Perinatal grief and emotional labour: a study of nurses’ experiences in gynae wards

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Abstract

Death through pregnancy loss is a tragedy which touches nursing staff as well as parents. Exposed to the intense emotions of parents, nurses must simultaneously manage their own emotions. This paper explores how nurses, through the use of personal narratives, develop and construct meanings around the professionally defined, but personally experienced, event of pregnancy loss. The methodology was based on in-depth interviews with fourteen nurses working in gynaecological units in Northern Ireland. The author, through the exploration of the nurse’s perspective, concludes that emotion can be conceived of as a valid resource for professionals when integrated into a nurse’s matrix of professional understandings. In addition, the study also demonstrates that value should be attached to emotional work which may not be fully visible, particularly for nurses working in gynaecological units. The emotional needs of nurses need to be fully acknowledged through recognition of the importance of managed emotion in the construction of professional knowledge. There is, therefore, strong justification for supporting the recognition of the importance of emotion in the development of nurse education policies and in valuing aspects of nursing practice that may have been marginalized.

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1. Introduction

This study developed out of a qualitative research project investigating the experiences of miscarriage and stillbirth among parents who attended pregnancy loss self-help groups (see McCreight, 2004). In order to assess the care received by parents from hospital staff, in-depth interviews were carried out with nurses and midwives in ten hospitals throughout Northern Ireland. The hospitals were chosen on the basis that they provided both maternity and gynaecology (gynae) services. Nurses and midwives, by the very nature of their occupation, encounter emotional and stressful work situations. Studies have shown (see Hunter, 2001; Mander, 2000, 1994; Devlin 1998; Foster, 1996) how midwives often suffer grief and fear when dealing with the loss of a baby and may find themselves unable to cope with their emotional distress. Very few studies, however, have investigated the concept of emotional labour and its application to the work of nurses in gynae units. It is important to establish the extent to which the need to engage in emotional labour presents a significant challenge to nurses working in gynae units. The study, therefore, aimed to collaboratively explore with gynae nurses how they constructed meanings through their narratives in relation to the professionally defined, but personally experienced, event of pregnancy loss.
The initial aim of the interviews with nursing staff was to investigate hospital practices and procedures for dealing with pregnancy loss. In the course of these interviews, several nurses also revealed the extent of their own feelings and emotions in dealing with pregnancy loss both in terms of its impact on themselves, and on the service they were providing to parents. The study was accordingly extended to include the personal experiences of nursing staff with regard to the adequacy of their training and the impact of such events on their own emotions.

Caring for parents who have experienced a pregnancy loss may present particular problems for nursing staff since such a role entails the management of a nursing process, which ends in failure as far as the parent is concerned while the success of the nursing support may easily be undervalued. When a baby dies in a hospital environment, the occurrence of death rather than birth throws into question the whole issue of modern childbirth practice and its inherent contradictions. Research suggests (Mander, 1994; Black et al., 1989) that death may be seen as a failure and may generate guilt, constituting a challenge to the nurse’s professional purpose. Mander (1994) suggests that nursing staff may experience difficulty in coping with pregnancy loss because the loss of a baby raises many deeply felt, long-hidden, and perhaps unrecognized emotions which may be associated with memories and anticipations of past and future intimate losses. Furthermore, Greaves (1994) illustrates that for some nursing staff, regular exposure to death may enable them to become ‘immune’ or draw on previous experiences and react in a ‘professional’ manner. The author suggests that this may be perceived as ‘masking their emotions’. Nursing staff working with bereaved parents may experience a personal response to each loss. Often nurses’ personal responses and emotions are ignored or denied, or are the subject of disapproval. Yet, as Mahan and Calica (1997) acknowledge, the feelings and emotions one has about grief work can help prevent ‘burnout’ and enhance professional practice.

2. Method

2.1. Participants

The purpose of the study was to investigate nurses’ experiences and feelings in dealing with parents who had experienced a pregnancy loss. Nurses’ perceptions in relation to training related to pregnancy loss were also explored. Semi-structured in-depth interviews were carried out with fourteen nurses working in gynaec units in Northern Ireland. The experience of the nursing staff, since first qualification, ranged from 2–32 years. During the study, nurses were extremely generous with their time and co-operation. While arrangements for carrying out the interviews proved difficult to co-ordinate, and were often time consuming owing to the unpredictable nature of nurses’ duties, they did not stint in their commitment to exploring the incidents of pregnancy loss they had encountered. Perhaps some of the readiness of the nurses to examine this area was connected with their own need to develop themselves personally and professionally by critically reflecting on their experiences.

2.2. Procedure

For the purpose of the study a letter was sent to the ward manager of the hospitals concerned asking permission to interview nurses. Thirteen hospitals were initially contacted, of which ten responded positively. In all cases the ward manager specified a date and time for the interviews to take place. In line with recommended ethical research practice, interviews began and ended with discussions of informed consent. Interviews were tape-recorded and their length ranged from 30 minutes to two and a half hours. Tapes were transcribed verbatim. Interviews were held at the hospital where the nursing staff were based. The criterion for inclusion in the study was a requirement that the nursing staff had experience of dealing with pregnancy loss. The nurses were informed that anonymity and confidentiality would be respected. Pseudonyms were used to protect the identity of the nurses. Interviews were transcribed and analysed using the QSR NUD*IST Vivo (NVivo) computer software package.

Through the format of a semi-structured interview, questions were posed concerning the adequacy of training they had received in relation to pregnancy loss and the emotional impact of pregnancy loss on the nurses. The questions were based on issues that had arisen in an earlier pilot study carried out with nurses.

3. Findings

3.1. Nursing staff and narrative

The questions served as a point of departure for the interview process. It rapidly became clear, however, that it was necessary to incorporate a narrative approach to interviewing which enabled the nursing staff to construct an account of their experiences by relating their personal stories.

The narrative method is a valid, relevant and effective tool for eliciting personal and professional knowledge. For example, May and Fleming (1997) have pointed to a tendency to perceive nursing as dominated by biomedicine. Criticizing this approach, they suggest that it reflects both analytic stability and institutional inertia. They suggest that overly deterministic approaches to
nursing have not been adequately informed regarding the ways in which nurses have struggled to create their own professional understandings. The use of a narrative approach leaves space for nurses to construct their own forms of explaining and has the potential to offer opportunities for transforming personal understanding as the nurse reflects on the meanings emerging from the testimony. In practice, the nurses presented their knowledge as ‘stories’, indicating that they had refined and configured their experiences to provide an analysis that was, for them, coherent, entailing a defence of their position in a context where they felt they had only restricted access to power.

In relation to nursing staff, narratives can be viewed as a method of organizing and communicating knowledge which are distinct from the institutional narratives that have traditionally held a dominant position in hospitals. The narrative form enables professionals to express the ‘nursing situation’, giving voice to their lived experience, or ‘life-world’ (Habermas, 1984) and unveiling the nursing knowledge embedded within. In this sense, nurses’ narratives may be a way of illuminating the ‘everydayness’ of their clinical world and the culture of nursing which remains poorly understood and under-theorized (Walker, 1995). Boykin and Schoenhofer (1991) assert that placing the self ‘wholly’ within the story has the potential to facilitate personal knowing. The authors note that without such knowledge of the ‘self’, nurses cannot truly ‘care’, for caring means entering the world of the other, understanding it and responding to it.

Several articles, adopting a narrative approach, have been written by nurses documenting their own experience of pregnancy loss. For example, Nash (1987) narrated her own experience of miscarriage in the hope that she may help to impart to midwives, and particularly doctors, a greater empathy regarding pregnancy loss. Equally, Gwilliam (1995) states that the purpose in writing her story is to try to enlighten those who have the very difficult task of dealing with the loss of a baby. This knowledge may not be formally constituted, and may be implicit (Schon, 1983), and tacit (Polanyi, 1969), rather than explicit. This ‘tacit knowledge’, which the nurses have gained as a result of their experience, needs to be recognized if they are to be able to value what they have gained and thus provide support for parents. These stories can be seen as stocks of situated knowledge which are not available in abstract form, but are called upon implicitly in response to the demands of particular situations and contexts. Kirkham (1998) points out that such means of learning give more power to the learner than didactic teaching. Furthermore, Hagell (1989, p. 226) claims that “nursing as a discipline, has a distinct knowledge base which is not grounded in empirico-analytical science and its methodology, but which stems from the lived experience of nurses as women and as nurses involved in caring relationships with their clients”. Since 1989, however, nursing has been transformed and the process has been charted by Heath (1998, p. 1054) who asserts that “nursing has progressed from a reliance on empirical theory applied to practice, to a recognition that experience develops knowledge that can guide the actions of practitioners”. Furthermore, Porter and Ryan (1996) have suggested a transformation in terms of a new professional ideology of nursing. Nevertheless, many nurses involved in this study had been trained in an earlier era and for them the process of articulating and constructing understandings of their practice may have been a relatively new experience.

3.2. Emotional labour of nursing care

The nurses, through narrative expression, made explicit; areas that were formerly tacit and through this process challenged formalized knowledge through their valuing of emotion. For the nurses, the experience of showing the strength of their feelings represented not the collapse of rationality but rather the assertion of a different form of rationality predicated on affective as well as cognitive aspects of expression. While emotion is often perceived as unrelated to rational thought and knowledge, the nurses were asserting a holistic view of knowledge, inclusive of their need to acknowledge their deepest responses to the grief they encountered.

The concept of emotional labour has emerged in opposition to the view that expression of emotion is a marginal or even dysfunctional aspect of the process of work. Nurses face increasing rationalization of their organizational contexts, as the hospital system struggles to become more cost-efficient, and this context can often serve to minimise further the emotional aspects of their professional role. Olesen and Bone (1998) point out that because the expression of emotions is thought to be significantly embedded in the work of nursing care and a dimension of nurses’ professional orientation, this trend creates the potential for tension between structural demands for efficiency and the expression of emotion. Furthermore, Olesen and Bone suggest that those who provide care within rationalizing organizations both experience and express emotion not only in response to the organization’s demands, but also because the selves engaged in such a context, and in part created within it, are multiple. There is the potential for role conflict, therefore, as nurses attempt to deal with the needs of patients while satisfying institutional demands and attending to their own emotional requirements.

There is a growing body of literature (see Bolton, 2000; Smith and Gray, 2000; O’Brien, 1994; Smith, 1992; James, 1992, 1989; Hochschild, 1983) applying the concept of emotional labour to the caring process. By
tradition, nurses undertake the management of others’ emotions as part of their routine work practices. Emotional labour is hard work and can be sorrowful and difficult, according to James (1989), who argues that emotional labour has been subject to a professionalized division of labour and a hierarchy of values discernible in the differential levels of recognition accorded to different groups of workers. For example, traditionally, it is the role of the doctors and consultants to explain medical procedures and interventions, very often in a form appropriate to a narrowly cognitive understanding. Cognitive knowledge, predicated on formal processes of knowledge accreditation, forms the basis of the professional lexicon for doctors and, by derivation, supports a supposition, now increasingly being challenged, that nurses should be subject to the same rules as doctors in respect of what is, or is not, valid knowledge.

The general view of the nurses was that their training had been focused on disciplinary knowledge which was not always helpful in enabling them to cope with the emotional demands of their work. The knowledge and competence derived from emotional experiences, since it cannot easily be codified, and is inherently gendered, is of questionable utility in the traditional hierarchy of medical knowledge. The following narrative from Denise, a gynae nurse, explained some dilemmas that arise in relation to nurse preparation:

“The only education was psychology applied to nursing and that was basically it. My first experience as a student going in to a patient who’d just delivered and I nearly died myself and really you’re going in and you don’t know what to say. Obviously people are different and we’re not going to go and have the same spiel, you take people as you meet them”.

The nurse, then, is not only left to face bereavement situations which she perceives she has not been adequately prepared for during training, but has also to offer support to parents. Since the only guidance received was derived from codified disciplinary sources, the implication was that her emotions should be considered a source of weakness, rather than a resource that might be used to strengthen her professional capability in supporting parents. There are, therefore, professional and gendered modes of understanding and valuing that impede the ability of the nurse to have her feelings accepted. Furthermore, because of the potentially high degree of emotional expression in the medical relationship, doctors and consultants often employ precautionary, or self-protective strategies, to limit investment of the self (Lupion, 1997), for example, by systematically limiting their involvement in the emotional aspects of their work.

A further division of labour often occurs when ‘breaking the bad news’ of pregnancy loss to parents. Although formally this is the province of the consultant, the view from the nurses was that it was normally the role of the nursing staff to deal sensitively with parents’ subsequent emotional distress. Porter (1994, p. 271) suggests that “doctors’ actions are animated by purpose-rationality. Their reliance on instrumental technological answers to the problems they encounter means that doctors do not feel the need to indulge in communicative action”. Furthermore, Porter (1997, p. 18) points out that “our life-worlds can only develop through another type of rationality, which involves mutual negotiation and understanding rather than reliance on technical fixtures”. What has emerged from the responses of the nurses, however, is that their accounts have been transformed through reflection on their emotional experiences, which they have used both to enhance their effectiveness as carers and to communicate methods of effective coping to new nursing staff. The mechanisms for this form of personal and professional growth for nurses are to be found in the bonds that link nurses to the parents, in ways that enable professionals to develop empathy. The intimate nature of the caring role means that nurses often develop a personal relationship with parents who have experienced a pregnancy loss, if for example, the woman has been in hospital for a significant length of time prior to the loss.

Most nursing work (see Field, 1989) involves at least the potential for contact with patients on an interpersonal basis rather than simply relating to them as medical cases, but personal involvement and a requirement for professional distance may pose a central dilemma for nurses. Emotional involvement of nurses with patients is difficult to avoid, and attempts by nurses to do so, in order to maintain professional distance, may result in problems for both nurses and patients (Gow, 1982). Furthermore, Field (1989) suggests that far from being detrimental to the nurse, a certain level of emotional involvement with patients can be of mutual benefit to both nurse and patient. In contrast, Mahan and Calica (1997) suggest that repeated exposure to loss may not be emotionally healthy, particularly for persons whose own personal losses were recent or remain unresolved. The present study found that there are dilemmas and controversies within hospital units concerning nurses revealing their emotions to patients. Although most of the nurses stated that they would ‘share a tear with the parents’, there was concern, among some staff that this may be perceived as inappropriate, both from the point of view of the parents and hospital managers. For example, several nursing staff stated that it would be inappropriate for them to show their own emotions in front of parents due to fear of further upsetting them. Nurses, then, work in a milieu of contested understandings regarding what is considered to be a responsible professional approach to grief.
The importance of the ward sister as a role model and source of training for nurses cannot be over-emphasized. In her analysis of student nurses, Smith (1992) found that in the production and reproduction of emotions, it is the ward sister, as architect of nursing work and organization, who sets the emotional agenda. Smith notes how ward sisters organize their work in different ways, often motivated by competing rationalities. Moreover, sisters who are oriented towards a nurturing rationality are more likely to value emotion work than sisters who are more medically orientated towards an ‘assembly line care of patients’. If the rationale of the ward sister deems it inappropriate to display emotions in front of the parents, nurses may experience, in Hochschild’s (1983) terms, ‘emotion management of a particular kind, founded on an empirico-rational concept of care’. By contrast, the findings from this study indicate that emotional involvement with parents by nursing staff, although emotionally draining, was more likely to be a positive feature of their work.

Women who have been admitted to hospital with a pregnancy loss under twenty weeks gestation will be admitted to a gynaec unit. Nurses working on gynaec units deal with a range of different conditions, from major surgery, to women who are pregnant but who are in hospital for excessive sickness, to women who have experienced a miscarriage. Nurses are not normally required to deal with stillborn babies. Some miscarried babies will, however, be fully formed, and the nurses in the study found this particularly upsetting. One nurse, June stated: “we have had people deliver here up to nineteen weeks and it’s very distressing and hard to deal with sometimes”. Furthermore, nurses related that their professional education consisted of recognizing different types of miscarriage and the symptoms women present, as well as forms of appropriate medical intervention, but that the emotional aspect of these incidents was not considered.

Farrington (1995) notes that there has been a shift in the previous fifteen years away from research focused on patient stress to the stress experienced by nursing staff. The author points out that this has been due to some extent to the desire of researchers to examine the work of nurses working in intensive or critical care units. In their study of emotional labour and care of bone marrow transplant (BMT) patient’s, Kelly et al. (2000) found that nurses sometimes attempt to deny their emotional attachment to the patient, owing to the difficult processes (including death) that are an unavoidable part of BMT care. The authors note that such emotionally intense work may result in some degree of stress among staff; and furthermore, that denial of emotional labour in the BMT setting can reduce the possibility of opening up new approaches and avenues of debate that may influence alternative modes of clinical practice. A study carried out by Guttuso and Bevan (2000) noted high levels of stress among nurses working in the field of aged-care. The authors found that this stress was related to conflicts experienced in balancing caring and efficiency demands and difficulties in managing emotions:

“In the organizational culture of aged care, as these women experience it, emotions such as frustration, anger and grief find little support and hence nurses must labour to shield such emotions from management, peers and residents” (ibid: 897).

Bolton (2000) carried out a qualitative study of gynaec nurses working in the North of England to determine how the introduction of ‘new’ management affected nurses’ work. The findings indicated that many nurses found their emotional involvement in caring for patients caused them the most anxiety. Nurses also related how dealing with a miscarried baby caused them the most distress. Paradoxically, however, “they also see the emotional stresses of the job as bringing the greatest potential for job satisfaction” (Bolton, 2000, p. 584). Nevertheless, the present study found that the ambiguities which surround miscarriage can entail emotional dilemmas for nurses who may have little or no guidelines on hospital policy for dealing with what is sometimes termed as ‘gynaecological scraps’.

Gynaec is an ambiguous category in medicine and nursing. The term gynaecology is derived from the Greek word ‘γυναικός’ (γυναίκος), meaning woman, and is intended to refer to disorders experienced by women. Yet, as McQueen (1997) notes, diseases of the breast are excluded from gynaec, and it is clear that the categorization is related narrowly to reproductive capability. Despite the sensitive nature of this area of nursing, nurses in the present study were not satisfied that they had sufficient preparation for the emotional issues they would inevitably encounter. Mary, a gynaec nurse noted:

“It made you come back to it, really think about what these women are going through, rather than just treating it as evacuation of uterus. We were a gynaec unit on its own and now we’re up here as a surgical gynaec unit. We have a few staff on the ward that would be surgical trained, they would have found it difficult at the beginning, some days you were busy and you didn’t have time for people, they were just rushed in and rushed out again”.

The narrative from Mary demonstrates that the classification of gynaec as a subset of surgery supports the tendency to marginalize emotional aspects of the work, and to focus on intervention treatment rather than application of care. In this case emotional work may become invisible and unnecessary, an adjunct to primary surgical tasks which require a high level of medical input and are perceived as prestigious. The
nurses, however, were clear that they needed to construct their own meanings. The primary reference point for nurses was their experience, which they managed as a resource to address emotional challenges posed by practice in the absence of preparation they considered appropriate. The following narrative from Cynthia, a gynae nurse, demonstrates the dilemma faced by nurses working on gynae wards:

“There are no specific courses for gynaecology, this is something that we have brought up. And I remember that was one of my worst fears, because never having had a miscarriage, my greatest fear was how do you speak to someone who has had a miscarriage. It was the fear of saying something to upset them more than they already were, it was only through experience though, you know you go on communication courses and all, but it's only really through experience that you learn”.

Cynthia, instinctively rejects the notion that the knowledge she needs can be provided through the medium of a formal learning programme, recognizing that the dilemma she faces on a daily basis can only be resolved through critical reflection on experience. Since many of the nurses may have their own personal experience of birth or pregnancy loss, or perhaps both, providing a service for women can raise complex issues for them. Nurses are required to address traumatic situations which they may have experienced, or, if they are pregnant themselves, raise deep concerns. In addition to dealing with the grief of the parents, they may be required to deal with their own private grief. It is important, therefore, that the stressful nature of the work of the nurses in this domain is fully recognized.

3.3. Nurse education

Nurses were asked if the area of pregnancy loss was adequately dealt with during their nursing education. The nurses were also asked if they felt there was any aspect of their practice that could be improved upon. Most nurses stated that they felt the need for more training in the form of study days. Furthermore, the nursing staff related how most of their knowledge and learning with regard to dealing with miscarriage came from other more experienced nurses. The following narrative from Katlin, illustrates the perspective of most of the nursing staff in the study:

“To be quite honest with you no, the general training here would be just for sort of big gynaecological problems. Basically the training you get on the ward here is your own sort of, how would you put it, your own way of dealing with any type of bereavement. Plus there are very experienced staff here who have worked in gynae for years and you find that they’re very adept in dealing with this kind of situation, they are extremely sensitive, and basically what you do is you learn from them, you take away parts of their way of dealing with it and adopt it for your own use, that’s basically how the training is done, nothing formal as such”.

What is being articulated here is the existence of collective bodies of embedded knowledge and practice consisting of accretions and adaptations being shared in collegiate fashion across generations of nurses. Knowledge is inseparable from relationships and its validity is regulated through the credibility of the practitioners involved; such an exchange system has strong resonances with Habermas’s (1984) ideal communication situation, where nursing hierarchies have been diminished, relative to traditional medical dominance. Moreover, the deficiency of the medical model is addressed through non-formal networks of carers supplying the human elements desperately needed by the parents. The study demonstrated that while nurses drew upon formal knowledge derived from the biomedical approach, when such was appropriate, they recognized the need for process knowledge based on ward experience and reflectively critical interactions among peers.

The study found that several nurses attended specific study days on miscarriage. Several nurses also attended general bereavement courses. Two nurses, however, related how they found the study days of no benefit, stating that they did not gain any knowledge from them. This is, perhaps, an indication that the organized study programme did not sufficiently deal with the needs of the nurses and may be a comment on the need for staff development to take account of the informal knowledge and situated learning of nurses. It is important to assess also whether such programmes take adequate account of the emotional work which nurses carry out. For example, one nurse, Jane, felt she had had a traumatic experience when attending a study day organized by the local hospital. During the study day she and her colleagues were asked to lie on the floor and to think of a person closest to them who had recently died. This experience was said by Jane to be extremely upsetting. Moreover, according to Jane, her colleagues also found the experience distressing to the point that they would ‘comfort’ each other on several occasions after the event. Furthermore, several staff in other hospitals related during interviews that they had been aware of the particular events, stating that this had prevented them from attending study days.

Several nurses related that study days, where parents came to talk to them about their own pregnancy loss experiences, were the most beneficial. In fact, the study revealed that several hospitals frequently invited parents who are members of the Stillbirth and Neonatal Death Society, and the Miscarriage Association, to attend
study days to share their experiential knowledge with staff. It is clear, therefore, that programmes that start from the experience of parents who have experienced a pregnancy loss have the potential to provide authentic learning experiences for nurses. Reflection on experience is, then, at the heart of learning for professionals, who have to cope with trauma and offer care on an individual basis. This is affirmed by Robinson (1991) who examines the relationship between medicine and nursing in higher education and has noted the difficulty of developing the formal knowledge base for emotional labour which is central to nursing.

It is apparent from the study that several nurses needed to be more aware of opportunities to enrol for study days relating to pregnancy loss. In response to the question of whether there was any training in the area of pregnancy loss during her nurse education, Rhoda, a gynae nurse, replied “no, there still isn’t. I don’t think, is there?”

In 1986 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) put forward proposals for future nurse training known as Project 2000 (UKCC, 1986). Project 2000 is based on the principle that nurses must have a flexible and conceptually driven education (Smith and Gray, 2001). This, and later initiatives (UKCC, 1999) related to nurse education and training, extend opportunities for continuing education in ways which may help overcome some of the difficulties in educating nurses on the experience of pregnancy loss. Some of the nurses in the study, however, had been in practice before the implementation of Project 2000. Additionally, some had trained in institutions outside Northern Ireland. Many in both these categories, with different experiences in education and practice, may benefit from additional opportunities for informed professional reflection and knowledge development.

The findings from the study indicate that although bereavement study days related specifically to pregnancy loss were available to nurses, they were not mandatory. Furthermore, the study days appeared to be centred on improving services for parents who have experienced a loss. While this aspect of ‘caring’ may enhance the practice of nurses when dealing with parents, it may, also, further marginalize the role of nurses as their own emotional needs may not be represented.

Although most nurses stated that they felt the need for more training, the responses from the nurses in relation to their views on professional education reinforce the view that other professionals are their key learning resource. Smith and Gray (2000), in their report on how student and qualified nurses learn to care, recommend that the role of the link lecturer and mentor in sustaining the emotional labour of nursing should be recognized. Learning is dependent on networks of communication among nurses, and their communications are in turn products of relationships within a knowledge exchange system, predicated on peer credibility. Where networked relations and exchanges of this kind exist, they may be considered examples of non-hierarchical community activity. Nurses reported that colleagues were their main source of emotional support. They also stressed that ‘time out’ would be beneficial for them after dealing with a pregnancy loss. They acknowledged, however, that due to time constraints and staff shortages, this would rarely be possible. As Mairead, a gynae nurse, commented:

“I have nursed a lot of women who have rang me at home so obviously I must be doing something right, but for me, I am trying to think if there’s anything I would need, maybe two of me. No it does wear you out, psychologically you’d be drained”

The narrative from Mairead is representative of the views expressed by many of the nursing staff in the study. Several nurses stated they could perhaps be required to deal with as many as five miscarriages in one day. It is apparent, therefore, that nursing staff may benefit from additional support in order to prevent ‘burn out’. The findings of the study indicate that although most nurses develop their own coping strategies, several may benefit from additional support.

4. Discussion

May and Fleming (1997) suggest that for health professions to engage with narratives, either institutional or personal, as critical reflection on practices that take place in ‘real time’, as well as a projection of the professional imagination, accords with a wider impetus towards apprehending and understanding socially constructed meanings. Such a process will, inevitably give rise to contested meanings in the case of nursing, since the profession has in recent years been engaged in a struggle to overcome the hegemony of medical professionals. A link has been postulated by Hearn (1982) between patriarchal and professional dominance, and Witz (1992), who has further argued that the medical profession has engaged in gendered demarcation strategies of professional closure, by attempting to bound professions within male (doctor, consultant) and female (nurse, midwife) categories. Concomitant with this process is the incorporation of previously ‘female’ tasks within male spheres of influence and attempts to deskill nurses by devolving other less highly valued tasks. The way in which emotional labour is regarded within the hospitals is such that there is a strong risk that the coping strategies of nurses in relation to dealing with emotions are likely to be marginalized.
The narrative experience has the potential to offer nurses a neutral reflective space within which to articulate their professional development across time, and chart autonomously the practical, intellectual and emotional tasks with which they are charged. This is an alternative to submitting to an imposed interpretation of their work, that may be more prescriptive, and through which their emotional work may have been overlooked. The study demonstrated that nurses, through reflecting on their practice, and drawing on experiential knowledge, enhanced their professional capability, deepening their understanding and gaining insights into patient care in ways that would not have been possible had their learning been confined within a positivist paradigm of knowledge. Nurses also signalled strongly their deeply felt awareness of the personal costs attached to the support they offer, evident in the rhetorical embellishments to be found within their testimony. This awareness is expressed through the use of terms such as ‘trauma’, ‘pressure’, ‘hard’, the need to ‘cope’, the need for a ‘break’. The terms afford insights into the ways in which narrative can help nurses recover essential elements of their work that have been excluded or devalued because of their emotional entailments. A greater focus on the modes of collaboration that nurses have devised to create understandings of emotional work can assist in the construction of new forms of meaning to contest prevailing stereotypes of nurse-patient encounters.

5. Conclusion

The nurses in the study responded from within a context where “the conventional or orthodox approach, dominant in Western culture, is one in which a wedge is firmly driven between reason and emotion—the latter banished to the margins of Western thought and culture” (Williams, 1998, p. 562). In the health service, doctors, the dominant professional group, practise within a scientific and positivist ideological framework. The patient is the site of different modes of practice, the medico-rational approach of the doctors, reinforced by institutional power, and the experientially grounded and personally oriented practices of the nurses, dependent largely on the resources of their less prestigious but medically derived form of professional preparation. The nurses interviewed, had received training under various dispensations, and those nurses interviewed with long periods of qualified service had been trained in disciplinary forms of knowledge in which the study of human relations tended to be reified within disciplines, particularly disciplines such as psychology. This disciplinary approach has tended to regard product knowledge as being of more value than the process knowledge nurses have gained through their professional reflections on their emotional labour. Since psychology, in the form of behaviourism, had been moulded in a positivistic configuration closely cognate with the medical model, the organizational control of the nurses was underpinned by this form of preparation.

Control should not, however, be equated with mastery, and the nurses brought other resources to bear in their struggle to care for patients and respond to their needs. Firstly, nurse preparation has undergone significant change and there is more recently a new emphasis on the development of a nursing model of practice that draws on a broader range of ideological tools. Secondly, partly as a result of this change and partly owing to the growing assertiveness of nurses as individuals and professionals, nurses were weaving together their own webs of understanding to construct meanings related to their interaction and emotional response to patients who have experienced pregnancy loss. Since nursing is a predominantly non-invasive form of caring practice, interpersonal relations were found to be emerging as the core of this practice. In dealing with relationships the nurses in this study were being led to question the reified forms of knowledge that had constrained their practice and, more profoundly, to critique the boundaries between cognitive and emotional responses that had come to be perceived as irrelevant and redundant.

In attempting this task, the nurses relied to a large extent on reflection on practice, working to improve the service to bereaved parents while dealing with their own feelings and emotions. Given the hegemony of the scientific model of medical practice, it is necessary for nurses to be able to defend the notion of reflective practice against criticisms asserting the weak evidential basis and generalizability of such knowledge. Clearly, it may be considered that such criticism is implicitly gendered, being directed towards the practice of a predominantly female profession. It is not necessary, however, to accept Kantian notions of the sovereignty of reason as the sole basis of a professional analysis of person to person interactions. If empathy is perceived as a valid and necessary component of professional decision-making in the caring process, then it is clear that nurses have to engage professionally with the emotional processes of parents. Furthermore the delivery of individual care designed to meet the specific needs of different parents must be informed by a knowledge of the parents’ emotional state. States of emotion cannot be accessed through scientific forms of measurement, and nurses should consider how they might gauge or evaluate patient needs. Furthermore, nurses have to prioritise the task of evaluation rather than measurement. Since evaluation is about making judgements, Najder (1975) considers that this is an essentially experiential process in which the experience occurs first and is then subjected to a period of
reflection. Najder further asserts that the emotional impact of experience is integral to the process of reflection and that the propositions generated may be non-verbal as well as verbal. The nurses in the study were in a position where they were able to adopt a more structured approach to the expression of emotion and had the professional confidence to recognize the validity of their own emotional responses. From this position, they were able to postulate emotion as a resource, rather than a weakness, or deficit, in professional behaviour.

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References


