

Title: An exploration of the relationship between professional wellbeing and caring. A comparative study of nurses and physiotherapists in NHS trauma care.

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Key Phrases:

- There is growing concern about lack of compassion in nursing
- Injured patients interviewed about their care suggested physiotherapists were more caring than nurses
- Nurses and physiotherapists providing trauma care were interviewed about their perspective on the provision of care
- Nurses felt 'under siege' and that caring was frequently subordinate to other demands
- Physiotherapists felt fortunate that they could currently provide caring care but that this was under threat
- Comparisons between these staff groups were used to make recommendations for nursing practice

Key words: Nursing, physiotherapy, compassion, caring, trauma

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Abstract

There is growing concern about lack of compassion in nursing. In patient accounts collected for the Impact of Injuries study physiotherapists were generally described as caring while nursing care was less consistent and sometimes uncaring. Semi-structured interviews with 11 physiotherapists and 12 nurses in 4 English hospitals were completed in 2012 to obtain their perspectives on the provision of care. Physiotherapists presented a distinct identity with caring both integral to the role and sustained by structural and organisational factors. Nurses had a diffuse identity with limited control within a medical and business model of care. They appeared 'under siege' and were nostalgic for caring which was frequently subordinate to other demands. Both nurses and physiotherapists faced challenges but nurses in particular felt the context of their work was not conducive to caring. Comparisons between these professions informed recommendations to improve nursing practice.

Introduction

There is mounting concern about lack of compassion in nursing (Hehir, 2013; BBC, 2012; Boorman, 2009) and evidence of failings in care (Francis, 2010). Previous research has attempted to measure and describe the problem (Poghosyan et al, 2010; Gibbons, 2010; Juthberg et al, 2010; Lund, 2008) and successive initiatives introduced to raise standards (NHS Commissioning board, 2012, Prime Minister's Commission, 2010). Patient experiences of care (as yet unreported) gathered by the Impact of Injuries study (Kendrick *et al*, 2011) suggest uncaring nursing is not uncommon and that other professions such as physiotherapy are more caring. In this study injured patients frequently mention physiotherapists in follow-up and described their care as individualised, holistic and caring. Nurses are often absent from their accounts. When mentioned their standards of care are less consistent and sometimes uncaring. For some patients nursing care appears to have exaggerated or even eclipsed the trauma of injury. One participant concluded '*they looked after my leg but they didn't look*

after me' another reported shouting out in frustration and pain *'I don't feel as though I'm being cared for.'* These negative experiences were most frequently attributed to distant, depersonalised or insensitive nursing⁽¹⁾. These differences in accounts of physiotherapy and nursing care suggest a growing divide between their ability to provide emotionally supportive care.

Background

Caring is difficult to define (Sargent, 2012) especially within caring professions where it is both moral endeavour and occupational requirement. Although studied from a range of ontological and epistemological perspectives, there is little consensus on its meaning (Morse *et al*, 1990). However caring is still regarded as a core value and central to academic, media and public discourse on nursing (Sargent, 2012). There is less debate about caring within other disciplines such as physiotherapy. Uncaring has more definite parameters including 'incompetence, indifference, lack of trust, mutual avoidance and disconnection' or over dependence on instrumentation (Wiman and Winkblad, 2004).

Ambiguity about the concept of caring within nursing leads to different perspectives on variations in care. Successive large quantitative studies have identified organisational and professional variables influencing standards of care such as; training (Gibbons, 2010), mentoring (Race and Skees, 2010), burn-out (Poghosyan *et al*, 2010), service duration (Iglesias *et al*, 2009) clinical leadership (Lund, 2008), workload (Aitken *et al*, 2008) and organisational culture (Rytterstrom *et al*, 2008). These studies view caring as a measurable homogenous construct which can be taught or instilled through appropriate supervision (Evans *et al*, 2008).

⁽¹⁾ There were no accounts of inhumane or abusive care neither of which are the focus of this study

Whilst aiding understanding of the extent and universality of the problem, they largely fail to address the personal and contextual nature of caring or interventions to effect change.

An alternative body of research uses a psychoanalytical perspective to understand the occupational strains of nursing on the individual (Stickley and Freshwater, 2002) and views caring as a personal and variable construct (Evans et al, 2008). Stemming from Menzies (1959) work they use psychoanalytical theory to explore psychological conflicts in nursing and qualitative methodologies to focus on issues such as the motivation for choosing nursing as a profession (Stickley and Freshwater 2002), defensive strategies for managing patient's emotional needs (Fulton, 2008), or experiential avoidance as a coping strategy (Hilliard and O'Neill, 2012). By focussing on the individual these studies may neglect the context of care and mechanism by which individual, professional and organisational factors interact.

Studies using the concepts of 'Stress of Conscience' (Glasberg et al, 2007; Juthberg et al, 2010) and 'moral distress' (Corley, 2002) provide opportunities to understand this mechanism and for comparisons between professional groups. These propose that moral distress or troubled conscience emerges when individuals 'face a situation with contradictory demands, are hindered from taking action, or act in a way that they consider to be wrong or not good'(Corley, 2002) and that the larger the gap between expectations and reality the greater the risk of burn-out. They therefore articulate a means by which external stressors and internal moral conflict can inhibit caring especially in more conscientious and motivated staff.

Many of these studies stem from different countries and do not explore the psychological or occupational adaptation required to function effectively in the NHS or make comparisons between staff groups. This independent study is part of a nested qualitative study within the Impact of Injuries study (Kendrick *et al*, 2011)(the parent study) a large multi-site NIHR funded East Midlands Collaboration for Leadership in Applied Health Research and Care study of the longer-term impact of unintended injury on the individual, their family, the NHS and society. This embedded study will expand on these emergent findings, contrast the situation of nurses and physiotherapists in the NHS and contribute patient and service provider perspectives on the same context of care.

Research questions;

- 1) Are the challenges facing nurses and physiotherapists different?
- 2) Do personal, professional and organisational factors differently affect these professions' ability to care?
- 3) How could this knowledge improve understanding of the patient experience or explain the antecedents of uncaring care?
- 4) What recommendations can be made to improve nursing practice?

Method

The Impact of Injuries study (2010-2013) included semi-structured interviews with service providers responsible for trauma care to explore; 1) service provision; 2) recent changes; 3) the needs of injured patients; 4) evaluation of services. For this embedded study further questions relating to personal, professional and organisational barriers and facilitators to care were added to service provider interview topic guides, for example;

Q. Some staff feel there are times when they can't give the kind of care they would ideally like to (Prompts; Do you find this? How does it affect you? Can you give me any examples? Has this changed over time? What helps you to give the care you'd ideally like to? What hinders you from giving the care you'd ideally like to?)

The amended topic guide was given ethical approval for use in all 4 study sites (Bristol, Nottingham, Loughborough/Leicester and Surrey). A qualitative approach was chosen to enable service providers to expand on the lived experience of working in NHS trauma care.

The sampling process was pre-defined by the parent study protocol (Kendrick *et al*, 2011). Service providers were selected to capture key services on the basis of injured patients' reported service use and sampled purposively to include both clinical and managerial staff. Nurses and physiotherapists who fitted the sampling criteria in each trust were identified by managers or embedded research nurses and invited to participate by postal or e-mail invitation. Study information and a reply slip were supplied. Contact was made by telephone to discuss the study and arrange a meeting. Signed informed consent was obtained at the time of the interview.

Those recruited completed a semi-structured interview following the study topic guide with additional questions. Interviews lasted approximately 1-1.5 hours and were taped with participant consent. They took place on NHS premises in a quiet neutral space where confidentiality could be assured. The 4 sites are demographically and geographically diverse. The study researchers conducting interviews have a variety of clinical and/or

academic backgrounds. All interviews were transcribed centrally. Notes on interview setting, progress and participant characteristics were documented by researchers. Interviews were analysed using thematic analysis following the methodology outlined in Braun & Clarke (2006) supported by Nvivo software. This involved a process of iterative cycles taking 5 months during which the primary researcher identified and refined key themes arising in the interviews (and noted divergent information). These themes were further refined and validated by researchers from 2 other sites. Finally a nurse and physiotherapist outside the study were asked to comment on whether summarised findings reflected their views, feelings, and experiences to test the credibility and transferability of findings (Ritchie and Lewis, 2010).

Sample characteristics

11 physiotherapists and 12 nurses were interviewed. This sample size was pre-determined by the parent study but there was consensus that saturation had also been reached (the point at which additional information contributes little or no new understanding; Green & Thorogood (2009)). All participants were involved in trauma care. Nurses ranged from entry level qualified nurses, to those with some team management or service level management roles (8 were above entry level). Most Physiotherapists had mixed clinical and managerial roles and were at an equivalent grade to nurse team managers (8 of 11 were Out-patient Department (OPD) based). Participants' ages reflected national statistics for the two professional groups; most were between 30-50 years and all female. Duration of service ranged from 2-36 years, among physiotherapists the majority had been employed 8-10 years while 5 of the nurses had >20 years' service duration. More detailed demographic data was not collected in accordance with the parent study protocol.

Analysis of data from nurse and physiotherapist interviews suggested the following broad themes to inform comparisons between roles; 1) identity and role definition; 2) expectations versus reality; 3) patient and time pressures; 4) individual versus task orientation; 5) rewards and job satisfaction; 6) support and training; 7) evaluation of services; 8) internal vs. external control and change. To ensure participants could speak freely and maintain anonymity quotes below are not attributed to individuals but were selected from a range of participants.

Findings

1) Identity and role definition

Nurses appeared 'under siege' and used terms such as 'battle' 'struggle' and 'survival' to describe a rapidly changing, diffuse and demanding role.

'You do have to put up this kind of hard exterior almost just to survive'.

Caring was frequently subordinate to management, medical priorities, paperwork and external targets. Nurses worked at full capacity or above with little flexibility to react to changes in workload and staff.

'We can't seem to cope with the peaks in demand ... we're constantly fighting... you have no flexibility.'

Physiotherapists on the other hand used terms such as ‘lucky’ and ‘fortunate’ to describe their current position in the NHS which they valued but felt was under considerable threat.

‘I think at the moment we’re lucky that we haven’t had drivers that have limited numbers of treatments and what we can and can’t see’

Physiotherapists presented a distinct and cohesive identity. Extended roles were regarded positively and as likely to improve patient outcomes. OPD physiotherapy appeared to benefit from relatively stable staff groups and physical distance from the medical hierarchy.

2) Expectations vs reality

Nurses felt many of the tasks expected of them did not require a nursing qualification and detracted from caring and clinical input. Enthusiasm for role extension was mixed.

‘There’s just so many things you don’t need to be a nurse to do. I don’t need to be a qualified nurse to tick a few audits..... if some of those things were taken off me then I would be able to support the team better on the ward and the patients better’.

They exhibited a pervasive nostalgia for caring and a tangible weariness which combined to give a sense that the realities of practice were very different to internal or external expectations. Band 7 or higher nurses spent most of their time on managerial tasks including daily adjustment of skill mix to counteract sickness and staff shortages. They regretted limited time for clinical practice, patient contact and mentoring staff which reduced their impact on quality of care.

'I enjoy very much the bedside nursing and I don't have much opportunity to do that anymore, so I guess my personal expectations, I would like to be given more bedside care ... because I think I can obviously make quite a lot of difference'.

Physiotherapist's expectations appeared more congruous with the realities of practice. Those with managerial roles retained significant clinical functions. However demand and pressures had increased over time and the workload could be unpredictable, stressful and hard to manage. Physiotherapists had some flexibility to accommodate such changes but voiced considerable anxiety that further cuts would affect standards of care.

'So I guess the only concern is ... that you know the next change would be not so helpful... you want to do the best for the patients but often you feel that kind of change is looming that wont.'

3) Patient and time pressures

Nurses commented on the fast throughput of patients and constant pressure to move people on to meet targets or free space. This inhibited formation of therapeutic relationships and continuity of care. They acknowledged sometimes avoiding patients' questions to meet other deadlines and struggled to connect fragmented services to manage the patients' NHS journey and co-ordinate care.

'I think the pressures on staff to get patients out of hospital is so rapid that we don't necessarily give them as much time just to talk through ... there are pressures on the bed and the staff know it and so you daren't ask a question in case you get held up'.

Physiotherapists described funding constraints which affected the range of treatments they could offer and felt they often filled gaps in services (e.g. psychological support). However there was a sense that their service was generally valued and its benefits understood

'They don't try and pull staff away at all which is good because they know how critical it really is to the organisation ... they're very promoting of it.'

4) Individual vs task orientation

Nurses found that task orientated care was sometimes essential to manage the workload. Tasks also lessened the emotional costs of caring and offered a means to avoid patient demands they lacked capacity to address. Nurses frequently felt unable to respond to longer term or holistic needs due to organisational emphasis on short-term goals (e.g discharge). They hoped that other services would address them instead.

'It's just easier just getting your head down and doing the tasks. During busy times especially just knowing that you've done this, this and this, right next this, this and this next. It's almost like once you've done the task then somebody else can care about the kind of emotional side of it.'

They revealed extensive knowledge about the needs of trauma patients but felt unable to use the breadth of their knowledge in practice. Their accounts made frequent reference to guidelines, targets and audit (against which performance was assessed); patients' individual needs were mentioned less often.

'Every patient has to have a forms assessment... a bed rounds assessment... a mental capacity assessment ... otherwise you fail on that document when I do my documentation audit.'

'It's just all been streamlined and there's a protocol for pretty much everything'.

Physiotherapist's accounts contained little reference to guidelines or protocol and emphasised patient individuality, independent professional knowledge and research. OPD Physiotherapists in particular felt generally able to deliver holistic individualised care and to decide on treatment protocols in collaboration with patients.

Trauma's not like elective orthopaedics where it's very protocol driven, it's very individual so obviously we'll give them exercise and advice based on very individual things.'

5) Rewards & job satisfaction

Nurses had chosen Trauma and Orthopaedics nursing because they enjoyed the challenge, variety and potential to make people better. However in practice rewards appeared limited. Conflicting demands for quality and economic efficiency created significant individual and professional tensions. Rapid throughput of patients prevented nurses from seeing the outcomes of their care.

'You don't actually get to see the consequences of what you've done and never really get to find out ...so I think people burn out because they don't get any gratification.'

Physiotherapists generally enjoyed the challenges of their role and had considerable job satisfaction. This was supported by continuity, time and clinical support within the team.

Observing patients recover over time was rewarding (although those with intractable problems could be draining). Emotional strains were mitigated by doing a good job and making a difference. Physiotherapists could use their clinical judgement to identify and target care at patients who were most likely to benefit.

'That's my interest really is being able to get the right treatment to the right bit of them at the right time. It's a challenge you know to do that and I like to see the results. So you know the improvements is rewarding'

6) Support and training

Nurses found the proportion of elderly patients with complex needs and/or dementia made the workload increasingly heavy, demanding and unremitting. They found it difficult to simultaneously address the needs of this population and younger patients in the same environment. Their work was emotionally and physically demanding. Nurses encountered patient distress or aggression on a regular basis with limited resource. Informal support within the team was important but there was little formal or consistent supervision or mentoring.

There is support, but minimal support if you know who and where to get it'

Nurses found little time for self-development or training. Learning opportunities provided by quieter periods were frequently used to address staff shortages elsewhere.

'Staff are pulled where they need to be pulled so as soon as there's a lull there's still not time to be able to ... you know learn'

Physiotherapists described structured pathways for career progression, mentoring and support. Most referred to current research and/or research activity. The job was emotionally demanding but they were well supported by colleagues and senior staff, some had access to psychologists.

'We also have quite a good mentoring structure so having the opportunity to spend time talking through challenging patients with someone more senior'

7) Evaluation of services

Nurses felt unable to always give their ideal standards of care and many evaluated aspects of the care they gave as substandard.

'It's not that we fail... but we don't do as well as I think we should do.'

This led to guilt, anxiety and lack of job satisfaction. However they felt they gave the best they could with the resources available.

'We feel guilty that we really want to help the patient... get the best care they can ... it's a catch 22 situation we will try and support everybody but we can't always.'

Physiotherapists rated their standards of care as largely good. However they regretted how little control they had over access to their service and felt some patients missed out.

'I think they get a good service here. I don't think it's perfect. But I don't feel frustrated by it... I don't spend days at work horrified by the lack of treatment, I don't feel that'

8) Internal vs external control & change

Nurses had little control over patient movement in the hospital resulting in many trauma patients being nursed in 'outlying wards' where specific trauma needs were neglected. Nurses had relatively little power or control to effect change. Even senior nurses felt most changes were externally driven and largely ignored professional knowledge and expertise.

'The Trust asked for an external review on the nursing figures on the wards ... I think it completely underestimated the patients with dementia, the patients that came in with very poor nutritional state.. .. So that was a massive battle and we went to a very low place in terms of nursing care.'

While physiotherapy services were described as being 'consultant led' individual physiotherapists could manage their own workload and diary according to patient need.

'It's just me running my diary as you know with my colleagues we tend to keep the same caseload of patients just for continuity'

External changes and targets imposed without consultation demanded additional time and resource for example complex strategies were required to manage patient movement within the hospital.

Common themes

A number of recurring themes emerged in interviews with both groups. Both described undue influence of targets, bed managers and medical staff over professional practice and patient priorities and ever increasing demands. They commented on the fragmentation of services and the need to co-ordinate care across disciplines and organisations. Specialist roles within both professions appeared to confer significant advantage. Both Nurses and Physiotherapists expressed concern over unmet patient needs (such as psychological support) and lack of resources and resorted to trying to bridge gaps themselves.

Divergent cases

Specialist nurses were more likely to cite research underpinning practice than other nursing colleagues. They could 'follow' their own patients through the system which improved individual care and job satisfaction but demanded enormous individual commitment. In-patient physiotherapy was more target driven and their main aim was to facilitate safe discharge. This could conflict with professional judgment and with other members of the multi-disciplinary team.

Study strengths and limitations

This study grew from and within a much larger study and has the strengths offered by a wide participant base and the insights of a diverse and experienced research team.

Qualitative studies with small sample size are frequently criticised for their lack of validity and generalisability (Polit and Beck, 2010). The robustness of this data is reflected in the consistency across sites and between researchers from different backgrounds, it offers a unique insight into the parallel experiences of staff and patients in the particular circumstances of care following an unexpected injury.

Embedding this study also imposed constraints in relation to the lack of detailed demographic data and sampling strategy with potential impact on the transferability of findings. Stratified sampling among the target professions may have improved representation of some groups (e.g. entry level qualified nurses and in-patient physiotherapists) thus aiding comparisons between professions. The utility in comparing seemingly different professions and roles may be questioned. Despite similarities in core values and training, Physiotherapists and Nurses have major demographic, professional and occupational differences. The work of OPD and ward based staff clearly differs irrespective of professional grouping.

Discussion

This study suggests that relegating caring to an incidental or subsidiary function neglects its importance to both care givers and recipients. There is little disagreement (Sargent, 2012) between practitioners/patients on key components of caring; 'taking time to talk' and 'relationship formation.' For service providers caring is both personal and professional and gives them a sense of purpose and reward. While it is difficult to quantify the effects of 'caring' on recovery evidence suggests the quality of patient-practitioner interaction can have direct consequences for healing (Zender and Olshansky, 2012). Furthermore there is

copious evidence that patients value and understand the benefits (Francis, 2010) especially in trauma care where the impact of injury can cause long term psychological and physical effects (O'Donnell et al, 2009).

This study demonstrates that both nurses and physiotherapists face challenges but that nurses in particular feel the context of their work is not conducive to caring. There are profound differences in personal, professional and organisational factors which influence these professions ability to care. These are strikingly demonstrated in their language. While physiotherapists use terms suggesting hope and fortune (albeit moderated by anxiety about change) nurses use terms more generally associated with warfare such as 'battle', 'survival', and 'frontline' to describe their work. The language of academic nursing (emphasising humanity, morality and openness) is therefore at odds with metaphors of practice. As in Beckett's (2003) analysis of the language of social work these reveal an underlying conceptual framework of conflict rather than caring in which managers, organisation, media and even patients are the enemy and nurses are under attack due to expectations and demands which they cannot emotionally or physically meet (and increasing risk of physical or verbal harm (Nursing Times, 2010)). As Fulton (2008) and Glasberg et al (2007) suggest experiential avoidance and depersonalised care may sometimes be a means to cope rather than sign of moral decay.

There is significant convergence between injured patient and physiotherapists accounts of physiotherapy care. Caring in physiotherapy appears both integral to the role and sustained by structural and organisational factors. This lessens the need for academic debate into its meaning in physiotherapy practice. Distinct identity and remit with defined outcomes also

enables physiotherapists to limit the impact of the wider organisation and demonstrate value. This study suggests concerns about the ability of physiotherapy to be patient-centred rather than biomedical are unfounded (Kell and Owen, 2008) but that further cuts could seriously impact on standards of care.

This study raises significant questions about nursing practice, resourcing and organisation within the NHS. There are clear parallels between nurse and patient accounts; both feel uncared for, place importance on caring and feel it is sometimes lacking. Nurses appear to have limited control, status or support within a medical and business model of care. The evolution of modern nursing identity has been driven both from within and without but in defining the profession in terms of a largely scientific evidence-based paradigm intuitive knowledge, hands on caring and compassion have been devalued in favour of more technical, auditable and demonstrable skills (Straughair, 2012). This places many nurses within a bio-medical model but without a distinct nursing identity. Current emphasis on adherence to protocol, guidelines and audit further devalues professional judgment, fragments the patient and reinforces the bio-medical model (Pinder *et al*, 2005). Nurses are placed in an unenviable position juggling conflicting personal, professional, organisational and public demands. This contributes towards a growing gap between the expectations and realities of practice, creates the conditions for burn-out and supports studies into stress of conscience (Glasberg *et al*, 2007) and moral distress (Corley, 2002). Current debate can dehumanise nurses and neglect strategies for enhancing compassion such as ensuring nurses 'feel safe and cared for (Smith, 2008 cited in Dewar and Mackay, 2010) ' or those which nurture and celebrate emotional engagement and caring practice (Dewar and Mackay, 2010).

Comparing nurse and physiotherapy perspectives offers insight into factors which sustain or inhibit caring. While it is not possible to directly infer from service provider accounts to standards of care there are clearly lessons to be learned from physiotherapy practice which could benefit nursing. These have implications for NHS resourcing, government policy and the profession.

Recommendations to improve nursing care:

- Nurses should develop a clearer identity which is distinct from medicine and has compassionate care at its core
- Caring should be accorded greater priority in nursing and NHS management
- Nurses should lead decisions affecting nursing practice
- Senior nurses should have resource to delegate non nursing tasks.
- Senior nurses should have protected time to supervise and support junior nurses
- Student nurse should be taught how to care in practice through mentoring
- Supervision and psychological support should be formally developed and available to all nursing staff
- Training and CPD should be given greater priority and protected time
- Protocols and guidelines are an important adjunct to clinical nursing but should not be the main drivers of care
- Efforts should be made to reduce fragmentation of care through budgetary separation and targets.
- Patients and practitioner voices should be central in developing and evaluating services
- Placing patient care at the heart of service provision should be supported by adequate resource

Conclusion

This small exploratory study contributes to our understanding of caring and poses questions about its place in a resource limited NHS. Caring is difficult to cost but may impact on patient recovery and the retention and attrition of staff. Caring is not hard to define but is dependent on a complex interplay of mutually dependent professional, contextual and individual factors. There are clearly parallels between professional wellbeing and patient experience; recommendations which fail to acknowledge this are unlikely to produce significant or sustained improvements in patient care. Where the reality of care is insensitive to service providers' needs and place unreasonable expectations and demands on them we should not ask why some carers fail to care but rather why most do not.

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References:

- Aitken L, Clarke S, and Sloane D. (2008) Hospital staffing, organisation & quality of care: cross national findings. *Int J Qual Health Care*. **14**: 5-13
- Beckett C (2003) The language of siege: military metaphors in the spoken language of social work, *Br J Soc Work*. **33**: 625-639
- BBC (2012) Nurses in Drive for 'Compassionate Care'. Available from: <http://www.bbc.co.uk/news/health-20583115> [Accessed 02.01.2013].
- Boorman S. (2009) *NHS Health & Wellbeing Review* [online]. Report number: Final report. Available from; NHS.healthandwellbeing.org. [Accessed 04/02/2012].
- Braun V, Clarke V. (2006) Using thematic analysis in psychology. *Qual Res Psychol*. **3** (2); 77-101
- Corley M. (2002) Nurse moral distress: a proposed theory and research agenda. *Nurs Ethics*. **9** (6): 636-650.
- Dewar B, Mackay R. (2010) Appreciating and developing compassionate care in an acute hospital setting caring for older people. *Int J Older People Nurs*, **5** (4); 300-308
- Evans A, Periera D, Parker J. (2008) Occupational distress in nursing: a psychoanalytic reading of the literature. *Nurs Philos*. **9**: 195-204.
- Francis R. (2010) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust. January 2005 – March 2009*. The Stationery Office, London.
- Fulton J. (2008) Strategies used by nurses when managing the emotional needs of patients. *Learning in Health & Social Care*. **7** (3): 158-167
- Gibbons C. (2010) Stress, coping and burn-out in nursing students. *Int J Nurs Stud*. **47**: 1299-1309
- Glasberg A., Eriksson S, Norberg A. (2007) Burnout & 'stress of conscience' among healthcare personnel. *J Adv Nurs*. **57** (4): 392-403
- Green J., Thorogood N. (2009 [2004]). *Qualitative methods for health research* (2nd ed.). Thousand Oaks, CA: Sage.
- Hehir B. (2013) Report 'A crisis of compassion: Who cares?' Battle of Ideas, 20–21 October 2012, London *Nurs Ethics* **20**(1): 109-114
- Hilliard C, and O'Neil I. (2012) Nurses emotional experience of caring for children with burns. *Journal of Clinical Nursing*. **19**: 2907-2915

Iglesias M, Vallejo R, and Funetes P. (2009) The relationship between experiential avoidance and burnout syndrome in critical care nurses; a cross sectional questionnaire survey. *International Journal of Nursing Studies*. **47**: 30-37

Juthberg C, Eriksson S, Norberg A, Sundin, K. (2010) Perceptions of conscience, stress of conscience and burnout among nursing staff in residential older care. *J Adv Nurs*. **66** (6): 1708-1718

Kell C, Owen G. (2008) Physiotherapy as a profession: Where are we now? *Int J Ther Rehabil* **15**(4): 158-64

Kendrick D, O'Brien C, Christie N, et al (2011) The impact of injuries study. Multi-centre study assessing physical, psychological, social and occupational functioning post injury - a protocol. *BMC Public Health* [online] Available from: <http://www.biomedcentral.com/1471-2458/11/963> [Accessed: 02.01.2013]

Lund C. (2008) Clinical leadership and patient care. *Nursing Management*. **15** (6): 16-17

Menzies L. (1959) A case study in the functioning of social systems as a defence against anxiety; a report on the nursing service of a general hospital. *Human Relations*. **13**: 95-121

Morse J, Solberg S, Neander W, Bottordoff J, Johnson J. (1990) Concepts of caring and caring as a concept. *Adv Nurs Sci*. **13**: 1-14

NHS Commissioning board, (2012) *Compassion in Practice: Nursing, Midwifery and Care Staff our Vision and Strategy* [online]. Report number: 18479 Available from: <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf> [Accessed 02/01/2013].

Nursing Times (2010) Report on study into nurses experience of violence at work [Internet] Accessed 29/01/2013 Available from <http://www.nursingtimes.net/whats-new-in-nursing/news-topics/health-workforce/over-90-of-nurses-experience-violence-or-verbal-abuse/5011127.article29>.

O'Donnell M, Bryant R, Creamer M, Carty J. (2009) Mental Health Following Traumatic Injury: Toward a Health System Model of Early Psychological Intervention. *Clin Psychol Rev* **28**(3): 387-406

Pinder R, Petchey R, Shaw S, Carter Y. (2005) What's in a care pathway? Towards a cultural cartography of the new NHS. *Sociol Health Illn*. **27** (6): 759-779

Poghosyan L, Clarke S, Finlayson M, Aiken L. (2010) Nurse Burnout and Quality of care: Cross-National Investigation in Six Countries. *Res Nurs Health*. **33**: 288-298.

Polit D, Beck C. (2010) Generalization in quantitative and qualitative research: Myths and strategies. *Int J Nurs Stud*. **47**: 1451-1458

Prime Minister's Commission, (2010) *Front Line Care: The Future of Nursing and Midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England*. Report number: 301576; ISBN 978-0-9565138-1-6. London

Race T, Skees J. (2010) Changing tides: improving outcomes through mentorship on all levels of nursing. *Crit Care Nurs Q*. **33** (2):163-176

Ritchie J, Lewis J, eds. (2010) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. 3rd ed. UK: Sage publications Ltd.

Roskell C. (2009) Patient-centred practice in physiotherapy: Linking professional identity and learning. *Int J Ther Rehabil*. **16** (5): 246-247

Rytterstrom P, Cedersund E, Arman M. (2008) Care and caring culture as experienced by nurses working in different care environments: A Phenomenological-hermeneutic study. *Int J Nurs Stud*. **46**: 689-698

Sargent A. (2012) Reframing caring as discursive practice: a critical review of conceptual analyses of caring in nursing. *Nurs Inq*. **19** (2): 134-143

Smith P. (2008) Compassion and Smiles: What's the evidence? *J Res Nurs* **13**, 367-370

Stickley D, Freshwater D. (2002) The art of loving and the therapeutic relationship *Nurs Inq*. **9** (4): 250-256

Straughair C. (2012) Exploring compassion: Implications for contemporary nursing. Part 1. *Br J Nurs* **21**(3): 160-4

Wiman E, Winkblad K. (2004) Caring and uncaring encounters in nursing in an emergency department. *J Clin Nurs*. **13**: 422-429

Zender R, Olshansky E. (2012) The Biology of Caring: Researching the Healing Effects of Stress Response Regulation Through Relational Engagement. *Biol Res Nurs*. **14** (4): 419-430