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What is Love in Nursing Care? A Qualitative Study

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Plymouth University

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What is love in nursing care? A qualitative study

by

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A thesis submitted to Plymouth University in partial fulfilment for the degree of

Research Masters

(ResM)

School of Nursing and Midwifery

Faculty of Health and Human Sciences

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Abstract

Tracie K. North

What is love in nursing care? A qualitative study

Recent failures in care highlighted through documents such as the Frances report have pointed to lack of kindness, respect and dignity in patient care and lack of professionalism. As a consequence, nurse education has come under the microscope, with questions about the potential to teach nurses compassion. The demonstration of these values were once, perhaps, more tangible and overt in nurse training and nursing care. The expression 'tender loving care' was used as an expression of nursing intervention, which often gave comfort and confidence to patients and their loved ones. There has been some speculation that as nurse training has become more 'technical' and degree-based, the emphasis has moved away from compassion and love in care.

The aim of this study is to explore, from the perspective of nurse educators, love in nursing care and to understand how the concept of love in nursing can be integrated into education.

The study design had two phases: A meta-synthesis of the literature and review which developed an understanding of love from the viewpoint of writers in theology, culture, history and sociology. How love is expressed in nursing was explored and presented. The relevant university research ethics committee provided ethical approval for the study.

Qualitative semi-structured interviews using a judgement sample of volunteer nurse educators was conducted. The research question was unambiguous, 'What is love in nursing care'? The transcripts of the interviews were analysed using Framework Analysis that is appropriate for health care and policy research.

The commentary that these educators chose to use revealed four themes, human values, therapeutic relationships, attitude and context, which make up love in nursing care.

The nurse educators in this research gave meaning to human values through their description of the reciprocity experienced in care, the interconnectedness which can occur with the maintenance of professional boundaries and through the unconditional positive regard described as knowing another's vulnerability and being there for that person.

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Author's Declaration and Word Count

At no time during the registration for the degree of Research Masters (ResM) has the author been registered for any other University award without prior agreement of the graduate sub-committee.

Work submitted for this research degree at Plymouth University has not formed part of any other degree either at Plymouth University or at another establishment.

This study was partially financed with the aid of an ESF-CUC Scholarship 2012-2013.

A programme of advanced study was undertaken, which included MSc Social Science modules totalling 40 credits covering philosophical and methodological, foundations of the social sciences, social research design, qualitative approaches in the social sciences and applying techniques of qualitative data analysis.

Relevant seminars and conferences were regularly attended and at which one international conference work was presented.

Conference attended and presented:

The European Aging Network Conference, Malta, 2012.

Under Section 10.4 a greater word count has been agreed by all the examiners, due to the reporting of a systematic review as part of a qualitative study: The agreed word limit is 29,000 words.

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Signed

Date

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Chapter One

Introduction into a study of love in nursing care

The purpose of the study

The purpose of this study was to explore from the perspective of nurse educators, love in nursing care and to understand how the concept of love in nursing can be integrated into education. This study is relevant to all nurses, as over the past decade there have been disturbing reports of poor nursing practice in England and the nursing profession has experienced national scrutiny (Francis, 2010).

Since nurse education was formalised in 1860 (Masson, 1985) it was increasingly recognised that there were inconsistencies in nurse training nationally and nurse educators were criticised for a failure to, ‘...stimulate originality and creativity in students, and a failure to provide them with adequate clinical supervision’ (Camiah, 1998, p. 369). Pre-registered student nurses were taught in schools of nursing which were integrated into hospitals. This often meant that student nurse education was heavily influenced by local factors impacting on the quality and pressures placed on care provision (RCN, 2007). To address these perceived deficits in student nurse education and training, Project 2000 was launched in 1986 (Willis, 2012). The Project was

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intended to remove nurse education from the influence and pressures of local services, and discard the apprenticeship model in favour of a nurse education aligned with Higher Education Institutions (HEI) (RCN, 2007). Project 2000 was radical and incorporated seven major changes to nurse's education, training and culture:

- Student nurse education aligned with HEI
- Student nurses became supernumerary and were no longer part of the nursing workforce.
- The theoretical aspect of the curriculum increased to 18 months within a 3 year training programme.
- A diploma qualification was a minimum requirement
- The education was designed around 'Health' rather than 'Illness' model.
- The common foundation programme (CFP) was introduced.
- The four specialist branches were introduced to follow the CFP (RCN, 2007).

In the 1990s, nearly a decade after the launch of Project 2000, student nurses felt that they had less clinical competence than nurses trained using the apprenticeship model (Smith, 2012). There was conflict within the profession with allegations that Project 2000 would lead to nurses who would be 'too posh to wash' (*BBC News*, 2004).

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In 2005 Mid Staffordshire Foundation Trust was investigated following concerns relating to sub-standard care provision within the Trust. Based on his report of Mid Staffordshire Foundation Trust, Robert Francis described nursing practice as 'devoid of dignity and respect for patients' (Francis, 2009). The Nursing and Midwifery Council (NMC) in 'The Code', Standards of Conduct, performance and ethics for nurses and midwives, (NMC, 2008) addressed concerns by describing the expected competence required of registered nurses on entry to the profession. 'Providing a high standard of practice and care at all times' is a key standard within the code (NMC, 2008, p. 6). To deviate from this standard may compromise nurses, 'fitness to practice' (NMC, 2008, p. 1).

The NMC informed by the Royal College of Nursing (RCN), published the 'Standards for pre-registration nursing education' that set out the competencies that student nurses must acquire before attaining registration (NMC, 2010). There were four domains, which included generic competencies which each student had to obtain to ensure that they could progress onto nurse registration:

- Professional values
- Communication and interpersonal skills
- Nursing practice and decision-making
- Leadership, management and team working.

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Nurse education and training has been continuously reviewed since the introduction of Project 2000 (Willis, 2012). Despite this concerted focus, and with over one hundred and fifty years of advancement in the field, the problems in Mid Staffordshire highlighted that there were still instances of substandard care. The Nursing and Midwifery Council supported by the Chief Nurses, in their response to the Francis report (Francis, 2010) explained that the culture within the NHS needed to change. The nursing profession needed to demonstrate nursing values, demonstrate 'fitness to practice', be proactive and ensure transparency (NMC, 2013. p. 3). In parallel with the Francis inquiry nursing was moving towards being an all-graduate profession; by 2013 all pre-registration nursing programmes became degree only courses (NMC, 2010).

In 2012 the Commissioning Board Chief Nurse and the Department of Health Chief Nursing Advisor (Department of Health and Commissioning Board, 2012) published 'Compassion in Practice'. In this strategy, these leading nurses talk of 'enduring values of nursing' (DH, 2012, p. 5). Where there needs to be a clear definition of what these values are, so that nurse educationalists can design future curricula with these values explicitly articulated in the programme. The Chief Nurse asserted that, 'The actions set out in this vision and strategy...will change the way we work, transform the care of our patients and ensure we deliver a culture of compassionate care' (DH, 2012, p. 6). This research study is designed to explore nursing values in more detail.

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Aim and Objective of the study

The Aim

The aim of this study is to explore from the perspective of nurse educators, love in nursing care and to understand how the concept of love in nursing can be integrated into education.

The Objectives

- Design and implement a research project using a qualitative methodology to meet the aim.
- To present the description of *love in nursing care* from the perspective of nurse educators.
- To identify patterns and subsequent themes which emerge from the nurse educators' perspective.
- To identify and share relevant findings to support the nursing professions' vision and strategy in contributing to future nurse education curricula.

The Rationale for the Study

Reflection, Johns explains (2010, p. 29) '...is awakening of self. With effort and appropriate guidance, practitioners can liberate themselves from limiting habits and views that constrain self-realisation'. I started my nursing career reflecting on my practice and understanding that the act of caring affected me emotionally (appendix 1); witnessing the confusion and suffering patients coped with created an interconnectedness between myself and those being nursed. Over thirty years of nursing I have witnessed the introduction of quality assurance systems, in the NHS, that reduces nursing performance to numbers and checklists (Wilkinson, 1994), measured against operational objectives. Through the evolution of nursing it appears that nurses have become viewed as '...most effective when doing for a patient' (Benner, 1984, P. 57). Expert nurses counter this assumption by asserting that it is the act of 'being with' the patient that can make the biggest difference, as in 'presencing' (Benner, 1984. p. 57), the act of openness and availability that incorporates reciprocity between patient and nurse (George, 2010). This might be described as the *art of nursing*. However during my years in nursing there seems to have been scarce attention paid to defining the art of nursing. Corbin suggests, '...in the quest for professional recognition nurses have come to devalue the most mundane tasks...these have considerable value because they offer opportunities to connect with ill persons' (2008, p. 164).

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I believe this study is relevant to health care provision in the twenty-first century as the demographic predictions in England forecast an increasing population of older people and people living with a long-term condition (LTC). These people require a nursing profession that can deliver an ever increasing complex, technical, physical, psychological, emotional and social care. Kitwood describes meeting this approach as *person centred care* (Baldwin and Capstick, 2007).

The demographic of patients are changing and the nursing profession needs to respond accordingly. It is estimated by the London School of Economics, Kings College London and The Alzheimer's Society (Albanese, Banerjee *et al.*, 2007) that there are over 683,597, (one in 88) people living with dementia in the United Kingdom (UK). This represents 1.1% of the entire UK population. The projected forecast is that we should expect to see an increase to, 940.110 by 2021 with an increase of 38% over the next 15 years, and a seriously dramatic rise to 154% over the next 45 years (2007, P. 16).

This vulnerable group of adults need a nursing profession that is able to demonstrate values, as consistently as it can demonstrate technical rational skills. The Department of Health has clearly identified the NHS's values in 'The NHS Constitution' (DH, 2013,). These six values help focus staff attention on their behaviour within the NHS and on who is recruited into the organisation:

- Working together for patients

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- Commitment to quality of care
- Everyone Counts
- Respect and dignity
- Improving lives
- Compassion

(Miller, et al, 2014, p. 23)

These are broad values and principles that integrate well with the Chief Nursing Officer's, *Compassion in Practice* (DH, 2012). It is important that these values are understood and the impact they make is appreciated by those expected to abide by them. Words such as dignity, respect and compassion are frequently used in relation to caring for vulnerable adults, and it is imperative that the meaning and understanding is obvious in the nursing profession. Nursing values are described by terms that include altruism, empathy, and kindness all of which could be identified with love. The word love is used infrequently, if at all now when quality of care is referred to in NHS reforms (Ballet and Campling, 2011) and it is these emotive values that will be included in this study.

Using a qualitative research approach this project is seeking to find the meaning and an understanding that goes beyond the superficial layers of the phenomena *love in nursing care*. A deep comprehension will be accessed through *mapping* and interpreting the narrative of participants' experiences, (Silverman and Marvasti, 2008).

Context of the study

In 2001 the National Service Framework (NSF) for Older People was published (DH, 2001). This comprehensive guidance described eight standards, including strategies for the prevention of ill health, care guidelines and attitudes required to meet older peoples' needs. In the NSF the future workforce was identified as needing to be prepared to work with a diverse older population, and nurses would have opportunities to be advanced practitioners and consultants in older peoples' care. There was recognition that nurses needed enhanced management and leadership skills (DH, 2001).

In 2013 the comprehensive report on the Mid Staffordshire NHS Foundation Trust's Public Inquiry was published. This report pulled together all the component parts that led to the, '...appalling suffering of many patients,' (Francis, 2013, p. 3). Robert Francis clearly states in the introduction to this second report, that there were systematic failures within the nursing profession to manage a positive culture, which resulted in poor standards of care. He concluded in his introduction that the nursing profession needs to be directed to improve its cultural issues, by focusing on specific workforce planning to,

enhance the recruitment, education, training and support of all key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do' (Francis, 2013, p. 7).

The Kings Fund in their report, 'Preparing for the Francis Report' (Dixon, Foot and Harrison, 2013) recognised that staff morale and wellbeing impacted on

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the quality of patient care. In this report a focus on a culture shift is advised, where values are explicit and transparency equates to learning rather than fear of retribution.

Increasing regulation and inspection is not seen as the mechanism to improve standards in nursing care. The Kings Fund report is clear,

the current system is complex and lacks coherence. There are many players in the system who have overlapping roles and responsibilities...this poses a risk that no one takes responsibility to address failures in the quality of care (Dixon, Foot and Harrison, 2013, p. 6).

The nursing profession recognises, in its Code of practice, that nurses themselves must take responsibility for the quality of nursing care delivered to patients (NMC, 2008). *The Compassion in Practice: Nursing, Midwifery and Care Staff, Our Vision and Strategy*, is the articulation of the professions' own initiative to improve nursing care (DH, 2012). In recognising the shifting cultural changes in England, (with an increasing elderly population), and the need to integrate health and social care, nurses need to ensure that peoples' fundamental needs are met with, '...dignity, respect and compassion.' (DH, 2012, p. 5). These principles are not revolutionary and nurse theorists such as Benner wrote about the necessity to have these values in nursing during the 1980s (Benner, 1984). Jean Watson, another renowned nurse theorist, in her assessment of Florence Nightingale's *Notes on Nursing* demonstrates that there is a resonance with the previous Kings Funds findings (Dixon, Foot and Harrison, 2013), and with the Nurses Vision and Strategy (DH, 2012). She states, ' this health knowledge and wisdom so desperately needed in Florence Nightingale's time, remains the call and manifest of our time the

need to reiterate the interconnection between person and environment, between person and nature, between the inner and outer worlds, between the private and the public, between the physical and the spiritual, as part of the natural healing responses of people and civilisations; the need to systematically develop nursing practice' (Carrol, 1992, p. 80).

In the Nursing, Midwifery and Care Staff vision and strategy, 'Compassion in Practice' (DH, 2012), The NHS Commissioning Board Chief Nursing Officer and the Department of Health's Chief Nursing Adviser described a strategy that would lead to high standards of care, which could be delivered with compassion and would enhance patients' health and wellbeing, (DH, 2012). The six 'C's are presented in this document as an expression of the agreed nursing professions values and behaviours, as it was informed through a consultation process with nurses and other key stakeholders. The six 'C' (DH, 2012, p. 13) are:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

These traits are viewed as necessary to give the caring workforce confidence, which could be expressed as empowerment, to influence and manage the changes required in the health and social care sector.

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This research project set within the context described above, aims to interview nurse educators to explore the value of love in nursing, and to understand if when and how this is expressed and can this value contribute to nurses' education.

In Chapter Two I provide a literature review, which critically analyses studies of love in nursing care. Chapter Three details the methodology used for the study, whilst Chapter Four presents the findings. Chapter Five provides a conclusion with recommendations as to how the findings from this exploratory study can inform pre-registration nurses' education and training.

Chapter Two

The Literature Review

This chapter draws together relevant literature to inform the research and provide further context for an exploration of love in nursing care.

The meta-synthesis has been completed using a systematic approach and the findings have enabled me to identify prominent themes. An understanding of love in nursing care was sought through reviewing contemporary nursing research studies.

The purpose of the meta-synthesis was to explore and critically analyse research studies that related to the project's research question. This was conducted by evaluating a range of studies from different sources, which included a broad number of professional journals. This process enabled me to explore the text and its epistemological evidence, to gain an understanding of the value of love in nursing care, and to identify any gaps that were present in our current understanding and knowledge of love in nursing care.

The literature identified key themes of love in general and in nursing care, and helped direct my interview guide so that I could achieve a deeper understanding of how love is considered and interpreted by nurse educators.

Aim

The aim of the meta-synthesis was to critically appraise and synthesise research relevant to the question 'what is love in nursing care'?

Objectives and methods

Summary of the literature search and selection strategy

The focus of the review was on studies that investigated or explored love in nursing care. Due to the nature of the research topic I felt it important to capture the history of love in nursing. This meant that the years included in the search were unlimited. I used the following medicine, nursing and allied health profession search engines CINAHL, MEDLINE and AMED to search for the terms:

- Love or Love in Nursing Care
- Nursing Care or Nursing Practice
- Love in Nursing Care Or Love and Nursing Care Or Nursing Practice

The literature search commenced in January 2013, and the process was repeated in August 2013 to ensure that no new studies were missed. The search was repeated in February 2014, where five new articles were retrieved. None of the papers were appropriate for this study because they referred to Buddhism, spirituality and loving the nursing role.

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Filtering

I carried out the filtering process using the inclusion and exclusion criteria.

Two additional researchers also considered the nine studies identified by me to be suitable for analysis.

Following this filtering process I had nine studies that met the inclusion criteria.

Inclusion Criteria

- Studies that described love in nursing care
- Studies that focused on love in nursing
- Studies relating to 'tender loving care'
- Studies written in the English Language
- Academic Studies in any time frame

Exclusion Criteria

- Studies that focused on spiritual love in nursing
- Studies that focused on spirituality or theology
- Studies that focused on romantic love

Data collection and analysis

The studies were assessed using qualitative evaluations incorporated into a quality framework (Spencer, Ritchie, Lewis and Dillon, 2003). Qualitative

research is associated with an inductive process and the development of meanings and explanations (Bryman, 2012). Qualitative researchers have a responsibility to demonstrate their research as 'robust'...and have 'relevance' and demonstrate the 'utility of the research' (Spencer et al, 2003, p. 4). The Quality Framework used 'guiding principles' to assess, *contributory* factors, which identified whether the study could enhance the understanding of a theory. The framework assessed how 'defensible' a study's design is and how 'rigorous the collection, analysis and interpretation of data' was conducted before the Quality Framework analysis sought to establish how 'credible' the study claims were (Spencer et al, 2003, p. 7).

Spencer et al. (2003) use eighteen quality indicators in their appraisal tool. I began by using the eighteen indicators then focused the appraisal in the following areas:

Quality Indicators (Spencer et al, 2003)

1. The concepts that emerge through analysis of the data
2. Discussion and interpretation of specific significant aspects of the literature
3. Explanations and emerging theory will be described
4. Clear commentary on opposing theory and concepts
5. Evidence of relationships between the aims of the study and the research question
6. Identified themes represented in a clear, well written narrative

7. The narrative will have a structure that will enable readers to understand the key relevance of all the data
8. The report will be accessible and will demonstrate relevance to its target audience
9. Pertinent information will be highlighted and summarised.

Results

Table 1: The record of citations identified in the database searches, prior to the removal of duplication and inclusion criteria.

Database	No date limitation
CINAHL	104
MEDLINE	49
AMED	4
TOTAL	157

A total of 157 citations were reviewed.

Figure 1 below, shows that one hundred and fifty seven citations were filtered against the inclusion criteria, and thirty-nine papers were sourced to assess the papers appropriateness. Nine of these papers met the inclusion criteria, (see Table 2 below.) A further search was carried out in 2014 and five papers were identified, these did not meet the inclusion criteria.

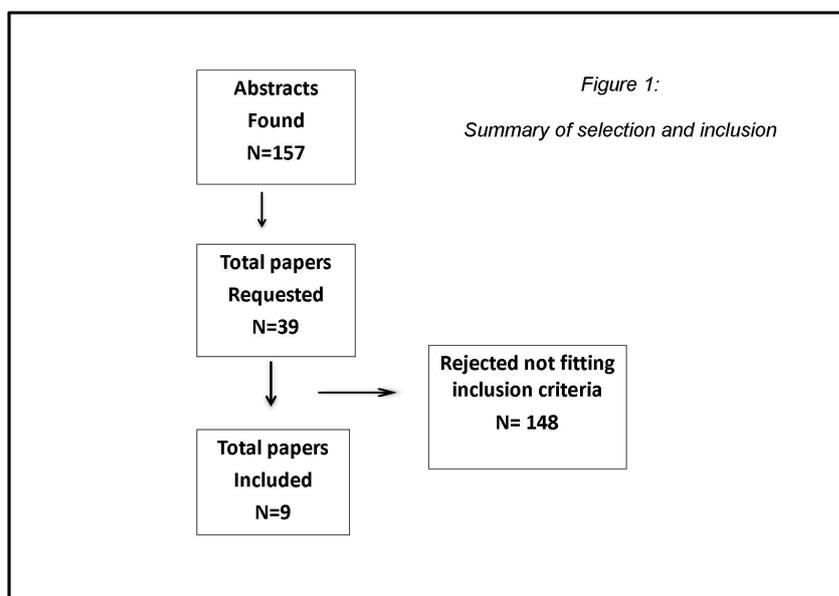


Table 2. Demonstrates the breakdown of the excluded articles and studies and the rational for their exclusion.

Table 2: Excluded articles

Religious/spirituality	16
Management (HR)	1
Literature review	2
Editorial/paper	80
Dissertation	9
Duplicates	17
Lacked specificity	23
Total	148

The search above included nine dissertations that were requested, but the library was unable to obtain these so these were excluded.

The Studies

Table 3 (Appendix 10.) represents the nine included

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Using Spencer, Richie et al (2003) quality framework, the characteristics of the nine studies are presented in Table 4(Appendix 11.). The study findings are summarised in Table 5 (see below) and a thematic analysis is presented as a narrative as follows.

Kangasniema and Haho (2012) explored the idea pattern of nursing ethics from the perspective of an early nurse pioneer, Estrid Rodhe (1911). They used historical text to describe a contemporary understanding of the current nursing professions culture and values. The authors presented Rodhe's nursing ethics, which were first published in the early 1900s. In their analysis, at the centre of Rodhe's 'idea pattern of ethics' is *human love*. Within this value Rodhe's described nursing as the work of 'virtuous' women who were 'altruistic' and 'unselfish' (2012, p. 805). Her cultural background influenced this, as her father and brothers were clerics, and she spoke of the love in nursing as being a Christian charity, demonstrated by subservient women. These beliefs originated in the values found in Christian, *caritas* (May, 2011).

In this study *love in nursing care* may be described as an attitude, where devotion is evident and the concept of *calling based altruism* is explored. Although this study is centred in a distant past the *History of Ideas* is a method, which enables concepts such as nursing ethics to be explored from an historical perspective, and the understanding acquired may be used to inform and generate present day theories in nursing to realign our contemporary understanding of nursing ethics for the 21st century and inform present day quality frameworks to assure clinical governance.

The work of Kangasniema and Haho (2012) is also reflected in the work of Persky, Nelson, Watson and Bent, (2008, p. 15) in their preparation to introduce a 'Relationship based Care' model. This sought to identify the characteristics of a 'Caritas nurse'. A mixed method methodological approach was used where the research suggested that the working environment and its culture affected caring nurses. Caritas nurses appeared to consciously love their patient holistically and this includes mind-body-spirit (2008, p. 17). Relationships were based on honour and love with time identified as a key requirement to administer authentic care. The research suggested that healthcare environments could adversely affect these relationships and the quality of patient care, in the pursuit of performance management to achieve national and local targeted outcomes.

Further to this, Kangasniema and Halo's paper directly corresponds with de Vries, (2004) study that identified with humility in nursing. This exploratory study used the washing of patient's feet as an experience, which might engender humility whilst caring for patients. De Vries describes humility as the 'root of love' (2004, p. 579) and situates this within Levinas ethics, as opposed to the *I-thou* ethics (Buber, 1958) described by Rodhe. Within Levinas's ethical philosophy 'being-for -the -other' (p. 579) de Vries recognises a subservient position and this is reiterated by two of her sample. To reinforce this, de Vries suggests that humility is 'practicing' beyond their 'duty of care' (2004, p. 584). The author identified that nurses found that there was

reciprocity experienced in the washing of the patient's feet and a sense of interconnectedness.

This is substantiated by the work of Fitzgerald and van Hooft (2000) who used the Socratic dialogue methodology and asked the research question, *what is love in nursing* in an extensive qualitative study. The highly moderated focus group used an example of nurse practice, which enabled the focus group to answer the research question informed, by the one example. The findings from this study have resonance with de Vries findings and suggest that 'going beyond' the 'traditional duty of care' (2000, p. 485) is a factor in love in nursing. Nurses that are prepared to take risks with, and for their patients demonstrated this. The small sample suggested that their practice was based on 'ethical decision making,' (2000, p. 488) but western healthcare environments can adversely impact on this focus. In contrast to de Vries findings, the authors suggest that their sample felt there was no reciprocity required, or felt when giving themselves to their patients. This sacrifice was acknowledged, but not how to limit or measure it. One aspect of the findings identified that the nurses in this study focused on people rather than health, and they expressed the need to nurture unconditional understanding and relationships.

The structure of nurturance was the phenomenon that Geissler (1990) analysed in her exploratory study. The sample was fourteen female nurse participants from various environments. Geissler identified that culturally, nurture had been recognised since the fourteenth century, whereas

nurturance, the noun, was only introduced into nursing theory in the twentieth century. In this study nurturance is seen to represent a 'shared humanity' (p. 529) and incorporated into this, is love. By placing nurturance into context it is described as the 'foundation of the nursing profession' (Geissler, 1990, p. 530). Nurturance is expressed through non-judgemental, compassionate care through trust and touch. Geissler describes nurturance as representing 'tender loving care' (1990, p. 530), which is sense driven, empowering for nurses and patients and represents the attributes of nursing attitudes.

This is amplified in the Greek study conducted by Vouzavali et al, (2011), who also identified that a certain attitude was present in nurses caring for patients in a critical care environment. Their research aim was to explore critical care nurses 'perceptions and meanings,' inherent in interpersonal relationships with patients. They employed Heidegger's philosophy (Langdrige, 2007) to understand the nature of *Being*, in relationships, and how this was expressed and interpreted using symbolism and language. The nurses spoke of 'selfless love' and 'self giving', (2011, p. 245) using touch to communicate with the critically ill patients. The importance of having time to care was discussed with experienced nurses, and how the cultural shift into a technological, procedural directed profession impacted on the quality of their feelings. The nurses describe the relationships in terms of a simile, expressed as being like 'syncytium' (p.143) where empathy and 'intense feelings of love' (p.144) were experienced. This highlights the features of altruism observed in Kangasniema and Haho's (2012) study as previously discussed.

The reflexive nature of 'Being cared for and not being cared for' was Karlsson and Bergbom's (2010, p. 60) research topic, and not only reflects Vouzavali, et al's (2011), study, but acknowledges the efficacy of using an autobiographic story of a patient to highlight the interconnectedness of the relationship between the nurse and patient, from a patient perspective. The autobiography describes a patient's, whose name was Lars, experience and feelings when being cared for in an intensive care unit. Severely burnt and in constant pain, Lars, described love in care and the absence of care. Karlsson and Bergbom identified that those nurses who were described by Lars as being present, were, 'sharing the suffering and demonstrated claritas.' (p. 63), there was 'love in their hands' when they touched Lars (p. 61). These nurses were being authentic in their relationship with the patient and demonstrated caritas, which the researchers suggested was at the core of nursing. The nurses who could 'listen with their hearts, who had love in their hands and warmth in their voice' (2010, p. 60) demonstrated a practice, which represented 'mercy' and 'ethical dignity' (p. 61).

In a less critical nursing environment, Thomas, Finch, Schoenhofer and Green (2004) sought to discover the *caring experience* with the nurse practitioner (NP) and patient relationship. Using a nurse theorist's, Schoenhofer's 'Nursing as caring research praxis approach' (2004, p. 1) interviewed fourteen participants in seven dyads. In this study the NP's and the nurses described a connection between human beings, which demonstrated 'enhanced personhood', valuing the person, a 'genuine knowing' and respect (p. 5). Love was experienced which was described as *tender*. There was a mutuality that

involved trust and a reciprocation between the NP and the nursed. Spiritual aspects were described as the NP role being 'God's will and a mission.'(2004, p.5) The research was conducted in the Southern region of the United States of America and this may have influenced the spiritual context of this study.

Swanson (1990) presented a phenomenological study, which looked at the care, provided in a neonatal intensive care unit (NICU). In this complex environment, where there was cultural diversity, with different levels of experience and a range of expertise; love was witnessed. The researcher described a phenomenological model, caring, attaching, managing responsibilities and avoiding bad outcomes. During the attachment stage there can be a 'falling in love' (1990, p. 68) and this is associated with trust and the ability to nurture. The philosophy within the unit was one of an *ethical humanity* that enabled dignity and encouraged connections between staff, relatives, and patients. To form and maintain attachments space and time was required to ensure that authentic care could be delivered. In this complex NICU one neonatologist suggested that a focus on *avoiding bad outcomes* where a move away from attachment could be connected to staff 'burnout' (p. 71) and less engaged practice, This is a factor acknowledged by Vouzavali et al (2011) above, who also noted how the changes in the cultural environment, where its technological, bureaucratic focussed profession not only impacted upon the quality of the feelings experienced by nurses, but influenced their nursing practice, (their attitudes, behaviours and perceptions), which has been evidenced in Robert Francis' report (2013).

Table 5: Findings of key papers that focus on ‘love in nursing care’

Study	Key Findings	Research topic explored	Emerging concepts	Themes identified	Scope for further enquiry	Methodological limitations
Kangasniemi <i>et al</i> (2012)	Human love was the ‘inner essence’ of the ideas pattern running through Estrid Rodhe’s historical nursing textbook and other limited text. Nurses were described as women who had a calling. This calling was based on ‘altruism’, which was influenced by the Christian philosophy. This was the first European ethical guide written for nurses.	Love in nursing was explored from the position of a woman living and working in the early twentieth century.	A nurse was described as having characteristics: Being a virtuous woman. Ethical duty to demonstrate subservience, which reflected ‘human love’.	Human love is the foundation of nursing ethics. Nurses who achieve this are virtuous women. It was the nurses’ duty is to be subservient to implement and practice ‘Human love’.	The exploration and enquiry of historical nursing text is useful in describing the context in which nursing ethics has informed the development of the nursing profession.	The ‘History of Ideas’ and <i>Ideas Pattern</i> were described, but there was no reference to how the text was systematically analysed. The researchers interpreted the text, but there was no subjective narrative indicating the researcher’s bias.
Vouzavali <i>et al</i> (2011)	Critical Care Nurses (CCN) experiences of intense therapeutic relationships with their patients.	Using Heidegger’s concept of ‘being’ the researcher’s explored the language and symbols nurses used in their narrative. Through	Love, awe, and compassion were described followed by empathy. All of these emotions	The symbiotic relationship was described as the ‘emotive aspects of the nurse-patient	This was a credible study and began with a description of ‘love in nursing care’. This paper	The scale of the study was small. The cultural and language issues may have caused some

	<p>Verbal communications are compromised; the intimacy of touch is used to express the caring role. Nurses felt love, compassion and empathy for their patients. The metaphor, 'syncytium' is used to describe the nurse and patient being as one organism.</p>	<p>assessing the nurse-patient relationship through space and time where the concepts emerged.</p>	<p>gave the nurses an experience of 'authentic care'.</p>	<p>relationship'. The researchers found: 1. A perception of ownership in the nurse-patient relationship. 2. The relationship was both gratifying and wearisome. 3. Nurses were aware of the spatiality and temporality of the relationship. 4. A relationship between body and gaze. There was a reciprocity, and mutual dependency.</p>	<p>invites further exploration on the emotional aspects of nursing care and the therapeutic relationship between nurse and nursed.</p>	<p>interpretation issues around the meaning of love.</p>
<p>Perskyet al (2008)</p>	<p>The authors correlated the 'Caring Factor Survey', completed by patients with the nurses 'Healthcare</p>	<p>Love was described as being part of the RBC approach. Caritas described as love and caring.</p>	<p>Watson's framework of Caritas was described for effective caring. This includes</p>	<p>Uses Caritas to describe love and caring which was seen as 'healing'</p>	<p>The researchers suggested that caring and love may be critical elements in 'healing and</p>	<p>The study made assumptions about the characteristic of the Caritas. It relies heavily</p>

	Environment survey' which suggested that nurses who demonstrated higher levels of love and care became more frustrated with inadequate healthcare environments and resources. This maybe because it impacted on their value system and care practice.		love. This was described as an integral aspect of care.		patient outcomes'. It is suggested that further research on healing and caring may demonstrate cost savings in our current Health care system.	on one nurse theory,' Watson's theory of caring and Caritas'.
DeVries (2004)	The act of washing feet may be a positive experience, through an 'interconnectedness' between nurse and patient. Not all nurses in the sample enjoyed the experience.	Love was explored in the literature review and interpreted in the samples' described experiences. : <ul style="list-style-type: none"> • Humility • Selflessness • Giving without reciprocity 	Through an act of touch the researcher interpreted the nurse's experience as representing, humility, love, caring with pseudo religious symbolism. The authors noted that the nurses were going beyond their duty of care. Reciprocity was		Further research on the effects of touch in relation to healing and caring.	The rational for 'foot washing' was not explained to the sample. Small study. No descriptive perspective from the patients.

			recognised as being present in the state of 'selflessness'.			
Geissler (1990)	The results were supported by 'Greenberg-Edelstein's model of positive reciprocity of nurturance. Reciprocity flows between the nurse and nursed.	Love is described as part of the conveyance of a shared humanity.	In building the theory 'conveying shared humanity, love was expressed with, touch, trust, caring, compassion, acceptance, understanding and holistic.	Nurturance Enabled which maximum potential, provides physical and emotional support, through the engagement of supportive interactions and conveying a shared humanity.	Nurturance as a broad topic was narrowed down to a set of the behaviours which can be further explored.	The sample was homogenous and restricted to RNs who were Caucasian females who mostly worked in the Northeast of the USA
Fitzgerald <i>et al</i> (2000)	Love in nursing was seen as going beyond the duty of care; being a knowing risk taker, sacrifice without reciprocity and empowering patients.	Love in nursing, an understanding, willingness and commitment to place the nursed before oneself without reciprocity.	Choice and control for patients. Nurses going beyond the traditional duty of care, a moral condition, flexible thinking, nurturing in a relationship of understanding	Love without reciprocity	This study was part of a larger research programme.	Focus group concentrated on one extreme nursing intervention.

			and other belief systems.			
Swanson (1990)	Complexity of care provision, caring, attaching, managing responsibilities and avoiding bad outcomes	Care in NICU described as 'Sometimes it's an act of love'. 'Falling in love' with babies 'Nurtured and come to love' 'An act of love more than anything else', mother's description.	Knowing, being with, doing for, enabling, maintaining belief, Communicating, performing Taking on, maintaining, letting go. Directing action, Inhibiting action	Caring Attachment Managing responsibilities Avoiding bad outcomes	Each of the themes can be further explored with NICU or other health care settings. Responsibilities management suggested as a topic, as emphasis on bad outcome avoidance may be associated with 'burnout'	Two papers are represented in one article, which compromises clarity.
Karlsson <i>et al</i> (2010)	Presence refers to more than the physical being present. Being cared for means there is a 'present carer' Not being cared for means the carer is absent.	Carer's with love in their hands. Soft, careful, doing good, ease, having an inner awareness, alleviate suffering, Mediate caritative caring.	Being present: Listening with their hearts, love in their hands, warmth in their voice. Not being present: not being there, insensitive hands, not listening	Being cared for: the carer is present Not being cared for: the carer is absent.	Use of autobiographies to explore 'love in nursing' from the patient's perspective.	This autobiography was selected for the quality of its description and the reflective accounts of one patient's experience.

<p>Thomas <i>et al</i> (2004)</p>	<p>The caring experience: love, respect, trust, mutuality, spiritual expression, and enhanced personhood.</p>	<p>Love: deep, tender affection, solicitude as found in kinship, underlying oneness.</p>	<p>Nurturing, non-romantic love, entering the world of the other, reciprocating caring. Spiritual expression, artistry in nursing, a shared lived experience.</p>	<p>Love, respect, trust, mutuality, spiritual expression, enhanced, personhood.</p>	<p>Researcher views spirituality and personhood as areas for further enquiry. Research to explore implementation of caring into NP curricula</p>	<p>Purposefully selected dyads. Randomly selected sample may be warranted.</p>
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Meta-synthesis

A meta-synthesis was conducted using the mapping principles and classification methodology described by Hart (2003, p. 142). The purpose of the mapping and analysis was to draw out the 'ideas and concepts' in association with the research method and design implemented, enabling access to 'knowledge on a phenomenon, topic or problem' (Hart, 2003, p. 142). Where a history of the topic can be identified and evaluated. The literature review is a comprehensive map of the topic being analysed (Hart, 2003).

A concept map was produced to review the literature. The ideas, concept and codes were systematically categorised to enable 'progressive analysis' (Hart, 2003, p. 157). The categories were then assessed and moved into appropriate themes. The analysis through mapping permitted me to see relevant connections between the categories and themes leading to 'declarative knowledge' (Hart, 2003, P. 145). This refers to having an understanding of the topic. A procedural knowledge is attained, whereby the information is categorised and relationships are formed between the identified categories and where knowledge is accumulated (Hart, 2003).

Meta-synthesis of themes within the literature

Table 6: Themes and codes that reflect love in nursing and the attitudes and core belief

Themes	Descriptive terms used (referenced)
Attitude: selfless, going beyond, touch, trust	<p>Rodhe's leading and absolute ethical basis to describe human love in nursing is altruism (Kangasniemi and Halo, 2012)</p> <p>The relationship with the patient is perceived as a close human relationship, which stirs emotions and evokes an experience of selfless love (Vouzavali et al 2011)</p> <p>...may have manifested as a result of the 'purity' of the act of washing feet, implying a state of selflessness which the nurse were unaware (de Vries, 2004)</p> <p>It is, in their words, 'going beyond the traditional duty of care (Fitzgerald and Stan van Hooft, 2000)</p> <p>Carers who had love in their hands were interpreted as an inner awareness of the ability to use their hands as tools for the alleviating suffering (Karlsson and Bergbom, 2010)</p>
Relationships: Being present Attachment Therapeutic	<p>For the nurses, "falling in love" with their primary babies was a fairly common experience (Swanson, 1990)</p> <p>"...nurse and patient form a syncytium. That is, they end up being the same organism. They are symbiotes, one effects, the other..." (Vouzavali et al, 2011)</p> <p>The caring between the NP and the one nurses manifests as mutuality-mutuality of love, trust, and respect. The connectedness between the NP and the one nursed reflects the intimacy of non-romantic love-a genuine knowing the other person' (Thomas et al, 2004)</p> <p>This more personalised statement suggests that the nurses nurture people in a relationship. But more, they nurture in a relationship of 'understanding with people' (Fitzgerald and Stan van Hooft, 2000)</p>

<p>Human Values: Ethics Benevolence Reciprocity</p>	<p>Conveying a shared humanity occurs when the nurse recognises, accepts and appreciates the feelings and needs of her patients and renders 'tender loving care' humanely, compassionately and non-judgementally regardless of the patient's behaviours, situation or beliefs (Geissler, 1990)</p> <p>...evidence of Caritas was inferred. That is, the patient viewed the more caring nurses as those who honoured their individual wholeness and unity of mind-body-spirit (Persky et al, 2008)</p> <p>We found that ethics is the cornerstone of Rodhe's conception of nursing, and the inner essence of her idea pattern consists of human love (Kangasniemi and Haho, (2012)</p> <p>The carers expressed something special that eased his suffering, something that he could not grasp, but could only sense as a good spirit: "The soulful thing you cannot see, but feel the result of" (Karlsson and Bergbom, 2010)</p>
<p>Context: Caritas History Western health care</p>	<p>...however, the new claim was that, for one to be an 'effective' nurse, one needs to go beyond the legalist view of the duty of care and to love in the act of professional caring (Fitzgerald and Stan van Hooft, 2000)</p> <p>Furthermore, frustration among high scoring CFS nurses may also arise from recognising that authentic caring ("caritas nursing") takes more time and resources than are available (Persky et al, 2008)</p> <p>The shared time and space between a nurse and a patient is awash with forceful experiences, implicit encounters and strong feelings impenetrable by all others (Vouzavali et al, 2011)</p> <p>One fact is clear, nurturance is fundamental to our profession and what we do for clients and with clients` (Geissler, 1990)</p> <p>Being present is understood as an expression of caritas, mercy and love, the "core" or essence of caring that provides caring with ethical dignity and the carer an ethical standpoint (Karlsson and Bergbom, 2010)</p>

In table six I present the themes with quotes taken directly from the studies text to best represent how codes emerged from the researcher's narrative.

The thematic analysis unveiled four themes. These themes, sub-themes and codes are presented in Table 7 below:

Table 7: Synthesis and coding

Theme	Subthemes	Codes
ATTITUDE	Selfless Going beyond	Tender Courage Sacrifice Touch Trust Authentic
RELATIONSHIPS	Being present Attachment Therapeutic	Nurture
HUMAN VALUES	Ethics Benevolence Reciprocity	Empathy Dignity
CULTURE/CONTEXT	Caritas History Western health care	Time

Discussion

Of the nine studies included in the review, all but one used a qualitative method. One study used a mixed method approach (Persky et al, 2008). Where the early history of the nursing profession and the attributes that described a good nurse was explored by one study (Kangasmiemi and Haho, 2012). This was a scene setting study, which has helped to provide context to the topic being explored, love in nursing care. The structure that identified how the knowledge on a topic was formed was an integral part of the review of the literature (Hart,

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2003) and the use of the *History of Ideas* has framed the nursing profession in its cultural origins, which influenced the early part of the twentieth century.

The meta-synthesis revealed that the concept of love might exist in nursing care; love appeared to be represented by four themes: attitude, relationships, human values, culture (context). All nine studies indicated that love in nursing care was associated with an attitude that was portrayed through devotion (Kangasniemi and Haho, 2012), selflessness (Vouzavali et al, 2011, de Vries, 2004), and going beyond a sense of duty, (Fitzgerald and Stan van Hooft, 2000, Karlsson and Bergbom, 2010). Attitude was also apparent through actions such as trust (de Vries, 2004, Fitzgerald and Stan van Hooft, 2000, Geissler, 1990, Swanson, 1990, Thomas et al, 2004), which demonstrated tenderness, (Kangasniemi and Haho, 2012, Geissler, 1990, Thomas et al, 2004) and touch, (Vouzavali et al, 2011, de Vries, 2004, Geissler, 1990, Karlsson and Bergbom, 2010). Love was viewed as being within a relationship with patients (Persky et al, 2008, de Vries, 2004, Geissler, 1990, Fitzgerald and Stan van Hooft, 2000, Swanson, 1990, Karlsson and Bergbom, 2010, Thomas et al, 2004). All nine studies seemed to suggest that love was expressed as an ethical approach to care, which was apparent in the benevolence demonstrated in caring, the sense of a shared experience and reciprocity. The final important construct associated with love in nursing care was the context in which the nursing was being explored. These nine studies described love within the context of the nursing professions' origins in the early twentieth century, and through the gaze of a westernised health care provision. The legacies of religions are evident in descriptions of *caritas* being the foundation of love in nursing (Kangasniemi and Haho, 2012, Persky et al, 2008, de Vries, 2004, Karlsson and Bergbom, 2010).

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An important element of love is the time dedicated to its occupation (Vouzavali et al, 2011, Persky et al, 2008, Swanson, 1990).

In describing love in nursing care the studies also indicate where love is diminished and the act of loving in nursing is compromised. Persky et al described how the care environment and situation could frustrate nurses and have an impact on nurses' job satisfaction. These nurses explained that there needed to be sufficient time, 'to give authentic care' (Persky et al, 2008, p19). In Vouzavali et al's, 2011 study of nurses' caring relationships in critical care environments, the researchers reported the nurses concerns that the, 'technology and professional and procedural' requirements can rob them of time and space needed to form connections with patients (Vouzavali et al, 2011, p148).

Fitzgerald and Stan van Hooft (2000), in their Socratic dialogue, highlighted a possible risk that Western health care culture may encourage staff to just aspire to reach minimum standards and not go beyond this in their practice. The efforts channelled into 'bad-outcome avoidance' (1990, p. 70) by nurses and other health care professionals in a Neonatal Intensive Care Unit (NICU) which were viewed as emotionally depleting, and 'the failure to value caring and attachment may serve to diminish their likelihood of occurrence' (Swanson, 1990, p. 72).

If love is to be evident in nursing care, this needs to be incorporated into education, and its essence written into care standards to ensure that love in nursing care becomes a standardised value and attribute for future training of

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nurses. The registered nurses professional code of conduct (NMC, 2008) continually reinforces that nurses are accountable for their actions and their omissions. Currently there is reliance on evidence-based practice for care and treatment of patients, whilst fundamental human, emotional, experience or instinct, appears not to be valued as a scientific outcome.

Limitations to the Literature review

It is important to note that there were limited research studies available which directly affected this research project, with only one study that fully supported the topic (Fitzgerald and Stan van Hooft, 2000). The literature review was conducted to identify the construct of love in nursing care. Finding research studies that explicitly explored the definition and meaning of love demonstrated an absence of research activity in this area.

An agreed definition of what love is in nursing care may facilitate explicit dialogue with nurse educators about how this might be transferred into student nurse enrolment, curriculum design, nurse recruitment processes, and to subsequently benchmark this against quality assurance systems that measure standards of care.

Conclusion

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Flick suggests that a good starting point for any research study is the 'contradictory results and findings' from previous studies (Flick, 2009, p. 51). There was a limited amount of research found in the literature search, which restricted the search review and further confirmed that no studies of this kind have been implemented for several decades. The nine studies that were reviewed here, although not in opposition with each other, gave scope for further exploration. Represented here is a small-scale literature review. This limitation may reduce the credibility of the review and further research into love in nursing care is warranted.

The patterns that have emerged from the meta-synthesis suggest that there is a nursing ethic, distinct to the nursing profession that should be revisited. Conducting further research to extract meaning and understanding of love in nursing care from the perspective of nurse educators may assist in the nursing profession articulating a clear nursing ethic, which can be integrated into nursing education.

Chapter Three

Research Approach and Research Method

The literature review provided an indication of the qualities of 'love in nursing care' that have previously been described. What is missing from the literature is an understanding of love in nursing care from the perspective of nurse educators.

In this chapter I will describe the research methodology and method that I chose to conduct this exploratory study. Greenhalgh suggests, '... that authors frequently misrepresent...what they actually did and over state its originality and potential importance' (2010, p. 49). Following Greenhalgh's guide the reader will be able to see clearly the 'type' of study carried out, the number and make-up of the participants, how information was gathered and the framework used to analyse the data, (Greenhalgh, 2010, p. 59).

There is a requirement for the nurse educators of today to play a pivotal role in ensuring that all graduate nurses join their profession fully prepared to demonstrate the six competencies defined by the Chief Nurses of England (DH, 2012). These were introduced in Chapter One and accord with the Francis recommendations and the NMC response, (2013).

Nurse educator's responsibilities extend to recruiting the right student nurses onto the graduate courses. The Royal College of Nursing (RCN) in their rejoinder to the Mid Staffordshire Hospital public enquiry, concurred with the recommendation that

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'...we must recruit student nurses who exhibit the right values, display a desire to deliver compassionate care and learn the technical skills essential to modern-day nursing' (RCN, 2013, p 4).

The Willis Commission, (RCN, 2012), reviewed pre-registration nurse education in England, and did not find any major concerns or short falls in the provision of nurse education. It was interesting to note that the Willis report was informed by the NMC and a public consultation; the public articulated the need for nurses to, 'practice in a compassionate, respectful way, maintaining, dignity and well-being...' (RCN, 2012, p. 13). The RCN initiated the independent Willis commission following, '...the concerns expressed about the modern nursing profession in many sections of the media...' (RCN, 2012, p 4)

There are many government, nursing and public reports that now use terms such as compassion, care, dignity, respect and values. Nursing once used the term *tender loving care*, which could be seen to encompass compassion, care and so forth (Wright and Sayre-Adams, 2005). However this phrase has vanished over recent years, thus it is within the context of recent issues regarding poor care, that it seems timely and appropriate to explore the topic of 'love in nursing care'. The search for meaning and understanding of this concept led me to approach this research using a qualitative method of enquiry. Qualitative research is normally the research method of choice when the researcher wishes to explore a phenomenon or topic to generate concepts and ideas through an inductive process (Bryman, 2012); this approach can enrich the area of research through offering descriptions of unseen meaning (Williams and May, 2005).

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Qualitative research has a rich history in the humanities, which includes sociology (Williams and May, 2005), where the structure and reason for social action was of interest. This is often associated with a social constructionist position (Robson, 2011) and the pursuit of meaning in the realities that exist for human beings (Williams, 2000). Before qualitative research was legitimised in the 1990s (Bryman, 2012), the quantitative, positivist approach was dominant (Gray, 2011). From the time of the enlightenment to the twentieth century positivism prevailed (Scruton, 2001). In this approach the natural sciences required empirical research to demonstrate that only objects that could be experienced by one's senses could be measured and thus known (Russell, 2001). The quantitative approach dictates that the topic being researched must be measurable, capable of representation in quantifiable data and generalisable (Fielding and Gilbert, 2011). The research findings from quantifiable research when conducted through clear and agreed protocols, aims to be representative of the wider population (Bryman, 2012). Examples of the instruments used in quantitative research are surveys in social sciences and experiments in the natural sciences.

It is for this reason that qualitative research is the preferred research method to explore, 'love in nursing care'. It would be improbable if not impossible to actually measure the love experienced by nurses and their patients. A qualitative methodology would provide rich narrative descriptions of the concept of love and how that is manifested in practice. It is the subject's description of their actions that informs the researcher about a phenomenon in the world (Flick, 2009), and the researcher's interpretation of these findings that builds knowledge about the phenomena (Saldana, 2013). Rather than this knowledge becoming generalised through a large population, an assumption of transferability is made when

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qualitative research is conducted appropriately (Guba and Lincoln, 1989). In this context, when researching love in nursing care the findings may be transferable across the nursing profession from which the sample was chosen (Bryman, 2012). This transferability may be considered sufficiently trustworthy to have relevance for a homogenous group, such as the nursing profession, which shares the same culture, beliefs, values and education as that of the sample (Guba and Lincoln, 1989). It is therefore essential that I demonstrated a quality assurance process (Flick, 2009) and that bias was reduced in the interpretation of the findings (Bowling, 2011).

Through reflexivity I can convey to the readers from which position I have approached the data (Saldana, 2013). This subjective perspective of the phenomenon is part of the research process and should be clearly articulated in the research findings (Silverman and Marvasti, 2008). When the subjective position of any researcher is unclear, then quality assurance concerns regarding bias are created. This is less apparent in quantitative research where the reliability is measured in the appropriate sample size, correlation statistical process controls and external validation processes (Robson, 2011).

We are now in a post-positivist era and even the natural sciences and the quantitative methodologists, on the whole, can bear witness to the value of the qualitative approach (Gray, 2011). In the twenty first century it is common to see the two research methods in tandem, the two paradigms collaborating to enhance the validity of the research, through the triangulation of study results (Gray, 2011).

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My personal reflections on love in my caring roles had led me to believe that it does exist, but this thought comes from my own interpretations of the experiences that I have felt and witnessed during my nursing career. Early in my nursing career I became aware of a sense of connection with the people I cared for. I came to understand that I formed strong relationships with patients and their loved ones. Reflecting on these relationships helped me understand that they stemmed from deep interpersonal communications. There was a clear synergy with Carl Roger's words, 'a sensitive ability to hear, a deep satisfaction in being heard; an ability to be more real, which in turn brings forth more realness from others; and consequently a greater freedom to give and receive love' (Rogers, 1995, p. 26).

Unless we as a society can grasp and understand the meaning of emotions such as love, compassion, dignity and respect, then we cannot know how to share them explicitly as part of nurse education and training (May, 2011). It is very difficult to write a standard that demands compassion in practice, without being absolutely clear about the behaviours that demonstrate expertise in this standard. I hope that this research will contribute to the understanding of the meaning within these words.

My previous experience of discussing love in nursing care throughout my health care career has generated a variety of reactions. When in groups I found that few nurses would discuss the subject without reverting to descriptions of professionalism and regulations. When talking to individual nurses I would often have quite emotional discussions with nurses who had not only experienced strong, deep emotions when caring for their patients, but also actually seemed too long to share their experiences. It was during these long, intimate conversations with

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colleagues who described the love in nursing with such conviction and reverence that I decided to commit to this exploratory research study.

The epistemological considerations in the research design are that I am seeking an understanding and meaning as a consequence of undertaking this qualitative research. Interpretivism is a philosophical framework that leads to the understanding of social realities and social order (Habermas, 2005). With interpretivism, one is searching for the meanings of human actions in association with the social reality that they inhabit. Bryman explains it thus, '...gain access to peoples 'common sense thinking' and hence to interpret their actions and their social worlds from their point of view' (Bryman, 2012, p. 30). Particularly pertinent to this research project aim was Gray's description of interpretism that '...looks for culturally derived and historically situated interpretations of the social life world' (Gray, 2011, p. 27). Williams and May describe the world as being interpreted through 'classification schemas of the mind' (Williams and May, 1996). The German social theorist, Habermas, in his two volumes, 'The Theory of Communicative Action', aimed to explore human actions and interpret their meaning and how social order occurs and is maintained. This has resonance with this project because the fear of being answerable and having to justify ones actions is one claim that maintains social order (Habermas, 2005). This may indicate that there is a fear that maintains a social order, and nurses when conforming to the fundamental NHS (NHS, 2013) rules of safety, effectiveness and efficiency may exhibit this same fear, practicing at a rational level and not engaging at an emotional level.

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Social constructionism is an ontological position that compliments interpretivism.

Ontology is the study of existence, the way of being, (Gray, 2011) whereas epistemology is an understanding of what it means to know (Gray, 2011, p. 17).

Ontology explores how we live, the organisation and our cultural existence, (Bryman, 2012). Normally social constructionism studies groups of people, communities and cultures, whereas social constructivists focus more on an individual (Robson, 2011). In this project social constructionism is the ontological position that I will inhabit. In these positions the social world was described as being separate to the people who live within the social phenomena. Idealism, interpretivism and constructionism view social phenomena and their meaning as being designed, interpreted and played out by the social actors involved (Bryman, 2012, p. 33).

Design Methodology

Data Collection

There are numerous means to achieve data collection when using qualitative methods. Primarily the information required is the description of the lived experience (Glasser and Strauss, 2008). This can be achieved through capturing narratives from subjects who make up the study sample, or through the researcher observing the subject living the experience. Qualitative research is designed to understand the experiences and behaviours of people. This poses the question *why* does someone or a number of people behave in a particular way (Silverman and Marvasti, 2008). This research study was designed to gain a deeper

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understanding of 'love in nursing care', and to disseminate the knowledge available about this topic in the nursing profession.

Previous research, undertaken to explore, love in nursing, used focus groups (Fitzgerald and Stan van Hooft, 2000). Focus groups can bring together a rich seam of experience into one setting (McGivern, 2009). When moderated skilfully focus groups can generate a great deal of information, which can be analysed for key words, phrases and sentences (Fitzgerald and Stan van Hooft, 2000). This narrative can be used to identify concepts, categories and themes. Focus groups as a research method were introduced in the 1940s and had its origins in commercial television in the United States of America (USA), (Silverman, 2011). Group interview techniques were seen to be 'flavour of the month', especially for politicians and social marketing (Silverman, 2008, p. 46). However there was an acknowledgement that focus groups can be problematic; for example the group dynamic can inhibit contributions, especially if the balance of age, gender and ethnicity is not considered carefully (Bell, 2010). My previous experience with practicing nurses' witnessed reticence to discuss love in nursing, or perhaps this was their fear of ridicule, as they appeared reluctant. I was concerned that this reticence might also apply to nurse educators; therefore I decided to use individual interviews to capture the data.

Observational ethnographic-phenomenology was not an option in this research method as I was interested in exploring nurse educators' perspective of 'love in nursing care'. I fully acknowledge that I had to be prepared for the possibility that the findings of this exploratory study may have informed me that there was no description of love, and that love was not experienced in nursing care.

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Ethnography is a discipline of qualitative research that was transferred from the field of anthropology, (Bowling, 2009). Once referred to as participant observation (Bryman, 2012), ethnographic studies require the researcher to spend considerable periods of time observing participants in their social domain. As Gray explains, 'ethnography seeks to understand social processes less by making reports of these events (for example, through using interview), than by participating within them...' (Gray, 2011, p. 170). A recognised risk when implementing an ethnographic study is that the researcher may influence, or alter the study's findings. Robson comments, 'critics of the approach are concerned about researchers getting over-involved with the people being studied, perhaps disturbing and changing the natural setting, and hence compromising the quality of the research.' (Robson, 2011, p. 142). For these reasons I decided not to use this methodology.

For this research project I chose to interview the participants, face to face, using a semi-structured interview technique to access data for analysis. Gray suggests that if the research being undertaken is exploratory and is seeking to examine emotions, this is the preferred approach (Gray, 2011). He explains, 'the use of semi-structured interviews also allows the researcher to 'probe' for more detailed responses where the participant is asked to clarify what they have said. This phenomenological approach, then, is concerned with the meanings that people ascribe to phenomena.' (Gray, 2011, p. 370).

Qualitative research is normally associated with two clear interview strategies, unstructured interviews or semi-structured interviews (Bryman, 2012). Prior to a semi-structured interview the researcher may prepare a research guide or prompt,

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so that certain key areas of the topic can be discussed. Robson refers to this as a 'shopping list of topics' that the researcher wants to hear descriptions of, or explanations of meaning described (Robson, 2011, p. 285). I prepared an interview prompt prior to the interviews for this project (Appendix 2) and if the participant did not cover all the areas on the prompt, I guided them to the topic. This interview prompt was designed during a pilot interview. I commenced the interview by asking the research question, 'what is love in nursing care' and the participant raised the recruitment of the right students into nursing training and education. These issues were then included in the interview prompt. The prompts should be used with consistency and form part of the interview record, (Robson, 2011). Bowling describes semi-structured interviews as interviews where there are structured questions, but these do not have 'response codes' attached to them (Bowling, 2009, p. 285).

One researcher provides clear guidance on how the questions should be asked, 'each of these is introduced by an open question and ended by a confrontational question' (Flick, 2009, p.156). This approach is more standardised than the one I used. I would describe my approach as one of guiding the participants to the question and facilitating them to answer, much in the way Gray describes the interview process, ' the interviewer has a list of issues and questions to be covered, but may not deal with all of them in each interview. The order of questions may also change depending on what direction the interview takes.'(Gray, 2011, p. 373).

With the increase in technological communication interviews do not have to be limited to one locality or one group of individuals. The use of 'Skype, webinar and other face to face electronic media can support a 'longer reach' for researchers

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than ever before (Richards, 3013). The telephone interview is also an option, with the advantages of resource efficiencies, such as travel time and cost to conduct interviews. The disadvantages though are of not being able to assure privacy and the possible depersonalisation of the process (Bowling, 2011). For this particular research study I felt that there needed to be the intimacy of a one to one encounter to facilitate the discourse around 'love in nursing care'.

The technique used for conducting an unstructured interview requires the researcher to allow a conversation to develop, pertaining to the research topic, and to ensure that the conversation remains as informal as possible (Robson, 2011). The unstructured interview is more often used when there are no presuppositions regarding the content of the interview. The informant is free to express him or herself with limited or no interviewee intrusion or organisation, (Morse, 1991, p. 191). This interview method is also known as non-directive interviewing, where, '...interviews are used to explore an issue or topic in depth and questions are not, generally, pre-planned' (Gray, 2009, p. 373).

Structured interviews are also available as a design strategy to collect data, but these are most often used to test theories in a survey situation. The procedure is highly organised with a clear schedule of questions (Morse, 1991, p. 190). This form of data collection presumes that the researcher has a predetermined understanding of the topic, or issue being investigated and is often designed to give quantifiable results.

The Sample and Recruitment

As this was a qualitative project, the sample size was appropriately small. This was to ensure that the narrative was captured in its entirety, which may result in a considerable amount of data to be analysed (Bowling, 2009). Bowling further explains the rationale for a small sample size, '...because the data aim to provide rich insights in order to understand social phenomena rather than statistical information' (Bowling, 2009, p. 410). The issue of resource was also a contingent to be considered. Time and cost would inevitably influence the sample size (Bryman, 2012). A qualitative research project should be designed to produce information that will enable the researcher to '...discover meaning through fine attention to content of text or images (Richards, 2013, p. 24)

The Sampling Strategy

A purposive sampling strategy was designed for this project, as this was the sampling technique best intended to draw out the experiences and understanding of a particular expert group. Purposeful sampling is not uncommon in qualitative research, and is used to ensure that the sample can add their experience of knowing to the subject, or topic being studied (Silverman, 2011). However as this was a small study based in one school the sampling strategy developed opportunistically. This method enabled me to include participants who had knowledge of the topic being researched and who were available. The strategy had disadvantages associated with the omission of data and the possibility of bias when selecting the sample (Gray, 2011). This was avoided in this study design, by

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ensuring that the advert, requesting participants for the research, was sent out across the entire Faculty of Health (Appendix 3). Although the nurse educators could be viewed as a homogenous group, their views with regards to the research topic were unknown to me prior to the interviews (Bowling, 2011). This purposeful strategy has been used to enhance the understanding of issues such as human emotion and experience; it is more concerned with an increase in this understanding than in the generalisability of the results of the study (Marshall, 1996). In this research study, the sample was selected because of the knowledge and experience the sample could bring to the research topic. Any contact and discussions between the participants would not adversely affect the findings, because it would be the samples interpretation and subjectivity in relation to the research question that was being explored, not a search for a known truth (Bryman, 2012).

For this study the sample would be required to have knowledge and experience of nursing and nurse education. A School of Nursing and Midwifery in England was considered a good source of sample participants. The inclusion criteria were that the samples were registered nurses, from any discipline in nursing. I had wanted to ensure a good mix of gender, length of service and nurses who worked in different settings and practice situations.

A consideration that I had to be mindful of was the work commitments and time constraints that all the nurse educators worked with. I decided that I would travel to each of the participants preferred location to meet with them, finding rooms to book, and to enable privacy during the interviews. I believed this

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helped to facilitate the involvement of some of the participants. For this exploratory study, a minimum of ten participants was judged to be necessary to capture sufficient data to contribute to the exploration and interpretation of the phenomena being studied. With the purposeful sample of ten nurse educators it was anticipated that sufficient information would become available to enable me to reach data saturation.

Sample Recruitment and Consent

The first part of the recruitment process consisted of sending a letter to the Head of the School of Nursing and Midwifery, to introduce the proposed research project (Appendix 4). I then had a meeting with the Head of the School of Nursing and Midwifery, and ensured that she was fully apprised of the aim of this research project and its methodology. My supervisors approved the project outline; in addition the Associate Head of School for Research assessed the proposal.

I requested that the senior administrator for the School of Nursing and Midwifery send out an invitation to nurse educators using the University intranet.

Participants contacted me directly via email. Once a nurse educator had indicated that they were interested in participating, I emailed them a letter of invitation (Appendix 5), an information guide and a consent form (Appendix 6).

Ten nurse educators contacted me by email volunteering to participate in the research project. All participants signed a hard copy of the consent form and

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this was filed securely, in line with Data Protection requirements.

The interviews were all conducted in private rooms, where confidentiality and some comfort could be afforded to the participants. Only on one occasion was the interview interrupted by a colleague entering the room. The interview was stopped, and the participant and I relocated in a quiet meeting room where no further interruptions took place. I ensured that the participant was not unduly troubled by the interruption and that they were calm and secure before restarting the interview.

The genuine enthusiasm of the participants who wished to take part made arranging the interviews fairly straightforward, as they were very accommodating even though they all had substantial work commitments. This appeared to be an advantage to conducting interviews, rather than using the focus group design. Trying to organise a number of busy people to commit to and liaise at the same time during a busy working day would have added to the logistic consideration in this project. Arranging individual interview meetings with the participants added much needed flexibility to the research design. As the researcher, I ensured that I had time away from all other work commitments during the month that the interviews were planned to take place. This worked very well enabling me to accommodate the participants preferred dates.

I did not receive any communication from any other nurse educator wishing to discuss the project in any more detail, or to express an opinion in any way.

Those who did offer to be involved appeared to be the number of nurse educators who were interested in the research topic. Previously I suggested

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that nurse educators may appear to be a homogenous group, those with similar values and views with regards to issues in their area of expertise (Robson, 2011) but this cannot be assumed, and there may be a heterogeneous sample that held varying and diverse views on the topic 'love in nursing care'. Using a different advert or implementing a different recruitment strategy may have encouraged a more diverse group of nurse educators to volunteer. The participant profiles are listed in Appendix 12.

A volunteer nurse familiar with nurse education assisted me to complete a pilot interview, prior to the sample interviews commencing. The procedure was conducted as a face-to-face interview, to ensure that the interview process was appropriate, and likely to ensure full participation of the interviewees. This aided me with my style, timings and consideration for the interviewee's comfort and confidentiality.

The Interview process

Once the participant had signed the consent form I asked if they wished to have any further information about this project prior to actual interview. They had all previously received the study information guide.

An understanding and acknowledgement of my perspective when embarking on this research, was an important part of the interpretive process in this qualitative research. Reflexivity and reflection through narrative was a creative and

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meaningful process that would add meaning to the research process and findings (Saldana, 2013). The ability to explain perceptual positions through an extensive vocabulary aids the research project, by ensuring that the phenomenon was put into context, (Saldana, 2013). Qualitative researchers are part of the research, they cannot leave their subjectivity behind, and so must be sure to make this part of the research process, an overt part of the information finding, interpretation and theory building (Bryman, 2012).

To demonstrate integrity I have been consistent in the information that I have given to the participants. This can be seen in the information guide sent to the participants prior to the interviews (Appendix 7), and in the reflective account that I used to introduce each participant to the interview process and this is evident in the field notes I wrote immediately following my interviews (Appendix 8).

Before the interviews could begin I explained that I would be using a digital recorder to capture the interviews verbatim. Consent to record the interviews was requested of each participant, and this I received prior to turning the recording device on. I endeavoured to make this recording process as inconspicuous as possible, as I did not want it to interfere with the required rapport building and retention throughout the interview. The whole process had to feel as comfortable as possible.

My responsibility was to hold the participant safely in the interview process, committing to a relationship for the duration, and possibly beyond the interview.

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Rapport takes effort and expertise (Guest, MacQueen and Namey, 2012). Time in the interview process had to be allocated to ensure that both researcher and participant could be 'mindful' of each other's sensitivities. I described the interview process, asked permission to record the interviews, guaranteed confidentiality and responded to participant's questions (Gray, 2011).

The information guide had been explicit in its explanation that the interviews would be confidential and anonymity would be assured. This started with me trying not to refer to the individual interviewee by their name during the recorded part of the interview. I did unfortunately use first names, on one occasion in three interviews. The interviewees were accepting that this would be omitted during transcription. Not using participant's names, I was concerned would have created rapport problems, but with good eye contact, gentle pacing of the questions and conversation rapport was not inhibited.

Only one participant was apprehensive that lack of concealment may occur, as their discourse had been generously revealing and emotional. I assured this participant that all appropriate research procedures would be used and that confidentiality and anonymity would be maintained.

The emotional aspect of the interviews should be given some consideration. The majority of participants became emotional and some were tearful whilst talking about 'love in nursing care'. At no time did I feel the emotions were inappropriate but I had a responsibility to monitor the participants and ensure they arrived safely to secure emotional ground at the interviews completion.

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The time that participants were engaged with the interview ranged from thirty minutes to one interview taking just over seventy minutes. The length of the interview seemed less important than the quality of the dialogue and description being offered. The shorter time frames did not equate to less valuable interpretations, they simply reflected a different means of sharing the participants' perspective. During the interview process I was mindful of the humanity each participant shared with me in their narrative and their demeanour. Part of my role as the qualitative researcher was to 'give voice' to my participants humanity (Guest, MacQueen and Namey, 2012, P.13).

All the recorded interviews were sent via secure email to a recognised professional transcription service, where the interviews were transcribed verbatim. Each interview transcription was sent back to me via secure email, and these were stored on my computer, which was password protected, in a password-protected file. All the digital recordings were stored on the digital recorder, in a locked draw in my home office. These recordings were then transferred onto my home password protected computer in my office and these were all coded to ensure anonymity.

The transcriptions were printed to make hard copies available to work on for the data analysis. The hard copy transcripts were stored in my home office in a locked filing cabinet and were coded so no names appeared in the text.

At the end of each interview I offered to send the participants their transcript. I wanted the participants to feel confident in the interview process and to share their words and thoughts with them. Two participants were sent their transcripts and neither wished to have changes made or contested the content of the narrative. This process is known as 'member checking' and normally takes place at the end of the research project. This process may present problems if used as Richards explains, '...it is important to think through the very many possible interpretations of members having agreed or disagreed with how you see it' (Richards, 2013, p. 149), because of this it is essential that this process is not used as part of the research quality assessment process. Originally Guba and Lincoln suggested that 'member checking' was important in demonstrating the credibility of a qualitative research project and went as far as to say, 'this is the single most crucial technique for establishing credibility' (Guba and Lincoln, 1989, p. 239).

Ethical Considerations and Data Protection

Ethics approval was sought and gained in November 2013 (Appendix 9) through Plymouth University's Faculty of Health, Education and Society.

This research project abided by NMC principles and this is evident in its design and the information given to the participants. The nursing profession has clearly articulated the ethical expectations required to be followed during the design and implementation of research, and these reflect the previous principles, which

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include, treating individuals with respect, ensuring transparency, honesty and the right to confidentiality, which is written into the nursing professions code (NMC, 2008).

The participants were all offered an opportunity to discuss the research project and any aspect of the methodology and outcomes, either face-to-face or with me on the telephone prior to conducting the interview.

The participants were allocated numbers and letter codes and were not referred to by name or location at any time before, during or after the interviews. This was designed to give participants confidence that their anonymity was assured.

The research question explored love in nursing care and there was a risk that this may have raised emotional issues. Love is an emotive word and its very use could be assessed as provocative and result in a negative reaction. In all research the benefits of completing a project must be weighed up against the negative consequences that may emerge (Robson, 2011). To ensure that participants came to no harm all research projects must conform to the European Declaration of Human Rights (Robson, 2011). Following the interviews I reminded the participants that they could contact me at any time if they required reassurance or support. One participant did become particularly emotional during the interview. I asked if we should stop the interview, but the participant wished to continue. The narrative that the participant was sharing had engendered emotional distress whilst describing an episode of end of life care. Following the interview we discussed the anonymity issues and the risk of any identity being disclosed. I sent this participant the full transcript of the

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interview and I asked if she would like me to withdraw this interview from the project. The participant was satisfied that I would ensure their anonymity and agreed for the interview to be included in the project.

Details of the University counselling service were available should it have been necessary for me to refer any participants for support.

This provides a clear demonstration of how important it is to honour participant's human rights. Gray clearly sets out the ethical principles that researchers must abide, 'avoid harm to participants, ensure informed consent of participants, respect the privacy of participants and avoid the use of deception (Gray, 2011, p. 73).

In undertaking the role as interviewer I understood that the interviews could have engendered emotions for me that I had not anticipated. To ensure that my own well-being was maintained I sought support from my two University supervisors. I was also aware of the resources available to me or to any of the participants, if needed, available through the university, such as on-line counselling services and the self-referral counselling service.

Qualitative Data Analysis

I have described briefly my own theoretical position with regards to this exploratory study. It is essential that those reading this study understand my approach and that I bring integrity to this work.

Interviews were transcribed by an independent transcription service. In order to assess the integrity of the transcriptions and ensure that there were no errors, I listened to all the interviews whilst reading the transcriptions. This also enabled me to interpret the silences and nuances in the participants' responses.

The data analysis was systematic and rigorous (Pope, Ziebland and May, 2000); using a Framework Analysis approach, which lends itself well to health care and policy research (Lacey and Luff, 2009). The sequence of analysis is linear and commences with familiarisation of the transcribed interviews. This can be undertaken as the research progresses and often enables a refining of the questions, and a discovery of emerging concepts and new areas for exploration (Pope, Ziebland and May, 2000).

As the familiarisation continues, the next phase of analysis commences, which is identifying a thematic framework. Here an index of themes and categories began to be identified and indexed. Again this is an intensive filtering and revealing process, similar to sieving for the gold particles in a stream, but the more the researcher sieves the more information will be revealed (Saldana, 2013).

The indexing process was applied to ensure that the thematic framework captured all the issues, from all the participants, and these were included to all the emerging themes. Once all the data had been coded. This information was used to chart the themes and the range of issues. Mapping the data gives a

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visual aid to the patterns that emerge and assists in the development of the interpretation of the data. Ultimately the researcher can have a map that has similar features to a scatterplot graph used in quantifiable research to visually demonstrate the observed trends.

In summary, the following framework analysis was used:

1. I familiarised myself with the data through reading and re-reading the transcribed interviews. This process continued through to writing up the findings.
2. Following familiarisation through reading the text, I listened to the recorded interviews (each interview at least three times). This assisted me with understanding the pauses and subtleties of expression and humour expressed by the participants.
3. Whilst listening to the recorded interviews I mapped out frequently used words and expressions. I did this for each interview and had ten completed colour-coded maps.
4. By examining the colour coded maps I could see patterns emerging through clusters of words and expression.
5. Recognising emerging categories of words assisted me in identifying the key thematic framework.
6. Using of a numerical system I looked for the clusters and categories in the written transcripts. This enabled sectioning segments of data that related to specific themes to be collated.

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7. I transferred all the segments onto separate charts to enable me to see the themes and subthemes clearly.
8. The themes were charted with heading and subheadings. This enabled me to interpret the meaning in the data.
9. Finally I interpreted the data, analysing the characteristics across the participants, (Ritchie and Spencer et al, 2003), which allowed me to develop an understanding of what (according to nurse educators) 'love' is in nursing care.

Trustworthiness

Credibility, transferability, dependability and confirmability (Bryman,2012) are the criteria which were established as standards by which to evaluate the reliability of qualitative research. Qualitative researchers recognised that the measurements of validity associated with the quantitative paradigm were not suitable in the evaluation of qualitative research. Quantitative researchers use an objectivist approach to quality assurance and their research is assessed from a positivist position (Guba and Lincoln, 1998). Guba and Lincoln explained that the judgement criteria of rigor, internal, external validity and reliability were unsuited to the constructivist inquiry, the qualitative paradigm. In qualitative research we are not seeking, 'truths' or 'causation', but exploring participant's experiences by attempting to interpret meaning.

Credibility is understood as judging the appropriateness of the study design chosen for a qualitative research project and assessing the methodologies

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implemented to access findings. This credibility is intended to give peers confidence in the findings of this study (Gray, 2011).

Transferability of this projects findings depended on the context in which it would be transferred. Guba and Lincoln state, '...transferability is always relative and depends entirely on the degree to which salient conditions overlap or match (Guba and Lincoln, 1989, p. 241). To enable transferability I have described in detail, the research method and design process implemented to conduct this study. By providing a complete description of this project facilitated the '...transferability judgements on the part of others who may wish to apply the study to their own situation...' (Guba and Lincoln, 1989, p. 242)

Dependability has been assured through seeking guidance and support from my supervisors. To ensure that my interpretation of the data was not unduly influenced by my own bias, I asked my two supervisors to code two separate transcripts. This coding was completed without consultation between the supervisors or with me. Each supervisor produced a short summary of their interpretation of the data following their own thematic analysis. This information was kept secure and only accessed by myself following my own analysis of the two transcripts. At a meeting with my supervisors we compared the independent thematic analysis results with my own. The results corresponded, with four themes clearly resonant in all three analyses. Following this assurance process I was then able to complete the thematic analysis of all ten transcripts.

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Following, Richie and Spencer *et al.*'s 'Framework Analysis' has meant that the analysis has been inductive, with the inclusion of 'a priori' data in association with emergent themes (Lacey and Luff, 2009).

Confirmability is compared with objectivity in quantitative research (Bryman, 2012) and is associated with the assurance of neutrality of the qualitative research. Guba and Lincoln explain, '...assuring that data, interpretations and outcomes of inquiries are rooted in context and persons apart from the evaluator and not simply figments of the evaluator's imagination' (Guba and Lincoln, 1989, p. 243).

This chapter has discussed the methods I have used to collect and analyse the data, which was gathered through the interview process. The rationale for the design and strategies used are based on the evidence available guiding qualitative research methods. In the following chapter (Chapter Four) I will present and report the findings of the interviews.

Chapter Four

Findings

The participants' demographic details are recorded in chapter three and this demonstrates that all ten participants were nurse educators with varying degrees of experience and specialisms.

The participants were selected to meet the aim of this project, which was to explore from the perspective of nurse educators, love in nursing care. The interview question, 'What is love in nursing care' was the anchor within all the interviews and was referred to by me, (the interviewer), and by the participants to ensure that the conversations remained relevant.

The semi-structured interviews were conducted with the aid of the interview guide (Appendix 2). This guide ensured that the concept was discussed in parallel with the area of education and recruitment. All ten participants talked freely and without hesitation and the conversational style of the interviews enabled an uninhibited disclosure of their perspective of this somewhat abstract topic. Interviews continued until no new data was emerging and saturation was achieved. This was true for all the themes presented here. All the data was coded during the analysis.

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In this chapter I will present the findings appropriated from the narratives shared with me during the interviews. This is a metaphysical exploration, which has involved much iteration of analysis and synthesis to reach immersion and saturation (Saldana, 2013). The process of data analysis was described in detail in chapter three. The major themes and sub-themes are highlighted and the participant's' direct quotes and are numbered per Case. Case one will be presented as C1 and the line from the transcription will be identified numerically i.e.

'Whatever it is it's just to be there with no holds barred.' (C1 65)

The three major themes that appeared following analysis are detailed below see Table 9.

Table 9: Major Themes

Major themes	Sub themes	Codes
Love in nursing care	Therapeutic Relationships Human Values Attitude Context	Presencing, nurture, non-reciprocal, reciprocal, unconditional, empathy, authenticity, touch, nursing culture, NHS culture, time.
Education, training and recruitment	Supervision Role models Recruitment	Nurture, mentorship, self-awareness, attitude, Process.
Barriers to love in nursing care	Fear Gender Pressure	Language, resource, time

Love in nursing care

The participants described love in nursing care as being related to relationships, values, attitude and context.

'It's more of the fundamental meeting someone on a human level, without a uniform, without a badge, without a name, it's to be alongside someone and support them in whatever they need.' (C1 62)

'For me love in nursing care is not about the bio-technical stuff, it's really about your essential humanity' (C4 25)

C10 provided a clear distinction with regards what love meant to her and the emotions, which the participant believes should be excluded in nursing care:

'I thought a lot about this, and I thought about what I regard as love, and I don't see it as love. I just don't. To me love is much more intimate. When I say I love – you know what I'm gonna say – I love my husband, I love my children. Do I love the dog? I don't know, but to me it's much more giving of myself in a way that I wouldn't give to a patient.' (C10 8)

Therapeutic Relationships

This theme developed from the idea that the relationship between a nurse and a patient has authenticity. A nurse feels fully present, being with and for the patient.

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C2 described therapeutic relationships as being selfless:

'And part of our conditioning or, if you like, in nursing is about therapeutic relationship which is where you give but expect nothing back because that is your role as a nurse. So I suppose if you look at it that way, love in nursing is to give love but not to expect it back. And I'm perfectly happy with that, that's not a problem for me at all' (C2 23)

In 2002, when writing about the art of loving and the therapeutic relationship Stickler and Freshwater commented, 'Love is central to human existence and must have a place in the caring professions' (Stickley and Freshwater, 2002,p. 255).

This was similarly described by C9 during the interviews:

'Love in nursing care has to be tied up with the relationship that you have with your patients. I would suggest it underpins compassion and kindness. And it's not about being in love with your patients, it's being able to demonstrate that you feel for them and share their experiences.' (C9 8)

Therapeutic relationships may be difficult to define, 'It is as though the mercurial aspect of the therapeutic relationship makes it at once instantly recognisable, but perennially unfathomable' (Welch, 2005, p. 161). In his study Welch describes therapeutic relationships as having all the following factors present, '...trust, power, mutuality, self-revelation, congruence and authenticity' (Welch, 2005, p. 163).

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Although C10 is clear that love does not exist in nursing care, the participant does equate nursing care with a therapeutic relationship:

'What caring means is – it is about relationship... because unless you connect with your patients you can't give them the best care... And it's really looking at them and their needs. And it's more than their needs. It's who they are.' (C10 35)

In the context of therapeutic relationships, participants talked about a number of examples that could be defined as *presencing*.

This is illustrated in a quote from the first interviewee, C1:

'Whatever it is it's just to be there with no holds barred.' (C1 65)

Karlsson and Bergbom, (2010) in their study of the patient's perceptions of being cared for and not being cared for depict 'The Present Carer', where "Being cared for" meant the carer is present in relation to the patient. More specifically, the carer is present in the task of taking care of the patient's burned skin, but they are also present within the caring relationship, which includes a presence concerning the other person's suffering. The carer is present as a person, which eases the suffering of the patient.'

C4 expresses this presencing as a therapeutic process as described below:

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'The essence of nursing which encapsulates love I suppose, is about being there at the side of a patient going through their experience and helping them to make sense of what their current experience is and how it might pan out.' (C4 20) *'...theories do talk about concepts like presencing and the therapeutic use of self and concepts of emotional intelligence...'* (C4 27)

Caldwell et al in their research described knowing the uniqueness of individual clients, staff listened intently, they cared with confidence, they involved clients optimally, they had the ability to mobilise multiple resources for the client and could agree on mutually defined effective change. This is summed up as, 'Presencing as a strategic channel used by staff in creating therapeutic effectiveness' (Caldwell, Doyle, Morris and McQuaide, 2005, p. 869).

C4 described an example of this presencing that the participant had witnessed in practice:

'And one of the best examples of love and care was a nurse who her main goal in that shift was to physically be present with him, to actually get down on the mattress and hold him. Now that wasn't a technical skill. It was a simple human act of closeness.' (C4 257) *...'* *And when she held him he would calm down. Now, you know, yes, you can never tell about somebody's subjective mental state but you can theorise though. That's a simple human act.'* (C4 262)

Nelms describes presencing thus 'Caring as the presencing of being' (Nelms, 1996, p. 386). She identified the themes of 'timelessness' and 'spacelessness'

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of caring (Nelms, 1996). Presencing is seen as caring with a conscience.

Nelms suggests that this conscience is related to authenticity, which is described as , '...the call to the inner most potential of our being selves' (Nelms, 1996, p. 372).

C8 explained being present as the use of the 'self' in practice:

'And you know that's not about being in the room and it's not about performing the tasks. And I think that for me when I've worked with service users, my colleagues in practice and with students, that you know, this is about talking about the self, right? What I bring is myself to my practice and that is a risk.'(C8 94).

Zerwekl writes '...receptive presence is the foundation for the nursing practice of presencing' (Zerwekh, 1997, p. 260). This researcher concluded, following the review of the literature presencing was a deliberate action and required focus and attention, which included receptivity, and ...'persistent awareness of the other's shared humanity.' (Zerwekh,1997, p. 261).

In addition to presencing *Nurture* was described as an important element in therapeutic relationships. Geissler in her 1989 study posited that nurturance is fundamental to the nursing profession (Geissler, 1990). She identified the following themes identified by her nurse sample, 'enabling maximum potential, physical and emotional protection, engaging in a supportive interaction and conveying shared humanity' (Geissler, 1990, p. 529).

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C2 described this fundamental behaviour below:

'Immediately my kind of, my analytical mind thought, right, well what's nursing? What's love? And how do they come together? So nursing at its essence for me is about nurturing somebody and I suppose love is actually, when I think about it, exactly the same. When you think about the people that you love in your life, they are people that you also nurture as well.'(C2 18)... *' That's the thing you see, is actually being professional to me does mean involving actually the way you use your nurturing skills.'* (C2 458)

Examining nursing from an historical position Kangasniemi and Haho (2012, p. 806) portrayed nurture as being situated in gender, '...essential characteristics as a woman, that is, their special ability to nurture and cherish'.

C6, a paediatric nurse expresses the ease in which she could love the children in her care:

'And I think in some ways it's easier for children's nurses to express love, because it's kind of expected in a way, that children are loved. They are cared for. They're nurtured, and it's easier to do that within the role than maybe it is for adults sometimes. I don't know that that's necessarily how it should be, but I think that's possibly – that there's something about that there.' (C6 277)

Fitzgerald and Stan van Hooft, make no comment of age being an influential factor in their research, which involved older people in their study example.

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They explain that, '...love is an act in which the intention implies acceptance or tolerance of the will of the other and where the other's choice is based on a well-informed health belief. It is bringing the nurses own self to a relationship of understanding and feeling with the patient in order to nurture a state of health, well-being and comfort' (Fitzgerald and Stan van Hooft, 2000, p. 489).

Vouzavali et al's (2011, p. 143) study within critical care described the nurse patient relationship, as emotive, and explained that, 'Caring for the critically ill triggers emotions of love, awe, compassion and concern, which according to participants form the basis for the development of a nurse-patient relationship...a close human relationship, which stirs emotions and evokes an experience of selfless love'.

Human Values

Human values in this sense relates to an individual's ability to give without assuming that giving will be reciprocated, it is unconditional.

C4 expresses this human value in nursing as the person's right to be:

'...now I'm here, you know I have a duty of care to you, so any conditions I might have based on your ethnicity, your religious views, all that equality and diversity stuff, as well as personal prejudices, which I might not be aware of, that has to be set to one side, I'm here. And the positive, the positive regard and looking at somebody on the assumption that they are worth, by the very fact that they're humanity, they are worth; they have a right to be. (C4 56)

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The sentiment shared by C4 was reinforced by C6:

'I think love is important in nursing care. And I think actually having that feeling for people, wanting to do the best that you can for them, you know, wanting to understand what their needs are and to help them in some way.' (C6 17)

In Fitzgerald and San van Hooff's Socratic dialogue the researchers suggested that love was evident when nurses responded and acted on the needs and wants of their patients without the expectation of anything in return. This was conveyed by one of their participants, 'the act is loving when the will of the other is accepted despite your distress' (2000, p. 488). The researchers proposed that love is expressed without any 'expectation' of reciprocity.

In C2's comment below she resonates with the participants in the Socratic dialogue above:

'And part of our conditioning or, if you like, in nursing is about therapeutic relationship which is where you give but expect nothing back because that is your role as a nurse. So I suppose if you look at it that way, love in nursing is to give love but not to expect it back. And I'm perfectly happy with that, that's not a problem for me at all' (C2 43).

Recently Carter has viewed altruism through the prism of 'political and 'civic life', incorporating 'both liberal and radical movements of the past two centuries (Carter, 2014, p. 697). In her study nurses were less prepared to call their

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motivations to 'give' care, altruism, '...while retaining a strong ethical disposition to their practice...' (Carter 2014, p. 703)

In contrast to Fitzgerald and Stan van Hooff's findings that suggested 'no reciprocity' was necessary to love in nursing, Thomas et al's (2004, p. 4) study looking at the relationship between nurse practitioners and their patients found that there was a 'mutuality' that was experienced, which was defined as, 'the quality of correlation; reciprocation; interchange; interdependence...'

C5 describes this reciprocation in her description of love in nursing:

'Love, I think, is about the passion to do something well, to take pride in what you do to care about the effects of what you do. To check in with the patient that they're reciprocating in the way that you want them to, I think. And I think there is no shame in making your patients feel loved and cared for.' (C5 12)

The study of humility through the washing of patients feet enabled de Vries to recognise the reciprocity experienced in this intimate act, '...for the nurses there was reciprocity that occurred through participatory experience that went beyond intentionality and may have been a response to the 'purity' of the act of washing feet, implying a state of selflessness of which the nurses were unaware' (de Vries, 2004, p. 584).

C6 describes being rewarded for her commitment to give time to her patient:

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'But if you did take the time and you spent the time and you got to know her, it was just so rewarding.' (C6 186). The participant expands on this sense of being rewarded: *'I mean that's what made it so rewarding really, was that, you know, you could tell that she was happy to have me, at that point, around. She would respond to me and she would look happy, coming in the room, and coming in spending time and so on. And that made a big difference as well. I think having that reciprocal relationship is just lovely.'* (C6 208)

Hem and Pettersen (2011) talked about having 'asymmetrical' professional relationships with all agents, involved in mature care, and these were of equal importance.

C9 suggested that the emotional bond formed in nursing between nurse and patient was natural and may not be transferrable through teaching:

'I mean I love nursing and I'm passionate about nursing, and what I like most about it is being with people. And therefore it is an emotional bond quite definitely. Those are the things I don't think you can teach other people. You either have a sense of reward and satisfaction just from the nature of how you are with people.' (C9 69)

The sense of connection was reinforced by C4:

'Go back to your fundamentals. If you can't see the connection between thinking ecologically and connectedness you can't see connections between human beings. If you can separate off that's not me, that's not me, that's

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nothing to do with me, and that's your philosophy then it's a small step going into a clinical ward and saying, you're not me, you're not me, you're not me either.'

The preparedness to be connected without proposing conditions was reinforced by Kangasniemi and Haho (2012, p. 805) when they explained Rodhe's concept of nursing ethics, '...Rohde's notion of nursing, and the inner essence of her idea pattern consists of human love; it is the heart of nursing, but also the moral imperative behind it, requiring personal moral courage'.

C 4 reflected on these behaviours in his comments:

'...things like unconditional positive regard as one of the three conditions that you approach the encounter with, and I think that applies in nursing education but it kind of like applies in, could apply in nursing practice. If you're expressing, if you're being loving in nursing, if you want a hook to put it on then unconditional positive regard might be a hook to put it on.' (C4 43)

This unconditional connectedness was described in Persky et al's study through patient's 'viewing' '...caring nurses as those who honoured their (patients) individual wholeness and unity of mind-body-spirit' (Persky et al, 2008, p. 18)

In C 7s description of caring for men early in her training, she explains the sensitivity demonstrated, by the experienced nurse to the male patients and their tenderness towards her as a novice:

'But they dealt with it so expertly that, you know, I was never alone, and it was done in such a sensitive way. Yes, it was shocking, when I think about it, yes, it was shocking but it was also done with love, you know. It was very practical love both for the person that we, you know, the patients that we were working with, the men. There was no sort of anti men or kind of, you know, managing these disgusting things that happen, you know, it was none of that. It was just very practical, this is what happens, natural, physiological response, this is how you deal with it. But it was done in a loving way.' (C7 307)

The courage to care for patients unconditionally is depicted by Karlsson and Bergbom (2012, p. 62) ' "Care for" can be characterised by the carers' expressions of the will and courage to be there for the patient...'listening to their hearts and allowing caritas to become the core within caring in practice'.

C8 explained what this unconditional care was in practice:

'For me I think it's that really being able to see another person's vulnerability. They're there, they're really in that place that no matter who they are, no matter what they've done, right then and there they need, they need goodness. Just need a person who is going to be able to be kind, actually.'(C8 366)

Kikuchi in her studies of nursing and transcultural values explained that people have wants and needs. The wants and desires are fuelled by human beings will (Kikuchi, 2005). When these wants become aspirant and seek the good of humanity they are seen as moral virtues. The more people possess the moral

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virtues and prudence, the more they are likely to make morally sound choices and decisions made in the light of the right desire (Kikuchi, 2005).

Attitude

In the study participants described characteristics that they saw as important to nursing attitude such as empathy, authenticity and touch.

C3 expressed this understanding of 'insightfulness' and his ability to associate the emotions with another:

'I think there is elements of love in relation to my own emotional state and how I feel as a person, and the idea of wanting to provide care and to support children through difficult times.' (C3 20)

Vouzavali et al (2011,p. 146) described empathy experienced in critical care, '...empathy is mediated by the mere sight of and contact with the patient's body and his/her gaze'. One of their nurse participants elucidates, ' ...empathy is so strong. You let yourself in the role of the patient, you can understand his feelings. You can see through his eyes. You see it, you see the anxiety, the agony, you see his eyes'.

A qualitative study that explored 'what is the lived meaning of quality nursing care for practicing nurses?' (Burhans and Alligood, 2010) suggested that nurses

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view empathy as, ‘...’appreciating the patient’s experience’, to ‘treat and view the patient as either yourself or your loved one’ and being empathic...’ (Burhans and Alligood, 2010, p. 1693).

C1 describes appreciating the patient’s experience:

‘where one person meets another person and tries to empathise in a situation in which they feel they may be able to improve, help, support, just generally bring a positive element’ (C1 52) ‘...the fact that someone on the other side of the table or in that situation will see that, or will fundamentally feel that you are trying to be compassionate, or trying to love them in that way.’ (C1 176)

Empathy is required to form a therapeutic relationship and is described as being able to position oneself in the emotional circumstance of another (Yu and Kirk, 2008).

In this short quote C5 describes empathy in her practice:

‘...reaching out to them lets them know that you’re there and you’re really feeling what they’re experiencing. ‘(C5 59)

Thomas et al (2004, p. 3) defined the love that reflected the meanings of empathy, which emerged from the narratives with Nurse practitioners, ‘ a deep, tender, ineffable feeling of affection and solicitude towards a person, such as

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that arising from kinship, recognition of attractive qualities, or a sense of underlying oneness’.

C7 provided an explanation of this love in action and how it guided her to her patients when they were in need:

‘I don’t experience or think of love as an emotion primarily any more. I think I may have as a sentiment at some point. But to me it’s deeply practical; it’s emotion in action. So it’s a feeling, I know what the feeling is; I know where it’s located in my body. I feel it in my heart. But I feel it in my whole body and being and it moves me. So I will move to the bedside, you know, I’ll move, I’ll know where to be.’ (C7 478)

C10 described a practical empathy, which reflected dignity and respect:

‘So the fact that you value your patient as an individual means that you don’t call them dearie, lovey and all the rest of it. You don’t open the curtains when they’re being catheterised. It’s all those little things that represent that you respect the patients and treat them with dignity, and they are people with a past and a future.’ (C10 174)

Authenticity as part of nursing attitude was the focus of a concept analysis by Ranheim, Karner and Bertero, with one of the concepts, authenticity, being

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described as 'a way of being authentically', 'an ability to be present to self and others in the dynamism of openness and frames of thought' (2012, p. 78).

C2 described how reflexivity in practice supported authenticity and empathy;

'...but actually when we talk about love as an overall, love and care as an overall thing as nursing, perhaps it is breaker-downable, you know, into, are you aware of how you feel about this patient at this time?' (C2 452)

Ranheim, Karner and Berero explained that authenticity was part of 'caritas', 'It has to do with the cultivation and deepening of self-awareness, of going beyond oneself, and being authentically present in the caring encounter...' (2012, p. 81).

C7 talked of self-awareness and in being able to 'self-love':

'...it provided the space for loving care, of self in the first place. And then learning how to do that for others.'(C7 414)

Karlsson and Bergbom used Lars' autobiography to explain that being cared for can be demonstrated through the carers 'warm voices'. They clarified that, '...The meaning of carers who have warmth in their voices can be interpreted as the patient realising the existence of the real truth of being present...Therefore he could probably believe in her as she appeared to be authentic and this made him feel good and eased his suffering' (2010, p. 61).

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C8 provided an example of this authenticity in practice:

' So I guess when I think about what does love in nursing means I think about passion for my work and a genuine compassion and concern for the clients that we're working with. And a genuine intention to help people to move forward and achieve the best that they can...that came from a place of sincerity and during that time I worked with individuals who had real integrity and honour in their practice and courage in their practice.'(C8 15/21)

The participant, C8, expands upon this act of courage, risk taking and authenticity:

'...I can dare to be honest and be real with the people that I work with and be saying to them, you know, I'm moved by that and that struggle has touched me in this way. And I think that's important. It's that part of a nurse being a real, authentic human being.' (C8 67)

C10 described her flexibility when caring for her patients:

'I had patients with... who were in my ward for weeks and weeks, so you did get to know them. It's about recognising their needs and them as a person, and to be able to bend the rules to meet those needs...'(C10 41)

Authenticity was described by Maris as; 'courage, honesty and competence' (Maris, 2010, p. 137).

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C1 gave an example of his authenticity:

' So it sort of risked a situation but they responded openly and they almost – well I think – they appreciated an open, frank, not a them-and-us, not a text book, I'm gonna give you to my text book nursing, you know, 'Never mind, we can try again some other time,' sort of thing. I was just open and honest about what I saw my role was in that situation and the stark reality of what was about to happen' (C1 108)

In Ranheim, Karner and Bertero concept analysis of Watson's Caring Science Theory, the researchers identified that 'being authentically present' was one of the nine concepts within caritas, 'It has to do with the cultivation and deepening of self-awareness, of going beyond oneself, and being authentically present, in the caring encounter' (2012, p. 81).

C8 introduced self-awareness as an attribute demonstrated by good nurses:

'And I do believe that people who are prepared to reflect and are aware of themselves have that sort of increased self-awareness, I think they do make better nurses.'(C8 100)

C7 reinforced the need for nurses to be self-caring and self-aware:

'And so I think if the actual physiological mechanisms around empathy were fully understood, nurses may be more able to self-care through being self-

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aware in the first instance. And seeing themselves as, you know, instruments, we're all instruments because we're cold constructing our experience all the time.' (C7 826)

In Karlsson and Bergbom's illustrated nurses extending themselves '...the carers who listened to their hearts were calm in themselves and had the courage to be there for him. They had a special character and ability to connect healing, caring and humanity when they changed the bandages on his wounded body' (Karlsson and Bergbom, 2010, p. 61).

C6 summarised the ability to be self-aware and described the importance of being able to 'feel' the care:

'...if I didn't ever feel care, you know, within myself about a child, and particularly when you got to know families and so on, that if that went then that would be the time to stop. Because I don't think you can do the job properly without caring, without really feeling for the people that you're looking after, and children particularly' (C6 367)

When exploring leadership in nursing, Sorbello and Lynn carried out a synoptic analysis of Ray's ethical theory of existential authenticity and described this concept as nurses demonstrating openness; they referred to this as 'unconcealing the self' and to being prepared to show their own vulnerability (Sorbello and Lynn, 2008, p. 46).

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Geissler's (1989, p. 530) in her study of female registered nurses and the meaning of nurturance suggested that touch was an integral part of 'conveying shared humanity', 'The nurse shares her own feelings and uses touch with patients throughout the life-span from the new-born to the dying elderly to let patients know they are safe in her care. She is reliable and can be trusted, she is there and she cares'.

C7 expressed the need to be aware that it was the quality of the touch that was important, so much so that procedures required modifying to ensure that the touch was meaningful:

'...I mean I feel quite strongly about touch because it is about the quality of touch also. I mean I wouldn't do the dressings in the way that was prescribed for example' (C7 608). This statement refers to the unnecessary ritual wound dressing prescribed for an individual patient that was not therapeutic and professionally questionable.

In the literature touch was divided into physical touch and therapeutic touch (Gleeson and Higgins, 2009). In their qualitative study observing physical touch they found that, touch was a powerful tool, it honoured peoples personal space, it was used for emotional communication and it made some feel uncomfortable (Gleeson and Higgins, 2009, p. 385).

C5's statement below was a straightforward approach to love in nursing which required time and consent:

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'And if someone has the time maybe love is just touch and permission to touch I suppose. That you're not forgotten, you are on our radar', (C5 18).

Therapeutic touch is not seen as casual or practical, but is founded on the belief that touch brings an energy, which flows, from one person to another (Doherty et al, 2006).

C8 described touching her patient and reinforcing her presence to him:

'And he woke up and he looked at me and he cried. I just sat there and I held his hand. And so for me the love isn't necessarily about doing anything amazing. It's not always about setting the world on fire. It is about those simple moments of really seeing someone and really being with them in that time.'(C8 349).

In his research synthesis Fredriksson described 'caring touch' as, '...communication of caring' ...'the outcomes of caring touch...comfort, security, enhancement of self-esteem and reality orientation...' (Fredriksson, 1999, p. 1172).

In critical care Vouzavali et al, heard from the nurses that patients often cannot communicate and 'manifest' themselves through their body' ...'according to participants' perceptions it is the experience of handling the body, its fluids or even organs that drives nurses to reflect and desire an approach to a patient's soul...the connection extends beyond the body and entails psychological and spiritual dimensions' (Vouzavali, et al, 2011, p 145).

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A Turkish study which identified the properties that nurses should exhibit included, compassion, empathy, humour, devotion and insightfulness, to name but a few attitudes (Coban and Kasilci, 2011).

Context

Cultural structure can be assessed through how we view and classify the world, the divisions and separations that are apparent influence this, and the management of those different states.

This explanation is supported by C7:

'There has always been the debate around whether nursing is vocational or not and the sense of it being vocational really involves the word love and a comfort with the word love.' (C7 36)

Kangasniemi and Haho place the nursing profession into cultural context explaining that nursing in the beginnings of the twentieth century began to assess the ethical foundations of the role as opposed to what the researchers refer to as nurse etiquette, which consisted of the 'educated nurse obeying with pleasure' (2012, p. 805), 'the characteristics of a good nurse consisted of being an altruistic and unselfish woman, with good health and willingness to devote herself to nursing'.

C2 reflects the change in cultural perception:

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'...somewhere along the line we, people tried to change our relationship, didn't they, between the nurse and the patient to make the patient more consumer-ish, if you like' (C2 48).

C2 is referring to an increased focus on patient participation:

'And I don't have a problem with people being respondent, but as long as they're still ready to accept the love and the care that we want to give them.'
(C2 97)

Swanson in her neonatal unit study describes a culture of complexity where, *'...responsible management of care is to avoid becoming too attached- a bad outcome of caring too much'* (Swanson, 1990, p. 70).

C8 addresses the culture of bureaucracy and care:

'we've got lots of stuff written about person centred care, right, we should all be person centred care. Everybody, yes, yes, yes. It's in all the policy documents. It's in all the Trust policies, it's everywhere. Yet I think what's happened is that there has been a lot change fatigue, cost cutting, tired nurses, and I think that things have got focused on productivity. Moving patients through like units'.(C8 263)

In the Socratic dialogue facilitated by Fitzgerald and Stan van Hooft (2000, p. 485) the study participants defined the health culture they worked within, *'...Australian's health system and supporting health care bureaucracy, to be the*

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result of the development of a system of health care founded on a duty of care that places boundaries on the role of the nurse, and, in their words, 'limits the possibilities of human caring'.

C6 asserts the importance of love in nursing care:

'I think love is a difficult word, particularly in our culture. I think people have lots of their own ideas about what love means. And for some people they don't actually want to use the word love at all. They think it's too powerful a word, too intense a word... But it's just so vital. It's fundamental I think to nursing. It's caring. It's such an important aspect of caring.' (C6 10-20)

In their qualitative study exploring how student nurses 'understood culture'

Gregory et al defined cultural competency, '...as both the theoretical knowledge and the interpersonal skills necessary for nurses to understand and navigate the differences and similarities between groups of individuals' (Gregory et al, 2010, p. 2).

C10 brings the realities of the nursing culture exposed in the twentieth century:

'What I have difficulty with is when I read things like the Francis Report, when I look at the kind of issues that some of our students bring up when we're looking at reflective practice, and there's almost a cruelty. What I find so disturbing is that people don't see it as that. Do you see what I mean? It's almost like they're not those people.' (C10 78).

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Persky, et al's study set out to explore the characteristics of the caritas nurse and assess the care and operational outcomes. The researchers identified that the nurses with the highest 'care factor scores' from their patients were also the nurses most frustrated by their working conditions. They report, '...frustration among high score CFS nurses may also arise from recognising that authentic caring ("caritas nursing") takes more time and resources than are available' (Persky et al, 2008, p. 19).

C2 describes the impact culture has on the display of love in nursing care:

'we talk a lot about how staff are cared for and I think love is something, you know, it's a bit of a ball that can sort of roll along and pick up things. A bit of a snowball, it picks up things as it goes along. So I think if you're in an environment where you are allowed to love you will. However, if you're in an environment where you're not being shown and not allowed to love you won't. And I think that the love is very much about the culture of the place in which you work... I think love might be circumstantial, contextual if you like. (C2 198-206)

C5 explains the importance of valuing staff in the NHS:

'if you value colleagues and they feel nurtured and cherished and you hope that they'll give back in some way, don't you, and I think the profession is changing.'(C5 210)

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A similar sentiment is expressed by C1:

'Until we get back to looking after our staff the rest will go to nothing, in my opinion.'(C1 438)

C10 explains that the present day NHS still reflects aspects described by Francis:

'I've used the Francis Report, the original one and subsequent ones when we've done management and leadership, and every group of students will identify with elements of that report, because they've seen it. What they haven't seen is it all together, which is what happened in Francis. So it's out there and they're seeing it.' (C10 119)

C10 recognises the importance of the construct of time in nursing:

'It's all those little things that represent that you respect the patients and treat them with dignity, and they are people with a past and a future. I'm using that phrase more and more now. I can't remember where I got it from, but I've got a quote somewhere, and I thought that's lovely, people with a past and a future.' (C10 176).

A number of participants felt that time had an impact on the quality of the care experience.

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Using Heideggerian hermeneutics where temporality is an intrinsic part of 'being' one of Vouzavali et al's (2011, p. 1440) participants explains, 'we are close to the patient all the time, it's the two of us, all the time we touch them, we embrace them, we teach them, we care for them...even more than our family ...this is very powerful'.

C3 explains that it is the quality of the time that is important in his practice:

'I think time is an important one. It is for me. I didn't dislike working within the ward environment, but for me it was more the fact that I went away from the end of those shifts, feeling, well you've done your best, but you've kind of focused on those areas of dealing more with the kind of physical needs, and the drugs and kind of arranging of various different things for the patient, but actually not being able to give them the quality time that they deserve.' (C3 76)

Teng, Hsiao and Chou conducted a quantitative study to measure the perceived time pressures on nurses by surveying how patients perceived this pressure, and how it affected the quality of their care. The results indicated that time pressure did affect the patient's care experience, due to nurses not being able to demonstrate sufficient, 'reliability, accountability, responsiveness and assurance'. (Teng, Hsiao and Chou, 2010, p. 281).

C5 describes the pressures experienced in caring in an acute hospital setting:

'Should we be encouraging or discouraging people to behave in this way when everything we do is timed? There are lots of pressures on us to move people

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around, to get handovers, to provide handovers. And the processes that drive what we do doesn't always allow a lot of time for this sort of demonstrative behaviour that's not, may be considered professional. Difficult.' (C5 41-46)

Chan, Jones and Wong interviewed five registered nurses (RNs) over a twelve-month period as part of a qualitative study into the issue of time in the work environment. The impact of the modernisation of health care was recognised as a shift towards, 'organisational and systems performance', measured through patient outcomes. The researchers advised managers to understand '...how RNs in their study describe the routinization of nursing work in the face of competing time leads to detrimental levels of patient care and a sense of guilt in nurses' (Chan, Jones and Wong, 2013, p. 2027).

C9 describes how she makes time to ensure that she can be with her patient, as her presence is understood to be an important part of care for her patient:

'When you're actually making the time to support somebody, and as I've said it's not even necessarily due to an assessment or needing to find anything out, it's just recognising that they need somebody with them. And that's what being with them is, it's just sharing that moment, whatever that moment might be.'(C9 37)

In examining the efficacy of the Productive Ward Programme, Wright and McSherry systematically reviewed eighteen articles to identify the impact of this initiative to the release of time to care (Wright and McSherry, 2013). In the literature nurses described feelings of negativity and poor job satisfaction, being,

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'...frustrated', 'unappreciated', 'deflated' and 'powerless' (Evans cited in Wright and McSherry, 2013, p. 1364).

Finally C3 speculates that in his view, time is associated with love:

'...love is sort of centred around different things, and time is one of those things, you know, that you can express, I suppose, the time that you give to people.'

(C3 30)

Bourdieu explains that the context in which we live has order and patterns, which he refers to as 'habitus', has a direct relationship with 'culture' (Jenkins, 2003). - Bourdieu describes this as a dualist model. This cultural structure is influenced by 'gender' and how this impacts on the 'real world' (Jenkins, 2003, p. 36).

Culture is distinct from society, whilst society is defined as 'social interactions and institution', culture, '...relates to the more specific processes of meaning-making and symbolic patterns' (Vandenberg, 2010, p. 240). Society's structures and actors influence the 'meaning-making and the patterns produced which make up organisational cultures,' (Vandenberg, 2010).

In the early part of the twentieth century the nursing culture was influenced by theological ethical values, one such is described as love, 'love, is thereby understood to form the ontological basis of caring concepts like compassion, empathy, sympathy, relationship, and presence...' (Arman, 2006, p. 11).

Education, training and recruitment

The nurse educators described their perceptions of 'love in nursing care' above. In the following section 'love in nursing care' related to the themes education, training and recruitment and is presented below. The sub-themes described are supervision, role models and recruitment processes.

C4 explains how nurse education and training requires further review and the curricula designed to support learning in practice:

'I can read an ECG, I know what COPD is, I know that this drug does, what that drug, marvellous. And as a profession we value that. The students value that. As a profession we value that. We give lip service to books like The Emotional Labour of Nursing, but because we don't know how to deal with it because it's intangible, you can't say, 'Look, there's somebody emotionally labouring over there.'(C4 463)...*'I think we need to refashion the model of nurse education that sees, theoretically and in terms of hours, practice is 50% of the course. But where the investment has not gone in is the people who are role modelling actual practice. They've not had the support so many of them can't model it.'*
(C4 490)

Supervision

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All those interviewed felt in order to maintain a focus on their patients the opportunity to discuss feelings and experiences would be essential.

C1 is clear that supervision is important but poorly implemented or adhered to:

'It has to be done. It's not a case of, 'Oh well, you know, we can't spare the time and look at the off-duty' sort of thing. No, no, no, it's done properly. And again it does cry into my grist when people talk about, you know, nursing as a profession, I think well no, get your act together and sort it out. You cannot dilly-dally in the shallows and say, 'Well, yes, but, yes of course we are a profession.' Well no, get your act in order, support your staff who are day in day out going into scenarios either by the paramedics, A&E, upstairs, downstairs, looking after people, supposedly showing compassion, confidence, competence and all the 6 Cs. But what infuriates me about nursing is they want the badge but unfortunately there's no money and there's no time to actually do it properly. And that's the way it will always be. Clinical supervision is fundamental, we both know that.' (C1 398)

Supporting C1's call for a more disciplined approach to the use of supervision, Koivu et al's quantitative study into the health and well being benefits for nurses, (when involved in supervision) suggests that 'efficient' clinical supervision may have an impact on preventing 'burnout' (Koivu, Saarinen and Hyrkas, 2012). These researchers concur with Wright, above, that there is insufficient research into the effectiveness of clinical supervision. Although this research focused on the well being of nurses and the loss of emotional resource available, to them

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when burn out occurs. This has a direct correlation to less favourable outcomes for patients. (Sheward, et al, 2005).

C4 asserts that nurses need to support each other emotionally in some form of supervision:

'We need a space where we can be engaged in adaptive coping mechanisms to emotionally support each other' (C4 432)... 'when you're hearing that, we have to be trained, just listen to the emotion. Doesn't mean that the emotion is right but just listen to it for a minute because that's how that person felt. You don't yet have to come back at that or explain yourself, just listen to the emotion first. And that needs training because we're not good at that because we can get defensive and start justifying. And now you're into a, maybe a sort of parent/child ego state rather than adult sharing' (C4 441)

Nurturing student nurses and nurses in general was seen as essential in the development of nurses and nursing. Thomas et al using a literature review explored the experience of pre-registered nurses in clinical placements. The development of emotional resilience was viewed as important in managing learning and in staff retention. They used mentorship and role models to develop and nurture students' emotional resilience (Thomas, Jack, and Jinks, 2012)

This is substantiated by C2 who noted:

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'I think it's so valuable because it's the 50% of nursing that's so important that we don't look at, and it should be there and it should be acknowledged and we should definitely be nurturing it in our student nurses.'(C2 638)

In McDonald et al's collective study, (following the introduction of a work based educational programme to support the group learning of 14 nurses and midwives), demonstrated that shared creative space away from the clinical area could improve staff well being and reduce stress. The educational programme included the 'establishment of positive nurturing relationships and networks (McDonald, Jackson, Wilkes and Vickers, 2012, p. 380)

This approach to the nurturing of relationships, was mentioned by C1 :

'I would skew everything towards the interpersonal as opposed to the professional. I would go far more into all the ethics and the moral dilemmas and how they would grow as an individual and place them in those situations and allow them to explore how their responses begin to shape how they're gonna then practise.' (C1 288)

An aspect of nursing, that was viewed by participants as critical to the support and devolvement of nurses is mentorship. Huybrecht et al, conducted a research project which used a mixed method approach to identify a definition of mentorship, the perceived characteristics of mentors were explored. In this study student nurses valued mentors and their role included, support, clinical skills training, enabling students to be reflective, enhance students learning and in some situations assessing students practice (Huybrecht,Loeckx,

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Quaeyhaegens, Tobel and Mistiaen, 2010). The researchers suggest that the mentor/mentee relationship may reduce student's anxiety and reduce stress and the mentors' ability to 'transfer' their enthusiasm was highly rated by the student nurses (Huybrecht et al, 2010, p. 276).

C4 articulates an enthusiastic and emotional commitment, which is evident in his definition of mentorship:

'So mentorship is that willingness to nurture the personal growth of that student. That's a big ask. And to do that, that means I'm gonna to share my life with you, I'm gonna share my practises with you. I'm gonna make it explicit what my values are and my frustrations and my hurts and my successes. That's mentorship.' (C4 396) *'...if you're gonna be somebody's mentor, because, yeah, you have a positive interest in their development and that's love. That is love'* (C4 407).

Webb and Shakespeare explored the judgement making processes used by mentors regarding the clinical practice of student nurses. In this qualitative study, using critical incident technique in interviews, they confirmed previous research findings that the 'good' students commit emotionally to their relationship with their mentor and this emotion is reciprocated by the 'good' mentor (Webb and Shakespeare, 2008).

C2 describes the emotional investment that she is prepared to give, and expects in the mentorship relationship:

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'...so I'm gonna match what your heart puts into this course with what my heart puts into you.' And some students find that very uncomfortable because they only want to talk to me about academic, you know, how far their placement is to practice and, do you know what I mean? And actually I want to connect to them on an emotional level because that's the only way I feel I can write a reference for them. ' (C2 372)

British and Finnish researchers conducted a joint qualitative study using focus groups, to identify the factors that influenced the effectiveness of mentoring students. Their findings suggest that there needs to be a 'seamless' approach to mentorship, involving educators, managers, mentors and students, where receptive relationships is advocated between mentor and mentee (Jokelianen et al, 2013).

C3 describes his view of mentorship and his willingness to extend and share his knowledge and 'feelings' to enable the mentee to develop:

Mentorship for me is, to be a mentor; you're bringing to the encounter a wealth of both intellectual experience and emotional experience. And to mentor somebody you are interested in their personal growth and development...'(C3 391)

Closely aligned with mentorship, the participants felt was role modelling. C2 describes below how seeing love may influence love being shown by colleagues.

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'If they see somebody going to the patients showing love I think they're more likely to follow. So, although, I think, you know, definitely it's important and I hope at some point in everybody's nursing career they have been able to experience that love for a patient. I don't think, you know, you can't turn it on and off.'(C2 239)

A number of the participants felt that it was possible to demonstrate love, as explained by C2 above, so that students could witness this concept in practice and learn from it.

C1 below is clear that love needs to be visible:

'Yes, demonstrate it, yes. Demonstrate it first then it might start to sink into perhaps a little bit more,' (C1 455)

Role models in practice and in education provide not only the clinical skills and knowledge required to support student nurses development, they are also essential in enhancing the students understanding of the underpinning values implicit within the nursing profession (Felstead, 2013).

C3 supports Felstead's view of the function the role model in nursing:

' I've always looked to myself for role models, people to kind of base my own care on and to look at those people which set a good example. And I suppose indirectly I've had individuals who have supported me in my professional role and in an emotional role as a nurse, you know, throughout the whole environment ' (C3 397).

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In Scott's editorial, which was published in 2014 (Scott, 2014), she emphasises the need for role modelling in nursing to maintain the behaviours and virtues that signify the 'art' of nursing, which are associated with Aristotle's philosophy of love and friendship (Thomson, 2004). Scott writes, '...via the help of role modelling and education, develops educated emotion and perception. This enables the nurse to develop *phronesis*, practical reason' (Scott, 2014, p. 177).

C5 describes how she has witnessed and valued the concept of role models:

'I suppose we will all see role models and perhaps as a younger nurse I might have seen somebody interact with a patient using the right terms, maybe terms of endearment or the right expression or the right amount of touch... 'Oh you did that so lovely, I wish I could do it like that.' So I think there's definitely something you can role model.' (C5 96)

The influence of 'role modelling' may have a benevolent impact on student nurses behaviour and practice, or it may have a reverse, malevolent legacy. Ballatt and Camping describe the, 'unconscious nature of imitation' and the 'discovery of *mirror neurons*' (Ballett and Camping, 2012, p. 64).

Role models need support with education and training and this is reinforced by C4:

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'But where the investment has not gone in is the people who are role modelling actual practice. They've not had the support so many of them can't model it.' (C4 360)

An element of self-awareness was viewed as important for nurses to be able to lead, teach and practice effectively. (Williams, Gerardi et al, 2009) their study using grounded theory and content analysis of student's reflective journals, described enabling self-awareness through reflection on practice. Their findings suggest that by using reflection students 'became aware, they felt pain, they identified learning and experienced personal growth' (Williams, Gerardi et al, 2009).

C7 reflected on where and how she found the space and ability to become self aware:

'...it provided the space for loving care, of self in the first place. And then learning how to do that for others.' (C7 415).

Exploring self-aware mindfulness and reduction in nurses' transference of stress and negative feelings towards patients, Scheick used a mixed method study design with the aim to compare mindfully trained student nurses and those practicing without the self-aware mindful preparation. The findings suggest that using a developmental tool could assist in, '...learned self-awareness skills likely to cause changes in self-awareness, aliveness, and self control' (Scheik, 2010, p. 122).

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C8 asserts the importance of being self-aware and the effect it has on the calibre of nursing:

'I do think that people are very scared to actually really be with themselves. And I do believe that people who are prepared to reflect and are aware of themselves have that sort of increased self-awareness, I think they do make better nurses.' (C8 99)

Psychodrama was introduced as an educational tool to enhance nurses self – awareness in Oflaz et al's study, with the aim to assess the tools efficacy in structured learning groups. It is recognised by the researchers that within the nurse patient relationship nurses may experience emotions ranging from 'elation through to disappointment and sometimes anger' (Oflaz et al, 2011, p. 569). They suggest that nurses need to understand these feelings and how they affect the nurses' emotional state because these may affect the behaviour and practice of the nurses towards their patients.

C9 describes this self-awareness in her practice, reflecting on her patient's feedback and adjusting her behaviour accordingly:

'...And you get a lot of that back from the patient, because the way that they respond to you lets you know whether or not it's acceptable for the way that you're behaving, and being able to adapt to that very quickly.' (C9 330)

C10 explains that self-awareness is associated with how nurse educators behave as role models:

'It's very much about self-assessment, being self-aware, looking at themselves. But it's also in how we relate to them as students. And also how we teach them.' (C10 208)

Wright conducted a systematic review of the literature seeking to establish the definition and effectiveness of clinical supervision. She identified that the nursing profession introduced this learning methodology in the early 1980s without supporting evidence to demonstrate its efficacy (Wright, 2012). The literature also revealed that some authors were critical of reflective practice and supervision, as these may engender 'harm' if practitioners were required to participate (Wright, 2012).

Recruitment

Student and registered nurse recruitment was a topic that the participants felt impacted on 'love in nursing care'. The NMC directs that student nurses must meet exacting standards of competence before registration. For example in the regulators response to the Francis report the NMC were clear students must practice in a 'holistic, non-judgemental, caring and sensitive manner that avoids assumptions, supports social inclusion, recognises and respects individual choice, and acknowledges diversity' (NMC, 2013).

C1 explains that in practical terms recruiting student nurses with the required aptitude is not as straightforward as the NMC standards stipulate:

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'...young people –... crystallise some idea about how they are as people before they've even put a uniform on, how they feel about caring for other people. And of course that's completely impossible because they're 17, 18, 19, 20, they're still forming themselves in all those psycho-social – they're finding themselves as human beings.' (C1 244)

As described earlier an attitude is required when nursing and these attributes are viewed as desirable when recruiting student nurses.

C2 describes the sense experienced when observing student nurses who appear to demonstrate the right aptitude:

'Some do bring it with them and you can see that straight off. If I look at my student nurses you can see as soon as they walk through the door, there's something about them where you can just think, I don't, all we need to do with you is provide you with the knowledge because you have the values and you have the feelings.'(C2 250)

Wood in her paper addressing the recruitment of student nurses onto graduate programmes, reinforces the importance of student nurses studying a 'humanising curriculum with care at its centre' (Wood, 2014, p.528) where nurses are enabled to face the challenges of practice and 'maintaining their caring values' (Wood, 2014, P529)

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C4 supports Wood's exertion that the nurse graduate curriculum needs to be more values focused:

'The goal of this practice placement is empathy, empathetic development. Now there's a challenge, right, how are we going to model that? How are we going to measure it? Can we measure it?' (C4 478)...But neither can you necessarily say, we can only recruit empaths, because I'm not sure yet we can actually identify that clearly enough. And what about the person who is that complete numpty, totally self-absorbed but none the less has this some sort of quasi understanding that maybe health and care is for me but can go through a learning journey, where they can get values and assumptions challenged. And then other areas of their life brought out, developed, argued over, loved. So point of registration, is our curriculum robust enough that at point of registration we can say, we've given them as much opportunity as possible to be empathetic, caring nurse?'(C4 681).

A Scottish study aimed to capture the perceived value based attributes required to embed compassion into nursing and midwifery care. Once these attributes were identified, through surveying nurses and midwives these would be translated into a personal specification tool to enable pre-registration candidates to self assess themselves and select or deselect themselves from recruitment. The survey identified the most prominent 'desirable' personal attributes were, ' honesty, trustworthiness, communication skills, being a good listener, patience and tactfulness, sensitivity and compassion...ability to seek and act on guidance ...be a good team worker' (Waugh et al, 2014, p. 1193).

C2 uses metaphor to describe how these students appear to her as a nurse educator:

'I suppose really what we're talking about, if you can see such a thing as they're an open soul. There's something about them where you can see they are open. And sometimes that open, and this is where you have to be careful about your nurses, sometimes that openness is a bit kind of like a flower. It's a very gentle, you know, kind of thing. And sometimes it's a bit like, you know a Venus Flytrap in that it can look a bit scary, because they look like they're trying to claw, and you have to just, you have to go with both of them. Because they're both curious and interested in life and people. They're just going at it in a slightly different way. But both of them need to be fed.' (C2 278)

The participants in this study understood that recruiting the 'right' nurses was an imperative and they also expressed a view that the actual process of recruitment does have an impact on who is enrolled into nurse training and in to nursing roles. A comprehensive Scottish study was conducted in an endeavour to achieve an explanation of the 'efficacy, reliability and validity of face to face interviews' used by Higher Education Institutions (HEI) (Taylor, Macduff and Stephen, 2014, p. 1155). Using a mixed method design the researchers identified that there was inadequate evidence to support the present interview processes used and the skill and attributes of the interviewers need further focused attention. This is an area where further research is required as at present there appears to be a lack of evidenced based decision making.

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C8 supports the reservation that the present interview process is not evidence based:

'you know, in the old days somebody said to me, 'It's very easy for a service user to pass a mental health review tribunal because all they've got to do is turn up and present as sane for 20 minutes,' That's perhaps a cynical view but I think there's something similar for students, you know, turn up well dressed and be very polite and give a good account of yourself for 20 minutes.' (C8 440).

Cadman and Brewer, described the perception that there was a collective 'increase' in 'emotional ineptitude' within society. In their paper they look at the importance of emotional intelligence, specifically 'Colman's' concept, and its importance as part of nurse recruitment and selection processes. They suggest that the feelings of the interviewers are significant and should be an integral part of the selection process (Cadman and Brewer, 2001).

C5 provides an example of how these feelings at interview are sometimes difficult to justify when working within the formal recruitment process:

'...you have to justify why you've recruited somebody and if it's just a gut feeling. And if it's a gut feeling that just this one person you think, oh wouldn't like them to be nursing me, then you might look to see if there's anything that would substantiate that. But when you're looking at recruiting 400 nurses you might only pick that quality up in one in every 20 you look at.' (C5 451).

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C10 reflects on the importance of person centred care when talking about process:

'And if we're looking at process, yes process of course is important, but we know the more qualified nurses we have the better the outcomes for our patients. So that's great. But what we need to look at I think is the patient experience, digging deeper than the outcomes. We measure the outcomes, but we need to look at the whole experience because that would guide our nursing care' (C10 61).

Barriers to love in nursing care

Within this concluding section the participants describe the barriers, which seem to restrict or inhibit nurses ability to demonstrate love in their nursing practice. Their perceptions are supported by evidence from studies and nursing literature.

C2 compares the NHS and patients perceived expectations with a commercial airline's philosophy of customer care:

'I suppose Ryan Air's a good one. It's incredibly cheap but we all hate the way we're treated by them. And perhaps that's the way we're starting to see the Health Service in that it's free, great, but actually the way we're treated by the doctors and nurses is appalling and it might not be safe and you need to keep an eye on them because they don't know what they're doing and, you know. So, yeah, perhaps that's what people now turn up expecting.' (C2 124)

Research exploring the reasons why nurses remain or remove themselves from practice was carried out by Mahon and McPherson. Using an ethnographic approach the researcher conducted semi-structured interviews and unobtrusive observations in an acute clinical environment. Their study suggests that 'demands for efficiency', 'increased workload and stress', 'reduced job satisfaction and an inability to provide optimal care,' 'increased use of technology', health care organisation's policies and guidelines impacting on the context of the nurses role' and the 'culture of healthcare, with class, gender and power relationship issues' (Mahon, McPherson, 2014, p. 9).

Fear

Many of the participants expressed that nurses were fearful of retribution in terms professional sanctions and negative societal attitudes reinforced by recent media coverage.

C4 may be highlighting that the closer the nursing profession emulates other esteemed professions the farther the nursing profession move away from the closeness involved caring:

'I mean emotional distance has been seen as a cornerstone of professional practice, across all professions, law, medicine, the clergy. You know, you could empathise but you don't get involved. And that's the same within nursing. And what that can do is then put that fear of, I won't get close.'(C4 305)

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Students' vulnerability and the learning required to maintain compassionate practice is the topic of Curtis' grounded theory in which she uses in-depth interviews with student nurses. Curtis asserts that student nurses need to develop 'professional wisdom and courage' to 'cope with the complexity of compassionate practice...Courage can be seen as the ability for students to confront their fears of personal emotional consequences from engaging in what seems the morally right action, compassionate practice, and thereby protect against the potential to abandon the professional ideal of compassion' (Curtis, 2014, 218). Curtis suggests that this is particularly important in the, 'changing, busy, and target-driven health environment of the 21st century UK health care' (Curtis, 2014, p. 212).

C8 offers an example of practice she has witnessed where the professional wisdom and courage seems lacking:

'I've witnessed nurses that have a much more detached mode that have concerns about attachment and getting too close. And a term that one of my student nurses called, they referred to them as the boundary police.' (C8 21)...
And in light of people being scared about any kind of emotional involvement with patients and this sort of tendency to distance, I think that there's a lot of fear around this work.' (C8 306)

C7 describes how she has witnessed student nurses react to incidence of distress:

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'But there is a quality of it being unusual and it being rather uncomfortable and a bit defensive' (C7 63)

The language that is used to describe love may create a barrier to the emotion being implemented as part of legitimate practice. Fromme describes the complexity of love and the diversity of meaning in association with many emotions (Fromme, 1995). In his book, *The Art of Loving*, he suggests that love, as with any art, requires discipline and courage (Fromme, 1995).

C1 demonstrated some frustration when trying to explain that love is not in the words nurses use but in their actions:

'say it's love because, you know, is it love is it compassion? No, it's just a word. It's who you are and what you want to bring to it. If you think that you're bringing love or you think you are bringing compassion you have got to be, by its very nature, be trying to do something positive in that situation.' (C1 168)

In Stickley and Freshwater's paper examining 'The art of loving and therapeutic relationship' they explain that love becomes confused with sexual intimacy that leads to concerns of 'boundary transgressions and the protection of vulnerable patients' and that love has been 'pathologised' (Stickley and Freshwater, 2002, p. 251)

C7 suggests that the word love and its absence is an issue that reflects on how it is perceived in nursing:

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'And I found myself wondering, well is love the right word? Which really was brought up by the realisation that we just don't use it, we don't put it and nursing together so when you see it, even in a sentence, you react to it. And I felt like I wanted to answer the question because there is a lot to say both about almost how the word has become contentious and how we don't use it. So therefore the absence of love in nursing in care is for me, the issue or it's the answer that the question raises is about the absence of love, the absence of talking about it.' (C7 17)

Finally C10 reinforces that the word love is language that cannot be associated with nursing:

'It's nursing. [laughs] To me it's nursing. You can explain it in lots of different ways, but it's the totality of it all. But I still can't bring myself to call it love.' (C10 151).

Jacono wrote in the later part of the twentieth century that nurses actually feared to care, to demonstrate service to others. Feminists may have had an influence on how subservience was framed and devalued in this time in western society. Defining care in nursing became problematical and with this nurses appeared less caring. This may reflect that society seemed to care less. Contributing to nurses fear of caring was the impression that health care colleagues did not value or care for nurses. In conclusion this nurse academic suggests that care involves 'loving' and 'nurses fear giving love' (Jacono, 1993, p. 194).

Gender

It was clear from both the female and male participants that nursing is still seen as 'womens' work' which they felt devalued the profession.

C4 voices the view that care is still associated with women and their work:

'...the fundamentals of care of how we look after each other is sidelined as a woman's issue, if it is raised, but more often than not it's shunted into the long grass – the Dilnot Report, for example, shoved into the long grass, somebody else will sort that out.'(C4 217)... *'Well again it's just another example of the misunderstanding and the total devaluation and the invisibility of what nurses can do. They've historically been used as dog's bodies, low paid, cheap labour, female labour. Nursing work is women's work and as such has no visibility or value. And then if you treat workers historically like that, is it any wonder that some of them will live up to that label? (C4 229)*

In research conducted in Australia the portrayal of male nurses on television was researched using a qualitative method. The researcher identified that although female nurses were stereotyped from 'angel' to 'bimbo' the male nurse representation exposed and reinforced these stereotypes. The male nurses sexuality was often questioned and their masculinity undermined. On the television their roles are minor, comedic and unimportant. This representation may not only affect male nurse recruitment but could reinforce the devaluing of the role as a whole (Weaver et al, 2014).

C7 describes the nursing role as one which women fulfilled and emotions as being 'female' and professionalisation of nursing shifting focus towards male oriented behaviours:

'...look at the emergence of nursing as a career and as a profession that primarily involved women until professionalisation processes, you know, it included men. I think that it was seen as a primarily female sense oriented, physical task oriented and emotions such as love were more, were tolerated and accepted because they were seen as part of the skill set of women. But as it became more professionalised but with the influences of medical profession and medical men then the drive to become more like men became part of the professionalisation process and the, you know, boys don't cry and the machismo of, you know, the problems with medical culture that infiltrated nursing maybe in a way' (C7 27).

Smith explains that care is still viewed as 'women's' 'natural' work' and this creates a lack of value and worth as compared to technically challenging medical work (Smith, 2012, p. 3). This conception could devalue the caring role as it is associated with a women's' gender traits. Caring is represented as being, '...intuitive, and instinctive' something innate perhaps which does not require learning (Smith, 2012).

Pressure

The Royal College of Nursing addressed the 'day to day' pressures on nurses and the effects of further calls for efficiencies, ' the government needs to realise what is happening on the ground...nursing staff are fearing for their jobs and services are being cut. This is having a real, negative impact on direct patient care' (Dault, 20110)

C5 clearly depicts 'day to day' pressure below:

'There are lots of pressures on us to move people around, to get handovers, to provide handovers. And the processes that drive what we do doesn't always allow a lot of time for this sort of demonstrative behaviour that's not, may be considered professional. Difficult.' (C5 42).

Although the productive ward is defined as seeking efficiencies so that nurses may have more time with their patients (Lipley, 2009) this is not the view of some nurses as described by C8:

'The productive ward. A term that I used in something that I wrote was something that I'd picked up on when I was reading this idea of the McDonaldised nurse. And how can you provide anything that real that goes beyond task fulfilment if that is the message that you're really receiving from the organisation that you're working in.' (C8 272)

Pressure, the participants felt, may be increased by factors such as the amount of resource available and the time to manage services and deliver care. In Wilkinson's 1995 paper on the NHS management culture and how he describes the introduction of the 'New Public Management' process that ushered in the concept of a commodity driven business model with efficiency at its heart, described as the internal market.

C1 expresses his frustration at the perceived lack of resources:

'But what infuriates me about nursing is they want the badge but unfortunately there's no money and there's no time to actually do it properly.' (C1 341)... *'I'm afraid some people they just are too short-sighted and, yes, there's no time, yes, there's no money.'* (C1 421)

In the recently published government response to the Francis report, (Department of Health, 2013) the government fully commits to the compassion required in quality care and also states that patients will come before organisational or systems interests. These sentiments may not have become embedded in all NHS organisations as C3 articulates:

'There is a big change. Time constraints is one of those things. There's more pressure put on nurses with the reduction in staff. I think it puts people under a lot of pressure to achieve the same jobs that they've tried to do before, without having that time. And I think over time it does affect those core principles for

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some individuals. Because when you're trying to maintain and hold onto those things and you're limited in the support and time' (C3 197)

In chapter three I described how the humanity of the participants was revealed during the interview process. Guest, McQueen and Namey (2014, P. 254) suggest that through the thematic analysis process the sample population may be lost and '...a thicker description of the study population may be warranted...' in the findings chapter.

By using the coding case numbers, e.g. C1, I became concerned that transforming the sample into data codes would diminish the participants' perspective and lose the rich / thick descriptions. I have therefore included two brief 'case studies' to illustrate the depth of feeling about this topic manifest in the interviews.

There were two participants who represented the concepts of love in nursing care evident across the entire sample. C7 and C8 were two experienced nurses with many years experience and a breadth of nursing knowledge. These participants shared their thoughts of what love in nursing care entailed, as well as the frustrating limitations that inhibited witnessing this love in action.

C7 railed against the hierarchy of power that committed her nursing colleagues to perform what she saw as unreasonable wound dressings. She viewed this as a procedure designed to demonstrate that treatment had been carried out, rather than an opportunity to focus on what the patient really needed and wanted. In

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this example C7 demonstrated a love in nursing which was courageous, which entailed critical decision-making that was wholly person centred. During this disclosure C7 wept for her patient, for his innocence and her inability to ease his suffering despite her nursing interventions. C7 sums up her care 'and all we did was loved the boy'. For this nurse being, present with her patients was important, she described moving to them when sensing their need, and connecting with them.

C8 talked about caring for the 'disenfranchised', being beside the postoperative patient when others were too fearful to be with him. This nurse educator talked of 'bringing herself' to her patients, with all the emotional risks associated with that. She defined being present, not judging and honouring those in her care as important aspects of love in her nursing care. During her career she had witnessed patients who had been 'brutalised' by the system designed to care for them. This system and culture of care she described as, 'mechanistic, 'macho', where the 'McDonaldised nurse' works on the 'productive ward'. C8 was genuinely distressed by this care environment and culture. For this nurse, she felt something deeply when caring for her patients. There was a genuine warmth and desire to support people in her care.

In this chapter nurse educators shared their perspectives of love in nursing care. Using thematic analysis I have attempted to reach an understanding of the concepts that underpin love in nursing care and used the participants' descriptions of how this manifest in practice. In the final chapter I will draw conclusion, explore implications for nursing practice and consider how love in nursing care could be addressed in nurse education.

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Chapter Five

Conclusion

The four previous chapters have described the rationale for this endeavour and the relevant literature generated by other researchers has been explored and presented in relation to the research question, 'what is love in nursing care'? The research methodology has been explained and the findings have been presented.

In this concluding chapter I will discuss the contribution that this work brings to the nursing profession. I will highlight the limitations of this exploratory study and make recommendations to take areas of work forward.

A new understanding of love in nursing care

The majority of nurse educators who participated in this study believe that love does exist in nursing care. The codes and themes that emerged to describe the love and some of the barriers' to it are represented below (figure two)

I believe that these themes may be a helpful representation of how the participants view the *art* of nursing care. The themes follow the ideas of Estrid Rodhes (Kangasniemi and Haho, 2012) who in 1911 attempted, for the first time, to define nursing ethics, as unique to the profession rather than

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borrowed from society's legitimate professions of law, medicine and theology. In her brief pioneering work she described nursing that incorporated love in the art of caring.

This research project has given me a greater understanding of what love in nursing care means to nurse educators. The words and meaning that the participants shared with me could form the basis of an educational resource that uses the words as a basis of discussion about the attributes and behaviour in nursing.

Relevance to nursing educators and the nursing profession

I have searched and reviewed the relevant nursing literature relating to this research project and no other study has explicitly explored what love is in nursing care from the perspective of nurse educators. The research is timely and could be used as evidence to inform the review and revalidation of the 'Standards for pre-registration nursing education (NMC, 2010).

The four themes identified in the exploratory study, human values, therapeutic relationships, attitude and context are represented in the four domains of competencies (below), which are required for entry to the nurse register (NMC, 2010)

1. Professional Values

2. Communication and interpersonal skills

3. Nursing practice and decision –making

4. Leadership, management and team working

Figure 2: The codes, themes and limitation to love in nursing care

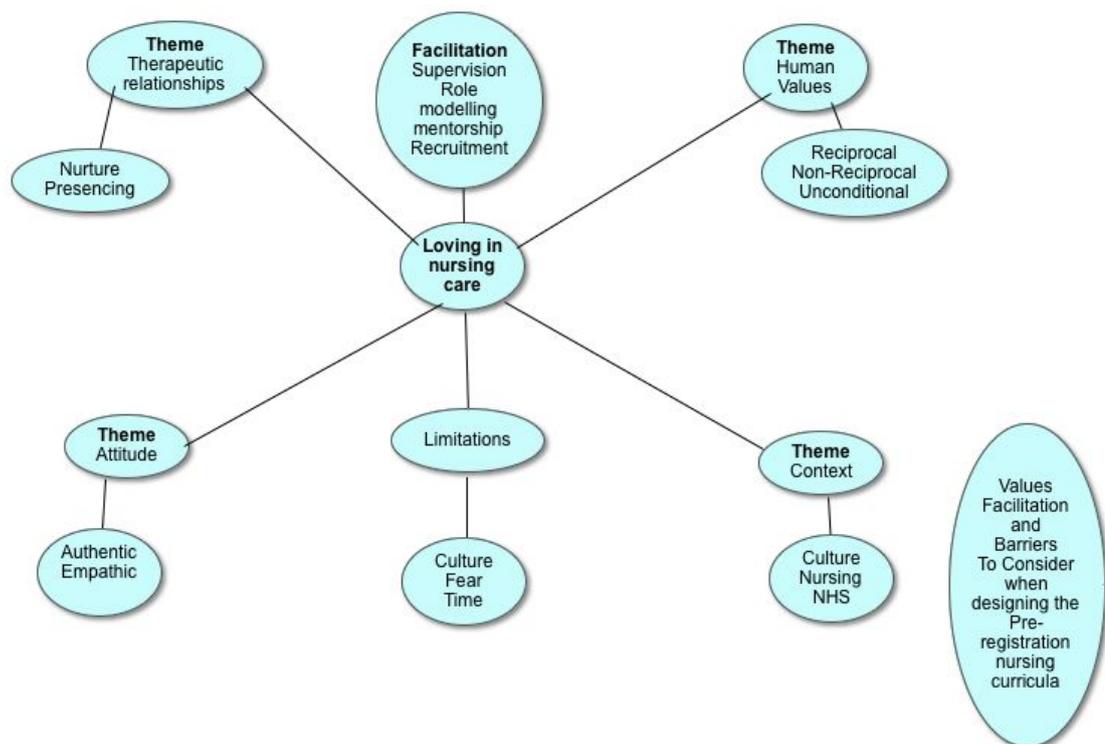


Figure 2. Represents the four themes that were constituent parts of love in nursing care, identified by nurse educators. Through thematic analysis codes emerged from the text which represented attributes and behaviours and these are represented in the diagram as being integral parts of the themes. In

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addition to these are the figure that identifies where there are limitations to love in nursing care that appear to influence nursing attributes and behaviours, or adversely influence health environments and the demonstration of love in practice. Situated centrally and prominently over 'Love in Nursing Care' are the processes that affect the education, development and learning within nursing. Pivotal to this is the design and implementation of a 'values based recruitment' system.

Professional values incorporate human values. These are described in a language that has become 'ritualised' and impenetrable by the nursing profession. Words such as 'accountable' and 'compassionate' are ubiquitous in the nursing directives but the actual meaning of these axioms is no longer explicit. The nurse educators in this research gave meaning to human values through their description of the reciprocity experienced in care, the interconnectedness which can occur with the maintenance of professional boundaries and through the unconditional positive regard described as knowing another's vulnerability and being there for that person.

Communication and interpersonal skills incorporates therapeutic relationships into the required competencies. The NMC standards (2010, p. 15) refer to competent practice that demonstrates, compassion, empathy and 'responding warmly and positively to people...' The nurse educators inferred that this competence was about being present with their patients, describing using ones 'self' as the instrument of practice. Connection with patients was seen once again as an important part of being competent.

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In domain 3 of the NMC education standards nurses are required to be competent decision makers, autonomous and compassionate (NMC, 2010, p. 17). This section reflects the nurse educator's description of nursing attributes, which demonstrate the art of nursing. The right attitude is required to monitor one's own emotional state and be capable to empathise and to support, help and improve a patient's situation. One participant described this attitude as love being an emotion in action (C7).

Finally domain 4 concentrates on the leadership aspects of nursing and the management and team working responsibilities. This is the cultural context in which nursing practice takes place and which registered nurses should confidently control. Nurses are expected to work with clinical governance processes to 'maintain and improve nursing practice (NMC, 2010, P. 20). The participants suggested that the organisational pressures asserted in the delivery of care in western health care organisations could be instrumental in the manifestation of fear in nursing practice. This view is supported by Fitzgerald and Stan van Hooft (2000) in their Socratic dialogue and also in Swanson's (1990) research into the care provided in a NICU. A participant suggested that the word love used within this culture is seen as difficult. Another referred to the 'snowball' effect of love in practice, where if it is expressed within the caring environment, and where it is witnessed it will encourage other nurses to demonstrate it. This requires nurse leadership to demonstrate courage (DOH, 2012) to reorganise service provision so that it is person centred and time is available to administer the art of nursing. True leadership comes through self-awareness and sound personal values (NMW, 2010). The standards stipulate that, 'all nurses must be able to identify priorities and manage time and

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resources effectively to ensure the quality of care is maintained and enhanced' (MNC, 2010, p. 20).

Reflexivity is the ability to look inward, to explore and analyse personal values and to monitor whether 'oneself' is being true to those values in practice (Bolton, 2014). This represents the 'Courage' quoted in the Chief Nurses' six 'C's and it is this 'C' that holds the key to a flourishing, ethical nursing profession, a profession where individual practitioners are prepared to hold themselves to account for their values, beliefs, behaviour and attitudes in practice.

These values are the foundation for the Value Based Recruitment (VBR) NHS strategy (Work Psychology Group, 2014) being led by Health Education England. This recruitment process was implemented to ensure that all future trainees, within the NHS, would be screened to understand if prospective new recruits values met the NHS values. Obviously the nursing profession is included in this strategy and needs to implement its own 'values based nurse recruitment' programme based on student nurses' abilities to connect with those on their care.

Limitations

The external reliability and thus trustworthiness of this study should be treated with caution due to the exploratory study being undertaken in one Higher Education Institution, in one specific region in England. Transferability of the study is feasible due to the rigour employed in the choice and implementation of the qualitative method and relevant research design, which demonstrates

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credibility. The views of other nurse educators exposed to different training and nursing experience may have allowed me to access more varied perspectives of love in nursing care. In this study only one nurse educator was categorical that love was not apparent in nursing care (see below). This is probably not an isolated view and indicates that this research should be repeated in a different area of England.

Time was a constraint in this exploratory study and the research proposal reflected this in the study's design. The semi-structured interviews were restricted to one per participant. Having asked the question and obtained the initial thoughts of the participants it may have been useful to have designed some reflection time and then repeated the interviews so that 'rich descriptions' (Bryman, 2012, p. 390) could have been captured and analysed. The participants gave their time generously but there were obvious work pressures, which restricted longer interview sessions.

My own inexperience as an interviewer also created limitations. Where silence and 'thinking space' would have been prudent I believe there were times when I filled the participants reflection time with a prompt to move forward with the interview. Gray (2011, p. 384) indicates that research interviewers should use self-reflection and '...make a conscious effort to hold back and leave spaces for the respondent to fill'

One participant (C10) was clear that love was not, in her mind, part of nursing care. For her love was bound to intimacy and her family. That said this participant was passionate in her articulation that caring was about connection

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and having a therapeutic relationship with those she nursed. C10 wondered if her cultural background moved her to see love through a different prism to some of her colleagues. C10 made a valuable contribution to the collective narrative and her voice was strong in expressing the values in nursing.

With the limitations in mind I believe that the research project findings make an intellectual contribution to the nursing profession. Love is not uniformed, objective and clearly tangible. When I first approached this study the complexity and contention, which seemed to constrain this topic, was intimidating. The depth of integrity demonstrated through reflection, which the participants shared with me, reinforced how important it is to incorporate 'love in nursing care' in nurse education and training.

Future actions

The participants, in this study, felt that this research was important and of value to the nursing profession. This indicates that the work on 'love in nursing care' should continue. The following actions are recommended:

- The research study should be repeated in other HEI in England to include nurse educators with different cultural backgrounds, to represent the country's professional demographic.
- The study findings should be disseminated through the nursing profession to raise an awareness of this research, its importance to nursing and to raise an intellectual debate within the profession.

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- To influence nurse education curricula the study findings need to be shared with England's Chief nurses, Health Education England (HEE) and the NMC.
- Love in care is not presented here as a monopoly of values and attitudes owned by the nursing profession. Multi-professional research with medical colleagues and professions allied to health would be an interesting collaborative endeavour. This may have benefits for the provision of health care in the NHS in the future.

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Appendices

Appendix 1.

Reflections: My position on 'love in nursing care'

A Narrative

Love in nursing care has been a thought, a concept that has been with me throughout my nursing career. The philosophy of love in care became apparent to me when I started out as a care assistant, at the age of 17. I entered the care 'industry', a loathsome term but one that I became very familiar with, so that I might explore 'older peoples' care. Prior to starting my nurse training I had a suspicion that I would find *geriatric*, as we called the speciality in the 1970s, difficult. More than that, I thought that older peoples care would be *repulsive*, distressing and difficult. I don't recall using these words but I believe they sum up much of my apprehension.

A small family run facility provided residential care to twelve older folk, all women apart from one gentleman who revelled in causing irritation to the 'woman folk'. I started work without any training or preparation apart from support from a colleague who had years of experience and treated her 'job' as a way of life. Most of the carers were women who came from a nearby village and town and most of the tasks, for that is fundamentally what the work seemed to entail, was carried out in a systematic, efficient, manner. The staff were reasonably friendly towards the older people, there would be laughter and a general sense of trying to do what the residence preferred but the work had to be completed, there were deadlines that had to be met.

This task-oriented routine didn't cause me any concerns when I started this work. I could see that people had to be helped out of bed, washed, dressed and transferred to the dinning area for breakfast. That job completed, the residence had to be helped to their *toileting*, with little discussion about want or need. As I slipped into the ritual of care it did not occur to me that the people I was caring for had also slipped into compliance to allow the homes routine to tick calmly on, hour after hour, day after day, week after week and so on. Every day had its occupation and entertainment. Afternoons were for snoozing and then knitting or having a sing along with the dreadful 'bought in' entertainer. On Saturdays, following lunch, the women would lay claim to their territory, in the large armchairs in the lounge. The wrestling would be sacrosanct, not a word, not a gesture was permitted unless it related to the two scantily dressed men bouncing off each other, on the screen. This fascination the women had for watching near naked men bemused me. Often there would be screeches of delight if the fighters really seemed to 'scrap' with each other. Perhaps this was a sign of virility, of real masculinity. It obviously excited our female residence, so much so that they would actually become agitated and verbally aggressive if we carers interrupted their entertainment.

On reflection my prejudice is obvious now. It did not occur to me that these women, although in their mature years, still enjoyed the urges of their female beings. The raunchiness of the wrestling was lost on me; an adolescent of the '70s, with my thrills coming from rock bands and carefully constructed TV heroes.

My prejudice was, I believe, not uncommon. Older people were viewed, by my fellow care workers and by a wider community, as 'gentle folk'. Or, perhaps by some, who judged them as 'doddery'. Even worse than that some saw them as decrepit! What a dreadful word 'decrepit'. The Collins English Dictionary defines the meaning as, 'enfeebled by old age; infirm'. Can it get any worse? Yes, the dictionary continues, 'broken down, worn out by hard or long use; dilapidated'. The origins of the word derive from the Latin, 'decrementum', from 'decrescere', to 'decrease'.

Perhaps this description was apt. My perception when I started caring for these older people was that they had diminished, decreased in stature, lessened as far as their relevance in western society was concerned. In addition and in contrast to this aged mantle, older people were revered and respected by many. So much so that as a reward for their years of hard toil, bringing up children, earning the crust, their roles were removed from them. Not in a cruel, spiteful way but through devotion and kindest by loving daughters, sons and grand children. How better to reward a lifetime of service than remove all chores and drudgery.

The only problem with this strategy is that it leaves older people, who had been active and busy, leading lives of quiet contemplation, with little need to rise in the morning, because washday no longer comes around and childcare demands are no longer required because people no longer trust you with their children. Hour after hour, day after day, of still, redundant time. The lucky ones would sew, eyesight permitting or knit, arthritic hands allowing. There is a strange cruelty in age, the time in ones life when time is bountiful arrives when the ability to indulge or enjoy it reduces.

This was the world of care that I entered as a novice carer. A world that had been described by 'Townsend' as the transition of older people from days of hard labour to a new retirement that could not be funded. An aged longevity that was not expected and had not been planned for. The Poor laws had gone, the workhouses contorted into 'Mental Hospitals' and old age inherited a status of redundancy. With the lack of fruitful work came a quiet acceptance by older people and society that this population was not resourceful. Our benevolent society would design a pension scheme that would rob people of their well earned income and drip feed it back to them in their retirement years, giving just enough to live on, to eek out a weekly allowance just sufficient for the requirements of sustained life.

As people lived longer and old age became a desired outcome of a hard fought life society started to use terms such as 'burden' to describe this growing population. When I started to care for older people I could relate to the stories of the two world wars. The lives these people had lived through these frightening times fascinated me. I could see that these people were talking histories. As I became familiar with the *Bettys* and the *Joans* I became aware of young women who had had desires, had lived in fear not just of the wars but also of their Fathers, of the church, of the sisterhood. I began to arrive at work wanting to be with these people, to enjoy their company as I gave them some personal assistance.

As the weeks went by the strange odours seemed to dissipate and in their place the sounds of peoples voices, retelling their experiences. So much detail, the colours, the seasons, the scent. The tales were told as much to keep these stories safe and alive as to tell me about their lives.

In those days, at seventeen, I fell in love with my caring role. More importantly I fell in love with the people I cared for. This love stemmed from an honouring of the people I cared for. I honoured their past, where memories laid bare stories of grim deprivation and fortitude. I honoured their present, where sheer will power and dignity gave them the strength to rise through aged pain and emotional distress. Each resident lived each day, their futures mapped out on the care homes schedule of activities and entertainment. In my adolescence I sensed a connection that would draw me to individuals who were waning, who either wanted to quietly pass from the present life or those who wanted to fight for life but had lost all reserves to remain here. I knew that my being with these people when they were transitioning from life to death made a small but distinct difference. My touch and my presence by the bedside eased, calmed and seemed to create some peace for these people. On reflection I witnessed this often with other carers, who would spend more time with people, there seemed a way of knowing when someone would soon depart.

All this experience I took with me as a novice student nurse. I thought we would build on this knowledge of 'knowing' how to care, expand on the humanity in care, being there for our patient. I believed that nurses, by using their own instincts of love, compassion, tenderness and kindness could improve patients' outcomes. I vividly remember as a first year student nurse bed bathing a very frail gentleman who was uncommunicative and isolated in a side room. I gently washed him, made sure his analgesia was sought before turning him, washing him and touching his fragile skin. As I cared for this man he started to respond, slowly, emerging from the stupor of pain and fear. Every attention to detail made him a human again rather than a conforming patient. By the end of the wash this man sat upright in his chair, clean pjs, and hair combed, spectacles polished, dentures in and clean. Some would suggest, not a particularly complex procedure, but one of enormous significance to that individual. I sensed as I cared for patients that their progress accelerated when we nurses could care for them appropriately. This was when I started to consider the aspects of the therapeutic use of self in nursing.

I knew that nursing was my career and that I could make a difference to the people I cared for. But I had a sense of disquiet. In my first six weeks of training my cohort, all exceptionally caring, dedicated nurses, were told by a tutor that we had better manage our emotional selves, there was no place for emotions in nursing, that we had entered a profession where science was king, diagnostic essential and following procedure was what made good nurses. This all seemed very sensible to me, but I could not understand why we would abandon the emotional aspects of nursing, the connection with patients.

Needless to say I have travelled my path in nursing ensuring that I have been present for my patients, giving love and support and receiving a sense of satisfaction in being able to extend myself for them. I owe a debt of gratitude to the patients I have cared for. Bolton defines reflexivity, '.... Finding strategies to question our own attitudes, theories-in-use, values, assumptions, Prejudices and habitual actions; to understand our complex roles in relation to others' (2014, P.7). This constant reflexivity in my practice and in all my varied roles in care has led me to question what are nursing values? Have we as a profession abandoned the 'Art' in nursing (or did it ever actually exist)?

Possibly nursing is a social construct that is imagined by society and the fiction is moulded into our nursing psyches. It would be interesting to explore nursing as a

Student Number: 726353

concept more but for now I am interested in 'what is love in nursing care' because I think I have experienced it.

TKNorth

2013

Appendix 2.

(Appendix F in initial proposal)

Topic Guide for interviewer

The following prompts will be used to facilitate the interview and assist the interviewee to answer the questions. The Interviewers will ensure that there is an initial introduction, where the interviewee is made to feel comfortable and time is allocated to build a rapport. The interviewers will give the interviewees a short personal and professional history so that commonalities can be identified.

Interviewer: My name is my role in this project is

The Interview

1. Q Have you read the information sheet sent to you?
2. Q. Do you understand your role in this research?
3. Q Have you signed the consent form?
4. Q Are you happy for this interview to be audio-recorded?
5. QI would like you (or could you) to describe, in your own words, what love is in nursing care?
6. Q Have you witnessed, experienced, love in nursing care?
Can you give me an example?
7. Q Do you think love in nursing care is important?
Can you say more about that?
8. QDo you think that the love in nursing care could or should be included in nurse education?
Have you any ideas about how we could do this
9. Q We have now come to the end of the interview, is there anything else you would like to say?
Is there anything you would like to ask me?

Helpful prompts

- That's interesting, tell me more about that?
- How does that make you feel?
- Are you comfortable talking about this?
- Would you like some time to think about this?

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- Can you give me an example of this/that?
- Are you interested in the outcome of this study?

Although this interview has some structure I am concerned to enable as much time for the interviewee to have space to think and to share their experiences unhindered by the interviewer.

If the interviewee wishes to describe her thoughts in some detail, and the exploratory enquiry is the focus of her narrative the interviewee will not be interrupted and some of the questions above will not be asked.

The most important and necessary questions are question numbers three and seven.

Tracie North
November 2013

Appendix 3.

(Appendix B in initial proposal)

Advert to be placed on University of Intranet and Nursing and Midwifery website and to be on the wall in the school of Nursing and Midwifery

What is love in nursing care? An exploratory study

November 2013

Recent bad publicity about nursing and nurses (Francis report; Willis report) has led to questions about whether and how nurses care about and for their patients. I am conducting a study to explore the views of nurse educators with regard to love in nursing care. What is love? How is it and can it be shown in our relationships with patients and how can we ensure loving care is embed in the nursing curriculum?

This small research project requires nurse educators who would be prepared to be interviewed. The interviews are confidential and your anonymity will be assured.

Although a small study, it is anticipated that it will be of value and contribute to the nursing professions perspective of emotional intelligence and how this may inform nurse educators and future curriculum design.

If this research project is of interest to you, on request, I will send you an information guide. The Information guide will explain in more detail the aims of the research project and how the interviews will be conducted.

If you would like further information or to be interviewed please email me at the address below.

Following this I will contact you and at a time convenient to you and we will arrange to meet at a time and place suitable to you.

Thank you for considering this research.

Tracie North
Research Project Lead
tracieKnorth@aol.co.uk

Appendix 4.

(Appendix A in initial proposal)

(Headed notepaper)

November 2013

A letter to invite Head of the Nursing and Midwifery School to request using the school as a research site:

What is love in nursing care? An exploratory study

Dear Dr XXX

Recent bad publicity about nursing and nurses (Francis report; Willis report) has led to questions about whether and how nurses care about and for their patients. I am conducting a study to explore the views of nurse educators with regard to love in nursing care. What is love? How is it and can it be shown in our relationships with patients and how can we ensure loving care is embed in the nursing curriculum?

I am studying for a ResM in the School of Nursing and Midwifery. My supervisors are Professor XXX and Dr XXX. I intend to seek the views of nurse educators with regards to love in nursing care. Although it is a small study I do believe it will be of value and contribute to the nursing profession's perspective of emotional intelligence and how this may inform nurse educators and future curriculum design.

I enclose the information sheet about the study. I would be grateful if you would allow me to place the attached advert on the School intranet and allow the information sheet to be made available at the next School Meetings and School leadership meetings. I hope you feel this study has sufficient value to allow me to interview those nurse educators in the school who express an interest in being involved. I am happy to come and discuss this with you or to contact someone you feel could take this forward.

Yours sincerely

Tracie North
Research Project Lead
Merlin
Old Canon Hill
Carnon Downs
Truro
Cornwall TR3 6LF

tracieKnorth@aol.co.uk

Appendix 5.

(Appendix D in initial proposal)

(Headed notepaper)

November 2013

A letter to invite potential participants to take part in a research project:

What is love in nursing care? An exploratory study

Dear

Thank you for your expression of interest to take part in this exploratory study. I am seeking the views of nurse educators with regards love in nursing care. Although it is a small study I do believe it will be of value and contribute to the nursing profession's perspective of emotional intelligence and how this may inform nurse educators and future curriculum design.

An information sheet is attached to ensure that you have a good understanding of the aims of the exploratory study and you are clear about what happens during the interview process.

I have also enclosed the consent form that will need to be completed prior to your involvement in this study. If there are any queries or unanswered questions please do not hesitate to contact me and we can meet or if more convenient we can discuss your queries over the phone.

Yours sincerely

Tracie North
Research Project Lead
Merlin
Old Canon Hill
Cannon Downs
Truro
Cornwall TR3 6LF

tracieknorth@aol.co.uk

Appendix 6.

(Appendix E in initial proposal)

Consent Form

Title of the study: What is love in nursing care? An exploratory study

Name of the Study Lead: Tracie North

Please note that if you have any unanswered questions about this study, please do not complete this form.

Please insert your initials in all the boxes.

1	I confirm that I have read and understood the information sheet dated November 2013 for the above study and I have had the opportunity to ask questions.	
2	I confirm that I have had the opportunity to discuss the study with the study lead. I do not have any further questions about this study.	
3	I understand that the information collected during this study will remain strictly confidential and accessible only to appropriate supervisors involved in this research and the study lead.	
4	I understand that my participation is entirely voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
6	I agree to take part in this study.	
7	I would like a summary of the final report.	

Name of Participant	
---------------------	--

Date and Signature	
--------------------	--

Name of the person taking consent	Tracie North
-----------------------------------	--------------

Date and Signature	
--------------------	--

Appendix 7.

(Appendix C in initial proposal)

Information Guide For Potential Research Participants

What is love in nursing care? An exploratory study

Recent bad publicity about nursing and nurses (Francis report; Willis report) has led to questions about whether and how nurses care about and for their patients. I am conducting a study to explore the views of nurse educators with regard to love in nursing care. What is love? How is it and can it be shown in our relationships with patients and how can we ensure loving care is embed in the nursing curriculum?

To explore these questions I am asking nurse educators if they would be interviewed. To help you with your decision-making I would like to explain the rationale for this research study. This information guide will describe the aim of the study and will give you an understanding of the important your involvement is to the study. This is a simple information guide and you may require further explanations to assist your understanding. It might help to discuss the study with your colleagues or contact me directly (details at the end of the information sheets). Your participation is vital but it is also completely your decision whether to volunteer or not.

Why would it be good if you participate?

As a registered nurse educator your views on this research subject are of absolute paramount importance. Your perspective will help to inform what good nursing practice looks like in the future.

What is the aim of the research project?

I am conducting this small research study to explore the views of nurse educators with regards to love in nursing care. The data that we capture will be used to contribute to the nursing professions perspective of emotional intelligence and how this may inform nurse educators and future training curricula.

This study approaches a topic less often discussed in nursing and we anticipate that involvement in the project will enable nurses to consider an area that is less well defined in the profession as opposed to the other technical, scientific and academic requirements needed to be evident in skilled nursing practice. The interview process will give nurse educators an opportunity to stop and reflect on what skill sets are required by students in their training to prepare them to deliver nursing care.

Student Number: 726353

The interviews will also enable educators to express their feelings about love in nursing or to discuss its absence. There is no right answer, but there is your perspective, which is really important to this project.

Your involvement would look like this

When you decide to contribute to the research project please complete the reply slip attached to the letter of invitation. This should then be forwarded to me using the pre-addressed envelope.

On receipt of the reply slip I will contact you directly. There will be a simple sampling process, recorded on an anonymous demographic detail record sheet, to ensure that there is a fair distribution across genders, length of service, length of registration and different service mix. **Interviews will continue until there is no new ideas are expressed. In the unlikely event of you not being chosen for interview I will contact you and explain this and you will be kept fully informed of the progress of the study and the results.**

The duration of the interview will be one hour. This will be an unstructured interview to allow you the space to voice your views without being steered by the interviewer. I will endeavour to keep any disruption to your routine to an absolute minimum. The time and the venue will be organised to suit you. The interview space will be arranged to ensure that it is quiet and that there will not be interruptions. I will facilitate the interview and this will be recorded using a digital recorder. This is to ensure that your exact words are captured and absolute accuracy can be assured. Once the research has been completed all digital recordings will be erased.

Will there be expenses paid?

A convenient location will be chosen for the interview in order that you do not have to do any unnecessary travelling.

Am I required to take part?

You are not required to participate in this study. It is imperative that you feel that you want to contribute and that you have a view that you wish to express. Once you have agreed to take part, you can withdraw at any time from the research project, no reason for you wishing to leave is necessary. This study is completely voluntary and it is your decision to take part or not.

If you do wish to participate we ask you to sign the consent form, which clearly confirms that your participation is voluntary. **Your Head of School has been briefed on the aims of this project but we will not disclose your participation to them unless you wish us to do so.**

Will my records be confidential?

Student Number: 726353

All information collected as a result of this study will be kept strictly confidential. All information will be securely stored electronically, will be password protected, in a document file that will be password protected. All information will be handled in compliance with the Data Protection Act (1998). All recorded interviews will be coded to ensure that no information that you give during the interview that directly relates to you can be passed on.

All information pertaining to you, your name, work location (which will only be used to contact you) will be stored separately from all other information you supply during the interview process. This will further ensure that you cannot be identified from any study records. All information will be destroyed at the end of the study.

What are the benefits of taking place in this study?

It is hoped that this project will be of interest to you both personally and professionally. The project itself may help to raise issues for you and support insights that may assist you in your future practice and the practice of your students. At the end of this study you will be furnished with the completed research report. This may stimulate further discussion and exploration in this area, which may improve nursing care.

What are the possible disadvantages of taking part in this study?

The study topic may engender strong feelings and these may be experienced during or after the interview. If at any time during the interview process you wish it stopped, it will be stopped. If you want to leave the interview, you can do so at any time. If following the interview you feel that some of the issues that were discussed have left you needing support, you will be given details of the staff counselling service.

Who is organising the study?

The research study is a project being undertaken as part of a Masters in Research and is supervised by the Faculty of Health and Human Sciences at the University of Plymouth. I am conducting this exploratory study because I am interested in the emotional aspects of nursing care, the effects that this has on care delivery and how customers/patients experience nursing care.

Who has approved this study?

Ethical approval was sought and agreed through the University of Plymouth.

How will I hear about the study's results?

The study will be completed by October 2014. The information from all the interviews will be analysed and the report written. It is anticipated that the literature review and study findings will be published in a professional journal. The summary of the completed research report will be sent to you if you agree following the completion of the report. At no time will anonymity be compromised and I give you an assurance that you will not be personally identifiable in any report or publication.

Student Number: 726353

Your rights

Your participation in this study is entirely voluntary. I emphasise that you may withdraw at any time during the study.

Contact for further information

If you require any further information about the study or you require any clarification please contact:

Tracie North
Research Project Lead
Merlin
Old Canon Hill
Cannon Downs
Truro
Cornwall TR3 6LF

tracieknorth@aol.co.uk

Thank you for taking the time to read this information sheet and considering participation in this research study.

Appendix 8.

18.03.13

Interview Field Notes (C8)

The interview commenced with me asking C8 if she required any further information. C8 had prepared for the interview and returned her completed consent form. She was keen to hear more about the exploratory study. I explained that I had entered the world of care at the age of 17 and fell in love with the work and the people in my care. I had chosen to work with older people, as I was not sure that I was suited to geriatric care. C8 seemed to empathise when I explained this.

I went on to say that this care experience had made me realise what a privilege it was to care for these people. I entered nursing thinking that I would love my new career. In the first six weeks of training as a student nurse I was told not to become too involved, not to be emotional and to be professional. It was as if being professional meant that there had to be a degree of detachment. My feelings then and now are that being professional actually means being aware of ones emotions and being involved with our patients.

I was conscious that I did not want to lead C8 in her interview narrative but I felt it important that C8 understood my perspective for embarking on this research project.

C8 was very comfortable in hearing my 'story' and her colour changes slightly, becoming flushed and her demeanour was relaxed. There was a sense of easement when C8 started to talk about 'love in nursing care'; she seemed to have been holding onto her thoughts and emotions, ready to express herself to a sensitive listener. Soon I found that I was mirroring C8 movements and posture and I think she was finding it easy to relate to me and the topic. As the interview progressed C8 demonstrated her depth of feelings by using expansive hand movements and when a point needed to be emphasised C8 used downward chopping movements. The narrative was rich in tone and content. C8 used the term authentic as meaning to be there for the patients. She described this as being present and I believe that C8 was very present throughout the interview process.

TKNorth

Appendix 9.

PLYMOUTH UNIVERSITY FACULTY OF HEALTH, EDUCATION AND SOCIETY	Application No: (for FREC use)
RESEARCH WITH PLYMOUTH UNIVERSITY Faculty Research Ethics Committee APPLICATION FOR ETHICAL APPROVAL OF RESEARCH Title of research: An exploratory study: 'What is love in nursing care ?'	
1. Nature of approval sought (Please tick relevant box)	
(a) PROJECT*: <input checked="" type="checkbox"/>	(b) PROGRAMME*: <input type="checkbox"/>
<i>If (a) then please indicate which category:</i>	
· Funded research project	<input type="checkbox"/>
· MPhil/PhD/Professional Doctorate project	<input type="checkbox"/>
· Other (please specify):	<input checked="" type="checkbox"/>
ResM Studentship Research Project	

2. Investigators/Supervisors

Principal Investigator (staff or postgraduate student)*:

Name: Tracie North (Postgraduate student)

Address for correspondence: 'Merlin' Old Carnon Hill, Carnon Downs, Truro, Cornwall
TR3 6LF

Email: tracieknorth@aol.co.uk

Other staff investigators: N/A

Director of Studies:

Professor Janet Richardson

(Faculty of Health, Education and Society)

Second Supervisor:

Dr Jane Grose

(Faculty of Health, Education and Society)

3. Funding body (if any) and duration of project/programme with dates*:

The ResM studentship is partly funded through the European Social Fund and is part of the ESF-CUC student ResM programme.

The time frame for the research project, which is part of the ResM programme, will be from January 2013 until October 2014.

The timeframe includes the following project plan:

- February 2013: Plan a detailed design of the exploratory study.
- March – November 2013: Conduct a thorough literature search
- November -December 2013: Commence the literature review
- November 2013: Identify sample and size of sample
- November 2013: Complete and submit the required University Ethics form for Ethical approval
- November/December 2013: Advertise for study participants. Send letters of invitation, information sheet and consent forms.
- January 2014: Collect the consent forms, arrange the interview dates
- January- February 2014: Interview participants
- February-March: Transcription
- March-April 2014: Transcription Analysis
- April-May 2014: Write up the analysis, report the results
- May - June 2014: Final chapter completed
- July 2014: Summary of the report to participants
- August 2014: Completion (final deadline is October 2014)

**Approval is granted for the duration of projects or for a maximum of three years in the case of programmes. Further approval is necessary for any extension of programmes.*

Research Outline:

4. What is love in nursing care? An exploratory study. Background

Once it was common to hear the phrase, 'tender loving care' (Wright, S. Sayre-Adams, J. 2006). This comforting term could mean anything from a cup of tea and sympathy to compassionate end of life care. There was no need to explain 'tender loving care'; it meant that now was a time for the tenderness of the human spirit to be extended to a patient through love so that care might be given in the most sensitive way (Kendrick, K. Robinson, S. 2002). These concepts were also developed by the psychologist Carl Rogers who coined the phrase 'unconditional positive regard' by which he meant 'significant others loving a person for what he or she is' (McLeod 2007). Ekegren et al (1997) used the term 'Compassionate stranger' when describing the role of the nurse having a positive effect on patient outcomes. These definers are significant in that they describe the action which may require 'love' as a starting point.

The twenty first century has brought a sharp focus on the nursing profession which has resulted in the investigation and finally the reporting of the 'Mid Staffordshire crisis and tragedy' (Francis. 2013). The public were shocked to hear the distressing accounts of older people being treated inhumanly in an NHS hospital. The care was not just poor it was negligent and in some cases appeared cruel. Does this episode reflect where we as people have arrived on our emotional, human journey into the twenty first century? Are we in a place where the ill, elderly and less 'valuable' people in society can be treated as processes with the NHS as a large production unit churning out episodes of care? What is the nursing professions responsibility to prevent this slide into a 'careless' health system?

This project is designed to explore the 'loving' in tender loving care and will inquire if love exists in nursing care. This is a metaphysical enquiry, with the word love having many meanings, definitions and associations for different individuals. The research project will draw upon the previous work of other researchers and philosophers to identify what, if any, love is in nursing care. In order to ensure we have a nursing force fit for the future in terms of providing compassionate and loving care as well as efficient and safe care there is a need to consider how we embed love in the nursing curriculum. In the first instance it will be important to understand from nurse educators and those working clinically what they understand by this term.

The Study's Aim

The projects aims are to identify what love is in nursing care, to explore if this can be defined, whether it exists in the nursing curriculum and if and how love can be part of the nursing professions' value system.

The study aim will be achieved by implementing a framework analysis (Srivastava, A.Thomson, S.B (2009)

Study Design

This is an exploratory study with two phases:

Phase one: will be a structured literature search and review

Phase two: will be to conduct an exploratory study using the Qualitative method. An unstructured interview methodology will be used to gain the information that is required

Unstructured interview methodology will be used to gain the information that is required to address the research question. To ensure that the review can be appropriately focused the research question for this study has been identified and purposely designed to draw a focus to a specific area, 'what is love in nursing care'. The intent is to maintain a discipline through the literature search and review process, which will enable a distillation of concepts and theories that can be used to identify commonality of views and contrasts to these.

The search question, 'What is love in nursing care'? Has been designed to be unambiguous and to give the participants a clear area of nursing care to focus. The words to be used in the literature search are:

- Love in nursing care
- Loving care
- Love in care
- Tender loving care

The inclusion criteria is that the paper reports research that informs the question, 'what is love in nursing care' and love in care.

Literature available in the English language only.

The exclusion criteria will be the following:

- Reference to romantic love
- Spirituality in nursing

Following Hart's (Hart, C. 2012) literature search and methodology I will:

1. Scope the academic library's dictionaries and encyclopaedias for origins and background information on my topic.
2. The Librarian will be a key expert and I will seek advice and support to source material which may be obscure, such as information published before the 1990's which will not be available electronically (Hart,C. 2012).
3. I will access the 'Online Public Access Catalogue' (OPAC) to find relevant books relating to the topic and its association in literature.
4. The 'Dewey Decimal Classification' (DDC) is a system of classification in the UK which will give me access to many sub headings, which may assist understanding the topic.
5. Professional journals will be accessed through, Cumulative Index for Nursing and Allied Health Literature (CINAHL) and through, Medical Literature (MEDLINE) (Hart, C. 2012)

A Quality Framework will be used throughout this study to assure that there is rigour in all aspects of research practice and this obviously includes the literature review. Using Ritchie and Spencer's framework for assessing research evidence (Spencer, L. Ritchie J. et al. 2003) this review will demonstrate the literature review captures and summarises the comprehensive knowledge distilled by previous researchers.

The frameworks principles require that the research methodology is 'Rigorous in Conduct' (Spencer, L. Ritchie, J. et al. 2003) and that this is evidenced by the...' systematic and transparent collection, analysis and interpretation of qualitative data' (Spencer, L. Ritchie J. et al. 2003 p 7).

The following quality indicators, as described in the Quality Framework (Spence Ritchie, J. et al. 2003) will be used to report the findings from the literature review

10. The concepts that emerge through analysis of the data
11. Discussion and interpretation of specific significant aspects of the literature
12. Explanations and emerging theory will be described
13. Clear commentary on opposing theory and concepts
14. Evidence of relationships between the aims of the study and the research question
15. Identified themes represented in a clear, well written narrative
16. The narrative will have a structure that will enable readers to understand the relevance of all the data
17. The report will be accessible and will demonstrate relevance to its target audience
18. Pertinent information will be highlighted and summarised.

The literature review should enable me to draw out prominent themes, which may lead to a number of conceptual ideas and theories. The review will enable me to be immersed in the epistemological and ontological core of the subject matter and to contribute to this body of knowledge on completion of the project.

Phase two, unstructured interviews

The interview methodology (Flick, U. 2009) will be used to facilitate a number of interviews with registered nurses both in academic and clinical roles to explore the research question. The purpose of the interviews is to gain an understanding about whether registered nurses believe that there is love in nursing care, how it is described and if there is any commonality which could lead to one clear expression of love that may be translated into nurse education for good nursing practice.

Sample

The sampling strategy will be designed using the judgement sample which is the sampling technique best designed to draw out the experiences and judgements of a particular expert group. This method will enable me to use a small but productive sample that will include participants who have knowledge of the topic being studied. However, this strategy can have disadvantages associated with the omission of data and the possibility of bias when selecting the sample (Gray, D.E. 2001). However it is desirable to enhance the understanding of issues such as human emotion and experience more concerned with an increase in this understanding than in the generalizability of the results of the study (Marshall, N. 1996).

The nurse educator sample will include the following:

- Gender mix
- Differing lengths of qualification
- Differing lengths of service and clinical experience
- Different locations (Truro, Plymouth, Exeter)

A letter will be sent to the Head of the Nursing School requesting permission for the study to commence within the school (Appendix A). I will then meet with the Head of the Nursing School (or her deputy) to discuss the project aim and the proposed research method and methodology. At this meeting the logistics and feasibility of undertaking this exploratory study will be assessed to ensure that it will not create resource issues or ethical concerns.

An advert placed on the school intranet (Appendix B) and the study information sheet tabled at the school team leaders meeting. A letter of invitation will be available for the contact person in the School to send to educators he or she feels might fit the inclusion criteria (Appendix D). My contact details of the researcher will be available for those requiring further information.

Those expressing interest in taking part will be sent an information sheet (Appendix C) and consent form (Appendix E) with a stamped addressed envelope for replies. Potential participants will be asked to return their signed consent forms prior to the interview dates and times being arranged. Once I have received the consent forms and responded to any queries I will contact participants to arrange a suitable time and confidential place for the interview to take place.

Interview Structure and organisation

The interviews will last a maximum of one hour. This will ensure that all participants have an opportunity to share their views and to make a clear contribution. The venue and times of the interviews will take into account which arrangements are most suitable for the participants. To assure project rigor there will be three interviewers, the study lead and two external, experienced researchers.

The interview will be unstructured, with the interviewer explaining the interview format and time constraints. The interview question will be the main focus to initiate the participant's contribution. However an interview guide with prompts (Appendix F) will guide the interviewer and keep the focus of the aim. Before the interview begins the interviewer will explain that the interview will be anonymous and confidentiality will be assured. It will be explained to the participants that the interviews will be recorded using a digital voice recorder. The interviews will then be transcribed, verbatim, by an accredited transcription service where confidentiality can be maintained

Qualitative Data Analysis

I have described, briefly, my own theoretical position with regards to this exploratory study. It is essential that those reading this study understand my stance and that I bring integrity to this work. The data analysis will be systematic and rigorous (Pope and May 2001) and will seek to answer the 'what' question in this study but I am sure through immersion in large quantities of text the how and the why questions will also be addressed to some extent.

In this study the data analysis will be completed using a Framework Analysis approach which lends itself well to health care and policy research (Lacey, A, Luff, D 2009).

The sequence of analysis is linear and commences with familiarisation of the transcribed interviews. This can be undertaken as the research progresses and often enables a refining of the questions and a discovery of emerging developments and new areas for exploration (Pope, C. Ziebland, S. May, N 2000)

As the familiarisation continues, the next phase of analysis commences, which is Identifying a thematic framework. Here an index of themes and categories begin to be identified and indexed.

The indexes process is applied to ensure that the thematic framework captures all the variables, from all the cases (participants) and these are included to all the emerging themes. Once all the data has been coded then this information can be used to chart the themes and the range of variables. Mapping the data gives a visual aid to the patterns that emerge and assists in the development of the interpretation of the data. In summary, the following framework analysis will be used:

10. Familiarization of the topic will be achieved through a systematic literature review and analysis of the transcribed interviews
11. The key thematic framework will be identified by recognising emerging themes and issues in the data collected.
12. A numerical system will be used to index references (Spencer, L. Ritchie, J. (2003). This will enable the sections of data that relate to specific themes to be collated.
13. The themes will be charted with heading and subheadings. This will enable me to comprehend the emergence of meaning in the data.
14. Finally I will map the data and analyse the characteristic, (Spencer, L. Ritchie, J. 2003) which will assist me in presenting the explanation of what love is in nursing care.

By utilising the Framework Analysis strategy, I will be able to demonstrate the research trustworthiness and its credibility. The quality assurance requirements constitutes four main criteria which include creditability, transferability, dependability and confirmability (Bryman, A. p390. 2012)

Project Quality Assurance

There are numerous quality assurance criteria to establish the validity of qualitative research. Guba and Lincoln are recognised as being the leading exponents of qualitative process rigor, which followed the principles of credibility, transferability and dependability (Bryman, A. 2012).

To further assure quality a random selection of volunteers will be asked to review their interview transcriptions for accuracy and their views on the concepts that may be generated from their comments.

Ethical Considerations and Data Protection

The proposed research proposal will not involve NHS patients or any vulnerable adult. The research process will not involve NHS staff or any NHS organisation. The research will be conducted in a School of Nursing in Higher Education (Plymouth University). The research project will abide by NMC principles and this will be evident in its design, the information given to the volunteers and the absolute right of any participants to withdraw from this project at any time. The nursing profession has clearly articulated the ethical expectations required to be followed during the design and implementation of research and these reflect the previous principles and include treating individuals with respect, ensuring transparency, honesty and the right to confidentiality (Nursing and midwifery council's code of professional conduct 2008).

To ensure that the participants can inform their own decision about participating in this research project, all involved will be given an information-briefing sheet (Appendix C). This will be written in accessible language and will advise the prospective participants of the rationale for the project, the research method, methodology and the commitment that will be required by the individual. The participants will be offered an opportunity to discuss this research project and any aspect of the methodology and outcomes at either a face-to-face meeting or with me on the telephone.

I will make it clear that participants can withdraw from the project at any time and they have the right to express any concerns about the project or process with the project lead at any time during and after to project completion. Transparency from concept to completion will, it is envisioned, stimulate participant enthusiastic involvement. Consent forms (Appendix E) will be given to participants with the comprehensive information sheets

To further reassure participants, the process of assured confidentiality will be explicit. Venues, where the interviews will take place, will be assessed for comfort and privacy. All interviews will take place unobserved and with the volunteers dignity a paramount concern throughout the whole process.

The interviews will be audio-recorded and this will be explained in detail before interviews begin. It is at this point that the interviewer will seek verbal consent to add to the previous written consent. All recorded interviews will be kept secure.

The sample being interviewed will be allocated a number and letter code and these individuals will not be referred to by name or location at any time before, during or after the interviews. This will give participants confidence that their anonymity will be assured.

The research question explores love in nursing care and the topic may stimulate an emotional response. Love is an emotive word and its very use could be assessed as provocative and result in a negative reaction.

Nursing is emotional work and feelings are often managed through strategies that inhibit the distress experienced, by some, whilst caring for others. There is a risk that during the interview, or after, following reflection, a participant may feel uncomfortable or disturbed. This possibility will be discussed with the participant before the interview takes place.

To ensure that participants do receive the necessary support that they may require during or after the interviews, supervision will be made available to them, whereby competent care supervisors can assist participants through safe reflection.

Undertaking the interviews may engender emotions in the study lead which I had not anticipated and to ensure that my own well-being is maintained I will seek support from my two dedicated university supervisors and seek further assistance from my own close network of competent peers.

The Study Report

On completion of this study I will produce a comprehensive report that will clearly evidence why this study was undertaken and what emerged through using an inductive approach and systematic data analysis. Prior to describing the study outcomes, I will ensure that the historical and social scene surrounding the study topic is clearly communicated to enable readers to understand in what context they took place. The themes that emerge, will be made transparent and discussed. All of this will be evident in narrative and vignettes drawn from the verbatim text. This will enable the reader to see clearly where and how concepts were generated, through the many variables shared by the participants.

The conclusions from this study will be shared through professional publications and it is expected that this work will be used to stimulate more enquiry into this topic. Ultimately it is to be shared to inform and enhance nurse training in the near future and to improve the experience of countless consumers of care who may not have the strength or desire to instruct nurses how to deliver loving care.

Conclusion

An agreed definition of what love is in nursing may facilitate explicit dialogue with nurse educators about how this might be transferred into student nurse enrolment, curriculum design, nurse recruitment processes and into quality assurance systems that measure standards of care.

If love is evident in nursing care this needs to be incorporated into the clinical governance framework and its essence written into care standards. The registered nurses professional code of conduct (Nursing and Midwifery Council 2008) continually reinforces that nurses are accountable for their actions and their omissions. There may be a reliance on evidence before care and treatment actions yet fundamental human, emotional, experience or instinct does not seem as valued as scientific outcomes.

References

- Bryman, A. (2012). *Social Research Methods*. New York: Oxford.
- Flick, U. (2009). *An introduction to Qualitative Research*. Sage: London.
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- Lacey, A. Luff, D. (2009). *Qualitative Research Analysis*. The NIHR RDS for the East Midlands/Yorkshire & The Humber, 2007.
- Marshall, Martin, N. (1996). *Sampling for Qualitative Research*. Exeter. Oxford.
- Nursing and Midwifery Council's code of professional conduct (2008). Nursing and Midwifery Council. London.
- Pope, C. Ziebland, S. Mays, N. (2000). Qualitative Research in health care. *Analysing qualitative data*. *British Medical Journal* vol 320 pp 114-116.
- Spencer, L. Ritchie, J. Lewis, J. Dillon, L. (2003). *Quality in Qualitative Evaluation: A framework for assessing research evidence*. A Quality Framework. Government Chief Social Researcher's Office: London.
- Srivastava, A. Thomson, S.B. (2009). *Framework Analysis: A Qualitative Methodology for Applied Policy Research*. *JOAAG*, Vol. 4. No. 2

5. Where you are providing information sheets for participants please INSERT a copy here. The information should usually include, in lay language, the nature and purpose of the research and participants right to withdraw:

Please refer to the information supporting this ethics application supplied in appendix A to F

- A. Letter to the Head of the School of Nursing and Midwifery seeking permission to proceed with this exploratory study-taking place in the organisation.
- B. Advert to be placed on intranet and in the School
- C. Study information sheet
- D. Letter of invitation to nurse educators
- E. Consent to participate
- F. Interview guide for interviewers

6. Ethical Protocol:

(a Informed consent:

)

All potential participants will be supplied with comprehensive information, on an information sheet. This will enable the potential participants to give informed consent to contribute to this exploratory study. The consent form (Appendix E) will be sent with a covering letter (appendix D) explicitly explaining that participation can cease at any time during the study.

Participation will not proceed without the written consent, on the consent form provided. All potential participants will be given the opportunity to discuss the research study with the study lead prior to giving consent.

(b Openness and honesty:

)

The dedicated information sheet will provide all potential participants with clear guidance as to the purpose of the exploratory study, its aims and objectives and the participant's right to withdraw at any time during the study. The potential participants will be made aware of what is required of them throughout the study.

The potential participants will be given the names of the study leads supervisors giving the participants a further opportunity to discuss any aspect of the study and to seek clarification about qualitative research and study methodology.

(c) **Right to withdraw:**

)

The study information sheet makes it clear that the potential participants may withdraw from the study at any time. This will not affect their employment, their human rights or compromise them in any way. The invitation to participate in the study is on a purely voluntary basis and there is no contractual element tying the participant to the study.

(d) **Protection from harm:**

)

The exploratory study is not considered harmful. A potential risk has been identified, which is that the study seeks to explore a meta physical aspect in nursing care. This may engender a positive or negative emotional response in the participants. This is covered in the information sheet and supervision will be available if any of the potential participants feel that they need time to reflect or recover their emotional equilibrium.

There will be a requirement for the study lead to spend a short period of time with each participant and this does mean that the participant's normal routine will be disrupted. An effort will be made to ensure that the interviews can be conducted in a venue that is convenient to the participant and that the time is used resourcefully. Confidentiality will be maintained throughout the interview by planning and using a private room.

The study lead understands that this research topic could engender difficult emotions in her and her well-being could be compromised if clear strategies are not identified to ensure she receives the appropriate support. To manage this, the study lead has actively recruited the support of her peers and will ensure that she receives good clinic supervision. The study leads university supervisors will also be closely scrutinising this work and maintaining contact to provide the appropriate academic and emotional support throughout this study.

The subject matter of this project will, it is hoped, enable the participants and study lead to enjoy a time of reflection, which may assist them in their emotional well being and future professional practice.

Does this research involve:

Please tick

Vulnerable groups	
Sensitive topics	✓
Permission of a gatekeeper for initial access	✓
Subjects being academically assessed by the researcher	
Deception or research which is conducted without full and informed consent	
Research that will include psychological stress, anxiety or humiliation or minimal pain	
Intrusive	

(e) **Debriefing:**

)

All participants will be offered the opportunity to have the final report summary. The participants will have been given an assurance that their anonymity will be secure and that all the study information will remain confidential.

Further to the final report summary being circulated to the participants, briefings will be arranged with all stakeholders to ensure that the learning from the study is made available to all those who participated and is presented in an accessible way for all involved.

The results of the study will be published in a suitable professional journal and all participants will be informed as to where to source the published article.

The study results will also be posted on the host organisation's website to ensure that all the participants have access via this medium.

(f) **Confidentiality:**

The interviews will be arranged to assure complete confidentiality. Time will be allotted at the start of the interview to reassure the participant that all information gathered in the course of this study will be kept secure. Anonymity will be rigorously adhered to and all person-identifiable information will not be utilised.

The interviews will be digitally recorded and these recordings will be stored in a locked draw, in a locked room within the study leads office. Once the recordings have been transcribed the digital recordings will be deleted.

The transcribed narrative will be anonymised and the transcripts will be password protected on a dedicated computer. The transcripts will be stored in a password-protected file.

Hard copy, paper data will be kept to a minimum. Any information generated will be coded to protect participant identity. Hard copies will be stored in a locked drawer in the study leads locked office.

At any time that a participant wishes to leave the study all material pertaining to that individual will be sourced and destroyed.

(g) **Professional bodies whose ethical policies apply to this research:**

)

The Nursing and Midwifery Council

7. Researchers Safety

(a) **Are there any special considerations in relation to researchers safety?**

)

There are no specific safety issues that the study lead needs to be cognisant of prior to the commencement of the interview.

Student Number: 726353

(b If so what provision has been made (for example the provision of a mobile phone
) or a clear recording of movements)

8. Declaration:

To the best of our knowledge and belief, this research conforms to the ethical principles laid down by Plymouth University and by the professional body specified in 6 (g).

Principal Investigator:

Signature

Date

Tracie North



6th November 2013

Other staff investigators:

Signature(s)

Date

Director of Studies (only where Principal Signature
Investigator is a postgraduate student):



Date 6th November 2013

Appendix 10.**Table 3. Studies meeting the inclusion criteria**

Authors (year)	Title	Journal	Volume, Issue, Page
Kangasmiemi et al. (2012)	Human love-the inner essence of nursing ethics according to Estrid Rodhe. A story using the approach of History of Ideas	Scandinavian Journal of Caring Sciences	26: 803-810
Vouzavali et al. (2011)	'The patient is my space': hermeneutic investigation of the nurse-patient relationship in critical care	Nursing in Critical Care	16 (3): 140-151
Persky et al. (2008)	Creating a Profile of a Nurse Effective in Caring	Nurse Administration Quarterly	32 (1): 15-20
Vries, de Kay. (2004)	Humility and its Practice in Nursing	Nursing Ethics	11 (6): 577-586
Geissler, E. (1990)	An exploratory study of selected female registered nurses: meaning and expression of nurturance	Journal of Advanced Nursing	15: 525-530
Fitzgerald et al. (2000)	A Socratic Dialogue On The Question 'What is Love In Nursing'?	Nursing Ethics	7 (6): 481-491
Swanson, K. (1990)	Providing care in the NICU: Sometimes an act of love	Advances in Nursing science	13 (1): 60-73
Karlsson et al. (2010)	Being Cared For and Not Being Cared For-A Hermeneutical Interpretation of An Autobiography	International Journal for Human Caring	14 (1): 58-65
Thomas et al. (2004)	The Caring Relationships Created by Nurse Practitioners and the One Nursed: Implications for Practice	Topics in Advanced Practice Nursing e-Journal	4 (4): 1-9

Appendix 11.

Table 4 Characteristics of the included studies

Study	Aims	Study Type	Methodology	Sampling	Data Collection	Data Analysis and validation
Kangasniemiet al (2012)	The aim of the study was, '...to describe the <i>ideas pattern</i> of nursing ethics in the textbook, written by the Swedish nurse Estrid Rodhe (1911). This at first appeared of limited relevance to nursing in the 21 century. The researcher's findings, through analysis of Rodhe's <i>ideas pattern</i> , identified with the characteristics of being a good nurse; this consisted of 'Human Love' - a concept that perhaps warrants further investigation	Qualitative using the 'history of ideas'	The authors described the methods used, History of Ideas, that it is informed by a hermeneutic understanding which is contextualised for its time. The language used in the text was sensitive to the context in which it was being used and studied. The need for an understanding of the researcher's subjectivity is mentioned.	Case study of written material by one nurse theorist	The data collection was conducted through the hermeneutic circular understanding and interpreting of the text.	To ensure trustworthiness the researchers describe their analysis as being 'as visible as possible' they describe the analysis of one historical text as a limitation that could be seen to compromise the trustworthiness of the study. They explain that 'multi-dimensionality' and 'sufficiency' were critical to the credibility of the project.
Vouzavaliel al (2011)	Using a phenomenological hermeneutics, to explore intensive care nurses' perceptions and meanings regarding their interpersonal relationship with critically ill individuals.	The design using a hermeneutical phenomenological approach based on Heidegger's philosophy.	Phenomenological Hermeneutical methodology using Heidegger's philosophy of 'Dasein'.	Twelve nurses who met the inclusion criteria: Critical care nurses with at least five years' experience and a willingness to be interviewed.	Repetitive interviews. The interviews were conducted over one to four times, taking one to three hours each time. The interviews were semi-structured	Hermeneutical cycle of interpretation using Heidegger's framework that included interpretations of symbols used for the description in the narratives.

						The rigor adopted in the analysis of their data, citing Draucker, Benner and Munhall's methodologies, which were employed, and the researchers analysed the information independently. Validation was achieved through returning the results to the participants
Perskyet <i>al</i> (2008)	To find the characteristics that make up the profile of the 'caritas' nurse. To study the environment in relation to care. To use the 'Participative Action Research Tool' to assist in the implementation of operation redesign.	Qualitative and Quantitative.	Mixed method using the participation action research (PAR) process.	Eighty-five patient-nurse paired Dyads.	The Healthcare Environment Survey The Participative Action Research Tool The Caring Factor Survey	The CFS and the HES were used to provide a correlation table (not provided). The Qualitative data was themed. Process not validated
de Vries (2004)	To describe how the washing of feet is a participatory experience; To describe how the experience of washing feet can change the relationship between nurse and patient.	Qualitative. Exploratory Study	Heuristic enquiry	'Post registration student nurses'. Five female, two male.	Face to face Interviews (not specific) Audio-taped interviews following a patient intervention (foot washing)	The thematic analysis is not described in detail but de Vries does explain that the findings are 'summarised and synthesised using the creative approach proposed

						by Douglass and Moustakas
Geissler (1990)	Female Registered nurses understanding of the meaning and expression of nurturance.	Qualitative Exploratory Study	Phenomenological analysis	Fourteen Registered nurses, indigenous to the USA, Caucasian and English speaking.	Audiotaped interviews Semi-structured interviews	Ethno graph computer programme. Validation was described through each respondent receiving the study's findings where all PARTICIPANTS confirmed that the data was a true representation of their beliefs and meaning pertaining to nurturance
Fitzgerald <i>et al</i> (2000)	To identify 'what is love in nursing'?	Qualitative	Adaptation of grounded theory	Seven registered nurses and two student nurses. Gender mix of seven female and 2 male.	High moderator Socratic dialogue Focus groups	1. Analytical chronology of the cases 2. Diagnosis of the cases, inductive reasoning and grounded theory 3. Interpreted and theoretical outputs, theory generated by grounded theory 4. Meta-level analysis
Swanson (1990)	To present a phenomenological study of the care provided in a Neonatal Unit. To discuss the phenomenological	Qualitative	Phenomenological Approach	Nineteen informants. Four physicians, five primary care nurses, five mothers, two fathers, one nurse administrator, a	Tape recorded interviews. Observational data gathered by attending ward rounds and through	Analyses through the phenomenological method. 1. Bracketing to suspend previous

	method.			social worker and a biomedical ethicist. Each interviewed one to three times over a twelve-month period. The interviews ranged from 45 minutes to 2.5 hours.	'simply hanging out' on the unit.	knowledge. 2. Analysing. 3. Intuiting. 4. Describing. The data was coded, indexing topics. Internally validated through informants quotes. External validation through sharing the data with those who had experienced the phenomenon.
Karlsson <i>et al</i> (2010)	Using a patient's autobiography, to describe 'being cared for' and 'not being cared for'.	Qualitative	Hermeneutic text interpretation approach. Listening and reading.	Autobiography selected by the researchers because it represented, 'explicit descriptions of both "being cared for" and "not being cared for"	Using a patients autobiography	Four readings of the autobiography. Dividing the text into two main themes with six sub-themes. Internal validation came when the themes were 'free from inner disagreements'. External validation was sought through sharing quotes and text with the carers. The carers had not been involved in the interpretation of the data.
Thomas <i>et al</i> (2004)	The aim of the study was not clear. The objective was to 'uncover the caring	Qualitative	Phenomenological approach	Purposeful sample of seven NP and seven nursed. Organised	Following the 'Nursing as caring research praxis	The 'Nursing as caring research praxis does not have

	experience in the NP-nursed relationship			into seven dyads.	approach interviews were conducted and audio recorded. The interviews were described as dialogue, where the researchers used interview prompts. The discussion was framed around 'caring occurring in the dyad relationship.	a defined data analysis approach. Phenomenological, immersion, incubation, illumination, explication and creative analysis were used. The four researchers interpreted the seven transcripts. The text was underlined and themed. The Senior researcher wrote a final 'exhaustive description of the caring experienced between the NP-nursed. Each of the four researchers validated the final themes.
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Appendix 12.**Table 8: Participant Profiles**

Gender/Age profile	Nursing Discipline/registration	Present role
Male Age 40-50	<ul style="list-style-type: none"> • Paediatrics/Neonates. • 11 Years experience in Neonatal nursing. • RCN 	Nurse Educator
Male Age 20-30	<ul style="list-style-type: none"> • Paediatric • 8 years experience in HD and critical care paediatrics • RCN 	Nurse Educator
Female Age 50-60	<ul style="list-style-type: none"> • Paediatric • 38 years of acute/critical/emergency/orthopaedic Paediatrics • RGN/RSCN/ONC 	Nurse Educator
Female Age 40-50	<ul style="list-style-type: none"> • Urgent Care • 16 years of experience expert critical care/emergency care • RGN 	Nurse Educator
Female Age 50-60	<ul style="list-style-type: none"> • Urgent Care • 39 years of district nursing/school nurse/sexual health/emergency/ITU care • SRN/RN 	Nurse Educator
Male Age 50-60	<ul style="list-style-type: none"> • Educator with Sociology background • 28 years of experience Adult nursing • RN 	Nurse Educator

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Female Age 40-50	<ul style="list-style-type: none">• Mental Health• 12 years experience community, inpatient with specialty personality disorder• RMN	Nurse Educator
Female		Nurse Educator
Female Age 50-60	<ul style="list-style-type: none">• Orthopaedics• 30 years of adult trauma and orthopaedics• RN/DIP Ortho Nursing	Nurse Educator
Female		Nurse Educator

Two participants preferred not to have their personal and professional information recorded as part of this research project.

Student Number: 726353

Student Number: 726353