

Involvement or over-involvement? Using grounded theory to explore the complexities of nurse – patient relationships

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Despite enormous interest in recent years in the subject of the nurse–patient relationship, relatively little attention has been given in the nursing literature to how nurses manage their personal involvement in these relationships. This paper describes how the methods of grounded theory were used to explore the complex phenomenon of involvement. Through the methods of constant comparative analysis, theoretical sampling, mapping and theoretical memos, a clear distinction between involvement and over-involvement was discovered, and theoretical saturation was reached. Involvement emerged as therapeutic and beneficial, while over-involvement was revealed as inherently dysfunctional. In addition it was discovered that the two phenomena could be separated by their consequences, with the former resulting in positive outcomes for both nurses and patients, and the latter bringing negative repercussions for all concerned. The study resulted in the development of a theory of managing involvement, which concerns how nurses manage their personal involvement in relationships with cancer patients. © 1999 Harcourt Publishers Ltd.

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Engagement oder Über-Engagement? Einsatz der Grounded Theory zur Untersuchung der Komplexität von Schwester-Patient Beziehungen

Obwohl in den vergangenen Jahren das Interesse an der Schwester-Patient-Beziehung sehr groß war, wurde der Frage, wie Schwestern ihr persönliches Engagement in diesen Beziehungen regeln, in der Pflegeliteratur relativ wenig Aufmerksamkeit geschenkt. Diese Arbeit beschreibt, wie die Methoden der Grounded Theory genutzt wurde, um das komplexe Phänomen des Engagements zu untersuchen. Durch die Methoden der konstanten vergleichenden Analyse, der theoretischen Stichprobenerhebung, der Felddaufzeichnungen und des theoretischen Memos wurde eine klare Unterscheidung zwischen Engagement und Über-Engagement entdeckt und eine ausreichende Grundlage zur Theoriebildung wurde gefunden. Engagement stellte sich als therapeutisch wirksam und förderlich dar, wogegen Über-Engagement als von Natur aus funktionsgestört erschien. Zusätzlich wurde entdeckt, daß die beiden Phänomene anhand ihrer jeweiligen Konsequenzen unterschieden werden konnten: Engagement resultierte in positiven Ergebnissen für Schwestern und Patienten, Über-Engagement brachte negative Auswirkungen für alle Beteiligten mit sich. Als Ergebnis der Untersuchung wurde ein Modell der Engagement-Steuerung entwickelt, das sich damit befaßt, wie Schwestern ihr persönliches Engagement in Beziehungen mit Krebspatienten steuern.

Involucrarse o sobre involucrarse? Explorando las relaciones entre enfermera-paciente basándose en la teoría

A pesar que en los últimos años ha aumentado el interés por entender la relación entre enfermeras y pacientes, existe poca bibliografía documentada sobre como las enfermeras deben manejar sus sentimientos personales en esta relación. Este artículo describe los métodos basándose en puntos teóricos que se han seguido usando para explorar el complejo de involucrarse. A través de los análisis comparativos, ejemplos, mapas y memorias se ha establecido una distinción clara entre lo que es involucrarse en la vida de los pacientes o sobre involucrarse. Involucrarse aparece como algo terapéutico, funcional, mientras que sobre involucrarse aparece como algo no funcional. En definitiva, se observó que los dos fenómenos pueden ser separados por sus consecuencias, teniendo

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en cuenta los resultados positivos tanto para la enfermera como para el paciente, así como las repercusiones negativas que conllevan. Este estudio se empezó por el desarrollo de una teoría sobre el manejo de lo que significa involucrarse, lo cual conlleva a saber como las enfermeras manejan sus sentimientos personales en relación a los pacientes con cáncer.

INTRODUCTION

In recent years, the nurse–patient relationship has been hailed as the cornerstone of professional nursing practice (Pearson 1988, Salvage 1990, Morse 1991, Smith 1991, Wright 1994, Savage 1995). Despite a wealth of literature concerning nurse–patient relationships, however, very little of it directly addresses the question of how nurses manage their personal involvement. Morse (1991), for example, proposes a theoretical model of nurse–patient relationships in which the level of involvement increases as the relationship develops; her research highlights the potential dangers of nurses becoming ‘over-involved’ with patients, but does not indicate how nurses might avoid over-involvement. Wright (1994) believes that nurses should set clear limits to their involvement:

Patients appear to want a positive, healing, helpful relationship with nurses, yet so often nurses are told not to ‘get involved’ with patients. Nursing, on the contrary, is about being ‘involved’ with patients, but it is an involvement within defined limits that they seek, a therapeutic relationship for patients that does not harm them while at the same time does not damage or exhaust nurses.

The following paper is based on a research study which used grounded theory to explore the nature of personal involvement from the perspective of the cancer nurse. One of the most significant findings of this study was that cancer nurses find it incredibly difficult to walk this tightrope of being involved whilst at the same time limiting their involvement. By contrast, it is extremely easy for them to become too involved. But just what does it mean to be too involved? Can over-involvement be clearly differentiated from involvement, and, if so, how? This paper will demonstrate how the methodology of grounded theory was found to be of great use in exploring these fundamental questions.

GROUNDING THEORY

Grounded theory was developed by the American sociologists Glaser and Strauss (Glaser & Strauss 1967, Glaser 1978). Dissatisfied with what they considered to be an over-emphasis on research aimed at the verification of theory, they set about creating a new research approach. The term ‘grounded theory’ refers to the generation of theory from empirical

data. The theory is ‘grounded’ in data or generated from within the real sociological world being studied (for example, the cancer ward), rather than imposed on this world from outside, and therefore has a high degree of relevance and utility to those living or working in this area. Thus although this study was concerned with the generation of theory about how nurses manage their involvement, the practical applications of this knowledge are potentially far-reaching.

Grounded theory can be seen as both method and methodology; it comprises specific strategies for handling data as well as an overarching methodological framework based on the philosophy of symbolic interactionism. Although it has much in common with other qualitative approaches, grounded theory is distinguished by its reliance upon three key features: constant comparative analysis, theoretical sampling and theoretical saturation.

Constant comparative analysis

It is a commonly held misconception that in grounded theory research the theory ‘emerges’ from the data as if by its own volition. However, Morse and Field (1996) contend that

‘Theory does not ‘emerge from data’ without immersion and complete familiarity with the data, and without intellectual work’.

The process of generating theory is one of deconstruction and reconstruction, and the principle strategy for achieving this is the constant comparative method of analysis. Through constant comparative analysis, data are broken down into meaningful fragments. Each data fragment is then coded with one or more substantive codes. A substantive code is essentially a label which signifies a category; this label describes the substance of the data. It is then the code rather than the data itself that the analyst works with, thus achieving a level of abstraction from the data. The codes are developed into categories, and the categories are finally integrated into theory.

Theoretical sampling

The development of categories is facilitated by further data collection. This is part of the strategy known as theoretical sampling, a fundamental principle of grounded theory, in which

data collection and data analysis occur simultaneously. Glaser and Strauss (1967) explain that:

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.

Unlike research in which the sample aims to be statistically representative of the general population, in grounded theory the sample is determined theoretically, and data are collected in order to ensure that the categories which develop are representative (Chenitz & Swanson 1986). Theoretical sampling enables links to be formed between categories, which leads to the generation of theory.

Theoretical saturation

Theoretical sampling allows the researcher to seek out relevant samples of respondents to describe and saturate the developing categories. Theoretical saturation occurs towards the end of a study and means that no new data are emerging to shed light on the theory. Thus the theory can be seen as fully developed, integrated and robust.

It is important to note that although these three features can be described separately, in reality they are intricately woven together. The process of doing grounded theory is best described as a complex matrix, rather than a linear step-by-step progression.

EXPLORING INVOLVEMENT AND OVER-INVOLVEMENT

According to the principles of theoretical sampling, the initial sample should be chosen to examine the phenomenon where it is thought to exist (Chenitz & Swanson 1986). The first site chosen for data collection in this study was a cancer centre in the South of England where the researcher had been employed and had observed the phenomenon of involvement. Subsequent data collection took place on two further sites in the North of England; a total of 40 nurses took part in the study.

Semi-structured interviews with cancer nurses were the main method of data collection. (The term 'cancer nurses' refers to nurses working in cancer wards, rather than those with a specific oncology qualification.) The nurses in the first sample ranged from newly qualified staff nurses to experienced ward managers; each nurse was interviewed only once. Later in the study, the emerging theory led the researcher to seek further data from nurses with a substantial

amount of experience in the field of cancer nursing; thus the sample was determined theoretically.

Although the idea of over-involvement was implicit in the early interviews in discussions about involvement, it was not named until the fourth interview, when the respondent expressed her opinion that:

I don't believe that we should go back to saying 'you can't sit on someone's bed and be supportive, you shouldn't, you shouldn't be over-involved', because we have I'm sure all been over-involved, and we've learnt lessons from it.

[Interview 4]

At the start of the study the researcher was concerned about using the terms 'over-involvement' and 'becoming too involved' because they seemed to contain an implicit judgement, suggesting that the nurse has become more involved than she should be. This is immediately problematic because it raises the question of who can or should decide whether or not a nurse is too involved. Since no appropriate alternative emerged, however, the term 'over-involvement' was adopted as it was the one used most frequently by the nurses.

In grounded theory, once a concept has been identified, the researcher's task is to explore and develop it as far as possible. The concept of over-involvement can be seen as a piece in a jigsaw puzzle, and the challenge was to discover where it fitted in relation to all the other pieces in order to see the whole picture or, in other words, the theory. Thus opportunities were sought in subsequent interviews to discover what other nurses thought about over-involvement, and constant comparative analysis of these data allowed the category of over-involvement to be developed.

From the analysis it soon became apparent that, although they are of course closely related, involvement and over-involvement are two distinct phenomena. However, it also became clear that distinguishing between them is by no means simple, as the following respondent observed:

It's difficult to know when somebody is over-involved or too involved. [...] because what for one nurse is a relationship that they can cope with may be over-involved for another nurse. And I think it just depends on the individual; when somebody can't cope with the depth they've got into in the relationship with their patient and the family.

[Interview 8]

In addition, many of the nurses interviewed regarded their relationships with cancer patients as friendships, and this concept added another dimension to involvement.

Friendship

Analysis of the data revealed that over-involvement often occurs when a nurse's relationship with a patient deepens into a close, personal friendship. Two codes relating to friendship emerged from this study; these were labelled 'befriending clients' and 'being a friend'. 'Befriending clients' signified a temporary alliance in which a nurse reaches out the hand of friendship to assist someone through a difficult time; this is very much a conscious and deliberate course of action chosen by the nurse for therapeutic benefit. Befriending clients was thus associated with a positive, beneficial type of involvement.

In contrast, 'being a friend' indicated a much more intense, permanent type of friendship, and was often associated with over-involvement. As with involvement and over-involvement, the demarcation between befriending clients and being a friend is not always apparent, and many of the nurses related experiences where patients had crossed this invisible line and become their friend:

You know, they were friends [...] Although they were patients, they were more than that.

[Interview 19]

Friendship, of course, implies reciprocity, and calls into question the boundaries of a professional relationship:

I did find it hard at first, just because it is really difficult; because you've got this professional front on while you're in work, and then just being yourself, you're then a friend to them outside and you're going out for a meal or you're doing whatever you're doing.

[Interview 9]

This extract provides a good example of how confusing befriending and being a friend can result in considerable role conflict. By attempting to maintain a professional relationship at the same time as a social relationship with this patient, the nurse has to wear two hats simultaneously, 'nurse' hat and 'friend' hat, and switching between the two is extremely problematic.

Data such as these give rise to the hypothesis that involvement is by definition therapeutic and professional, and has positive benefits, whilst

over-involvement is essentially dysfunctional. Constant comparative analysis allowed the exploration and development of related categories which added weight to the hypothesis; it also sparked the idea that it is the consequence of an action which distinguishes it as either involvement or over-involvement, rather than the action itself.

CONSEQUENCES OF INVOLVEMENT AND OVER-INVOLVEMENT

In the very first interview, the nurse explained that, to her, being involved meant:

being part of a situation where your actions have a consequence – there is a result by it. [...] you are a part of a situation, and by being a part of it there is a consequence, whether it is positive, negative or whatever.

[Interview 1]

In his book *Theoretical Sensitivity*, Glaser (1978) suggests various ways of ordering data into 'coding families' so that relationships between concepts can be fully explored. One of these coding families, the '6 C's', is essentially a causal-consequence model, and this was found to be useful in exploring the phenomenon of over-involvement. Searching for the causes and the consequences of over-involvement led to the discovery of many related concepts and categories, and ultimately led to a clear distinction being made between involvement and over-involvement.

The analysis was also greatly facilitated by another important strategy of grounded theory, that of mapping, whereby concepts can be visually depicted in relation to each other. An example of mapping is given in Table 1. This simple map was constructed early on during data analysis, and captures the idea that involvement can have both positive and negative consequences. It is important to note that this map, like the others that were constructed during the study, is tentative rather than definitive. A key element of grounded theory analysis is the researcher's creativity (Glaser 1978, Strauss & Corbin 1992), and maps are one way of allowing the analyst to play with the data and view them

Table 1 MAP-Consequences of positive and negative involvement

	Positive involvement	Negative involvement
Consequences for nurses	job satisfaction feeling valued	possessiveness over dependence inability to switch off
Consequences for patients	continuity of care security/safety trust	dependence problems when nurse off duty inequality in care

from many different angles, until ideas take hold and start to crystalize.

Positive consequences

As can be seen from this map, involvement can have some very positive consequences for both nurses and patients. For example, it can result in a great deal of job satisfaction for nurses, and provide them with a particular sort of personal fulfilment. This is evidenced in the following data extract:

[...] it's a sense of 'yes, I'm valued here, I've made a difference; I've not just gone on and sat at a desk'. You actually are making a difference to people's lives. And that's really nice feeling. Even if it is when they're bereaved or whatever, the fact that you and all [the other] nurses are making a difference.

[Interview 3]

Although this study explored involvement from the perspective of the cancer nurse rather than that of the patient, many of the respondents believed that there are also significant advantages to be gained by patients from the nurse's involvement. For example, involvement provides the patient with someone to confide in and trust, someone to support them through a stressful time, and someone to advocate for them.

Negative consequences

However, there are also some potential dangers for both nurse and patient if the nurse's involvement becomes too deep. For instance, a patient may begin to rely too heavily on one particular member of staff:

The effect on the patients ... I think it makes the patient dependent on that nurse. Dependent psychologically, physically, I'm not sure. But they see that nurse as the only person who can do anything positive for them.

[Interview 5]

The effects of dependence may be far-reaching, impacting on the rest of the ward and the organization of care, if, for example, the ward practices team nursing yet the patient only trusts one member of the team. In addition, if a nurse is

very involved with one patient, he/she may spend a disproportionate amount of time with them, and thus risk compromising the care of the other patients.

Over-involvement may also result in negative consequences for the nurse, perhaps the greatest of which is emotional pain. Many of the nurses in the study related experiences of being involved in very long-term relationships with cancer patients, and perhaps not surprisingly they found themselves feeling extremely upset when the patient died:

And this particular lady had been with us on and off for about four and a half years, and she was a very nice lady, very sensible, very determined; a really nice person. [...] we got on well as people as well I think, apart from everything else. And she died, and it was very very personally upsetting, and I was upset for quite a few days about her really.

[Interview 32]

Of course, to some extent it is only natural that a nurse should be upset in such circumstances; as one nurse commented, 'we're only human after all'. However, occasionally a nurse's involvement may cause him/her great distress, as in the following extract:

[...] at the time when I became too involved with a patient, when she died I felt like I never wanted to nurse another cancer patient again. It's that painful really.

[Interview 7]

Thus further exploration of the consequences of involvement and of over-involvement enabled the researcher to clarify this distinction between positive, therapeutic involvement and negative, dysfunctional over-involvement.

Theoretical memos

Throughout the study, the analysis was facilitated by another important strategy of grounded theory research, the writing of theoretical memos. Glaser (1978) explains that:

The core stage in the process of generating theory, the bedrock of theory generation, its true product is the writing of theoretical memos. [...] *Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding.* Memos lead naturally to abstraction or ideation.

Early analysis of the study data had suggested that certain types of behaviour might be

Table 2 MEMO – Becoming too involved

The more I think about involvement and over-involvement, the more I think it is simply not possible to list certain types of behaviour under the two headings of 'involvement' and 'over-involvement'. So far I seem to have been trying to identify which types of behaviour the nurses feel would indicate positive involvement or negative, dysfunctional over-involvement, and I have asked some of the nurses which category they would consider behaviours such as attending funerals or socializing with clients outside of work to belong. The nurses have been almost universally reluctant or unable to make these judgements about behaviour, and feel that it depends on the circumstances of each case. This has led me to think that it is not the behaviours themselves which are important, but rather the manner in which they are done and the effect they have on the nurses and the other people around them which matters, and that this is how involvement can be differentiated from over-involvement.

Table 3 MAP – factors associated with involvement and over-involvement

Involvement	Over-involvement
predominantly professional relationship (patient as client)	predominantly friendship (patient as person)
objectivity	lack of objectivity
realistic view of cancer patient	idealistic view of cancer patient
clear boundaries	unclear or no boundaries
experience	inexperience
team support (shared responsibility)	lack of support (individual responsibility)
education	inadequate education
good skills (e.g. communication skills)	inadequate skills
strong leadership/management	lack of leadership/management
awareness	lack of awareness

indicative of involvement or over-involvement, and so could be grouped accordingly. However, as the analysis continued, the researcher became increasingly doubtful about the usefulness of this approach, and these doubts are captured in the memo extract in Table 2.

So, for example, in the case of nurses attending patients' funerals, it seems that if the nurse accepts the patient's death and attends their funeral simply to show support to the family then his/her involvement is essentially positive; but if he/she is grief-stricken and needs the funeral for personal reasons, he/she may well be over-involved. Thus it is not the action of attending the funeral per se which indicates the extent of involvement, but rather how he/she is affected by the patient's death.

MANAGING INVOLVEMENT

The process of doing grounded theory is one of constant movement. As the analyst continually sifts through the data, exploring relationships between the various categories, the emerging theory shifts and changes. Table 3 is an example of a map which was constructed relatively early in the study, but contains ideas which were eventually integrated into the final theory.

The study resulted in the theory that cancer nurses undergo a process called 'managing involvement' through which they learn to manage their personal involvement in relationships with cancer patients. Although it is beyond the scope of this paper to describe the whole process in detail, two important components of it – developing awareness and controlling involvement – will be briefly highlighted.

Developing awareness

Before nurses can properly control their personal involvement they need to increase their awareness of involvement and over-involvement. As one experienced nurse commented:

We've probably all seen younger, less experienced nurses becoming involved, very emotionally

involved, without any real knowledge of what's going on.

[Interview 16]

The process of developing awareness is in itself a learning process which occurs over a long period of time. As they gain experience and knowledge nurses become more aware of the effects of their behaviour both on themselves and on those around them. Developing awareness is closely connected with growing up and gaining maturity, because although nurses clearly learn a great deal in the clinical arena, they also learn from their experiences of life, as another respondent pointed out:

I mean there's no doubt that your development as a person outside work, you can take to work what you learn from experience in life and relationships and heartache and other growth, you take to work and you use at work.

[Interview 18]

The data strongly suggested that the more experience a nurse has the better able he/she is to manage their involvement. With experience, a nurse gains awareness of the benefits of involvement and the dangers of over-involvement, and thus is in a much better position to exert some control over the extent of his/her relationships with patients.

Controlling involvement

The study revealed that in order to conduct a professional relationship with a patient, a nurse has to be in control of how far he/she becomes personally involved; as one respondent put it:

... it is a professional relationship you're looking at. And I think you do need to feel that you're in control of it.

[Interview 11]

Analysis of the data revealed that nurses, particularly those with less experience, do not always make a conscious decision to enter into an involved relationship with a patient; often involvement 'just happens' in a spontaneous and uncontrolled manner. However, more experienced nurses appear to control the level of their involvement in highly sophisticated way,

and, in addition, do so almost instinctively, without having to stop and think about it.

A large amount of data was concerned with two particular strategies which are employed by experienced nurses in order to control involvement. The first, setting boundaries, enables nurses to make a conscious decision about how far they will take their personal involvement. Returning to the question of friendship for example, one nurse provided a particularly helpful illustration of where to draw the line between befriending and being a friend, explaining that:

[...] the patient may want you to be a friend, but they don't want your pain, or your problems. They may be able to take on the light problems; you know, like 'gosh, the car won't start', and things like that; very light, basic problems. But 'my mum has died' or whatever, things like that might not be appropriate. So I don't think that if I had something that was quite painful to me that I would discuss that with them.

[Interview 25]

Such a distinction is for this nurse a clear boundary; she would divulge a certain amount of personal information, but any more would be risking over-involvement.

The second strategy used by experienced nurses to control their involvement is that of switching off. Switching off means that the nurse stops thinking about work when she goes home, and is able to get on with her life outside work. It is important to emphasize that this does not mean that the nurse is detached and uninvolved with the patients; rather, she is positively involved while she is at work but is able to disconnect herself emotionally once she leaves:

I'm usually attached enough to be upset when they develop problems but then I can switch off quite easily afterwards.

[Interview 30]

CONCLUSION

The emergence of a clear distinction between involvement and over-involvement was central to the theory of managing involvement which was developed through this study. This paper has delineated the principal features of grounded theory research, and demonstrated how these were utilized in the study in a quest for greater understanding of the complex phenomena of involvement and over-involvement.

The theory of managing involvement makes an important contribution to existing knowledge about nurse-patient relationships and involvement. This study revealed that the process of learning how to manage involvement is in many respects a difficult and painful process for nurses to go through; yet they must go through it if

they are to become proficient at establishing and sustaining involved relationships with cancer patients. While previous research (Morse 1991) points to the dysfunctional nature of over-involvement, this study sheds much needed light on what constitutes over-involvement, how it can be distinguished from involvement, and how nurses can be involved with cancer patients at the same time as avoiding over-involvement.

The uniqueness of involvement and over-involvement in each individual situation undoubtedly adds to the challenge of trying to unravel these phenomena and develop theory which is relevant and useful to cancer nurses. One respondent, for example, questioned whether it is possible to teach nurses about involvement:

I think [being involved] is something that you can't be taught. Because nobody knows how they're going to react to a situation until they're in it; nobody knows how close they can become to a patient until they're actually in that situation.

[Interview 7]

For this nurse, the unpredictability of relationships between nurses and patients makes involvement impossible to teach. However, theory has an important predictive role; thus the theory of managing involvement should enable cancer nurses to predict with reasonable accuracy what is likely to happen if they become very involved with patients. Such theory is therefore of great value to nurses who are learning about involvement.

This study has also highlighted the need for teaching to be tailored to each individual nurse. There is an important role for educational strategies such as guided reflection, mentorship and clinical supervision in enabling nurses to learn about involvement. It is clear that theory such as this, which is derived from practice and grounded in the realities of the cancer ward, has the ability to inform nursing practice and facilitate its development. It is also clear from this study that nurses, particularly those with least experience, require both educational and emotional support from their more experienced colleagues if they are to learn how to manage their involvement in a positive and constructive way.

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REFERENCES

- Chenitz WC, Swanson JM (1986) *From Practice to Grounded Theory: Qualitative Research in Nursing*. Addison-Wesley, California

- Glaser BG, Strauss AL (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine, Chicago
- Glaser BG (1978) *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Sociology Press, California
- Morse JM (1991) Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing* 16: 455-468
- Morse JM, Field PA (1996) *Nursing Research: The Application of Qualitative Approaches*, 2nd edn. Chapman & Hall, London
- Pearson A (ed) (1988) *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Units*. Croom Helm, London
- Savage J (1995) *Nursing Intimacy: An Ethnographic Approach to Nurse-Patient Interaction*. Scutari, Harrow
- Salvage J (1990) The theory and practice of the 'New Nursing'. *Nursing Times* 86(4): 42-45
- Smith P (1992) *The Emotional Labour of Nursing: Its Impact on Interpersonal Relations, Management and the Educational Environment in Nursing*. The Macmillan Press, London
- Strauss AL, Corbin J (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage Publications, California
- Wright SG (1994) *My Patient - My Nurse: The Practice of Primary Nursing*, 2nd edn. Scutari Press, London