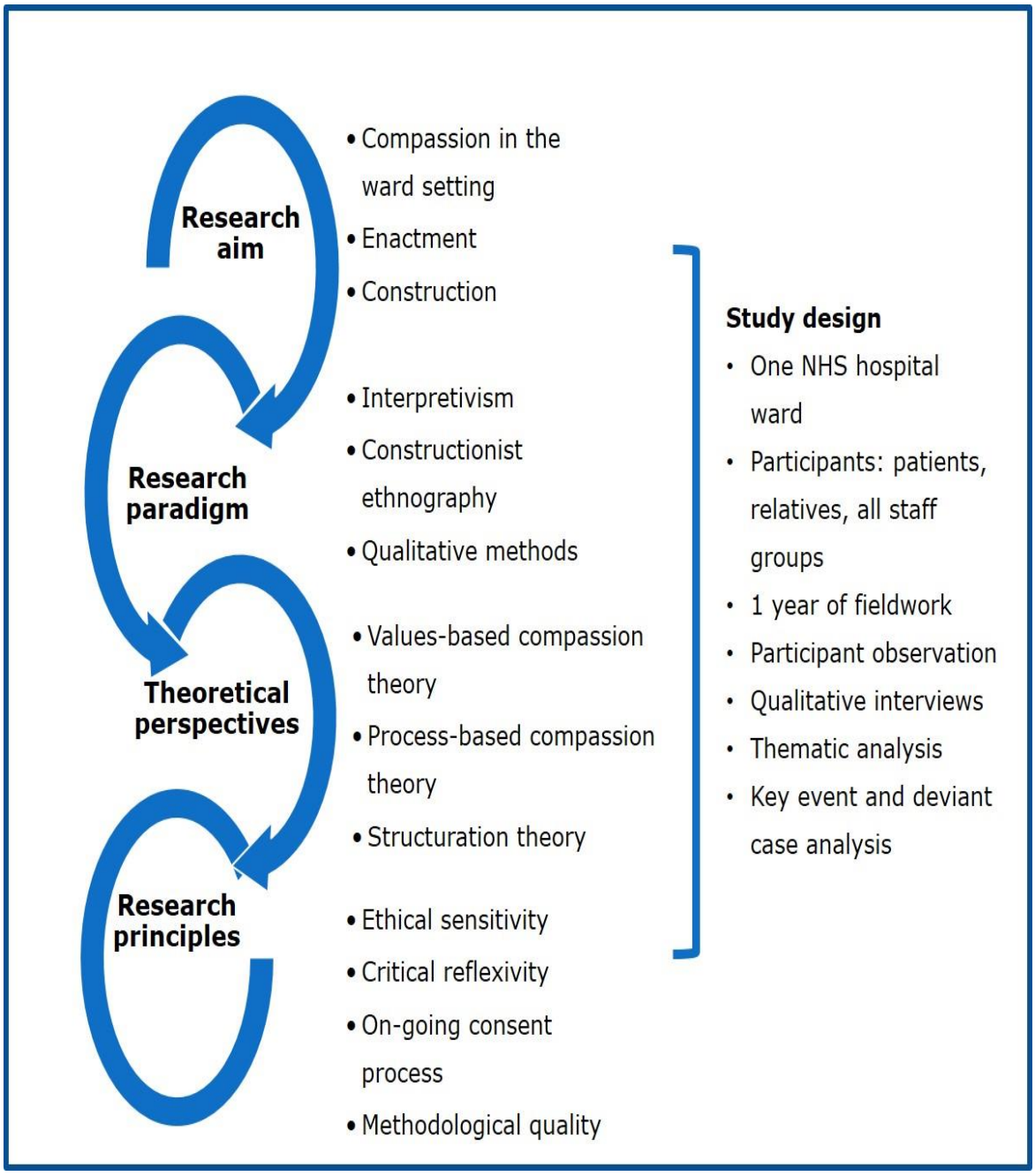


Figure 3 Overview of study methodology and design

3.1.2 Ethnography

I consider ethnography a methodological approach (O'Reilly, 2012, Pope and Mays, 2006) that is both process and product (Roper and Shapira, 2000). The aim of ethnographic research

is to construct an authentic account of the phenomenon, which broadens the scope of how the phenomenon is currently understood (O'Reilly, 2012, Murphy and Dingwall, 2007, McCoy, 2014). Though I consider ethnography to be a methodology, it is understood in a variety of ways, for example a theory, practice or data collection method (Nader, 2011, O'Reilly, 2015, Savage, 2000, Brewer, 2000). A general definition of ethnography is that it relates to the study of a social group and aims to identify, interpret and understand the associated culture within a specific context (Holloway and Wheeler, 2002, Murphy et al., 2014). I have used O'Reilly's description as an orientating definition, as this best reflects my understanding of the approach:

> *Ethnography … examines social life as it unfolds, including looking at how people feel, in the context of their communities, and with some analysis of wider structures, over time; that also examines, reflexively, one's own role in the construction of social life as ethnography unfolds; and that determines the methods to draw on and how to apply them as part of the ongoing, reflexive practice of ethnography.*
>
> (O'Reilly, 2012, p1)

There is consensus regarding a number of typical ethnographic characteristics. For example, studies generally involve multiple methods and data sources and use participant observation as a primary method (Fetterman, 2010, Brewer, 2000). However, the use of these will tend to likely change as the researcher gains a better understanding of what best illuminates the phenomenon (Brewer, 2000, O'Reilly, 2012). Fieldwork is generally of a significant duration, although in recent years the use of shorter time frames is becoming more popular (Knoblauch, 2005). Sufficient time is necessary, however, to develop familiarity with the field and its people, processes and practices (Seymour, 2007, O'Reilly, 2008, Bonner and Tohurst, 2002). The immersion and understanding that develops from this deep engagement allows the researcher to discern the 'strange' in the familiar routines, which is otherwise hard to discern (Savage, 2000, Swinglehurst et al., 2011, Hammersley and Atkinson, 2007). The researcher is then better equipped to richly describe their account of the phenomenon in its local and broader context (Hammersley and Atkinson, 2007). Lastly, data collection, analysis and writing up are concurrent, though there are likely to be phases where one element is more dominant (O'Reilly, 2008). A critical consideration of the researcher's role in constructing the findings should weave throughout the reporting of the study, so that the final account

reflects the influence of participants, the researcher and the temporospatial context (O'Reilly, 2008, Fetterman, 2010, Seymour, 2007).

3.1.2.1 Ethnography and nursing research

Ethnography has been used extensively to reveal the broad and complex range of care experiences that exists within hospitals (Roper and Shapira, 2000, Savage, 2006, Long et al., 2008). It offers researchers a framework to examine the invisible contribution that 'mundane' organisational routines (Swinglehurst et al., 2011, p2) make to nursing practice and culture. In terms of nursing research, complex phenomena such as hidden nursing practices (Manias and Street, 2000, Latimer, 2008), emotional labour (Sorensen and Iedema, 2009), dying in clinical settings (Seymour, 2000), intimacy (Savage, 1995) and stress (McGibbon et al., 2010) have all been addressed with ethnographic methodologies. Roper and Shapira (2000) describe how nurses, through their work, are familiar with observing, listening, gathering information and interpreting the meaning of these signs and signals. Perhaps most importantly, nurses are familiar with using themselves as a tool of work, and so may be comfortable with the reflexive nature of contemporary ethnography (Roper and Shapira, 2000).

Despite the shared characteristics of the research noted here, ethnographies can differ significantly according to the philosophical and theoretical standpoint of the researcher. Latimer (2008) notes that nursing research is often informed by multiple, cross-disciplinary theories. Some view such a pluralistic approach as advantageous, while others argue it lacks rigour (Mauthner and Doucet, 2003, McCoy, 2014, Latimer, 2008). However, O'Reilly (2012) posits that the value of ethnographic research is its focus on understanding the phenomenon or problem of interest, and from this perspective, the approach that best illuminates the phenomenon is the most appropriate for the study.

3.1.3 Constructionist influences

For this study, I considered that a social constructionist ethnography was beneficial for the topic and aim. As discussed in chapter two, I am concerned with current discourses of compassion in healthcare, and their relation to political agendas, unspoken assumptions, and the care experiences of NHS staff and patients. For example, terms such as 'compassionate' and 'uncompassionate' are used unproblematically (Volkmann Simpson et al., 2014) by the media, politicians and in healthcare documents, and yet are loaded with moral, professional and relational significance for the staff they often refer to.

A social constructionist perspective highlights how taken-for-granted knowledge about the world comes into being (Koro-Ljungberg, 2008). Knowing is understood as a product of an intersubjective world and the interactions, communication and social practices of those within it (Berger and Luckmann, 1991). For researchers, this perspective urges an active focus on *how* social phenomena like compassion are brought into being in these ways (Holstein and Gubrium, 2008). Part of this process is to critically consider the relationship between social phenomena, knowledge production, social practices and the wider context (Burr, 2015, Bury, 1986, McCoy, 2014). This perspective therefore highlights why some discourses became dominant and others marginalised. The following quote illustrates the active, questioning approach of the constructionist ethnographer:

> *[The researcher] questions how social realities are produced, assembled, and maintained. Rather than trying to get inside social reality, the constructionist impulse is to step back from that reality and describe how it is socially brought into being.*
>
> (Holstein and Gubrium, 2008, 375-6)

Crucially, this approach has people as a central concern (Latimer, 2008). It seeks to engage the people who, through

social interactions and discursive practices, shape and are shaped by social phenomena (McCoy, 2014). In terms of compassion, this approach enables me to convey how current discourses influence the everyday lives of those within hospital settings. Lastly, for nursing research, constructionist ethnography can provide a richer and more nuanced account of nursing research than the reductive and decontextualised interpretations that currently dominate (Latimer, 2008, Allen, 2004a, Allen, 2004b).

In the next section, I briefly outline the interpretivist roots of social constructionism and ethnography. However, their development from radical methodologies to mainstream research was not linear, and both are interpreted in various ways depending on the discipline, aim and research context (O'Reilly, 2008).

3.1.4 Philosophical influences

Constructionist ethnographic research is associated with an interpretivist paradigm, and figure 4 depicts the philosophical, theoretical and methodological aspects of that paradigm in relation to this study.

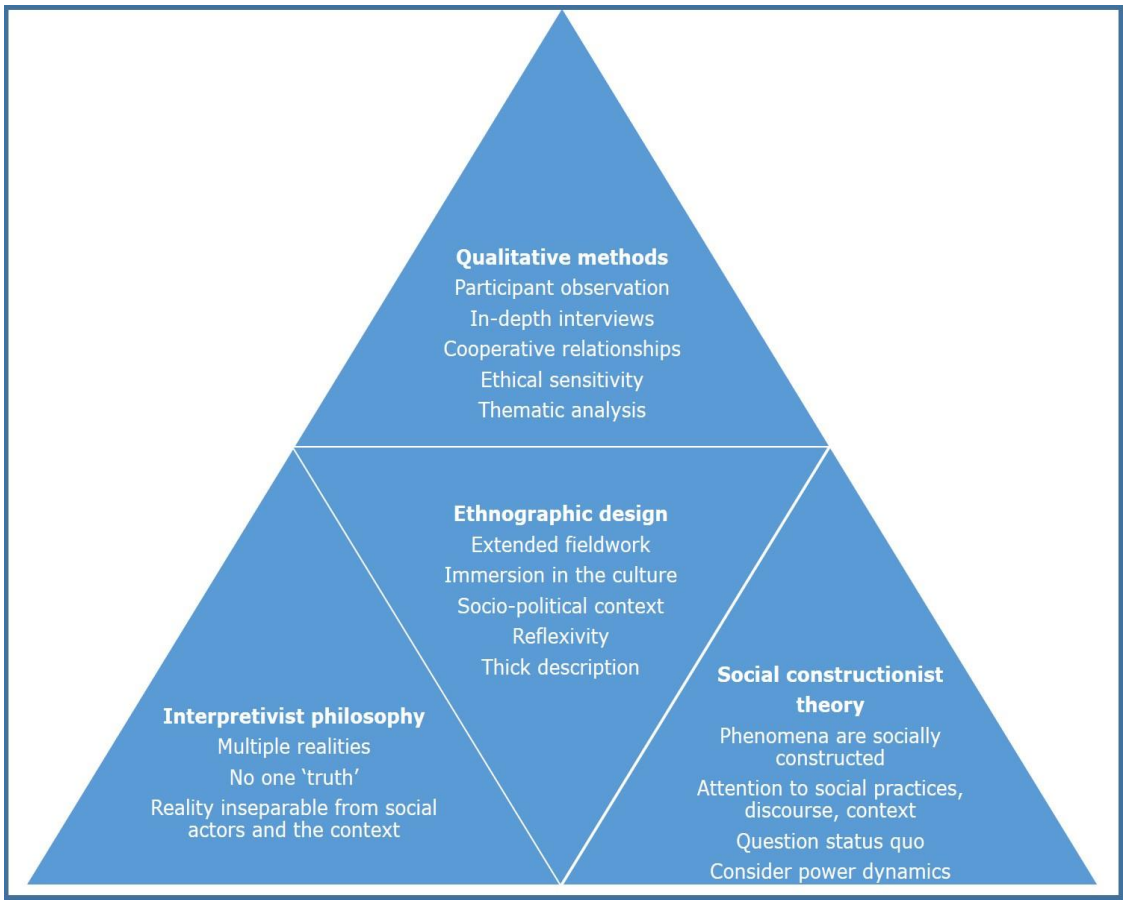


Figure 4 The research paradigm for the study

Situating an ethnography within an interpretivist paradigm is not unusual today, but epistemologically, this mode of inquiry contrasts sharply with early ethnographies. In the 1900s the prevailing realist philosophy and positivistic research paradigm encouraged researchers to investigate social phenomena in the same manner as the natural world (Scotland, 2012, Parahoo, 2014). Ontologically, a realist philosophy understands reality as a fixed entity (Grix, 2002), or assumes that a 'real world' exists independently of our ideas (O'Reilly,

2008). Therefore, knowledge production involves the 'discovery' of phenomena, and laws that can explain or predict social life (Bury, 1986). The positivistic process of inquiry prioritises objective collection of empirical data and the testing of conclusions and theories (O'Reilly, 2012, Parahoo, 2014).

The early ethnographies were rooted in this intellectual climate, and further shaped by the anthropological background of the researchers (Deegan, 2001). They tended to view the culture of interest as an 'exotic other', and aimed to objectively collect data from people's lives as facts (O'Reilly, 2012) and leave with a picture of how things 'are' (Rashid et al., 2015). Examples of this work include Mead's study of life in Samoa (1928), Malinowski's exploration of New Guinean culture (1922) and Radcliffe-Brown's investigation of Andaman Islanders (1922). These studies are considered seminal, and their focus on the wider context of social phenomena, substantial length and depth of field engagement, and use of multiple methods and data sources shaped the development of ethnographic research (O'Reilly, 2012, Rashid et al., 2015, Deegan, 2001).

However, philosophical and social shifts over the nineteenth century encouraged a questioning of existing knowledge and modes of inquiry. The positivistic notion that we might wholly

know the social world came to be considered naive, while realist philosophy was increasingly perceived to be stifling and dogmatic (Burr, 2015). Interpretivism offered an alternative standpoint. Its central ontological conviction is that reality is inseparable from social actors and the context in which they exist (Parahoo, 2014, Holloway and Wheeler, 2002). Viewing the relationship between social actors and the world as dynamic and interactional opened the possibility of multiple realities existing simultaneously (Parahoo, 2014). German social theorists, such as Marx, Durkheim and Weber, played a key role in advancing research from this perspective (Deegan, 2001). Weber's concept of 'verstehen', for example, emphasised the value of developing an understanding of the social world from the subjective view of those being researched (Scott-Jones and Watt, 2010, O'Reilly, 2008). Through this subjective understanding, the researcher can better interpret the diverse meanings given to social phenomena within the context in which they occur (Holloway and Wheeler, 2002). An interpretivist mode of inquiry, therefore, is a dynamic process of understanding the motivations that shape human agency rather than a search to discover the external forces that direct it (Scott-Jones and Watt, 2010, Leitch et al., 2009).

Interpretivist philosophy was influential for a leading group of North American social researchers working in the early 1900s (O'Reilly, 2012). Based at the University of Chicago, their faculty was later referred to as the 'Chicago School' (Scott-Jones and Watt 2010). Led by sociologists Park and Burgess, and heavily influenced by the early anthropological ethnographies, the Chicago School produced pioneering ethnographic research. Deegan's (2001) review of the group's work cites Anderson's exploration of homeless men, Johnson's work on segregation in the American south and Whyte's study of the Italian-American community in Boston as key examples from the 1920s to the 1940s. Their use of the life history method and symbolic interactionist theory, and their attention to local cultures triggered significant developments in ethnography (O'Reilly, 2008, O'Reilly, 2012). However, despite a closer relationship between researcher and researched, an 'objective gaze' continued to construct the cultures under study as 'other' (Rashid et al., 2015).

Perhaps the most dramatic developments in ethnography took place from the 1960s onwards. Wider cultural and social shifts of this era prompted a questioning of the status quo, and a consideration of alternative ways of viewing the world. The studies of Becker, Bulmer and Goffman from the 1960s through to the 1980s scrutinised how participants made sense

of their environment and constructed order in their lives (Scott-Jones and Watt, 2010). The ways in which forms of language constituted social phenomena and structures gained particular attention (Latimer, 2008). Critical, feminist and social constructionist perspectives offered new modes of inquiry and challenged taken-for-granted notions of reality (O'Reilly, 2012, Bury, 1986). These perspectives shared a concern with issues of power, representation and contextualisation (Scott-Jones and Watt, 2010) and with reflexively accounting for the researcher's role in constructing the account (O'Reilly, 2008, Seymour 2000). Reflexivity is now integral to much qualitative research and involves a critical consideration of how the personal, social and theoretical position of the researcher is reflected in the conduct of the study (Allen, 2004a, O'Reilly, 2012, Hammersley and Atkinson, 2007). I discuss reflexivity in more depth shortly.

3.1.5 Limitations

Despite these epistemological developments and shifts, in health research particularly, positivistic assumptions retain a powerful influence (Latimer, 2008, Allen, 2004b, Paley, 1998, Rolfe, 2006). Ethnography, as well as other interpretivist methodologies, have been criticised for producing 'qualitative positivism' (Latimer, 2008, Hammersley, 2013). This relates to an underpinning assumption that lived experience of

participants is a 'reality' that can be accessed and known through the research process (Latimer, 2008). Mauthner and Doucet (2003) describe how during their doctoral studies, they approached the research from an explicitly interpretivist standpoint, but later identified that they had implicitly assumed their interview accounts directly reflected participant experiences. They did not fully appreciate the roots and influences of these assumptions until the studies were over. Mauthner and Doucet (2003, p419) describe a 'positivist pressure' to meet scientific research ideals or traditions. The lack of awareness of how influential the positivistic tradition is reflects its historical dominance, and suggests why it is so hard to 'shake off' (Wien, 2005).

Similarly, the social constructionist methodology is criticised for being inherently contradictory or a 'victim of its own critique' (Maze, 2010, Stam, 2001). Constructionist researchers are accused of denying that any assertion can be 'true', and yet asserting truth claims in their own work (Maze, 2010). However, Edley (2001) argues that such a critique is based on a conflation of the ontological and epistemological aspects of constructionism. Edley (2001) draws from the work of Edwards (1997) and Danzinger (1997) to posit that critics misunderstand, or misrepresent, the constructionist distinction between representation and reality. He refers to seminal

constructionist work to demonstrate that historically there has never been a clear distinction between the two (Edley, 2001). Instead, it is *descriptions* rather than *entities* that are socially constructed, as discourses or discursive practices bring objects not into being, but into our understanding (Edwards, 1997).

Maze (2001) asserts that constructionist research has strength in exposing the 'logical fictions' of social constructs. From this perspective, researchers can scrutinise and articulate how certain phenomena are constructed according to particular agendas. Maze (2001) uses the examples of 'altruism', 'antisocial' and 'womanly' to argue that descriptive terms are often infused with moral significance and presented as 'intrinsic' qualities. I have argued in the previous chapter that 'compassion' is a social construct that has been morally and politically imbued to serve particular agendas. In that sense, constructionism offers an appropriate framework to examine the various ways compassion is conceptualised, and why. In addition, constructionism coheres strongly with the ethnographic design and qualitative methods.

Like ethnography, both have been criticised for 'political paralysis' (Edley, 2001) and offering little contribution to practice (Hammersley, 2013). However, Hammersley and Atkinson (2007) link this criticism to an overestimation of the

political and practical value of research generally and an underappreciation of modest contributions to knowledge. I would argue also that the practical influence of any study depends on how the researcher articulates, shares and employs the findings, regardless of the methodology. As noted earlier, I engaged various members of the host organisation in the study from an early stage and hope that from that I can make a locally practical contribution.

Lastly, although constructionist ethnography overlaps with other interpretivist methodologies, I inevitably illuminated some aspects of compassion in the clinical setting and neglected others by taking this approach. An explicitly feminist approach, for example, would have emphasised the role of gender in the framing of NHS care problems and the subsequent media and political response. Critical theories may conversely have focused on the discourses of professional power and techniques of control, of both individuals and staff groups. The value of these theories for the study would have been in magnifying particular elements (e.g. gender, power) and scrutinising their role and impact. However, my aim was to expand the current narrow and individualised view of NHS care problems to take in the multiple wide-ranging influences on compassionate care. A social constructionist ethnography offered the best framework for this. It allowed me to centralise

the phenomenon of compassion, but to show how it takes the 'shape and meaning' (Bury, 1986) ascribed to it in that time and space through everyday practices, language and social structures (Al-Saggaf and Williamson, 2006, Holstein and Gubrium, 2008b). I could thereby explore the dynamic interrelationship between sociopolitical influences, relational practices and participants' experiences of giving and receiving care.

Before detailing the practical methods of researching compassion, I briefly discuss the ethical, reflexive and quality issues of the study. These three aspects weave throughout the entire research process, and I introduce them here to explicate their fundamental position to the overall inquiry.

3.2 Ethics

Qualitative researchers are increasingly advised to develop an ongoing ethical sensitivity, rather than to view only certain aspects (for example, consent, vulnerable participants, confidentiality) as being of ethical concern (Murphy and Dingwall, 2007). This was the approach I adopted, as it was appropriate given my topic and setting. I have noted the political and professional sensitivity of compassion, and this meant it was important for participants to feel safe in the setting while the research was taking place. Confidentiality

and a non-judgemental approach were also important. It can be emotional and sometimes distressing to discuss experiences of care; therefore, the pastoral support of participants was important, as was being mindful of my own emotional responses. The highly pressurised acute ward setting intensified the potential for distress, and it was incumbent on me to ensure the study did not impede the work of staff. Lastly, my nursing background gave me the skills to manage some of these issues, but also complicated the researcher role (Allen, 2004a). I now detail how formal ethical frameworks and an ongoing ethical reflexivity supported my management of these issues.

From a formal perspective, I adhered to the University of Nottingham research guidelines and undertook the National Institute for Health Research *Good Clinical Practice* training. As a registered nurse, I was also used to acting in accordance with the Code of Professional Conduct (NMC, 2015). I sought advice from experienced healthcare researchers in the university prior to applying for ethical approval, and received a favourable opinion from the local Research Ethics Committee (see appendix 2).

The institutional research advice recommends that researchers set up a Patient and Public Involvement (PPI) group. In the

last decade, it has become more common to ensure an independent lay perspective on the research process, which means that studies are ethically conducted and have a wider social resonance (Staniszewska et al., 2011). The PPI group for this study was a group of service users with a long-term condition that met monthly for peer support. The group provided invaluable feedback on my conduct throughout the research, and my interpretations of events.

Overall, the formal ethics advice and review processes were beneficial in encouraging me to anticipate and plan for likely problematic scenarios. For example, I developed a plan of action should I become aware of poor practice, a risk to welfare or participant distress. I also developed a protocol for my remit on the ward. I shared this with ward staff at the beginning of fieldwork so that they were aware that I could not act clinically, but in an emergency, I would respond appropriately. Although it was helpful to be prepared for these problematic scenarios, in practice they did not cause me any dilemmas, because the best course of action (notifying the ward manager or nurse in charge, or discussing events with the supervisory team) was generally clear.

Conversely, it was the less dramatic, everyday experience of observing people in pain or distress that created a sometimes

paralysing dilemma for me. This included listening to a confused elderly patient searching for her mother, comforting a newly qualified nurse who was crying from exhaustion and anxiety, supporting a patient who had just learned his disease was terminal, and watching a patient writhe in agony as she waited for her pain medication. As a nurse, I had the knowledge to improve these situations, and I often questioned whether I was acting ethically (or compassionately) by not intervening. However, I was also worried that my intervention may contravene my conditions of access or ethical approvals. Furthermore, my role in the setting may have shifted towards the clinical and away from that of researcher. I found negotiating these ongoing quandaries to be emotionally draining and destabilising.

Two scenarios illustrate the kind of everyday ethical challenges I encountered. The first was with Sue, a patient I had talked to several times. On one occasion I approached her just after she had seen her medical team and been told that she had heart disease, which needed urgent treatment. Sue had not fully understood what the medical team were saying, and when I approached her she was highly agitated. She was convinced she would die imminently, and she began to worry about how her husband would cope and to discuss her estranged relationship with her son. Sue cried for some time and I

stayed with her until she settled. On leaving her I felt compelled to relieve her confusion about her condition. I spoke to Sue's nurse, who understood the source of the misunderstanding and arranged for someone to go back to Sue. I realised then that by explaining the scenario to the nurse, I had breached Sue's confidentiality. Sue had not consented to me sharing our conversation, and more importantly had not actually asked me to help. Later that week, I explained my actions to Sue and apologised. She told me she was glad I had intervened, as she felt better informed and reassured after speaking with the doctors again. However, I continued to feel uneasy that the situation could easily have had a negative outcome.

After this I was more cautious. I found I was over-analytical and inhibited in how I reacted to events. In one scenario, I chose not to intervene where I normally would have without hesitation, and I later regretted this. I became aware of a distressed patient, who was in severe pain. She had a long wait for pain medication, and then for the medication to take effect. The response from the care team was inadequate due to several concurrent issues on the ward. An unregistered staff member was trying to support her, but I felt sure that a more confident manner, a hot compress and drawing the bed curtains would be more effective. The patient looked directly

at me, but I rationalised that medication had been given, she was not alone, and I might offend staff by stepping in. The same patient later responded to one of my study flyers on the ward, requesting to participate in an interview. However, I found the interview difficult and later reflected that I felt ashamed of my failure to act, which affected my ability to engage with her openly.

These examples happened early in the fieldwork. Analysing them reflexively helped me to understand that I was feeling distressed at witnessing suffering and that this sometimes caused me to act impulsively to relieve my distress. Furthermore, my nursing background meant that I felt compelled to act in situations that resonated with my clinical experience. However, analysing such quandaries with more experienced colleagues provided the most fruitful source of support. One colleague cautioned against underestimating the 'emotional burden of observing without intervening', a thought which has stayed with me throughout the research. These colleagues helped me to refocus on the relationship between my interpretation of events, my personal experiences and events in the field (Woolgar, 1991, Mauthner and Doucet, 2003, Hammersley and Atkinson, 2007). This enabled me to develop a deeper understanding of how I was an integral part of the field itself and how reflexivity provided a way of

harnessing my emotional responses as a 'springboard' for my interpretations (O'Dowd, 2016, Koro-Ljungberg, 2008).

These discussions also led me to develop several case studies of ethically challenging scenarios from my fieldwork, which we used to provide resources for other researchers in the university. Furthermore, the university are using the case studies as a training resource for local Research Ethics Committee staff, to be delivered in 2018.

I also encountered ethical challenges in relation to methods of consent, participant observation and qualitative interviews. I discuss these in the upcoming data collection methods section of this chapter. I now turn to reflexivity, which overlaps significantly with ethical issues, and discuss its significant role in constructionist research.

3.3 Reflexivity

Intersecting with an ethical approach to research is a concern with notions of reflexivity: a practice of self-reflection and self-referral which proceeds concurrently with the process of inquiry (Woolgar, 1991). For all qualitative research, reflexivity offers a way of self-critically accounting for how the research was conducted (Seale, 1999). For constructionist ethnography in particular, it is an integral part of the entire research process, involving a continual sensitivity to how the

researcher's social position, perspective and context shape the study (O'Dowd, 2016, McCoy, 2014). It is inseparable from epistemological notions of how, and in what context, knowledge is produced (Holstein and Gubrium, 2008b, McCoy, 2014).

Despite the fundamental role of reflexivity, there is little discussion of how it is practically achieved (Mauthner and Doucet, 2003). Reflexive journaling is one practical suggestion. This enables the researcher to articulate and then analyse the influences on their decision-making (Carolan, 2003, Pellatt, 2003, Green and Thorogood, 2013). I did this by allocating a column of my field note book and transcription documents to my immediate responses to events and participants' words. This helped me to recall and incorporate my feelings at the time of the event and to link my interpretations to wider personal and contextual factors (Woolgar, 1991). For example, certain events and terms used by participants would trigger memories of my own experiences as a nurse, or might connect to a wider event such as the national strikes by junior doctors in early 2016. Having my immediate response documented next to the field notes and transcriptions also helped to keep my subjective reporting of events visible, especially during periods of intensive data

analysis, when it was easy to get lost in the data (Mauthner and Doucet, 2003).

A more challenging strategy for ensuring that reflexivity is sufficiently analytical is to make the process public (Coghlan and Casey, 2001, Aranda, 2006). I exposed my findings to the scrutiny of others at various stages of the process, and although public criticism is difficult to receive, it was highly beneficial. For example, my plan to conduct the study on three separate wards was thoroughly criticised by my academic peers. This led to significant critical discussion on what I thought this would achieve. I realised I was aiming for a type of generalisability and that my understanding of ethnographic quality at that stage was inadequate. I altered the design to one ward and was quickly able to appreciate the benefits of the deeper focus it allowed.

I also had cause to reflect on a difficult personal experience during fieldwork. My young son became unexpectedly critically ill, and the reflexive consideration of how this influenced the study was something I could not fully do until some time after his recovery. Talking with a colleague about the experience, I remarked that we had not been well cared for. My colleague pointed out the difference in how I spoke of my son's care, and of care in the study setting. After much reflexive work, I

realised I was more sympathetic towards inadequate care in the study setting than I was in relation to my son's care. I had not previously appreciated how fear and emotional vulnerability can affect patients' perspective and until then had not incorporated this in my consideration of service-user data. My fieldwork shifted after this point, and I had a greater awareness of how my own identity and emotion affected my interpretations in the field.

The ways in which my nursing identity shaped my interpretation were also important to consider (Pellatt, 2003, Goodwin et al., 2003, Allen, 2004a). It was advantageous in many respects, allowing me to draw from experience to anticipate staff concerns about the research and support distressed participants. It also gave me a nuanced understanding of the context, language and practices of care. However, this perspective may conversely have meant that I missed aspects of the culture that were too familiar to be noticeable (Seymour, 2007). Again, sharing my findings with non-nursing research colleagues often pointed out where this was the case.

Finlay (2002) highlights the importance of the researcher's awareness of the 'emotional investment' they have in research relationships. For me, nurses, ward support staff and patients

were the groups most represented in the data. I had experience of all these roles and so shared commonalities with these participants and developed rapport more easily. I was also conscious that these groups had a 'weaker' public or professional voice, and I was keen to represent their experience adequately. It was crucial to maintain my awareness of how these factors affected my fieldwork. Furthermore, these groups were most frequently on the ward, and therefore maintaining a positive relationship improved my sense of comfort in the setting.

Duncombe and Jessop (2002) present an interesting argument concerning how researchers 'do rapport'. A reflexive awareness of how one uses relational and emotional skills to generate intimacy with participants can expose unethical conduct. Duncombe and Jessop (2002) argue that a false rapport encourages participants to share more than they might if the researcher made the study agenda more obvious. The emotional nature of my fieldwork meant that participants often engaged with me as a source of support, an ally or, more rarely, a friend. Duncombe and Jessop (2002) advise that researchers 'worry' about how they use the information arising from such interactions. I analysed these exchanges carefully and treated them individually, often omitting or adapting the data accordingly.

However, there are limits to how reflexive the researcher can be while conducting the research, and this should be acknowledged (Silverman, 2011, Finlay, 2002, Seale, 1999). Mauthner and Doucet (2003) describe how they were only able to fully appreciate the influences on their research some years after their doctoral studies were complete. This suggests that reflexivity is an ongoing process, and one that improves with the experience of the researcher. A commitment to reflexivity also demonstrates that the researcher is concerned with providing a transparent account of their work, so that readers might better judge its quality. The next section addresses markers of quality research and the framework guiding my approach to the study.

3.4 Quality

Determining quality in qualitative research continues to be a contested issue (Seymour, 2007, Hammersley, 2006). This relates to the wider debate, discussed earlier, about qualitative research's relationship to dominant positivistic paradigms of inquiry (Hammersley, 2013, Mauthner and Doucet, 2003, Seale, 1999). Spencer et al. (2003) note a range of positions within this debate, from the belief that quantitative criteria can be applied to qualitative research, to the rejection of the notion of criteria for qualitative research altogether. For this

study, my approach to the research process as a whole has been guided by the framework developed by Spencer et al. (2003). This is advocated by the National Centre for Social Research (Spencer et al., 2003) and is depicted in figure 5. This thesis sets out my attempts to apply these principles to my research practice.

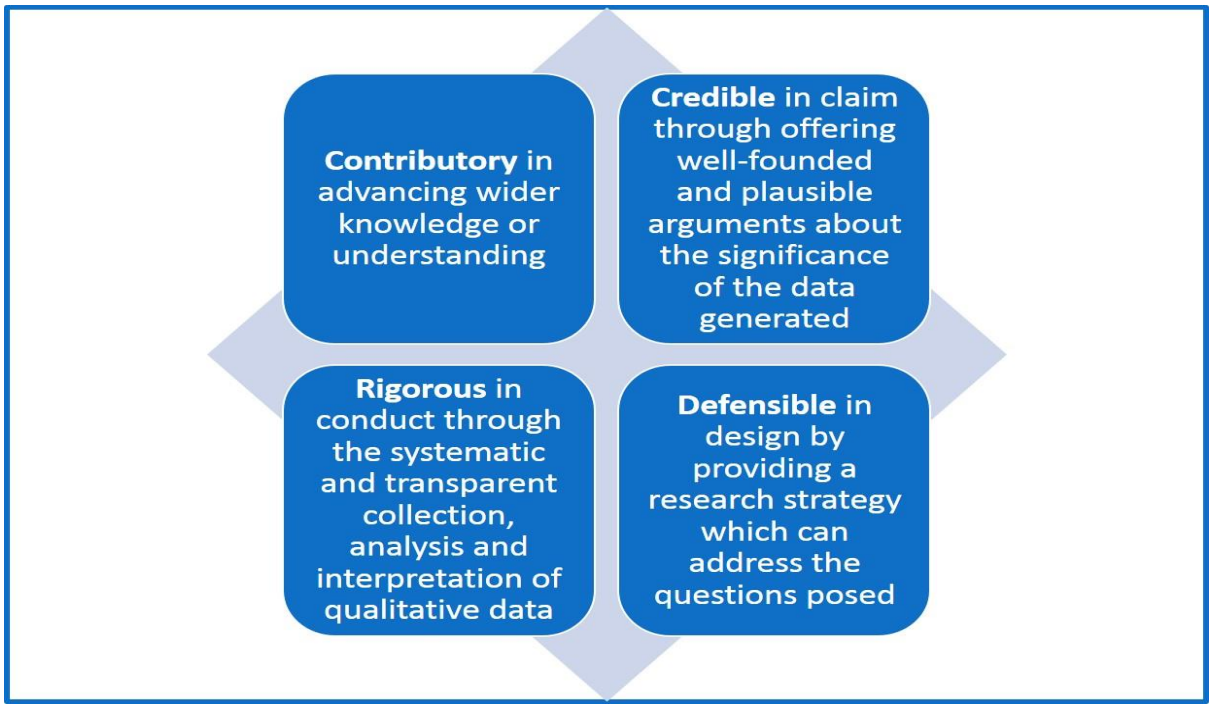


Figure 5 Principles of research quality

3.5 Study design

In this section I set out the design details of the study in order to give a transparent account of my conduct and the research process overall (Spencer et al., 2003). I describe specific aspects of the design and methods, including the selection of

the setting and participants, the methods of data collection and analysis, and reporting. I begin with a brief outline of the study design. Figure 6 shows the main design elements.

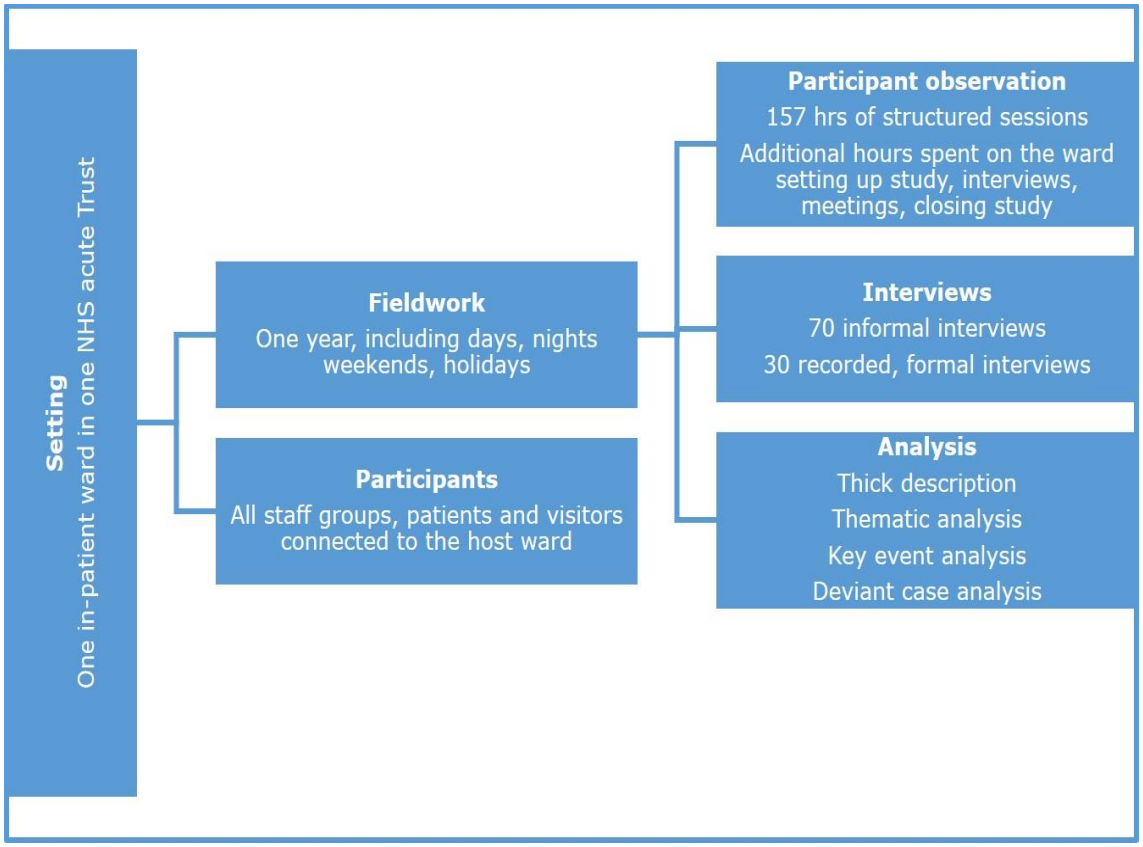


Figure 6 Study design

I conducted the study on Hazel ward in Oakfield Hospitals NHS Trust (OHT)[1]. Participants were all adult individuals connected to the ward, and included staff groups, patients and visitors. Fieldwork lasted one year and involved participant observation, informal interviews and recorded in-depth

[1] All names and locations are referred to by pseudonyms in order to protect anonymity of the setting and participants.

interviews. I used thematic, deviant-case and key-event analysis, and wove thick description throughout the presentation of findings.

3.5.1 Setting selection and access

Oakfield Trust is a large acute NHS trust in England. It employs around 15,000 staff and serves 2.5 million local people annually, while providing specialist services to a further 3 million people from neighbouring counties (OHT, 2017). There are two main sites: Poplar and Birch. Hazel ward is within Birch site and is one of five wards which share a medical speciality. These five are referred to as Willow Unit. Figure 7 overleaf depicts this configuration.

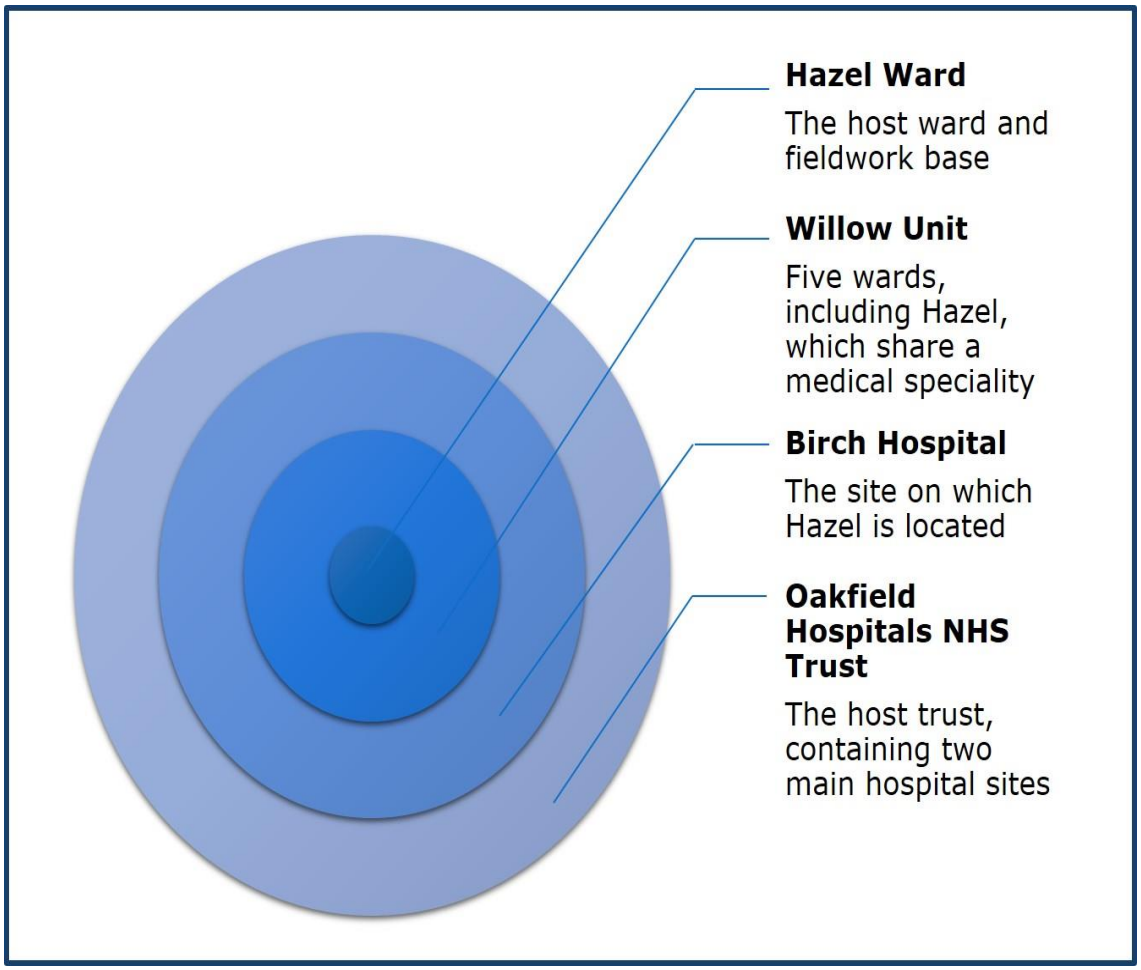


Figure 7 The study setting

I selected Oakfield Trust as the host site for several reasons. To aid my transition from full-time nurse to nurse-researcher, it was helpful to conduct the study in a setting where I had no clinical connections (Allen, 2004a). Given the context of my research, it was also necessary to choose an NHS hospital setting. More practically, Oakfield was easy to travel to, which was essential for long fieldwork sessions at all times of the day.

3.5.2 Ward selection and access

The aim of selection in ethnography is to identify the setting or case that best demonstrates the phenomenon and context (Luck et al., 2006, Hammersley and Atkinson, 2007, Silverman, 2011). I therefore looked for a ward that was average in aspects such as size, staffing and patient population. Although there are no 'typical' wards, as each has a unique culture and characteristics, a ward with a distinct speciality (such as paediatrics, intensive care or midwifery) would introduce an additional 'subculture' that would detract from the research aim. I chose a single ward rather than several to enable a deep investigation of the phenomenon, related practices and wider context (O'Reilly, 2012, Fetterman, 2010, Holstein and Gubrium, 2008a). Choosing a ward that was characteristic of many others across the county and developing a deep understanding of its culture also enabled me to consider the transferability of findings to similar settings (O'Reilly, 2012, Seale, 1999).

The initial contact with Oakfield was an email recruitment advertisement written by myself and circulated by my associate supervisor to all clinical leads (appendix 3). My supervisor held a senior research post at Oakfield, which facilitated access to the trust by providing an efficient way of reaching a large number of senior ward staff. However, I was

concerned that the involvement of my supervisor may pressurise clinicians into taking part. To address this, I subsequently conducted all ward selection and access negotiations independently, although I discussed my progression with my supervisory group as a whole. I independently applied to Oakfield research unit for permission to conduct the study there, with my academic institution as sponsor. They granted access (appendix 4) once I had received NHS Research Ethics Committee approval.

I compiled a shortlist of potential wards. I eventually selected Hazel ward for several reasons. Firstly, it had a diverse patient population – which included those with acute and chronic conditions, young and older patients, and long-term patients with social care problems – and provided specialist palliative care. Although it was a female-designated ward, it had eight side rooms that were generally occupied by male patients. Secondly, at the time of recruitment, Hazel ward was stable and performing averagely according to Oakfield parameters. There were some staffing issues and problems related to an earlier, more chaotic period, but overall the ward could facilitate the study without it being burdensome. Its staffing, size and management structure also suggested it was representative of other NHS medical wards, which would

enhance the wider resonance of the findings (Hammersley, 2013, Gobo, 2008).

It is important to briefly note the characteristics of the wards I did not select, as this indicates what my research missed, or how my findings might have been different (O'Reilly, 2012). The excluded wards were typically in a state of turbulence, and had serious staffing issues and/or extreme operational pressures. A clinical lead or senior manager had put them forward for participation, but when I met with the ward team, I received an ambivalent or apathetic response. Many clinical areas across the county are in similar circumstances, and it is important that research examines the barriers to compassionate care that they face. Nevertheless, the ward must also be able to facilitate the study in some ways. It was very difficult to organise even the preliminary selection meetings due to cancellations, staff not turning up or lack of engagement. In view of that, I did not feel I could address my specific research aim in these settings. However, spending time on these wards during the period of site selection contributed substantially to my understanding of the organisation as a whole.

3.5.2.1 Defining boundaries

Hammersley (2006) warns that it can be problematic to boundary ethnographic research, especially when the wider context is relevant to the aim. Hospitals present a particular challenge, as their borders are fluid, with people continually moving back and forth across wards, units and the local community. It was therefore necessary for me to define some boundaries in order to practically manage and focus the fieldwork (Atkinson et al., 2001, Fetterman, 2010).

I considered Oakfield Trust as the broad perimeter for research activities, and Hazel ward as the unit of analysis (O'Reilly, 2008, Hammersley and Atkinson, 2007, Gobo, 2008). As an 'interactive' unit, the ward was a field in which the characteristics of social processes could be easily observed, making it an appropriate choice (Gobo, 2008). However, to accommodate the emergent nature of constructionist ethnography and allow me to flexibly respond to events in the field, the boundaries of the setting were necessarily permeable (Atkinson, 2015, Silverman, 2011), and I regularly moved outside of the ward to areas across the entire trust site. For example, I attended trust meetings with Hazel staff, followed participants who had moved to other wards and met with corporate staff to gain additional information about organisational issues.

Within-case sampling is also crucial, as it is impossible for researchers to cover all aspects of a setting (Hammersley and Atkinson, 2007). I chose to cover all parts of the 24-hour period, but not always according to the ward shift pattern. For example, at times I would arrive in the afternoon and leave at night, so that I was not always aligned with the working pattern of one participant group. Similarly, I spent time in all areas of the ward but chose not to observe in the ward staff room, so that staff participants retained a private space for respite.

The fieldwork time limit was one year, which was sufficient to experience how the culture changed across weekly or monthly cycles (Hammersley, 2006) and to interpret the cultural meanings and practices within that (Rashid et al., 2015). This duration enabled me to incorporate the effects of several major local and national events, such as a Care Quality Commission inspection and numerous external audits, two strikes by junior doctors, and two major organisational restructures. I also saw the impact of 'winter pressures' on staff – a national period of increased demand for hospital beds that in reality lasts for most of the year (O'Dowd, 2016).

3.5.3 Informing and accessing participants

A condition of my ethical approval was that I should sufficiently inform all in the setting about the research. Once the study details were finalised with the senior ward staff, I contacted all staff groups connected to Hazel ward via the ward secretary. This email gave study information as well as inviting questions and concerns. After this I began to visit the ward with information materials. This served a dual purpose of giving information, and having a lead-in period to the fieldwork. In terms of the information, I displayed a large poster in a prominent area, which remained until I completed the fieldwork (see image 1), as well as smaller flyers and leaflets in various places across the ward. All these materials included my photograph, contact details and a study outline, and encouraged people to get in touch.



Compassion in the ward setting: a study taking place on Hazel ward

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

A study is taking place on Hazel ward and at times you may be aware of research activities taking place here.

What is the study about? The study is supported by the University of Nottingham and the Economic and Social Research Council. We are investigating how compassion takes place in the hospital ward environment. We hope to develop our understanding about this so that we can enhance the compassionate environment of the ward for all those being cared for and working within it.

How will the study be conducted? The study will begin in July 2015 and last for 12 months. It will not interrupt the work of staff or the care of patients. These remain a priority for the ward.

We will gather information by a combination of observations, interviews, audio-diaries and documentary analysis.

Observation sessions will take at various times throughout the week. We are observing the usual activity of the unit, rather than individuals. No intimate care will be observed.

Ward notices will announce when an observation session is taking place. Please feel free to raise concerns at any time and we will find an acceptable alternative. For example, it may be appropriate to continue observing the nearby area. Or it may be preferable to move the observation to a different part of the ward. If you or your relative want to opt-out completely, the observation session could also be paused or stopped.

Donna Barnes is the principal researcher and is a nurse with 12 years' experience. She is happy to discuss any aspect of the study. Please approach Donna on the ward or leave a message at reception. Alternatively, call 07944684335 or email ntxdmba@nottingham.ac.uk. You can also speak to the ward manager if preferred.

Image 1 Information poster displayed on Hazel Ward

Visiting the ward to deliver these materials allowed me to progressively increase my time in the setting, meet with staff informally, discuss the study and generally orientate myself to the field. This gradual starting period is beneficial for developing confidence in the setting and allowing participants to get used to the presence of a researcher (Wolf, 2012, Bisaillon and Rankin, 2012).

My ethical approval conditions stipulated that ward staff must make first contact with patients and visitors. In the main, this was the discharge coordinator, who spoke to all new patients on admission or shortly after. She gave patients and relatives a study leaflet (appendix 5) and asked their permission for me to approach. We kept a communication folder in a locked office to note who she had spoken to and any issues.

3.5.4 Selecting participants

In terms of formal inclusion criteria, participants had to be over 18 years old, and connected to Hazel ward occupationally or as a patient or visitor. For the recorded interviews, the inclusion criteria were the same, but those who were unable or unwilling to provide consent were excluded. For observation sessions, anyone who wished to opt out, or who appeared uncomfortable with the observation, was also excluded. I discuss the details of opt-out consent alongside participant observation shortly.

Participant sampling in qualitative research is contentious. There are debates over the broader epistemological issues discussed earlier, and how the smaller numbers and non-random nature of qualitative sampling relate to generalisability (Gobo, 2008, Hammersley and Atkinson, 2007). My strategy was based on my research aim and field, and I therefore drew

from the population within Hazel ward, and those connected to it by occupation or as a visitor. I considered that this population were able to illuminate my aim, as they contributed to the social processes of care on the ward. For the participant observation, participants were those who were present in the field at that time (Fetterman, 2010, O'Reilly, 2012). As I became more familiar with the setting, I became more strategic and would try to observe or talk with certain people who could clarify my interpretation of a certain event. Several people became 'key participants' whom I engaged with extensively, because they had a broad overview of the ward and those in it (for example, because of their role or the length of time they had spent in the setting).

In terms of the interviews, I adopted a more selective approach, although it is still probably best described as convenience sampling (Gobo, 2008). I wanted to represent the composition of the field in order to explore the perspectives of all those who contribute to the social dynamics in the setting. Furthermore, the earlier literature review showed that compassion research often selects one participant group (for example, nurses or patients) for investigation. Hospital wards are spaces where multiple individuals and groups interact continually, and thus studying participants in isolation from the others may not accurately reflect social practices in the

field. I therefore aimed to interview people from all the groups I identified on Hazel ward (i.e., staff groups, patients, relatives). Table 1 shows how the various participant groups were represented in the interviews, and the fieldwork overall. It demonstrates that, as mentioned earlier, nurses, ward support staff and patients dominate.

Role	Recorded interviews	Informal interviews	Field note representation
Nurse	8	7	Substantial
HCA	2	2	Substantial
Student	2	3	Moderate
Admin	1	1	Substantial
Domestic	1	1	Minimal
Doctor	2	3	Moderate
Patient	3	45	Substantial
Relative	4	5	Moderate
Therapist	2	2	Minimal
Discharge team	2	1	Moderate
Corporate	3	0	Minimal
TOTALS	30	70	

Table 1 Participant groups featured in the fieldwork activities

Patients and relatives were fairly diverse in terms of age, family support, illness and time spent on the ward, providing a

range of perspectives within this group. I have discussed that I found it harder to engage allied health professionals (AHPs), medical staff and corporate staff and that this likely contributed to their under-representation. An additional barrier was the fact that they were present on the ward much less than the nurses, patients and support staff. In that respect the data is relatively representative of the ward composition.

3.5.5 Data collection methods

My main methods of data collection were participant observation and qualitative interviews, with some documentary analysis such as non-confidential paperwork and trust documents. From a constructionist perspective, compassion is a socially occurring phenomenon made visible through the practices and talk of those in the field (Allen 2004, Latimer, 2008). Consequently, studies are typically multi-method and incorporate forms of interview and observation (O'Reilly, 2012, Holstein and Gubrium, 2008). Additionally, the triangulation of both methods and sources means that the researcher's interpretations can be challenged or supported from multiple perspectives (Seale, 1999), thus exposing the nuances and contradictions inherent in the social practices of the field (Holstein and Gubrium, 2008b).

Fieldwork typically generates large volumes of data, which makes it challenging to retain research focus and to clearly demonstrate how the findings relate to the original data (Silverman, 2000). My management strategies included reflexive memo-writing while transcribing field notes and interviews, and close liaison with my supervisors to monitor that the data and aim were evolving congruently (O'Reilly, 2012, Fetterman, 2010).

Identifying phenomena such as suffering and compassion is notoriously difficult (Wilkinson, 2005, Sturgeon, 2008). I recognised compassion by first identifying suffering, and then considering how it was noticed and responded to. To interpret suffering, I relied on a range of indicators – for example, facial expression, body language and vocalisations, and prior knowledge of the person. Talking to the person, obtaining the views of others and looking for alternative explanations were also part of this complex process. As I explicate in the upcoming analysis section, the process of interpretation continued beyond the data collection.

3.5.6 Participant observation

Participant observation is a key characteristic of ethnography, and the two terms are often used interchangeably (O'Reilly, 2012, Brewer, 2000). Holstein and Gubrium (2008) argue that

the method is a source of both empirical material and analytic inspiration for social science researchers. For constructionist ethnographies in healthcare, participant observation offers researchers an 'inside' view of the interplay between the structural resources and social practices that shape interactions in clinical settings (Latimer, 2008). This affords the opportunity to richly describe *what* is happening, as well as *how*, by focusing on the practical activities that people enact to 'construct, manage and sustain' their social worlds (Holstein and Gubrium, 2008, p375).

3.5.6.1 Ethical issues around participant observation

The method preferred by ethics committees for gaining consent for observations is to secure written consent prior to observation. However, this presents substantial challenges for ethnographies set in wards, and an 'opt out' method is increasingly common (Denscombe, 2010, Moore and Savage, 2002). Opt-out consent is based on the premise that a hospital ward is a semi-public space, and that researchers can observe activities as any ward visitor could do (Houghton et al., 2010). The unobtrusive nature of observation, and the low risk of disruption to the setting or associated harm, support its use (Murphy and Dingwall, 2007). It is particularly effective for capturing the experience of frail patients who cannot participate in interviews (Lawton, 2001). However, the

researcher must provide or display sufficient information to inform and safeguard participants and to enable them to opt out (Lawton, 2001, Houghton et al., 2010). It was for this reason that I spent significant time on developing and making available a range of informational materials, as well as incorporating a lead-in period to discuss concerns. No one did raise any issues about observations, although I did on occasion adjust or stop sessions if participants seemed uncomfortable.

In the lead-in and early fieldwork periods, some staff made comments about my trying to 'catch them out' or to monitor 'how compassionate' they were. Although these were expressed in a jocular way, given the sensitivity of the topic for hospital staff I was concerned not to make people feel anxious or uncomfortable. I adopted an open and honest approach and made it clear I was not reporting on individuals, but observing the ward as a whole, and that if anyone felt concerned then I would stop. Aranda (2006) criticises measures aimed at reassuring participants, arguing that they actually serve the researcher's agenda. I would agree that the researcher's original purpose for developing a relationship with participants in the setting is to conduct their research. However, I would argue that when a busy, under-resourced setting agrees to support a project, the researcher feels a

genuine appreciation for this. Furthermore, my experiences both as a member of staff and as a service user mean that I am aware of the vulnerable position that participants have in relation to the researcher and of the need to be mindful of that power dynamic. Lastly, the nature and duration of fieldwork means that meaningful relationships are developed, and as a result I wanted to ensure my work did not negatively impact on others.

In practice, staff quickly became used to me, including me in social conversations and inquiring about the research. Within a few weeks, I was told I did not need to pre-arrange sessions, so I came and went unannounced. When those participants that continued to seem uncomfortable were present, I situated myself away from them and, at intervals over the fieldwork, checked with senior staff to see if the ward was happy to continue.

3.5.6.2 'Doing' participant observation

I conducted approximately 160 hours of observation in 46 separate sessions, where I went to the ward specifically for participant observation. However, I was in the field much more than just these sessions. For example, during the gradual lead-in period I visited the ward often, observing the atmosphere, people and activities while there. The fieldwork

exit period was similarly lengthy, and I attended the ward for meetings, interview recruiting and administrative activities related to the study during this time. In addition, I often arranged to meet interview participants on the ward before leaving for the venue, and I considered all these times in the field (the rest of the hospital as well as the ward) as observational opportunities. The planned observation sessions varied in length, but on average were three to four hours long. I observed during the day, overnight, at weekdays and weekends, and on some public holidays, including over the Christmas period to get a sense of the shift-related, temporal and seasonal changes in the setting.

Over the course of the fieldwork, there was a broad-to-narrow progression that is characteristic of ethnographic observation (Spradley, 1980). The emergent nature of ethnography means that the focus becomes clearer as the study progresses and the researcher becomes more familiar with the field (Hammersley, 2006). This was true of my fieldwork experience. Sessions were unstructured at the beginning, allowing me to take in the physical space and sense of the setting. Over time, I was more selective as I sought to clarify my interpretation of events, or to find out more about a specific person or role.

3.5.6.3 Negotiating the observation-participation balance

In order to 'get inside' the field, ethnographers need to pay attention to the sites, materials and practices of the environment (Latimer, 2008, Holstein and Gubrium, 2008). Overcoming the 'selective inattention' we maintain in ordinary life to prevent being overloaded with information, is one of the biggest challenges of participant observation (Spradley, 1980). Instead it is necessary to retune to the environment, in order to see it and hear it afresh. This is often more complicated for nurse-researchers observing within the familiarity of the healthcare environment (Allen, 2004a). Deciding and developing the appropriate balance between participation and observation, and research identity more generally is therefore crucial (Pitts and Miller-Day, 2007). However, regardless of the planned or preferred level of participation, achieving and maintaining this is a constant challenge and not always within the researcher's control (Bonner and Tohurst, 2002, Pitts and Miller-Day, 2007).

My intended level of participation in the field was decided after much reading and discussion with supervisors and other experienced researchers. Spradley's (1980) text on this topic was particularly influential. Spradley (1980) explicates the various stances the ethnographer might take, and these are set out in figure 8 below.

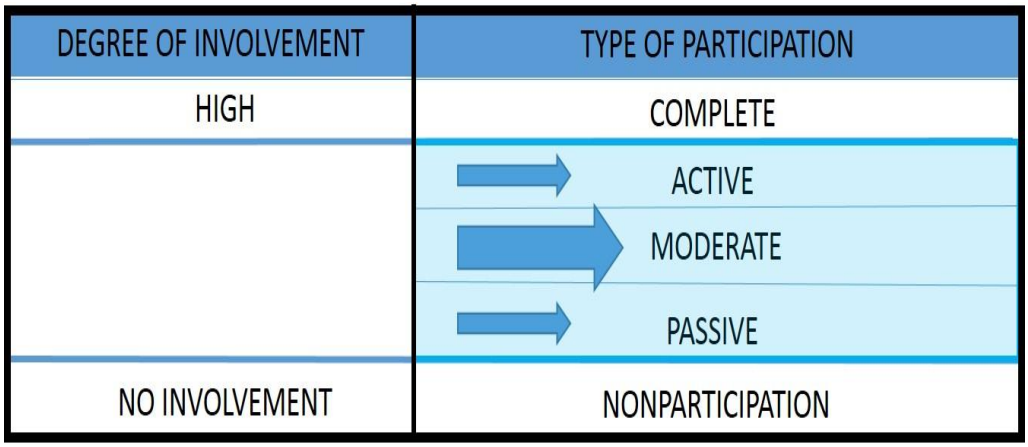


Figure 8 Possible involvement and participation stances in observation (adapted from Spradley, 1980). Participation for this study highlighted with arrows.

I chose to adopt a moderate participation role, appropriate when seeking to maintain a balance between "an insider and an outsider … participation and observation" (Spradley, 1980, p60). Within this stance, the researcher participates in some activities to a degree and this fluctuates according to the activity and fieldwork stage (Spradley, 1980). In practice, my participation level shifted throughout fieldwork as indicated in figure 8, depending on the group I was with and the type of activity. At some points I would have more active participation. For example, when observing in one bay for several consecutive days I became aware that the hearing aid of an elderly patient was not working and her engagement with staff and other patients was being impaired. The fact the

batteries needed replacing was handed over from shift to shift but was not actioned by anyone. After several days, I arranged for new batteries from the audiology department, collected them, replaced them, re-set the hearing aid and ensured this was documented and handed over to staff. At other times, such as when attending medical ward rounds, my participation was much more passive in order for me to take note of the dynamics between groups and the way care was negotiated with a range of patients. Most commonly however, my role was moderate and is best described as a hospital volunteer. When not interviewing participants, shadowing staff members or taking part in meeting or ward rounds, I participated in ward work such as directing visitors, making refreshments, helping with meals and running errands. My main activities quickly became talking with patients and dealing with phone calls which both provided insight into the wider workings of the ward and the various groups that operated within it.

It can be argued that a higher degree of involvement with complete or active participation in the clinical work of the setting may have achieved greater insight into the phenomenon, giving access to the 'embodied knowledge' of participants (Allen, 2004a). In practice this would have meant participating as a nurse, or in clinical care, to a significant

degree (Bonner and Tohurst, 2002). However, there were several reasons why participating as a nurse was not the right stance for this study and its aim. These mainly related to my lack of research experience and my previous lengthy nursing career. I anticipated that a high level of participation would complicate my transition from clinician to researcher as I would perhaps be drawn to the comfortably familiar nursing role and find it more difficult to maintain a research perspective. The pull to act as a nurse would not only be personal but also likely encouraged by the level of need in the setting. The shortage of nursing staff meant I would be providing much-needed clinical support. I could not simply withdraw this support as it suited me. Allen (2004b) explored these ethical challenges inherent in the dual practitioner–researcher identity and highlights the inevitable tension between acting in the interests of the study and in the immediate interests of participants. Even in my moderate participation role, I was strongly influenced by the needs of the setting. In some sessions, I would be almost entirely occupied by taking phone calls, dealing with visitors and doing small jobs when I actually wanted to observe other events. For example, on one session there was a complex situation involving a young patient demanding to be discharged before her the team felt she was fit. The nurses were working closely

with the doctors on this case and I wanted to observe these groups negotiated their differing perspectives. However, I became engaged with a friend of a patient who had recently died and who had not been informed by the patient's family about the funeral or any other details. The friend was greatly distressed by this and the ward staff were unable to support him, so I spent a long time with him until he felt able to leave. I considered this a valuable experience as it showed the range of suffering on the ward and the difficulties responding to this. Nonetheless it was clear that my study activities were necessarily shaped by the needs of the ward, and I believe this would have been to a greater extent if I had been in a nursing role.

A moderate non-nursing participation level allowed me to engage with a wider range of participants and to move more freely towards areas, people and activities of interest. It also allowed me to take a more detached position when I felt the need to be more reflective on events in the moment. However, choosing this non-clinical participation role prevented me from transitioning towards an 'insider' position (Spradley, 1980, Allen, 2004a) with the permanent ward staff and, further, could not observe intimate aspects of care. My literature review of existing nursing research on the topic suggested that this position was commonly taken by nurse researchers. My

aim was to achieve a broader understanding of how compassionate care was enacted in the ward and how the various groups contributed to this. The adoption of a non-clinical moderate participation role therefore intended to gain the expansive view of the ward setting and the diverse roles, responsibilities and needs within it.

An expansive view is perhaps more important for constructionist ethnographers attending to the 'materials' and sites of social and discursive practices (Latimer, 2008, Holstein and Gubrium, 2008). In hospital wards, the bedside is a primary site (Latimer, 2008), and I found that clinicians, support staff, patients and visitors are all located here at some point. In terms of nursing and the current compassion debate, the bedside is also a site of contention, with much discussion about nurses' presence or absence in this space. During my fieldwork, I often placed myself at a small desk that sat between two six-bedded bays and faced the reception desk. I was therefore positioned near to the two main sites of discursive practice on the ward. In addition to the bedside, I found that the reception desk was a dominant site of social activity. Almost everyone who entered the ward went first to the desk. For clinical staff, it housed their prime resources (telephones, computers, patient notes, documentation and the main information board containing the current bed and

discharge state). There seemed always to be some kind of congregation around the desk. It was regularly the site of emotional outpouring, arguments, critical treatment discussions and information sharing, despite its very public position. As I show in the next chapters, this site features heavily in the findings.

During observation sessions, conversations were a major activity – either listening to them or engaging in them myself. Snatched chats in corridors, intense emotional talks at the bedside or an informal interview in a briefly empty room all helped me to explore how compassion and care more generally were made meaningful by participants (Holstein and Gubrium, 2008a, McCoy, 2014). In terms of note-making, I tried to record any talk as close to verbatim as possible, which Holstein and Gubrium (2008b) argue is important so that data can later be 'unpacked' and analysed for the constructive work involved. I also sketched the environment or events. For example, when the trust's bed management team were under pressure and came to the ward to try to urge the staff to process discharges more quickly, they would often stand at the reception desk around one nurse and communicate strongly the need to 'free up' beds. I would sketch the positioning of the actors in such cases, to remember how this added to the almost physical sense of pressure that the ward

team could often be under. On many occasions, however, practical issues would impede sketching and detailed note-taking. In those cases, I would write up notes as soon as possible after sessions.

3.5.7 Recorded semi-structured interviews

In addition to chatting with participants on the ward, and informal impromptu interviews, I also conducted 30 recorded semi-structured interviews. They were on average 60 minutes long and were conducted in a private room on or near the ward, or at the participant's home. All who considered an interview received a participant information sheet (appendix 6) and a consent form (appendix 7) to review. I went through both these documents with the interviewees before the interview unless they felt they already understood the information. The interviewee signed the consent form and I countersigned it. I had a topic guide (one example provided in appendix 8) and added or omitted certain prompts or questions depending on the participants' role and my prior observations of them. However, sometimes the topic guide was unnecessary, especially with those participants I had engaged with a lot on the ward. I aimed for a relaxed structure and a conversational atmosphere (Ritchie et al., 2013, Roulston, 2010).

As well as digitally recording each interview, I took notes to capture contextual detail and non-verbal information. I transcribed the interviews verbatim and included my own speech and written notes in the transcript to keep my contribution to the account visible (Koro-Ljungberg, 2008, Roulston, 2010). The supervisory team reviewed the transcripts and we discussed early interpretations as they developed.

The combination of recorded interviews and participant observation is very common in ethnographic studies and allows the researcher to analyse the participants' own words, rather than a paraphrased version of them (Atkinson et al., 2001, Wolf et al., 2012, Sorrell and Redmond, 1995). The interview account is understood as one part of a bigger picture that suggests how the phenomenon is constituted in that setting (Sorrell and Redmond, 1995). From a constructionist perspective, interviews are considered 'active' (Holstein and Gubrium, 2008b). This means that rather than seeing the interviewee as providing the 'answers' about their social world (Holstein and Gubrium, 2008b), accounts of social life are co-constructed dynamically between interviewer and interviewee.

The constructionist interview process proceeds similarly to other qualitative interviews, but the difference lies in how the

account produced is perceived and therefore analysed after the event (Holstein and Gubrium, 2008b). The interview transcript is seen as a product of the researcher's active contribution during the interview, the social circumstances surrounding it and the researcher's transcription and presentation of the interview (Koro-Ljungberg, 2008, Fontana and Frey, 2005). As well as taking these aspects of production into account, the researcher attends to what the participant is '*doing* with words' in the interview (Holstein and Gubrium, 2008b, p389, emphasis added). This allows the researcher to explore how participants construct the phenomenon under study, and as such locates 'culture in action' (Silverman, 2011, Roulston, 2010).

I found that interviews had other benefits for the study. For example, within the busy ward setting, the recorded interviews gave precious time and space to talk more thoughtfully. Many participants chose to interview for longer than the approximate 45 minutes we had planned, and expressed enjoying the experience. Participants' choice of words often acted as a springboard for me to make associations that I had not previously thought of.

In support of the context-dependent nature of interviews (Holstein and Gubrium, 2008b), I found each to be a different

experience. For the majority of interviews, the power balance was in my favour, encouraged by the fact that I invited the participant to the interview, organised it and asked the questions. I tried to put participants at ease by starting with a general chat about themselves and their role, making tea for us and paying attention to how we were seated. Most participants appeared relaxed after a few minutes of starting.

However, the interviews with corporate staff all took place in the participant's office at their desk, which shifted the power dynamics dramatically. The interviews that took place in participants' homes were conversely more relaxed. However, the power balance was still tilted towards the 'host' and away from me as the 'guest'. It was important to consider the influence of such contextual and relational issues when analysing the individual interviews. This data was then considered alongside the observational data, in order to construct a meaningful whole. The process of analysing the whole data set is now explicated, with a focus on the techniques of key-event and deviant-case analysis.

3.5.8 Data analysis

In this section I show how I managed, organised and analysed the collected material in order to move from a mass of data towards a set of findings that answered my original problem.

The analysis process was an iterative ethnographic style of repeatedly reading the data, writing up thoughts and checking back to draw out patterns and relationships. My overall approach was abductive and within this I used thematic analysis (Clarke and Braun, 2014, Braun and Clarke, 2006) as a guiding framework. I also employed key-event analysis (Fetterman, 2010) and deviant-case analysis (Silverman, 2011, Seale, 1999) where the data warranted a different approach.

3.5.8.1 Ethnographic analysis

Ethnographic analysis aims to 'make some sense' of the data in order to provide a detailed account of what was experienced, as well as theoretically relevant observations (O' Reilly, 2008, O'Reilly, 2012). This simple description belies the complexity and messiness of the process, for which there is no standardised process to follow. There are however, several recognised phases. These include: intensive, repeated reading of the data; an early management and sorting phase in which data are coded and categorised; a descriptive level of analysis and a later interpretive level of analysis, which is closely linked to the context of action and the wider literature (O'Reilly, 2012, Brewer, 2000, Hammersley and Atkinson, 2007, Holstein and Gubrium, 2008b). The start and end points of analysis are blurred, but there is typically an identifiable

beginning when data collection starts, and reporting the findings tends to bring a close to analysis (Brewer, 2000), for that particular project at least. O'Reilly (2008) describes the ethnographic analysis process as spiral-like, beginning with a broad aim and a wide-ranging search for information which gradually narrows to the data that answers the question.

3.5.8.2 The analysis activities

This 'spiral' description reflects the broad to narrow progression which was characteristic of my analysis process. However, I modified the spiral image to a more irregular shape (illustrated in figure 9) to convey my personal experience of a process that was ill-defined and jumbled. The continual inching forward and checking back was intensely frustrating and I often felt 'stuck'.

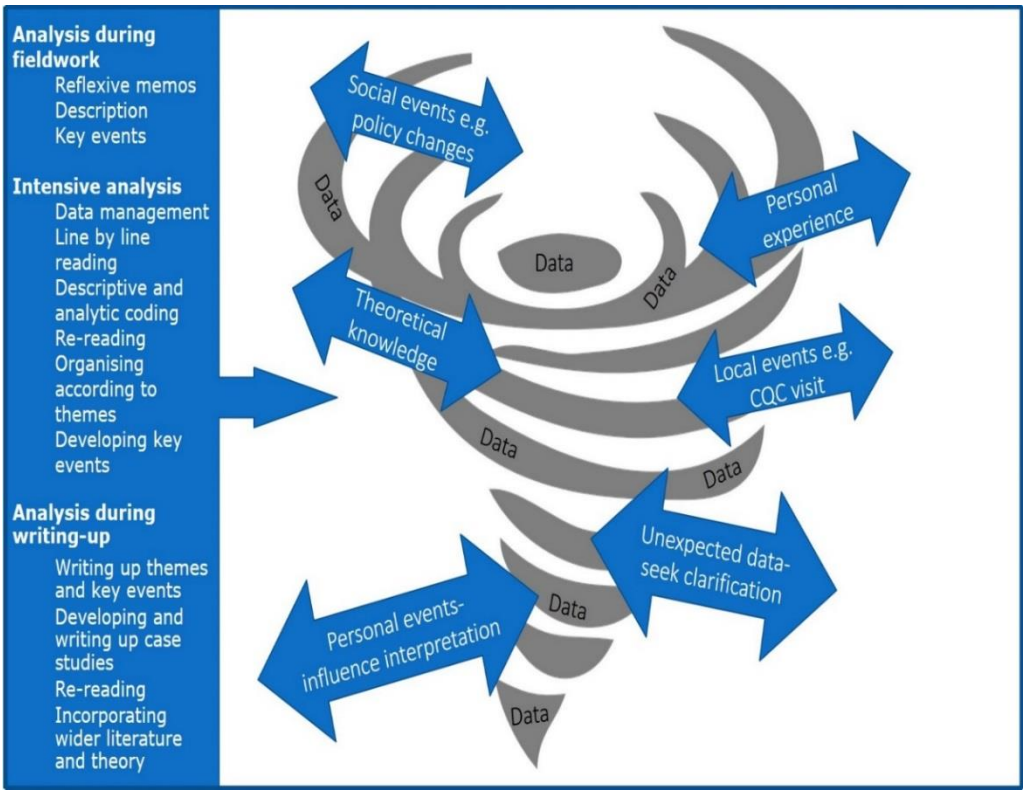


Figure 9 The spiral like data analysis process

I later realised that this iterative process enabled me to make links between early and later parts of the data that otherwise would have been missed. It also gave me a strong sense of the corpus as a whole, rather than as a chronological set of field notes and interviews. Holliday (2002, p107) claims it is crucial for the researcher to make this conceptual move if they want to avoid a 'blow-by-blow account' of what was observed, and move towards a richer argument about why it was important.

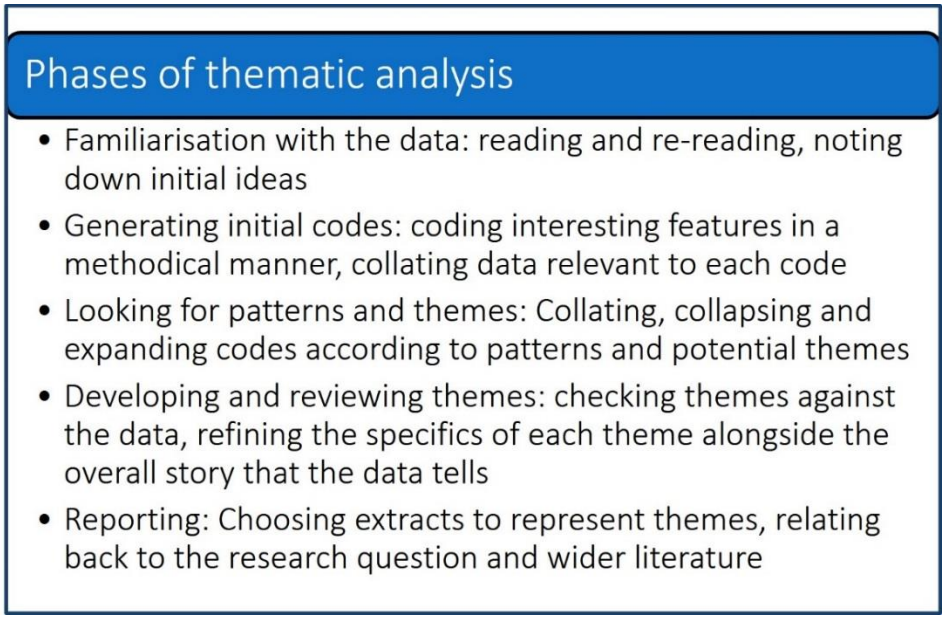
Figure 9 also shows how the stages of analysis differed in form and intensity as the study progressed. Crucial analytic activities took place during fieldwork and writing up but these were not as intensive as the concentrated period of analysis between these points.

During data collection, analysis was in the form of reflexive memoing while transcribing, generating descriptive codes and noting potential connections between what I was seeing, my wider knowledge on the topic and broader events. I uploaded transcribed fieldnotes and interviews on to a qualitative data analysis software package (NVivo Pro 11) as soon as possible after each event. Nvivo provided an invaluable space to house the copious amounts of data in an organised and accessible way, and was useful for data reduction and organising, descriptive coding and making broad connections between different parts of the data.

3.5.8.3 Thematic analysis

Once fieldwork was complete, I focused entirely on data analysis. I used Braun and Clarke's thematic analysis method (2006, Clarke and Braun, 2014) to begin, and later employed deviant-case and key-event analysis for the data that warranted a different approach. Thematic analysis was invaluable as an established, widely-used and structured

framework, which enabled me to start the daunting analysis process. Although I relied on this framework less as the process progressed, it remained an anchoring and supportive structure. The principles and phases of thematic analysis are similar to other qualitative analytic processes but it is not tied to a particular theory (Clarke and Braun, 2014). It has been widely used in ethnographic studies (McGibbon et al., 2010, Hinder and Greenhalgh, 2012, Greenhalgh et al., 2011), and its overlapping stages resonate with the aforementioned description of ethnographic analysis (Braun and Clarke, 2006, Clarke and Braun, 2014).



Box 2 Phases of thematic analysis

These six phases (summarised in Box 2) reflect the order and form of my process of analysis, although I modified and added to the stages to suit my data and my own style of learning. An essential part of the analysis process for me was to interact with the data in various ways, such as through computer software, on paper, verbally with peers and via physical touch and movement. This helped me to make the difficult transition from fragmented, descriptive ideas to interpretation of the corpus as a whole.

My early activities aimed become 'immersed' in the raw data by repeatedly reading to spot patterns and contradictions within, across and outside the dataset. Although Nvivo was useful for data display and organising early codes and themes, it was not my preferred medium. Instead I worked more effectively with hard copies of fieldnotes and interview transcripts. I collated these into three volumes of fieldnotes (four months in each volume) and one volume of thirty interview transcripts. I used coloured pens and adhesive notes to identify points of interest, patterns and contradictions and then typed these into Nvivo later, as can be seen in images 1 and 2.

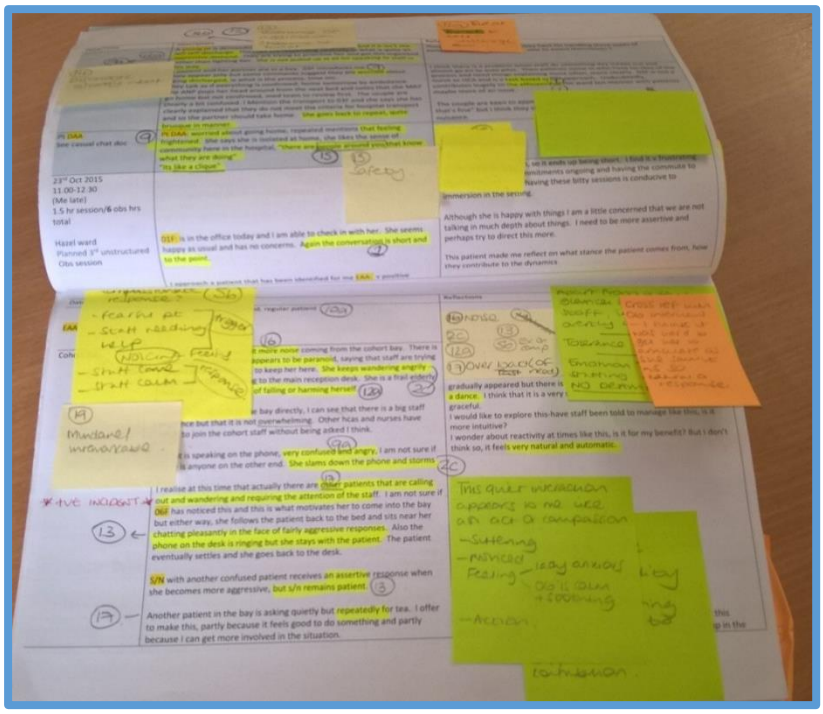


Image 2 Early analysis: Intensive reading of hard copy data, descriptive coding and memoing.

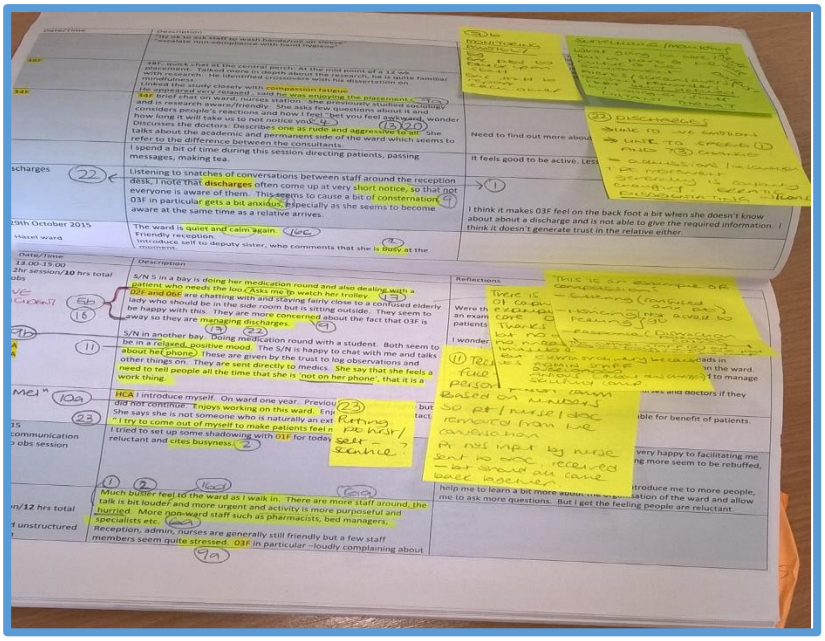


Image 3 Early analysis: Intensive reading of hard copy data, descriptive coding and memoing.

Mid-point stages were aimed at identifying patterns, connections and contradictions and beginning to develop themes. Activities included transferring major codes and categories on to large sheets of paper and spreading these out on a spacious surface. I had the data volumes with me at these times and used the two sources to make annotated drawings depicting possible categories, relationships and interpretations. The act of creating these visual representations (see image 4) helped me to make sense of interesting and puzzling aspects of the data and to draw seemingly disparate elements together.

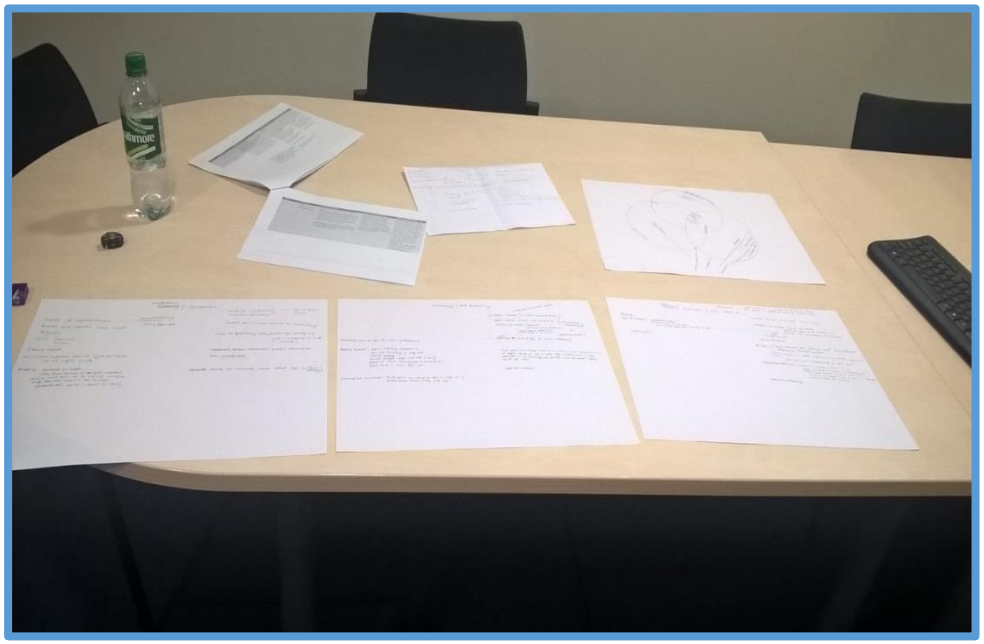


Image 4 Mid-stage analysis: Visual representations of possible categories, relationships and interpretations.

I would then write-up the thoughts generated by these sessions within Nvivo, and later, in Word documents. This writing-up process led to further clarification of my ideas and developed into more coherent accounts of the main themes. Towards the later stages of analysis, I would again display the hard copy versions of these thematic accounts, and develop visual representations and more interpretative ideas. As in earlier stages, I kept the data volumes and frequently checked back to this to ensure my ideas were rooted in the original data.

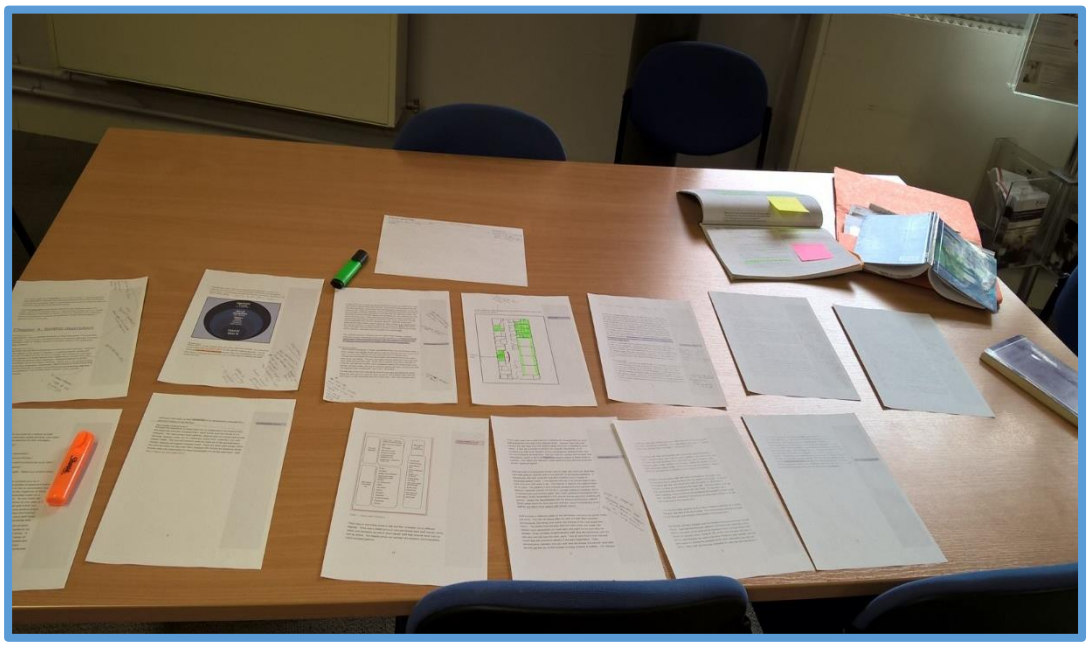


Image 5 Late stage analysis: Visual representations to develop interpretations.

Throughout this progress, I discussed the evolving codes, patterns, themes and interpretations with both the supervisory team and with research peers. Articulating my ideas to those who had a more objective stance towards the research enabled further analytic processing, as well as a different and sometimes challenging perspective (Fetterman, 2010, O'Reilly, 2012). I also discussed the early findings with a key participant (the ward manager), who reported that my interpretations resonated with her experience. Crucially, she was able to expand on and clarify some aspects of the findings, which I then incorporated into the later stage of analysis.

3.5.8.4 Use of theory

In the late stages of the analysis process, I began to incorporate ideas from wider reading. Aspects of this triggered interpretations of data that I had previously struggled to make sense of. The use of existing theoretical knowledge for ethnographic analysis is much debated (Wilson and Chaddha, 2010, Wacquant, 2002, Anderson, 2002, Duneier, 2002). Analysis is typically described as being either deductive (theory-driven) or inductive (data-driven). Ethnography has been more strongly associated with an inductive approach (O'Reilly, 2008) but there is a growing acceptance that the inductive/deductive dichotomy is inaccurate and that much

research incorporates both (Ezzy, 2013, Shank, 1998, Fereday and Muir-Cochrane, 2006, O'Reilly, 2012, Wilson and Chaddha, 2010). The reflexive use of theory in data collection and analysis has been termed iterative-inductive (O'Reilly, 2008) and abductive (Shank, 1998) the latter of which is perhaps the better-known term.

Holstein and Gubrium (2008a) argue that it is inevitable researchers draw from their theoretical knowledge, as well as personal experience and wider events during fieldwork and analysis. Anderson (2002) goes further to suggest that ethnographers are 'edified' by using theoretical knowledge in combination with local knowledge and empirical data. Nevertheless, these influences should not direct the researcher nor blind them to the data (O'Reilly, 2008). Instead, they can encourage to researcher to look again, more closely at the data for an 'overall coherent picture' to explain the local observations (O'Reilly, 2008). Furthermore, a theoretically informed approach can allow researchers to make logical inferences about the world, or generate "plausible explanations" (Shank, 2008, p1). For ethnographers specifically, it can offer a method of 'pulling together' the complex, rich and diverse fieldwork data in order to theorise about future events or similar settings (O'Reilly, 2008, Shank, 1998). For me, the use of existing theory outside of the

nursing field led to the development of a major finding, relating to how compassion is received in the ward setting. This was done in combination with deviant-case analysis technique which is explicated in the following section.

3.5.8.5 Deviant-case analysis

Data that do not seem to fit a pattern – that are atypical or 'deviant' in some way – can be an important analytic tool (Potter, 1996, Pope et al., 2000, Silverman, 2011, Madill et al., 2000). Rather than omit such instances, they should be scrutinised for what they reveal about the phenomenon (Silverman, 2011). From a constructionist perspective, Potter (1996) and Madill et al. (2000) argue that deviant cases do not necessarily disconfirm a pattern, but may usefully delimit its applicability or even support it. Careful analysis of deviant cases can evidence the researcher's openness to nuance and contradictions in the data and can be considered a quality marker (Potter, 1996, Madill et al., 2000, Silverman, 2011).

During the intensive analysis stage, I noticed that several participants responded in an atypical way to care and that there were some shared characteristics between them. My early interpretations suggested that these participants had received poor care from staff. This account was supported by wider studies, but I was uncertain about my interpretation

overall and did not develop the data further at that stage. However much later, when writing-up the early findings and re-engaging with wider reading, I found that the psychological theory of 'social safety' (Kelly and Dupasquier, 2016, Gilbert et al., 2014) shed a different light on the atypical data.

I gathered all the field notes pertaining to these instances and formed several case studies. This allowed me to analyse within and across the cases, as well as across the whole data set. I then developed a framework to analyse each case study more methodically (see figure 10).

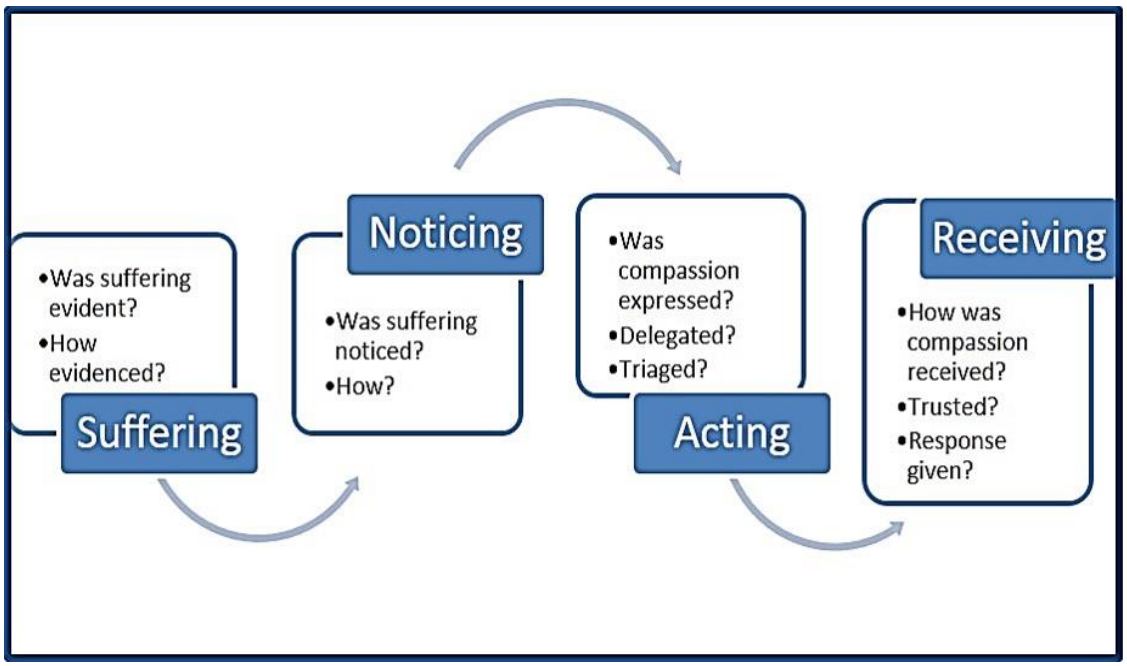


Figure 10 Framework for analysing deviant cases

The framework was based on the theory of social safety and related research on compassion (Gilbert et al., 2014, Gilbert et

al., 2011, Kelly and Dupasquier, 2016), and it supported my development of the six case studies presented in chapter seven.

In short, I found that some participants struggled to recognise, trust or feel soothed by compassion, and this may have related to a lack of 'social safeness'. Gilbert et al. (2014) describes the notion of 'social safeness' as an essential sense of security, or feeling safe in the world, and argues that it is related to early attachment experiences and social support networks. When individuals chronically lack social safeness, they may find it difficult to be emotionally vulnerable, a state that is required to seek and receive compassion from others. This notion is not presented in nursing work on compassion. As noted in the literature review, much compassion research assumes that compassion is received passively by the sufferer (not resisted) and is a wholly positive experience. I had expected to find that the sufferer had a more active role than is traditionally presented, but did not anticipate that some may not recognise compassion or may have negative associations.

This deeper and alternative exploration of data which was inadequately explained via thematic analysis, was fundamental to this finding. There were other aspects of the data that

warranted an alternative analytical technique, and for this I used key-event analysis.

3.5.8.6 Key-event analysis

Fetterman (2010) argues that key events can reveal additional aspects of the broader culture under study. I developed several key events for analysis, the most fruitful of which involved the host trust failing an audit by an NHS regulatory body. The inspection team warned they would return in three weeks to re-audit, and that there would be organisational sanctions if they failed again. Having just watched a nearby trust go into special measures for a similar regulatory failure, Oakfield responded with uncharacteristically punitive measures. While the re-audit was passed successfully, there were negative implications across the trust, which I expand on in the findings chapters. As a key event, it revealed atypical reactions can occur in response to threat or pressure. When reflecting on this event in interviews, corporate staff felt the managerial response was regrettable but understandable given the pressure they were under. However, they did not justify poor care by front-line staff in the same way, judging it instead as unacceptable under any circumstances. Therefore, my analysis of this key event drew attention to the impact of organisational threat, and how managers constructed patient care very differently to the care of staff.

Furthermore, key-event analysis can demonstrate the interrelationship between participation, observation and interpretation. For example, on one extremely busy, understaffed pre-Christmas shift, I watched multiple new admissions being brought into the ward at the same time. It was late afternoon, there were no support staff, and the nurses and HCAs struggled to attend to the various issues that were unfolding simultaneously. No one had taken a break since I had arrived five hours earlier. I had long put down my notebook to take phone calls, direct visitors, answer the doorbell and run errands. Although I had no official responsibility there, I felt some of the pressure that staff were under and some of the anxiety that patients were experiencing witnessing the nurses dashing back and forth. Not only did this guide my observations, but it highlighted key participants whom I could explore the experience of this shift with. When I could interview one of these staff members, she knew what I had seen, and we were able to quickly arrive at a more meaningful discussion of the experience. I was able to talk from a position of sharing the experience, not just watching it, and the participant's engagement was thoughtful and emotional.

Figure 11 below provides a basic illustration of the progression from early coding to final themes that was achieved thought

the analysis process described above. The next section explicated how I translated a set of themes into a coherent, authentic set of findings, and how this was a similarly iterative process that involved further analysis of, and movement between, the data and wider literature, research and policy.

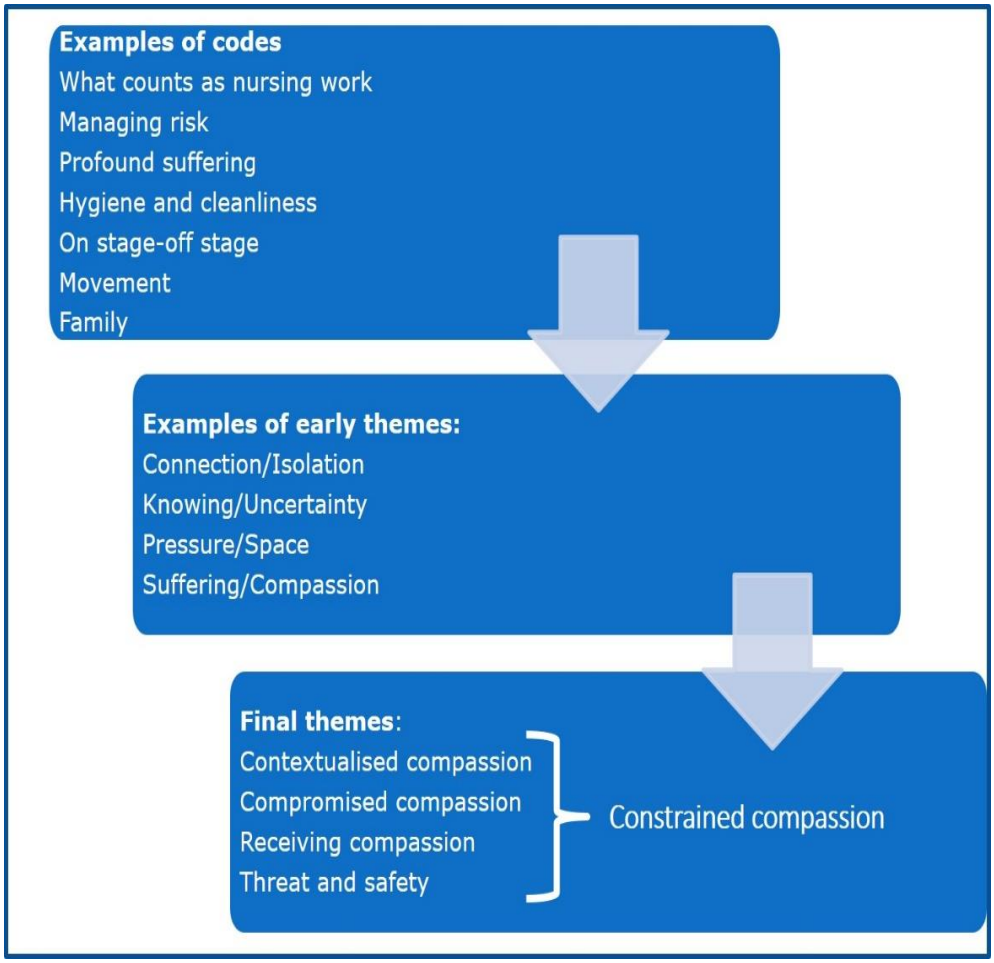


Figure 11 An example of progression from codes themes

3.5.9 Writing ethnography

For a thesis format, there was much that had to be condensed, and indeed put aside, in order to produce a

readable account which responded to the study aim. To this end, my original question and objectives, in conjunction with the most prominent findings, guided my selection of *what* I wrote. However, I was also influenced by the principles of ethics, quality and reflexivity discussed earlier, and by a constructionist ethnographic concern to reveal the myriad elements around *how* phenomena, and knowledge, are constructed (Holstein and Gubrium, 2008b).

Thick description is a key characteristic of ethnographic reporting (O'Reilly, 2015) and is a way of conveying a sense of the setting and its dominant characteristics (Holliday, 2010, Humphrys and Watson, 2009, Green and Thorogood, 2013). More than the provision of extra detail (Ponterotto, 2006), thick description communicates the complex 'webs of social relationships' that shape the findings (Denzin and Lincoln, 2000). To report the study, I also use verbatim quotes, field-note extracts, key events and case studies to achieve the same effect and to bring the report 'to life' (Humphrys and Watson, 2009). I have also endeavoured to write in the same ethically self-reflexive style I have tried to apply throughout the study (Finlay and Gough, 2008, Mauthner and Doucet, 2003).

Ethnographic description must be balanced with protecting the anonymity of the participants and the setting (Goodwin et al., 2003). Researchers can inadvertently identify participants through local descriptors, reports of the scenario, participants' roles or verbatim quotes (Gibson et al., 2013). McDonnell et al. (2000) chose to exclude direct quotes in order to protect the anonymity of their participants, but the resultant report was criticised for lacking richness and life. A thinned-out account can also mean that participants' voices are less powerfully conveyed (Goodwin et al., 2003, O'Reilly, 2012). I have used participant and setting pseudonyms, removed identifiers, altered non-important details where necessary and have had my writing checked for anonymity by a member of the host trust. Ultimately, I have tried to achieve a balance between authentic, rich representation and protection of those who have contributed to my work.

3.6 Conclusion

In this chapter I set out the methodology, design and methods of the study. I outlined that the value of the constructionist ethnographic approach lay in its concern with how compassion was brought into being for those working and being cared for in the ward. I also described how this orientated the researcher towards attention to social interactions, discursive

practices and close engagement with the people enacting those. Lastly, this methodology allowed me to consider the wider sociopolitical context, which I have argued in earlier chapters is integral to a consideration of compassion in contemporary healthcare settings. Throughout this discussion I also considered some of the limitations of this approach, and what elements may have been missed by my choice of focus, approach and design. I address the limitations of the methodology in more depth in the concluding chapter.

I also emphasised the importance of conducting the study with ethical and critically self-reflexive sensitivity. I showed how these principles were woven through the whole project and how, although a challenging and ongoing process, reflexivity was crucial in keeping the researcher's influence visible. Lastly, I gave the details of the study design and the methods used as well as explicating my decision-making around these choices. The following section consists of four findings chapters, each relating to a different aspect of compassion in the ward setting.

Findings section: Structure and outline

Findings section introduction

The findings section comprises four chapters, each covering a different aspect of the findings, and they progress in a broad-to-narrow pattern. In the first chapter, chapter four, I present an opening 'scene-setting' section. This is a thick description of life on Hazel ward. It illustrates the key aspects of the ward culture, such as the team relationships, the organisational processes and the physical environment. Within this, I introduce many of the main themes that contributed to the findings, which I expand on in the subsequent chapters.

Chapter five retains the broad scope of the previous one, but focuses on how a range of contextual elements – operational pressures, organisational demands, the presence of suffering and a sense of threat – impact on social relations of the ward. I focus on the discursive and social practices of the participants, and demonstrate the role of threat in inhibiting compassionate care. In chapter six I present a more focused set of findings regarding how compassion is socially constructed. I present two accounts in depth: compassion as intrinsic, and compassion as extrinsic. Based on these I develop the theme of 'compromised compassion' and suggest that for staff, the enactment of compassion incurs both

compromise and personal cost. Lastly, in chapter seven, I set out the theme of 'receiving compassion'. I use case studies to illustrate that receiving compassion is a complex process in itself and is an essential part of the compassion process overall. I demonstrate that the sufferer plays an active role and that their response may in turn influence those expressing compassion. This leads to the idea that the process of compassion does not end with the 'delivery' of compassion to the sufferer; rather, it is dynamic and ongoing. I conclude the whole findings section with a comprehensive summary that draws out the key points taken forward for discussion.

Chapter four: Setting the scene

> *Each and every person here is suffering in their own way. I try to make a difference to that.*
>
> (HCA Suzy, informal interview)

4.0 Introduction

In this chapter I present a thick description of life on Hazel ward. I aim to convey a sense of life in the setting and to present the ward as a whole unit before going into the detail of the findings. In this way, I hope to contextualise the findings and to articulate the broader contextual influences on social interaction on the ward. As noted in the literature review, compassion research, and nursing research in general, often gives a narrow, decontextualised account of care (Hewison and Sawbridge, 2016, Nairn, 2009). While this can illuminate the fine detail of care interactions, it can overemphasise the autonomy of staff and obscure the contingencies of practice.

This chapter is structured in four sections, beginning with a description of the setting. Detail on the people and the ward environment follow. Lastly, I describe the prevalence of suffering in the ward, relating to both patients and staff. Given that compassion is understood as a response to suffering, the extent of distress and need on the ward is important to

convey, as it suggests the enormity of expectation placed on healthcare staff.

4.1 The setting

The study was set in Hazel ward, a busy medical ward within Oakfield NHS Trust. This large acute organisation has two main hospital sites: Poplar and Birch. Birch Hospital houses Willow Unit, a group of five wards with a shared medical speciality, and Hazel ward is one of these five. The boundaries between the trust, Birch campus, Willow Unit and Hazel ward can be described as fluid, as there was a continual flow of people through each area. Events which occurred in one area often generated ripples in the others. Oakfield Trust itself was similarly porous, as its organisational practices and processes were shaped by wider social and political influences. The regulatory systems imposed on the NHS by the DoH were particularly high on Oakfield's agenda at the time of the fieldwork. A neighbouring trust had recently gone into 'special measures': a consequence levied on NHS organisations that are judged by the Care Quality Commission (CQC) to have serious quality and managerial failures (Monitor, 2014). A consequence of this sanction is that trusts lose their organisational autonomy and are put under intense performance scrutiny. Additionally, trusts in special measures

commonly experience increased financial deficits, recruitment difficulties, decreased staff morale and a poor public profile (Rendel et al., 2015, Murray et al., 2014).

My experience of the setting was that it was a permeable site, with diverse types of people and groups continually arriving, departing and moving between the hospital and the community. This is very different to Coser's (1962, in Long et al., 2008, p72) early ethnographic description of the hospital ward as a 'tight little island' cut off from normal life. Social practices on Hazel ward were not isolated from normal life, but were dynamically connected to local and wider influences by the people flowing in and out of its doors.

Hazel and the other wards within Willow Unit were located together in one section of Birch Hospital, and had shared management and regular movement of patients and staff between all five wards. Staff described the connection within Willow Unit positively and as a source of support. Some referred to Willow Unit as a 'family' (Kath, recorded interview), with common goals and problems. One nurse commented that she met with other Willow Unit staff as much as possible, because:

> *… the chances are that, whatever you're stressing about, your counterpart is as well.*

(Senior nurse Dawn, recorded interview)

The building that houses Willow Unit is old, and its rundown state could be problematic in terms of lack of space, an unreliable heating system and harsh lighting. Patients and relatives would complain about these issues to staff, who would then repeatedly report the problems to the estates department, as well as trying to improve patient comfort. Although the environmental problems may seem trivial, when combined with the anxiety or discomfort of illness, they could be very upsetting for patients and relatives, who often approached staff in an aggressive manner about them, despite the efforts of staff to improve the situation. The interview excerpt below illustrates this. Ken's wife was seriously ill and they had experienced a long wait for investigations:

> *He shakes his head, telling me that the staff are 'great' but the ward itself has been 'freezing'. His body language is aggressive, and he is leaning forward as he talks and making exasperated hand gestures. He says there has been no heating on and nurses had to go for extra blankets. 'We've had to put blankets and towels up to stop the draft coming in, it's unacceptable!'*

(Relative Ken, informal interview)

Despite such environmental issues, Hazel ward functioned fairly well and was achieving relatively good-quality indicators of care at the time of the fieldwork. This was in terms of the trust measurement system (such as rates of patient falls, infections and pressure sores) and positive ratings on the Friends and Family Test[2]. The vast majority of patients and relatives also reported a good standard of care on the ward.

4.2 The people

There were many different groups of staff that worked within or around Hazel ward. A core group of staff were based on Hazel permanently, while others rotated across wards in the trust. Box 3 lists those I engaged with during fieldwork, which is the majority of trust staff groups.

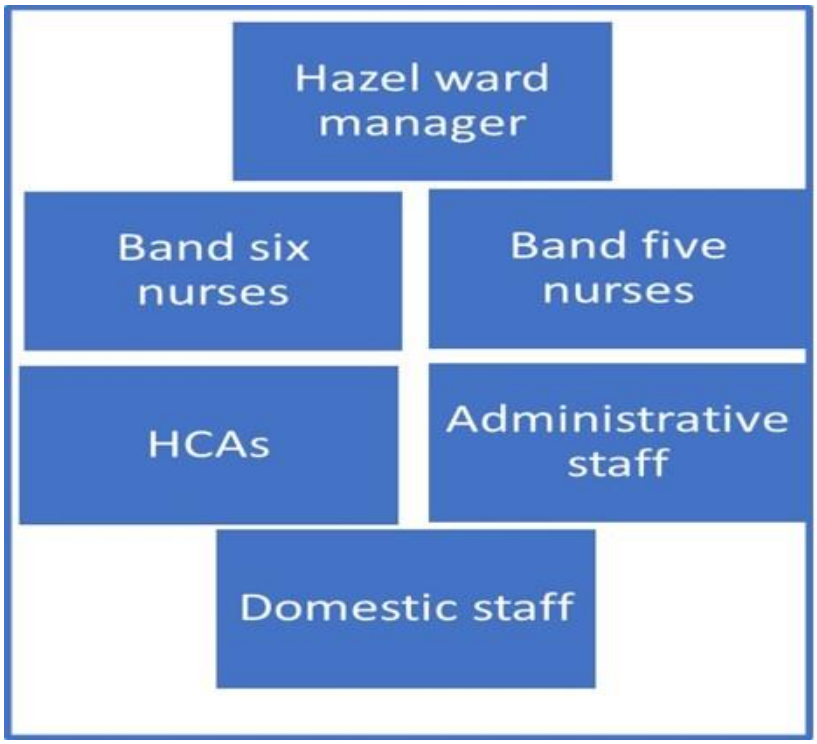
[2] The NHS Friends and Family Test was launched in 2013 to measure patient satisfaction with the service provided. It is a card given to all patients, which asks how likely they would be to recommend the service to their friends and family if a similar service were needed. The patients can tick a box on a five-point continuum ranging from 'extremely likely' to 'extremely unlikely' and indicate why they feel that way.

- **Nursing staff**
  - Ward manager
  - Senior and junior nurses
  - Students
  - Specialist nurses
- **HCAs**
- **Medical**
  - Senior and junior medics
- **Allied health professionals**
  - Occupational therapists
  - Physiotherapists
  - Pharmacists
  - Social workers
- **Support staff**
  - Administrative staff
  - Kitchen staff
  - Cleaners
  - Patient transport staff
- **Corporate staff**

Box 3 Staff groups involved in fieldwork

4.2.1 Permanent ward staff

The staff group shown in box 4 were those I had the most contact with. They were based on Hazel ward permanently and most had been on the ward for many years. I referred to this group as the 'core' staff group, as their familiar presence and close team dynamics gave the ward a sense of stability. Nurses and HCAs made up the majority of this core group.



Box 4 Permanent Hazel staff members

Band five nurses included those who were newly qualified and also nurses that were very experienced but did not have a formal managerial role. Band six nurses were senior ward staff with some managerial responsibility.

The ward manager, Dawn, was a key figure on the ward. She had been in post for approximately two years. This was a contrast from an earlier period. Several ward managers had come and gone in quick succession, some of whom had 'left in tears' (senior nurse, informal interview). General staff turnover was higher at this time, and staff described never knowing who was in charge or who would leave next (junior nurse, informal interview). Staff also reflected on the poor

team dynamics, anxiety and uncertainty of that time, which was supported by comments from those outside Hazel ward. It had a reputation for incivility to other trust staff, and a culture of 'every man for himself' (senior nurse, informal interview). Dawn had specifically focused on addressing the instability when she took up the post, and aimed to make the environment feel safer for staff, rather than targeting individual behaviour:

> *For me, it's about the patient feeling safe, but in terms of my role as a sister, that's true for my ward as well … It's not so much about the individuals delivering compassionate care, but it's as a team, how do we support each other? I think if you can build it into the culture of the ward, then [compassion] kind of naturally comes out.*
>
> (Dawn, recorded interview)

Dawn felt she had been successful in improving the ward atmosphere and team dynamics. In the main, staff appeared to have a positive relationship with her, as with those outside the ward. Dawn emphasised the fact that the same staff members worked on the ward and improvements were related to positively supporting them:

… they just needed a bit of love … because it's still the same staff that are here now, but they're completely different … It's the environment … all they needed was stability, because they'd had [a lot of] managers, and everyone was leaving and no one listened to anyone … and when someone came and started listening … it was like, oh great! [Laughs]

(Dawn, recorded interview)

Towards the end of the fieldwork, a large organisational restructuring plan altered Dawn's role and also that of the Willow Unit matron. This reduced the time they could spend on Hazel ward, which appeared to unsettle permanent staff members:

We never know when [managers] are going to be around … I'd normally go to the junior sisters for support, but they're acting up, so they need support too.

(Administrative staff, field notes)

[Matron]'s gone, [ward manager] is hardly here. The junior sisters are acting up, and the band fives have to coordinate more … I feel lost!

(Junior nurse, recorded interview)

The notion of instability reoccurs throughout the findings, and I show shortly how this contributed to a general sense of threat in the ward.

HCAs also constituted much of the core staff group. The HCA team were diverse, in terms of age, care experience and remit on the ward. Some performed extended duties, such as phlebotomy or working on patient discharges. HCAs worked closely with the nurses, and together these two groups had the most direct patient contact of all staff groups. HCAs and nurses generally had positive relationships, with some tension relating to how workload was shared between them. HCAs sometimes complained that nurses left too much of the personal care to HCAs. Nurses reported feeling conscious of this fact. Some managed it by making additional efforts to fit in more personal care alongside their other duties, while other nurses complained it was due to a lack of understanding of the scope of the nursing role. The HCA team had a strong intra-group bond and were often observed being tactile with each other and sharing jokes. Many patients remarked positively on the care they received from the HCA team.

The support staff were a crucial part of the ward team. Despite not having an official care role, these staff members were fluid in their remit and helped with all aspects of ward work. I often

observed them chatting with patients or reading magazines to them, keeping confused patients company, doing patients' hair or nails, or going to check on a patient who was walking about the ward but known to be unsteady or confused. Some of these support staff members had worked on Hazel for many years. The following excerpt is an example of the type of warm and caring interactions with patients:

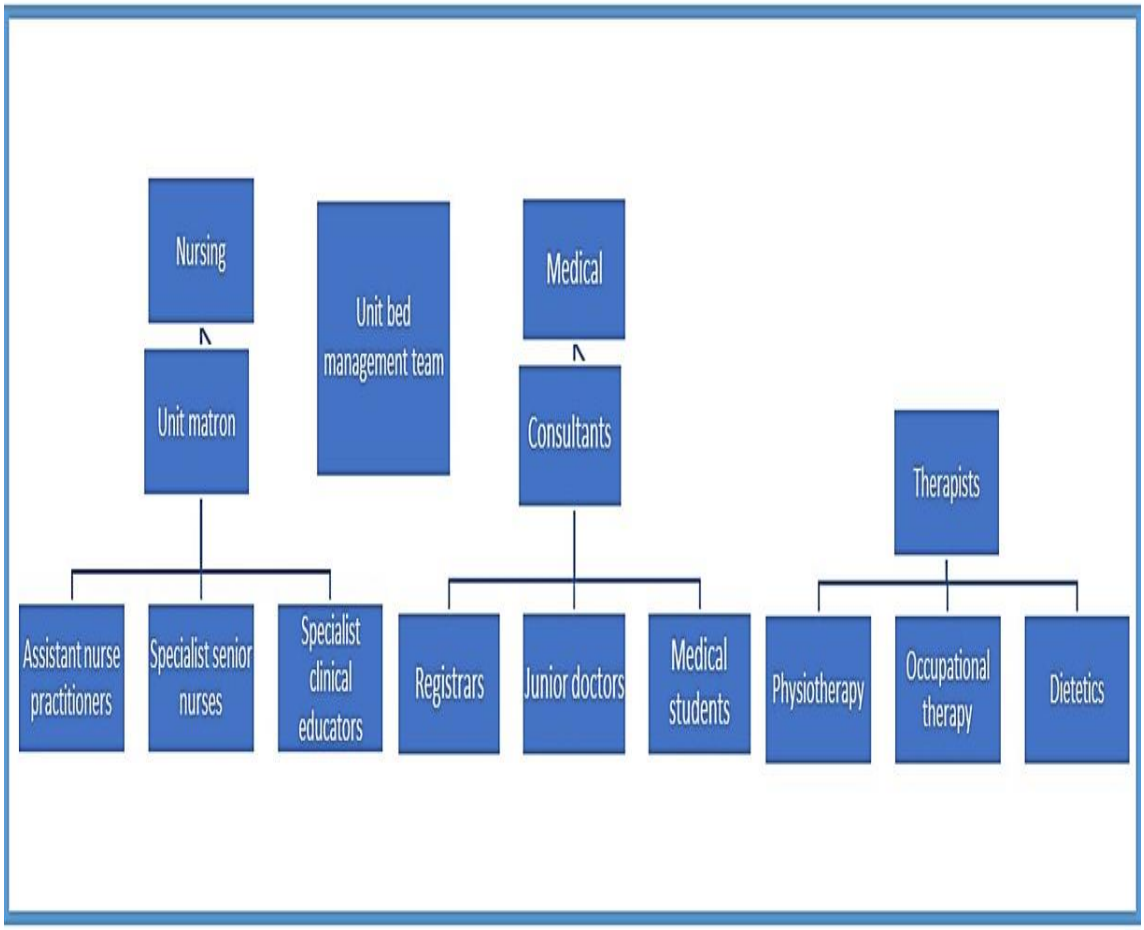
> *The cleaner is buffing the floor and there is cleaning equipment all around. She pauses when she notices a patient getting up. 'Where are you off to?' she asks gently. 'Cause I've wet the floor and I don't want you to slip … It's OK, c'mon, I'll walk with you.'*
>
> *This feels like a very natural response and not unnecessarily risky. The patient is frail but weight-bearing and mobile. As they get to the toilet, the cleaner says loudly in the direction of some HCAs: 'I'm doing your job for you!' They laugh, as does the patient who thanks her with a hand on the cleaner's hand. 'You're welcome. Careful when you come back as well.'*
>
> (Field notes, 22/11/15)

Overall, this core group of permanent staff were highly visible on Hazel ward. Patients being readmitted to the ward after a period were often reassured to see 'so many friendly faces'

(Patient Joan, field notes). Hazel staff often referred to themselves as a 'family' (senior nurse Clare, recorded interview) and made efforts to support each other. This was most visible during the very pressurised shifts, when I noted the exchanges of concerned looks, arm squeezes, and nods as staff checked in with each other in brief but meaningful ways. Together, the individuals in this core group gave the ward a comforting sense of constancy amid the surrounding flux.

4.2.2 Staff working across Willow Unit

As noted, many trust staff worked across Willow Unit and so were familiar on Hazel ward but present less frequently (see box 5). The matron of the Willow Unit, Paula, had worked in several posts in that speciality for many years. She therefore had a good knowledge of all five wards and provided a recognisable link for the unit overall. Paula was widely respected for her clinical knowledge, and although some commented on her 'no nonsense' manner (senior nurse, field notes), she was known to be supportive and responsive when staff had personal problems.



Box 5 Staff groups working across Willow Unit

The medical team and particularly the junior doctors worked closely with ward staff. They appeared to have good working relationships overall, and some individuals engaged very well with the Hazel staff. This was shown by a fair amount of social chat between the groups. However, awkwardness was evident when the medical team rotated and a new group of junior doctors arrived, and also when a difference of opinion needed to be negotiated.

The only negative comments about group dynamics concerned the medical consultants, and this was mainly in terms of communication and attitude. One nurse was particularly upset, but felt she couldn't complain:

> *Well, I've personally had that experience myself – which was horrendous – with a consultant, trying to explain my role and job and just made to feel this big and thinking, 'Y'know, just because you don't get it and because you're not listening, doesn't mean it's a waste of time … There's a hierarchy, which is just so pathetic. There's no need for it … and it wasn't just a one-off, it was every day!*
>
> (Senior nurse Lindsay, recorded interview)

However, other staff members felt confident to tackle it directly:

> *I think consultants are rude … There's not any 'excuse me', they just come and pull the curtains round! But then I say, 'An "excuse me" would be nice!' They do apologise then! (Laughs)*
>
> (Cleaner, recorded interview)

The consultant rotation arrangement was quite unusual and perhaps affected the inter-professional group dynamics. Two

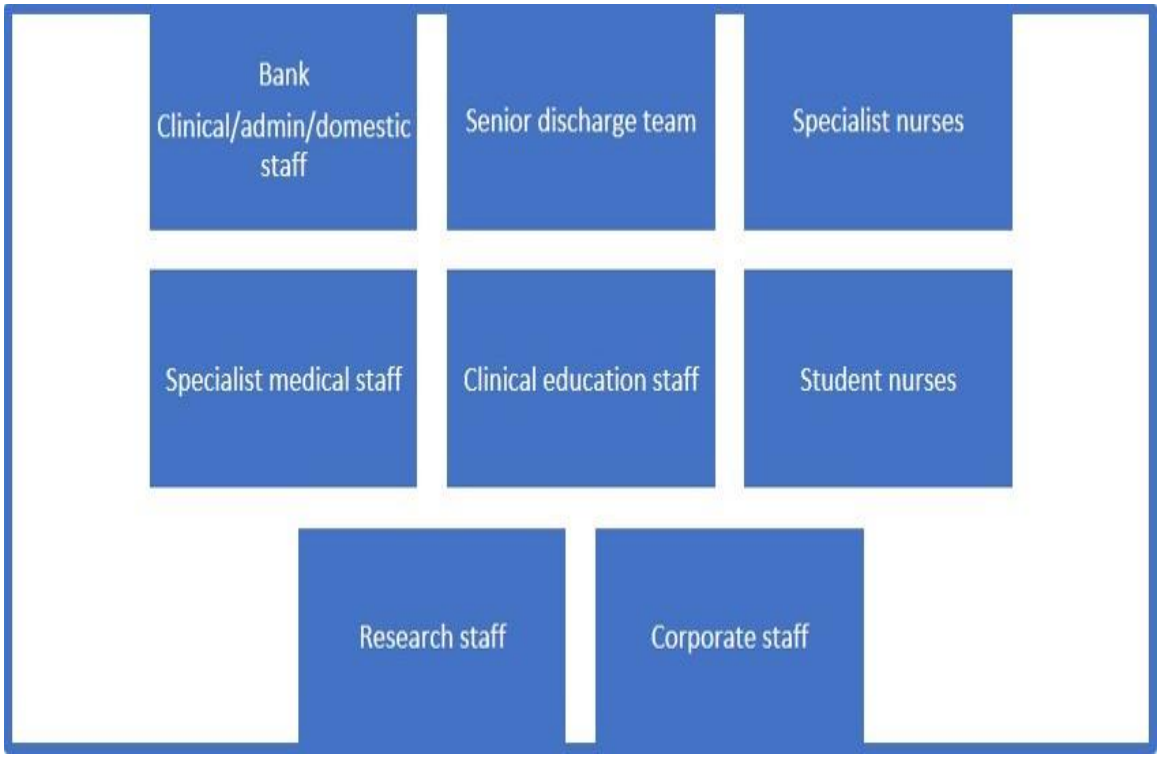
consultants worked permanently on the ward, and these had a good relationship with ward staff. This was evident in the relaxed way they approached and communicated with each other. A larger group of consultants, however, alternated with each other, each spending short periods covering the ward. Nursing staff commented that they did not 'know' many of these consultants, and were 'never sure of who was on when' (senior nurse Ellen, field notes).

The AHPs had strong intra-group dynamics and relatively weaker relations with Hazel staff. This was shown by their spending more time together discussing work and social issues, and in the main only interacting with individual ward staff to discuss patient-related issues. There did not appear to be a great deal of social talk across these groups, but the working relationship was positive. Occupational therapy seemed to have the weakest bond with other staff groups, spending most of their time together, and having fewer interactions with any other groups. Ward staff would sometimes mention not knowing who individual occupational therapists (OTs) were, or how their processes worked.

4.2.3 Staff working across Oakfield Trust

The group of staff that were present on Hazel ward least frequently were those that worked across all trust sites (box

6). Apart from those staff members that had worked in Oakfield for a substantial amount of time, these groups generally had distant group relations with Hazel staff.



Box 6 Staff groups working across Oakfield Trust

The exception to this was the student nurse group. These would be placed on one ward for periods of four to eight weeks, and sometimes longer, depending on the stage of training. They worked closely with assigned mentors on Hazel, and there could often be four students on the ward at one time. The student participants in the main reported positive experiences on Hazel, in terms of relations with staff and opportunities to learn. This was supported by my observations

of relaxed and warm relationships between students and staff and the fact that several students either expressed a desire to work or actually did work on Hazel after qualification.

4.2.4 Service users

As described earlier, the patient population on Hazel was varied, and although the ward was female designated, its eight side rooms were often occupied by male patients. I met patients across the age spectrum, from 20 to nearly 100 years of age, though the majority of patients were approximately 50–70 years old. The patient group featured those with acute and long-term conditions, and some who needed a long-term stay. The ward also had several beds designated for the care of patients who were assessed as end-of-life (EOL).

A group of patients considered themselves, and were considered by staff, to be 'regulars'. These were frequently readmitted to Hazel, commonly several times over a year. A few patients were readmitted around nine times in one year. These regular patients mainly talked positively about the ward, and were reassured by the familiar staff faces, the fact that staff remembered them, and the fact that they 'knew what to expect' (patient Nora, field notes) on the ward. Interestingly, they also used the term 'family' to describe the ward:

> *I feel very safe here, it's like a little family.*

(Patient Joan, field notes)

This regular group of patients, like the 'core' staff groups, also contributed to an internal sense of constancy on the ward. Hazel staff members got to know them, and their family members, in a more personal way. During fieldwork, several regular patients died, and this seemed to be particularly upsetting for staff. One nurse reflected:

> *I got to know her quite well, her daughter was lovely, she'll be devastated. It's hard to put it out of your mind sometimes.*

(Senior nurse Lizzie, field notes)

Many patients commented on a feeling of community with other patients on the ward, describing their relationships with other patients as 'like a little clique' (patient Rebecca, field notes), 'a support group' (patient Fiona, field notes) and as though they were 'pulling together … like in the war' (patient Catherine, informal interview). Catherine's comment referred to camaraderie between patients, but her experience of care was poor. She felt she was 'lucky' that she was independent and able to speak up for herself. She worried about other patients who could not:

> *They just get left … neglected, because they're not able to shout out, or have family to do it for them.*

(Patient Catherine, informal interview)

Other patients similarly noticed the vulnerability of those around them, and would typically get help for those who could not press the call bell themselves and check on them regularly, or share newspapers, magazines or food with patients who did not have visitors.

Some patients expressed a caring attitude towards staff members. Senior nurse Helen (field notes) described the 'boost' this gave her, while Clare (senior nurse, informal interview) felt that receiving care from patients helped her to 'get through to the end of the shift'.

> *[Patients] say, 'What time are you finishing?' 'Oh, you look tired, you need to go to bed' (Laughter) … I still remember one lady from when I first started [nursing]. I was a little bit, quite shy, she used to always try and give me a KitKat, and make me laugh even though she had her own problems … she was looking out for us … Patients do see you running about and they see you, being stressed out, and they're sort of showing the compassion back to you and you need it, it really helps.*

(Senior nurse Lizzie, recorded interview)

There were occasional observations and reports of tension between staff and patients, and this tended to relate to a poor

attitude. Staff found it difficult when patients were 'cantankerous', 'unhelpful' or 'challenging', while patients most often complained of an 'uncaring', 'rude' or 'patronising' attitude. Very infrequently, patients mentioned staff behaviour as being 'rough' or 'bullying' and appeared unhappy on the ward. Staff also had examples of patients who were 'hostile' or 'aggressive'. I witnessed hostile behaviour from relatives and patients towards staff, but no violence on the ward. However, during interviews, several nurses and HCAs referred to aggression and violence, and this was supported by the staff survey (OHT, 2016), which showed an increase in reports of violence. One nurse reflected:

> *As nurses we do take a lot of violence and aggression … Y'know, a punch in the mouth just because somebody's confused …*
>
> (Senior nurse Lucy, recorded interview)

Overall I found relations between staff groups, and between staff and patients, to be largely positive and caring.

4.3 Ward life

4.3.1 Processes and procedures

Hazel ward had 31 beds, made up of both bays and side rooms. It received patients directly from the community, the

emergency department (ED) and medical receiving units. There was a constant traffic of admissions and discharges at all times of the day. The processes and paperwork for admissions, transfers and discharges were almost universally seen by staff as onerous, overcomplicated and transient. Staff were often frustrated that the trust promoted personalised and engaged patient care but mandated that staff work within standardised and time-consuming processes, which they felt prevented them from being with patients. The feeling of being in a catch-22 situation reoccurred in the language of staff participants. It suggested that staff felt that organisational processes reduced their capacity to provide good care, or that they were caught within conflicting organisational priorities. The excerpt below from an experienced nurse encapsulates this no-win scenario. The nurse had felt pressurised to discharge an elderly lady, but the patient's daughter could not be at home to support her until the next day. The patient was tearful and anxious, but the bed managers reminded the nurse of the patients in ED waiting on trolleys:

> *So what do we do? … Do I upset that patient, ignore what she's feeling and push her out to make way for the new admission? Or do I leave some other poor thing lying on a trolley somewhere? It's a lose–lose!*

(Senior specialist nurse, informal interview)

There were other examples where staff felt organisational processes impeded good care. The drive to standardise practice across the trust was referred to as a 'one size fits all' approach (senior nurse Helen, field notes), which opposed the notion of individualised care promoted by the organisation. Additionally, many commented on the frequent auditing and recording of ward activities, which kept staff away from engaging with patients. As one nurse reflected: 'I end up writing about patients that I've not even met!' (junior nurse, field notes). There was a strong notion that documented information carried more weight than clinical opinions, as Dawn reflected:

> *… you go to a meeting and so and so says, 'I've looked at the dashboard and I've looked at this and I've looked at that', but they've not actually spoken to me! (Laughs) It's so frustrating!*
>
> (Senior nurse Dawn, recorded interview)

4.3.1.1 Conflicting priorities

Staff participants did acknowledge that many of these procedures were necessary for the smooth running of the organisation. Nevertheless, there was a feeling that a set of

tacit priorities ran parallel to explicit organisational goals regarding quality of care. Put bluntly by one doctor:

> *Looking like you are doing the right thing is more important than actually doing the right thing.*
>
> (Consultant, informal interview)

Many participants described a confusing array of priorities and no clear indication of which was most important. A senior nurse commented on the overwhelming nature of the demands:

> *We get told, 'Yeah, be compassionate, keep the flow going, make sure everything is clean, ooh, now you're on red alert, purple alert!' ... We can't win!*
>
> (Senior specialist nurse, informal interview)

A range of staff noted that senior staff would 'harass' them (senior nurse Lizzie, recorded interview), 'tell them off' (junior nurse Ellen, field notes) or 'prod' them (junior nurse Alice, informal interview) for issues relating to documentation, audits, checklists and discharge times. However, in terms of patient care, there was little incentive or reward:

> *If I were to say, 'No, I don't have any discharges for you, but I have spent an hour comforting a patient', they would go mad!*

(Senior nurse, informal interview)

A junior nurse expanded on a similar thought:

> *They do [promote compassion] on paper, and when CQC are here, but they don't actually give you the manpower, or the time … or the tools to deliver the care that they publicly state … Because management, and this is a sweeping statement I know, but management simply don't value compassion as part of someone's role in a management position – if they are deciding to promote someone, they don't think, 'Oh yeah, that nurse is really caring and compassionate, let's give her a band six!'*
>
> (Junior nurse Andrea, recorded interview)

As well as creating confusion, these contradictory messages also made it difficult for staff to know if they had done a good job. For example, participants expressed doubt over whether they had done the 'right' things (junior nurse, informal interview) or 'done enough' (HCA, field notes). The following excerpts give an idea of how unsure some members felt:

> *On some days you've got like two poorly patients in your bay and all your other patients and making sure all the paperwork's done, and the cleaning list, and your discharges ready on time and everything like that, and you think you've got it, but then a patient will say, 'Oh,*

we've not seen you much today, Amelia.' And my heart's like, 'Oh no!', and then the bed manager is on at you because you've not got someone ready for transfer, and I just think, what am I doing wrong? … Sometimes I cry on the way home and, erm, it can get me quite down really.

(Junior nurse Amelia, recorded interview)

I seem to get into trouble for getting behind with work because I'm talking to the patients too much. But they want me to, and I want to, actually. But it's no good if we're getting behind, I suppose.

(HCA Suzy, informal interview)

I'm supposed to be an advocate for patients, but most of the time I feel we're not doing the best by them, we're just rushing them out. Even when I'm trying to work out what to do for the best with a patient, everyone's like, 'Speed up a bit, we need the bed.'

(Senior nurse Nancy, field notes)

4.3.1.2 Nursing insecurity

Nancy's words above reflect the finding that when nurse participants talked about their work, they tended to express considerable uncertainty about what constituted 'good'

nursing. This was particularly in respect of 'bedside' care, as the following excerpts show:

> *HCAs show you more respect if you're hands-on, toileting and washing patients.*
>
> (Junior nurse Ellen, recorded interview)
>
> *I try to be right [in the bay] as much as possible, because I hate for anyone to be thinking of me, you know, 'Where's she gone? Why is she not caring for the patients?'*
>
> (Junior nurse Alice, field notes)
>
> *Sometimes I get a little bit of time and I think, right, I'll get out the way and do my writing now … But really I think I should stay there in the bay so people can see I've not just gone off. But when you do that, you get interrupted or people don't think you're actually working.*
>
> (Senior nurse Lizzie, informal interview)
>
> *I've been sat at the desk before, updating [the patient database] or doing patients' TTOs, ordering something, and then I've had relatives come up to me … 'Why aren't you with my relative, why aren't you doing something?' … I feel like turning the screen round and saying, 'Look, I <u>am</u> doing work!'*

(Senior nurse Lucy, recorded interview)

These excerpts reflect anxiety from all levels of nursing staff about the worth and visibility of the work they did. Nurses were aware that others, for example, patients, other staff groups and their managers, placed a different value on aspects of their work. The value of 'bedside' or 'hands-on' care was particularly contentious and the main source of tension between staff nurses and HCAs. However, shifts in the way care is delivered increasingly locate nurses away from the bedside and encourage the delegation of personal care to non-registered care staff. This is the case internationally (Plumb et al., 2017, Allan et al., 2016) and was evident at Oakfield, with the established practice of using mobile technology to record and monitor health status, liaise with other professionals, arrange investigations, and communicate ward information. However, in Oakfield's publicly available information booklets, there were few images of nurses working with technology or away from the bedside (such as doing paperwork or speaking on the telephone). Images predominantly showed nurses close to patients, generally at the bedside and often touching. No other participant groups expressed this type of doubt and conflict over their working role, which suggested that nurses had additional sources of work stress to other staff groups.

4.3.2 Patient flow

There was little doubt among staff that efficient 'patient flow' was the main organisational priority. The term refers to the swift movement of patients through the hospital system towards discharge, and has been an NHS priority for around a decade because of the huge demand for inpatient services (NHS Improvement, 2014). Oakfield Trust is typical of other NHS trusts in terms of its discharge processes, which include establishing a discharge date to aim for on admission, closely monitoring length of stay and developing numerous discharge-related strategies. For example, there was intense promotion of the discharge lounge[3] at Oakfield, a dedicated discharge coordinator for every ward, a dedicated senior discharge team at every hospital site and for the trust overall, and frequent discharge meetings of varying seniority to 'address bottlenecks' (discharge team member, informal interview).

There were periods of greater or lesser intensity, but patient flow pressure was virtually permanent, creating a sense of relentless forward motion. When asked to describe a typical working day, participants tended to refer to patient flow

[3] The discharge lounge is an area with chairs, TV and refreshments where independent patients can wait for their discharge to be finalised, e.g. for medication or transport. It is staffed by HCAs. By moving a patient to the lounge, a new admission can be moved on to the ward.

demands almost immediately, with some explicitly stating it was *the* organisational priority:

> *The primary end point of good care appears to be getting patients out of hospital, not correct diagnosis. And that's immensely frustrating.*
>
> (Senior doctor, recorded interview)
>
> *[Discharging patients] takes up the main part of my day, and is the biggest cause of stress.*
>
> (Junior nurse Amelia, recorded interview)
>
> *Well, the primary aim is to get the patient from A to B as quickly as possible.*
>
> (Junior doctor, informal interview)
>
> *There is this need to just push patients through the system as quickly as possible.*
>
> (Senior nurse Helen, field notes)
>
> *It's the pressure on beds … We get pressure from the senior people … and I've definitely observed people who seem to have lost all compassion completely because they're focused on the numbers and the beds. They're getting so much pressure from other people and that stress is overtaking them, and it's people I know are*

kind and caring, but the situation they're in, it just becomes too much.

(Senior nurse Dawn, recorded interview)

The language used to describe the patient flow was evocative of a disorientating pressure. For example, seeing patients was described as a 'conveyor belt' (OT, recorded interview), and staff felt like they were 'running from one [patient] to another' (senior nurse Helen, field notes). Admissions were being 'piled on them' (junior nurse, field notes), staff were being 'constantly pushed' for discharges (physiotherapist, field notes), and they sometimes couldn't even say goodbye to their patients:

You can't even speak to the patient sometimes, you go over and, oh, they've already packed up their things, patient is ready to go! Sometimes, it's nice to say bye, and see them better [from] how poorly they were.

(Senior nurse Clare, recorded interview)

The language of non-clinical staff groups reflected the same sense of pressure, despite their having no direct responsibility for discharges:

The bed managers come in and say, 'We need the beds, we need the beds', but we've still got poorly patients on

here and it can be really frustrating, because they don't listen. I know there are poorly patients that need to come over, but we've just not got the beds, what can we do?

(Administrative staff, recorded interview)

It impacts on the whole ward to be honest, because it's not just the doctor discharging a patient, it's not just a nurse trying to get the medication, it's the whole team … I can have eight exit cleans to do in the day … and the phone is ringing and it's [ED] saying, 'We're sending the patient over, is the bed ready?! When will the bed be ready?!'

(Cleaner, recorded interview)

However, the patient flow pressure seemed to affect nurses and doctors most intensely. The language they used expressed both powerlessness, and anxiety:

You're always getting badgered to get [the discharges] out before ten, before twelve. Which I understand is the priority, because there's always patients waiting to come in. But you want to make sure that your patients are going to be safe … And then they're whipping the patient off to discharge lounge with all the paperwork, and you've not done your paperwork yet. [So] it's not taking

into consideration the nurses' working day … I need to make sure I've done it properly.

(Junior nurse Ellen, recorded interview)

Y'know, we have patients flooding ED … our readmission rate is sky high, and we're not, in my opinion, sorting out care properly on the wards to prevent that. Or maybe there's a failure in social care as well. If we're not careful, we'll get to a Mid Staffs point where we are just spinning the wheel faster and faster and faster.

(Senior doctor, recorded interview)

One senior nurse reported refusing a promotion because of this pressure:

One day, we had four patients swapping wards and I had my own eight patients, and was coordinating [the ward] with one agency nurse and one new starter, and two of my patients had tracheostomies. And at the end of the day, the bed manager comes and says, 'Why have you not moved that patient? They have been waiting forever!' That is too much pressure for me … That's the only reason I [didn't take the post].

(Senior nurse Clare, recorded interview)

Staff participants expressed an awareness of why this pressure existed and felt concerned for those patients waiting in ED. Nevertheless, it was clear that patient flow was a major source of work stress. It was also another 'lose-lose' situation for staff, who felt anxious both about the patients waiting for beds and about compromising care to speed up discharges.

Patient flow also affected patients, who were frequently asked to move beds or wards to accommodate others. Many patients were moved three times or more, and each move created additional work for staff. Patients tended to find multiple bed moves disruptive and occasionally upsetting. Sue's words below show how the disruption could play out on the ward:

> *They asked the lady next to me if she would move beds so they could get a poorly patient in where they could observe her. Ooh, she really went up in the air about it! She went to look at the new room and there was only a small window and she didn't like that, and she said to the nurse, 'I'll be on me own! I'll not be able to socialise!' And this nurse was getting fed up and says, 'It's a hospital, love, not a hotel!'*
>
> (Patient Sue, recorded interview)

Grace was moved several times in one week, and I commented that I couldn't keep track of her:

> *She gave a sardonic laugh at this and told me she had just heard that she will be moving again, this time to a different ward. 'I've never been moved so much, it's like pillar to post,' she says. She adds that she supposes they have to do these things, but she doesn't understand it. 'It seems such a waste, the cleaners have just done this room and now they will have to do it again.'*
>
> (Patient Grace, field notes)

Multiple new admissions could be brought on to the ward simultaneously, sometimes with little or no warning. When this happened, ward staff would focus on urgently organising the attendant medication, doing paperwork and cleaning just-vacated bed spaces, and patients could be left looking uneasy among the urgent activity.

4.3.3 Constant flux

4.3.3.1 Staff changes

In addition to the pressurised and continual movement of patients, there were regular staff changes and large-scale reorganisations within the trust. In terms of staff, there were the rotations and temporary moves to other wards that are typical of healthcare organisations and a necessary part of clinical training. Although it was typical and planned for, the

introduction of new junior doctors to the trust every August created additional work for the clinical staff who were supporting them to settle in. Agency staff usage was relatively low on Hazel ward, but nurses and HCAs were often asked to cover other clinical areas with little notice. Staff disliked moving, because, as one participant put it, they preferred to 'stay with the family' (senior nurse Clare, field notes). On one occasion I did observe a nurse refuse to move, but in the main staff reluctantly agreed. Nurses in particular seemed to be unsettled by the mid-shift movements, worrying about incomplete documentation, working in unfamiliar surroundings and being responsible for an entirely new set of patients.

In addition, a number of participants reported that they were asked to extend their remit of work and generally did not feel either ready or able to take on the additional load. One participant recalled the panic she felt when she was asked to extend her scope:

> *Well, they said to me on Monday that I would have to cover eight wards as well as here, and I said I can't do it … I physically cannot cover eight wards and 50 patients!*
>
> (Administrative staff, recorded interview)

Staff participants from all groups referenced the seemingly constant introduction or amendment of policies, procedures

and initiatives, which generated a sense of transience. For example, staff felt they worked on 'unstable ground' (junior nurse, field notes), that changes in procedures were introduced for 'change's sake' (administrative staff, informal interview), or that the old protocols would 'soon come back round again' (senior nurse, field notes). Often staff would ignore new procedures, continuing with their normal practice until it was clearer that the new initiative would stay. The following excerpts show the lack of confidence in new procedures:

> *I've just printed out a new guide [for social work referrals], but I'll just put it here for now, because no doubt that'll change again before the end of the week.*
>
> (Administrative staff, informal interview)
>
> *Well, our scores aren't good in terms of the dashboard, but there is a new model being developed … so I'm not really focusing on those anymore.*
>
> (Senior nurse, informal interview)
>
> *They're saying [safeguarding is] our remit now, so god knows what we're supposed to do about this [case] … Let's just refer to safeguarding anyway, that's what I'd normally do?*

(Nurse, field notes)

Well, now they said they want us to report <u>all</u> patients, even though last week they only wanted the new admissions … But when the matrons take over, they won't want that, they'll just change it again, so just leave it as it is.

(Administrative staff Val, field notes)

So we have different numbers to indicate what level the patient's [medications to take home] are at. A 'two' is awaiting pharmacy screen, and it goes up to a 'seven' where we are just waiting for a nurse to sign them off. It should be that the [medications] are at a six or seven before we can send them to the discharge lounge. But really, they pick and choose the level according to the pressures for beds. It's totally confusing. I just treat it as a joke now. I say, 'So when can they go today, matron? A five? A two?!'

(Junior nurse Ellen, recorded interview)

These frequent changes created a chronic feeling of instability at ward level. However, this was also the case at the broader trust level, and in combination the sense of flux was evident.

4.3.3.2 Organisational changes

Although again it was typical of contemporary healthcare organisations, Oakfield seemed to be in constant flux. Organisational restructuring, planned and unannounced inspections, workforce strikes, and spikes in bed pressures were some of the events during fieldwork. Within six months of fieldwork finishing, nine key members of staff had moved, left or announced their upcoming departure, including the chief executive of Oakfield, the matron of Willow Unit and the Hazel ward manager. It is important to recognise also that such changes took place during a period of unprecedented turbulence in the NHS (Boyal and Hewison, 2016). The impact of this constant change on staff was also destabilising for corporate members of the organisation:

> *Every time there is a change [in government] they change the whole system and we all have to reorganise, and it's really frustrating, because ultimately I'm just a nurse who wants to look after her patients, and I want my nurses to be able to look after their patients, but … if we don't tick the boxes … then we will get fined for not ticking boxes, and that's money that doesn't go into patient care.*
>
> (Corporate staff Patsy, recorded interview)

Patsy's words suggest how macro-level pressures directly filter down to front-line patient care. In the context of organisational and ward-level instability, this contributes to an unpredictable and insecure working environment.

4.3.4 Working space

Hazel ward had a rectangular shape, with a long central pathway (see figure 12). Along the right side were four six-bedded bays, each with large windows that brightened the ward when the bed curtains were drawn back. The left side of the ward was always darker, because the rooms had doors which blocked out the natural light.

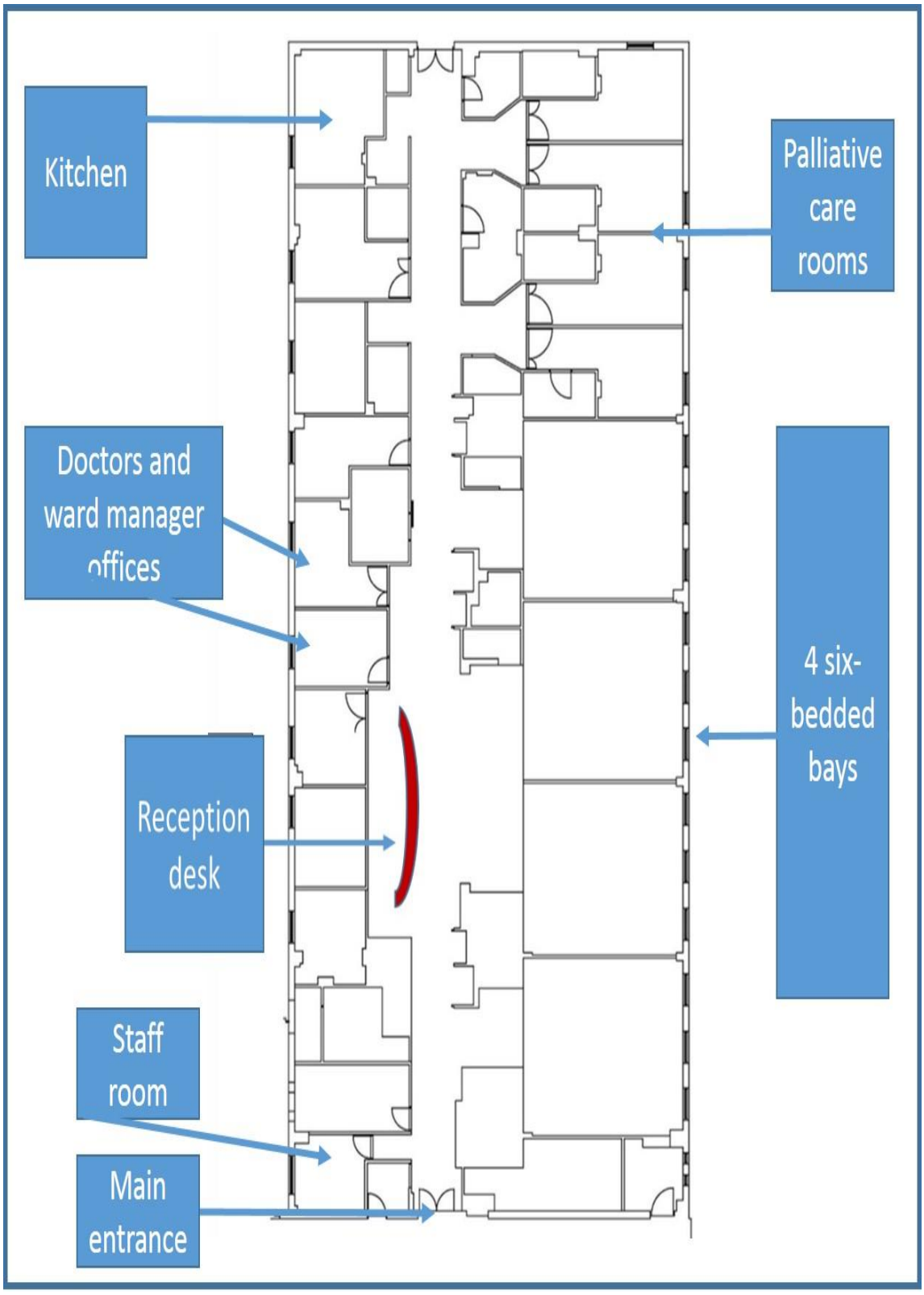


Figure 12 Hazel ward layout

Almost every wall space was lined with monitors, tables, chairs, computers, trolleys and the like, meaning the central pathway was the only clear area. The lack of space was problematic, especially during clinical emergencies, as furniture and equipment needed to be moved out of the way by staff. At visiting time, the ward was particularly crowded. Strict visiting rules aimed to minimise congestion by limiting the time and the amount of people, although individual requests to visit outside the set times were sometimes accommodated. Staff frequently had to remind visitors or enforce the visiting rules, and this was not always taken well.

Weekday mornings from 09.00 until 13.00 were the busiest times of the week. The cleaning team, phlebotomists, medical firms and their attendant trolleys and equipment competed for space with the nurses and HCAs, who were giving medication, meals and care at the same time. Groups of physiotherapists, OTs and pharmacists crowded into any remaining gaps to discuss their plans. Towards the end of the morning, new patients were wheeled in, while discharged patients squeezed past them to get out. I found these times to be overwhelming. The permanent staff were generally uncomplaining, but during these periods I saw people fanning themselves, looking flushed and uncomfortable, and commenting about headaches and thirst.

Staff generally struggled to get off the ward for food and drink due to workload and staffing issues. This was recognised by the trust, and posters were put up urging staff to take their allocated breaks. One doctor reflected on this:

> *There's that poster on the toilet door that says, 'Make sure you take a break' and 'If you need to contact someone …' There's a little box … to show who you should contact – and it was just blank! On every single one that I've seen, it's been blank!*
>
> (Junior doctor Rob, recorded interview)

Nurses appeared to find it particularly hard to get off the ward. I often saw a nurse announcing they were taking their break, only to be diverted by a colleague or relative so that they missed all or part of it. Breaks were often taken alone, or with just one other staff member, due to lack of staff cover. No one complained about this during fieldwork. However, there is no other informal private space for staff, and the trust discourages staff from having social conversations, eating or drinking in public areas (Oakfield Trust, 2015). Behind the reception desk was a small doctors' office, and the ward manager's office, and occasionally care staff used these, but it required them to leave the clinical area, which was impractical for off-the-cuff private discussions. There was therefore little

time or space for nurses to privately talk, or to get support or brief respite from the intensity of ward work, and they consequently spent the majority of their 13-hour day 'on stage' (Bolton, 2001).

4.3.4.1 Screens and notices

In addition to the congested corridors, the ward was also crowded with notices and posters along the walls and doors. Three patient information boards stood behind the reception desk. The largest of these was a digital board, the left side of which flashed a rapidly changing set of bed numbers and names. On the right side was a diagram of the ward layout, with pulsing alerts, warning triangles and various symbols for key information. Computer screens were visible from all areas of the ward. Vivid screensavers had been designed by the trust's communications department to message the staff throughout the 24-hour period. The screensavers rotated, and each one had a different bold colour and message. Box 7 shows a selection of the messages I saw during fieldwork.

"Escalate delays – every second counts!"

"Introduce yourself to patients"

"Make every interaction with your patient meaningful"

"Follow strict hygiene practices and help prevent infection"

"Help avoid patient falls from hoists-are your staff competencies up to date?"

"Flu has now hit! Protect yourself and your patients!'

"Nails must be short, no longer than fingertip length. Follow our uniform policy"

"Keep the nurse's station clean and tidy"

(Fieldnotes, various dates)

Box 7 A selection of screensaver messages seen on Hazel ward

Many staff described the messages as 'negative' (senior nurse Lucy, field notes), 'annoying' (junior nurse Amelia, field notes) or 'directive' (corporate staff, recorded interview). One screensaver caused particular irritation to ward staff. It announced that only black or blue hair ties were acceptable for staff, and sparked numerous exasperated comments relating to the clinical importance of hair tie colour. One senior member of staff contacted the communications department to complain, and suggested that occasional positive messages

would be appreciated. However, by the end of fieldwork there had been no changes to the screensaver communication.

The messages had a negative inference – an assumption that the instruction had not been carried out. The wall notices and posters which directed, prompted or warned staff of various issues reinforced this inference. Along the wall on one side of the ward, I noted three cleaning checklists, two notices cautioning staff about being overheard discussing patient details, one asking if they were bare below the elbow, two reminding them they were responsible for any health and safety issues they discovered, and three encouraging staff to report colleagues who did not follow the handwashing protocol. Conversely, there was only one positive notice in the open ward. This was a feedback board on which Hazel ward staff themselves could write comments from patients or relatives about things they were doing well. Numerous participants complained about a lack of positive feedback from the organisation:

> *It seems to be always 'Remember this, remember that' rather than 'Congratulations! This week you achieved the 90% target.'*
>
> (Senior nurse Lucy, recorded interview)

They are quick to criticise but not quick to praise … we mostly get [praise] from patients and relatives … I've seen some positive things [from the trust] on Twitter, but I don't go on it that often, so people that don't use it won't see it. It would be nice, though.

(Junior nurse Ellen, recorded interview)

We don't usually get to know about the care we gave, you know, if it was good, bad, we don't get to know … Sometimes, [a patient] might email and say, 'We appreciated the care', but they always forget our names!

(Senior nurse Clare, recorded interview)

Dawn expressed her disappointment at the lack of positive response after a period of intense effort by Hazel staff to pass an audit:

… we did amazing! And I've had one email from the medical director to say thank you – nothing from the chief nurse, nothing from anyone else. So it's things like that I think, well, thanks!

(Senior nurse Dawn, recorded interview)

The dominant presence of negative instruction, given whether needed or not, was interpreted as continual 'nagging' (senior nurse Lucy, field notes) or 'prodding' (junior nurse Alice,

informal interview). One doctor gave a vivid description of the pressure he felt:

> *We just constantly have emails and even the screensavers … and they're shouting, 'We're in the code red!' or whatever it is … 'We're over capacity!' … and 'Prioritise pre-noon discharges!' and blah blah blah … It's just constant, unceasing all the time, and you just can't fight against it … It's the biggest impact on all the personal stuff.*
>
> (Junior doctor Rob, recorded interview)

Rob's last comment indicates that the ultimate end point of the relentless 'badgering' (junior nurse Alice, informal interview) is to shift staff attention away from caring interactions in order to manage the operational demands.

4.3.4.2 'Work talk' and 'chit-chat'

The visual 'nagging' of the notices and screensavers was reflected in the dominant sounds of the ward. It was most often filled with 'work talk' and harsh sounds. Work talk describes the direct, sharp-toned exchanges of question-and-answer dialogue. This was the main type of conversation between staff, and often between staff and patients. There seemed to be no space in these dialogues for non-essentials, and I found myself paring down and speeding up my own

conversation to match the staff I was talking to. The movement of staff at these busy times was also distinct: fast-paced, zigzagging and purposeful. Often they would travel with their head down, suggesting a kind of physical defence against any further requests. Buzzers, phones, bleeps, alarms and bells added to the staccato work talk, so that at the busiest times, the ward could be hot, noisy and crowded.

There were more relaxed periods, but they were fewer and further between. There could often be a calmer time most weekdays around lunchtime, as Oakfield, like other trusts, had protected mealtimes when no non-emergency tasks should occur. The ward was generally less crowded, because doctors and AHPs tended to take their breaks at this time. Weekends and public holidays could be similarly quiet due to the reduced staffing. During these periods, the sound of 'chit-chat' replaced 'work talk'. Chit-chat refers to social conversation, and was characterised by relaxed tones, laughter and a slower pace. Patients highlighted these relaxed social exchanges:

> *The staff are great, especially when they get a bit of banter going, and it makes you forget your aches and pains … It distracts you, otherwise you would be all focused on it and gloomy.*
>
> (Patient Jenny, informal interview)

> *I'm a regular here so they know me … We have little nicknames for each other and we can have a nice chit-chat.*
>
> (Patient Nora, informal interview)

The atmosphere around this social talk was also more relaxed. I described it after my first weekend observation:

> *The atmosphere is more gentle and marked by pauses … in these pauses individuals drift together … there seems to be more chit-chat and touching between staff and staff, staff and patients.*
>
> (Field notes, 31/1/16)

In these relaxed moments, there appeared to be greater time and space; staff took longer to get where they were going, stopping to comment on superfluous details as they passed others, and laughter, hugs and compliments extended conversations. The staff seemed to gravitate towards the patients, so that even when a task drew them away from the bedside – the phone ringing on the desk, for example – they would drift straight back. One HCA reflected:

> *When it's quieter, I try to start chatting with people, get a bit of banter going so you can include them in the conversation.*

(HCA Suzy, field notes)

I love working Christmas. We can get the music on, take our time … have a natter. There's no one else here to give us all the extra jobs!

(Junior nurse Nancy, informal interview)

There were instances of poor care during these relaxed periods, and many examples of warm interaction during peak times too. However, the atmosphere of the ward seemed different at these quieter times, so that it appeared easier for people to engage more personally with those around them. The following field-note excerpts give scenarios from typical relaxed ('Hospital corners') and busy ('Pressure point') periods. They show how the quality of the engagement between people and the style of communication could differ between these times.

Hospital corners

I hear laughter from bay 2 and turn to see a few patients chuckling with Amelia [staff nurse] and Suzy [HCA]. There is an easy flow of conversation between them. The patients watch the staff make beds. They are all talking about hospital corners and the way they were told to make their beds by their parents, and how they now make their beds at home. One patient is knitting,

one is leaning forward towards the other ladies, one looks up from her magazine occasionally to join in.

Pt 1: Ugh, hospital corners, I used to hate doing them, but that was how my mum liked it.

Pt 2: Yeah, I did those before, but now I just have the fitted sheets – what a revelation, so easy!

Pt 1: Ooh no, they drive me crazy!

Suzy: Why? They're so easy! Just your sheet, then chuck your quilt on!

Pt 2: No! Gotta have a top sheet on with the quilt!

Pt 3: Well, that keeps the quilt clean, doesn't it?

Suzy: Just wash the quilt!

A burst of gentle laughter rises, and there is a general air of warmth and connection. Amelia and Suzy are in and out of the bay, making beds, doing jobs at the reception desk, then coming back to the bay, dipping in and out of the conversation. Suzy keeps repeating things one patient has said to a hard-of-hearing lady in the corner, although this lady doesn't join in. The cleaner enters the bay and hands a small rubbish bag to one of the ladies. 'You get through them, don't you?!' They all

laugh and the conversation turns to Christmas preparation.

(Field notes, 27/11/15)

Pressure point

Lizzie is coordinating today. We start chatting at the reception desk and she tells me how tricky it was yesterday. She was coordinating that day too but also had a bay of patients to look after. She says she always finds this hard.

Someone calls her name and I notice that a lot of people are now around the reception desk. I see two surgeons reviewing a patient's notes, a family of three who have been called in to see their deteriorating relative, three members of the bed management team, two porters waiting, a few nurses and two HCAs. Most of them want Lizzie's attention. Some call her name or lean over the desk to touch her arm, while others wait, looking impatient. Standing next to Lizzie, I feel hot and crowded and I'm struggling to decipher who is saying what. The tone of the voices is direct and urgent.

Lizzie speaks to the person nearest to her about the new process of reporting defective mattresses. After that she tries to deal with the others one by one, although

sometimes she is interrupted by someone else. She is looking flushed but manages to stay patient. She starts talking with the surgeons, but as she does, three members of the bed management team come up to the desk, leaning in to question a staff member who has been managing a tricky discharge. Their tone is sharp: 'Why did that happen?' 'Why didn't you do it like this?' The staff member is looking under pressure, leaning back from them slightly, trying to explain why.

Lizzie tries to listen to what they are saying while also talking to the surgeons, but they look annoyed and speak louder, holding up a file to point something out. As they finish, the phone rings and Lizzie answers it. Her voice is flat and she looks exhausted. I remain in the area for a while after this. It is at least an hour before Lizzie gets away from the desk, and sometime after that that she has a break.

(Field notes, 9/11/15)

After the calmer lunchtime period, there is another high-activity time around 14.00 on weekdays. Visiting starts at 14.30, but people begin to trickle in earlier. Doctors and AHPs return, and porters arrive to bring patients or collect them from the ward. Most people go straight to the reception desk,

and I found this to be a significant site of communicative activity on the ward. Most face-to-face conversations, phone calls, electronic communication and documentation happened here, and many key events occurred at this site. It was a dark wooden desk, long and narrow. It supported phones, computers, files, multiple charging tablets and the odd contraband coffee cup. Behind the desk was the door entry button. Even in the rare daytime moments when no one was at the desk, the flashing screens, ringing phones and buzzing doorbell maintained its appearance as a hub of activity.

The concentration of bodies and activity around this small space reflected the ebb and flow of ward activity throughout the day and night. On weekdays before 17.00, it was crowded with people leaning in, reaching over, and combining talking with writing, typing or searching. After this time, the bodies around the desk started to disperse, the phones rang for longer, and the activity became more balanced across the ward. After around 18.00, there were mainly only HCAs and nurses on the ward, and relatives sitting at the patients' bedside. In the evening the desk area seemed to be on standby, as staff would drift back and forward to the desk more sporadically, to answer the doorbell or phones, or document their work. Preparations for the handover to the night-shift staff began around 20.00. There would sometimes

be a doctor finishing off on the ward or dealing with a serious event, but around this time the medical team and AHPs would leave the ward to hand over to the out-of-hours service. This service is delivered by a small medical and nursing team, which takes responsibility for the hospital overnight, providing on-call clinicians as required. Overnight, the desk became enlivened again, providing a base for the nurses and HCAs on the night shift. The glow from the screens illuminated the desk in the dark ward, lighting up the faces of the staff using spare moments to document, update, and complete training or assignments. There were very few of these spare moments, however, as the reduced staffing meant nurses and HCAs would go back and forth from bed to desk until the morning shift arrived again.

4.3.5 Suffering and compassionate care

Lastly, it is important to convey an aspect of ward life that was fundamental but not immediately obvious to me. I started fieldwork with compassion high in my mind and looking for what might illuminate that. During an early informal interview, I asked a staff member, quite clumsily, what compassion meant to her. She replied simply:

Each and every person here is suffering in their own way. I try to make a difference to that. I think that's what compassion is to me.

(HCA Suzy, informal interview)

This quote came to my mind many times subsequently and led me to shift my perspective during observations. I began paying more attention to suffering, and realised how extensive it was in the setting. The following reflective field-note excerpt illustrates the pervasive nature of suffering on the ward, and that it was not confined to patients:

Suffering

Today's session was totally draining. In a single bay of six patients I saw a frail woman tightly curled up in the bed, eyes staring out as though she was experiencing some invisible terror. Another elderly patient was desperately searching for her mother and was utterly bewildered as the receptionist, gently leading her back to the bed, told her that her mother wasn't here. A third patient gripped the bars of her bed as waves of nausea flooded through her. The nurse in the bay was kneeling on the floor by another patient, gently bandaging her painful leg ulcers while at the same time trying to ease the woman's frustration about not being able to get

home, patiently explaining the need for a care package and mobility aids. The HCA emerged from the curtains of the sixth patient, who was now brightly sitting up in bed after personal care. The woman experienced severe bone pain from her cancer and the HCA had called another staff member from the next bay so they could move her more gently in the bed. It seemed to be successful, as I had not seen her looking so comfortable in the past two days in the ward. As the staff member went back to her own bay of patients, I saw her stop to rub her back. I knew she had long-standing pain issues, but she felt unable to take more time off work. A nurse then came out of the clinical room, eyes red and teary. She was coordinating the ward that day, as well as her own bay of six patients, and that morning had told me she still felt woozy from her previous night shift. At this point it was only 11 o'clock.

(Field notes, 3/2/16)

The extent of suffering is perhaps unsurprising, as the hospital environment, and the provision of healthcare services therein, draws those who suffer to its doors. It is reasonable to suggest that those choosing to work in ward settings expect to deal with the pain, distress and multiple needs of others. Hazel

ward staff demonstrated an acceptance of, and resilience to, suffering in the main, through their efforts to discern, and their readiness to engage with, the suffering of others. The language of ward staff worked to minimise the extent and impact of suffering in the setting. This may be partly a protective strategy to enable staff to manage their emotional responses while on the ward. It might also have reflected how suffering was normalised on the ward. However, a consequence of this minimising and normalisation was that their response to suffering – predominantly compassionate care – was similarly diminished.

An example of this was the general lack of acknowledgement on the ward of what was a profoundly difficult period. A group of patients had particularly distressing circumstances and required intensive support from the ward staff. The following field-note extract from a bed management meeting[4] illustrates the 'bad patch':

> *Hazel staff present the current inpatients. There are a couple of 'complex' cases – a patient whose main carer has been found dead while she has been in hospital.*

[4] These were weekly meetings, in which the coordinating nurse and the staff member responsible for discharges would go to meet a senior member of the discharge team. They presented all the patients with the purpose of facilitating discharge and escalating any discharge-related problems.

Another who has young children that she alleges have been abused by her partner and father. I've watched the ward staff struggle to deal with the safeguarding issues connected to this. The discharge team member offers some contacts and sends off an email at that point, to 'escalate the issue'. These complex cases are interspersed with 'straightforward' cases of protracted dying, unrelieved symptoms, depression, terminal diagnoses, family estrangement and distressed patients requiring support because they have been judged 'not safe' to go back home. The list is reeled off matter-of-factly. It utterly belies the time, energy, frustration and sadness that I have seen in the staff dealing with these cases, and the fact that they have done this alongside the normal operational headaches. They are also received matter-of-factly by the discharge team. I am shocked that no one wants to ask how the hell the ward are managing with it all?

(Field notes, 30/11/15)

In addition to these challenging cases, staff managed their normal caring work, as well as heading into the winter pressure period and undertaking the preparations associated with that. However, there was little mention of the sustained

emotional work being carried out by ward staff, or of the potential cumulative effects on them. Ward staff described this period as 'a bad patch' (administrative staff, field notes) or a 'tough time' (senior nurse, field notes), or dismissed my comments with a shrug, saying, 'It's just part of the job' (HCA Tina, field notes). These comments suggest a superficial engagement with the patients involved, but their discursive and social practices on shift suggested that staff were often emotionally invested in, and working to relieve, patient suffering.

It is important to note there were staff responses to suffering that were not meaningfully engaged. Interactions could be cold or indifferent, and unrelieved and unnoticed suffering was evident at times. Frequently this inadequate care occurred alongside compassionate care, and often involved staff members that I had otherwise observed in thoughtful and caring exchanges. This does not negate the impact of poor care, but it does suggest that compassionate care is more complex than the actions of 'compassionate' or 'uncompassionate' people.

4.4 Conclusion

In this chapter I have set the scene of Hazel ward – its people, processes and atmosphere. In doing so I aimed to give a

sense of the conditions of practice and the dominant aspects of the ward that shape the interactions within it.

I described the often crowded, hot, noisy atmosphere and the practical problems this caused. I highlighted organisational factors, such as the relentless changes, regulatory processes, intense operational pressures and conflicting priorities. A consistently high workload and compelling forward motion reduced the opportunities for respite from, and support to manage, work-related stress. Lastly, the pervasiveness of suffering meant that the emotional demands on staff were constant and intense, but generally unacknowledged.

Despite these factors, I found Hazel ward to be a caring, safe environment. This was related to compassionate concern shown by staff towards patients, but also care from service users towards staff. However, the feeling of care and safety was difficult to achieve and maintain. Ultimately, tensions could arise and escalate to poor care or aggression. In the following three chapters I unpick this description of life on Hazel ward, to show how the issues introduced here relate to compassion, in terms of its broader context (chapter five), its construction (chapter six) and how it is received (chapter seven).

Chapter five: Contextualised compassion

> *That's why you get those nurses that just crack or burst into tears … or they're going to lose their temper. They're going to shut themselves somewhere where nobody can see them because they're absolutely at their wits' end.*
>
> (Senior nurse Lucy, recorded interview)

5.0 Introduction

In the previous chapter, I described Hazel ward and presented several elements of the context that seemed to dominate in the language and practices of staff. In this chapter, I present the theme of 'contextualised compassion' which refers to the notion that the ward setting has a distinctive context, characterised by operational pressure, organisational processes, suffering and threat. This context shapes how staff enact compassion, as well as social relations generally on the ward.

This chapter is structured in five sections. I first discuss care on the ward that is generally of a high standard, compassionate, and rewarding for staff despite the contextual challenges and difficult nature of the work. These are: end-of-life care (EOLC), care of patients in the cohort bay, and emergency care. I examine how compassionate care appears

to be enabled by the organisation in these situations. I then discuss contrasting care situations, particularly those relating to high bed pressures, and consider how the organisational context appears to inhibit compassionate care.

In the next section, I suggest that contextual factors in combination (e.g. relentless changes, regulatory processes, conflicting priorities, inadequate staff support, sustained operational pressures) create a threat-based context. I present findings to evidence that the impact of threat is reflected in the language and practices of staff. I follow this by demonstrating how this threat context appears to impact on care.

I conclude by suggesting that ward work is inherently challenging, and that staff are prepared and able to manage this to a degree. However, a lack of organisational acknowledgement of its physically and emotionally demanding nature, and of positive, organisationally embedded practical support to manage it, make the challenges intolerable. As a result, the capacity of staff to engage with patients compassionately is reduced.

5.1 The context of compassionate care

In this section I present data to suggest that working in a context of suffering, pressure and uncertainty was not in itself

problematic for staff. This type of context is typical of clinical settings, and healthcare staff expect caring work to be challenging. I present three aspects of ward care now: firstly care relating to patients in the cohort bay, secondly, then EOLC and lastly emergency care. These examples are revealing because, despite multiple difficulties, staff not only gave excellent compassionate care, but also found the work positive and rewarding. I then suggest how these examples illuminate how a hospital can support compassionate care.

5.1.1 Care in the cohort bay

The cohort bay on Hazel ward was a designated six-bedded bay that was clearly observable from the reception desk. Patients who were cognitively impaired, were unable to summon help themselves or required close monitoring were allocated to this bay. A member of care staff was also allocated to the bay, and they wore a coloured badge to remind other staff not to call them out of the bay to do other things. If they did need to leave, they had to pass the badge to another staff member who would then take responsibility for the bay. This is a care strategy that is used in many other UK hospitals. It meant that unless there were no patients meeting the criteria, this bay had multiple patients who were experiencing significant suffering. There would typically be several patients with agitation, paranoia or confusion, and

multiple patients exhibiting behaviour such as aggression, crying, repetitive calling or wandering.

Although working in this bay was emotionally and physically demanding, I consistently observed skilled and compassionate responses to the suffering of these patients. Some staff members were even able to use their own experiences of suffering in a positive way, describing this as 'helpful' for themselves as well as patients (HCA Iris, field notes). One participant described this from the patient's perspective:

> *This HCA came up, and, immediately, she just knew what to do, she just soothed me right away. Oh, I was just so upset, I broke down, I just poured it all out to her. And she shared all this personal stuff even though I didn't know her. I told her, 'It's people like you that make this bearable.' She said, 'That's what we're here for', and I thought, good god, what a job.*
>
> (Patient Fiona, informal interview)

In some cases, compassionate care appeared to prevent suffering. I saw instances where patients were becoming agitated or distressed, but then settled in response to skilled and thoughtful care. I watched a range of staff, including support staff, stroking patients' hands, and singing, soothing, or sharing personal stories with patients. They would reassure,

check up on – 'just popping my head in!' (HCA, field notes) – and comfort those who were distressed. The following excerpt illustrates the often-understated nature of compassion, as well as its role in the prevention of suffering:

> *Cohort bay care*
>
> *I can hear different noises coming from the cohort bay. There is a confused patient who appears to be paranoid, saying that staff are trying to harm her, poison her, keep her here. She is wandering angrily around the bay, to the main reception desk and back again. She is a frail elderly lady and looks like she could easily fall. Her movements are sudden and erratic.*
>
> *I become aware of more staff around the area. I have not heard anyone call for help and no buzzers have been pressed, but two more HCAs and a staff nurse have come into the cohort bay. The incoming nurse joins the cohort bay nurse at the other side of the patient. She does not touch the patient, but her hand hovers at the small of her back, I think in case she goes to fall.*
>
> *Both nurses try to help her to use the phone. The patient is asking to call her daughter so she can tell her she is being harmed. The patient snatches the phone and starts speaking, very confused and angry, fearful. I*

am not sure if there is anyone on the other end. One nurse gets the patient a chair and gently helps her to sit. Then the nurses look back towards the bay and move into it.

I realise now that there are other unsettled patients, perhaps agitated by the commotion. One is calling out quietly but anxiously and repeatedly for tea. One is getting out of bed. Another is shouting at her neighbour. Staff members move into the bay and attend to each one, seemingly without communicating with each other.

[Administrative staff] Emily notices the lady on the phone getting up. She follows her back to her bed, at a bit of a distance. She sits on a chair at the bedside and chats pleasantly in the face of aggressive responses. The phone on her desk is ringing, but she stays with the patient. The patient eventually settles and Emily goes back to the desk. I look back to the rest of the bay. The other patients have settled and the extra staff have gone back to their bays.

(Field notes, 4/5/16)

There were several similar episodes of care, and each seemed like a skilfully coordinated dance, with staff gravitating intuitively to where they needed to be. Participants did not

mention these episodes when I asked for examples of compassionate care, instead giving examples that were more dramatic. When I cited these examples as compassionate and asked about them, staff were often surprised and would remark that they thought it was 'just general care really' (HCA Mel, field notes). In longer conversations and interviews, the language of staff suggested significant expertise underpinning this care. They talked of anticipating care needs, by drawing on prior knowledge of the patient and personal experiences. They also noted how effortful it was to remain gentle and focused with one patient, while feeling overwhelmed by the needs of others close by. Reflecting on these examples of compassionate care sometimes led to staff describing a feeling of 'pride' (HCA, field notes) or 'reward' (senior nurse, informal interview) with regard to the care they gave. I was unsure if staff would have expressed these feelings without the opportunity to reflect on the high quality of their work.

5.1.2 End-of-life care

Working with patients who were dying also exposed Hazel staff to some of the most complex psychosocial and/or physical suffering. EOLC involves caring for the whole family and managing the challenging dynamics generated by a terminal diagnosis and symptoms. However, staff participants frequently expressed pleasure when they were allocated to the

EOLC section of the ward and reported a high degree of reward from this care. The EOLC given by staff was widely recognised by staff external to Hazel ward to be excellent, and was regularly described by patients and families as skilled, personalised and compassionate.

The organisation of EOLC was quite different to the rest of the ward. The patient-to-staff ratio was lower, but patients generally required more care due to the stage of their disease and symptoms, and their families also required support and information. The greatest difference in care organisation was that nursing staff had greater autonomy to manage the care of their patients. They also worked more closely with the HCA and gave more personal care than when in the bay. This was facilitated by support from other staff with simple but time-consuming tasks, and from senior staff who relieved them of certain jobs or responsibilities. One nurse described being 'allowed' to forget about discharges, for example (junior nurse, informal interview), while Alice similarly commented:

> *It's only when you have those really poorly patients that other things can take a back seat, because then people can see, they can see you have these very sick patients, and they help you so you can focus on them.*
>
> (Junior nurse Alice, recorded interview)

These comments highlight several key issues: firstly, the notion of permission for nursing staff to manage patient care as they judged fit; secondly, the idea of visibility, as nurses felt their work was 'seen' and so could be valued; and, lastly, but perhaps most importantly, the idea of nurses receiving adequate help. The ward team provided this support, but they could not do so without sanction from senior management. Lucy's words below again suggest an implicit permission to give more personally engaged care for patients with EOL conditions:

> *It's like [EOLC] is top of the list for compassion, and it's OK for us to just give that!*
>
> (Senior nurse Lucy, recorded interview)

The permission to organise care unencumbered by additional operational pressures appeared to result in nurses choosing to engage with patients and their families more fully, and to deliver more personalised and intuitive care. Importantly, participants did not express uncertainty about what care is required or how to enact that care. Working closely with the patient, family and other staff, they are confident of the type of care they give. Furthermore, participants expressed strongly positive feelings from delivering this care. For example, junior nurse Amelia described how she supported a

grieving husband to stay with his deceased wife's body for over five hours. It was demanding work:

> *I've never seen someone cry so much, just sobbing, he was heartbroken, it was so hard to see him like that.*
>
> (Junior nurse Amelia, recorded interview)

However, Amelia found it 'rewarding … so pleased I could do it'. However, she recognised she could not have given this care if senior staff had pushed her to 'process' the death and arrange for the next admission (junior nurse Amelia, recorded interview).

Another nurse recalled feeling 'proud' because she arranged for a dying man with no family to have a staff member with him all the time. Again, this was only because the ward supported her despite their general staffing problems. Mel, an HCA, poignantly described giving last offices to a patient together with the patient's wife, at the wife's request. This was unusual and, again, deeply emotional work:

> *There were points when I just wanted to get out of there, to get away from the sadness.*
>
> (HCA Mel, recorded interview)

Mel became teary reflecting on this scenario. She felt the task of giving last offices took much longer, but the wife talked to

Mel throughout, about her husband's life and the way he had died. Mel felt that process helped the relative deal with the patient's suffering before death, and she felt 'real happiness' that she could support the wife in this way (HCA Mel, recorded interview). Again, the support of the ward management was crucial to Mel being able to provide this time-intensive care.

5.1.3 Clinical emergencies

During fieldwork there were numerous high-pressure clinical emergencies, such as acute deterioration, cardiac arrest, collapse or intractable symptoms. These situations often involved many members of the multidisciplinary team as well as external trust staff, such as the resuscitation team or surgical specialists. Despite the clinical uncertainty, potential for loss of life, mixed staff groups and sometimes the presence of family members, these scenarios were generally managed in a confident, skilled and caring way. The following field-note extract illustrates the characteristic calmness of these pressurised occasions:

> *I realise there is some kind of emergency in the bay behind me when the registrar strides past and joins two medical colleagues and two senior nurses, Lizzie and*

> *Clare, behind a curtain. I can see the crash[5] trolley is in there and hear a doctor giving instructions. Lizzie comes out looking flushed, and she and Clare move rapidly, but the atmosphere is controlled and the voices between the team are calm. I can hear jolly voices in the next bay, some laughter and social chat. The team dealing with the emergency come from behind the curtains and leave for ITU. Staff in the next bay ask me where they are going and clearly didn't realise what was going on either. I can't believe the contrast between the management of this life-or-death situation and the chaotic discharge last night!*
>
> (Field notes, 31/12/15)

The lack of panic could be explained by staff becoming inured to these situations over time and disconnected from the emotion of the event. Staff did display a serious and highly focused manner, but also appeared to engage with others when necessary. For example, staff would 'check in' with each other, asking if a colleague was OK and if they needed help, or asking the team: 'What is the best thing for me to do now?' (nurse Helen, field notes). They also noticed the needs of

[5] The crash trolley is a large cabinet on wheels that contains all the equipment for medical emergencies and cardiac arrests.

other patients, by reassuring them, informing them or delegating someone to sit with a patient who was distressed.

Senior nurse Clare's reflection on an emergency gives a strong sense of both individual and team confidence during these occurrences, and the shared goal:

> *We all know the priority is the patient, and we are all working to get them better … I don't think we need to get panicky – we all understand that every second is valuable. The patient's oxygen level is going down – OK, we know what to do for that – or the patient's colour is changing – OK, we need to try this … OK, let's get some more help, make sure someone is with the other patients, someone is giving oxygen, someone's calling the doctor. It's OK, it's all about the experience.*
>
> (Senior nurse Clare, recorded interview)

Clare's words suggest that despite the unpredictable clinical situation, the team derived confidence from their experience and their shared knowledge of what to do. Other participants similarly described a feeling of clarity or knowledge while also feeling 'anxious' (junior nurse Alice, recorded interview). Lucy remarked that one cardiac arrest had been 'stressful, but I knew what I needed to do and where everything was' (senior

nurse Lucy, field notes). Similarly, Nancy reflected after an unexpected death:

> *It was horrible, but we did all we could do, and I know we really did everything we could.*
>
> (Junior nurse Nancy, field notes)

All these quotes reflect the notion of 'knowing' that underpins their actions. Staff had experience of these situations, they had the knowledge relating to appropriate response, and they were aware that knowledge was shared between the team. Nancy's words also suggest that 'knowing' provides some comfort when a patient dies, because Nancy can feel sure she did the right things. Interestingly, patient participants also detected this knowledge. Rebecca was in a bed next to a difficult resuscitation:

> *Everyone seemed to know what they were doing … There was no shouting or anything like I would have thought.*
>
> (Patient Rebecca, informal interview)

Hayley, meanwhile, remarked after her own deterioration:

> *I didn't realise how serious it was, because there was no panic or anything.*
>
> (Patient Hayley, informal interview)

Despite the inherent uncertainty in these situations, staff drew confidence from having a clear, shared purpose and preparedness for the event.

5.1.4 Enabling compassionate care

These three examples have a number of commonalities. They are all challenging, pressurised, unpredictable scenarios in which suffering is central. Nevertheless, participants responded with confidence, skill and intuition, and drew from the practical and available support of colleagues and other resources.

It can also be said that suffering was at the centre of these events, and the intensive response that was required was organisationally recognised. Participants expressed an awareness of *permission* to act as they judged appropriate, but also that these actions would be enabled by extra resources, in terms of expert or additional staff, relief from other tasks, or ready equipment. These are *practical* forms of support for care, rather than guidance or instruction on how to give care. With the addition of practical support, staff chose, and knew how, to give skilled and personalised compassionate care. Furthermore, they enjoyed this challenging work.

5.2 Contextual barriers to compassionate care

In this section I present findings relating to contextual factors that appeared to complicate the work of the ward. These factors relate to the contextual elements introduced in chapter four, such as operational pressures, ambiguous priorities and lack of practical and pastoral support. I then consider how they are reflected in the discursive and social practices of participants, and look at their impact on care.

5.2.1 Conveyor-belt care

There were numerous pressurised situations on Hazel ward – situations that were characterised by insecurity, panic, confusion, poor interpersonal relations and inadequate resources. These were most often related to organisational problems such as delayed discharges, bed shortages, regulatory audits and restructuring. In these situations, there was confusion around the exact source of the problem, how to remedy it and who could help, alongside a feeling of urgency to find a solution. Wider support for front-line staff in these situations was usually absent.

Patient flow issues were most often central to these situations. One participant described the sense of perpetual forward motion as feeling like patients were on a 'conveyer belt' (OT, recorded interview). It was the notion that one could not stop to think clearly that seemed to underpin the panic associated

with these scenarios. Lizzie's words below contrast the tense nature of discharge problems with clinical emergencies, and highlight the uncertainty:

> *[In emergencies] I think you are aware of the other patients … even though you're concentrating on that sick person. And, to work together best, you know that you need to be calm and that's the best way to think of what to do next. And you are taught to do that, to support each other to work it out. But with discharge problems … there are a lot of different people that get involved. And sometimes you are not sure who they are or what they are getting involved for. The [bed management team] come on the ward, they are on at the coordinator of the ward, and, sometimes, the sister is involved, because she's getting told from the matron, 'You need to move patients.' I think there's so many people involved in that, that have their own stresses, and … then the voices get higher and I get annoyed of how much, how stressed you are made to get over discharges, when, actually, you have got these poorly patients.*
>
> (Senior nurse Lizzie, recorded interview)

Lucy alludes to the same contrast:

[It's] the small daily things that stress you out so much, much more than a full blown cardiac arrest situation does.

(Senior nurse Lucy, informal interview)

The interactional style during discharge disagreements was often tense, with urgent tones and 'snappy' responses (senior nurse Lucy, field notes). Although they were infrequent, there were also instances of angry blaming of others, shouting and standoff situations, where no compromise was reached. The next excerpt illustrates the accusatory tone and lack of perspective-sharing that were characteristic of these interactions:

OT had told me, yes, they would see [a patient] on Monday morning, sign her off and she could go. But I … got four phone calls that day because they still hadn't got this lady's commode! What had they been doing? I rang them up and I said, 'Look, you knew about this, you said you would do this by Monday morning!' I told them, 'The transport's been and gone, they won't take her now because you were supposed to bring the commode and it hasn't come.' So they shouted at me, some rubbish. And they said I was having a go at them!

(Nurse Helen, recorded interview)

The use of body language and positioning was also distinctive during these interactions. In one scenario the positioning of the actors was striking. A Hazel ward nurse had managed a complex discharge that was delayed by 12 hours due to problems coordinating medication, transport and a substantial care package. The next morning, three members of the bed management team arrived on Hazel to find out what had happened. The three team members crowded round the discharging nurse at the reception desk where she was dealing with another patient matter. Their tone was severe, the questions were quick-fire, and the nurse had little chance to give a full answer. One member of the team told the nurse how she should have done it differently. The nurse said little in response and leaned back in her chair, away from the bed manager. The interaction continued until the nurse was called to deal with another matter. The situation appeared to achieve little in terms of working out the nature of the problem, and how to manage it differently in the future.

In contrast with the EOLC described earlier, another scenario suggested the important role of organisational support. Junior nurse Nancy was caring for Joan, a terminally ill patient with intractable pain. Joan was identified as being terminally ill, but, due to a lack of side rooms, was being nursed in a bay area. Joan had previously expressed a desire to die at home,

and plans for discharge were in motion and difficult to interrupt. Joan had deteriorated unexpectedly quickly and now required regular pain medication and considerable nursing attention. Nancy felt it was no longer appropriate for Joan to go home, but struggled to engage other staff in reviewing the plans:

> *I just felt it was wrong, but … I wasn't sure I had the skills, the experience. You know, to be able to say [to the patient], 'I think you are imminent and this is not right for you.' And all the time I was trying to work through that, I had everyone at me, the discharge coordinators were huffing and puffing, saying, 'What's your rationale? Why are you blocking this?' And the doctors were busy and didn't want to review it. And we had allocated the bed already, so admissions were coming, but I knew it wasn't right. I just needed everything to stop so I could work it out with them.*
>
> (Junior nurse Nancy, recorded interview)

Nancy eventually managed to cancel the discharge, and Joan died within hours, with her husband present. Nancy had anticipated the increased suffering for Joan and her husband if she had died in transit, and her efforts had ameliorated that. Therefore, the contextual factors did not prevent the patient

from receiving excellent care, but they made the experience troubling for the nurse. Nancy expressed regret about her management of the care. She felt that she had taken too long to act, and had lacked the 'right' communication skills to support Joan's husband. Nancy also felt unsure about her ability to manage EOLC in the future, despite displaying considerable skill in this respect. Though it is very common to have to deal with multiple complex issues simultaneously in healthcare, the 'pushing' that Nancy experienced to keep moving forward with the discharge and attend to other jobs made Joan's care more difficult. The pressure reduced Nancy's capacity to engage with the patient's situation and required Nancy to make additional sustained efforts to provide compassionate care. The difficulties appeared to negate Nancy's sense of reward for the work she had done.

5.2.2 Lack of organisational support for emotional work

5.2.2.1 Lack of time and space to process work

The 'conveyor belt' style of working encouraged by intense operational pressures meant that staff had little time to reflect on or work through the intensely emotional aspects of care. A number of participants described the difficulty of rapidly transitioning from working with profound suffering to general

care. A senior, experienced nurse described the personal effects of this by reflecting on an experience early in her nursing career. She described caring for a young long-term patient with whom she had a good relationship. He died in 'awful' circumstances, and although she was very distressed about his suffering, she needed to immediately go back to the ward to attend to other work. She remembers clearing away some of the young patient's belongings with 'tears running down my face', when a patient shouted for her to fetch them something. She recalled: 'It was so hard to park those feelings of rawness and distress' and engage with the next person who needed her (Paula, informal interview).

Oakfield Trust had no well-embedded or compulsory supervision programme for ward staff, and as noted in chapter four, there was little accessible private space for staff to seek or receive support with the everyday challenging work they did. Lucy's words illustrate why time and space to process their emotional responses was important:

> *That's why you get those nurses that just crack or burst into tears … They're going to crack, they're going to cry, or they're going to lose their temper. They're going to shut themselves somewhere where nobody can see them because they're absolutely at their wits' end.*

(Senior nurse Lucy, recorded interview)

Lucy later referred to the pressure to wear a 'magic mask' which hides her real feelings. Her words evoke the concept of emotional labour (Hochschild, 1983, Hochschild, 1979) and the work that healthcare staff are required to do to create and sustain the correct emotional climate on the ward (Bolton, 2000). Other participants described the emotional strain of maintaining a professional front while wanting to express their sadness, frustration or other intense emotions triggered by caring work. Alice, for example, was acutely conscious of being watched while working:

> *In the bay when you're working, people are watching you … You have to be very careful about what you say … Sometimes you just need to break away from that, it's too much.*

(Junior nurse Alice, recorded interview)

Alice's description of 'being watched' contrasts with the invisibility of much nursing work, as discussed earlier. The phrase 'being watched' has different connotations to 'being seen' and is suggestive of being monitored or scrutinised. In this case, Alice feels her *conduct* is being watched, but her work is still not necessarily being seen.

The notions of private and public spaces, hiding behind a 'magic mask' and being watched also resonate with Goffman's dramaturgical theories, and the idea of nurses being 'on stage' (Bolton, 2000). Interestingly, Oakfield uses the term 'on stage' in its behavioural standards guide for staff. The guide encourages staff to:

> *Imagine that anywhere patients or visitors see or hear us is 'on stage'. So always look and behave professionally, acting as an ambassador for the Trust, so patients, families and carers feel safe.*
>
> (OHT, 2015, p16)

The advice to 'look and behave professionally' supports traditional nursing approaches of maintaining a detached manner so that emotions can be appropriately managed on shift (Savage, 1995).

However, given the nature of ward work described thus far, the mandate that staff personally engage with patient suffering, and the lack of time and space to process the feelings inevitably elicited by this, staff may find themselves confused and overwhelmed. Participants often used physical and dramatic language to describe the personal effects of their work. Lucy's words presented earlier gave a sense of nurses

'cracking' and 'bursting', while the excerpts below are equally powerful:

> *It suddenly just hits you [when they have multiple deaths] … and then it's harder to talk to patients and really be open and honest with them, when you've got those things on your mind.*
>
> (Senior nurse Lizzie, recorded interview)
>
> *[The difficult death of a patient] was just awful; I'm finding it hard to shake it off … I could do with a good blub really, but I don't think I'd get away with that in the middle of a shift!*
>
> (Senior nurse Helen, informal interview)
>
> *Inside, I just wanted to scream and shout, and I might, I'm not abrupt with [patients], but I'm, you know, if they start asking me questions while I'm doing the medication round, I'm like, 'Oh, please don't ask me anything.'*
>
> (Junior nurse Ellen, recorded interview)

All these excerpts suggest that the intensity of emotion could impact on the way they related to others, and highlight how the needs of patients could begin to feel like an intolerable, additional demand.

When staff could get respite from the main ward and access a private space or support from ward colleagues, it was highly valued. One student nurse remarked:

> *It's alright to let it slip, with your colleagues, because they can handle it.*
>
> (Student Holly, recorded interview)

Holly also referred to wearing a mask, and she expressed feeling 'safe' to let the 'professional mask' slip when she was out of patients' view and supported by other staff. She went on to describe a period when she had needed to do this, during a tough time when a number of her patients died consecutively. On one shift, Holly found herself crying with a grieving relative and unable to stop. Her mentor encouraged her to take a break, and the support she received from other staff helped her to accept her emotional response:

> *[I went to] the staff room, and everyone was like … don't apologise for being human, don't apologise for getting upset, obviously … you're going to develop a thicker skin! But … don't ever apologise for caring.*
>
> (Student Holly, recorded interview)

The need for staff to be able to access a private space to process the emotional impact of their work was also revealed

in how staff used the ward manager's office. Dawn described how staff often came to her office, which was located in the middle of the ward, during shifts. This was not always to get support from Dawn directly, but often just for a 'breather' or to 'let off steam' (Dawn, informal interview). Dawn had also set up a private Facebook page, for organising nights out and team days and for swapping duty rotas. However, she was surprised to see that it quickly became an outlet for sharing emotional issues and personal feelings, especially after difficult shifts. Both the manager's office and the Facebook page were inadequate for fully supporting the emotional needs of the staff, but they demonstrate that some form of emotional outlet was desired and necessary.

5.2.2.2 Lack of respite and recovery from ward work

As well as a lack of on-shift time and space to manage the effects of caring, there was also a lack of time away from the ward. Staff rotas appeared to be shaped by the need to cover the ward safely rather than the need for staff to have personal and social time away from work.

Most Oakfield shifts were 13 hours long. The introduction of these 'long days' was claimed to be about improving work–life balance, as staff work fewer days in the week (Griffiths et al., 2014). However, long days also enabled trusts to reduce the

number of staff on duty per day (Griffiths et al., 2014). In addition, staff often asked to work more than three long shifts in one week. One nurse showed me her rota:

> *Alice tells me she has five long shifts next week, and then four the week after that. I am incredulous and ask if that is usual. 'Hmm, it's a bit more than normal.' We are in the middle of the ward and she seems uncomfortable talking openly about it. On one of these shifts, she finishes a night, goes home to sleep and returns to work the following morning, meaning her 'sleep day' (when she does not return home until around 9am) is counted as a day off. 'I hope it's not a tough night!' she says, wincing. I wonder how she will manage regardless, as the opportunity for rest is non-existent.*
>
> (Field notes, 20/6/16)

Staff were sympathetic about the staffing issues that encouraged these rotas and rarely complained:

> *There's nothing you can really do about [lots of shifts consecutively] because of staffing, because they can't move anybody else … so you just have to get on with it, which we do … Although I do get totally exhausted sometimes, and worry about errors happening.*
>
> (Junior nurse Alice, recorded interview)

However, they found it difficult to recover from these long stretches of duty, especially when the work was compounded by intense emotional labour:

> *Last week I did four long days. Three of my patients died. So, you're doing last offices, caring for the families, documenting them, handing it all over. You end up dreaming about it. It made me ill, I'm still ill from it.*
>
> (Junior nurse, Amelia, informal interview)

A senior nurse who had moved from ward-based work into education reflected that in her current role, she could cancel meetings or 'shuffle' her diary if she was tired or ill. However:

> *… for those doing 13 hours on the wards … the pressure is huge and there is just no slack anywhere in the day. You have to give 100% constantly.*
>
> (Specialist nurse, informal interview)

Patient participants noticed the regularity with which staff members would be on the ward, and frequently made comments such as 'Haven't you been home yet?' (patient Norah, field notes) and 'Do you live here?' (relative, field notes). Many were sympathetic, noting that staff looked tired or were 'flagging' (patient Rebecca, informal interview).

However, they also recognised the impact staff tiredness could have on patient care:

> *[The nurse] was struggling to keep her eyes open, they were so heavy … I'm not sure if she was following what we were saying.*
>
> (Patient Angela, informal interview)

Staff themselves acknowledged the impact that exhaustion had on their social interactions and felt they were sometimes indifferent, avoidant or detached:

> *I do sometimes feel myself becoming less compassionate, because you see [patients] more as a burden and not a patient that's actually poorly. You know, because it is human nature, it's human nature to feel like that. That doesn't mean people are going to go out and abuse them and things like that, that's not what I'm saying. What I'm saying is, you lose that compassion, that understanding. You just don't have the energy for it.*
>
> (Student, informal interview)
>
> *You try and be compassionate, but then, I don't know. It can be very difficult when you have everything else to do, and you have the one-to-one things, take someone*

to the toilet, you are behind with your meds, you have doctors at you, and you are trying to be in six places at one time. And I do feel, and I don't like to admit it, but I do feel … myself getting quite, not snappy, but I don't feel I've got as much compassion left.

(Junior nurse, recorded interview)

These candid reflections highlight a further consequence of the operational pressures and organisational context of care, which is the distress and guilt felt by staff at not being able to give compassionate care.

5.2.3 Threat-based setting

So far in this chapter I have evidenced the intensely challenging and emotional nature of ward work and compassionate care and suggested that a range of contextual factors – such as prolonged operational pressures, insecurity and a lack of practical and personal staff support – make the enactment of compassionate care more difficult for staff. In some cases, this potentially causes distress for staff. I now present a scenario that has elements of all these factors, including the wider sociopolitical influences on healthcare delivery. I suggest that the combination of all these problematic contextual elements creates a threat-based work environment. I present the scenario first, before showing how

threat is evidenced in the language and practices of staff participants and how a threatened state may impede compassionate care.

5.2.3.1 The failed audit

Like many other NHS trusts, Oakfield had struggled to meet regulatory standards of cleanliness and hygiene consistently. During fieldwork, one ward in particular, Rowan, failed an external audit for the second time. The external regulator informed Oakfield that they would audit again in a month. Oakfield responded to this with several actions. One action – to develop a cleaning manual for nurses – was relatively standard and was not produced until some time after the audit. However, their immediate response was uncharacteristically punitive. Corporate trust staff made the decision to remove the Rowan ward manager and demote their senior staff to lower bandings. These staff members were moved to other clinical areas, and new staff were brought in to Rowan. Oakfield also sent a letter to all clinical leads, emphasising the seriousness of the situation and the accountability of ward managers in this respect.

The staff reaction to this, across the trust, was shock and fear. Some front-line staff took the 'pretty much unprecedented' (Denise, senior specialist nurse, informal interview) decision to

go directly to the chief executive of Oakfield to express their concerns about the treatment of Rowan nursing staff. Hazel staff were fearful that the 'same thing might happen' to them (Dawn, field notes), felt 'demoralised' that front-line care staff could be so harshly treated (administrative staff, field notes) and even feared for their jobs (cleaner, field notes). This apprehension was exacerbated by a sudden increase in spot checks across the trust:

> *Everyone was very scared, everyone was talking about it … Our matron was coming on the ward a lot more often, doing spot checks. I don't know, I think we're a clean ward …*
>
> (Junior nurse Amelia, field notes)

The consensus among Hazel staff was that the trust's response was 'punitive' (nurse Helen, field notes). The language they used to describe events had a vivid quality. For example, the Rowan senior staff were described as being 'stripped' of their banding (senior nurse Lizzie, field notes), and the ward manager was described as having 'disappeared … no one knows where to' (senior nurse Helen, field notes). Nurse Lindsey struggled to reconcile the extremity of the action with her knowledge of the Rowan staff involved:

It was definitely about blaming someone … and I knew some of the people involved and the way they were, er, dealt with, shall we say, was just horrific. But then maybe it was an isolated case, maybe I don't know the full story … maybe they were fair. But because I knew them, I just felt, no.

(Senior nurse Lindsey, recorded interview)

Lindsey's words also reflect a degree of confusion about the exact events and the reasoning behind the trust's response. Hazel staff were unsure about how to fit in the extra cleaning work, which was now being closely monitored:

You won't believe what we had to do for [the cleaning checks]! Even in the staff room – lift the cushions, is it clean? Check the microwave. The staff toilet, is the toilet brush clean? That's one of the questions! I was thinking, how do we do this in time? We've got to go from the top to the bottom of the ward, checking everything … I know the manager has the responsibility and she can't do it without our help, but, at the same time, we just can't help with all this. I mean, I try, and of course I want my ward to be clean, it's my second home. I want to keep everything tidy. But this extra responsibility to do all of

that, I don't feel very happy about that. Who is looking after my patients when I am checking the staff toilet?

(Senior nurse Clare, recorded interview)

Numerous Hazel staff relayed their workload concerns back to clinical and corporate leaders, but as one senior nurse stated:

No one was listening to what we were saying … it was very difficult.

(Senior nurse, informal interview)

The third inspection of Rowan ward was passed successfully. However, over the following year, cleanliness standards in various parts of the trust declined again (OHT, 2016), and cleaning standards remained another top priority, alongside speedy patient flow and compassionate care. Staff seemed unsure of how to maintain the focus on cleanliness without compromising quality of care, so there was a sense of staff trying to sustain multiple spinning plates. A number of comments suggested that staff felt compassionate care did not have an equal footing among the other organisational priorities:

Nobody gets promoted because they're compassionate! … What they want to know is what are your [dashboard] scores? How many patients can you get out before

breakfast? … Honestly, if you've got five minutes to spare, they don't want you talking to a patient, they want you to get the [wipes] out and start cleaning!

(Senior specialist nurse, informal interview)

Hazel staff appeared to remain in a state of vigilance about 'failing' audits, 'spot checks' and balancing the additional work, even after passing their own external audit. After this successful audit, the Hazel ward manager expressed shock and exasperation that she received no positive internal feedback from senior nurses. Without this formal confirmation that they were achieving good standards, it seemed difficult for them to relax.

The words of corporate staff in the trust had similarly anxious, uncertain and threatened overtones. One participant recalled her dread at the wider organisational consequences had Rowan failed the third audit:

Reputationally, it would have been horrendous … You can see the front pages: 'Oakfield Trust has dirty hospitals, its nurses don't wash their hands.' … We would have been put in special measures, we would have been in breach of the hygiene code … We would have been fined by the commissioners … And the media are very, very quick to jump on us, so that kind of thing

is the stuff that the front page of the Daily Mail is made of … And the bigger consequence to that is around the punishment that's given to the organisation, and in some cases that can be hundreds and thousands of pounds … that's hundreds of thousands of pounds that isn't there for patient care.

(Corporate staff Patsy, recorded interview)

Patsy referred to a neighbouring trust, Yew, and knew the impact that being put on special measures had for the organisation's services and staff:

Look at what's happening with Yew Trust. There's an organisation that didn't jump through all the hoops … [They] got a really poor CQC inspection, then they got another really poor CQC inspection, and the view was – that's enough! You are not allowed to manage yourselves anymore, you obviously can't do it … so there's always a consequence …

(Corporate staff Patsy, recorded interview)

Other corporate staff expressed similar anxieties, and their language and tone suggested that the pressure to achieve a positive inspection was immense. Margaret felt they 'just couldn't afford' to fail (corporate staff Margaret, recorded interview), while Ann concluded there was 'not much choice'

(corporate staff Ann, recorded interview) but to go in with a 'strong response' in order to pass the third inspection. In this sense, it appeared that regulatory pressures and threats applied at the top of the organisation were passed downwards through middle management to front-line staff. Clare's words below vividly illustrate the process of trying to deflect a threat in an effort to protect oneself, even with the knowledge that the wider consequences could potentially be negative:

> *We have to push people to get them to do what we need, but they don't like to be pushed and we don't really want to, but at the same time, we are being pushed, so what can we do?*
>
> (Senior nurse Clare, recorded interview)

In the next section I demonstrate how a threat-based organisational context was evident in the language and practices of staff, before showing how contextual threats can in turn affect compassionate care.

5.3 Threat-based practices

Psychological theories suggest that when a person's threat system is activated by perceived risks to safety, it can generate emotions such as anxiety, fear and anger, and defensiveness (Gilbert, 2009). These emotions were often manifested in the social interactions, language and practices of

Hazel staff. I described earlier that the interactional style around discharge problems could be tense and even aggressive. I now consider the use of language in more detail.

5.3.1 Language

The language and practices of staff participants suggested a deep sense of insecurity and vulnerability. In interviews, as well as in the work talk on the ward, there were frequent references to making errors, harming patients and being blamed. Most striking was the regularity with which a coroner's inquest or court case was referenced. The following extracts illustrate that a wide range of staff used this type of language:

> *My name is over the bed … If the care goes wrong, I will be the one in the coroner's court.*
>
> (Consultant, recorded interview)
>
> *Ultimately I will be held to account.*
>
> (Corporate-level clinician, recorded interview)
>
> *I just feel unsafe … like something's going to slip through the net.*
>
> (Junior nurse, recorded interview)
>
> *When things like that [an investigation into a failed audit] happen, you feel like your job is at risk.*

(Cleaner, informal interview)

You'd better make sure you document those calls – we won't have a leg to stand on if anything comes back from this.

(Administrative staff to nurse, field notes)

In addition to these comments, stock phrases such as 'the shit hitting the fan', needing to 'cover one's back' and things going 'tits up' were commonly used by various staff groups (field notes, various dates).

5.3.1.1 Differences between staff groups

Although most groups used this kind of threat-based language, there were some subtle differences in expression between staff groups. For example, AHPs did not often use the stock phrases mentioned and generally described a more stable and secure working experience overall. Some AHPs referenced issues such as bed pressures, but as one OT indicated, this was 'in the background' (OT Elaine, recorded interview). Similarly, a pharmacist remarked, 'We don't feel the general pressures as much' (pharmacist, recorded interview). At most, there was an awareness of the need to work 'efficiently' (physiotherapist, recorded interview), but even in that, AHPs reported feeling 'well supported'.

There were also discursive differences associated with the relative power and status of different staff members. For example, those with more power in the organisation tended to express their concerns with indignation or anger. Excerpts from two senior trust staff illustrate this:

> *You're not in control of the patient's care; however, you're accountable, and that's a very dangerous situation to be in. I've got no control! … However, the first person that the coroner will collar is me.*
>
> (Consultant, recorded interview)

> *… when things go wrong they are often as a result of multiple failures … but … somebody always has to be made a scapegoat! And as a result of that, that is why there are so many [senior nursing role] vacancies around the country … Someone is held accountable, and usually the response to that is too punitive.*
>
> (Corporate staff member, recorded interview)

Nurses and junior medical staff tended to use physical descriptors, suggesting a feeling of bodily vulnerability. The following excerpts are from experienced but relatively junior staff. I had generally observed them to be calm and capable on the ward and was surprised by the language they used and the anxiety they revealed:

We're just constantly pushed, like with emails and even screensavers saying … 'We are in the code red' or whatever it is, just totally over capacity … It's just constant, unceasing, all the time, and you can't fight against it.

(Junior doctor Rob, recorded interview)

We kept getting emails saying, 'This hasn't been done, what about that?' And they're trying to scare you and say, 'If it doesn't get done, you'll be coming with me in front of this person, and you'll be explaining why you haven't done this', and you think, oh my god!

(Senior nurse Lizzie, recorded interview)

Lizzie additionally used phrases such as 'getting told off', 'getting into trouble' and feeling like a 'target'. Interestingly, Lucy also felt like a 'target', and described being 'knocked' and 'pressurised' but just having to 'take it':

Patients are not the most stressful, because they know it's not your fault, even though they do take it out on you … But then you've also got [admissions unit] ringing you, shouting, 'We're eight over! We're six over!' … And you've got bed managers coming on the ward: 'I'm bringing four patients over.' … They come at you from every angle.

(Senior nurse, Lucy, recorded interview)

Alice similarly described being 'pulled', 'pushed' and 'split in different directions' (junior nurse Alice, recorded interview). She felt patients were 'angry' at her, that other professional groups 'offloaded' on to her and that senior staff 'overrode' her. Perhaps unsurprisingly, she felt 'unsafe' and as if 'something bad is going to happen' (junior nurse Alice, recorded interview). Amelia was also a junior nurse, and although she expressed less anxiety, she did suggest that organisational risk was a part of nursing:

> *I struggle – I can't give the care that I want to in the day anyway because of all … the referrals and checks and people I need to talk to and whatever other stuff you have to do to be a nurse and not get in trouble.*

(Junior nurse Amelia, recorded interview)

Patients and relatives also discerned 'the pressure' that staff were under (patient Mags, recorded interview). Mick felt that staff were being 'told exactly how to do things and when' (relative Mick, informal interview), while Fiona commented that it seemed staff were being 'watched very closely' (patient Fiona, field notes). Trevor's wife was in hospital for a long period. He visited her daily on several different wards and observed:

[The staff] have a big long queue of jobs, you'd see them looking at their paper and going from this to this to this, and they've got to do it all by this time or else they'll get in trouble.

(Relative Trevor, recorded interview)

Lilly, like many service users, was sympathetic to staff. She felt they seemed to be constrained, and remarked:

They want to do more for you, but their hands are tied.

(Relative Lilly, informal interview)

5.3.2 Defensive practices

Defensive practices are regular behaviours that aim to protect the professional and are typically overcautious, risk averse and concerned with how a scenario might be interpreted by others, particularly if things were to 'go wrong' (Harris and White, 2013, p134). They are self- rather than other-focused and can therefore inhibit compassionate engagement, as the aim of the behaviours is primarily to eliminate or avoid the threat (Gilbert, 2009). On Hazel ward, defensive practices included excessive checking, contacting the ward while off shift, a lack of trust in policies and procedures, and feeling anxious about the need to document all care. I expand on this first.

5.3.2.1 Documentation as a defensive practice

Documenting all aspects of care is a professional obligation for nurses (NMC, 2015), so a desire to ensure that it is done accurately is not surprising. However, the language and behaviour around documentation suggested that it served a protective function for nurses. The following excerpts illustrate this:

> *I put a lot of emphasis on the writing, because if something goes wrong, it will go to court.*
>
> (Junior nurse, recorded interview)

> *I try to just write everything that I've done at the time, otherwise I won't get the chance to come back to it. Or I'll forget. Then there's no proof of what you did and you end up in front of the coroner without a leg to stand on.*
>
> (Senior nurse, field notes)

The references to 'proof' and things going wrong suggest that documentation is seen as providing a defence against a perceived risk. The anxiety nurses expressed about not being able to complete their documentation supported this.

There was no dedicated time or space for nurses to document care, and they were vulnerable to frequent interruptions. I would regularly observe nurses begin to write their

documentation and moments later leave it to attend to something else. To counter this, nurses would try to document in places away from public gaze, such as the corners of the ward, or on their breaks. Nurses regularly stayed late on the ward to complete documentation, as it was one of the only ways to ensure they were not interrupted. Nevertheless, it had a high personal cost, as Nancy reflected:

> *One night shift, because I had twelve patients and an acute patient who was still for [resuscitation] and who was deteriorating … I didn't have the time to sit down and write … I ended up leaving the ward at half past nine and I was supposed to be on my train at five past ten. I've not mentioned it because nothing's going to change. But that, for me, was horrendous.*
>
> (Junior nurse Nancy, informal interview)

The struggle to document care was recognised as being particular to the nursing staff, as Suzy noted:

> *The nurses go home late a lot because they have writing, whereas we don't have all that responsibility. Especially if they've got poorlies, it's just too much, I've seen them struggling.*
>
> (HCA Suzy, recorded interview)

Increased workload and pressure on the ward increased the risk of error or missed care and led to nurses having a stronger desire to record their activities. However, the high workload and fast throughput of patients at these times actually made it more difficult for nurses to do so, meaning their anxiety was increased. Two nurses below give a vivid account of this type of scenario:

> *[The bed manager] says, 'Right, move that patient', but we don't even get time to scribble what we have done, you know, like the district nurse referral – I didn't document it. But all of those things, at the end of the day, we are completely responsible for. And if anything happens, they will say, 'Oh, there's nothing documented.' … But we don't get a chance, the patient has already been moved and someone has taken the notes!*
>
> (Senior nurse Clare, recorded interview)
>
> *Discharges are so stressful, they never run smoothly. And you are trying to coordinate everything – the care, the meds, the transport, the relatives – and write it all down. But then you're getting badgered to get them out before ten, before twelve. Which I understand is the priority, because there's always patients waiting to come*

in. But I need to know the patient is going to be safe when they are discharged, and that everything's in order … But there's always that pressure to get them to the discharge lounge. I tell them, 'Oh, they've not had their breakfast yet' or 'Can I wash them and dress them first?' And then they're whipping the patient off to discharge lounge with all the paperwork, [and] you've not done your paperwork yet.

(Junior nurse Ellen, recorded interview)

Others in the ward did not recognise the protective function that documentation served for nurses. Some patients and relatives were openly disapproving of nurses 'just sitting and writing' (relative, field notes) or being 'on the computer' (patient Norah, informal interview). Their language suggested that documentation was an activity distinct from caring work. Nurses were aware of this disapproval, and felt inhibited about being seen doing documentation:

When the relatives come, you hear them saying, 'Oh, they're sat down!' You feel you could cry sometimes … I wish I <u>was</u> just sat down! I want to say, 'Yes, I am sat on my bum, and if I'm called to the coroner, this will be the only thing that's going to save my job!'

(Senior nurse Lucy, recorded interview)

The context of threat on the ward encouraged nurses to see documentation as a form of protection and to feel anxious about ensuring this was done. However, a lack of support that would enable them to do this, and a lack of time in the working day, meant that this was difficult to do without incurring a personal cost. The combination of feeling the need to protect oneself and yet not being able to engage in this defensive practice may have increased anxiety levels further, as well as making nurses feel an increased vulnerability.

5.3.2.2 Over-reliance on rules and checking

Another type of defensive behaviour was an over-reliance on rules and checking. This was most commonly displayed by nurses and junior doctors, and was more marked than the general risk aversion and practising 'by the book' that was common in all staff groups in the trust. Acute safety awareness and close following of standardised policies and procedures was promoted as an explicit safety mechanism, and the following excerpt illustrates the type of organisational message that staff received:

> *… when we don't follow the policies and procedures that are put in place to protect patients, then we can harm. And not only can we harm, but staff need to understand as well that many of these policies and procedures are*

> *there to protect them. So when we deviate from them … and they are in front of the coroner … for a nurse to be stood up in front of the coroner under oath with all the media there and say they didn't follow good practice is the worst place in the world to be.*
>
> (Corporate staff member, recorded interview)

However, I observed that some doctors and nurses engaged in more marked risk-aversive behaviour as a way of the practitioner protecting themselves from errors or incidents or 'covering their back' (junior doctor, field notes). This could become problematic, for example by creating delays, causing distress or generating tensions in the staff–patient relationship.

One occasion where unnecessary checking caused delay and upset for a patient was when a nurse was waiting to 'check with the doctors' (junior nurse, field notes) about referring a patient to chaplaincy services. The patient had just received news that her disease was terminal, and as a deeply religious person, she wished to speak with a priest. She had full capacity and made the request clearly, and there was no requirement on the nurse's part to have the referral approved by the medical team. There were no family members who could be with the patient at that time. There was a significant

delay in the patient seeing the priest because of the nurse needing to check. However, the nurse felt a strong need to inform the medical team:

> *… just to make sure everyone is happy with the plan, I just like to check with everyone in case I miss something.*
>
> (Junior nurse, field notes)

Frequent problems arose around the need to check medication issues, and this could sometimes cause distress for patients. Hospital inpatients are increasingly self-medicating, but nurses remain accountable for assessing and monitoring that patients are self-medicating appropriately. Yvonne was a patient in her 50s who was independent with her personal care and had no cognitive impairment. She managed her medications at home and had requested to self-administer in the ward. Though staff had said they would assess her for it, they had not done so yet. Yvonne felt there was reluctance on their part and became increasingly angry because staff were not administering her medication as she needed them to. Her tablets needed to be taken prior to meals, but this was not in line with the ward drug round and so was repeatedly missed:

> *You have to rely on them to give you them and it's never at the right time, so I end up with symptoms from that.*

And some of [the staff] don't understand about them. Like with my codeine phosphate – I take that for my Crohn's, it helps with my bowels. But they were treating it like a pain medication and wouldn't listen to me trying to explain … I managed to sneak my inhalers in my bag, though, at least I can get to them.

She felt infantilised by not being 'allowed' to self-administer:

You are treated like a child, it's infuriating that I can't do it myself! I do it at home and I know them better than the staff here …

(Patient Yvonne, informal interview)

Yvonne's words show that she felt the problem was that staff did not see her as credible. However, the language of the staff suggested that they were focused on their accountability, and were attempting to retain control of administration to minimise any risks. In the threat-based context, patient self-administration was perhaps perceived as a risky practice. One nurse reflected that her caution around risk sometimes upset patients, but that was preferable to patient harm:

There are so many variables that we can't control, but we're <u>accountable</u>. It comes back to us when things go wrong so … You just have to manage things as best you can. It does annoy [patients], yes, but I'd rather they

were cross at me and everything was safe than you let someone go out for a walk and they collapse.

(Junior nurse Lara, informal interview)

Some patients expressed an understanding of defensive practice, although evidently it still caused tensions:

For me, I need to be as independent as I can be, that's my biggest thing, is the independence. And that's where me and the nurses have sometimes clashed, but, y'know, they've got to do it by the book, I suppose.

(Patient Rebecca, informal interview)

Grace, however, felt angry about the unnecessary inconvenience caused by a nurse 'covering herself' and was offended that her account was not given credence:

It was the failing of the staff that put me into the position, not doing their job properly. Like the consultant, he didn't write it in the book, the fact that my pump could be switched off for me to go to the toilet. We'd talked about it, but he didn't write it down in the [communication] book. So when they turned the shift over, the new nurse went, 'It's not in the book, no, I can't let you go' … So I refused to have any tea … I needed to take control of it, because there was <u>no way</u> I

was going to go on a commode in the middle of the ward. Even though the other nurse told her the consultant had allowed it, she said, 'Well, this patient is in my care and I'm not happy with this unless a consultant's telling me.' So it was obvious she was just covering herself … Then the consultant came on and just waved his hand, 'Yeah, that's fine', and zoom, I was off the pump! I'd spent all that time explaining, and, no, she couldn't take my word for it, but the consultant barely looks at her, just nods, and it's like, 'Oh, that's fine then!'

(Patient Grace, informal interview)

Staff themselves had noted that many of the procedures and protocols were 'one size fits all' (senior nurse, field notes) and that part of the professional role was to interpret them in light of the patient's particular situation. However, many did not feel confident to do this. A student described how some staff even manually turned independently mobile patients in bed, purely because they had been charted as requiring assistance with their pressure-area care. Similarly, staff were waking patients hourly overnight for observations because they met the criteria for that, but were otherwise presenting as well. Danielle, a student, felt that often the staff undertaking these

procedures knew they were unnecessary, but continued 'just in case' (Danielle, recorded interview). She reflected on this:

> *I think it's just people are so scared of missing something, getting it wrong, and then the trust gets sued and blames them for not doing observations and things. I don't think it's intentional, that people are looked at as a number, but when these things get implemented in, then everyone sticks so rigidly to that and it becomes about the score or the number or whatever, rather than the patient that's sat there chatting away to you, obviously fine … You end up seeing them as just a number, you're seeing them as just a body that you need to make sure you're checking, and it's a number written down, and you need to make sure that they've moved. Not thinking, hang on, this is a person that's walked in here, they're independent, they're doing exactly what they would do at home. It's just like become number-fixated.*
>
> (Student Danielle, recorded interview)

Danielle's words suggest that an over-reliance on standardised procedures may inhibit staff from feeling confident to interpret them in light of other information about the patient, and, in that sense, this over-reliance inhibits the development of

clinical judgement and experiential practice. A senior consultant who found the situation equally frustrating echoed Danielle's thoughts:

> *Medicine [has] become guideline based, and we've reduced care down to 'Have we done the DVT checklist? Have we done their antibiotic stop date? Have we thought about bundles of care? Have we got DNR decisions properly documented?' And that's not really what medicine's about, that's not really holistic care, that's not what Francis is talking about. It drives me slightly potty … So you haven't got to employ me on an expensive salary to go round making sure all the boxes are ticked, but that's what I do. And I spend less and less time being able to apply my experience and knowledge to a problem and sorting out a solution …*
>
> (Consultant Mark, recorded interview)

I have shown in this section that a sense of threat exists on the ward, and that insecurity, risk aversion and self-protection are demonstrated in the language and practices of staff. Psychological theories suggest that a defensive state militates against the confidence and openness of mind required for sustained and meaningful engagement with the suffering of others (Gilbert, 2009). In the next section, I present findings

which suggest that compassionate care of patients may be inhibited by a dominant sense of threat on the ward.

5.4 The impact of threat on compassionate care

In this last section of the chapter, I draw from the previous segments to show how a combination of contextual problems combined to generate a sense of threat that underpinned the work undertaken on Hazel ward. I present findings to suggest that this threat-based context could inhibit the capacity of staff to notice, engage with and act to relieve suffering. Again, patient flow and capacity issues are central to the scenarios I present here, which reflects how frequently they impacted on the ward atmosphere and practice. However, there are other contributory contextual elements present, such as staffing issues, inadequate respite and insufficient support of staff.

On the evening of a very busy pre-Christmas shift, several tired staff members were preparing their sixth patient for discharge home. It was essential that the timing of the transport and the care package were coordinated for this frail, elderly lady, as she could not otherwise get into the house. The transport crew arrived, and the carers called to say they were at the patient's home but the medication had not arrived from pharmacy. Ward staff made frantic phone calls, but they were only told that the medication was 'on its way'. The ward

staff got the patient ready and helped her onto the trolley, hoping that the tablets would turn up in time. The transport crew became agitated with waiting, telling staff that they had other patients to collect. The ward staff paid little obvious attention, and continued to do other tasks while waiting for the medication to arrive. The transport started to shout at the ward staff, who gave angry responses in return. Within earshot of the patient, one of the crew threatened to 'unload' the patient if the medication did not arrive (field notes, 23/12/15) and get on with the rest of their jobs. The increasingly harassed nurse in charge, who was also supporting a newly qualified nurse (NQN) and a student, told the crew to 'just take her now' and planned to transport the medications later by taxi. No one was with the patient at the time, or noticed her distressed expression or her reaction when the crew threatened to unload her, and so she received no reassurance before she left.

During another pressurised shift, a number of nurses were acting up to fill staffing gaps. An NQN was having difficulty caring for multiple distressed patients in her bay. She became distressed herself, and tried to get support, but other staff were also overloaded and did not notice the extent to which she was struggling. The NQN was acutely aware of the suffering of two of her patients (one in severe pain and the

other who had just received news of a terminal diagnosis) and tried to meet their needs while also attending to her other responsibilities. However, she was not able to respond to these patients adequately, and ultimately their suffering was extended as a result.

During a period of intense pressure for beds, a member of the bed management team decided to bring a patient to the ward, despite staff telling her they were not yet ready. The patient sat anxiously in a wheelchair while ward staff tried to express their concerns to the bed manager, who waved them away, repeating, 'We are full, we need the beds, there are queues of patients in A&E' (field notes, 6/11/15). All staff focused on cleaning and preparing the bed space, and no one spoke to or reassured the patient until the immediate pressure had passed.

Lastly, I present an extended field-note excerpt relating to a Friday evening, when four patients were brought to the ward in quick succession. It gives a sense of how pressure could shape relations and interactions, even among individuals who ordinarily had good relations:

> *Two admissions arrive, one right after the other, so that the ward staff are still settling the first patient when the second arrives. It takes the staff a minute to figure out*

who is going where, so the patient waits, looking concerned. They appear irritated with each other, making snappy comments about outstanding jobs that haven't been done. Nobody welcomes the patient, and she is left alone for some time before a different staff member approaches to welcome her and settle her into the bed space.

Two nurses are dealing with their discharges; one is checking urgent medication and the other on the phone. A third admission arrives before the porters for the last have left, causing a blockage in the corridor with the trolleys. No staff member is free and a patient's voice is now calling for the toilet. The porters argue with each other about who was supposed to be doing a job.

The nurse next to me, Helen, is trying to complete her already very late drug round. She is abrupt and agitated. One woman is confused about her medication and Helen is responding in a loud, impatient manner. 'No, you don't have that one now … no … one in the morning and one at night … No! It isn't time yet!'

Another nurse comes past. 'Can't you get the admission?' asks Helen. 'But bed 4 needs the toilet! No one else is free, and I'm not going to get my lady home

at this rate.' 'Where is the student, can she do it?' It is 6pm and the ward manager, receptionist, administrator and discharge coordinator have all left now. The coordinating nurse also has a bay of patients and has her own admissions and discharges waiting. The other nurse is still on the phone, and a relative is leaning over the desk, waiting for news. The nurse is asking about a patient who went down for a scan some time ago, and her relative wants to know how long she will be. The nurse is also clutching a drug chart to be checked and turns her back to the relative while she continues on the phone. The ward doors open again and a fourth admission is brought in. The nurse on the phone puts her head in her hands, and Helen looks like she is going to cry.

(Field notes, 8/1/16)

These examples show how a context of threat can influence language and practices. Individuals can adopt a defensive stance and have less capacity to notice, engage with and attend to any issues outside of those deemed most urgent. These episodes are in stark contrast to those presented at the beginning of the chapter, in which the same staff members

acted intuitively, skilfully and compassionately in response to suffering.

5.5 Conclusion

In this chapter I presented findings to support the theme of 'contextualised compassion', which refers to the notion that in the ward setting, the organisational milieu heavily shapes the enactment of compassionate care. Therefore, considering compassionate care without close consideration of the context gives only a partial picture.

I demonstrated first that ward work is inherently challenging. However, I showed that staff were able to give compassionate care, and to enjoy the rewards of that. In these situations, the ward unit and the wider trust supported staff to prioritise and provide compassionate care. I presented evidence to suggest that this wider support for care was related to a widely held view that the circumstances (clinical emergencies, EOLC, cohort bay care) warranted intensive, compassionate care. However, in terms of 'general' ward work, there was a lack of acknowledgement about the demands of care and how they impacted on staff, and a lack of practical, positive support. In these situations, staff struggled to enact compassionate care and experienced it as draining, or as another demand to meet.

I also argued that a combination of contextual factors – such as relentless change, regulatory processes, conflicting priorities, inadequate staff support and sustained operational pressures – meant that a sense of threat underpinned ward work. The language and practices of staff reflected the sense of threat through a narrative of defensiveness, anxiety and insecurity. When the ward or individual staff were under significant pressure, care was frequently inadequate and suffering was missed. I suggested that autonomy, clinical skill, stability and clear, shared organisational goals appeared to facilitate compassionate care. However, practical organisational support in the form of staffing and reduced workload appeared to have a particularly positive impact on the capacity of staff to engage in personalised, meaningful care interactions, and to notice and effectively relieve suffering in the ward setting.

Chapter six: Compromised compassion

> *Compassion? Well, that is loving, tenderness and that. But how can they be like that in here? They've a job to do, and not just with my mum, there's all the others. So really, they can't be too compassionate …*
>
> (Relative Dave, informal interview, my emphasis)

6.0 Introduction

In this chapter I show how staff and service users on Hazel ward constructed compassion through their social interactions. I show that participants understood and enacted compassion in a wide variety of ways. Like other social phenomena, compassion can be understood to have multiple constructions, each accomplished through a the dynamic relationship between people and their cultural environment (Al-Saggaf and Williamson, 2006, Berger and Luckmann, 1991). The findings show that compassion is brought to life in the 'hurly-burly' (Edley, 2001) of everyday life on the ward, and often has little connection to ascribed etymological and scholarly definitions.

The chapter is structured in three main sections: constructions of compassion; compassion as an intrinsic phenomenon; and, lastly, compassion as an extrinsic phenomenon. I do not suggest that these constructions comprehensively explain the nature of compassion in the ward context. However, I show

the distinct patterns in the data to expand our understanding of the phenomenon in relation to clinical settings.

I open with an overview of how participants understood compassion, in order to reflect the variety that exists even within this one ward. For the main body of the chapter, I then give in-depth accounts of two prominent constructions: compassion as an intrinsic phenomenon, and compassion as an extrinsic phenomenon. I developed these two accounts by analysing participants' discursive and social practices and exploring how compassion is constituted through these (Holstein and Gubrium, 2008b).

I firstly present 'compassion as intrinsic' and describe the moral narrative underpinning this account. Compassion is understood as a personal quality, which individuals either have or don't have, and is strongly associated with self-sacrifice and traditional representations of nursing. I secondly discuss 'compassion as extrinsic'. I draw out the economic narrative in this account and the construction of compassion as a limited resource that healthcare staff necessarily ration at times. It is important to note, however, that the constructions were not as sharply defined as I suggest here. Participants' accounts were in practice more blurred, fluid and contradictory, and I point to this throughout the chapter. However, I separate the two

constructions in order to more clearly discuss the distinctive elements.

I conclude the chapter by suggesting that two factors underpin both accounts. Firstly, the influence of the distinctive healthcare context is evident in both constructions. This suggests that '*in here'*, as Dave points out in the quote opening this chapter, compassion is different from how it might be constructed in a non-healthcare setting. Secondly, the distinctive contingencies of the ward setting mean that the expression of compassion necessitates compromise. I show however that participants differ in how they make that compromise.

6.1 Constructions of compassion

I found that compassion was understood to have very different meanings for participants. Some equated it with basic kindness and politeness, while for others it was akin to love and to sharing the suffering of another. Compassion was therefore of varying levels of significance, from being 'just everything' (patient Mags, recorded interview) to 'irrelevant' (relative Jim, informal interview). There were patterns in terms of how staff and service users conceptualised compassion. For example, staff members generally talked about 'giving' compassion – taking the role of the person

expressing compassion to another. Contrastingly, patients talked about compassion from the role of receiver. These conceptualisations reflect social notions of illness and care-giving which cast the service user as the sufferer, and healthcare staff as 'givers' of compassion. In this sense, participants' accounts of compassion are immediately framed by the healthcare context, because they locate themselves first as patient/sufferer or staff member/giver of compassion.

6.1.1 'The little things' or 'going the extra mile'

Interestingly, it was equally common for compassion to be understood both as 'the little things' and as going 'above and beyond' or 'the extra mile' – descriptive phrases that feature frequently in media accounts and the wider literature (Ford, 2015, Sawbridge, 2017). Occasionally, the same participant would use both descriptions within one sentence:

> *It's kindness, I think, going the extra mile, y'know, doing those little things.*
>
> (Senior bed manager, informal interview)

The fact that these are opposing phrases – one meaning small, simple actions, and the other referring to grand gestures – reflects the confusion that participants felt about compassion and the difficulty they had when trying to describe it.

6.1.1.1 The little things

When participants described compassion as the 'little things', they tended to refer to actions that had an air of simplicity. The following excerpts illustrate this:

> *It's those little touches and looks, the little things that show you care.*
>
> (Senior nurse Helen, informal interview)
>
> *It's really thinking about those little things that often get missed, making sure you do their hair nice, check their nails …*
>
> (HCA Suzy, informal interview)
>
> *Compassion is really all about the little things, like being respectful and kind to all your patients, regardless of how they are presenting.*
>
> (OT Elaine, informal interview)
>
> *For me, it's those little things. You can tell if they are really listening to you, y'know, not just doing the smile-and-nod thing.*
>
> (Patient Cath, informal interview)
>
> *[Compassion is] remembering the small things – people say they don't have time for compassion, but things like eye contact, remembering people's names, these small*

things are more important than some of the high-level decisions the board makes.

(Senior bed manager, informal interview)

Framing compassion as the 'little things' can equate it with simple acts of kindness or politeness, and is in some ways reductive. There is no reference to suffering in these descriptions, or to the skill, clinical judgement and emotional labour of care that was depicted in the previous chapter.

6.1.1.2 Going the extra mile/going above and beyond

'Going the extra mile/going over and above' was often used to indicate giving *time*, or giving something that was outside the realms of normal expectation or the official remit. For example, in the extract below, Fiona suggests that the care she received was special not because of what the nurse did, but because the nurse is giving her precious time:

When we got down to the waiting area, we realised I was going to be on my own really. There was one nurse, but she was in and out, doing something else as well. [The nurse who brought me down] said, 'Oh no, you can't wait on your own', so she called back to the ward and said she was staying and she'd bring me back. And she had brought me down herself because I'd waited so long for a porter! I kept thinking about all her work, but

she was adamant about not leaving me … They're like that, though, they go over and above for you …

(Patient Fiona, informal interview)

'Going the extra mile/going over and above' was also used to refer to staff members buying and bringing in goods for patients, such as toiletries, magazines, food or drink. This excerpt illustrates one example:

The confused woman has now stopped the volunteer with the shop trolley. She wants to buy chocolate and a magazine and the volunteer is gently trying to tell her she has no money. An HCA comes over and checks the patient's purse, but it is empty. The volunteer says the patient does this most days and moves to the next patient. I notice that several staff members in the close vicinity (a cleaner, an HCA and a nurse) have gathered together and are counting up some coins. The HCA calls over to the volunteer and asks how much the items were. Looking back at the coins, she says, 'Yes, I'll just get another pound from my locker.' The cleaner goes over to the volunteer and tells him: 'Just leave the stuff with her and we'll give you the money in a minute.' No one really comments on this, and it does not seem

unusual. The patient is unaware and settles down with the magazine.

(Field notes, 7/5/16)

Many patients described similar scenarios where staff seemed to have acted beyond their 'official' remit. Rebecca's words again suggest that it is the knowledge that the person went further than required in their caring action that made it compassionate, rather than the action per se.

It's going the extra mile, isn't it? Things like bringing you books and magazines and whatever … The nurses were talking about [a novel] they'd all read, and I said, 'Ooh, that sounds good!' And the nurse said, 'Well, you can have it next then and tell us what you think', and she brought it in for me … makes you feel part of the family, I suppose.

(Patient Rebecca, informal interview)

Mags was a patient who was extremely anxious about being in hospital and having surgery. She was positive about her care and treatment overall, but when she described her experience, it was the interactions that she felt were more than 'the standard thing' that she identified as compassionate:

I don't think I'd have been able to deal with being in hospital if [the staff] hadn't have been compassionate … It would have been so easy for my experience to have been a totally different one … But the people here, they all go the extra mile for you. I mean, who goes home when you've done a shift like that and does further research? [A nurse looked up side effects of a treatment at Mags's request.] He was a really caring, lovely person. And then, with my operation. It wasn't just the standard thing … The way they managed the whole thing was so impressive and organised … otherwise I would have been so frightened … [After her operation, she couldn't shower independently.] There was an HCA, and I said to her, 'Oh, I wish I could wash my hair', so she said, 'Well, we'll wash your hair, we'll find a way.' And she did and it felt really good! She took the time and she thought about how we could do it. She didn't have to do that, but it made me feel so much better.

(Patient Mags, recorded interview)

Interestingly, what student nurse Holly describes as 'above and beyond' is being thanked for her contribution, suggesting this is not the norm:

> *The nurse who … I think's fantastic at their job, always goes above and beyond to make everyone feel involved, included, like she cares about you. So it's about giving compassion to your colleagues as well, isn't it? At the end of the shift she'll always say, 'Thank you, you were so helpful today, you did great.' … That, for me, feeling involved and engaged, just makes me want to go above and beyond then.*
>
> (Student Holly, recorded interview)

When participants constructed compassion as 'going the extra mile/over and above', they described actions that involved another going beyond their official remit to respond to a perceived need. In this sense, there was again little reference to great suffering or clinical skill. Instead, it was the idea that another person was doing something additional for them, especially giving extra time, which was valued.

Summary

As noted earlier, stock descriptors such as 'going the extra mile' or 'the little things' can give the impression that compassionate care is straightforward and devoid of emotional labour, judgement or skill. This is a version of compassion that is often presented in the media, with headlines that decry the

need to teach healthcare staff such a 'basic' nursing quality (Borland, 2013, Chapman and Martin, 2013).

However, these phrases also gave participants a way of articulating an aspect of their hospital experience that was complex and emotional. Almost all participants expressed difficulty about putting their thoughts about compassion into words, as this nurse reflected:

> *Hmm, it's hard to describe it in words; it's so physical, isn't it? You do it, show it, it's sort of, it's part of being with people …*
>
> (Junior nurse, recorded interview)

In text form, the stock phrases are divorced from the clinical setting which they describe. However, when they are considered in the context of the pressurised, threatening, unstable ward environment described in chapters four and five, their significance is somewhat different. In the ward setting, interactions that dedicate time and space to non-essential acts of care are the result of intelligent judgement, complex decision-making and skilful implementation, as well as a commitment to relieve and prevent suffering.

I now move from this broad overview to an in-depth consideration of two particular accounts: compassion as an intrinsic phenomenon, and compassion as an extrinsic

phenomenon. I draw out both the similarities and the differences between these constructions, but also show that for individual participants, conceptualisation of compassion is more nuanced and contradictory.

6.2 Compassion as intrinsic

The construction of compassion as an intrinsic quality, independent of the context, is underpinned by an assumption that compassion is a personal quality or stable trait. Individuals are either compassionate or uncompassionate, and the qualities and efforts of those expressing compassion are the most important determinants in how compassionate care is experienced.

Participants who constructed compassion in this way tended to self-identify as compassionate people, a stance that shaped the way they related to others generally and not just in the healthcare context. There was a moral element to this construction, in that being compassionate was seen as right or good. There was also a narrative of self-sacrifice, as it was accepted that extending compassion to others incurred a personal cost.

It was mainly nurse and HCA participants who understood compassion in this way, plus many patients and relatives. It was least evident in the AHPs and medical staff, which may be

connected to the development, culture and organisation of these professional groups.

6.2.1 Compassion as a personal quality or trait

When compassion was conceptualised as an individual quality or trait, the values of the person expressing compassion were the prime factor in how/whether compassion was expressed. This could encourage a somewhat polarised view, as the following excerpts illustrate:

> *You've either got it or you haven't, really.*
>
> (Administrative staff, recorded interview)
>
> *People are either compassionate, or they're not.*
>
> (Senior nurse Lizzie, informal interview)
>
> *[Compassion is] all down to the individual … You can tell someone what compassion is, but if they haven't got it in them, that thing in them … they're never going to do it, they won't have the actual feeling.*
>
> (HCA Mel, recorded interview)

Mel's words suggest that as an intrinsic quality, compassion cannot be taught or developed. These excerpts also suggest compassion is independent of the surrounding context; it is 'in them', as Mel says. Ann's words below allow for the

development of compassion, but suggest that compassion has to be 'in' a person to start with:

> *[We're] trying to recruit people who we believe demonstrate the right values and behaviours and come with some compassion in them to start with … If people haven't got [that], it's hard. You can enhance it, but you do need some raw material to work with.*
>
> (Corporate staff Ann, recorded interview)

Lilly, whose husband had died on Hazel ward, gives a sense of how meaningful compassion can be for individuals. It is its intrinsic nature, and the fact that compassion is being bestowed from one to another, which distinguishes it as special. Referring to the staff member as 'you', she told me:

> *You've got to show [the patient] that someone loves them, that <u>you</u> love them, and that you are <u>right there</u> in that place with them. So that they don't feel alone, feel frightened … You've got to be tender and love them so that they <u>feel</u> that love. You can't pretend, or they won't feel it, and they'll feel alone.*
>
> (Relative Lilly, recorded interview)

This gives an evocative illustration of compassion as a deeply emotional quality that can directly soothe the suffering of

another. It is an understanding of compassion that is wholly divorced from the context, for example other patients or responsibilities.

Most of those who understood compassion as intrinsic also self-identified as compassionate. The excerpts below suggest this and, again, convey the idea that compassion is expressed 'naturally', rather than being taught or developed:

> *I'm quite a compassionate person, I like to show people … even someone that's not my friend, that I care about them, just because I think it's good for everyone.*
>
> (Junior Amelia, recorded interview)
>
> *[Compassion] comes naturally to me … I feel it's so important to have a personal relationship with people – that is what good-quality care is based on.*
>
> (Physiotherapist Caroline, informal interview)
>
> *I don't ever actually think about [compassion], I just do it by nature … It's just my way, how I am, and why I wanted to nurse in the first place.*
>
> (Junior nurse Alice, recorded interview)

These examples also suggest that when compassion is considered an intrinsic quality, it is a way of being in the world that pre-exists and is independent of the healthcare context

they are now in. It is a personal trait that shapes their relationships with others in life, and they bring this to the ward.

6.2.2 Compassion is given, not received

Participants who constructed compassion in this way spoke mainly of expressing compassion to others, rather than receiving it. This was demonstrated through the recurrent use of the verb '*giving'*, such as giving time, care, reassurance or presence. In contrast, there was little reference to receiving compassion. When I asked participants directly about this, they appeared to value others showing concern or care for them, but they did not expect it:

> *We do get compassion too, I suppose, [my seniors] always thank you, most of them … They will say, 'You're doing brill, thanks for doing what you're doing' … or, 'We know how hard it is.' … [That] can make a massive difference to how you come out feeling.*
>
> (Administrative staff Kath, recorded interview)

> *I think we get compassion from our patients a lot, they always say 'What time are you finishing?' 'Oh, you look tired, you need to go to bed' (Laughter) … Patients do see you running about and they see you being stressed*

out, and they're sort of showing the compassion back to you and you need it, it really helps.

(Senior nurse Lizzie, recorded interview)

I also asked participants about self-compassion. As noted, this is a concept that has been under-represented in healthcare literature and did not arise spontaneously during fieldwork. Participants had generally not heard or thought about self-compassion, but likened it to a basic form of self-care such as resting and nutrition:

Self-compassion? Er, no. (Laughter) I mean, that doesn't really come into it, does it?! You've just got to keep going until you collapse, you can't stop to think about that kind of thing!

(HCA Tina, informal interview)

Nurses never tell themselves, 'Well done!' You can smile to yourself and think, 'Hmm, that's a good thing', but you'd never say it. You would say to the other people, 'You did fantastically.' … But you never sit there and say, 'Oh, I did really well.' … And it's the same when we're poorly. We come to work, ill, snotting all over the place, no voice. But you can't let your colleagues, you can't let the patients down. You'd feel terrible at home in bed knowing others were struggling.

(Senior nurse Lucy, recorded interview)

I think nurses put themselves last, because we're the ones that care. We're very much like, 'As long as my patient's alright, as long as my colleague's alright, then that's fine', and you don't really think about yourself.

(Senior nurse, Helen, informal interview)

Self-compassion? Looking after yourself and things? … Well, it has to be the patients first, and I mean, for me, it would be part of the category that's a weakness.

(Junior nurse Amelia, recorded interview)

Amelia's words are more explicit, but there are evident negative undertones regarding self-compassion. As noted in chapter two, it is not unusual from a Western perspective for self-compassion to be viewed as weak or indulgent (Gilbert et al., 2011). Furthermore, the historical development of nursing and the associated culture of vocation and selflessness (Pask, 2005, Rickett, 2010) may mean that nurses are particularly uncomfortable with the idea.

6.2.3 Compassion is a virtue

There was a strong moral narrative running through the understanding of compassion as an intrinsic quality, as it was presented as 'good' or the 'right' way to be:

I'd rather be late and do the right thing … stay longer with someone … than rush off. I want to be there, to be that person that shows them compassion.

(Junior nurse Amelia, recorded interview)

I do feel, you know, you have to go very much above and beyond. And you do have to give your all, and to me, you can't go into nursing if you're not prepared to give everything you've got for your patients.

(Student nurse Chantelle, informal interview)

The flipside of this moral interpretation is that those whose behaviour is not seen as compassionate are judged negatively:

I thought [the nurse] was selfish, she wasn't giving her all to that patient, her whole person.

(Senior nurse Helen, field notes)

Nurses, we kind of say … be nice, be kind to [the patients] … we find that we're more compassionate than other people. I'd say we're the most compassionate profession.

(Junior nurse Alice, recorded interview)

There's a great variation in my peer group. I know those who are purely 'job' doctors; they will only do the essentials, like, 'Right, I have this many bloods to do, I

will do that, then I'm done.' And there are others I know who will … actually go and sit with the patient for half an hour, and give their time.

(Junior doctor Paul, informal interview)

[Some people] are really task orientated, and that's what the system encourages. And a lot of people find it easier just to comply and go along with the system … especially if they want to be promoted. Because … management-type people simply don't value compassion.

(Junior nurse Amelia, recorded interview)

In this last quote, Amelia judges the organisation itself as uncompassionate, and numerous participants shared this view. Interestingly, when the organisation was framed as uncaring, then the enactment of compassion appeared subversive. For example, Amelia described rejecting organisational imperatives and ward rules *in order to* care for patients:

Sometimes, I just think, 'Oh, sod it, I'm just going to go and sit with that patient for a bit.' … I don't care if the writing's not done! … If I can improve someone's life just by showing I care, then I will!

> *The [other staff] say: 'Oh no, we can't make people tea at [3am], Amelia! And I'd say, 'Well, I'm going to do it!' And they say, 'Oh, but if one wants it, then all of them will want it!' So I say, 'Well, I'll make them all tea then … the whole ward!'*
>
> (Junior nurse Amelia, recorded interview)

There were other accounts of circumventing explicit or implicit organisational rules in order to give compassionate care. Most commonly, these related to prioritising issues of care over patient flow. These were not medically urgent care issues and so would not otherwise have been prioritised over a quick discharge. However, staff perceived these issues to be crucial for the well-being of the patient. They therefore prioritised them despite the risk of repercussions. One nurse described 'dragging her heels' with discharges if she felt the patient would become distressed by being rushed (junior nurse, informal interview). Another nurse described being put under pressure to transfer a patient to another ward. When she asked the patient, the patient reluctantly agreed, but then began crying about having to move in the middle of the night. The nurse then decided not to move the patient, and pretended that she had refused to be transferred when the bed manager called (senior nurse, informal interview).

Ellen, an experienced staff nurse, described how she wanted to prioritise the particulars of the oxygen arrangements for a patient going home. It was not medically necessary but made the patient feel more comfortable and secure. She described how she neglected her other tasks and the jobs that others were telling her to prioritise in order to organise this care. Ellen reflected she was happy that she had done it, even though she did 'get told off', because she knew it was the 'right' thing to do (Ellen, informal interview).

6.2.4 Compassion involves self-sacrifice

As Ellen's words suggest, not complying with organisational rules incurs a risk of repercussions. Staff seemed to accept this risk, however, as well as other types of personal cost, in order to care compassionately. Furthermore, some saw personal cost as an inherent part of compassion:

> *That's the reality of [compassionate care], you do suffer … physically and mentally.*
>
> (Junior nurse Amelia, recorded interview)

For staff, personal cost took the form of working late, and working through pain, illness or emotional distress. These costs were not incurred for 'essential' care or work, but to respond to what participants saw as patient distress or need. For example, some staff shared their own still-painful

experiences of bereavement to help relatives cope with similar situations. When talking about this, participants tended to frame their suffering as secondary to that of patients. Georgia, for example, was experiencing extremely difficult home circumstances, but described her situation as 'nothing' in comparison to what she knew patients were experiencing (HCA Georgia, field notes). Mel similarly felt that it was her 'job' to 'put myself out of my comfort zone, for the patients' sake' (HCA Mel, field notes).

I asked Lizzie how she managed to carry out emotionally and physically intensive work with patients despite her own challenging problems. She responded that she needed to be 'open and available' for her patients, or they wouldn't be able to open up to her:

> *I need to put my [difficult personal issues] aside, I just can't let that affect patients, it's not fair.*
>
> (Senior nurse Lizzie, informal interview)

Despite their short time in healthcare, student-nurse participants shared a similar notion that compassionate care inherently involved some kind of personal sacrifice. Coming back to placement with long-standing pain issues, Danielle dismissed her discomfort as:

… something I have to be careful about, but ultimately I have to put patients' needs first.

(Student Danielle, field notes)

Another student explicitly defined compassion in terms of self-sacrifice:

Compassion is about putting my patients' needs first, so if I have to miss my break or go home late, that's what I have to do.

(Student Chantelle, informal interview)

The acceptance of personal cost included the tolerance of aggression and hostility. Staff tended to frame these scenarios as 'part of the job' (senior nurse, field notes). Furthermore, when violence was felt to be caused by the patient's illness, it was seen as acceptable. However, as violence towards healthcare workers is a growing and widespread national problem (Spector et al., 2014), its tolerance could be related to a sense that it was normal.

Some participants inferred that it was their caring role specifically that made aggression and violence acceptable. For example, one staff member described her efforts to 'keep calm and understand where the aggression was coming from' (HCA, informal interview) when a patient was shouting at her. She

felt she 'should' try to understand their perspective and how their illness made them feel confused and aggressive. Another nurse gave a striking account of violence in the ward. I observed Lucy as a confident and experienced nurse, who would quickly rebuke her seniors for rudeness to colleagues. However, when talking about patient violence, she implied that her position as a care giver made it acceptable. This is made explicit in the final words of the quote:

> *As nurses we do take a lot of violence and aggression … Y'know, a punch in the mouth just because somebody's confused? I don't know anyone who hasn't accepted it as a nurse, I don't know anybody that's taken it to the police … I know a lot of the time it's to do with the person's illness, so you just have a different level of what's acceptable. But patients' families can be really verbally aggressive. You would never stand someone swearing at you in the street, you'd just walk away … You do take it here, though, because you care.*
>
> (Senior nurse Lucy, recorded interview)

Lucy's words suggest that some ward staff are willing to accept extreme personal risk or negative consequences because of their caring role. Her reference to other nurses (rather than other HCPs) draws a link to the historically

selfless image of nursing and the virtuous construction of compassion. Other professional groups made very little mention of violence or aggression, which was perhaps linked to the fact that they had less direct patient contact. However, when they did refer to aggression, they were clear that it was unacceptable. Several participants described a similar strategy of leaving the patient until their behaviour changed:

> *I just said [in response to an aggressive, swearing patient], 'Look, I'm here to help, to work with you, but you can't swear at me.' And I got a bit firm with him … Then I said I'll leave it for now, because you're obviously not feeling very well, and I'll come back later.' And when I went back later, he was nice as pie.*
>
> (OT Elaine, recorded interview)
>
> *I said [in response to a patient shouting at him], 'I won't accept you talking to me like that, and I can't help you like that, so I'll come back later, but only if you're more reasonable.'*
>
> (Junior doctor Paul, informal interview)

Participants cited this strategy of withdrawing attention and presence, even for a brief time, as effective. However, it was not a response that nurses suggested, and was perhaps linked to a tendency to tolerate personal cost in order to provide

care. In the next section, I suggest that a further cost associated with compassion is interpreting poor care as a personal failure or fault.

6.2.5 Poor care as a personal failure

Across participants generally, there was an acknowledgement that the overloaded and under-resourced working environment inevitably meant that staff missed or delayed aspects of work, or that care was often compromised. It was common for staff to reassure each other that this was a normal result of a challenging environment. However, when compassion was constructed as an intrinsic quality, poor care was necessarily seen as a personal failure or fault. The following extracts illustrate the sometimes intense feelings of self-blame and regret:

> *I feel like I've let myself down, my patients down, and their families down. Especially if you've known them previously and they expect that level of care from me. But some days … I can't physically do it … and I feel like crap about myself.*
>
> (Junior nurse Amelia, recorded interview)

> *[When I am very tired] I don't like to admit it, but I do feel myself getting quite, not snappy, but I don't think I have the compassion as much as I did on my first shift.*

And that's no disrespect to the [patients]. That's just my failing.

(Junior nurse Alice, recorded interview)

[When] I don't get everything done, I get disheartened … I feel very conscious, I try and get it all done, I really do. So if I don't … I think, 'I'm sorry.' I do apologise; I spend a lot of my time apologising.

(Senior nurse Lara, informal interview)

For some of these participants, there appeared to be a particularly strong commitment to deep personal engagement with patients and their suffering. Occasionally, the participant's need to give intensely involved care could override the best interest of the patient. For example, by fostering a patient's dependency on their care, becoming overwhelmed by emotion at the patient's suffering, or neglecting other patients and responsibilities. Amelia described several emotionally charged scenarios with patients, in which she found her own emotions difficult to manage. Referring to one, she said:

I had to go, just get out of there and just cry, because I really, really felt her pain.

(Junior nurse Amelia, informal interview)

Lara also struggled to disengage from particular patients at times. In one instance, she was caring for a dying patient over a couple of days. When she was allocated to another area, Lara continued to intervene in the patient's care, obstructing and openly criticising the work of the nurse.

6.2.6 The patient perspective

Lastly in this section, there were numerous patients who understood compassion as an intrinsic quality:

> *You are either compassionate or you aren't, it's as simple as that.*
>
> (Patient Chrissy, informal interview)

Their accounts reflected similar themes of compassion as virtuous, a self-identity and dependent on the characteristics of the person expressing compassion. Interestingly, these patients did not always see themselves as the receivers of compassion. This was even when we were explicitly discussing their experience of care. The accounts of these patients suggested that they noticed and felt concerned for the distress of staff and other patients. I often watched them getting help for other patients or asking their own relatives to bring items for other patients. There were likely a range of reasons for this – for example, some patients liked to 'keep busy' (patient Rebecca, field notes) or distract themselves from their

symptoms. However, some participants appeared to be particularly sensitive to subtle cues of distress. For instance, Rita noticed some patients did not have regular visitors and often wandered from her own bed space to theirs, checking on them or stopping for a chat. Yvonne picked up on the 'vulnerability' of some patients, commenting that they had no one to 'speak up for them and they can't do it themselves' (patient Yvonne, informal interview).

Some patients retained this other-focused compassionate perspective despite their own suffering. One example of this took place shortly after Esther received unexpected bad news about her prognosis. Nurse Lara was working in her bay and was clearly having a bad shift. She looked anxious and irritated, far from her usual bright self. Esther called her over to her bedside and said gently:

> *'Darling, I really think you could do with a hug. Can I give you one?' Lara's shoulders immediately drop and her face breaks into a smile. The HCA in the bay starts laughing, making eye contact with me. Lara walks over to Esther's bed with her arms outstretched. It is a long, warm cuddle, close-bodied, with their chins on each other's shoulders. Me and the HCA smile at each other, it's a lovely thing to watch.*

(Field notes, 3/2/16)

Other staff reported similar acts of compassion from patients and described the 'boost' (junior nurse, field notes) this gave them, which enabled staff to 'get through to the end of the shift' (senior nurse, informal interview).

Where patients understood compassion as an intrinsic quality, as self-identified as such, it appeared to be irrelevant that they were being cared for in a hospital ward. Their sense of themselves as 'compassionate people' meant that they responded to the suffering of others regardless of the context they were in and of the traditional role that they might be expected to adopt.

Summary

In this section I have shown that an account of compassion as a context-independent, personal quality incorporates a number of prominent themes and practices. Seen as independent of the healthcare setting, and as a virtuous way of being, compassion can become subversive. Patients disregarded the traditional passive recipient role, while staff were prepared to disregard organisational rules in order to enact compassionate care where they judged it necessary. The construction of compassion as an intrinsic quality reflects the value-based nursing scholarship discussed in chapter two, and this perhaps

offers an explanation for why it was predominantly nurses who framed compassion in this way.

For many participants, this notion of compassion was intensely meaningful and enhanced their experience of giving and receiving care. For staff, there was a sense of reward from practising in a way that reflected their self-identity and felt 'right'. Having an other-focused stance and sensitivity to the suffering of others is also clearly beneficial in the challenging healthcare environment. However, the tendency to tolerate personal cost in order to fulfil the caring role is problematic, particularly where this involves aggression or violence. Furthermore, in today's climate, resources are stretched, and the ability of the health service to meet the needs of patients is severely compromised. In this context, staff who construct compassion as an intrinsic quality may feel increasingly demoralised and self-critical about the inadequacy of care and the suffering of patients.

6.3 Compassion as extrinsic

Participants who understood compassion as an extrinsic phenomenon tended to foreground the healthcare context and its distinctive contingencies. They therefore framed compassion in terms that were tightly related to their professional role, rather than identifying themselves as

compassionate individuals. A range of staff groups, patients and relatives understood compassion in this way, although this conception was mainly found among AHPs and medical staff.

An economic narrative characterised this account. Compassion was viewed as a valuable resource, but one that was within the caring repertoire, rather than denoting that an individual was particularly virtuous. In the same way that other healthcare resources could be restricted at times, compassion was limited when necessary. Some common scenarios were identified where compassion was deemed essential, such as EOLC, and concerted efforts were made in these cases to ensure that patient care was sufficiently engaged and personalised. Lastly, when lengthy and engaged care was not possible, it was viewed negatively, but was located as an operational problem rather than a personal failure.

6.3.1 Contextualising compassion

In this extrinsic account, the healthcare context shapes the construction of compassion. Many participants expressed a dual understanding, giving a personal and contextualised meaning. Dave's words below illustrate this, as well as encapsulating many themes of this account. On a personal level, he described compassion as akin to love. However, he

then qualified that description by stating that 'in here' the priorities were different:

> *Compassion? Well, that is loving, tenderness and that. But how can [staff] be like that in here? They've a job to do, and not just with my mum, there's all the others. So really, they can't be too compassionate … They do a fine job – Mum's safe, she's looked after … They are nice people doing their best in a hard situation.*
>
> (Relative Dave, informal interview)

Dave's words also suggest *why* compassion is different in the ward setting. He notes that staff have a 'job' to do, suggesting that they need to focus on treating the patients' health complaints. He also refers to the extent of demand. These two factors create a 'hard situation', which means that care cannot be about love. Instead, he implies that being nice and doing their best is an acceptable alternative.

Other patients and relatives gave similar accounts, often dismissing the term compassion with a shrug or shake of their head, and going on to talk instead about the good care they had experienced. For example, I asked Jim what compassion meant to him. He shrugged and gave a more practical description of care:

It's not really about that, is it? You need them to do something and they do it if they can … That's that.

(Patient Jim, informal interview)

It often appeared that compassion was considered to be either unnecessary or inappropriate in the setting, and a more fitting alternative was offered instead. For example, Sarah was a patient with a complex background, urgent physical needs and mental health issues. She waved her hand when I asked about compassion:

I know that stuff is all in the papers and everything, but that's not really the thing … I need the communication to be excellent, I don't want to have to keep explaining [her complex background] over and over again … I need my treatment … to get better, stronger … to get home. I feel very safe here, but I don't like it – nobody likes being in hospital, do they? But I don't expect the nurses to get me to have a nice time here … They just need to get me home!

(Patient Sarah, informal interview)

Sarah's words introduce the idea of 'expectation' – a term used often by service users. Participants who constructed compassion extrinsically tended to expect kindness,

appropriate treatment, safe care and physical improvement, but not necessarily compassion:

> *I was so sick when I came in here, I couldn't even tell them what I was on, they had to get my GP notes from the computer. But look at me, I'm on my way home now … They've been very kind … They've got me better, so they've done what I needed them to do … I don't really expect more than that.*
>
> (Patient Cara, informal interview)

Jasmine had a similar view, but also suggested that there were situations where compassion was appropriate and necessary. Jasmine had a frightening emergency admission, but felt she had 'a positive experience all the way through' and that staff were 'caring' and 'kind':

> *I'm not sure about compassion, exactly, but I've been really happy with the care … There are a lot of old people here, very frail … They have a lot of needs … I can see they need a different kind of care … They want the nurse to be with them a lot … Some of them are frightened of just being in here … Those kinds of patients really need compassion, whereas I'm OK, I can manage now I'm better.*
>
> (Patient Jasmine, informal interview)

Jasmine's words suggest she was aware of the varying levels of need and that it was acceptable to engage differently according to those needs.

Staff participants were acutely conscious of the extent and the differing degrees of need and suffering as well as their multiple responsibilities. Maintaining this awareness was necessary to manage the needs of the ward as a whole, but by doing that, their engagement with patients was affected. A number of participants described this awareness using the phrase 'the things in the back of your mind' or something very similar. Helen suggested how this impacted on compassionate interactions:

> *There are so many jobs to do, too many. I aim to give compassionate care, but while someone is talking to me, I am thinking of these other jobs that I really need to do right now, and the other patients that are waiting.*
>
> (Senior Nurse Helen, field notes)

> *Treating people as you would like to be treated yourself, imagining them as a family member … I mean, compassion really goes beyond that, but in this environment it's about expecting people to be treated in a respectful and kind manner, really … and not doing them any harm.*

(OT Elaine, recorded interview, my emphasis)

In this sense, providing appropriate care that meets the extent and range of need in the setting is foremost in the minds of staff, and their understanding of compassion is shaped in relation to that.

6.3.2 Professional compassion

The following examples show that within this extrinsic account, the construction of compassion is practical and specific to the role of the staff member. Stephen, for example, understands compassion as making interactions more personal and caring. However, he frames the interaction using the term 'treatment' and therefore situates compassion in the healthcare domain:

> *[Compassion] is about treating patients in the way I would like to be treated or how I would approach the treatment of a family member.*

(Consultant Stephen, informal interview)

Other participants gave similar accounts, which can be termed 'professional compassion', as both compassion and suffering are tightly associated with the individual's professional role and remit:

> *[Compassion is] things like looking at the viewpoint of the patients … because obviously they may have*

different opinions to what the MDT [multidisciplinary team]say … So, if they're feeling that they've got an itch [from a medication side effect], it's something that we need to look at, because it can obviously affect their mood …

(Pharmacist Sam, recorded interview)

I would always think of compassionate care as being … safe and comfortable, because if they're distressed, then that's obviously going to have a detrimental effect on the way that they think and the way that they feel … From a physio point of view, if … they're struggling to breathe, then staying with them and going through some breathing exercises, or seeing if we can clear the chest … that would be my two things that I would try and do.

(Physiotherapist Nick, recorded interview)

In Mark's account, compassion is similarly role-specific. In addition, his concern for addressing the root of the patient's suffering (and therefore preventing future health-related suffering) overrides a concern with being nice or kind:

At the end of the day, the patient needs the right advice from you, and if that advice is something they don't want to hear, they still have to hear it … I'm gonna give

> *the advice straight, in a way they understand, in a way that they can discuss, and they can feed back to me … And that's misconstrued as bad care or a lack of compassion … [But] if the patient is in your opinion doing something that is silly for them, like smoking post lung cancer operation, for example … You can be compassionate and be straight …*
>
> (Consultant Mark, recorded interview)

His words also suggest that compassion is conflated with keeping people happy or being nice. In healthcare, it is often the case that actions to reduce health-related suffering are viewed negatively by patients, and staff are required to balance this tension.

It may seem unremarkable that some health professionals refer to compassion in a role-specific way. What is striking about these accounts is the contrast with the intrinsic accounts given by nursing staff. These could be both personal and seemingly limitless:

> *[Compassion is] letting them know I am there for them … It's about being there.*
>
> (Junior nurse Lara, field notes)

> *For me, it's the ability to understand the emotional status of someone … joining with their feelings. And … also being willing to stay with them and work through [their feelings] … reassuring them by your presence … Compassion – it comes from in here (points to heart).*
>
> (Senior nurse Clare, recorded interview)

Lara's phrase of 'being there' for the patient is common in the nursing literature, particularly when describing holistic care (Savage, 1995). These intrinsic descriptions of compassion suggest that the nurses do not see their sphere of responsibility as tied to the patient's health issue. In contrast, the extrinsic accounts locate the source of suffering as well as the compassionate response to the patient within the specific role and remit of the professional. For example, the physiotherapist focuses on breathing difficulties and breathing exercises as a response, the pharmacist focuses on a drug's side effects and reviewing those as a response, and the consultant focuses on lung disease and encouraging smoking cessation as a response. Furthermore, the compassionate responses are described in specific, problem-solving terms and in that sense can be described as practical. This is again a contrast to the earlier presentation of compassion as a virtue, and perhaps by seeing compassion as a practical caring

resource meant that participants saw it as acceptable to limit its use when necessary.

6.3.3 Compassion as a limited resource

An economic narrative ran through this extrinsic account that constructed compassion as a resource for caring, and justified its restriction if its 'costs' could not be 'afforded'. Participants related the restriction of compassion to periods of high workload or pressure, and situations where the patient was thought not to 'need' it. For example, OT Elaine felt that spending too much time with one patient presented an unacceptable cost if it meant she could not attend to the health needs of that patient, or others who were waiting:

> *You have to herd [your] time because otherwise you're not being constructive across the whole ward. Or even for [that patient], really, because they might want to sit and talk to you … but you're not actually helping them in the long run because you're not working effectively with them.*
>
> (OT Elaine, recorded interview)

Pharmacist Rose similarly understood that some patients might require a more in-depth interaction, but felt that she needed to be 'careful' about this, because spending too long

with individuals meant she had less time to facilitate discharges:

> *And that means ultimately patients are lying on trolleys in the ED, not able to get a bed … That's not fair …*
>
> (Pharmacist Rose, informal interview)

Physiotherapist Nick felt that 'equality' and 'fairness' were intrinsic elements of compassion and emphasised the need to 'evenly spread' (physio Nick, recorded interview) his time between all patients on his caseload. A senior nurse similarly described how she managed when a number of her patients had urgent needs:

> *I try to stand back to look at the grand scheme of things, and think, 'Whose needs are most critical here? Who can wait? Who can't I afford to ignore?'*
>
> (Senior nurse Andrea, field notes)

Andrea uses the term 'afford' to suggest how she weighs up the needs of the patient group as a whole. These financial expressions were common in the general ward discourse regarding care or other work-related practices. They were less common when discussing compassion, although they still featured prominently within extrinsic accounts of compassion:

I can't afford to sit all morning with her. I know she's very anxious, but … you have to think of those that you haven't seen at all yet.

(Senior nurse Helen, field notes)

If I can afford to give that time, then I will, but often that's not possible.

(Junior doctor Paul, informal interview)

Well, compassion comes at a cost, I suppose.

(Social worker, field notes)

You sometimes have to bargain with [patients] and say, 'Right, this is what I can do now, and later, if I can, I will get back to you about the rest.'

(Junior doctor Rob, recorded interview)

The assets in the healthcare system are the consultants, [so] surely your priority should be that those consultants are in the right position to deliver care as well as they can? … I'm not saying that consultants are the most important thing by any means, but Ryanair wouldn't work well without its planes running properly.

(Consultant Mark, recorded interview)

I discussed the notion of compassion incurring a *personal* cost for staff who constructed compassion as intrinsic. Contrastingly, within this economic narrative, it is patients that incur the cost when there are barriers to compassionate care. As Mark suggests, if the organisation does not look after the 'assets', the care that consultants deliver to patients will be impaired. Similarly Rob, Paul and Helen either 'bargain' with patients or cut short their time with them, in order to treat more people.

Although compassion is presented as a general resource within this extrinsic account, some aspects of healthcare were judged to be worth the 'cost'. This was particularly the case with EOLC and situations of profound or extreme suffering. Patients with intractable and distressing symptoms, or extremely difficult personal circumstances (such as abuse or trauma), appeared to warrant a compassionate approach regardless of how it impacted on the wider workload. The tone of the social worker's words below is businesslike, and she won't 'negotiate' when it comes to palliative care:

> *Well, yes, because I have many palliative-care patients on my caseload, and when I do fast-track cases, I just have to make time, it's like a non-negotiable thing … So in those situations compassion is essential.*

(Social worker, field notes)

In these 'non-negotiable' situations, which included palliative care, the ward team or organisation also recognised the need for compassion. As noted in chapter five, this means that additional resources are provided, and these offset the wider costs to the workload of the ward as well as individual staff.

6.3.4 Contextualising poor care

In the preceding sections I have shown that the restriction of compassionate care is justified according to a rational or utilitarian approach. This belies the feelings of frustration, regret and despondency that participants expressed. Junior doctor Rob felt 'gutted' that he couldn't spend time listening to patients, which he found enjoyable as well as helpful in working out how to treat a patient's health problems. Senior nurse Andrea was similarly dissatisfied about the fact that she was not able to deliver 'that kind of gold-standard compassionate care' to everyone, as this was the nursing she came into the profession to do, and was the most 'rewarding' for her (senior nurse Andrea, field notes). Mark used another business analogy to indicate how demoralised staff were by the situation:

> *I don't think people set out to be not compassionate, I think people just get hammered … And they end up*

getting tired and fed up of treating patients like McDonald's treats burgers …

(Consultant Mark, recorded interview)

In contrast with the intrinsic account of care, however, the source of this problem was also located externally and was attributed to the trust or the health system rather than seen as a personal failure. Nick's words below directly link quality of care to the degree of demand, suggesting that when demand is low, compassionate care is the norm:

I wouldn't have said there was a lack of compassion in the team … more that there is extra stress on the team, for example, or where you have higher demands. But then when those kinds of demands go down, then I think everyone has equally good care, that's what I've experienced anyway.

(Physiotherapist Nick, recorded interview)

Consultant Mark located care problems within a much broader sphere, blaming cultural shifts in the wider healthcare system. He cites several factors that 'militate against compassion': not being 'allowed to fail' in medicine, a focus on discharge and a standardised, procedural approach to care (consultant Mark, recorded interview). OT Elaine's account is more personalised, but still identifies operational pressures (time and workload)

as the source of these problems. However, she acknowledges that these factors influence the way she relates to patients:

> *There are some scenarios that make it really difficult. I don't think I ever lose sight of compassion, but sometimes … I can get a little bit frustrated. But I find I just have to breathe a little bit … Sometimes you just have to remove yourself a little bit, because you're human and you can feel yourself getting a bit agitated.*
>
> (OT Elaine, recorded interview)

In Elaine's account, her sense of self is intact, as she never loses 'sight of compassion'. Instead she contextualises the scenario, and sees her frustration as a normal 'human' response to operational pressures.

Summary

Within this extrinsic account, compassion is constructed according to the conditions of the healthcare setting. It is cast as a luxury item in a poor market, to be used prudently except in situations of extreme need. The economic narrative of this construction might seem cold and at odds with the caring context. However, it is entirely in line with contemporary health service organisation and delivery, in which financial solvency is an explicit target for all NHS trusts (Molinsky et al., 2012, de Zulueta, 2013a).

Staff were deeply frustrated, angry and despondent about needing to limit engagement with some patients. They all had a warm and caring approach, but the economic discourse makes that difficult to convey in text. Although participants felt it necessary to limit compassion, they were committed to providing a high standard of efficient and safe care. As mentioned in chapter two, an unexpected corollary of the increased attention to compassionate care has been a devaluing of good, safe clinical care. However, as evidenced here, many patients have expressed that they expect and are satisfied with this, and do not expect a deep personal engagement with staff.

Like compassion, the source of care problems was located externally, and there was little evidence of self-blame. Alongside that, there was a highly boundaried representation of professional role and remit. Compassionate care was constructed in relation to that, and its scope was similarly boundaried. This clear sense of role may explain why staff did not feel they had to respond to all need. As there was little moral association with compassion, participants may not have judged less engaged types of care as lesser. Participants appeared to recognise the complex and deeply emotional nature of compassion, but were also highly conscious of the conditions of the context. In order to incorporate the former

within the latter, they adopted a more practical approach. This involved carrying out their role in a caring and competent way, while being sensitive to those scenarios where more intense engagement was necessary. In this sense there was a reassertion of the value of good clinical care, which has been devalued in the recent debates about compassion in healthcare.

6.4 Conclusion

In this chapter I explored the diverse ways in which compassion was conceptualised by staff and service users on Hazel ward, and challenged the assumption of a shared understanding of the phenomenon. I also suggested that individuals are fluid in their constructions of compassion, as with other social phenomena, and that rather than absolute positions, people often hold nuanced and contradictory understandings.

I then presented two constructions in depth: compassion as an intrinsic and as an extrinsic phenomenon. Within the intrinsic account, compassion is a virtuous way of being and an ideal type of care. However, because of the contextual barriers to care on the ward, practising compassionate care can incur risks and damaging personal costs. Some staff are prepared to subvert organisational rules in order to give compassionate

care. By doing so, they assert the value of compassion for patients and the importance of caring in a way that is aligned with their ideals. However, their subversion is necessarily hidden; therefore, their compassionate work and the effort and skill this involved is also kept from view.

An extrinsic account of compassion constructs compassion as a limited healthcare resource. A pragmatic and utilitarian approach justifies the compromise of personalised, individual engagement in order to ensure that those with the greatest need are able to receive compassionate care. By doing so, more patients can be well cared for and efficiently treated. However, it is recognised as a compromise. Though the economic rationale fits with the narrative of contemporary healthcare delivery, it does not fit with participants' personal constructions of compassion.

I noted that participants' accounts of compassion were less distinct then presented here and featured more fluidity and contradiction. Nevertheless, there were strong patterns among professional groups, with a tendency for nurses and HCAs to construct compassion as an intrinsic quality and for AHPs and medical staff to construct compassion as part of the caring repertoire. This suggests a connection between the construction of compassion and the historical development of

these professions and, more specifically, their ties to gender and power.

However, there are two common elements of these constructions which are perhaps the most helpful in developing a fuller understanding of compassion in healthcare. Firstly, the primacy of the healthcare context is evident in both. This context presents a specific and unique set of challenges which hinders the process of compassion in that setting. Secondly, and following on from that, HCPs are required to compromise in some way in order to respond to the suffering and needs of the setting as a whole. The differences then lie in how individuals enact that compromise, and the impact this has personally and for others in the setting. Next, in the final findings chapter, I retain the focus on context but show how it shapes the way in which compassion is received in the ward setting. Accounts of compassion that are intrinsic or values based can omit the complexity of receiving compassion, and suggest that 'giving' compassion is the end of the story. I show that the sufferer has an active role in the compassion process, and does not always receive compassion unproblematically.

Chapter seven: Receiving compassion

There are times I just want to pull the curtains round and tell them to piss off; I don't want your compassion!

(Patient Chrissy, informal interview)

7.0 Introduction

The previous findings chapters have focused on the expression of compassion, which is typical for research on the topic. In this chapter, I present data which shows that the compassion process does not end with the 'delivery' of compassion to the sufferer and further suggests that receiving compassion is not simply a case of passive acceptance. I found that, instead, responses to receiving compassion varied widely, were sometimes unrelated to the expression of compassion, did not always relieve suffering and sometimes generated negative emotions. Furthermore, I found that the recipient's response to the expression of compassion could in turn influence further expressions of compassion, creating a dynamic 'feedback loop' (see figure 13). In this sense, the sufferer's response is as much a part of the whole compassion process as the expression of compassion and the context in which it takes place.

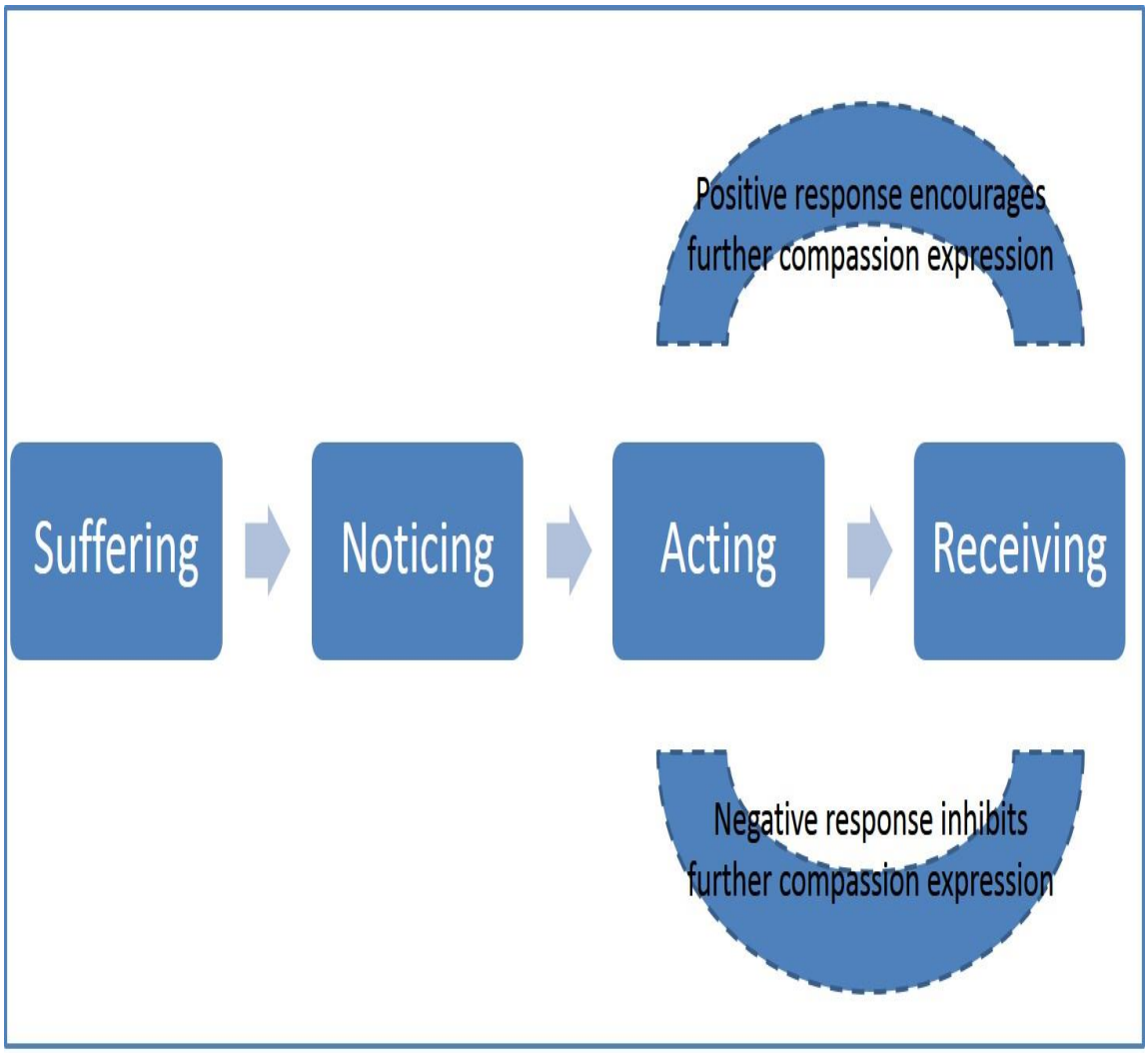


Figure 13 The sufferer's response to expression may contribute to a dynamic feedback loop

I have structured the chapter around a number of case studies that illustrate variation in the way compassion is received. I open with a brief overview of receiving compassion to illuminate the points subsequently raised by the case studies. I then present the cases. The first three illustrate difficulty in receiving compassion, and the last three exemplify instances

where compassion is conversely received with ease. I then summarise the findings and consider the analytic limitations. To conclude, I argue that receiving compassion is a complex, multifactorial process in itself, and is a crucial part of understanding the barriers and facilitators to compassion in healthcare.

7.1 Receiving compassion

As noted earlier, receiving compassion is one of three orientations of the construct, the others being the expression of compassion to others and self-compassion (Gilbert, 2009). It is largely absent from the nursing literature in favour of a focus on the expression of compassion above all else. Consequently, receiving compassion appears passive and unproblematic, rather than a dynamic, relational experience. In other fields, receiving compassion is recognised as active and potentially problematic, and has been examined more fully.

Organisational theory, for example, presents the sufferer as a 'full and active participant' in the compassion process, and views their 'wilful and persistent cooperation' as an essential element (Kanov et al., 2004, p754). Psychological research has explored receiving compassion in more depth. Gilbert (2009) and Kelly and Dupasquier (2016) suggest that some

people struggle to seek, perceive or trust compassion from others and may experience negative emotions in response to care. They posit that those individuals may have feelings of worthlessness or vulnerability, or deep-seated psychosocial issues (Gilbert et al., 2011, Kelly and Dupasquier, 2016, Liotti and Gilbert, 2011). Generating feelings of safety and reducing threat has been posited as helping individuals to seek, recognise and feel comforted by compassion (Gilbert et al., 2012, Gilbert et al., 2011). It is important to note that it was not within the scope of this study to examine the psychological state of participants. However, I was interested in contextual elements that may influence the compassion process in the setting, and threat has emerged as an important theme. Therefore, I have drawn from psychological theories relating to the role of threat and safety in compassion to inform my interpretation of my data.

7.2 Developing the case studies

I anticipated that sufferers may play a more active role in the compassion process than is presented in the nursing literature and research on compassion. However, I did not expect to find such variation in how compassion was received, or that some individuals might not recognise or trust compassion from others. I began to develop the theme of receiving compassion

after noticing considerable inconsistencies between reports and descriptions of care from sufferers, and observations and reports of care from others. I viewed these inconsistencies as *different* accounts of events, rather than seeing one account as 'true' and another as 'false', and was intrigued to explore the contradictions in more depth.

As detailed in chapter three, I developed the case studies after analysing the whole data set thematically. I noted examples where there was an unusual response to the expression of compassion and collated all the related data into separate case studies. The six case studies all related to participants that I had significant engagement with and who were typically in the setting for a longer-than-average period. This afforded me greater opportunity to gather related data. These cases therefore give rich contextualised examples of how compassion was received in the setting.

7.3 Variations in receiving compassion

I found that there was wide variation in the way people perceived, trusted or reacted to compassion. Some appeared to struggle to recognise it, and others reacted negatively to it. Conversely, I also found that some participants seemed to easily perceive and accept compassion, and to derive

exceptional comfort and positive emotion from what appeared to be 'standard' care.

The way in which patients respond to the expression of compassion from staff is undoubtedly multifactorial. For example, chapter five showed how organisational systems and operational pressures affected the compassion process. Additionally, many patient participants reported negative feelings relating to just being in hospital, such as fear, uncertainty and vulnerability. Some participants hinted at how these affected their engagement with others. One young patient reflected that her illness and its treatment were distressing, and while she knew this was necessary, it made her reluctant to interact with others:

> *[The treatment] is horrible … I mean, I know that's what has to happen and it's no one's fault, but … I just feel awful … I just want to be on my own.*
>
> (Patient Hayley, informal interview)

However, even with these negative contextual influences, the majority of participants considered compassion as a positive aspect of care, from which they derived comfort and amelioration of suffering. I therefore considered the following three cases to be atypical or deviant.

7.4 Atypical case studies: Difficulty receiving compassion

7.4.1 Bliss

Bliss was a young patient who was on Hazel ward for around two weeks. I had four informal interviews with her and observed the care she received from a variety of staff members. Bliss reported being estranged from her parents and living with her older sibling from a young age. Her sibling had asked her to leave the home, so for the previous year Bliss had been living in hostel accommodation. She was not working and struggled financially. She had a severe and unstable medical condition that was exacerbated by her housing conditions. Bliss had been admitted to intensive care several times in the last year, and on each occasion after being stabilised, she was moved to Hazel ward for recovery care. She told me she 'hated' being in hospital and being on Hazel ward in particular.

Bliss spoke forcefully and with strong body language, such as bold hand and arm gestures. In our interviews, she often criticised the staff and care on Hazel ward and projected her voice beyond me, and out towards the rest of the bay.

7.4.1.1 Suffering

Despite her aggressive manner, Bliss's language had strong elements of vulnerability, fear and insecurity, particularly

regarding her future. When talking of her home life, she would often go silent for a time and look down at the bed. She talked about missing her sibling and her friends, but she was unable to contact them as she had no phone credit and no money to buy more. She rarely received visitors. She was upset that she had to wear a hospital gown over her trousers, because the paramedics had cut off her top to resuscitate her. The precariousness of her health status was frightening and distressing for her. She referenced her own death regularly:

> *I keep nearly dying.*
>
> *I could just die one day and no one would know.*

She told me she was 'terrified' of seeing someone die while she was in hospital and described spending one night watching the chest of the elderly woman opposite rise and fall, unsure if she had died every time there was a pause.

Although Bliss 'hated' being on the ward, she also 'dreaded' going back to the hostel. She felt 'out of place' among the older patients in the bay. She told me:

> *They worry about me; they always ask if I'm OK. I try to pretend I am to stop them asking.*

Bliss also complained about the 'depressing' style of the unit, the lack of a common area and the limited choice of food,

drink and reading materials. She linked many of these complaints to her age, and felt she did not fit in on the ward.

7.4.1.2 Compassionate response

Some care staff did not appear to engage compassionately with Bliss's suffering. They had limited and detached interactions with Bliss, and tended to approach her only for task-related reasons. Though it was difficult to explore staff feelings relating to this, one nurse expressed that she felt Bliss rejected their help:

> *She doesn't like us going near her; she doesn't want to be here, so … why should I bother?*
>
> (Junior nurse, field notes)

In the main, however, the ward staff appeared to notice Bliss's suffering and make efforts to relieve it. For example, they would discuss her social situation sympathetically with each other when handing over or in ward rounds:

> *OK, so, Bliss, gosh, she is having a hard time, she's not living with her [sibling] anymore, she's in a hostel now, and we really need to find out if we can get her moved out of there …*
>
> (Senior doctor Simone, field notes)

In bed 1 is Bliss. You will remember her from her last admission. She was blue-lighted in to ED, very frightening, and a close call this time by all accounts, she seems very shaken …

(Senior nurse Helen, field notes)

I often saw nurses, HCAs and doctors engaged with her for sustained periods, smiling, listening and occasionally touching her forearm or shoulder sympathetically. Many staff members seemed surprisingly unperturbed by Bliss's frequent negative and personalised outbursts. Some depersonalised her behaviour:

We're used to all kinds of abuse here, it's par for the course.

(HCA Tina, field notes)

People often come in angry like that, and we can't take it personally.

(Junior nurse, informal interview)

Others framed Bliss's behaviour in terms of her suffering:

She is tricky, you tread on eggshells really, and then you think, 'Hang on, I'm trying to help you here!' But it's not surprising, given what she's been through. And she's got no one really, not that I've seen.

(Senior nurse, field notes)

Staff tended to be firm with Bliss when she directed hostile comments towards them, and they made it clear her aggression was not acceptable. However, they generally continued engaging with her. The excerpt below gives Nancy's response as an example:

> *Nancy wanted to find out more about Bliss's home situation before she spoke to the housing department, so she went over to her bed. As she did, Bliss began to complain loudly about another nurse in the bay, pointing and saying how long she had to wait for her [equipment]. 'OK, OK, that's not helpful, it's not fair to speak like that … Let's look at that in a minute after we talk about how we can sort the housing out.' Nancy stayed close to Bliss throughout, sitting on the bed. Bliss looked annoyed at being stopped mid-flow. Once Nancy started talking about her situation at the hostel, she began to answer her, and seemed more comfortable.*

(Field notes, 12/11/15)

I also observed the team's efforts to relieve Bliss's suffering. For example, there were several heated exchanges with external agencies in order to improve her housing situation, and the team regularly reviewed her treatment plan together

to minimise her symptoms and prevent future deterioration. Care staff also brought in magazines for her to relieve her boredom, as well as reserving her favourite juice, as Bliss frequently complained about the lack of drinks she liked.

7.4.1.3 Bliss's experience of compassionate care

Bliss described the staff and specifically the nurses as 'mean' and 'terrible' and stated: 'They don't care about me.' She expressed her negative feelings openly and was often hostile towards the nurses in particular. One example happened during our interview, when Bliss shouted at a passing nurse:

> *Her especially, there (pointing at the nurse in the bay), that one, she never smiles … doesn't give a toss.*

Bliss reported that she had to request things multiple times from different people before she got what she wanted, and that her call bell was left to 'ring and ring'. Bliss was particularly angry that no one had given her a new top so that she would not have to wear the hospital gown.

Bliss felt that the staff did not care about *her* in particular, and let *her* call bell ring, rather than that care on the ward was poor generally. Furthermore, Bliss seemed to distrust the motivation behind any caring actions, as these comments suggest:

Some of the nurses talk to you nice, but you can tell they don't really care.

They got someone from the housing place to come and see me [to encourage more appropriate accommodation]. They're just sick of me coming back here.

Bliss also told me that on a previous admission, a nurse had given her money for a taxi home because no one would collect her. I asked if this was the nurse's own money, and Bliss shrugged:

I don't know; she just wanted to get rid of me.

These examples suggest that Bliss was aware of some caring actions, but felt that they were not compassionately motivated and instead were expressed insincerely or for the benefit of the staff. For Bliss they represented a form of rejection. One nurse seemed aware of this distrust, but felt there were barriers to building a trusting relationship with Bliss:

She feels that we are against her; it's hard to show her that we are on her side … I think if we had the time to sit down with her and start from scratch, it would be better, but we just can't do that.

(Senior nurse, field notes)

7.4.1.4 Summary

The suffering that Bliss experienced was complex and long-standing. I found that in the main, staff noticed, felt concerned about and acted to relieve aspects of this suffering. Many, though not all, engaged with her in a caring way and tolerated her angry outbursts. However, Bliss did not interpret *any* actions as caring or compassionate and did not appear less distressed over time.

Contextual factors may have contributed to this. For example, much of Bliss's care took place away from the bedside (e.g. liaison with other departments and external agencies), so she was not always aware of the efforts of staff. Furthermore, responding to Bliss's complex suffering required extensive one-to-one time, which was rarely possible on the busy medical ward. It is also likely that the expression of compassion affected how Bliss received compassion. There was indifference and a lack of warmth from some staff members. Although they were a minority, this may have affected Bliss's trust in the team generally.

Bliss could not identify *any* positive care, felt uncared for and interpreted compassionate efforts as insincere. This suggests that she had some difficulty in recognising, trusting and/or feeling soothed by compassion from others while she was on

the ward. Beyond the realm of this study, Bliss's life experiences may have contributed to a range of blocks or resistances to compassion. However, regardless of the psychosocial factors, Bliss's case is valuable for illustrating the social and relational dynamics involved in the compassion process and the complexity of care interactions.

7.4.2 Chrissy

Unlike Bliss, who struggled to experience positive care at all, Chrissy's case illustrates that responses to compassion can vary even in the way individuals respond to different people. Chrissy felt significant relief from her suffering through the care of the HCA team, junior doctors and support staff. However, she reacted differently to nursing care and sometimes felt additional distress because of this.

Chrissy was admitted to Hazel ward for investigations after becoming unwell at home. She was diagnosed with an aggressive reoccurrence of cancer after a period of remission. Chrissy was an inpatient for around three weeks, receiving treatment for her symptoms and an additional infection. I conducted four informal interviews with Chrissy, each over an hour long, and we shared numerous social chats. She was in her 50s and had a husband but no local support network, as they had recently moved to the area.

7.4.2.1 Suffering

Chrissy's words, body language and topics of conversation suggested she was suffering in a number of ways. She was 'devastated' by her diagnosis. I met her shortly after she had received it, and she was visibly shocked and upset. She had just celebrated several years of better health and had moved to the countryside to 'enjoy life again … to relax'. They had chosen a home with a large, beautiful garden to 'get back to nature'. She had spent the last summer in it:

> *It was wonderful, idyllic … full of birds, butterflies and bees … a dream to get out of the city after such a tough few years … but now my friends and family laugh at me, stuck in hospital again: 'Where's your healthy lifestyle now?!'*

There was sadness and some bitterness about the 'unfairness' of the cancer returning after her previously hard-won battle to recover. Chrissy was also anxious about the effect on her husband, Charlie, and the change in their relationship dynamics. Charlie had nursed his mother when she was dying of cancer, and Chrissy reflected: 'Now he has to look after me all over again.' The physical changes that Chrissy experienced because of her illness limited her independence and disrupted

her sense of self. She often spoke of how distressing she found these changes:

> *Look at these legs! [Severe bilateral oedema] These aren't my legs, what can I do with these? Nothing!*
>
> *I can't move even to reach things, I'm hooked up to all this stuff [intravenous pumps and chest drain]. I can't wear my own clothes, and even when they clear it, it just comes back again … is this going to be it? Lying on a bed all the time?*

Chrissy was also deeply troubled by memories of an earlier hospital stay, in another region of the country. She described witnessing an incident of 'appalling abuse' of a patient by two nurses. She said that although this had happened years previously, it had affected her greatly. She felt 'guilty' that she had not done something to stop the abuse at the time. Chrissy's anguish was therefore multilayered, and although she could be distracted with conversation, she frequently looked distressed and dejected.

7.4.2.2 Compassionate response

Staff generally spoke about Chrissy in a positive way and with sensitivity to the range of suffering she was experiencing. The HCA team seemed to enjoy a much closer relationship with Chrissy. I often observed them on or near her bed, talking

with heads close together in an intimate manner that appeared to be welcomed and reciprocated by Chrissy. They spoke of her as 'sweet hearted' (HCA Tina, field notes), 'always very grateful' (HCA Mel, informal interview) and 'so brave … the way she's coping with this all again' (HCA Iris, field notes).

Chrissy's descriptions of care from the HCA team were similarly positive. She described their 'beautiful teamwork' and felt they always knew the 'right things to say' about her difficult circumstances. She appeared to trust and feel soothed by their care, as the following excerpt shows:

> *… nothing is too much trouble, it is like being in a hotel sometimes, they can't do enough for you. They work so hard, some of them are just here all of the time. And they see when you are struggling and they know what to do, they've made such a difference to me. Not just me, though – one lady in this bay was crying out and [an HCA] came up and, immediately, she just knew what to do, she just settled her right away.*

Chrissy also praised the support staff, junior doctors and students for their 'compassionate' care:

> *I can see we are going to have some great doctors in the future … There is one student who is following my case,*

she is so bright, so full of questions … But they are very sensitive, they really do care.

Some of the most compassionate people in here are the ones who aren't even meant to be! The cleaners and the kitchen lady – she is always looking out for me, getting me little treats!

I often saw support staff going out of their way to obtain the 'off-menu' food and drinks that Chrissy liked because 'she is really struggling to eat right now' (kitchen hostess Mary, field notes). The regularity and length of visits from junior doctors and students also suggested engaged and personalised care. There were occasional mentions of Chrissy being 'prickly' (junior doctor Joanne, field notes) and 'bossy' (senior doctor Simone, field notes) when handing over. However, the overall context of these comments was neutral rather than disparaging. There were many sympathetic references to Chrissy's difficult situation. For example, in ward rounds the junior medical team discussed the 'unfairness' (junior doctor Paul, field notes) and 'cruel' (junior doctor Joanne, field notes) nature of the aggressive reoccurrence of the cancer after her remission.

I observed the consultant in charge of her care discuss her case a number of times. This was in an objective manner that

was similar to the way he discussed other patients on the ward round. He talked sympathetically of her symptoms and, as with other patients, worked hard to relieve her difficult symptoms and her physical suffering. The bedside interaction between the consultant and Chrissy was formal and short, but again this was in keeping with the consultant's general approach.

Chrissy's description of the consultant's care was that it was 'unhelpful'. When he broke the news of her reoccurrence, Chrissy said:

> *He just told me like that, without any compassion, very matter-of-fact … I don't think he was particularly busy; he just didn't seem to have it, have compassion.*

Although Chrissy described this in a negative way, she did not express anger or surprise. She went on to reflect on the possible reasons for this, believing that:

> *Consultants do have to detach themselves to cope with the stress of the job … so when they talk to you, you can tell they are that one step removed.*

7.4.2.3 Chrissy's experience of compassionate care

Chrissy described her experience of nursing care in a much more animated way, expressing both shock and anger. I asked Chrissy about care on the ward. She replied, 'Nurses are

horrible, just horrible!' She went on to talk about the abusive incident years previously. I asked her if she had experienced anything similar on Hazel ward, and she replied:

> *They wouldn't get away with it now, I wouldn't let them.*

Chrissy did not mention any specific incident of poor care, except that the 'nurses' had left the elderly patient in the bed opposite 'calling out for hours'. Chrissy talked more about the nurses' manner towards her, which she found 'patronising' and 'offensive'. The following excerpt exemplifies how she described interactions with the nursing staff:

> *We talk about the ideal type of care Chrissy would like to receive in hospital, what it is that makes the difference between good care and bad. She immediately and forcefully highlights respect: 'I think respect is important, care needs to be respectful. Nurses don't work like that, they see us as an amorphous whole … I told one of them that, but she didn't have a clue what I was talking about.' Her face is quite screwed up at this point and she looks disdainful. She continues: 'Even when they are doing a good job, they are patronising and bullying, like those nurses in [the abusive incident].' Chrissy adopts a baby-like voice to describe how one nurse came to her and said, 'Shall we give you a little*

wash? I want to give you a little wash.' Chrissy now has a horrified expression. 'And then she goes and washes other people's skin! I don't want that, I don't want her to touch my skin.'

(Field notes, 17/11/15)

When I spoke to the nursing staff about Chrissy, or observed them talking to others about her care, they were generally positive about her. This surprised me, given the strength of Chrissy's feelings about the nursing team. However, unlike Bliss, she was not openly hostile towards them. The interactions between the nurses and Chrissy were distant and formal, and the nurses tended to more often stand by the bed than sit on it or kneel in. This was in contrast to how other staff interacted with Chrissy and in contrast to how nursing staff were with other patients.

Nurse participants referenced Chrissy's manner as 'a bit odd sometimes' (senior nurse Andrea, field notes) and felt she 'doesn't want us to fuss around her' (junior nurse Clare, field notes), but generally framed this in terms of her situation. In doing so, they appeared aware of her suffering:

I think she's still in a state of shock, really … seems like she is just going through the motions sometimes.

(Senior nurse Clare, field notes)

> *She seems quite angry at times, but then given the circumstances … very frustrated by her loss of independence, which the physios have noticed too …*
>
> (Senior nurse Helen, field notes)

These types of comments demonstrated knowledge of her personal circumstances and her feelings that suggested they had some meaningful level of engagement with Chrissy. I observed nursing staff engaging warmly with Charlie, generally away from Chrissy's bay, as he would come to the reception desk prior to leaving. Charlie expressed concern that Chrissy was neglecting her personal hygiene and asked the staff to encourage her in this respect. The nursing staff often asked him about Chrissy's state of mind and preferences. They also enquired about this with the HCA team and seemed to recognise the positive relationship that Chrissy had with this team.

In terms of acting to relieve her suffering, I observed the nursing team liaise with the multidisciplinary team about increasing her independence, comfort and wider support needs. I also saw them regularly checking and attempting to engage with her and noticed that often Chrissy did not reciprocate. Staff participants expressed no awareness of the issues Chrissy had shared with me about the nursing team or

her previous experience of witnessing abuse. Only one nurse spoke negatively about Chrissy, referring to her as 'spiteful'. This nurse was reluctant to speak openly about her feelings, but expressed that Chrissy 'didn't like' her. She felt that she must have 'done something to offend' Chrissy (junior nurse, field notes). In one interview, Chrissy described an incident with a nurse who was:

> *Very nice but so patronising … She would say, 'We have to take our tablets now, don't we?', like I was a child.*

Later that day, Chrissy said there was a doctors' round, and when they came to her bed, she saw the same nurse:

> *I said in front of all of them, 'I don't want her here, she's got to leave', and they told her to go.*

Chrissy then reflected:

> *I shouldn't have done that, that wasn't right … I did apologise to her afterward and I told her I'll make it right.*

It often appeared that Chrissy felt anger towards the nursing team, particularly when she felt she was not being treated respectfully. Even when I asked Chrissy about care experiences *generally,* she tended to respond specifically about *nurses*. It was also common for her to weave her

previous traumatic experience into discussion of care on Hazel ward, and it was clear this experience had affected her significantly.

Though she seemed to welcome close contact and assistance with personal care from the HCA team, this was not the case with the nursing team. Chrissy made comments such as, 'I don't want them to do that for me' when talking about wound dressing, mobility assistance and other aspects of care that required nursing input. At one point she admitted:

> *There are times I just want to pull the curtains round and tell them to piss off; I don't want your compassion!*

There seemed to be distrust of care from nurses 'even when they do a good job'.

7.4.2.4 Summary

The data presented here demonstrates that Chrissy experienced significant suffering while on Hazel ward, and that in general the ward team responded compassionately to the various aspects of that suffering. It also suggests that Chrissy could seek, perceive, trust and feel soothed by some of these compassionate efforts. Most notably, she demonstrated trust and positive engagement with the HCA team care. Additionally she appeared able to tolerate care that did not relieve her suffering, such as her interactions with the consultant.

There was a difference in how she received nursing care. This is likely to have been multifactorial. For example, the nurses may have expressed compassion differently from the HCA team. There may also have been contextual factors that affected the compassion process, such as a lack of time to engage on a deep personal level to encourage trust and rapport. However, Chrissy also appeared to interpret the compassionate efforts of the nursing staff differently to those of other staff members. Chrissy recognised some efforts, noting that they could 'do a good job'. However, she seemed to experience strongly negative emotions, such as being patronised and bullied by the nurses. Furthermore, she was often reminded of her traumatic past experience, which aroused other negative emotions. Chrissy's case illustrates that individuals may receive compassion in a way that is distinct from the intentions of the person expressing it. Furthermore, at times the response may be highly specific (e.g. related to nurses only) rather than a global presentation, as seen with Bliss.

7.4.3 Beryl

Beryl's case also illustrates that some people may respond negatively to the expression of compassion. However, there is also the suggestion that Beryl's response was interpreted by the care team as upsetting and a failure on their part, which

may point towards the idea of a cyclical compassion process, or a feedback loop.

Beryl was an elderly patient whom I interviewed informally on two occasions, both times with her husband Mick present. She was admitted to Hazel after becoming unwell, and this was her second stay in the month. Beryl had always been the more robust and had cared for Mick through several major health issues. However, lately she had experienced a sudden and dramatic decline in health. Beryl looked extremely frail and bruised and was breathless even when resting. She had an acute lung infection on top of a worsening chronic respiratory condition. They had no family support, only help from similarly elderly friends. The ward team felt Beryl would struggle to recover fully from this illness and that the couple needed support to prepare for that.

7.4.3.1 Suffering

Beryl's body language strongly indicated that she was suffering extensively, in a physical and emotional way. She reported having 'lots of aches and pains', but the way she lay very rigidly on the bed, her deeply furrowed brow and the extent of her oedema and arthritis suggested significant pain. Mick's comments supported this, and he himself found her pain distressing:

I can't bear to see her like this, she's never been one to lie on her bed, she's in that much pain.

Beryl's breathlessness also prevented her from being able to talk as she wished, so that she often stopped mid-sentence, unable to continue. Mick's descriptions of Beryl as 'feisty', 'light on her feet' and 'a little whirlwind' suggested how physically changed she was by her illness. They also suggested that Beryl would find the immobility and exhaustion a distressing restriction.

The couple worried about their increasingly uncertain future, and Beryl referenced this frequently:

I don't know what's going to happen with my breathing, if it's going to get better.

I don't know how we're going to manage when we get home, I normally do everything in the house.

I don't know what's going on half the time … everyone's just in and out, in and out.

This last comment suggests that the ward environment itself was troubling for Beryl. She described it as 'noisy', 'confusing' and 'unfriendly' and often referred to it as 'this place'. It had been over 20 years since they had used hospital services, and Mick talked at length about how it had changed 'for the worse'.

It appeared then that Beryl's suffering was physical and emotional and that her husband was deeply troubled by her pain and discomfort too.

7.4.3.2 Compassionate response

The behaviour and language of the ward team suggested that they noticed the suffering of Beryl and Mick and acted to relieve it. When discussing Beryl's case, the ward staff sympathetically referenced her symptoms, her uncertain future and ways in which they could address these. Ellen, a nurse on the ward, suggested I interview the couple, as she felt they might benefit from talking about their situation.

Beryl required much assistance with personal care, and I observed the HCA and nursing teams carry this out tenderly and with Beryl's comfort in mind. For example, the nurses arranged for extra staff when moving Beryl so that this would involve less exertion for her. Their voices were kind and patient as they informed Beryl of each step of the process, despite Beryl's abrupt responses. This process took much longer, but the extra time and staff were supported by the ward generally.

The ward team also appeared to act to support Mick and relieve his distress. He was always welcomed into the ward despite arriving before visiting time and was generally brought

refreshments that were not normally allowed for visitors. Staff made efforts to liaise with internal and external professional groups to provide support at home and consider a suitable alternative. I also observed regular 'checking in' on both Beryl and Mick, outside of care-related tasks, which suggested a high level of concern for their situation.

Both Mick and Beryl could be abrupt and unfriendly with staff, giving monosyllabic answers to their enquiries. In Beryl's case, this did not always appear to be related to her breathlessness. The care staff acknowledged their lack of engagement and 'cantankerousness' (senior doctor, field notes), but framed it in terms of their difficult circumstances:

> *Well, they are having a tough time right now, it's hard for them.*
>
> (Junior nurse, field notes)
>
> *They just don't want to be in here, they want to be at home.*
>
> (HCA, field notes)

Beryl appeared to improve a little clinically, and the medical team felt that she could be discharged on intravenous antibiotics under a relatively new initiative: outpatient

administration of intravenous antimicrobial therapy[6] (OPAT). She had been discharged under OPAT some years earlier and found it difficult. Beryl felt her dexterity had decreased since then, and she was reluctant to undergo the insertion of a new intravenous cannula. Her previous cannula had required many attempts and left Beryl with severe bruising over her entire right arm that was still very visible. Despite Beryl's reservations, the medical team felt it was worth trying given her desire to go home.

Beryl and Mick felt that the medical team put pressure on Beryl to accept an OPAT discharge in order to 'get someone else into the bed'. They felt the doctors 'did not want to know' about their opinion, and Beryl described the conversation as an 'interrogation'. She said they were so 'insistent' that she grudgingly agreed:

> *I ended up just saying, 'Do what you want then', just to get rid of [the doctor]. But I feel sickened now; I wish I hadn't said yes.*

[6] OPAT is the administration of intravenous antimicrobial therapy to patients in an outpatient setting or in their own home. It allows patients with ongoing infections but who are otherwise stable to be discharged early. Patients are normally supported by community services to ensure safety. OPAT is now common in the UK, and its increased use has been driven by the need to discharge patients as early as possible and make efficiency savings, as well as to improve patient experience.

The MDT discussed the option at length with part of the team, arguing that it was not suitable given Beryl's increasing frailty. Beryl stayed on the ward for another week until her infection cleared, but remained vocally unhappy about being there.

7.4.3.3 Beryl's experience of compassionate care

Beryl described her experience of care as 'non-existent' and appeared most upset about not feeling 'known' as a person. Her comments suggested that she felt the ward team held a negative view of her:

> *They don't take time to get to know you. It's just, 'You OK? Yes? Right, next.'*
>
> *They think I'm just some old fool.*
>
> *They think I don't know what's going on, that I'm just some silly old woman.*

When I asked directly about the care she received, she referred to the discussion about the OPAT discharge, and it was clear from her angry expression and depth of feeling that this had distressed her significantly. Aside from that, Beryl did not talk about any specific incidents. She also used the term 'they' to refer generically to staff. Again, she focused on how she felt she was viewed:

> *They talk to you like you're an idiot.*

They don't really care.

When I asked about her personal care on the ward, she shook her head:

There's too much fussing, I just want to be left alone.

These comments and her interactions with staff suggested that Beryl did not perceive that staff recognised her suffering or acted to relieve it. Furthermore, she felt disliked and actively disrespected. It appeared that not only did she not feel soothed by expressions of compassion, but some actions of care seemed to increase her suffering.

The ward team expressed an awareness that Beryl was unhappy on the ward. They had a noticeably cautious approach to her, which was different from their interactions with other patients, although the HCA team seemed more comfortable with both Beryl and Mick. Nevertheless, they expressed a feeling that they were 'bothering' Beryl when they attempted to care for her.

It's a bit upsetting, really … You try to make [personal care] as gentle as you can, but she still gets cross, so we're still not getting it right.

(HCA, field notes)

The ward team appeared troubled that they were not able to relieve the couple's suffering, as these excerpts show:

> *We're struggling to help here, Beryl is clearly still uncomfortable, we're not really progressing on the home front … I don't think we're doing much good.*
>
> (Senior doctor 1, field notes)
>
> *Hmm, it's very difficult to know what to do for the best if they won't talk to you.*
>
> (Senior nurse, field notes)
>
> *I'm feeling a bit like we're making things worse for her [by] keeping her in … I don't think she's fit for home, but … she doesn't really want us near her … We're not making her feel any better.*
>
> (Senior doctor 2, field notes)

There was a sense that Beryl's negative response to staff contributed to their cautious interactions with her, and this stilted manner militated against warmth or openness between them. Furthermore, there were occasions in which Beryl expressed anger or distress as a result of personal care or attempts to talk about the couple's future and home situation, for example. This in turn may have affected the way staff expressed compassion towards Beryl, and perhaps

discouraged them from repeating those behaviours (being physically close, touching, personal engagement) that appeared to trigger the negative response. It is therefore possible to suggest the idea of a 'feedback loop' in action here (see figure 14).

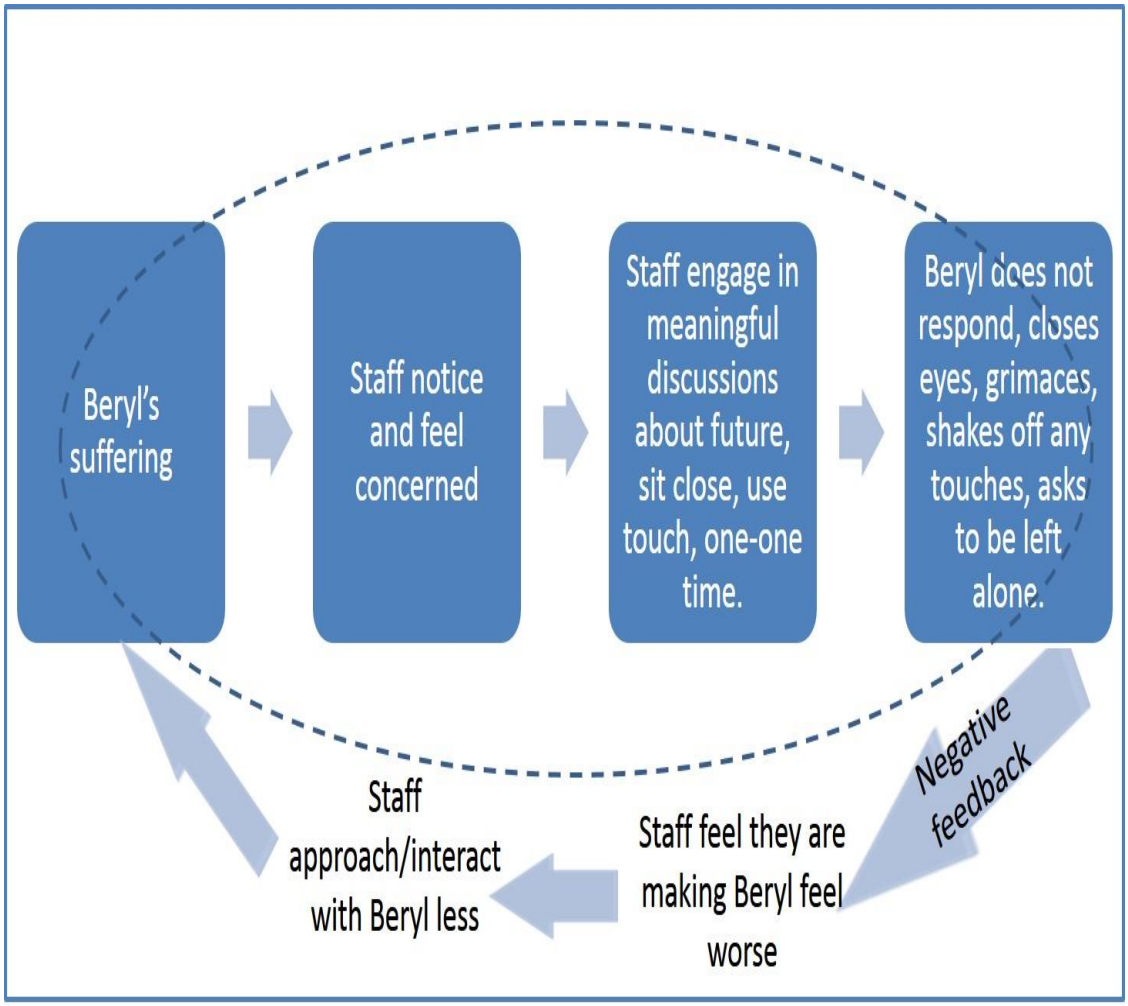


Figure 14 Possible feedback loop for Beryl's case

7.4.3.4 Summary

I have shown that Beryl experienced significant suffering and that in general the ward team appeared to notice and respond

compassionately to various aspects of that. However, Beryl felt uncared for and had a negative response to engagement with the staff team.

This response was likely to be the result of a number of factors. Again, the context of care on the busy ward was a barrier to the kind of lengthy personal engagement that might have developed Beryl's trust. Similarly, Beryl also required urgent medical treatment and social support at home.

The expression of compassion could also have been a factor. The staff perhaps did not appreciate the extent of her suffering, how uncomfortable she was in hospital and her fears for the future. Although Beryl was already unhappy about her care prior to the discussion about the OPAT discharge, this incident may have had a greater effect on Beryl's trust in the staff than they realised.

Aside from these aspects, this case suggests that Beryl had difficulty in receiving compassion from ward staff. She struggled to recognise the compassion of expression at all, and in many instances felt negatively about receiving even gentle personal care. The words and cautious behaviour of staff suggested that they were aware of Beryl's negative response. Furthermore, they felt troubled by her continued distress. Therefore, this case raises the idea that negative

responses to compassion may in turn affect those expressing compassion and have a bearing on the compassion process as a whole.

7.5 Atypical case studies: Ease in receiving compassion

It is interesting to compare the previous three case studies with some examples of where participants seemed to seek, perceive and trust compassion from others with exceptional ease. These participants also appeared to derive exceptional comfort from what seemed to be 'usual' care. Although these examples provide a contrast with the first three cases, they add weight to the notion that receiving compassion is a complex, active and relational process.

7.5.1 Sue

Sue was admitted to Hazel ward for investigations into a deterioration in her health. Her mobility and independence had reduced significantly. She had several chronic illnesses that appeared to contribute to this, but it was unclear what had caused this sudden and significant deterioration. She had been discharged from Hazel a week previously, and then readmitted with the same complaint. Sue was in her 60s and had been working full-time until a few months previously. I had four interviews with Sue, all lasting over an hour, the longest conducted at her home.

7.5.1.1 Suffering

Sue's suffering was predominantly around her physical symptoms of pain, breathlessness and exhaustion. The lack of mobility was particularly distressing, as she was an independent and active person. She also expressed her fears and uncertainties around her illness and was frequently unable to control her emotions. She was frustrated by the organisational processes of the ward, which she felt did not give her an opportunity to talk about the change in her health. As a result of this, she worried that the medical team did not appreciate the extent of her deterioration. Like Beryl, Sue frequently made comments related to uncertainty and not being known:

> *I don't feel like they know me.*
>
> *It's like I don't know myself like this, just sitting about, crying.*
>
> *I just need to know what's happening to me, I don't understand.*

7.5.1.2 Compassionate response

I observed that Sue had generally warm interactions with staff on Hazel ward. Relations were more formal with the medical team, but they spent time talking and she felt able to ask numerous questions, which were answered in a caring way.

Her interactions with other ward staff were more informal. This included nurses and HCAs as well as the administrative and domestic staff. Their conversations were social as well as medical, and staff tended to sit close to Sue or on the bed, and share physical touches.

In ward rounds and among themselves, staff talked about her in a sympathetic way and were sensitive to the distress caused by the uncertainty around her illness. They sometimes expressed frustration at the amount of questions Sue asked and the time involved, but this was expressed in a neutral way and did not appear to cause them to avoid her or cut short interactions.

7.5.1.3 Sue's experience of compassionate care

Sue described her care experience as 'brilliant' overall. I was therefore surprised that, having said that, she also mentioned a number of problems that had directly affected her. For example, she described an incident with a registrar as 'uncaring' because she felt he had dismissed her fears, and she spent that night crying and feeling like she was 'imagining' her illness. She was also 'angry' that she had been discharged inappropriately, and she felt this decision had been based on her 'looking alright' (she was readmitted two days later).

The relentless forward motion of the ward context also troubled Sue:

> *They come in, they go out, they've not got time to get to know you.*

Additionally, Sue criticised the admission and handover processes, which she felt led to gaps in communication and a 'frustrating' lack of consistency in advice. Nevertheless, she felt that the team as a whole were 'trying' and 'doing their best' and that this was shown by the fact that her symptoms had improved since she'd been admitted.

Alongside these problematic aspects of Sue's care and treatment, she also described numerous examples of 'brilliant' care. The care that seemed most beneficial to her was where she felt she had been 'given time' by a staff member, or where she felt 'known'. This included when she 'broke down' after finding out a relative was seriously ill and an HCA had talked with her for 'most of the night'. Also, when the hostess knew her food preferences without asking, she felt this showed the hostess had 'remembered her'. When staff chatted to her during tasks, she felt they not only gave her time, but knew she liked 'a bit of a laugh':

> *When they were having to [measure blood sugar], they used to say, 'Well, what do you think it's going to be?',*

and so the nurse would say, it's so and so, and I'd guess something else, [and] we'd go, 'Ooh, yeah!' (Laughs) It was just something they did, to help me relax I think. And it worked!

She spoke appreciatively of the gentleness of touch from staff who needed to wake her in the night for observations. She also highlighted having assistance with a shower as a specific example of compassionate care:

One day I said to the nurse, 'Oh, I'm desperate for a shower to wash my hair and whatever', and she says, 'Well, when this runs out we'll disconnect you and we'll get you in the shower.' … And she came, she got my bag ready, puts my dressing gown on, everything. But even though she was helping me, by the time I got halfway I couldn't breathe! But they sorted it out, got me a chair, waited for me, talking to me … Anyway, I got there in the end, and she got me settled and goes: 'How do you feel?' And I went, 'Great!' Well, actually I felt rubbish, but I was clean! And thankful for the time and, you know, the gentleness, and, well, it's just no trouble, is it?

This extract shows that despite her ongoing suffering, Sue was able to discern that compassionate care was being expressed.

The action itself was not exceptional, as helping patients with personal hygiene in a caring, patient manner is an everyday part of work on the ward. However, Sue picked up on the gentleness, the time given and the enquiries into her feelings within the caring action. She acknowledged that these things are hard to achieve in the context of a busy ward. Sue welcomed and engaged with these expressions of care, and although her symptoms and fears were not removed, she ultimately felt soothed by them.

7.5.1.4 Summary

I have shown that Sue experienced significant suffering. Although the ward team as a whole responded compassionately to that, there were some incidents of indifferent treatment, and the ward context in many ways added to her suffering. However, within that Sue was able to perceive, trust and engage with expressions of compassion in the setting. She was able to derive comfort from the simplest acts of care. This allowed her to feel safe and cared for in hospital and enabled aspects of her suffering to be relieved.

7.5.2 Mags

Mags's case is similar to Sue's in that it is an example of how individuals can perceive and feel comforted by expressions of compassion despite ongoing suffering and additional problems

with hospital care. In Mags's case, this was even when there were errors in her treatment. She was also a patient who, like Chrissy, had had traumatic past experiences of healthcare. Despite these apparent barriers to compassion, she felt expressions of compassion actively relieved aspects of her suffering during her stay.

Mags was admitted to Hazel ward for investigations and required significant medical treatment and surgery. She was an inpatient for around three weeks, and I conducted several informal interviews plus one recorded interview at home. Her healthcare experience was complicated by her long-standing hospital phobia and fear of surgery. She was in her 50s and had a traumatic experience in hospital as a child, which was then exacerbated by problematic interactions with primary care practitioners. When we met, her fears were so bad that she would not attend routine health appointments such as dental appointments or routine mammograms.

7.5.2.1 Suffering

Mags's suffering was predominantly around her fear of hospitals and surgery, but was made worse by physical symptoms of pain and her lack of mobility. The environment in the hospital added to this. While she was an inpatient, it was winter, and the ward heating system was only working

intermittently. Her family brought in extra bedding for her, and the patients in her bay were putting towels and blankets at the window to keep the draughts out. She also found the food 'disgusting', so her family brought food in for her each day.

She felt staffing on the ward and in the hospital generally was inadequate and MDT communication was ineffective. Mags also experienced multiple extensive waits for porters, medication and a surgical bed, which impacted significantly on her discomfort and anxiety.

Her chest drain was inserted incorrectly and needed to be redone, which was distressing as well as meaning that fluid was not being drained over that period.

7.5.2.2 Compassionate response

I observed that Mags had very warm interactions with the staff as a whole on Hazel ward, with much joking and physical touches. Relations were informal with the medical team as well as other groups, and Mags felt able to ask questions and to talk openly about her fears. She also had friendly interactions with other patients, whom she initiated conversations with and 'looked out for' when she felt they needed help.

In ward rounds and among themselves, staff talked about Mags in a sympathetic way. They were very conscious of her

phobia and discussed how best to minimise this. Nursing, HCA and support staff talked affectionately of Mags, describing her as 'a lovely person' (HCA Tina, field notes), 'caring' (nurse Nancy, informal interview) and 'easy to care for' (nurse Helen, field notes). One nurse suggested that Mags's positive response to her compassionate efforts alleviated the challenges of her care:

> *But I do try to give patients my time when they need it, especially with patients like Mags who are so anxious and they need to be able to express it. That's difficult because she really needs a lot of reassurance, but it's OK, you know, a lot of patients are similar. But Mags does settle well if you can give her the time and reassurance. She wants that help and she takes it on board … You do get some patients … who are not confused but who are very demanding of your time … but no amount of time is enough for them.*
>
> (Junior nurse, informal interview)

This excerpt hints again at the idea of a feedback loop in action, in that the nurse finds compassionate care difficult to enact but is encouraged by the positive impact it has on the patient.

7.5.2.3 Mags's experience of compassionate care

Mags herself reflected on the honest way she engaged with staff and sensed that they 'responded' to that:

> *I tell people I have the fear [of hospitals] because I don't really like to let it stop me communicating, and I like to be honest to people. … Things like … people seeing my body … male nurses … asking people for help … a lot of that was a struggle for me … But I think because I am quite open, people respond to it.*

This reflection hints at the dynamic and reciprocal nature of compassion, in that an openness with others may influence the way they respond.

Mags described her experience of care as 'brilliant', 'amazing' and 'compassionate'. However, she was also open about the problems. Mags talked at length about numerous contextual factors that negatively affected her time in the ward. These excerpts show that alongside those negative experiences, Mags could still perceive and feel comforted by expressions of compassion:

> *… the staff were lovely … They were really nice, all of them … Their manner, their attention, if you needed them they were straight there … Because you read a lot of negative stuff, don't you? But if you buzzed for them,*

they came straight there … They were really caring, they really made sure that when you needed any injections and things, they didn't hurt you. And that ward was absolutely freezing where I was, so cold it made me feel worse. But they brought us extra blankets and stuff for the windows … But, you know, everything really, they would come and talk to you, they were just brilliant … and that was <u>all</u> of them, <u>everybody</u>.

It seems everything within the ward that the staff are in control of is amazing. But everything that they're relying on, the things that aren't within their control … that all goes to pot … Y'know, when you wait hours and hours and hours for a porter … I waited eight hours and still didn't get one! I had to phone my husband and say, 'I need you to come to the hospital and take me for my X-ray, otherwise I'm not going to get it.'

Mags explained many of these issues as problems with the 'system' or a consequence of 'not enough money'. However, there were also interactions that she described as uncaring, and a result of the *manner* of the HCP:

I felt some [staff] probably needed to learn a little bit more of a bedside manner, be a little bit more compassionate and think about what it's like from the

other side. … When the consultants did their rounds, they were very, 'Oh yeah, de de de de de de', and they're talking about you among themselves and you're like, 'I'm here!'

Interestingly, the numerous negative aspects of her care do not seem to cancel out the good, or affect her trust in the ward team overall. Her interview narrative shows how the good and bad aspects of her hospital experience are interwoven, so that alongside the considerable negative effect of inadequate staffing and resources, Mags gives innumerable examples of compassionate care, and the comfort she derived from this. She concluded:

It would have been so easy for my experience to have been a totally different one because, well, there's so much negative press. But I don't think I'd have been able to deal with being in hospital if [the staff] hadn't have been compassionate.

7.5.2.4 Summary

Mags's case shows that she experienced fear and anxiety from her phobia, in addition to her physical symptoms and the discomfort caused by the organisational context. In the main, the ward team responded compassionately to this, and Mags perceived their compassionate efforts. Mags's entrenched

hospital phobia, in addition to the clinical error and the multiple resource issues she experienced, might have been presumed to lead to a negative experience of care overall. However, Mags was able to trust and accept compassion from staff and felt significant relief from her suffering as a result. Additionally, this case raises the idea that the sufferer's response may affect those expressing compassion. Mags's response was positive, and staff were encouraged to continue with the behaviours (personal engagement, proximity, touch, etc.) that triggered this response. As with Beryl, this can be seen as a feedback loop in action, but with a positive rather than a negative effect.

7.5.3 Esther

Esther's case is another example of a positive compassion feedback loop. Esther experienced physical and mental suffering and appeared to receive a compassionate response from ward staff. I observed one episode of poor care which might understandably have led to a loss of trust in staff or a negative engagement with the team overall. However, Esther did not mention this as problematic. She engaged positively with expressions of compassionate care, which appeared to be rewarding for staff as well as relieving aspects of her suffering.

I had several informal interviews with Esther on the ward. She was a lively, warm person and very tactile. Her husband had died some years previously and she expressed her sadness about this. She described the 'joy' she got from spending time with her two adult children and her 'delightfully mischievous' grandchildren.

Esther was admitted for routine investigations after experiencing what she thought were 'minor' symptoms, mainly of excessive tiredness and weakness. She had always enjoyed good health and had rarely been in hospital. However, she received a diagnosis of an aggressive form of cancer and later found that it could not be cured.

7.5.3.1 Suffering

Esther's suffering was around her 'profoundly shocking' diagnosis and her increasing weakness. She seemed visibly shaken by the unexpected nature of it and repeated two phrases often:

> *I just can't quite believe it.*
>
> *What can be said now?*

She had always been religious, but felt this had 'shaken' her beliefs:

Why does God let bad things happen? Why can't he make things easier? I have always struggled with that, but now I think of it a lot.

Her worries for her family seemed tied up with her own fears of the future, in terms of how they would react to the news and cope with her death.

7.5.3.2 Compassionate response

The staff team expressed their awareness of Esther's suffering and acted to relieve it in their comforting interactions with her and her family, and in their organisation of her treatment and care. However, Esther's diagnosis was given to her alone rather than calling in family or having a nurse present. The medical team also neglected to tell Esther's nurse, though the coordinating nurse was aware. This seemed to be more a case of miscommunication than an indifference to potential suffering, as the doctor explained:

We weren't really breaking <u>new</u> news as such; we were expanding on something we had already told her, confirming things really.

(Junior doctor, field notes)

Nevertheless, the doctor admitted that they had not asked Esther if she wanted anyone present when she was given the news. The doctor had also failed to notice that for Esther, the

diagnosis *was* 'new news'. This suggests a lack of sensitivity and empathy that may have contributed to Esther's suffering, although Esther herself did not mention this as problematic or upsetting.

The staff team talked fondly about Esther both to me and among themselves. The nurses and HCAs expressed awareness of her distress about the diagnosis. They appeared to have a great deal of background knowledge about Esther and her family that suggested a significant level of engagement with both of them. Esther's daughter, who visited every day, said the care they received on the ward made the news 'easier to cope with' (relative, field notes).

I regularly saw nurses, HCAs and support staff sitting on Esther's bed, hugging her, holding hands and occasionally kissing her. I watched one of these hugs from the reception desk, and the nurse beside me remarked:

> *Don't you just want to take her home with you?*
>
> (Senior nurse, field notes)

Sometimes I saw Esther crying with staff, and occasionally the staff member would be tearful too. Despite the sadness around her situation, staff generally spoke very positively about caring for Esther, describing it as a 'pleasure' (HCA Tina, informal interview) and 'rewarding' (student nurse Chantelle).

> *[Nurse] Andrea comes back to the desk after talking to Esther for some time. She looks teary. I ask her if she's OK. She tells me it's 'hard to hear … someone talking about their death', especially when she knows that 'we can't do anything about that'. She brightens a little and says that if Esther can 'deal with' talking about her death, then 'we should be able to'. Andrea also felt that being with her, even in silence, was helpful to Esther: 'You can see that, even though she's crying.'*
>
> (Field notes, 3/12/16)

Even staff who were not normally particularly tactile or emotional seemed more affectionate with Esther. Iris felt that Esther 'brought out the best in everybody' (HCA Iris, field notes). There was a sense that Esther's response to compassion helped staff to tolerate the challenges involved with her care and to express compassion that was able to relieve her suffering, at least in part.

7.5.3.3 Esther's experience of compassionate care

Esther felt the care she received 'couldn't have been better' and cited many 'ordinary' acts of care as compassionate, for example assistance with personal care, mobility and nutrition. When describing these interactions, she highlighted details such as 'tenderness', 'kindness', 'listening' and feeling 'known'.

Despite the issue around how the news was broken to Esther, she felt the medical team had been 'faultless'. She said the consultant in particular was 'very caring' and described one of their interactions:

> *He had a very kind manner. He sat here on my bed and I asked him about this bleeding I was having, which has been worrying me. Do you know he has been the first person to explain to me in a way I understand? And he told me honestly, if it gets worse we will have to do an operation, but it will be a bad operation, quite serious. So now I know and I can be prepared to cross that bridge when I come to it.*

When talking about her experience of care, Esther often described her own role, suggesting that she played a part in the process. For example, she talked about needing to be 'open' with people and not 'hiding' the things you fear. She also repeatedly mentioned giving thanks:

> *The [HCAs] spent so long with that lady and afterwards she looked so refreshed, they pulled the curtains back and she had this huge smile! … I told them, bless you for that, darlings, what a fantastic thing you've done there.*
>
> *We have to remember that no matter how small it is, someone is doing that for you.*

Esther often kissed the hand of the staff member before they left her, as she did to me after we spoke, before thanking me for listening. Though I am not a demonstrative person myself, I felt it hard not to react by touching her hand in response.

7.5.3.4 Summary

Esther's case shows that she experienced shock and deep distress from her terminal diagnosis as well as becoming increasingly weak and dependent on care. Although the news of her diagnosis was broken insensitively, the ward team were aware of her suffering and responded to it compassionately. Esther engaged with their compassionate efforts and welcomed them, feeling that they comforted her, and her family, significantly. However, this case also suggests that the compassion process does not end with the alleviation of suffering. Like Beryl's and Mags's cases, Esther's suggests that the sufferer's response can impact on the person expressing compassion. Esther's positive engagement with, and response to, compassion created further positive feelings in staff and seemed to increase their inclination to continue to express compassion towards Esther (see figure 15).

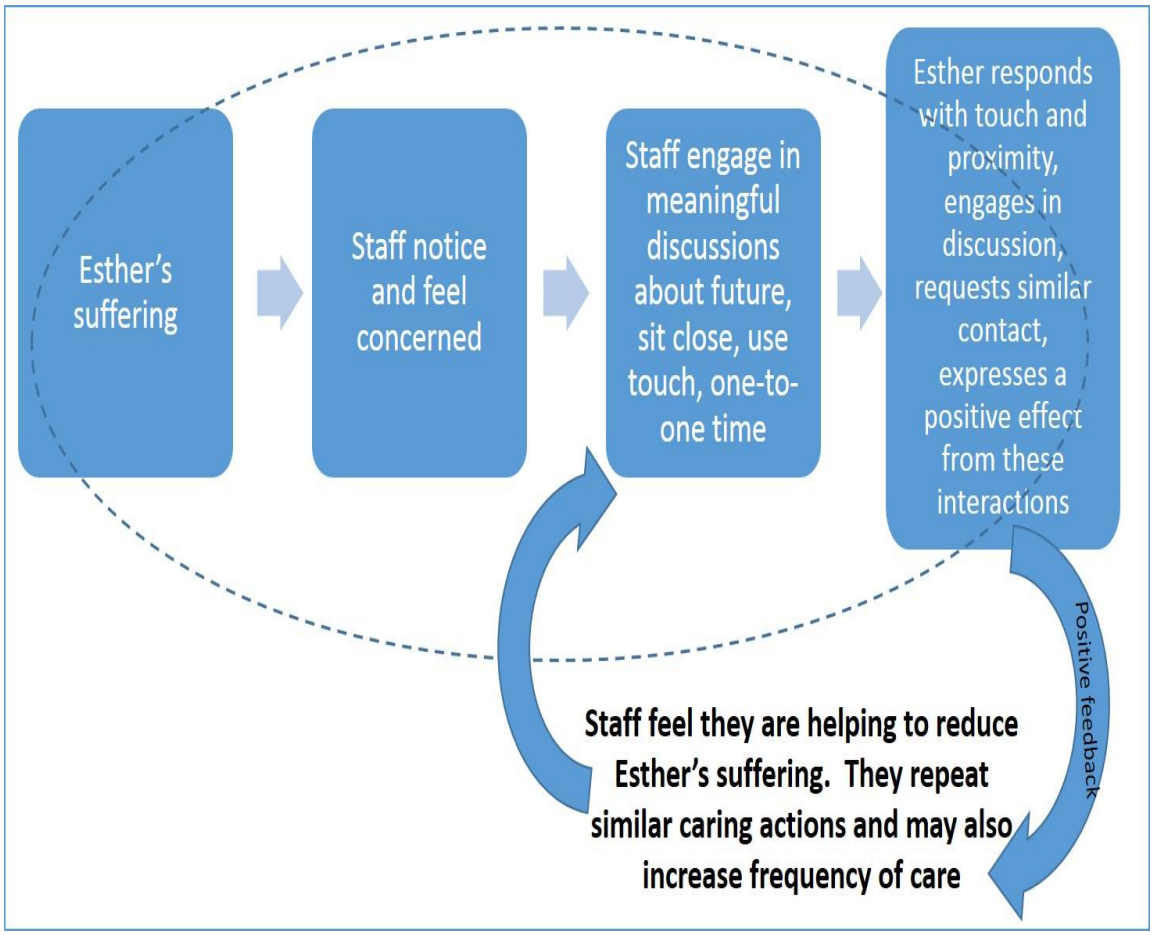


Figure 15 Possible feedback loop for Esther's case

This dynamic feedback suggests a cyclical process of compassion in which the contributions from both the expresser and the receptor are influential, rather than there being a unidirectional 'delivery' of compassion.

7.6 Summary of the six cases

Overall, the case studies show that on Hazel ward, the compassion process was not linear and did not end with the 'delivery' of compassion to a sufferer. Rather, the actions of all

those involved continued to influence the process and did so in relation to the context. There was a particular contrast between the first three 'negative' case studies and the latter three positive cases, which might be helpful to explore. This involved the degree to which the participants felt safe or threatened on the ward.

As noted in the introduction, feelings of safety and threat may impact on how compassion is received (Gilbert et al., 2012, Gilbert et al., 2011, Gilbert, 2009). For example, when a person feels under threat, they may have a heightened sensitivity to additional perceived risks and struggle to trust others. However, when a person feels safe and secure, they may find it easy to be open to, and trust in, care and compassion from others, and to reassure themselves in times of distress (Gilbert et al., 2012, Gilbert et al., 2011, Gilbert, 2009).

Bliss, Chrissy and Beryl appeared to rarely feel safe. They expressed feeling *personally* disliked or neglected by staff, rather than feeling that care was *generally* poor on the ward. This may tie in with Gilbert's notion of threat, in that these participants, who already feel unsafe in the world, may be sensitive to additional signs of threat. For Chrissy, this was only with the nursing staff, with whom she appeared generally

uneasy and distrustful. For Beryl and Bliss, this was in a more global sense.

All three participants were dealing with numerous threats in addition to the physical threat of their illness. For example, Bliss was not only young, but had almost no social or family support. She felt vulnerable in her accommodation not only due to other residents, but also because it was triggering acute exacerbations of her life-threatening illness. Chrissy and Beryl, in contrast, had good relationships with their husbands. However, both spouses were limited in their ability to care for their wives, and both women were now unable to continue their caring role. Additionally, there was no social network or extended family to support the couples. Beryl's rapidly increasingly frailty strongly suggested that she was reaching the end stage of her chronic condition. Chrissy, on the other hand, had experienced a traumatic incident about which she still felt bewilderment, fear and shame. The experience seemed to be triggered by the nurses on Hazel ward, so that Chrissy maintained a guarded relationship with them. The complexity of the individual factors around these three participant's sense of threat may have made it difficult for them to feel safe in the context of a busy acute medical ward.

In contrast, Mags, Sue and Esther had strong social and family networks made up of different types of family and friends. These had come forward to help them during their illnesses. The three participants had also developed good relationships with a range of ward staff and other patients on the ward. The notion of 'social safeness' describes a state of low or absent threat, in which the person feels a sense of peaceful well-being, affiliation and trust (Gilbert et al., 2012, Gilbert et al., 2011, Gilbert, 2009). Having this fundamental sense of security may have meant that these participants had more effective strategies for coping with their suffering and the physical threats caused by their illnesses. In terms of their relationships with others on the ward, a sense of safeness may have meant that they felt more able to 'risk' being open to, and trusting, compassionate care from others. Mags, Sue and Esther appeared to readily perceive, engage with and trust compassionate care from all ward staff. Furthermore, they expressed care and compassion towards staff and other patients.

Interestingly, these participants all experienced either errors in their care or episodes of poor care. However, they seemed to brush off these negative events, rather than perceiving them as personalised occurrences. As a result, the participants' relations with the staff and their experience of care did not

change. Conversely, Bliss, Chrissy and Beryl perceived personalised threat easily, and seemed to hold on to it as proof that they were not cared for by staff. Their existing high threat state may have been exacerbated by any seemingly negative occurrence. Furthermore, they may have required more obvious demonstrations of compassion to counteract that.

It is important to note that there could have been many other reasons for these findings, and my interpretation of the cases was necessarily subjective. For example, participants who reported extremely positive feelings related to compassionate care may have been keen to present themselves as grateful or undemanding patients. They might have been reluctant to criticise care given their dependence on the ward staff. In terms of the more negative responses to compassion, it may have been the case that the participant's extensive suffering had such a psychological impact that it negatively coloured their relations with others. There is also the likelihood that there were incidents or interactions that I was unaware of, which may have shaped the participant's interpretation of subsequent care.

Ultimately, it is not possible to speculate on the participants' psychological states and how those influenced their response,

nor is that the focus of the study. Furthermore, I do not suggest that the expression of compassion was insignificant in how compassion was received, or that contextual issues did not contribute. However, I argue that the findings add empirical evidence from a healthcare setting to support Gilbert's theory of social safeness. Furthermore, the application of Gilbert's theory to this study of a hospital ward population, potentially extends nursing scholarship of receiving compassion.

7.7 Conclusion

In this chapter, I have presented findings to suggest that receiving compassion is not a case of passive acceptance, as is typically implied in nursing research and literature on compassion. These case studies demonstrate that responses to the expression of compassion can vary widely, and that the sufferer is an active contributor to the process as a whole. It may be the case that their contribution is shaped by a range of factors, such as social support networks, previous experience of healthcare or mental state. Therefore, receiving compassion is neither passive, nor entirely dependent on how compassion is expressed.

Furthermore, I found that the recipient's response might in turn encourage, modify or discourage further expressions of

compassion. This suggests that the compassion process can be understood as a dynamic feedback loop. In Beryl's case, the care team appeared to interpret her negative response as upsetting and as a failure on their part. Therefore, it may be reasonable to suggest that this decreased their confidence in repeating expressions of compassion with Beryl. Conversely, Esther's positive response appeared to encourage staff to repeat the compassionate behaviours, and helped them to tolerate engaging with her suffering.

Importantly, though, the effect of the feedback was not straightforward. For example, despite Beryl's hostility to staff, most continued to express compassion and engage with her warmly, albeit in a more cautious manner. Similarly, although Esther responded to compassionate care with enthusiastic gratitude and her own efforts to care for staff, there were some who found her positivity 'intense' (junior nurse Freya, field notes) and declined or avoided her hugs and hand-holding.

Instead, I suggested that the data demonstrates that receiving compassion is not passive or static, and does not always relate to the way compassion is expressed. I also suggested that the process of receiving compassion is complex and multifactorial and is another important factor in understanding how

compassion takes place within specific settings. Lastly, I suggested that feelings of safety and threat may have a role in how participants received compassion. This is particularly important given earlier findings that a variety of factors created a threat-based context on the ward.

Conclusion of findings section

I now conclude this findings section by summarising the main points that I take forward for discussion and by presenting a model of compassion in the ward setting that illustrates the . The study aim was to describe and explore compassion in the ward setting. The findings covered the context of compassion, its enactment, construction and a more detailed examination of how compassion is received from others. These were presented in four chapters, the sequence of which mirrored the broad-to-narrow scope of the findings.

I began with a rich description of the ward context. I showed that staff on Hazel ward were committed to providing safe and effective care, and that in the main patients felt this to be the case. However, there were a range of contextual elements relating to organisational and operational factors that complicated the care process, and negatively affected the working life of staff. In the following chapter, I displayed those contextual elements in more detail, and showed how they

impacted on care. I suggested that in the ward setting, compassion is contextualised – that is, it is shaped by the contingencies of the clinical environment. In some cases, the provision of practical support enabled staff to enact skilled, personalised compassionate care, and to enjoy this work despite its challenges. However, in the main there was a lack of acknowledgement of the demands of care on staff. When organisational support was lacking, staff struggled to provide good care consistently. I also suggested that the combination of operational and organisational elements created a sense of threat, which underpinned ward work. The language and practices of staff reflected this sense of threat and encouraged a defensive stance, which inhibited the noticing of suffering.

I then presented the theme of compromised compassion. I showed that participants constructed compassion as either an intrinsic or an extrinsic phenomenon. The former framed compassion as a virtue, in which its expression was dependent on the efforts of the carer. It had moral overtones, and participants tended to accept that practising compassionate care incurred risk and personal costs. An extrinsic account understood compassion as a limited healthcare resource. Like other care resources, it was necessarily rationed to ensure those with the greatest need could receive compassionate

care. An economic narrative characterised this account, which reflected the business model of contemporary care delivery.

I followed this with a more focused chapter, looking in depth at the unexpected findings relating to receiving compassion. I presented six case studies to demonstrate that receiving compassion is not a case of passive acceptance, as is typically implied in nursing scholarship. Instead, it varies widely, can arouse negative feelings, and involves the active contribution of the sufferer. I also more tentatively suggested that the compassion process may involve a feedback loop, in which the sufferer's response to the expression of compassion influences subsequent care interactions. Lastly, I suggested that threat and safety may have a role in all aspects of the compassion process: from feeling safe to seek care from others, through being able to notice and act on others' suffering, to making one's self vulnerable to receive compassion.

These findings suggest that compassion is a deeply contextualised, multifaceted phenomenon. They also suggest that the ward setting has numerous contextual characteristics that make it distinctive. The dynamic interrelationship between the phenomenon, the setting and actors give a distinctive form and shape to compassion, which often results in care that is compromised, curtailed, inadequate or costly for staff. As

such, I suggest compassion in the ward setting is constrained, and I move now to discuss possible explanations, why this is important, and how the findings relate to wider literature, research and policy.

Chapter eight: Discussion

8.0 Introduction

In the findings chapters, I showed how the enactment, construction and reception of compassion were inseparable from the clinical context of Hazel ward. In this chapter, I discuss the significance of the findings, in relation to research, policy and theory. The chapter has three main sections. I begin with a statement of findings, and the core message that compassion was constrained in the ward setting, by a range of contextual factors.

I then move to a detailed discussion of the significance of the key findings in relation to wider cross-disciplinary literature, research and healthcare policy. I address four aspects in particular: staff well-being and suffering, receiving compassion, compromise and costs in accounts of care, and constrained compassion. Within each section I show specifically how these findings relate to existing research, and where they may extend the current body of knowledge.

In the first section I discuss how staff suffering is underrepresented in the wider literature, and that organisational causes of this are often obscured. I then consider how threat impacts on staff well-being and

compassionate care, using the psychological theory of compassion as a social mentality.

Next, I discuss how the findings on receiving compassion can contribute to an understanding of the more nuanced aspects of compassionate care. I again apply a psychological theory – in this case social safety – to highlight the potential role of threat and safety in how compassion is received from others. In the third section, I consider constructions of compassion. I examine the relevance of the economic narrative, and how this may reflect the compromise and costs involved in compassionate care. I focus specifically on nursing accounts and how their language suggests nurses have multiple, powerful influences on their decision-making. Lastly, I consider the core finding of constrained compassion. I argue that compassionate practice in the ward setting involves a dynamic inter-relationship between staff agency and multiple structural constraints. I demonstrate how Giddens' structuration theory (Giddens, 1984, Hardcastle et al., 2005, Stones, 2005) interrelationship. I conclude by summarising the main points and how they are taken forward into the closing chapter.

8.1 Statement of findings

I developed this research project in response to the national debate on NHS care, which was widely presented as a 'crisis of

compassion' and a nursing problem (Tveit and Raustøl, 2017). The political and scholarly response has been characterised by a decontextualised and reductive research output (Curtis et al., 2017, Sinclair et al., 2016b) and a values-based policy strategy. The nursing response has been characterised by confusion about what compassion means practically, and what is expected from them regarding patient care (Sinclair et al., 2016a, Maxwell, 2017, McCaffrey and McConnell, 2015a, Perez-Bret et al., 2016).

The intention of this study was to conduct an examination of compassion that was rooted in the clinical setting and engaged with those working, and being cared for, within that context. My research aim was to develop a descriptive and explanatory account of compassion in the hospital ward setting, with the objectives of examining its elements, construction and enactment. I drew from my clinical experience, and cross-disciplinary theories and compassion research to design a constructionist ethnography. I conducted fieldwork in one NHS hospital ward, over one year, and collected data using participant observation and interviews. I took an abductive approach to analysis of the data, using thematic analysis as a framework, and key-event and deviant-case analysis for specific aspects of the data.

I found that compassion was constrained in the ward setting. A range of contextual factors limited the capacity of staff to notice, engage with, and relieve the suffering of patients as well as the distress of their colleagues, and themselves. I also found that the sufferer actively contributed to the compassion process, and that in some cases, compassion could arouse negative reactions.

In situations where the organisation practically and positively supported staff with ward work, they gave skilled, compassionate care. However, in the main, practical and pastoral support was inadequate. Instead, staff worked in a threat-based context and this was manifested in their defensive language and practices. I found that participant accounts of compassion reflected both a moral imperative to personally engage with the suffering of patients, and an economic rationalism that suggested compassion was too costly. Staff negotiated this contradiction with a combination of compromised care and personal cost, both of which were demoralising. It also led to patient care that was inconsistent and sometimes inadequate. I developed the notion of 'constrained compassion' to convey a core sense of these findings. This notion is illustrated in the model below (see figure 16). Bothe the model and the findings are explicated in depth in the following sections through a discussion of how

they relate to wider compassion and sociological scholarship, and healthcare policy.

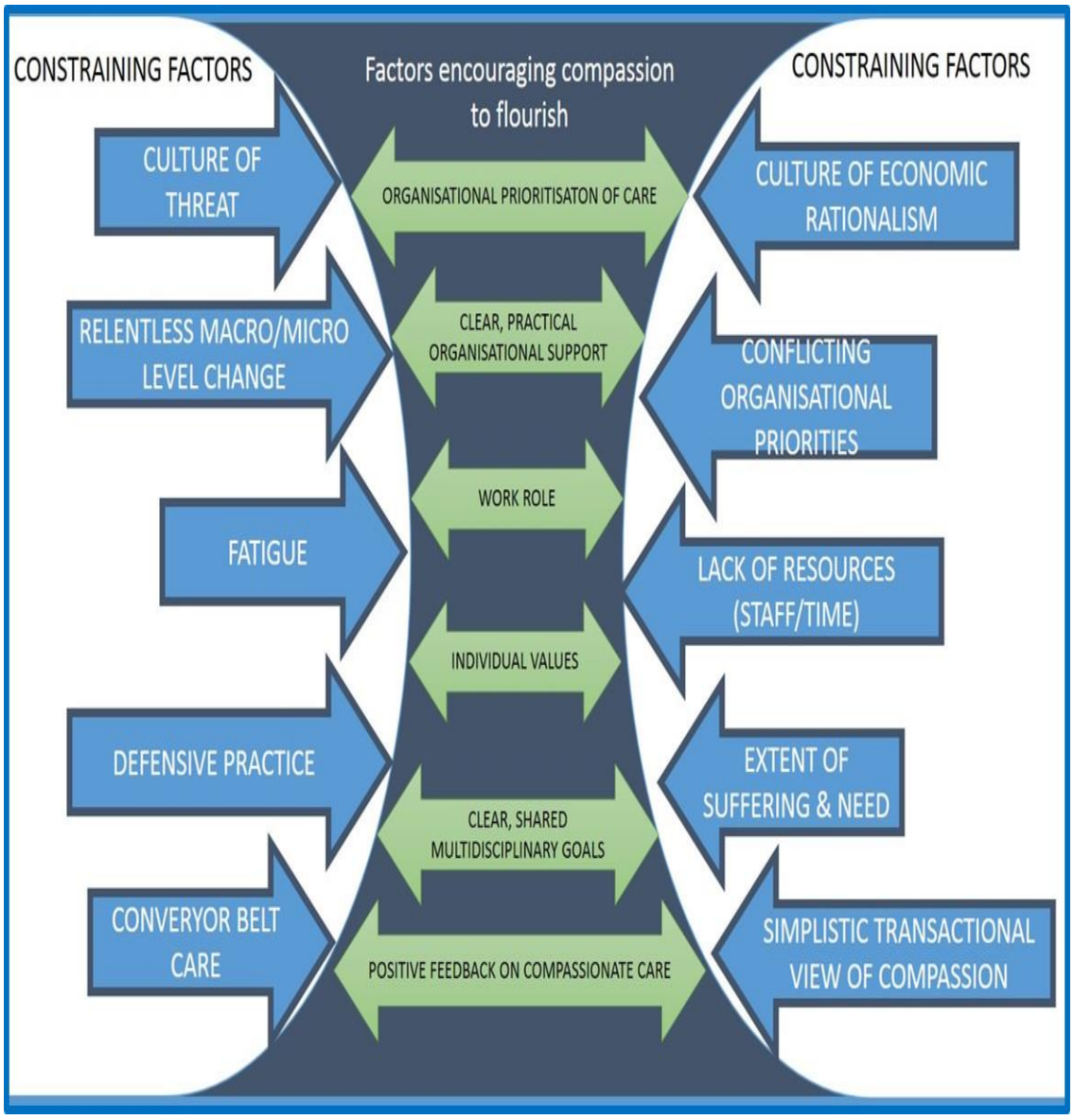


Figure 16 A model of 'constrained compassion' depicting the range of factors found in the study to inhibit compassion, and those that enable it to flourish in the ward setting.

8.2 Staff well-being and the role of threat

A recurrent element of the findings was the negative working experience of ward staff. As part of the healthcare role, Hazel staff necessarily worked in challenging circumstances, such as clinical uncertainty, pressure and managing the multifaceted suffering of patients. However, these challenges were compounded by a lack of acknowledgment of the difficulties of ward work, a lack of adequate respite or support, and a threat-based context relating to organisational instability, conflicting demands and sustained pressure. The negative impact on staff well-being was evident in their defensive language and practices, and reports of pain, exhaustion and work-related anxiety. These findings resonate with other studies of compassion in healthcare settings (McPherson et al., 2016, Crawford et al., 2013, Tierney et al., 2017b) as well as several recent national reports. A survey by the Cavell Nurses' Trust (2016) found that nurses and HCAs in the UK experience worse mental and physical health and more financial hardship, and are more likely to be victims of domestic violence, than the average population. A five-year analysis of violence against all NHS staff (Dixon, 2016) found that physical assaults by members of the public had risen by 25%. Neither report received significant media coverage or any political response. However, in September 2017 nurses voted for the

first time to strike over pay and conditions, prompting some to suggest that nurses are currently finding their working lives intolerable (Merrifield, 2017a).

8.2.1 Representations of staff suffering

8.2.1.1 Compassion fatigue

Despite these signs that negative working conditions in the NHS is damaging their well-being, there are few representations of staff suffering. There is a body of work which explores HCPs as 'wounded healers' (Christie and Jones, 2014) and a growing research base on NHS staff stress and the negative impact of that (de Boer et al., 2011, McGibbon et al., 2010, George, 2016, Jones et al., 2013). However, in compassion scholarship, staff suffering is rarely considered as an issue in its own right. George (2016, p5) describes staff suffering as an 'organisational blind spot' and attributes this to the fact that only patients are perceived as sufferers, which ultimately limits our knowledge of compassion in healthcare.

Rather than examining staff suffering, the compassion literature generally represents it using the construct of compassion fatigue. As discussed in chapter two, compassion fatigue has a contested place in the compassion literature. It features heavily in the nursing scholarship on the topic, but compassion fatigue is a distinct construct (Sinclair et al.,

2017). It originated instead from psychotherapy and crisis counselling, and is closer to models of stress and burnout than compassion (Sinclair et al., 2017, Ledoux, 2015).

This situation, where nursing research under-represents staff suffering but over-represents compassion fatigue, is relevant to the findings. The perception of a good nurse as one who suffers for her patients has endured (Nelson, 2001). It is closely associated with representations of compassionate nursing, thereby normalising nurse suffering, and perhaps even reifies it (Rickett, 2010, Chiarella, 2002). From this perspective, compassion fatigue may offer a way of voicing nurse suffering that is 'acceptable' because it is tied to caring for the patient, rather than 'selfish' concerns.

The care-standards debate brought these Victorian notions of selfless service and vocation centre stage, alongside the idea that too much education was damaging for nurses (Bradshaw, 2017, Campbell, 2013, Straughair, 2012 a). Bradshaw has been at the forefront of calls to return nurse education to a Nightingale-style focus on developing a virtuous, selfless character in order to improve compassionate nursing care (Bradshaw, 2009, Bradshaw, 2011a, Bradshaw, 2011b, Bradshaw, 2014). Similarly, Van der Cingel, who has published several highly cited papers on compassion, (van der Cingel,

2009, van der Cingel, 2011, van der Cingel, 2014) suggests that nurses can use 'de-selfing' to help them maintain a compassionate stance. This is a clinical concept used in mental health to describe individuals, often in an abusive relationship, who lose all sense of their self to a domineering partner (Lerner, 2005). Its use as a tool for care is therefore concerning given the vulnerable position it would leave nurses in. Other commentators, who have a less traditional approach, still suggest that nurses' concern for adequate pay, academic development, technical competency and career progression is a sign of decreased altruism or even decreased concern for patient needs (Davison and Williams, 2008a, Straughair, 2012 b, Schantz, 2007). Some of these commentators do acknowledge the pressures of clinical practice and barriers to care. However, they contend that organisational barriers can be 'transcended' by compassionate nurses (Schantz, 2007) and are therefore 'no excuse' for poor care (Kneafsey et al 2016, p78).

Within this literature then, compassion is constructed as a moral imperative, and one that requires selflessness. As presented in the findings, this was a conceptualisation of compassion that many nurse participants held. However, if nursing scholarship presents self-sacrifice as a normal part of expressing compassion, it may encourage nurses to tolerate

personal cost and risk in order to give care. The well-being of nurses may then suffer as a consequence.

The literature on compassion fatigue presents the associated nurse suffering as problematic, but also as an 'inevitable' or 'natural cost' of compassionate care (Sabo, 2011, Yang and Kim, 2012). Furthermore, the literature tends to present the effects of compassion fatigue as problematic because of how they impact on patient care, rather than on the nurses' well-being. For example, Abendroth and Flannery (2006) state that their rationale for examining compassion fatigue was fourfold: to improve patient care, decrease costs related to absenteeism and sick payments, increase family satisfaction with the organisation, and improve the hospice reputation (Abendroth and Flannery, 2006 p355). There was no mention of the personal effects of compassion fatigue on nursing staff in terms of their well-being or job satisfaction. Similarly, Durkin et al., (2016) state that the importance of researching compassion fatigue lies in ensuring that nurses are 'fit to face the demands of their profession' (Durkin et al., 2016, p113).

Staff suffering is also under-represented outside of the compassion fatigue literature. When it *is* acknowledged, ways of addressing staff suffering are self-directed rather than organisational. For example, suggestions to build resilience,

develop moral courage and attend support groups are common (Horsburgh and Ross, 2013, Bray et al. 2014, Curtis, 2014, 2013, Curtis et al. 2012). Self-compassion is also suggested as a strategy to 'reduce feelings of burnout' and to enable nurses to 'develop compassion for their own suffering' (Durkin et al., 2016, p113). While these strategies may be helpful, they do not address or convey a concern about the *causes* of suffering. The onus is instead on individual practitioners to find strategies to cope with 'inevitable' suffering.

8.2.1.2 Process-based compassion research

Where staff suffering is well-represented, it tends to be in those studies that take a process-based approach to compassion (McPherson et al., 2016, Tierney et al., 2017a, Crawford et al., 2013). When compassion is conceptualised as a process, rather than an intrinsic quality, there is less emphasis on the roles of actors. This means that staff and patients can be perceived as *either* sufferers or those expressing compassion.

For example, McPherson et al. (2016) in their study of compassion set in NHS dementia wards, provide a rich picture of work-related distress. It was described as affecting participants' relationships at home, their mental and physical

health, and generated feelings of worthlessness, confusion and exhaustion. In this study, participants also described the experience of aggression and violence in the workplace, which was an issue that emerged in my own findings. No other compassion studies I reviewed discussed the impact of working with violence and aggression, even though it is an increasing problem in hospital settings (Blair, 2013, Croft and Cash, 2012, Laschinger and Grau, 2012, Spector et al., 2014).

Similarly, the study of compassion and diabetes care by Tierney et al. (2017b) found that staff discourse reflected a sense of physical harm. For example, participants described feeling 'pushed', 'pulled', 'split', 'squeezed', and having extra work 'thrown' at them. They described being shouted at, and felt they 'absorbed' the negativity of the work environment (Tierney et al., 2017b). Crawford et al. (2013) found that participants' language was equally threat-based. Despite the interview topic of compassion, staff discourse was devoid of compassion-related terms and replete with 'production-line' or business references. The themes of threat, distress and being physically overwhelmed in these studies resonate strongly with my findings and support my argument that staff suffering is a significant problem.

8.2.2 Threat as a source of suffering

I have discussed how contextual factors have contributed to staff suffering, and have drawn attention to the experience of that for staff in terms of their work satisfaction and physical and mental health. I now focus on the role of threat as a contributor to staff suffering, before considering the psychological work on compassion and threat.

'Threat' is commonly defined as the feeling that something dangerous will happen (Merriam-Webster Dictionary, 2017, Collins English Dictionary, 2017) or the perception that our safety is at risk (Liotti and Gilbert, 2011). Responses to threat involve actions aimed at defending oneself from harm (Gilbert, 2009). The notion that hospitals and healthcare involve work that is pressurised, distressing, frightening or disgusting has long been established, along with the distancing techniques that HCPs have employed to protect themselves from the effects of this (Long et al., 2008, Hinshelwood and Skogstad, 2002, Lyth, 1990). However, my findings show that in participant accounts, threat was not related to the *nature* of care work, but to contextual factors such as organisational insecurity, regulatory systems and operational pressures.

NHS settings have been widely described as anxiety-laden and toxic (Cole-King and Gilbert, 2011, de Zulueta, 2013a), and,

as shown earlier, empirical work has linked staff suffering with threat (Crawford et al., 2013, Dixon-Woods et al., 2009, McPherson et al., 2016, Manuel and Crowe, 2014).

Few compassion studies go beyond evidencing the presence of threat, to show how it impacts on compassionate care. Manuel and Crowe's (2014) study connects feeling threatened and defensive practices (such as documentation anxiety, shifting responsibility, and avoiding decision-making). However, they do not show how threat, or defensive practices impact on care. I presented scenarios that suggested staff were too focused on managing perceived contextual threats to notice, or act on, patient suffering. In the next section, I apply a psychological theory to my empirical findings. I suggest that Gilbert's (2014) model of social mentality can facilitate understanding of *why* and *how* feeling threatened inhibits compassionate care.

8.2.3 The role of threat in compassionate care

A growing body of psychological work examines how threat-based motivational systems decrease our capacity for compassion. Professor Paul Gilbert has been at the forefront of developing this work. As described in chapter two, his work is rooted in evolutionary psychology, attachment theory and affective neuroscience. Gilbert's theories are based on a process-based approach to compassion, and he posits that

compassion is a social motive or mentality (Gilbert, 2009). Social mentalities are innate motivation systems which regulate psychological functioning to pursue a particular motive (Gilbert, 2014). Figure 17 shows how the three systems – affiliative, drive and threat – are interrelated.

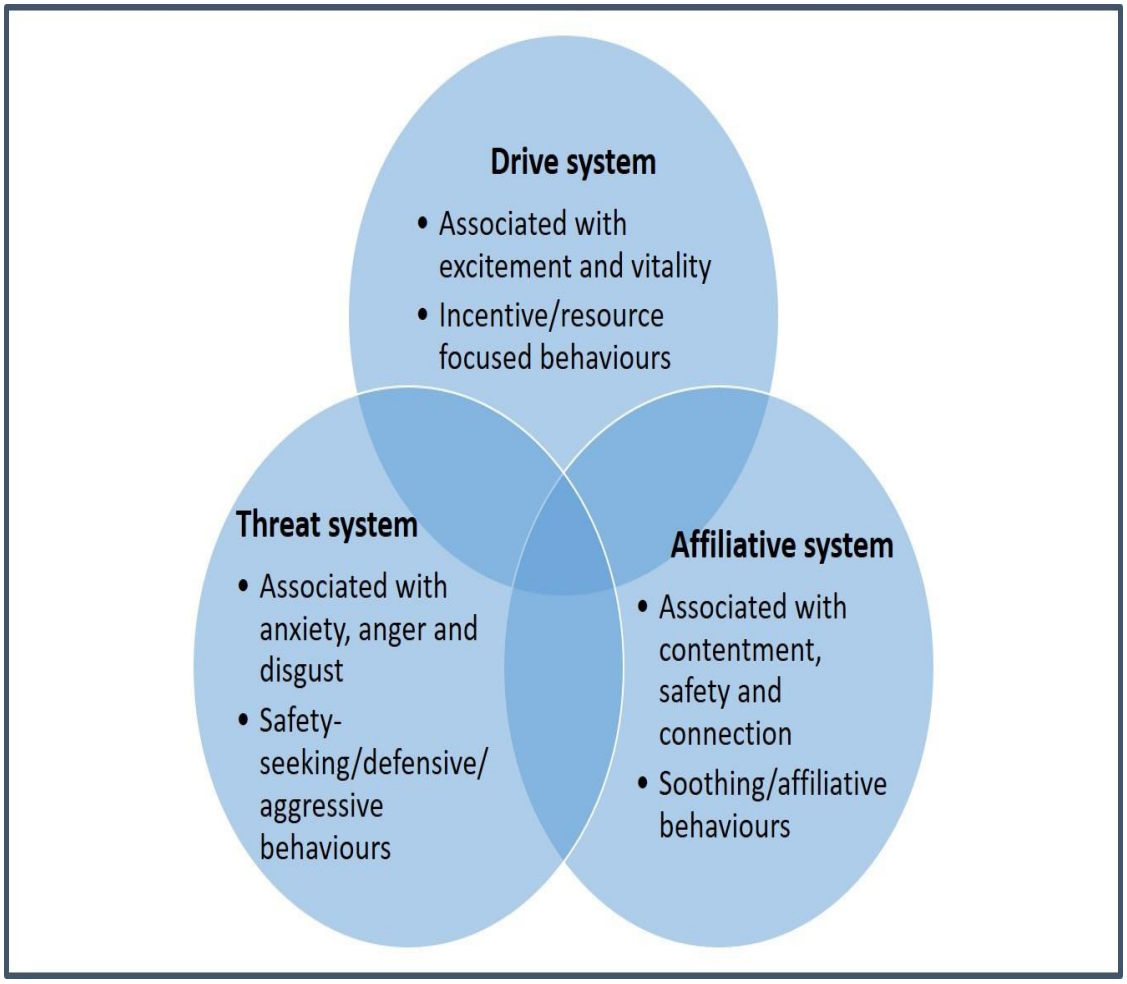


Figure 17 The three emotion regulation systems (adapted from Gilbert, 2009)

To illustrate the role of context in the activation of a particular regulation system, the example of applying for a highly prized

job is helpful. If I wanted a job but knew others were interested in it, then my attention, thinking, emotion and behaviour would be directed by the drive system, which triggers competitive, self-orientated behaviour. This would encourage me to work hard on the job application and preparing for the interview. However, when I returned home, the context and therefore my motivations would be different. For example, my child may tell me he is frightened of a monster in his room. This would likely activate my affiliative motivational system, and my attention, thinking, emotion, and behaviour would be directed by that. I would adopt a soft tone of voice, position myself closer to him and use touch and eye contact to soothe him. These examples show how social context and interpersonal relations influence the motivation systems, triggering one, and inhibiting another (Gilbert, 2014).

Compassionate behaviour is associated with the affiliative motivation system (Gilbert, 2009). This system functions to signal when it is safe to rest and care for kin, and is triggered by cues of security, warmth and affiliation (Kelly and Dupasquier, 2016, Gilbert, 2009). It generates feelings of calm and contentment in the self and towards others. The drive system evolved to ensure humans are motivated to seek the resources necessary for survival, such as food, sex and money

(Gilbert, 2009). Cues of reward and status trigger this system, and when activated, it generates feelings such as excitement, pride and elation (Kelly and Dupasquier, 2016, Gilbert, 2009).

The threat system functions to notice danger and signals the need to seek protection. It is triggered by perceived risks to safety (Kelly and Dupasquier, 2016, Gilbert, 2009). Interpretations of risk and safety will vary according to the context and individual, but a common powerful trigger is stress (de Zulueta, 2013b). When the threat system is activated, it can generate emotions such as anxiety, fear and anger, and encourage defensive behaviours such as fight, flight or submission (Gilbert, 2009). When in this emotional state, attention is focused on the perceived source of threat and protection from that. The motivation to notice, engage with or act to relieve the suffering of others is therefore significantly decreased (de Zulueta, 2013b, Gilbert, 2009). Furthermore, the impulse to make oneself emotionally vulnerable to engage with another's suffering is strongly inhibited (Dewar, 2013).

Applying social mentality theory to the findings then, suggests that periods of intense pressure on the ward activates the threat system in staff. This would divert their attention to the perceived source of threat, and at the same time inhibit

motivations to look for, notice, or act on the distress of others. Staff participants commonly described problematic discharges as their main source of stress, and referenced a range of official and informal sanctions that followed a delayed or failed discharge. Scenarios in which poor care occurred predominantly involved discharge problems. Remarkably, clinical emergencies did not appear to threaten staff to such an extent. During these, staff acted with greater urgency and focus, but continued to notice and act on the needs of others in the area. As described in chapter five, the main difference between the two types of scenarios appeared to be feeling knowledgeable about, and supported with, clinical emergencies.

Social mentality theory has much in common with the notion of 'inattentional blindness', which nursing scholar Paley (2014) drew from social psychology to explain events at Mid Staffordshire Hospital. He argued that pressure in hospital settings forces staff to focus on the perceived priorities and that when they are fixated on these, they can fail to notice other important events in the setting (Paley, 2014). Social mentality theory however, offers a more substantial model, and one which is compassion-specific. As such, it provides an alternative way of understanding care and compassion in

clinical settings, and supports the argument that factors other than staff values need to be considered.

Summary

In this section I have discussed staff suffering, the role of threat, and the impact on staff well-being and patient care. I showed that other process-based compassion studies have evidenced threat and staff suffering in the clinical environment (Tierney et al., 2017b, McPherson et al., 2016, Crawford et al., 2013). I suggested that a process-based approach is better able to illuminate staff suffering, because it does not cast healthcare staff as the 'giver' of compassion, and patients as the sufferers. However I argued that overall, staff suffering is under-represented.

I also demonstrated that much nursing scholarship on compassion normalises suffering as an inherent part of caring work. Some of this literature may even valorise self-sacrifice as emblematic of compassionate care. Such scholarship also fails to discuss organisational causes of suffering. Instead, staff are encouraged to develop strategies to manage the negative effects rather than challenging them.

Lastly, I showed how threat in the clinical environment negatively impacted on the well-being of staff and patient care. I applied the theory of social mentality to explain that

threat may work to 'switch off' compassion and inhibit our capacity to notice or relieve suffering. In combination with the empirical findings from the study, this provides a compelling argument for addressing threat in clinical settings, and developing strategies for safe working environments in healthcare.

8.3 Receiving compassion: an active process

A key, and unexpected finding from the study was that receiving compassion was a complex process, contributed to by the sufferer, and which could sometimes arouse negative feelings. In the main, patients responded positively to compassionate care. They appeared to actively seek care by sharing their suffering with staff, they recognised expressions of compassion, and they engaged positively in the interaction. However, there were many unusual aspects of the data, and I developed these into six atypical cases. In three of these cases, patients struggled to seek, recognise, trust, or accept compassionate care. I presented data to suggest a range of factors that might have contributed to this situation. I again drew from Gilbert's theories – in this case social safety – to highlight the potential role of threat and safety. I also suggested that the process of receiving compassion may

involve a dynamic feedback loop, in which sufferers' responses influence subsequent care interactions.

8.3.1 Nursing scholarship relating to receiving compassion

These detailed empirical findings on the nuances of how compassion is received are significant, because there is little relating to this topic in the nursing scholarship. Its absence implies that once compassion is expressed, the sufferer passively accepts it. Volkmann Simpson et al. (2014) argue that this under-representation stems from a religious conceptualisation of compassion, which privileges the act of bestowing compassion over receiving it. I would also suggest that when compassion is conceptualised as a virtue, there is little expectation that it will be received negatively, and therefore little reason to examine that aspect.

In terms of healthcare, the provision of care has traditionally dominated representations of professional-patient interactions. The patient is cast as the passive recipient of care, with the professional delivering care in their best interest (Larsson et al., 2011). This model of care reflects the transactional depiction of compassionate care in nursing scholarship. Even in studies that examine the patient experience of compassion, there is little suggestion that they actively contribute to the

compassionate interaction (Bramley and Matiti, 2014, Crowther et al., 2013, Lloyd and Carson, 2011, Lown et al., 2017, Kret, 2011, Sinclair et al., 2015). For example, Lloyd and Carson (2011) describe compassion in terms of equality, collaboration and shared understanding between patient and professional. However, their findings only depict the contribution of the HCP (i.e. persistent engagement, giving respect, ensuring dignity, conveying value), and the patient is described as benefitting from these. There is no sense of a dynamic engagement between the two.

Similarly, Sinclair et al. (2015), Lown et al. (2017) and Kret (2011) investigate patients' experience of compassionate care. However, their findings depict how patients perceive the qualities and behaviours of staff, rather than how patients interact with, respond to or engage in the compassionate interaction. Therefore, the relationship between patients and staff again appears transactional instead of interrelated.

I found some examples of nursing research which references the receipt of compassion, but they are few. For example, the studies associated with the LCCP (outlined in chapter two) describe compassionate care as being about both 'giving and receiving' (Dewar, 2011, p263). This approach is reflected in the study methods, which involve staff and patient participants

and refer to the interdependence between these groups (Dewar, 2011). A Swedish study (Wiklund Gustin and Wagner, 2013) explores the idea of receiving compassion in more depth, although this is in relation to self-compassion. The authors conceptualise compassion as a process, and describe it as requiring 'a recipient … who has the courage to be cared for' (Wiklund Gustin and Wagner, 2013, p180). Their findings suggest that trust and openness play a role in how compassion is received from self-to-self, but they do not look at how compassion is received from others.

Tierney et al. (2017b) look at how compassion is received in more detail although they do not incorporate a patient perspective. Instead, they examine how staff appraise the patient response to their expression of compassion. For example, whether staff see a patient's refusal to comply with treatment as a positive challenge, or as a judgement of their clinical competence. The authors suggest that how staff appraise patient responses then influences how (and if) they give care subsequently. This study is valuable for evidencing that the compassionate interaction does not end with the simple 'delivery' of compassion to a patient. However, it is based on staff interviews only and therefore is limited in how far the topic can be explored.

8.3.2 Wider scholarship and receiving compassion

Even outside the nursing field, receiving compassion has been studied least in relation to expressing compassion and self-compassion (Jazaieri et al., 2013). However, there is a more substantial body of work on this topic. Again, this research is based on a process-based model of compassion. For example, in the organisational field, compassion is conceptualised as a multistage context-dependent process (Dutton et al., 2006), in which sufferers are 'full and active participant[s]' in the compassion process. Organisational theorists Volkmann Simpson et al. (2014), describe the compassionate interaction as involving active decision-making from both parties:

> *… the compassion giver chooses to act in a way that they construct as compassionate. Similarly, the subject of that act of compassion may choose to recognize that action as a legitimate action for the other to initiate (as opposed, for instance, to one that is patronizing) …*
>
> (Volkmann Simpson et al., 2014, p475)

Psychological scholarship has also developed a body of work on receiving compassion (Gilbert, 2009, Gilbert et al., 2011. Kelly and Dupasquier, 2016, Liotti and Gilbert, 2011, Jazaieri et al., 2013). From this perspective, receiving compassion is one of three compassion orientations. The others, as described

in chapter two, are the expression of compassion to others, and self-compassion (Gilbert, 2009). Within this field, it is recognised that some individuals can respond negatively to the expression of compassion. This may be because they associate it with weakness or vulnerability, or they feel undeserving of compassion (Gilbert et al., 2011). These ideas can arise from psychosocial issues, related to attachment problems or depression for example (Kelly and Dupasquier, 2016, Liotti and Gilbert, 2011, Gilbert et al., 2011). Additionally, compassion may engender negative emotions, such as fear, and this may be related to experience of trauma or abuse related to early care-givers (Gilbert et al., 2011).

8.3.2.1 Social safeness and receiving compassion

I demonstrated in chapter seven, that Gilbert's theory of social safeness (Gilbert et al., 2012, Gilbert et al., 2011, Gilbert, 2009) is useful for explaining the atypical responses to compassion. It explains why some struggle to seek, recognise or receive compassion as well as why some find it very easy. Gilbert et al. (2012) describe social safeness as an ability to draw from personal resources and relationships to regulate one's emotions. Therefore, an individual who has a strong sense of social safeness has the capacity to gain a feeling of security and confidence based on their experiences, family and social networks (Gilbert et al, 2012, Gilbert et al., 2011). They

sense that the world is safe through regular experiences of connectedness, acceptance and belonging (Kelly and Dupasquier, 2016, Akin and Akin, 2015, Gilbert et al., 2009). Empirical research on the topic is growing, but is somewhat limited by being mainly cross-sectional studies that rely on retrospective recall and generalised reports of experience (Kelly and Dupasquier, 2016). There have been no studies of social safeness and staff–patient relationships in hospital settings that I am aware of.

Social safeness is thought to be important for individual health and well-being (Kelly et al., 2012), as it can enable individuals to cope better with daily life problems, feel more in control of their lives and act in a more prosocial manner (Akin and Akin, 2015). Those with a weak or absent sense of social safeness may feel more threatened by daily life problems and struggle to seek help from, trust and develop secure relationships with others (Gilbert, 2005, Gilbert, 2009, Gilbert et al., 2011b, Gilbert et al., 2012, Akin and Akin, 2015). It is likely that a range of factors create a sense of social safeness, but early attachment experiences seem to be crucial (Kelly and Dupasquier, 2016, Gilbert et al., 2011, Gilbert et al., 2012). In terms of compassion, individuals who have a weaker sense of social safeness may fail to perceive, seek out and trust compassion from others, may have a relative inability to feel

soothed by others, and may even experience an anxious response to compassion, and they may therefore tend to avoid, not recognise or reject compassionate expressions (Gilbert, 2009, Gilbert et al., 2011, Gilbert et al., 2012, Akin and Akin, 2015, Gilbert, 2005, Kelly and Dupasquier, 2016).

Applying this theory to the findings, it may be the case that Bliss, Chrissy and Beryl had a weak sense of social safety, while Mags, Sue and Esther had a powerful sense. For example, Bliss, Chrissy and Beryl had negative experiences of care, but this was not reflected in observations of care, or discussions with other participants (though I acknowledge this is not confirmatory in any way). The discursive and social practices of these participants suggested vulnerability and defensiveness. All three participants were dealing with numerous threats, including their physical health and a lack of wider social/family support, while two had past experiences which still troubled them. A theory of social safeness might suggest that these participants already struggled to feel safe in the world, and so had a heightened sensitivity to additional signs of threat. A busy acute medical ward full of the suffering of other patients and overstretched staff may therefore have decreased their sense of safeness further. This may have made it difficult for these participants to feel confident to seek, recognise or feel soothed by compassionate care when it was

offered. Furthermore, the inconsistency of care provided by staff may have exacerbated their distrust.

In stark contrast, Mags, Sue and Esther had extremely positive experiences of care despite negative occurrences and their own immediate suffering. All three conveyed a sense of assurance and calm that was remarked on by others in the setting. They all had strong and long-established social networks made up of diverse types of family and friends. They also developed good relationships with a range of ward staff and other patients on the ward, and were known for expressing care and compassion towards others in the setting. They all also experienced negative occurrences (e.g. errors in treatment or poor care). However, they seemed to brush off these events, and their self-assurance, experience of care and relations with others did not appear to change. If a strong sense of social safeness means one feels safe in the world, connected, accepted, hopeful and in control (Kelly and Dupasquier, 2016, Akin and Akin, 2015, Gilbert et al., 2009), then this perhaps applies to the cases of Mags, Sue and Esther. Having this fundamental sense of security may mean that these participants had more personal and social resources for coping with their suffering, and the physical threats caused by their illnesses. In terms of their relationships with others on the ward, they may have felt more able to 'risk' being open to,

and trusting, compassionate care from others. These participants appeared to actively ask for support, recognise it even in the most task-orientated care, and fully engage with compassionate care from ward staff.

Summary

In this section I have discussed the finding that receiving compassion is an active process, influenced by the sufferer, the person expressing compassion, and the surrounding context. Furthermore, I found that responses to compassionate care could vary, and sometimes be negative. These aspects are not yet widely recognised, particularly in the nursing scholarship. I suggested this was due to an almost exclusive focus on the role of the staff member in the compassionate interaction, and the expression of compassion, to the detriment of other aspects. I demonstrated that a process-based approach can better illuminate how compassion is revealed, and that a significant body of work using this approach exists in the organisational and psychological fields.

I applied the psychological theory of social safeness to the findings to offer one explanation for why some may struggle to seek, recognise, trust or accept compassion. The theory has not previously been related to situations where compassion is easily received. However, I applied it to the three case studies

where participants appeared to effortlessly perceive and derive benefit from compassionate care. The theory provided a plausible explanation for why some may have an atypical response to the expression of compassion. It also supports my assertion that the staff member, or person expressing compassion, is not the only determinant in the sufferer's experience of compassionate care. Furthermore, it supports the finding that some people may not recognise or react positively to expressions of compassion. Nevertheless, the application of this theory to the findings is significantly limited. This was not a psychological study, and did not look at individual motivations or states, or study the six participants exclusively.

However, the use of this theory shows the value of exploring cross-disciplinary work on the topic, and suggests that it can extend knowledge of previously unrecognised aspects of the phenomenon, and the range of factors that influence it. Lastly, these findings can help healthcare staff to understand that problematic responses to compassion can occur, and why they may arise. In turn, this knowledge can help to reduce feelings of confusion, frustration and guilt in staff when patients respond negatively.

8.4 Constructing compassion: Compromise and costs

I now discuss the two accounts of compassion I presented in the findings section: the intrinsic and extrinsic constructions of the phenomenon. The former located compassion as a personal quality, and a virtuous way of being. There were moral overtones in this account, as well as an assumption that the enactment of compassion involved personal cost. Within this account, compassion gave meaning to care work for participants who derived reward from practising in a way that felt 'right'. The latter extrinsic account presented compassion as one important aspect of patient care, but not always the priority. Compassion was tightly related to the role and remit of the participant, and as such, was a practical account. Within this ran an economic narrative which rationalised the restriction of compassionate engagement with some patients in order to preserve it for those with the most need. As with the restriction of other healthcare resources, participants saw this as a frustrating compromise and frequently demoralising. These accounts of compassion are important in terms of healthcare, because they suggest that compassion is heavily shaped by the clinical context, and that enacting compassion in this setting can involve frustrating compromise and personal cost.

8.4.1 Compromised compassion

The finding that staff routinely enact compromise in their provision of compassionate care is well supported (Curtis, 2013, Horsburgh and Ross, 2013, Maben et al., 2007b, Bridges et al., 2013). There are also several studies that highlight the need to qualify compassion, because without some modification, the phenomenon does not 'fit' well with the context. For example, Ali and Terry (2017) found that the healthcare context imposed 'conditions upon' compassion. The authors interviewed corporate healthcare staff during which participants identified kindness, authenticity, person-centredness, and emotional intelligence as aspects of compassion. However, participants also felt these qualities were highly problematic in a business-focused NHS. The authors suggest that one participant's term - 'gritty compassion' - was a more realistic fit with the context. Gritty compassion involves being courageous, for example to prioritise meeting targets over 'time for kindness' (Ali and Terry, 2017, p83).

Tierney et al. (2017b) developed the qualified term 'professional compassion'. The authors described 'compassion itself' as innate, and akin to a personal value. The term 'professional' was used to situate compassion specifically in the clinical setting, and distinguish it as relational, skilled and

'part of participants' job-related repertoire' (Tierney et al., 2017, p7). Furthermore, Tierney et al. (2017b) found that staff felt frustration and anxiety and were prone to self-blame for poor care, despite the evident contextual barriers to compassion. Similarly, Brown et al. (2014) developed the idea of 'practical compassion', which they described as a repertoire of care activities that staff enacted with patients. Participants made distinctions between their caring, therapeutic work, and the organisational barriers that often blocked it. The corpus-assisted discourse analysis of the same data by Crawford et al. (2013) suggested participants felt they had little autonomy, and felt pressurised to work efficiently rather than with compassion.

These three studies have a strong resonance with my findings, as they present the idea that compassion does not 'fit' the healthcare context. It instead necessitates compromise, modification, squeezing in or rationing out. Crucially, these studies also find that it is staff who must enact the compromise, and as a result they express frustration, self-blame and dissatisfaction.

8.4.2 Negotiating compassion in the ward setting

Participants' constructions of compassion were nuanced, complex and multifaceted. From a constructionist perspective, this complexity represents the interrelationship between phenomena, context and interpersonal relations, and the process by which compassion is 'socially brought into being' for ward staff (Holstein and Gubrium, 2008, p375).

For nurse participants, accounts were typically conflicted. Their descriptions of care interactions featured elements of self-sacrifice and subversion, guilt and pride, and reward and resentment. Nurses also referenced a tangled set of influences, including professional requirements, public expectations, personal identity and organisational pressures. The complexity of these accounts, and the range of emotions described may reflect the range of powerful influences shaping nursing practice.

As discussed earlier, the moral and religious roots of nursing are still manifested (Gordon and Nelson, 2006, Price et al., 2013). Furthermore, feminist scholars continue to draw attention to sociocultural models of caring and gender and the ways in which they are enmeshed with professional ideals of compassionate care (Neff, 2011, Rickett, 2010, Schantz, 2007). The nurse accounts presented also tended to feature a

blurring of home and work life, demonstrated in the way they would refer to Hazel ward as their 'home' and to those in it as their 'family'. This was evidently a positive source of support for participants, but the blurring brought a very personal influence to decision-making at work, and perhaps made it difficult to enforce boundaries or limits. Compromising patient care is not presented in nursing scholarship as a strategy for managing the challenges of the clinical context. Instead, nurses are encouraged to be 'consistently compassionate' to all patients (Kneafsey et al., 2016) and to find personal strategies to achieve this.

The contrast between the tightly boundaried AHP and medical accounts of compassion, and the limitless quality of nursing accounts suggests both gendered and professional influences on nurses' construction of compassion. The difficulties of defining the boundaries of nursing care have long been debated (Gavin, 1997, Brown et al., 2000, Pearson, 2003). The move towards holistic care in the 1980s vastly expanded the scope of nursing, as well as encouraging a more intimate, personalised style of care (Allen, 2004b, Maben et al., 2006, Savage, 1995, Salvage, 1990). Nurse participant accounts of compassion also reflected wider sociopolitical expectations and concerns about public blame for inadequate care. The vicious media and political blaming of nurses that took place after the

Mid Staffordshire inquiry perhaps conveyed to nurses that in the public opinion, they bore the responsibility for compassionate care.

In contrast, AHPs and medical participants typically constructed compassion in a role-specific way. Although these participants were from different professional backgrounds (e.g. OT, physiotherapy, pharmacy, medicine), there were strong similarities across accounts. This was particularly in terms of a precise understanding of their professional and care remit, and a willingness to assert limits. AHPs and medical staff are exposed to the same values-based NHS policies as nurses, and are expected to uphold similar professional caring ideals. However, their accounts did not suggest that these ideals were intertwined with their self- identity.

8.4.3 The economic narrative of compassion

Many scholars have argued that the business model of healthcare at a macro-level now dominates micro-level practice, and has encouraged a preoccupation with productivity, efficiency, measurable outcomes and target chasing (Christiansen et al., 2015a, Crawford et al., 2014, de Zulueta, 2013a, Cole-King and Gilbert, 2011). Constructions of compassion as a limited resource have clear associations with an economic narrative, and participants' discourse of care

featured notions of bargaining, balancing costs and resources, and affordability. Compassion was costly, in terms of time, resources and energy, and its outcome was incalculable, which ultimately reduces its value in a business context. I noted that AHPs and medical participants typically constructed compassion as a resource, to be spent or saved as they judged appropriate. In contrast, nurse participants constructed *themselves*, rather than compassion, as the resource. As such, they drew from their own reserves to care for patients.

The use of self as a tool of care is a common theme in nursing scholarship, again linked to the holistic, personalised nursing style which emerged in the 1980s (Allen, 2004b, Savage, 1995, Salvage, 1990). Indeed, nursing care has been described as a 'gift of self' (Dunn, 2009, p45) which nurses choose to give to their patients. The notion of 'gifting' care is interesting in the context of the economic narrative, and the wider business model of healthcare, as gifts are freely given. In Dunn's (2009) study, nurses described actively choosing to go beyond their official remit to give some care, and they derived reward and energy in return. Bolton (2000) also found that nurses reported choosing, and finding it rewarding, to give 'authentic' emotional care as a gift. Crucially, however, there is a sense of autonomy to give the gift of care in these studies. Bolton (2000) for example, noted how nurses

sometimes chose to withhold the 'gift' of care. When participants felt negatively towards patients, they sometimes chose to withhold the emotional connection, retaining a sense of detachment instead. Additionally, these nurses described a high degree of agency around time. Bolton (2000, p584) described how, when they felt it was necessary, they would 'allocate themselves the time' to give extra emotional care to patients.

This contrasts with my findings. As demonstrated in chapter five, participants more often described a lack of control over time and space for care. Goodman (2016) argues that nurses are mandated to express compassion, but in a way that is 'authentic' rather than professional. This presents several problems for nurses. Firstly, there is little freedom in gifting something that you have been mandated to give. Secondly, the mandate also refers to the way in which the gift is given – that is, authentically, and not in a detached professional way. Thirdly, in other aspects of care work, nurses can be heavily sanctioned for being unprofessional, and the line between when professionalism is demanded and when it is disallowed is unclear. Fourthly, though compassion is mandated, it is not enabled, and Goodman (2016) refers to the paradox of encouraging nurses to offer compassion freely as a gift, within a setting of increasing constraints on nursing autonomy and

reduced opportunities for personal engagement. While acknowledging that choosing to give care as a gift can be important for staff, he argues that, fifthly, it perpetuates the economic devaluing of care work, and weakens nurses' ability to effect change (Goodman, 2016).

Summary

In this section I considered participants' constructions of compassion, and how they reflect the costs and compromises of ward care. I demonstrated that my findings resonate with other studies, which suggest that compassion needs to be qualified or modified to 'fit' with the contextual constraints.

I then extended this idea of a poor fit between compassion and the healthcare setting, by examining the economic narrative running through participants' talk. I linked this to the broader corporate model of healthcare, and argued that different professional groups managed this poor fit in different ways. I applied nursing theories of care to highlight how nurses are encouraged to give the gift of authentic compassionate care. However, I argued that being organisationally mandated to give personalised care as a gift raises a range of problems for nurses, as individuals and as a profession.

In this section then I have drawn attention to the diverse influences that shape nursing practice. Consequently, not only is nursing care compromised by organisational barriers, but nurses' ability to negotiate the compromises they make is also heavily constrained by social, political and historical influences. Given the current problems with nursing recruitment and retention, poor nurse well-being, and blame directed at nurses for standards of care, these powerful constraints on nursing autonomy are an important contribution to the national compassion debate.

8.5 Constrained compassion: A structuration theory of care

In this section, I unite the findings to consider the main message of the thesis. I found that staff struggled to give compassionate care consistently, and this was related to a tension between their ideal practice, and the care they could enact. This tension resulted in compromises, costs, frustration, demoralisation, and sometimes inadequate, care. I concluded that compassionate care was constrained within this setting. Here, I apply Giddens' structuration theory to illustrate the dynamic interrelationship between structure and agency that is inherent in the findings.

I outlined the theory in chapter two, therefore I begin this section by explaining why I have applied structuration theory to the findings. I consider how others have applied the theory, and then detail how four key concepts - duality of structure, contextuality, knowledgeability and ontological security- illuminate my findings. I then conclude by considering the value of structuration theory for compassion research.

8.5.1 Structuration theory

I have found no studies that apply structuration theory specifically to compassion in healthcare, but it has formed part of an analysis of compassion in three organisational studies (Dutton et al., 2006, Lilius et al., 2011, Volkmann Simpson et al., 2014). In each of these, structuration theory was not the main theoretical framework. For example, Dutton et al. (2006) applied the concept of duality to illuminate how compassion 'unfolded' through a complex interaction of social architecture and human action. Lilius et al. (2011) similarly examined how social practices fostered organisational conditions that both enabled and constrained members' capacity for compassion.

In nursing scholarship, structuration theory has been used to explore care. For example, it informed studies of decision-making (Hardcastle, 2004), attentiveness (Klaver and Baart, 2011), self-management of diabetes (Hinder and Greenhalgh,

2012), and hospital spaces (Purkis, 1996). Purkis (1996) employed structuration theory specifically to address the decontextualised accounts of practice that blamed nurses for poor care and obscured the structural constraints on practice – a situation which remains problematic today, suggesting how entrenched the personalised focus on nursing is.

Nairn (2009, p191) points out that nursing research on the whole favours theoretical approaches that emphasise agency and neglect structure, and that the result is a 'thinned out' perspective on structural constraints. As noted in the literature review, I found numerous studies examining compassion in the healthcare setting, where the clinical context was almost indiscernible but was relevant to the research aim (Crowther et al., 2013, Waugh et al., 2014, Brown et al., 2016, Graber and Mitcham, 2004, Kret, 2011, Lown et al., 2017, Papadopoulos et al., 2016). For example, two quantitative studies (Lown et al., 2017, Kret, 2011) examined patients' assessments of how compassionate healthcare staff were. They employed rating scales to do this but did not consider that the findings might be influenced by any contextual variables (e.g. staffing, workload, clinical emergencies) or patient-related variables (e.g. length of stay, pain levels, or previous hospital experience). Similarly, in a qualitative study, Crowther et al. (2013) presented a distressed relative's

experience of her father dying in an open ward area rather than a side room. The relative did not complain about the manner of staff, but was upset that her father did not have the privacy of a side room (Crowther et al., 2013). The authors described the lack of side room as an example of 'uncompassionate' and 'unkind' staff. However, there was no suggestion that contextual factors might have affected the decision not to move the patient (such as the availability of private rooms, his condition, or the infection status of other patients). The study therefore implies that staff *chose* to withhold the side room from a dying man. These examples demonstrate that when the structural aspects of practice are omitted and staff decision-making is presented as unconstrained, then the experience of giving compassionate care appears as a simple case of motivation.

I demonstrate now how structuration theory illuminates my findings, by helping to explain how and why compassion is constrained in the ward setting. I apply four key concepts in the following order: duality of structure, contextuality, knowledgeability and ontological security.

8.5.1.1 Duality of structure

The notion of 'duality of structure' is the central concept of Giddens' theory (Craib, 1997) and refers to the dynamic

interrelationship between agency and social structures. As I have set out, this concept represents the heart of the findings and the struggle to enact compassionate care on the ward. Duality denotes that individual agency and social structures are one 'thing' with two aspects; therefore, neither aspect has primacy, and instead both enable, constrain and shape the other (Craib, 1997, Hardcastle et al., 2005). I have described in detail the constraints on practice. However, I have also described the ways in which staff were *enabled* to care within the context. Their organisational role identified them as a source of help, put them in a place where those who were suffering could access their care, and surrounded them with similar people who could teach, support and validate their caring role. I gave examples of circumstances (e.g. EOLC, clinical emergencies) where practical organisational support regularly enabled compassionate care to flourish.

I showed how staff shaped the organisational context, drawing from their reflexive understanding of 'how things are' in the ward, to gauge when they could ignore or subvert certain practices and reinforce others, and when they could withdraw from social interactions or encourage them. Participants were also rewarded, sustained and encouraged by their work and through their social relations with others in that setting.

However, there appeared to be many more constraints that inhibited staff from engaging in personalised care, taking adequate respite or obtaining positive support with the challenges of compassionate care. Furthermore, there were significant ways in which staff were shaped by the context. For example, becoming demoralised and guilt-ridden by not being able to respond to the suffering they saw.

A similarly contradictory picture of practice emerged. Compassionate care occurred frequently, and was enabled by the skill, support and qualities of those in the setting. When it was enacted, it created an uplifting and comforting sense of connection, the experience of which encouraged staff to tolerate the negative experiences of their work. However, compassion was also heavily constrained, so that it was frequently curtailed and required significant compromise to practise. In this sense, the ward context enabled, shaped and constrained the compassionate actions of staff, while simultaneously they resisted, reconstructed and reproduced the context and its constraints (Klaver and Baart, 2011). The notion of duality weaves through the other key structurational concepts: contextuality, knowledgeability and ontological security. I turn next to the concept of contextuality.

8.5.1.2 Contextuality

Contextuality reflects the assumption that life is a historical process, and social interaction is situated within a specific time and place (O'Reilly, 2015). This again means that social interaction shapes, and is shaped by, that specific temporal–spatial context (Hardcastle et al., 2005) and is therefore always significant (Foley et al., 2015). In terms of the findings, contextuality highlights the influence of wider occurrences: the NHS care scandals, public inquiries and public compassion debate, which continued to evolve across the course of the study. The compassion discourse that emerged from these events reified the term, and separated it from ordinary nursing care. Nurse participants' talk reflected this wider discourse. For example, they expressed confusion about the meaning of compassion and what it meant in terms of everyday practice, a situation other researchers have noted (Barron et al., 2017, Brown et al., 2016, Blomberg et al., 2016, Kneafsey et al., 2016, Hewison and Sawbridge, 2016). The recent reification of compassion has also led to a devaluation of the term 'care', so that nurse participants in my study often elevated compassionate care above 'basic' or 'ordinary', but nonetheless essential, care.

Additionally, contextuality helps to explain the highly inconsistent nature of care quality. The same staff members

could give both good and poor care, and both good and poor care could coexist in the same moment. The concept of contextuality suggests this is a product of the 'situated character' of interaction (Giddens, 1984). For example, the ever-fluctuating workload, staffing, and patient numbers, and regular organisational changes or unanticipated events, all shaped interpersonal relations at the micro-level of the ward. As a result, although care interactions broadly resembled each other much of the time, each interaction was the product of various elements intersecting in a particular way.

This is perhaps best exemplified by the differences in care for dying patients. For example, patients who were formally identified as being terminally ill were cared for in the palliative care side rooms. The side rooms provided a boundary which protected staff from interruption, meaning they had greater opportunity to engage with patients and their families than staff in the bay areas. Furthermore, the organisation was incentivised to support good palliative care, as NHS trusts are formally rated on the quality of care for the dying (Gomes and Higginson, 2008, Ellershaw and Ward, 2003). Contextuality therefore highlights the situated character of care, and how micro- and macro-level influences affect the capacity of staff to provide good quality care to patients.

8.5.1.3 Knowledgeability and ontological security

Knowledgeability refers to a person's understanding of social structures, in terms of the related rules and resources, and the routine practices of daily life (Craib, 2014, Hardcastle et al., 2005). It also relates to self-understanding – for example, having a reflexive awareness of one's social position, skills and actions, and how they are enacted in relation to other people (Hardcastle et al., 2005). Crucially, however, it is an individual's capacity to *draw from and use* this knowledge that constitutes knowledgeability (Stones, 2005). By drawing from an understanding of self, others and social structures, actors have a greater capacity to choose, act and take an active part in social life (Craib, 2014). Knowledgeability of 'how things are' can therefore provide individuals with a fundamental sense of security, which ultimately supports their agency (Giddens, 1984, Hardcastle, 2004).

Groves et al. (2011) examined patient safety from a structuration perspective. They posited that nurses' knowledgeability stems from their experience, training and awareness of the organisational 'punishment and reward systems' (Groves et al., 2011, p1851) relating to practice. They found that nurses' ability to create and sustain a safety culture in the setting was inhibited by a competing economic discourse. Groves et al. (2011, p1853) concluded that the

organisation could increase nurses' knowledgeability by 'strengthening the patient safety rules and resources available to nurses, and decreasing those supporting other values'.

Groves et al. (2011) present a straightforward view of how structural rules and resources can be consciously manipulated to increase nurses' knowledgeability. In contrast, I found that the organisational context was so erratic and unstable that it threatened HCPs' knowledgeability. For example, staff were unsure how to manage multiple competing priorities, and the range of explicit and implicit rules. In addition, resources were unpredictable, meaning that staff were often unsure of what, and from where, they could obtain support in a given moment.

When circumstances were more predictable, staff knowledgeability appeared greater. For example, during clinical emergencies, all those taking an active role in the management of the incident had a shared knowledge of the roles, rules and resources, and these properties enabled excellent care to take place. The routines for emergencies were well embedded through regular training, and resources were plentiful and immediately accessible. Therefore, staff had capacity to access and employ organisational rules and resources to enable excellent emergency care. In contrast, when organisational rules and resources were not evident or

available, staff knowledgeability was limited and quality of care suffered accordingly. The many examples of discharge and admission problems illustrated this, as well as the discursive uncertainty of staff regarding rules, priorities and even their own remit. Limited knowledgeability can cause a sense of destabilising unpredictability, which Giddens refers to as ontological insecurity.

Giddens (1984) theorises that social practices have an essential routinised nature, which provides 'well-worn tracks along which agency flows' (Hardcastle et al., 2005, p227). As discussed above, knowing what to do enables individuals to develop knowledgeability, and contributes to the continuity of social life (Hardcastle et al., 2005). Predictability of 'day-to-day' life provides a sense of safety or ontological security. (Giddens, 1984) argues this is necessary to prevent individuals from being 'swamped' by existential anxiety. He links this concept to psychological theories of early attachment and the human need to feel safe (Giddens, 1984). This notion has clear similarities with the theory of social safeness discussed earlier, and therefore further supports my findings that threat and safety are a major factor in compassionate care in ward settings.

As noted, participants identified patient flow as the most stressful aspect of their working day. I suggest this can be partly explained by limited knowledgeability, and a sense of wider insecurity about the consequences of this. At Oakfield, patient flow was one of several priorities. Compassionate care, hygiene and cost efficiency were the others. However, there was no explicit direction regarding how to prioritise among these when they clashed. Staff appeared to draw from tacit knowledge in order to identify that patient flow was the 'priority priority'. Nevertheless, although though they identified this, they felt distressed and frustrated that patients were not receiving adequate care because they were attending to discharge or admission related tasks. This frustration was heightened because staff were also inhibited from achieving efficient discharges, by inconsistent rules and resources. There were no 'well-worn tracks' to follow as discharge procedures lacked continuity, shared goals, or feedback with which to inform future management of problematic discharges. It was during problematic discharges or multiple admissions that a disrupted sense of security was most evident in staff. Even experienced senior nurses expressed doubt and anxiety around decision-making, and it was during these scenarios that care was more frequently inadequate.

Summary

In this section I have used structuration theory to illustrate the core finding of 'constrained compassion'. Through this lens, compassionate care is revealed as a dynamic interrelationship between the agency of staff, and multiple micro- and macro-level structural constraints. One cannot be understood without the other, as staff agency is bound up with a web of unpredictable structural rules and resources. From this perspective, the practice of staff members simultaneously resists, reconstructs and reproduces (Klaver and Baart, 2011) the enabling and inhibiting contingencies of the ward through the care practices.

8.6 Conclusion

In this chapter I discussed the key study findings, and situated each within wider cross-disciplinary scholarship and broader sociopolitical events. I began with the finding that staff experience poor well-being and work-related suffering. I demonstrated that nursing scholarship on compassion implies that suffering is a normal part of compassionate caring and that it may even valorise self-sacrifice in nursing work. I showed that the organisational causes of suffering are often obscured in nursing scholarship, which instead emphasises that staff should develop strategies to cope with the negative

effects of care work. I suggested that a process-based approach to compassion better illuminates staff suffering, as it does not cast healthcare staff solely as the 'givers' of compassion. Within this section, I also emphasised the role of threat in contributing to staff suffering. I applied Gilbert's theory to suggest how threat can negate a compassionate motivation, and thereby inhibit the capacity to engage with suffering. In combination with the empirical study findings, this discussion provides a compelling argument for examining threat in clinical settings and developing safe working environments for staff.

I then focused on receiving compassion. I argued that the study findings evidence that receiving compassion is an active process, influenced by the sufferer, the person expressing compassion, and the context. I suggested that responses to compassionate care could vary, could be negative and may involve a dynamic feedback loop. I established that there was a dearth of nursing scholarship on this topic and linked this to a values-based, transactional view of care interactions. I showed that other fields have developed a body of work on receiving compassion, though hospital ward populations appear unrepresented. I applied Gilbert's psychological theory of social safeness to explain why some may struggle to accept compassionate care. Lastly, I argued that these findings

extend nursing knowledge of receiving compassion, but that more empirical research is necessary.

Next I discussed the social construction of compassion using the findings relating to intrinsic and extrinsic accounts of compassion. I argued that these findings suggest the costs and compromises of struggling to 'fit' compassionate care into the constraints of the clinical setting. I also discussed the economic narrative running though participants' talk of compassion, and its relation to a business model of healthcare. I related this to scholarship which constructs nursing care as a 'gift'. However, the contradiction of being politically, professionally and organisationally mandated to 'gift' was evident. This discussion around nurses' accounts of compassion are valuable because they reveal the range of organisational and sociopolitical constraints on nurses' agency. It is important to articulate this discussion because the freedom of nurses to practise as they choose is consistently overemphasised in the nursing scholarship, as well as in media accounts of healthcare. The lack of acknowledgement of contextual constraints may perpetuate the blaming of nurses for poor care in clinical settings.

Finally in this chapter, I focused on the core finding – that compassionate care was heavily constrained in the ward

setting. I used structuration theory to illustrate the dynamic interrelationship between agency and structure to argue that one cannot be understood without the other. Through this discussion, I have demonstrated that my work resonates with other research, but also that it extends the body of knowledge to offer alternative ways of researching and conceptualising compassion in a hospital setting. I also suggested that this work makes novel contributions in the areas of staff suffering, the role of threat, and the complexities of receiving compassion. In the following and final chapter I summarise these contributions in relation to the original research aim. I then discuss the limitations of the thesis, and offer a set of recommendations for theory, research, policy and nursing.

Chapter nine: Conclusions

In this closing chapter I demonstrate how I have met the research aim, and how this thesis contributes to nursing and compassion scholarship. In doing so, I acknowledge the limitations and broader implications of the study, and present specific recommendations for research, theory and policy.

9.0 Compassion in the ward setting

The research aim was to develop a descriptive and explanatory understanding of compassion in an NHS hospital setting, which incorporated its key elements, and how participants constructed and enacted compassion. I hoped to untangle the complexity of a topic that was central to my working life, and to make an empirically-informed, meaningful contribution to the international compassion scholarship, and related healthcare policy.

I found compassion in the ward setting was constrained by multiple structural barriers. This caused distress and frustration to both staff and patients, and an inconsistent quality of care. All actors contributed to the dynamics of compassion on the ward. I found that staff valued compassion as an aspect of their care, and for some it was part of their identity and gave meaning to their work. Patients also valued compassionate care, felt comforted by it, and responded

positively, which in turn was uplifting for staff. Unexpectedly, some patients struggled to recognise, trust or feel relieved from compassionate care. I found that a sense of threat dominated the ward culture, which was evident in the language and practices of staff, and could inhibit their capacity to engage compassionately with others. However, when the organisation provided positive practical support, compassionate care often flourished.

9.1 Limitations

The aim of this study was to develop a contextualised understanding of compassion in a hospital ward, rather than to draw generalised conclusions. However, the professional, political and social significance of the topic meant it was important to achieve findings that would have resonance and utility beyond the setting. There are several aspects of the study which affect the transferability of the findings, and its overall credibility. I now set out these arguments here.

9.1.1 Role of theory

My use of existing cross-disciplinary theory throughout the study is seen from some perspectives as increasing the transferability of the findings (O'Reilly, 2008, Shank, 1998), and by others as a serious limitation of the study. I have employed several theories throughout the study, and either

explicitly drawn from them or directly applied them. For example, I chose a constructionist theoretical framework to inform the research approach, I used process- and values-based theories of compassion in the narrative review and data collection and analysis, and I applied psychological and sociological theories to illuminate the findings. In the data analysis section, I discussed how, from certain standpoints, a theoretically-informed approach 'contaminates' or 'stifles' analysis of the data (Mills et al., 2006). Other perspectives view this as true for the research process overall. Therefore, while it may be acknowledged that researchers cannot enter the field as 'blank states,' some contend they should minimise the 'biases' of pre-determined thoughts and theories (Mills et al., 2006). This is a perspective that underpins methodologies such as traditional grounded theory, which require the researcher to focus only on what emerges in the setting (Charmaz, 2011). Views on the role of theory are diverse, and there are various positions on what stage of the research, and to what extent, theory should be employed (O'Reilly, 2012). In terms of this study, using theory throughout as well as conducting a literature review, may be considered a distorting influence on fieldwork data and therefore the findings (Anderson, 2002, Wilson and Chaddha, 2010).

However, for this study topic and aim, a robust theoretical grounding, in combination with new empirical evidence, was beneficial (Wilson and Chaddha, 2010). It enabled me to articulate explicitly that differing theories of compassion exist, and that each theory has diverse roots and consequences. Conversely, much compassion scholarship fails to state which approach to compassion informs the study, or even that diverse theories of compassion exist. This results in research that is underpinned by implicit assumptions, but which does not acknowledge how they shape the study and its findings.

Furthermore, by taking theory-informed approach, I have been able to demonstrate how different models of compassion throw light and shade on various aspects of this complex phenomena. The combination of psychological and sociological theories within a nursing study has supported the development of a broad set of findings. They give both a sense of the everyday experience of compassion for participants, and how wider structural constraints shape that. Therefore the findings contribute to cross-disciplinary scholarship, as well as extending knowledge of compassion in hospital settings.

I also suggest that an ethnographic methodology means the researcher retains a strong connection to the field, despite also considering relevant theory. The extensive engagement in

the setting, participation in its practices, and close relationships with participants means that researcher is sensitive to data emerging from within the field (Seymour, 2007, O'Reilly, 2008, Savage, 2000, Hammersley and Atkinson, 2007). During fieldwork I felt grounded in the sounds, smells, emotion and urgency of Hazel ward. The duration of fieldwork gave ample opportunity to check my interpretations and clarify if it resonated with participants' experience (Murphy et al., 1998). Additionally, the multiple methods and multiple perspectives, meant that rather than obtaining a 'snapshot' of practice, I was able to get a sense of the various influences around actions and events (O'Reilly, 2012, Seale, 1999). My pre-existing knowledge was just one way of sorting through the mass of information gathered from this engagement in the field.

9.1.2 Thick description

Thick description of the setting, people and practices, and the interrelationship between those, can allow readers themselves to judge transferability (Murphy et al., 1998, Seale, 1999). Hazel ward was one ward in one NHS trust and, like all clinical settings, had its own unique culture. However, as documented throughout, Hazel shares many characteristics with other acute NHS settings. When presenting the findings to external clinical and academic audiences, there have been positive

responses that my interpretations resonate widely. Furthermore, I have demonstrated in the thesis that aspects of the findings are supported by national research. These elements suggest that the findings may have utility beyond the setting of Hazel ward and Oakfield Trust.

9.1.3 Theory-specific limitations

In terms of the theories themselves, I have discussed the limitations and strengths of values- and process-based compassion models throughout the thesis. For example, from a process-based perspective, I identified a greater range of compassion-related phenomena than is typical with a values-based approach (Volkmann Simpson et al., 2014). Using a values-based lens helped me to interpret the nursing accounts, and better appreciate that an intrinsic construction of compassion makes care meaningful for many. However, I have also demonstrated that the conceptual specificity of these theories made them inadequate for explaining the broader aspects of the findings.

I incorporated structuration theory to enhance the explanation of the tangle of structural contingencies that gave 'form and shape' (Giddens 1984, p.256) to the everyday experience of compassionate care. However, this theory has been subject to a range of criticisms and Giddens' original work has been

revised considerably (Stones, 2005, Archer, 2010). Many find structuration theory too abstract, and argue that it lacks empirical grounding (Hardcastle et al., 2005, Lock and Strong, 2010, Nairn, 2009). Indeed, some have suggested it is just a collection of others' concepts, as Giddens borrows from Garfinkel, Goffman, Heidegger, Habermas and Foucault (Lock and Strong, 2010, Hardcastle et al., 2005). However, its theoretical hybridity can also be considered a 'skilful synthesis' of ideas, which, in the early 1970s, provided a much-needed bridge to counteract an unproductive dualism in sociological scholarship (Lock and Strong, 2010).

For this study, however, the abstract nature of structuration theory is advantageous. It enabled me to apply Giddens' theoretical framework to the topic of compassion, and use my empirical findings to flesh out that structure. This combination of data and theoretical insights, illuminated the nuances of the relationship between compassionate practice and the structural contingencies, and from this I developed the core finding of 'constrained compassion.'

By highlighting the wider sociopolitical factors however, it can be argued that structuration theory sidelines compassion. Duneier (2002) argues that an over-commitment to macro level explanations can detract from the nuance of micro-level

data. However, for this study, structuration theory augmented the data and highlighted that for many participants practice *in general* was constrained. The findings suggested that the relentless pressure on ward staff inhibited their capacity to enact *any* meaningful care consistently. As I have noted earlier in the thesis, the intense focus on compassion in healthcare at times acts as a smokescreen to obscure the range of organisational, political and social factors affecting the delivery of care. In that sense, Giddens' theory is crucial to incorporate the broader structural factors at play.

A more significant criticism, perhaps, is that Giddens overstates individual agency (Hardcastle et al., 2005). It has been argued that this is part of a wider neglect of power, as the theory fails to consider the influences of gender, race and class, for example (Archer, 2010, Lock and Strong, 2010, den Hond et al., 2012). Instead, structural constraints seem to just 'be', rather than be a product of political interest or agenda (Hardcastle et al., 2005). Furthermore, Giddens' notion of agents transcending and transforming structural constraints (den Hond et al., 2012) does not fit well with my findings. Ward staff were often too overwhelmed with meeting the immediate needs of the service to reflect on how their practice was constrained or to find strategies to transcend it. Nevertheless, there was some evidence of individual

transformative acts, despite the weight of contextual constraints. The frequent relief of suffering, pockets of resistance to bureaucratic practices and, at a wider trust level, introduction of innovative changes, was suggestive of this. Considering the limitations, the application of this theoretical framework has benefited the thesis. It has illuminated the nuances of compassion in the ward setting, and tethered the practice of care to the multiple micro-and macro-level structural constraints, thereby insisting that one cannot be understood without the other.

9.1.4 Design and method-related issues

My failure to equally represent all participant groups can also be considered a limitation. This was due to several factors. The under-represented groups - medical, AHP and corporate staff - were fewer in number, and were on the ward less frequently due to rotation. Therefore my contact with them was much less than the core Hazel staff groups. Nevertheless, even when medics and AHPs were present on the ward, I found it harder to engage and establish rapport with these participants. Medical and AHP staff seemed particularly indifferent to participating, and it would have been valuable to understand why this was. Some participants indicated it was about the methodology of the research. One doctor commented that qualitative research didn't 'produce any

answers' (consultant, field notes). Some participants implied that they felt the topic did not relate to them. For example, a pharmacist commented that she 'didn't really have anything to do with compassion', as she did not have significant patient contact (pharmacist, field notes). This reveals an interesting view of compassion and healthcare roles that would have been illuminating to explore. Nevertheless, more engagement with these groups would have illuminated how they understood their roles in relation to compassion, and would also have enabled more detailed comparison across occupational groups.

The timing of the study was both a weakness and a strength. Its proximity to the release of the Francis report (2013) undoubtedly helped to secure funding for the study, and its high political profile facilitated access to the setting. However, throughout the fieldwork I was frustrated by its heavily loaded nature, as its meaning for many participants was inseparable from the Mid Staffordshire scandal. I came to understand this as part of the data, and this contributed to the sociopolitical aspects of the findings. Nevertheless, it did contribute to some suspicion of and hostility towards the research on the part of staff. It gave many participants a sense that they were being monitored or rated, and that I was trying to catch them out. While this sense reduced over time, ultimately the distinctive context of the study influences the findings.

Lastly, it is crucial to consider how my personal worldview has influenced the research (Murphy et al., 1998, Seale, 1999). I have endeavoured to be explicit about my assumptions throughout and to provide a transparent account of my methods and conduct (O'Reilly, 2012, Pellatt, 2003). A reflexive approach to the research process overall has been a key part of critically analysing my decisions, and accounting for why certain data were chosen, analysed or interpreted as they were (Corbett et al., 2007, Pellatt, 2003).

A reflexive journal has helped in this respect, and I have discussed the role reflexivity played when my son became ill during fieldwork. Reflexive journaling was vital for monitoring how my emotional experience in one hospital affected my research work in another. However, to prevent reflexivity becoming an exercise in narcissistic introspection (Savage, 2000), the process must be recognised as one concerned with power and positioning (Aranda, 2006). One way of achieving sufficient scrutiny is to make the process public (Coughlan and Collins, 2001), although this is both personally and professionally challenging. To this end, I exposed my interpretations to a variety of audiences both formally and informally, including my PPI group, other researchers in the department and key participants. Significant changes in the

study or in my perspective resulted from processing criticism from these sessions, as I discussed in chapter three.

The use of 'deviant cases' and search for alternative explanations for my findings have also strengthened the credibility of the study (Seale, 1999, Murphy et al., 1998). I have demonstrated through the thesis that many researchers interpret poor care differently, for example as a failing of individual staff. I acknowledge the contribution of this work and have engaged with that as a way of further challenging my own interpretations of the data.

9.2 Implications

Within the thesis I have demonstrated that my work is consistent with previous research, particularly the process-based studies conducted by Tierney et al. (2016, 2017a, 2017b), Brown et al. (2014), Crawford et al. (2013) and McPherson et al. (2016). These authors offered a contextualised account of compassion and made similar conclusions that compassionate care is fraught with challenges because of threat or pressure, and multiple contextual constraints.

However, my study is the only one I am aware of that is longitudinal, uses multiple methods and sources, and is both contextualised and informed by compassion-specific theories.

This study therefore makes a novel and valuable contribution to the existing body of work on compassion in healthcare, which has been limited by a lack of relevant empirical research (Crawford et al., 2014). The next section suggests more specifically how the findings can contribute to the areas of policy, research and theory.

9.2.1 Contributions and recommendations

9.2.1.1 Healthcare Policy

The findings of this study raise questions about the current values-based health policy, the government strategy rapidly introduced in response to the Francis inquiry (2013). It suggests that individual staff values are *not* the major barrier to compassion. Instead, a wide range of organisational and operational factors were found to create barriers to compassionate care, even when staff held compassion as a caring ideal. In view of this, and findings from other studies discussed earlier, I argue that the values-based policy is inadequate for improving care in ward settings. Furthermore, it creates additional problems for caring staff and nurses in particular.

For example, the narrow focus on staff values infers that it is the individual principles of the nurse that determines the patient experience of compassionate care. This approach

reduces compassion to a transaction, between the nurse that holds compassion as a fundamental value, and the patient who passively receives it. As well as concealing the nuance and complexity of compassionate engagement, a values focus also separates care from the health context. These findings evidence that the distinctive ward context is inseparable from the enactment and experience of compassionate care and that without taking account of it, the structural constraints and interrelational dynamics are obscured.

Additionally, a values-based approach suggests that nurses, rather than all healthcare professionals, are responsible for the compassionate care of patients. This study demonstrated that *all* those in the ward environment contribute to the interpersonal dynamics of care. Other hospital staff groups not only influence the patient experience, they also shape nursing practice; from the corporate staff translating regulatory demands and government directives into local policy, and the non-nursing professionals treating, informing, equipping and rehabilitating patients, to the support staff fulfilling the vast range of roles to manage, process and enable care on such a large and continuous scale. One problematic effect of neglecting the role these other staff groups play is that their vital contribution to patient care is diminished. Another is that an intolerable burden of responsibility is placed on one

element of the healthcare team. I demonstrated the impact of this burden in the findings with numerous accounts of nurses expressing self-doubt, guilt and failure for inadequate care. These accounts are similar to those currently being articulated in various national media sources (for example Merrifield, 2017b, Tringle, 2018) and have been associated with nurses leaving the NHS in unprecedented numbers.

In light of these findings, healthcare policy aiming to improve the quality of care in NHS hospital wards should shift to take full account of the distinctive context in which it is enacted. This includes the complete range of staff, as well as various organisational and operational constraints that prevent staff from engaging meaningfully with patients. One first step towards this would be to develop policy using a model of compassion which is broad enough to accurately reflect the healthcare environment. The process-based theory of compassion set out in this thesis, which understands the phenomenon as a dynamic relational exchange, enacted between people and their social environment (Kanov et al., 2004, Jazaieri et al., 2013, Lilius et al., 2008, Gilbert, 2009, Crawford et al., 2013) would be appropriate. Rather than a narrow focus on individual values and specific roles, a process-based approach encourages us to see others in the environment as potential sufferers or as extenders of

compassion. This is essential in a vast and challenging healthcare setting to encourage a collective approach to care and a more mindful noticing of, and response to, other's distress.

This collective organisational approach also reduces the pressure on individual care staff to go 'over and above' their normal (and already demanding) occupational role to demonstrate compassion. Instead, organisational processes and polices should be developed in such a way that they either inherently enable compassion to flourish, or at least do not hinder it. Making care the explicit work and goal of the organisation in this way will reduce the need for care staff to battle to provide it.

A process-based approach also understands the context and culture of the environment as a critical barometer for care. I demonstrated that the role and impact of threat in the ward setting was a major factor on care, and the quality of social interaction more generally. It is therefore imperative that long-term and wide-ranging strategies to acknowledge and reduce threat in the ward environment, and to increase the sense of safeness and security for staff. Alongside this, healthcare policy and local trust strategies must articulate these contextual and cultural barriers to compassion, to

reduce the blame directed at nurses and other front line staff for poor care and to improve public understanding of the factors that contribute to it.

The findings suggest that there are some relatively simple ways that individual trusts could begin to take a more practical and collective approach to improving compassionate care. For example, positive engagement from senior levels of the organisation to front line care staff could be achieved via trust-wide computer systems. Using these to send positive messages acknowledging excellent care would provide some regular moments of optimism and reward while at the same time reducing the amount of negative and/or directive messages circulated.

Organisational promotion and enabling of healthy shift patterns and on-shift respite is also urgently required. The study participants often worked in an extremely fatigued or unwell state, and struggled to take adequate breaks or even refreshment. This situation is common in trusts across the country but is damaging to staff well-being as well as unsafe (Cavell Nurses' Trust, 2016, Merrifield 2017b). Trusts can acknowledge the emotional and physical effects of caring work by promoting and facilitating adequate time off and breaks

and by avoiding the expectation that staff must always be 'on stage' (OHT, 2015, p16) while working.

A more substantial strategy, which could address several of these issues, is the provision of mandatory, non-managerial supervision for all nursing staff. Restorative supervision is a formal process of psychosocial staff support, which aims to address individuals' needs in relation to their workload and work environment (Hewison and Sawbridge, 2016). It is a positive supportive system that is emerging as potentially beneficial for ward staff well-being and quality of care (Williams, 2017, Blewitt et al., 2015, McPherson et al., 2016)

Within Oakfield Trust, there was no compulsory non-managerial supervision programme for nursing staff. A non-compulsory model was running but had poor uptake and a lack of trained supervisors. At the time of writing, I had compiled a business case for Oakfield Trust, reviewing their current non-compulsory system of nursing supervision and suggesting a compulsory restorative model. I provided evidence from the literature, existing research and my own findings to suggest how it might contribute to their efforts towards nursing recruitment and retention and their compassionate care agenda. I hope to progress with this and to be able to report on it in future work.

9.2.1.1 Research and theory

In terms of future nursing research, a process-based model for investigating compassion would be similarly beneficial for shifting the focus from individual nursing values to incorporate the many other contextual elements and actors that shape compassionate care. While nurses have the insight and experience to examine the interpersonal aspects of compassionate care, we are also well-placed to illuminate the broader contingencies of ward and hospital culture and how these impact on care practices. Taking this approach to research can ensure an improved balance between values and context in the body of knowledge on compassion, and may expand the evidence base for policy in this field. Furthermore, increased and improved nursing research on the topic would strengthen the professional voice on the issue of compassionate care and in turn, on associated health policy and practice.

It is important to also note the value of the findings on receiving compassion. I described the organisational and psychological work that exists in this area but there is a need to expand investigation on how compassion is received in hospital ward settings. Developing the nursing scholarship on this is crucial to give a more comprehensive understanding of the compassion process generally, but also for staff to be

aware that some individuals may struggle to recognise and receive compassion.

This thesis also demonstrates that theoretically-informed compassion research can be beneficial, and can encourage researchers to articulate the assumptions underpinning their approach to the study, and how they shape the findings. This work also extends nursing scholarship on compassion as a context-dependent process, and points towards future research that can investigate the broader aspects of the phenomenon.

In conclusion, I have taken a cross-disciplinary approach to this constructionist ethnographic study of compassion in the ward setting. I found that a tangle of micro- and macro-level structural contingencies shape the experience of giving, and receiving, compassionate care. I have offered the notion of 'constrained compassion' as a descriptive and explanatory framework for understanding the phenomenon in this context, and have detailed how threat and safety, compromise and cost are inherent in its enactment. I have suggested these findings are transferable to similar settings in other NHS trusts and argued that organisational, social and political factors should be addressed if compassionate healthcare environments are

the goal. This thesis therefore offers an important empirical contribution to the current body of scholarship on compassion.

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Appendices

Appendix 1 Table of studies reviewed

Author (s) and date	Aim	Design and methods	Participant group
Adamson and Dewar (2015)	To examine the use of stories to enhance compassion knowledge and skills	Action research and appreciative inquiry Reflection and use of story	Student nurses (n=5)
Ali and Terry (2017)	To understand how leaders and senior staff in community setting perceive compassionate leadership	Qualitative Semi- structured interviews	Staff in leadership positions (n=11)
Barron et al. (2017)	To describe interpretations and perspectives of compassion in order to develop its meaning	Qualitative Semi-structured interviews	Community mental health nurses (n=9)
Beardsmore and McSherry (2017)	To identify the experiences of staff in relation to the different factors they feel contribute to the culture of the organisation	Qualitative Semi-structured interview	A range of healthcare staff (n=11)
Bramley and Matiti (2014)	To understand how patients experience compassion within nursing care and explore their perceptions of developing compassionate nurses	Qualitative Semi-structured interviews	Hospital in-patients (n=10)
Bray et al. (2014)	To explore qualified health professionals' and pre-registration students' understanding of compassion and the role of health professional education in promoting compassionate care	Mixed methods Surveys and semi-structured interviews	Qualified health professionals (n=155) and students (n=197) from a range of health and social care disciplines

B. Brown et al. (2014)	Examine practitioners' accounts of compassion in their daily work. To explore how they formulated, interpreted and deployed the concept and its concomitant practices in the context of their working lives.	Qualitative interviews analysed using constructionist discourse analysis	Mental health practitioners and students from a range of disciplines in one unit (n=20)
M. Brown et al. (2016)	To investigate the experiences of patients with intellectual disabilities, family and paid carers regarding the role of liaison nurses and the delivery of compassionate, person-centred care	Qualitative Semi-structured interviews and focus groups analysed using Interpretative Phenomenological Analysis	Patients with intellectual disabilities (n=5), their family and paid carers (n=13)
Christiansen et al. (2015)	To explore how health professionals and pre-qualifying healthcare students understand compassionate care and factors that hinder or enable them to practice compassionately	Mixed methods Qualitative interviews and quantitative questionnaire	Qualified staff (n=146) and students (n=166) from a range of health and social care disciplines
Crawford et al. (2013)	To examine what language of compassion is used by acute mental health practitioners, and how threat might be influencing their language choices	Qualitative Corpus-assisted discourse analysis of qualitative interviews	Mental health practitioners and students from a range of disciplines in one unit (n=20)
Crowther et al. (2013)	To explore the experiences of caring for a loved one with end-stage dementia, before and after death.	Qualitative In-depth interviews	Bereaved carers of people with dementia (n=40)

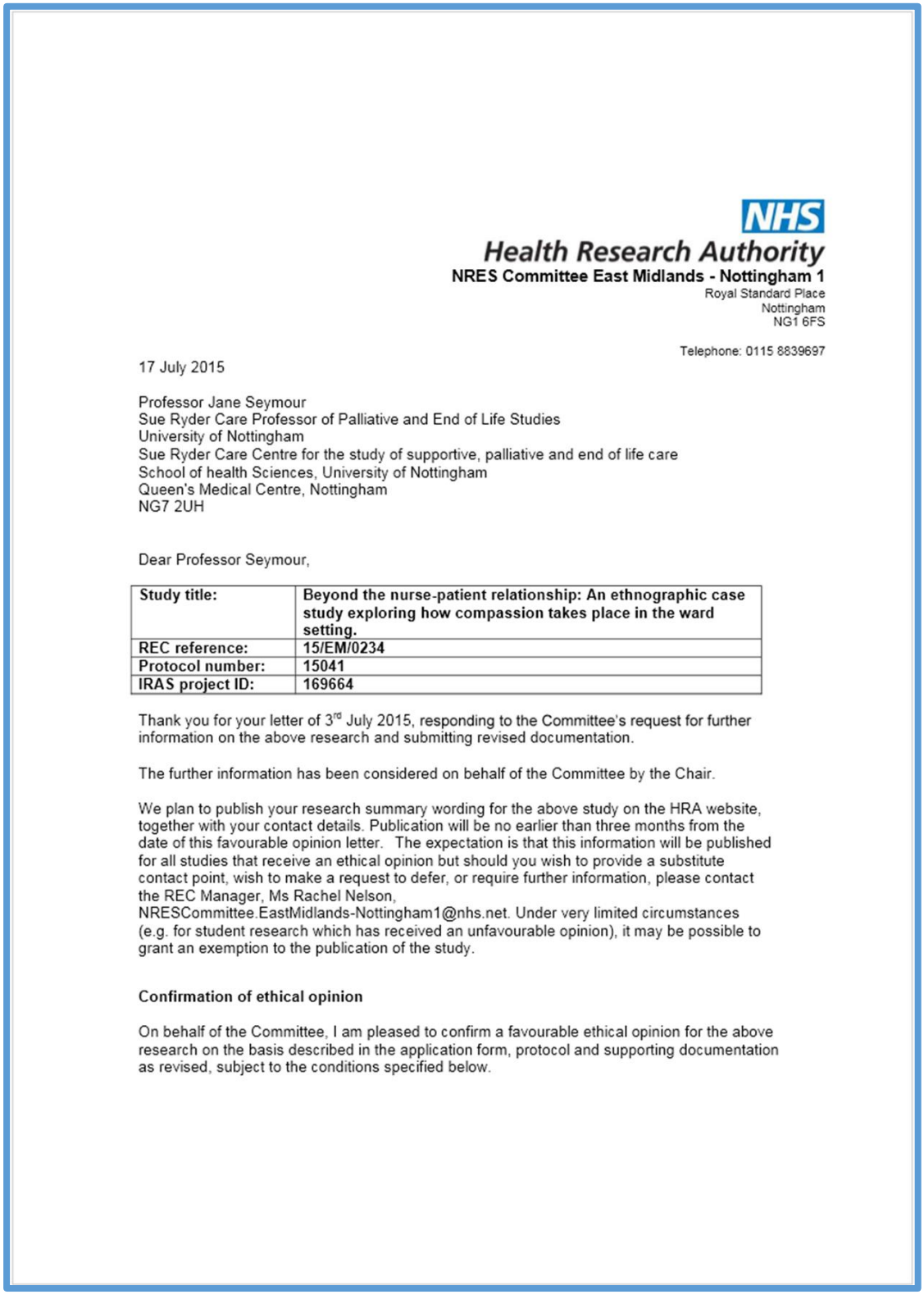
Curtis (2012)	To uncover nurse teachers' experiences and concerns in their preparation of student nurses for compassionate practice	Qualitative In depth interviews using an aesthetic phenomenological approach	Nurse teachers (n=5)
Curtis et al. (2012)	To explore the student nurse experience of socialisation in the 21st century compassionate practice	Mixed method In-depth interviews plus NHS patients and staff survey data	Interview participants were student nurses (n=19) and nurse teachers (n=5). NHS Survey participants were staff (n=290,000) and patients (n=72,000)
Curtis (2014)	To explore student nurse socialisation in compassionate practice.	Qualitative In-depth interviews	Student nurses (n=19)
Curtis et al. (2017)	To develop compassion training for NHS staff, including 'train the trainers' approach; an evaluation of 'compassion lead' roles and a multi-modal compassion toolkit.	Appreciative inquiry Focus groups and interviews	Healthcare workers from range of disciplines in 4 NHS organisations (n=not specified)
Dewar and Cook (2014)	To develop ways to support staff to work together to develop a culture of inquiry where feedback, support and being curious about practice are responded to positively.	Multiple method Action research and appreciative inquiry Methods include questionnaire and semi-structured interviews	Range of staff members Questionnaire participants (n=405) Interview participants (n=65-78% of staff)
Dewar and Mackay (2010)	To explore, develop and articulate strategies that enhanced compassionate relationship centred care in an acute hospital setting, caring for older people	Appreciative inquiry and action research Multiple methods such as participant observation, photo elicitation, group and single interviews, stories	Stories: Staff (n= 10) Students (n= 9) Patients (n= 10) Family (n= 12) Photo elicitation: Staff (n= 16), Patients (n= 2) Families (n= 4))

Dewar and Nolan (2013)	To develop a definition of compassionate relationship-centred care and identify strategies to promote such care in acute hospital settings for older people.	Appreciative inquiry Multiple qualitative methods including participant observation, interviews, storytelling and group discussions	Registered nurses, non-registered care staff, allied health care professionals and medical staff (n=35) patients (n=10) and families (n=12) participated
Dewar et al. (2010)	To explore the experiences of service users to uncover compassionate or dignified practice and develop ways of supporting it	Appreciative Inquiry and action research Emotional touchpoint technique	Patients (n=16) and relatives (n=12)
Durkin et al. (2016)	To measure associations between self-compassion, compassion fatigue, wellbeing, and burnout in community nurses	Quantitative Standardised psychometric questionnaires	Community nurses (n=37)
Horsburgh and Ross (2012)	To explore newly qualified staff nurses' perceptions of compassionate care and factors that facilitate and inhibit its delivery	Qualitative Six focus groups	Student nurses (n=42)
Kneafsey et al. (2015)	To explore key stakeholders' perspectives on compassion in the health care context. To present the 'Framework for Compassionate Interpersonal Relations'	Qualitative Nine focus groups	Academic staff, health care students, clinicians and service users (n=45)
Lloyd and Carson (2011)	Explore mental health users involvement in care	Qualitative Ethnomethodological focus groups (n=5)	Mental health service users (n=30)

McPherson et al. (2016)	To explore the experiences of managing work pressures in front-line NHS staff caring for older adults with dementia and the factors that facilitate or hinder self-compassion and mindfulness.	Qualitative In depth interviews	Nurses and HCAs (n=10)
Papadopoulos et al. (2016)	To develop learning tools aimed at promoting culturally competent compassion	Qualitative Multiple methods	Student nurses (n=not specified)
Smith et al. (2010)	To enhance the experience of relationship centred, compassionate care, and learn from what works well	Action research approach and appreciative inquiry Multiple methods including observation, interviews, emotional touch point process (ETPP), staff interviews and reflective accounts	Senior nurses reflective accounts (n=4) Staff exit interviews (n=37) Patients, relatives and staff (n=not specified) involved in ETPP
Smith et al. (2014)	To explore and respond to the perceptions of nurse lecturers in regard to experiences of compassion in the workplace.	Qualitative Participatory action research Four reflective workshops involving activities such as collage and reflection	Nurse teachers (n=8)
Tierney et al. (2016)	To explore healthcare professionals' views of measuring compassionate care.	Qualitative Semi structured interviews and focus groups	A range of healthcare professionals, including doctors, nurses, dietitians, podiatrists, healthcare assistants and administrators, took part in an interview (n=13) or focus group (n=23)

Tierney et al. (2017)	Explore and advance understanding of compassionate care by considering a critical situation	Semi structured interviews and focus groups (from study above)	Analysed data from a range of healthcare professionals (see participants above)
Tierney et al. (2017)	Explore how compassionate care is enacted and what it means to healthcare professionals (HCPs).	Semi structured interviews and focus groups (from 2016 study above)	Analysed data from a range of healthcare professionals (see participants in 2016 study above)
Waugh and Donaldson (2016)	To explore the learning that occurred from listening to narratives of compassionate care, and to identify students' preferred story formats and other potential uses of such stories	Qualitative Open-ended 7-item questionnaire	Students (n=13)
Waugh et al. (2014)	To identify perceptions of potential attributes and key skills to include in a values based person specification for nursing and midwifery candidates	Quantitative Online survey	Registered midwives and nurses (n=276) and student midwives and nurses (n=226)

Appendix 2 Research Ethics Committee approval letter, pages 1-4



NHS
Health Research Authority
NRES Committee East Midlands - Nottingham 1
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839697

17 July 2015

Professor Jane Seymour
Sue Ryder Care Professor of Palliative and End of Life Studies
University of Nottingham
Sue Ryder Care Centre for the study of supportive, palliative and end of life care
School of health Sciences, University of Nottingham
Queen's Medical Centre, Nottingham
NG7 2UH

Dear Professor Seymour,

Study title:	**Beyond the nurse-patient relationship: An ethnographic case study exploring how compassion takes place in the ward setting.**
REC reference:	**15/EM/0234**
Protocol number:	**15041**
IRAS project ID:	**169664**

Thank you for your letter of 3rd July 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Ms Rachel Nelson, NRESCommittee.EastMidlands-Nottingham1@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management

permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [PRE-OBS SESSION NOTICE CompassionInTheWardSetting Final v1.0 05.05.15]	v1.0	05 May 2015
Copies of advertisement materials for research participants [PATIENT INFORMATION LEAFLET CompassionInTheWardSetting Final v1.0 05.05.15]	v1.1	02 July 2015
Copies of advertisement materials for research participants [POSTER GENERAL INFO CompassionInTheWardSetting Final v1.0 05.05.15]	v1.1	02 July 2015
Copies of advertisement materials for research participants [STAFF STUDY INFO SESSION CompassionInTheWardSetting Final v1.0 05.05.15]	v1.1	02 July 2015
Covering letter on headed paper [COVER LETTER CompassionInTheWardSetting Final v1.0 05.05.15]	v1.0	07 May 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [CERTIFICATE OF INSURANCE CompassonInTheWardSetting Final 1.0 05.05.15]	v1.0	29 July 2014
IRAS Checklist XML [Checklist_08052015]		08 May 2015
Letter from funder [PROOF OF FUNDS CompassionInTheWardSetting Final v1.0 05.05.15]		08 May 2015
Letter from sponsor [SPONSOR LETTER CompassionInTheWardSetting Final 1.0 05.05.15]	v1.0	06 May 2015
Other [PIS STAFF CompassionInTheWardSetting v1.0 05.05.15]	v1.1	02 July 2015
Participant consent form [INTERVIEW CONSENT FORM CompassionInTheWardSetting v1.0 05.05.15]	v1.0	05 May 2015
Participant consent form [AUDIO-DIARY CONSENT FORM CompassionInTheWardSetting v1.0 05.05.15]	v1.1	02 July 2015
Participant information sheet (PIS) [PIS PATIENT&RELATIVE CompassionInTheWardSetting v1.0 05.05.15]	v1.1	02 July 2015
REC Application Form [REC_Form_08052015]		08 May 2015
Referee's report or other scientific critique report [CR REPORT CompassionInTheWardSetting v1.0 05.05.15]		
Research protocol or project proposal [PROTOCOL CompassionInTheWardSetting v1.0 05.05.15]	v1.0	05 May 2015
Summary CV for Chief Investigator (CI) [CI CV CompassionInTheWardSetting Final v1.0 05.05.15]	v1.0	20 October 2014
Summary CV for student [STUDENT CV CompassionInTheWardSettng Final v1.0 05.05.15]	v1.0	20 April 2015
Summary CV for supervisor (student research) [CI CV CompassionInTheWardSetting Final v1.0 05.05.15]	v1.0	20 October 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research

Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

15/EM/0234	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

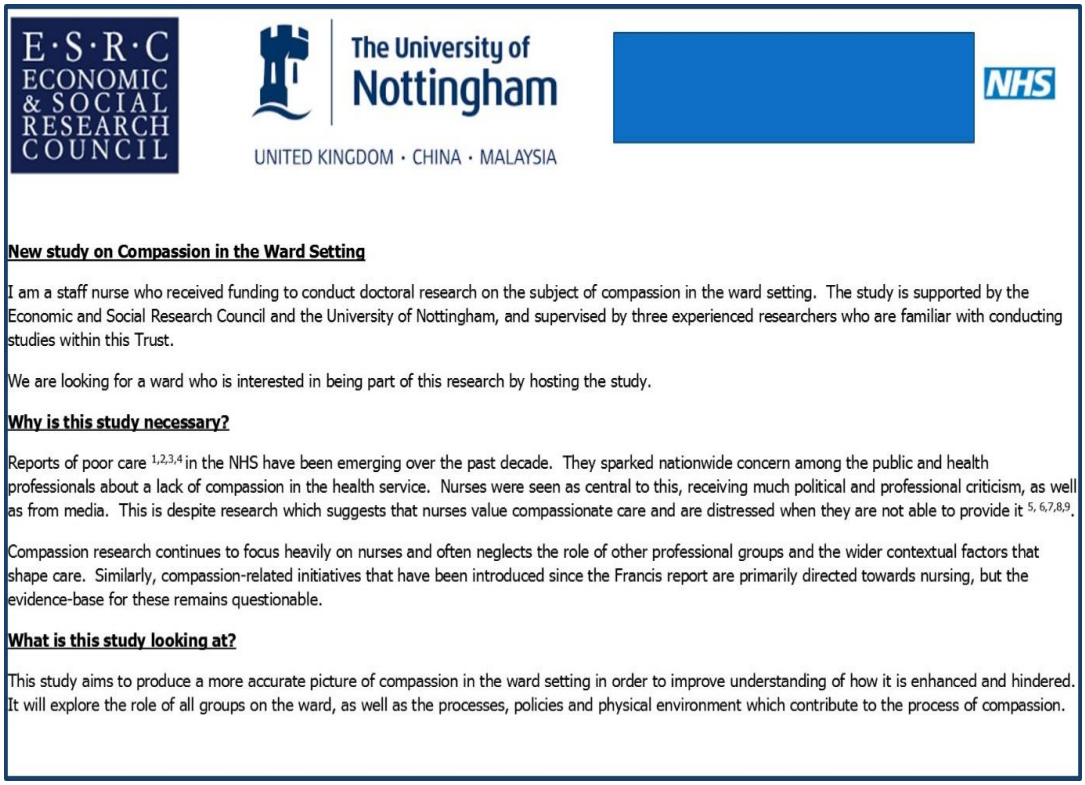
Yours sincerely,



Dr Carl Edwards
Chair

Email: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Appendix 3 Initial recruitment email, pages 1-2 (Redacted)



New study on Compassion in the Ward Setting

I am a staff nurse who received funding to conduct doctoral research on the subject of compassion in the ward setting. The study is supported by the Economic and Social Research Council and the University of Nottingham, and supervised by three experienced researchers who are familiar with conducting studies within this Trust.

We are looking for a ward who is interested in being part of this research by hosting the study.

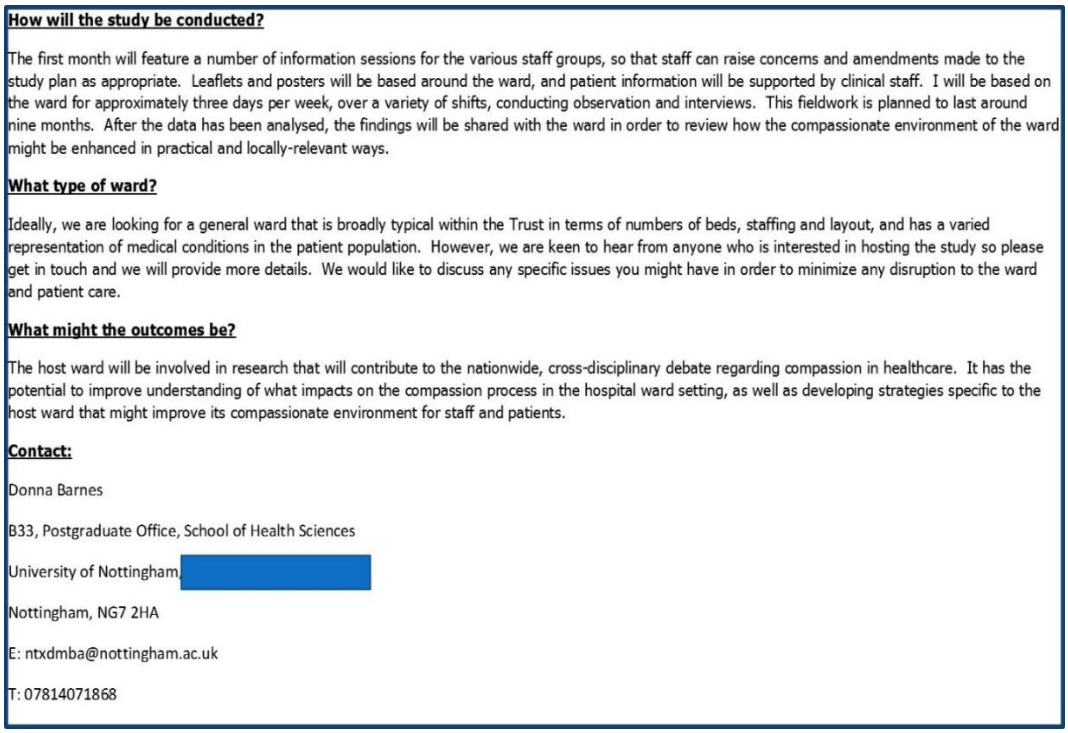
Why is this study necessary?

Reports of poor care [1,2,3,4] in the NHS have been emerging over the past decade. They sparked nationwide concern among the public and health professionals about a lack of compassion in the health service. Nurses were seen as central to this, receiving much political and professional criticism, as well as from media. This is despite research which suggests that nurses value compassionate care and are distressed when they are not able to provide it [5, 6,7,8,9].

Compassion research continues to focus heavily on nurses and often neglects the role of other professional groups and the wider contextual factors that shape care. Similarly, compassion-related initiatives that have been introduced since the Francis report are primarily directed towards nursing, but the evidence-base for these remains questionable.

What is this study looking at?

This study aims to produce a more accurate picture of compassion in the ward setting in order to improve understanding of how it is enhanced and hindered. It will explore the role of all groups on the ward, as well as the processes, policies and physical environment which contribute to the process of compassion.



How will the study be conducted?

The first month will feature a number of information sessions for the various staff groups, so that staff can raise concerns and amendments made to the study plan as appropriate. Leaflets and posters will be based around the ward, and patient information will be supported by clinical staff. I will be based on the ward for approximately three days per week, over a variety of shifts, conducting observation and interviews. This fieldwork is planned to last around nine months. After the data has been analysed, the findings will be shared with the ward in order to review how the compassionate environment of the ward might be enhanced in practical and locally-relevant ways.

What type of ward?

Ideally, we are looking for a general ward that is broadly typical within the Trust in terms of numbers of beds, staffing and layout, and has a varied representation of medical conditions in the patient population. However, we are keen to hear from anyone who is interested in hosting the study so please get in touch and we will provide more details. We would like to discuss any specific issues you might have in order to minimize any disruption to the ward and patient care.

What might the outcomes be?

The host ward will be involved in research that will contribute to the nationwide, cross-disciplinary debate regarding compassion in healthcare. It has the potential to improve understanding of what impacts on the compassion process in the hospital ward setting, as well as developing strategies specific to the host ward that might improve its compassionate environment for staff and patients.

Contact:

Donna Barnes

B33, Postgraduate Office, School of Health Sciences

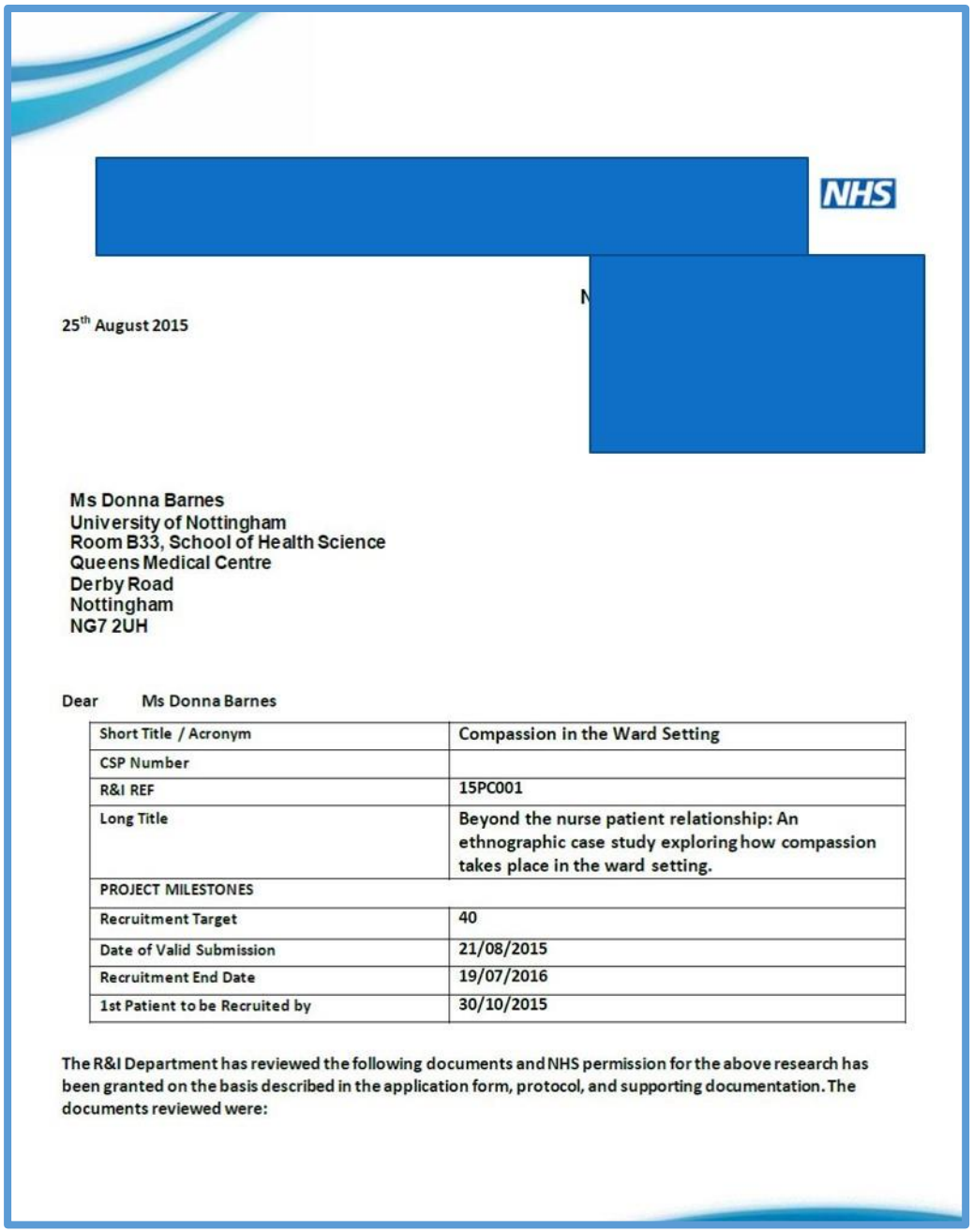
University of Nottingham,

Nottingham, NG7 2HA

E: ntxdmba@nottingham.ac.uk

T: 07814071868

Appendix 4 Trust letter of access, pages 1-4 (Redacted)



[redacted]

NHS

[redacted]

25th August 2015

Ms Donna Barnes
University of Nottingham
Room B33, School of Health Science
Queens Medical Centre
Derby Road
Nottingham
NG7 2UH

Dear Ms Donna Barnes

Short Title / Acronym	Compassion in the Ward Setting
CSP Number	
R&I REF	15PC001
Long Title	Beyond the nurse patient relationship: An ethnographic case study exploring how compassion takes place in the ward setting.
PROJECT MILESTONES	
Recruitment Target	40
Date of Valid Submission	21/08/2015
Recruitment End Date	19/07/2016
1st Patient to be Recruited by	30/10/2015

The R&I Department has reviewed the following documents and NHS permission for the above research has been granted on the basis described in the application form, protocol, and supporting documentation. The documents reviewed were:

Your study now has NHS permission, on the understanding and provision that you will follow the conditions set out below.

Document	Version	Date
Protocol	1.0	05.05.15
Participant Information Sheet (Staff)	1.1	02/07/15
Participant Information Sheet (Relatives/Carers)	1.1	02.07.15
Poster General Info	1.1	02.07.15
Staff info ppt session	1.1	02.07.15
Patient Information Leaflet	1.1	02.07.15
Consent Form (Audio diaries)	1.1	02.07.15
Consent Form (interviews)	1.0	05.05.15
Pre-Obs session notice	1.0	05.05.15

Conditions of Approval

The Principal Investigator is responsible for:

1. **Compliance with all relevant laws, regulations and codes of practice applicable to the trial including but not limited to, the UK Clinical Trials Regulations, Medicines for Human Use (Clinical Trial) Regulations 2004, principles of Good Clinical Practice, the World Medical Association Declaration of Helsinki entitled 'Ethical Principles for Medical Research Involving Human Subjects' (2013 version), the Human Rights Act 1998, the Data Protection Act 1998, the Medicines Act 1968, and the NHS Research Governance Framework for Health and Social Care (version 2 April 2005). Should any of these be revised and reissued this will apply. Copies of the up-to-date regulations are available from the R&I Office or via the R&I website** [redacted]
2. **Submission of study amendments to the Ethics committee and MHRA in accordance with the IRAS guidelines. Amendments and information with regards to changes in study status must be sent to R&I, (this includes changes to the local study team). Within 35 days from the receipt of a valid amendment submission, the R&I department will inform you if the amendment cannot be implemented locally. If no objections are raised NHS permission is valid and the amendment may be implemented.**

   When submitting documents for studies adopted into the NIHR portfolio please send the information to the Clinical Research Network: East Midlands (CRN:EM) [redacted]
   When submitting documents for all other studies please use the em [redacted]
3. **Ensuring all study personnel, not employed by the** [redacted] **ust hold either honorary contracts/letters of ac** [redacted] **cess to any patients or staff, their data, tissue or organs or an** [redacted]

4. For initiating and delivering research in accordance with the Department of Health's Plan for Growth. The first patient, first visit should occur within 70 days from the receipt of a valid submission in R&I. This applies to all studies where :

    i. The research is classed as a "clinical trial "on the IRAS filter page (first 4 categories)

5. Ensuring the research team via an identified individual, collaborates with the department of R&I and the CRN:EM in reporting recruitment data using Documas and the CRN EM Study Tracker.

6. Ensuring that for GTAC-approved studies, the NHS permission is forwarded to GTAC via the sponsor. GTAC should then issue a site authorisation letter which must be received by each site prior to recruitment commencing. A copy of this letter must be forwarded to R&I.

7. Comply with requ[redacted] comply with the Research Governance Framework and other applicable regulations.

8. Record *all* types of adverse events (including Suspected Unexpected Serious Adverse Drug Reaction - SUSARS) in the patient medical records and study documentation and report to the sponsor as required by the protocol.

9. Report any Serious Breach of the UK Clinical Trial regulations in connection with the trial or Serious Breach of the protocol, immediately after becoming aware of the breach to the study sponsor.

10. Reporting any changes to the study to R&I by letter or e mail. These should not be implemented until agreed with R&I.

[redacted]vestigator is responsible for:

i. All duties as detailed in the "Clinical Trial Delegation of Sponsorship responsibilities to Chief Investigator" agreement.

ii. Contacting the sponsor for review of all amendment documentation prior to submission to the HRA and MHRA. Please note that according to HRA and MHRA regulations, all submissions of amendments need to be signed by the authorised sponsor's representative. All relevant documentation should be emailed to[redacted]

iii. Sending copies of the completed Annual Progress Reports, Development Safety Update Reports, and End of Study report required by the Ethics Committee and the MHRA (if appropriate) to the sponsor re-[redacted]

iv. [redacted]Es by completing and sending the *"Serious Adverse Event reporting form"* to R&I (only via fax, e-mail or by hand), within 24hrs of becoming aware of the event. Further guidance can be found in the R&I Adverse Event SOP (SOP-RES-019).

v. Reporting any Serious Breach of the UK Clinical Trial regulations in connection with the trial or Serious Breach of the protocol, immediately after becoming awa[redacted] ther guidance can be found in the R&I Non Compliance and Serious Breach Reporting SOP (SOP-RES-017).

This approval letter constitutes a favourable Site Specific Assessment (SSA) for this site.

If you have any queries regarding the milestones or points detailed in this letter, please contact the Research Project Manager responsible for managing the p[redacted]mation is available [redacted]

Please note that the R&I department maintains a database containing study related information, and personal information about individual investigators e.g. name, address, contact details etc. This information will be managed according to the principles established in the Data Protection Act.

Yours sincerely,



Dr Maria Koufali
Deputy Director Research and Innovation
[redacted]

Appendix 5 Patient information leaflet displayed across Hazel ward and given to patients and relatives on admission, pages 1-4



The University of Nottingham

UNITED KINGDOM · CHINA · MALAYSIA

Compassion in the Ward Setting: a study taking place on Hazel Ward

Information for patients, relatives and visitors about research taking place on the ward.

This document can be provided in different languages and formats. For more information please contact:

Donna Barnes
B33, Postgraduate Office
School of Health Sciences
University of Nottingham
Nottingham, NG7 2HA
Phone:07944684335

Public information

Information about the study

A study is taking place on Hazel ward. It has been developed by our research team at the University of Nottingham and is funded by the Economic and Social Research Council. I am the principal researcher of the team, Donna Barnes. I am a staff nurse with 12 years experience and I am interested in how we can enhance compassion in healthcare settings.

The study will begin in July 2015 and last for12 months. The study will not interrupt the work of staff or the care of patients. These remain a priority for the ward.

What is the aim of the study?

A lack of compassion in healthcare has become a major concern for both patients and staff in the NHS. Attempts to improve this situation have resulted in a number of changes to healthcare practice. However, there is little research to support these changes and it remains unclear how compassion can best be incorporated into the complex clinical environment. In particular, there is a lack of research which examines compassion in the ward setting and which considers the contribution of the many groups and elements within it.

This study aims to examine these groups and elements in order to improve our understanding of how compassion takes place in the ward setting.

2

Do I have to take part?

Hazel ward supports this study because the information gathered can help to enhance compassion on the ward for all those working and being cared for in it. We feel that the experience of patients and their relatives or carers can contribute much to this important research. However, you are not obligated to take part. If you choose not to participate, your care, or that of your relative, will not be affected in any way.

How will information be gathered?

This study involves interviews and observation of the routine ward activity.

Observation sessions will take place three times per week, at various times of the day and night. Notices around the ward will tell you that a session is taking place. If you, or your relative feel uncomfortable with the session, please voice your concern to me or a staff member. I will discuss the situation with you and find an acceptable alternative. For example, it may be appropriate to continue observing the nearby area. Or it may be preferable for me to move to different part of the ward. If you or your relative wanted to opt-out completely, I could also pause or stop the observation session and re-schedule for another time.

Contacts

I am the principal researcher, Donna Barnes. Please feel free to approach me at any time on the ward to discuss the study.



Alternatively, you can leave a message for me at reception, call 07944684335 or email ntxdmba@nottingham.ac.uk. f you prefer, the ward manager is also happy to discuss the study.

Feedback

We appreciate and encourage feedback. If you need advice or are concerned about any aspect of care or treatment please speak to a member of staff or contact the Patient Advice and Liaison Service (PALS):

Freephone: 0800 183 0204
From a mobile or abroad: 0115 924 9924 ext 65412 or 62301

Appendix 6 Patient information leaflet

The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA
Faculty of Medicine and Health Sciences
Office of Head of School
School of Health Sciences

A Floor
South Block Link
Queen's Medical Centre
Nottingham
NG7 2HA

Tel +44 (0)115 951 5151
Fax +44 (0)115 823 1208

Participant Information Sheet
Patient and relative/carer participants
(Final version 1.1: 02/07/15)

Beyond the nurse-patient relationship: An ethnographic case study exploring how compassion takes place in the ward setting.

Name of Researchers: Professor Jane Seymour (Chief Investigator)
Professor Paul Crawford (Co-investigator)
Dr Joanne Cooper (Co-investigator)
Donna Barnes (Principal Researcher)

I would like to invite you to take part in a research study being conducted by me and my colleagues. Before you decide I would like you to understand why the research is being done and what it would involve for you. As the Principal Researcher who will be conducting the study on the ward, I am keen to discuss any aspect of the research that may not be clear and answer any concerns you may have. You are welcome to approach me on the ward, leave a message for me at the reception or use the contact details provided at the end of this document. The ward manager is also happy to talk about the study with you, and you are free to discuss it with others if you wish.

What is the purpose of the study?
A lack of compassion in healthcare has become a major concern for both patients and staff in the NHS. Attempts to improve this situation have resulted in a number of changes to healthcare practice. However, there is little research to support these changes and it remains unclear how compassion can best be incorporated into the complex clinical environment. In particular, there is little research which examines compassion in the ward setting and which considers the contribution of the many groups and elements within this unit.

The study has been designed to examine these groups and elements in order to improve our understanding of how compassion takes place in the ward setting. I will use the information gathered to develop strategies with staff and patients to enhance compassion on the ward for all those within it.

Why have I been invited?
You are being invited to take part because your experience as either a patient or a relative/carer of a patient on this ward, can improve understanding and knowledge of compassion in this setting. I am inviting all who are connected with the ward (all staff groups, patients and relatives/carers) to take part, so that I can obtain as comprehensive a picture as possible.

Do I have to take part?
Although the ward has agreed to support the study, you are free to decide whether or not to take part. If you decide you would **not** like to participate, this will be confidential and there will be no impact on your care, or that of your relative, as a result. If you **do** decide to take part, you remain free to withdraw at any time, permanently or temporarily, and without giving a reason. This would not affect your care in any way.

If you do decide to take part you will be given this information sheet to keep. This study involves a number of different research activities and this sheet describes what is involved in each. This may help you decide which, if any, you wish to be involved in.

How will this study be conducted?
The four ways of collecting information for this study will be:

- Observation of the routine ward activity
- Interviews with some members of staff, patients and relatives
- Audio-diaries, recorded by some staff, patients and relatives about their thoughts and experiences of compassion
- Analysis of different ward documents to find out more about the organisation of the ward and the Trust.

These methods will give a broad view of how compassion takes place in the ward setting. This will help to show how all individuals on the ward, as well as the procedures, policies and physical environment of the unit, contribute to the process of compassion.

The study will last between nine and twelve months and I will be present on the ward at various times of the day or night, depending on the research activity at that time. I am not permitted to be involved in patient care but I can help with non-clinical errands such as taking refreshments to patients or collecting things from other departments while on the ward.

What will happen to me if I take part?
This will depend on the research activities that you decide to participate in. Details of the main activities are outlined below.

1. Observation

When observation sessions take place, I will be noting the routine activity of the ward, rather than focusing on individuals. The purpose of the observation is to gain insight into general daily practice and how this contributes to the process of compassion in this particular setting. I will make hand-written notes which will be confidential, and will not identify anyone by name. Observation sessions should in no way interfere with your care or that of your relative.

I will mainly observe from public areas of the ward such as the nurses' station or main corridors. I will also occasionally ask to shadow a staff member for some part of their shift, observe ward rounds or observe a care interaction between staff and patients/relatives. However, you are free to decline

this without giving a reason. I will not ask to observe any intimate care, or follow anyone to private areas of the ward without permission.

Rather than collecting written consent for the observation sessions, an opt-out process will be used. This means that if you are not happy to be observed, you need to communicate this to myself otherwise I will assume you have no concerns about the observation session at that time.

You can opt-out at any time, either before or during a session. Every observation session will be pre-arranged at least 24 hours beforehand. I will also report to the nurse-in-charge immediately before each session and put up notices to say the session is in progress. Additionally, I will frequently check that all present are happy with the observation taking place, and look for any non-verbal signs of concern.

If you do raise any concerns, I will discuss the situation with you to see if it is possible to find an acceptable alternative. For example, it may be appropriate to continue observing the nearby area. Or it may be preferable for me to move to different part of the ward. If you or your relative wanted to opt-out completely, I could also pause or stop the observation session and re-schedule for another time.

1. Interviews

You may be asked if you would like to take part in an interview. If you agree, I will go through an interview consent form with you and you will be asked to sign this prior to the interview taking place.

You will be invited to attend two 30-60 minute sessions, a first interview and a follow-up interview two months later. These will be held either within a private room on the ward, a private room elsewhere in the hospital or at an alternative venue that is convenient for you. You will be asked questions about your perceptions of compassion and experiences you may have had that relate to this.

If you do not wish to answer any of the questions during the interview, you may say so and I will move on to another question. You may ask for the interview to be terminated at any time. No one else will be present (unless you would like someone else to be there). The entire interview will be digitally voice-recorded, and then typed-up by me. No one will be identified by name.

2. Audio-diaries

You may be asked if you would like to take part in keeping an audio-diary. If you agree, I will go through a consent form with you and you will be asked to sign this prior to the audio-diary commencing. I will also explain the recording device to you and how to create the diary.

You can then take the recorder to your home or side-room on the ward, and can keep it for two months. During this time, you can record diary entries on your perceptions and experiences of compassion in the ward setting, as often as is convenient for you. A prompt card will be provided if you wish but you may talk about whatever you feel is relevant.

You are encouraged to record your diary entries in a private place. If anyone other than you is inadvertently recorded, this will be disregarded by the researcher. You can edit and delete passages as you wish and there will also be a period of two weeks after the return of the device when you can contact me to edit or delete passages if necessary.

My contact details will be provided and I can be contacted at any time if you need guidance with the diary or if any of the issues you have recorded make you feel upset or in need of support. When you return the diary, there is also an opportunity for us to meet to talk about your experience of keeping the diary. I will then type-up the recordings. You will not be identified by name in this, and neither will anyone else that is mentioned on the tape.

Expenses and payments
Participants will not be paid to participate in the study but travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?
There is a very slight risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable or possibly upset talking about the topic. However, I do not wish for this to happen. You may ask for any research activity to stop at any time. You do not have to answer any questions if doing so would make you feel uncomfortable. I will be available to discuss any concerns openly if more clarification is needed.

What are the possible benefits of taking part?
I cannot promise the study will help you directly, but the findings may show what helps and hinders compassion in the ward setting. This may help to inform the Trust of how compassion can best be incorporated into the challenging environment of the hospital ward setting.

What happens when the research study stops?
When all the information has been collected, I will analyse it with support from the chief and co-investigators. I hope to review the findings with you and patient representatives in order to develop ways of improving the compassionate environment of the Trust.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. My contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting The Patient Advice and Liaison Service, NUH NHS Trust, c/o PALS, Freepost, NEA 14614, Nottingham NG7 1BR. You can also call them on 0800 183 0204 (free from a landline) or 0115 924 9924 ext 65412. Alternatively, you can email: pals@nuh.nhs.uk

Will my taking part in the study be kept confidential?
I will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and they will do their best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, and only members of the research team will have access to your personal data.

The information collected during the study is confidential. However should you disclose anything which I feel puts you or anyone else at any risk then I may feel it necessary to report this to the appropriate people.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your care being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis. This is because once the data has been entered onto the secure computer system because it has been made anonymous and the data analyses draws together information provided by all participants it becomes impractical to extract and remove individual data from the system.

What will happen to the results of the research study?
A report of the study results will be made available for the ward which you will be able to access. You can also contact me directly for updates or the report. The findings will be shared within the Trust and are likely to be presented and published in conferences and journals so that other interested people may learn from the research. The results will also be published as a doctoral thesis in Autumn 2017.

At all stages of this process, personal details will be removed and every effort will be made to ensure information is not attributable to participants in any way.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is being funded by the Economic and Social Research Council.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by East Midlands Research Ethics Committee.

Further information and contact details

Principal researcher:

Donna Barnes
B33, Postgraduate Office
School of Health Sciences,
University of Nottingham
Queen's Medical Centre
Nottingham
NG7 2HA
Phone: 07944684335
Email: ntxdmba@nottingham.ac.uk

Chief investigator:

Jane Seymour
Sue Ryder Care Professor in Palliative and End of Life Studies
School of Health Sciences
University of Nottingham
Queen's Medical Centre
Nottingham
NG7 2HA
Phone: 00 44 (0)115 8231202
Email:
jane.seymour@nottingham.ac.uk

Appendix 7 Consent form for interviews

The University of Nottingham

Faculty of Medicine and Health Sciences
Office of Head of School
School of Health Sciences

A Floor
South Block Link
Queen's Medical Centre
Nottingham
NG7 2HA

Tel +44 (0)115 951 5151
Fax +44 (0)115 823 1208

CONSENT FORM FOR INTERVIEWS
Final version 1.0: date 05/05/15

Beyond the nurse-patient relationship: An ethnographic case study exploring how compassion takes place in the ward setting.

REC ref: 15/EM/0234

Name of Researcher: Donna Barnes

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1.0 dated 05/05/2015 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded using a digital voice recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself or criminal behaviour. ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes.

Appendix 8 Example of topic guide for interviews

Short study title: Compassion in the Ward Setting

Topic guide for in-depth open interviews

All participants

- What does compassion mean to you personally?
- Does it feature prominently in your everyday life?
- What does it look like to you? Can you give me an example or scenario?
- In that scenario, who is compassion being extended to? /who is extending it/receiving it?
- Do you feel that certain people/groups of people have a particular responsibility to extend compassion to others?
- Thinking of this/healthcare/clinical setting specifically-does that make a difference? Does compassion look different? Are there different responsibilities/expectations? How?
- What are your experiences of care in hospital wards/this ward?
- What do you think led to/created that type of/particular experience
- Have you experienced/seen any any excellent care? Can you describe?

Staff

- Can you tell me what are the first things you think of when you are planning your day/what are the factors that shape your working day?
- What would you say are the main priorities in the organisation?
- How do you feel at the end of a shift?
- Do you ever feel troublesome emotions at work? What do these tend to be connected to? How do you manage them?
- Do you find it easy to relate compassionately to others in your environment? What sort of circumstances help/hinder?
- Would you describe your practice/care as compassionate? Is this static or does it change according to circumstance?
- Do you feel you receive compassion in your working day? Can you describe a scenario? What is the effect of this?
- Do you have thoughts on the idea of self-compassion?