

Spring 5-17-2013

The Corporatization of America's Healthcare System: Implications for Compassion Fatigue among Nurses

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The Corporatization of America's Healthcare System:
Implications for Compassion Fatigue Among Nurses

A Thesis

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Master of Arts
in
Sociology

By

Erika LaShael Gathron

B.S.N., University of Texas, 2004

May 2013

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DEDICATION

For more than a decade now, I have been nursing the afflicted, advocating for the afflicted, serving the afflicted, and on many occasions witnessing the loss that often times accompanies the afflicted! Loss is a hard but rightfully normal part of life on this side of heaven. I do not know if it is the loss itself, or the immediate stages after the loss that are hardest... But I agree with Simone Weil when she stated in her book *Gravity and Grace* that *“Love of God is pure when joy and suffering inspire an equal degree of gratitude.”*

I am still not able to fully articulate how the deeply painful loss of my mother has in turn become the very catalyst that has given my life so much sagacity and wholeheartedness. Romans 8:28 instructs that *“We are assured and know that all things work together and are for good to and for those who love God and are called according to His design and purpose.”* Suffering loss allows or maybe forces one to gain a deeper revelation of what it means to have all things work together! Either way, I am assured of these things and through this grace- filled revelation brokenness and gratitude have kissed and a window in my life has opened. Grace and Mercy have entered and Gratitude stands tall! I do not know if it is the wow factor of envisioning my mother in heaven as she communes with Christ or the window in my life that has opened in her absence. But I do know that, everywhere and in every way, I acknowledge these things with profound gratitude.

This thesis is dedicated to my mother, Marsha Kaye Gathron,

February 4th, 1951- August 4th, 2009.

ACKNOWLEDGEMENTS

The completion of this thesis was possible thanks to the love and support of many people, as well as the mentorship and guidance of many others. I deeply appreciate the contribution that each one of you had in reaching this final step and in making the whole experience throughout my master's journey a joyful one.

To Dr. Vern Baxter, thank you for believing in my capability to accomplish this, for supporting my idea, and for making this experience significant.

To Dr. Pamela Jenkins, thank you for teaching me what it means to be a research methodologist, and for answering all of my questions with such generosity.

To Dr. Charles Figley, thank you for your dedication to the field of traumatology. Your work teaches me how to be a better nurse, by learning the importance of taking care of myself, as I take care of others.

To Dr. Natosha Smith, thank you for reading my first drafts and for your friendship and support.

To my nursing colleagues, thank you for teaching me what it means to be a dedicated and committed nurse. I learn from you every day and I am honored to call you my colleague and friend.

To my friends Cheryl, Lety, Michelle, LaQuetta, Ifeoma, Alexia, Mary, Jana, Kezia, Ann, Megan, Kelly, Sarah, Frankie, and many others, for believing in my, for encouraging me, for your love and for giving me the generous gift of your friendship. I will always be thankful.

To my family, thank you for your unconditional love and for being the support that I could rely on as I accomplished this goal.

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ABSTRACT

The purpose of this study is to expand on the existing framework for the analysis of compassion fatigue by exploring contributing factors not traditionally examined such as increases in the number of patients assigned to each nurse, more hours of work per shift, the use of non-licensed clinical personnel instead of licensed clinical personnel, and changes in work flow management. This thesis explores one main research question: *How does the corporatization of America's healthcare system contribute to nurse's lived experience of compassion fatigue?* Michael Burawoy's extended case method is deployed in order to gain a broader understanding of compassion fatigue.

Content analysis of one semi-structured life world interview and two nurses' blogs reveal four major themes that enlarge the scope of compassion fatigue: professional disheartenment, adverse implications, ethical conflict, and technological distress. Results reveal that the corporatization of America's healthcare contributes to compassion fatigue amongst nurses.

Keywords: compassion fatigue; nursing work

CHAPTER ONE

INTRODUCTION

Turn on the television to any news channel or finger scroll the latest report to go viral and you'll undoubtedly run across headlines reading, "Stressed Healthcare Workers Battle Flu Epidemic", "13 year-old girl molested- Mother's boyfriend in Custody", "Eight Combat Soldiers Killed by Suicide Bomber in Afghanistan", or "Trauma Hospital Closes due to Fiscal Crisis." On any given day there is a bombardment of catastrophic news broadcast throughout the airways. News reports tell stories of traumatic events occurring on a routine basis in the United States and abroad. Suffering experienced during war and the day-to-day trauma of abuse, accidents, and critical illness are all causes for ongoing anguish. Not only do those who actually experience these events firsthand suffer so do those who care for or help the distressed individual. Wander into any hospital or clinic and you will not only be met by the faces of distressed and suffering individuals, but also by the faces of overburdened and fatigued nurses. The reason, I know this is because I am one of those nurses!

I like being a nurse. I like caring for my patients, and I like witnessing them regain their health. I am systematic in my presentation as a nurse. The night before a scheduled shift, I gather my stethoscope, organize my uniform, and place my nurse's bag near the front door. Driving in to work, I role play with myself; organizing my thoughts and thinking through my internal checklist of the duties I will be expected to accomplish during the next ten to twelve hours. I say a prayer

asking God to help me with my patients and that the clinic will be adequately staffed to care for them.

I am a highly skilled nurse as evidenced by my advanced training in the specialty of Nephrology. I am a compassionate nurse, confirmed by the remarks left on my patient's comment card, "She's my favorite nurse, when she's here I know everything's going to be copasetic!" I am also exhausted! The last time I spoke with my manager about working short staffed, I was told to "step up to the plate!" I think twice about vocalizing my rebuttal because I recognize that my boss, a fellow nurse, is also tired! We both work in a profession where nursing labor is persistently challenged by the systemic demands of a corporatized American healthcare system.

Dr. Charles Figley's dominant theoretical framework is noted for referring to compassion fatigue as "the cost for caring" and defines compassion fatigue as, *"a state of tension and preoccupation with traumatized patients by: re- experiencing traumatic events, avoidance or numbing of reminders, and persistent arousal (e.g. anxiety) associated with the patient (Figley, 1995)."*

Beyond this natural by-product of therapeutic engagement, Figley (1995) emphasizes that if nurses are not empathic or exposed to the traumatized, there should be little concern for compassion fatigue. Discussion centers on the special vulnerabilities (e.g. empathic capacity, personal experience with traumatic event) of nurses that make them more susceptible to compassion fatigue (Figley, 1995).

I argue that the dominant theoretical framework is limited for a number of reasons. First, situating compassion fatigue within a medical framework without considering the socio- economic and political environment in which it occurs overlooks an important set of conditions that contribute to compassion fatigue.

Second, concentrating on the specific traits of nurses, such as a high degree of empathy, or 'at risk' individuals who are unable to set boundaries, supports the idea that the 'problem' of compassion fatigue lies with the nurse (Ward- Griffin, 2011). Such logic blames the nurse (Butterfield, 1990), and suggests that it is the nurse's responsibility to find the solution (Raphael & Bryant, 2002). Recommendations that remind the nurse to take care of him or herself or to develop personal strategies imply that the solution lies within a nurse's control. If it is not within their control they are obliged to accept or adapt to what they cannot control (Najjar, 2009).

I propose an alternative approach to compassion fatigue that includes the recognition of the socio- economic and political environment of compassion fatigue and how that contributes to nurses' lived experience of compassion fatigue.

PURPOSE OF STUDY

The purpose of this study is to expand on the existing theoretical framework for the analysis of compassion fatigue by exploring contributing factors not traditionally examined. Michael Burawoy's extended case method is deployed in order to gain a broader understanding of compassion fatigue. The extended case method, which builds on prior theory, separates the ordinary from the extraordinary, shifts from the "micro" to the "macro", and links the present to the past in expectation of the future (Burawoy, 1998). This dwelling in theory enables the deepening and broadening of the dominant theoretical framework. This thesis explores one main research question: *How does the corporatization of America's healthcare system contribute to nurse's lived experience of compassion fatigue?*

Although there is a growing body of literature on compassion fatigue among healthcare professionals, to date no published study has specifically examined how the corporatization of America's healthcare system contributes to compassion fatigue. Research focused on improving the negative health effects of compassion fatigue need to situate compassion fatigue within the socio- economic and political environment in which it occurs. It is important to examine the socio-political context of nursing (e.g. corporatization, organizational hierarchy, privatization) that shapes the professional environment where nurses perform their work (Ward-Griffin, 2011).

There is a need to identify the effects of the environment on compassion fatigue, rather than focus primarily on an individual's coping skills and personal capacity to prevent or manage compassion fatigue. I specifically argue that the dominant

theoretical framework should include how the corporatization of healthcare has changed the socio- economic and political environment of nurses' work and how that contributes to nurse's lived experience of compassion fatigue. This thesis is an exploratory study designed to address this gap in the literature. Contributions from sociology and related disciplines are applied to controversies currently discussed by nurses and in the discourse of the nursing profession about the problem of compassion fatigue. In this study, the reader is challenged to consider the *proposition* that nursing labor is objectified through the corporatization of America's healthcare system. This objectification places systemic demands on nurse's lived experience that contribute to widespread compassion fatigue.

RESEARCHER'S STANDPOINT

I graduated from The University of Texas at Austin School of Nursing well equipped to provide patients with compassionate care. I spent four years immersed in a curriculum that focused heavily on patient- centered care, learning skills such as how to develop a therapeutic relationship, and the importance of empathetic listening. My class discussions often evoked dialogue on topics such as the plight of healthcare in America, and caring for vulnerable populations like the elderly and disabled.

As a registered nurse who specializes in Nephrology (study of the kidney), I am confronted with the daily task of giving care to a population that is chronically ill and dependent. My work environment consists of providing care to patients who have been diagnosed with End Stage Renal Disease (ESRD). ESRD is commonly referred to as kidney failure, and is classified as a chronic illness- any disease state persisting for more than three months. The treatment of choice for this population involves a care plan that consists of blood toxicities monitoring, electrolyte monitoring, nutrition monitoring, fluid intake monitoring, and infection monitoring.

Although I feel proficient in my expertise as a Nephrology Nurse, I struggle to develop the coping skills needed to manage the occupational stress consistent with the profession of nursing. As I prepare to celebrate my ten-year anniversary as a registered nurse, I am persuaded that my struggle to develop these skills is due to a gap in my education. Throughout my course of study little attention was given to teaching nursing students the skills needed to successfully negotiate the emotional

demands of working in a relentlessly stressful profession (e.g. 12:1 patient/ nurse ratio, 12-hr shifts, no auxiliary staff).

Additionally, I received no training on the various types of occupational stress, how to distinguish various types of occupational stress and the risk factors associated with each type. It is from this standpoint that I am combining both my experience as a former nursing student and my experience as a Nephrology Nurse with my role as a Compassion Fatigue researcher.

RESEARCHER'S APPROACH TO STUDY:

SOCIAL CONSTRUCTIVISM

This study is exploratory and combines deductive with inductive logic to explore a new proposition about compassion fatigue. I find it important to ground my research from a social constructivist viewpoint. Social constructivism holds that individuals seek understanding of the world in which they live and work. They develop subjective meanings of their experiences with certain objects or things. Research questions are broad and general, allowing the participant to construct meaning of a situation and the researcher listens to what people say or do in their life setting. Researchers recognize that their own background shapes their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences-deductive logic. Thus, the goal of the researcher is to address the process of interaction, relying on participant views of the situation under studied, and to inductively develop a theory or pattern of meaning (Creswell, 2003).

RATIONALE FOR STUDYING COMPASSION FATIGUE IN NURSES

The American Public Health Association (2006) identifies best practices for nurse retention; among them are flexible work options, mentoring programs, phased retirement, workplace redesign, ergonomic improvements, and care giving and grief resources. Concerted attention is paid to care giving and grief resources because studies examining the root cause of the nursing shortage reveal that burn out and stress contribute to a nurse's decision to leave the profession (Aiken, 2001; Buerhaus, 2001).

Coetzee and Klopper (2010) suggest that because compassion fatigue is not formally defined within nursing practice, the phenomenon has not been explored, described, or explained so nurses can effectively identify and combat compassion fatigue. A few studies have addressed compassion fatigue in nursing but they explored only a few specific populations and do not address a broader population of nurses and other care providers. Compassion fatigue needs to be studied in its entirety.

CHAPTER TWO

LITERATURE REVIEW

Chapter two reviews the current literature on compassion fatigue. First, Figley's (1995) *Compassion Fatigue: "The Cost for Caring,"* closely examines the nomenclature associated with this phenomenon, and compassion fatigue as "the cost of caring". I provide the reader with a contextual understanding of compassion fatigue that illustrates how the dominant theoretical framework does not consider the socio-economic and political environment in which compassion fatigue occurs.

COMPASSION FATIGUE: "THE COST OF CARING"

Nurses have a longstanding history of witnessing tragedy and are frequently enmeshed in issues surrounding life and death (Showalter, 2010; Yoder, 2010). Nurses often enter the lives of others at critical junctures and become part of a mosaic of caring within a family framework that may be fraught with anticipatory loss, tension, and disbelief. Often, they cannot leave the situation after a death has occurred, placing the nurse at the center of an interchange that makes the nursing role unique. Fagin and Diers (1983) describe nursing as "a metaphor for intimacy often involving the most private aspects of patients' lives. Nurses do for others in public what healthy persons do for themselves in private." Thus, nurses' work is distinguished from other human service occupations in two prominent ways. First, there is no global recognition of the potentially negative implications of nurses' work (Aycock & Boyle, 2009), and few systematic supports are in place to help nurses deal with their emotional responses to witnessing the tragedy of others and experiencing the associated sadness, grief and loss. Second, the risk for nurses to

experience heightened intensity of emotional responses to conditions at work is unique in that nurses are not only 'first responders', they are also sustained responders, who are expected to provide ongoing (vs. time- limited, episodic) support and interventions to highly vulnerable patients (Bush, 2009).

A review of the literature leaves little doubt that their work takes a toll on the psychological, social, and physical health of nurses. Recent studies have identified several types of occupational stress including burnout, vicarious traumatization, secondary traumatic stress and compassion fatigue. Nurses working in several specialty practice areas, such as intensive care, mental health, pediatrics, chronic, oncology, and hospice care are particularly vulnerable to work- related stress (Sabo, 2011). For example, in one study that focused on the prevalence and risk of compassion fatigue among 216 hospice nurses, Abendroth and Flannery (2006) found that survey respondents in the moderate to high-risk category for compassion fatigue (N=170) displayed 'self- sacrificing behaviors' as the major contributing risk factor. Approximately 34% (N=47) of the 170 nurses who exhibited this behavior were high-risk for compassion fatigue.

Dr. Figley's (1982) research found the terms compassion stress and compassion fatigue appropriate when describing the "cost of caring" experienced by nurses, emergency workers, and other professionals who work with trauma victims. Feeling the stress, and even the fatigue of compassion in the line of duty as a nurse or therapist better describes the causes and manifestations of their duty- related experiences (Figley 1995). This approach holds that compassion is another name for empathic distress (Ekman, 2003). People often mirror the emotions of those around

them and vicariously experience other's emotions. From the empathic distress perspective, compassion is a term that people apply to their vicarious experience of distress in response to another person's suffering. The implication is that the state of compassion is associated with the expressive behavior, physiological response, and underlying appraisals of the state it mirrors, most likely distress, pain, sadness, and fear (Goetz, et. al, 2010).

For nurses, compassion fatigue arises when they have close interpersonal contact with a suffering patient and their emotional boundaries become blurred to the point that the caregiver unconsciously assimilates the distress experienced by the patient (Bush, 2009). While this study places emphasis on compassion fatigue, attention must be given to how burnout, vicarious traumatization, and secondary traumatic stress are distinguished from compassion fatigue.

BURNOUT

Psychologist Herbert Freudenberger (1974) introduced the concept burnout in his classic article, "Staff Burnout," published in the *Journal of Social Issues*. Burnout was mentioned in relationship to mental health workers in Pines and Maslach's (1978) article "Characteristics of Staff Burnout in Mental Health Settings". Maslach describes burnout as,

"A syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work. It is a response to the chronic emotional strain of dealing extensively with other human beings when they are troubled or having problems."

Pines and Aronson (1988) later defined burnout as a 'state of physical, emotional, and mental exhaustion caused by long- term involvement in emotionally demanding situations. This early conceptualization of burnout, which focused on

the relationship between care provider and care recipient, has expanded to include the negative physical, mental, and emotional effects of all occupations (Leiter & Schaufeli, 1996). As research has shifted from descriptive to inferential study designs, findings strongly suggest that this relationship is not the key driver of burnout (Lee & Ashforth, 1996; Leiter, 1993). Research now supports six work- life issues that involve person- job mismatch as the most likely explanation for burnout. These issues include work overload, lack of control, lack of reward, lack of community, lack of fairness, and value conflict (Leiter, 2006).

VICARIOUS TRAUMATIZATION

McCann and Pearlman coined the term vicarious traumatization to describe the effects trauma work can have on psychotherapists. They conceptualize vicarious traumatization within Constructivists Self- Development Theory (CSDT), which describes how exposure to traumatic material is processed in an effort to make meaning.. CSDT asserts that individuals construct their realities based on perceptions and schemas (Trippany, White Kress, & Wilcoxon, 2004). Vicarious traumatization describes a “process of change resulting from empathetic engagement with trauma survivors” (Pearlman, 1999). For Pearlman, the hallmark of vicarious traumatization is a disruption in one’s sense of identity, worldview, and spirituality, all components that constitute one’s frame of reference. This disruption can be extremely painful for the psychotherapist and can persist for months or even years after work with a traumatized person (McCann and Pearlman, 1990).

Likewise, Saakvitne and Pearlman (1996) offer further clarity in their seminal work, *Transforming the Pain*. They write,

“Vicarious Traumatization is our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people’s pain and loss. Thus, we are forced to recognize human potential for cruelty and indifference. It is our numbing, our protective shell, and our wish not to know, which follow those reactions.”

SECONDARY TRAUMATIC STRESS

Secondary Traumatic Stress is defined as “the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1999). Secondary Traumatic Stress is about your work- related, secondary exposure to extremely or traumatically stressful events. The symptoms of STS are usually rapid in onset, are associated with a particular event, and may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind one of the event (Stamm, 2009).

COMPASSION FATIGUE

Joinson (1992) used the term compassion fatigue in a study that examined burnout in emergency department nurses to describe the “loss of the ability to nurture.” Valent (2002) regards compassion fatigue and burnout as related but separate concepts. Valent believes the two concepts arise from separate failed survival strategies: burnout arises from an assertiveness- goal achievement response, and compassion fatigue arises from a rescue- caretaking response. Valent theorizes that burnout arises and declines more slowly, and occurs when one cannot achieve his or her goals and results in “frustration, a sense of loss of control,

increased willful efforts, and diminishing morale”. Conversely, Valent (2002) suggests that compassion fatigue appears suddenly and subsides more quickly, and occurs when one cannot rescue or save the individual from harm and results in guilt and distress.

Gentry and Baranowsky (2009) contend that compassion fatigue consists of the two components secondary traumatization and burnout, and affects almost every caregiver at some point in their professional career. Gentry, and Baranowsky, in collaboration with Figley, (1998) define compassion fatigue as an interactive or synergistic effect among primary traumatic stress, secondary traumatic stress, and burnout in the life of afflicted caregivers.

Gentry and Baranowsky (2010) assert that compassion fatigue occurs when an individual becomes secondarily traumatized during exposure to traumatic incidents directly experienced and relayed by another. The reverberation of client trauma in a caregiver’s life can take the form of PTSD- like symptoms that mimic the client’s disturbances. Building upon the dominant theoretical framework, they maintain that empathy is the tool that caregivers use more often to establish a healing relationship. Over time, working continuously in emotionally charged situations, empathy can become overtaxed and exhausted even when the caregiver diligently maintains self- care skills.

DOMINANT THEORETICAL FRAMEWORK

Dr. Figley presents a model that conceptualizes compassion fatigue within a stress- process framework (Adams, et al., 2006; Figley, 2002) that accounts for how and why some people develop compassion fatigue.

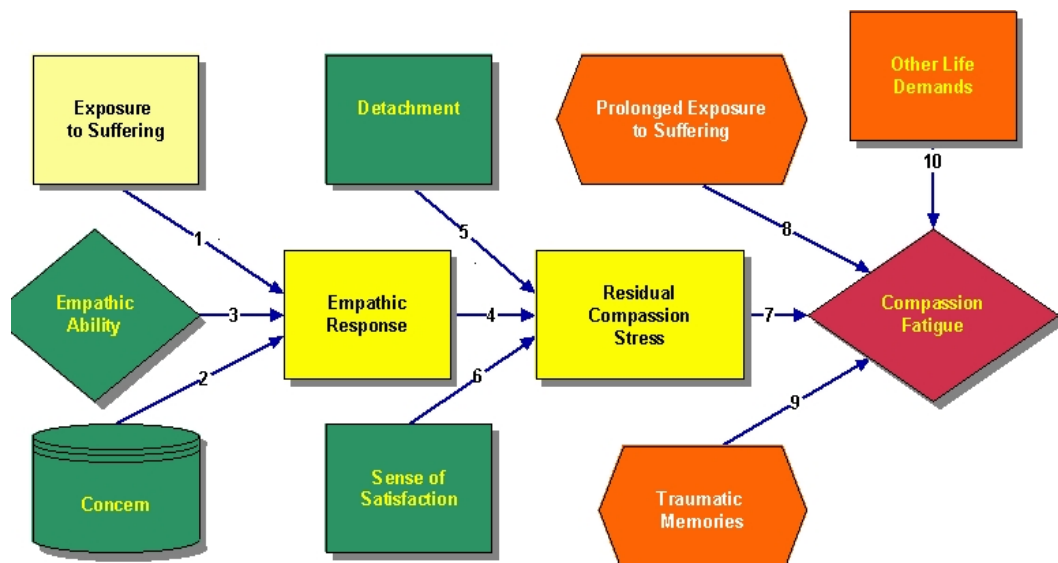


Illustration 1- Dr. Charles Figley's Conceptual Model of Compassion Fatigue (2002)

The dominant theoretical framework of compassion fatigue encompasses the concepts of empathy and exposure. Key elements of the model include empathic ability, empathic response, and residual compassion stress. The model is based on the assumption that empathy and emotional energy are the critical elements necessary for the formation of a therapeutic relationship and a therapeutic response. The model is depicted as a series of cascading events beginning with exposure to a patient's pain, suffering, and / or traumatic event. The nurse must have concern and an empathic ability or feel motivated to respond when they perceive that the patient is suffering. When nurses have this empathic response,

joined with an unwillingness or inability to detach from the situation and the absence of feelings of satisfaction, the nurse develops compassion stress.

Compassion stress (residue of emotional energy) results in compassion fatigue if the nurse has prolonged exposure to suffering coupled with traumatic memories and competing life demands. The risk increases if the nurse experiences ongoing exposure to suffering, memories that elicit an emotional response, or unexpected disruptions in her/ his life (e.g. death of loved one) (Figley, 2002).

EXTENDING THE DOMINANT THEORETICAL FRAMEWORK

In chapter three, I situate nursing work within the corporate discourse of a capitalistic healthcare system. *Extending the Theory of Compassion Fatigue* applies Dorothy Smith's standpoint theory at the intersection of healthcare corporatization and nursing work. Dorothy Smith's standpoint theory complements the already referenced extended case method because I am able to engage and incorporate the actual work and work environment of nurses with a method that extends the dominant theoretical framework. This highlights for the reader my alternative approach to compassion fatigue that locates the socio-economic and political environment in which it occurs.

AN ALTERNATIVE APPROACH TO COMPASSION FATIGUE:

DOROTHY SMITH'S STANDPOINT THEORY

Dorothy Smith (1979) raises a fundamental question posed by Karl Marx (1974): *"How does it happen that individuals' social relations assume an independent existence over them?"* In Smith's conception, a sociology "for" is not the same as a sociology "of" or "about" a group of people. She outlines a method that, in an effort to "preserve the presence of the subject", begins with real individuals and outlines linkages between their day to day situations and more common characteristics of the society, particularly capitalist social relations which contextualize everyday life. Dorothy Smith proposes that by starting from people located in actual work situations we can explore how their lives become objectified by the organizational processes of corporate capitalism and how, along the way, subjects get turned into objects.

A sociology for the nursing profession centers primarily on how the work of nurses is objectified by the organizational structures and language which encase it. When nursing work is measured against criteria constructed within the context of capitalist medicine, nurses become invisible and their work is objectified (Diamond, 1984). For example, regarding the nurse shortage debate, nurses are swept into a frame of reference that encompasses their work as a part of the hospital, rather than hospitals conceived as part of their work. Invisibility begins when nurses and their work is defined by the institutions of capitalist medicine (Diamond, 1984).

It does not stop at the point where nurses are named as something else, but makes that process part of the analysis. Thus a theory which bases its conceptions about nursing in a philosophy that assumes the capitalist context offers little towards the empowerment of nurses because it makes a decision about how to view nursing work and eliminates another perspective that might otherwise belong to nurses. The sociological task is to display that there is a choice. In producing their everyday work, nurses have a choice in naming it because there are socio-economic and political alternatives through which they can link their work to the larger society (Smith, 1974; Diamond, 1984).

A sociology that situates the lives of nurses within a framework that presumes capitalist medicine offers less than one which holds that framework in question. Contemporary nursing is embedded in a corporate discourse which defines and delimits the scope and conditions of work (Diamond, 1984). This discourse is based primarily on profits available from the buying and selling of services in the context of a market economy. Nurses are labor within this corporate discourse and the

priority is centered on profit margins, labor costs, and productivity. The most significant issue is that nursing labor is a constituent element of capitalism as it defines America's healthcare system. Nurses' work is a commodity from which profits are earned and this context is relevant to the conception and analysis of compassion stress and compassion fatigue.

CHAPTER THREE

METHODOLOGY

A pilot study was done to investigate how the corporatization of America's healthcare system contributes to nurse's lived experience of compassion fatigue. An exploratory, qualitative research design was selected, with the aim of reinforcing propositions derived from the historical analysis of the nursing profession and critique of existing theory to potentially contribute new insights into compassion fatigue. This design makes it possible to obtain knowledge and understanding about the meaning people give to actions, processes, beliefs and values in naturalistic settings (Larrabee, 2004).

Starting with assumptions and the employment of interpretive theoretical frameworks that guide the examination of research problems, qualitative research addresses the meaning individuals or groups ascribe to a social or human phenomenon. Appropriate when literature is scant on the phenomenon of interest qualitative researchers use an emergent approach to study the problem. Data collection involves a natural setting appropriate for the people and places under study, and data analysis creates patterns or themes through inductive and deductive reason. The final written report or presentation incorporates the voices of participants, the researcher's reflexive process, a multifaceted description and interpretation of the problem, and its contribution to the literature (Creswell, 2013).

EXTENDED CASE METHOD

The extended case method is used to guide the analysis because the study extends the dominant theoretical framework on compassion fatigue by exploring the connections between the corporatization of America's healthcare system and nurse's lived experience of compassion fatigue. Following a reflexive model of science, the extended case method incorporates the researcher's bias with the phenomenon of interest (Burawoy, 1998). Reflexive science values intrusion, process, environment, and theory reconstruction. Applying reflexive science to ethnography, the extended case method describes our involvement with our surroundings, and depends on theory to engage the participants in rich dialogue.

Situated on preexisting theory, the extended case method separates the ordinary from the extraordinary, transitions from the petite to the gross, and links the present to the past in expectation of the future (Burawoy, 1998). Theory is critical to each element of the extended case method because it directs interventions, forms situated knowledge into social processes, and captures those social processes in the broader context. Dependence on the dominant theoretical framework engages the researcher and participant in a rich and informative dialogue that provides explanations of empirical phenomena. Reflexive science uses the first dialogue between observer and participant, situates it within a second dialogue between native processes and nonnative processes that are understood through a third, expanding dialogue of theory with itself.

Dwelling in theory facilitates the deepening and broadening of the dominant theoretical framework in four contexts: the interview, the researcher's motivation,

the environment, and the social situation of the participant. First, the interview is an intrusion into the participant's life that reveals the discreet mystery of their world and removes them from their own environment and schedule and exposes them to the environment and schedule of the researcher (Burawoy, 1998).

Second, the researcher's motivation impacts the interview because questions are regulated. However, participant's understanding and response to the questions is independent because participants come to the interview with numerous experiences. Reflexive science directs the researcher to unload those experiences and reduce them into single meanings by traveling with the participant through their environment and schedule (Burawoy, 1998). This shift from situational experience to process is always contingent on prior theory (Burawoy, 1998).

Then, the environment within which the interview occurs is considered a factor of the setting within which research takes place. The researcher moves past the social process to engage and define the social forces that impose on the ethnographic setting. Reflexive science studies the daily world from the standpoint of its structure by acknowledging that the environment is continuously shaped by external factors (Burawoy, 1998).

Last, focusing on the participant's social situation allows the researcher to draw more comprehensive generalities about the phenomenon of interest.

Michael Burawoy's extended case method is consistent with Dorothy Smith's standpoint theory, which begins by studying individuals and making connections between their daily circumstances and the broader features of society. By contextualizing historically and locating structurally and theoretically the

situational experience of nurses in a corporate and privatized health care system, I can explore how their work becomes objectified and I can illustrate how this challenges the core occupational ethics of the nursing profession. The result of this challenge ultimately contributes to pervasive compassion fatigue among nurses.

DATA COLLECTION

Data are collected from a semi-structured life world interview and content analysis of two blogs authored by nurses who work in America's healthcare system. I seek in both situations to understand the interviewee and blogger's perspective and experiences in light of theoretical propositions advanced earlier, while remaining open to new ideas gleaned from the data.

SEMI-STRUCTURED LIFE WORLD INTERVIEW

Two registered nurses were asked to participate in one 60-minute audio taped semi-structured life world interview. A semi-structured life world interview attempts to understand themes of the lived everyday world from the subjects' own perspective. This kind of interview seeks to obtain descriptions of the interviewee's lived world with respect to interpretation of the meaning of the described phenomena. It comes close to an everyday conversation, but as a professional interview it has a purpose and involves a specific approach and technique; it is semi-structured- it is neither an open everyday conversation nor a closed questionnaire. It is conducted based on an interview guide that focuses on specific themes and includes suggested questions (Kvale, 2009).

The interview was taped and transcribed using Microsoft Word. After the interview was transcribed, it was read through to gain a sense of the whole. The

results of the interview depend on the quality of the interviewer-interviewee interaction, thus it is the outcome of the interview that is analyzed and not the interaction.

NURSES' BLOGS

1. EMERGIBLOG

The first blog, Emergiblog at www.emergiblog.com is written by Kim McAllister. Kim McAllister started her blog in 2005, and it currently has 1389 subscribers. The exact number of published blog entries is unknown, and the researcher's attempts to contact the author proved futile. However, based on the number of years (8) Emergiblog has been in existence, and the average number of entries per month (3-4), the researcher estimates a range of 288-384 published blog entries.

Kim McAllister describes herself in the following manner:

"I'm a registered nurse in the San Francisco Bay area, and I've been blogging about my life and times as an ER nurse at Emergiblog for six years. I've been a nurse for 33 years having graduated in 1978 with my ADN. The ER has been my home for 20 years, but my background also includes critical care, telemetry, psychiatry and pediatrics. The purpose of Emergiblog is to give me a forum to discuss my experiences as a nurse in the emergency department and other topics related to nursing. When I started blogging in 2005 I just talked about what it was like to be a staff nurse. That was my "voice." The stories flowed off the keyboard. Blogging was a creative outlet. Blogging was fun. Today, an old-school Catholic nun sits in my head, rapping my knuckles with her ruler if I even consider posting something that isn't "prim and proper". The trouble is, "prim and proper" is not my style. Now, I can write "prim and proper" with the best of them. But a blog is not the place for that. This blog is not the place for that. And to be honest with you, I have not been all that enamored of health care in the last year or so, of watching my wonderful small community hospital become an appendage of a corporate behemoth. Or of reading about health care in terms of partisan politics every single day in the news."

2. CODEBLOG

The second blog, Codeblog at www.codeblog.com is written by nurse Gina. Gina started her blog in 2002, and currently has a total of 401 published blog entries.

Gina describes herself in the following manner:

"I am Gina. I have been a nurse for 15 years, first in med/surg, then CVICU, inpatient dialysis, CCU and now hospice. This blog is about my experiences as a nurse, and the experiences of others in the healthcare system - patients, nurses, doctors, paramedics. We all have stories! This is a weblog specifically for personal medical stories. Many interesting things happen in hospitals, clinics, schools, hospices, at ball games, recitals, and on planes and trains. Almost everyone that comes into contact with someone in some sort of medical situation has at least one good story, be it an RN, MD, LPN, nurse's aide, unit clerk, unit support, manager, or volunteer. This is a place for sharing stories. It all started on our personal weblog. As an RN, I started posting stories about what happens at work, and people really enjoyed reading them. A friend suggested that I start an entire blog dedicated to medical stories. I thought it was a great idea."

CONTENT ANALYSIS

I analyze the interview and blogs using content analysis, which means I focus on what the text says. The unit of analysis is the interview text and published blog entries in their entirety. Units with a meaningful relation to the aim of the study were then identified. The units of meaning consist of words, sentences and text sequences that emerge from the data. I identify emerging codes from the transcripts. I use memos as supplementary notes to inform the analysis. The codes relate to the comprehensive content of the meaning units. The differences and similarities in the codes are compared and sorted into themes. I iteratively refine the themes as the common themes emerge from the transcript. The final step of analysis is to identify those quotes that most accurately capture the themes.

VALIDATIVITY and RELIABILITY OF STUDY

The analysis is validated by utilizing three strategies; credibility, authenticity, and integrity (Smith & Osborn, 2007). First, credibility is derived because the links made between the findings of the study, and assertions in the extant literature broaden the dominant theoretical framework. Second, authenticity is established because the content of both the interviewees and the nurses' blog are first person life world experiences and are stated in person's own words (voice). Last, integrity is upheld because I disclose that personal experience as a nurse guides my research and inquiry.

In addition, as partial fulfillment of course requirements, my peer group analyzed the semi-structured life world interview. This allowed me to incorporate intercoder reliability, which allowed for the agreement on the coding of the content of interest. The peer group consisted of 14 individuals who read through a transcription of the semi-structured life world interview. After reading the transcription, my peers engaged in-group interactions, openly discussing the content of the transcription and deriving codes from the text. Peer group analysis revealed the following codes: making money, nursing as a calling, patient-relationships/ connectedness, changes in nurses' work, and disillusionment. This process rendered the intercoder reliability at 95%.

CHAPTER FOUR

RESEARCHER'S ESSENTIAL ARGUMENT

In chapter five, I begin my essential argument that the corporatization of America's healthcare system contributes to compassion fatigue among nurse. First, I guide the reader through *The Evolution of America's Nursing Profession*, which explores the historical roots of the nursing profession, addresses how nursing ethics embody practicing with compassion as the functioning paradigm that guides the nursing professional, and traces the role of private duty nurse. Framing the nursing profession in a historical context draws attention to how the profession was founded on the ideas of beneficence, charity/service to others, and providing compassionate care to the sick and infirmed.

I further lead the reader through *The Corporatization of America's Healthcare System*. In this section, I heavily scrutinize the restructuring of America's healthcare system and review the current tasks and responsibilities of nurses as they have evolved during a period of increased privatization and corporatization of healthcare delivery. I contend that the recent transformations in culture and practice of nursing as a result of restructuring stands in direct opposition to fundamental nursing ethics. Nurses are no longer able to "practice their calling" due to the objectification of their work.

Below, Illustration 2 depicts this opposition which sets up the pilot study to further investigate my proposition.

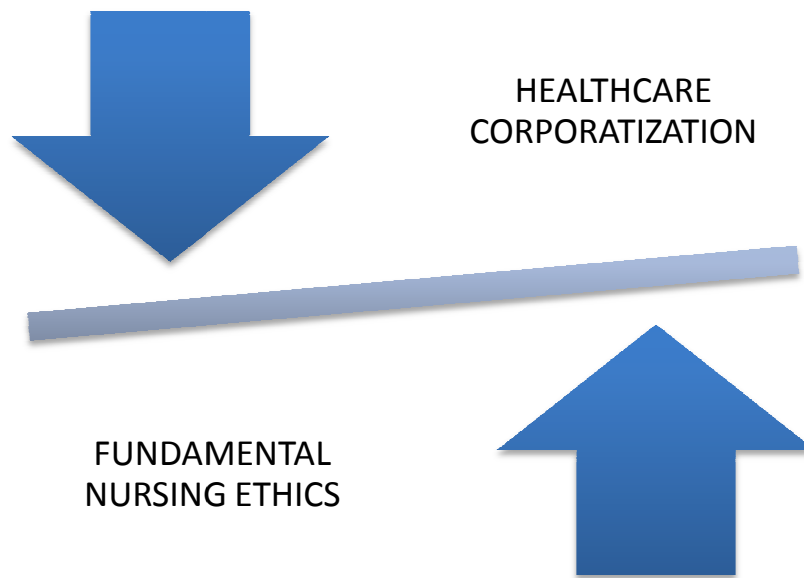


Illustration 2: Healthcare Corporatization opposes Fundamental Nursing Ethics (2013)

THE EVOLUTION OF AMERICA'S NURSING PROFESSION

When the American Civil War began in 1861 there were no nursing schools, or 'trained' nurses, which resulted in a lack of military nurses in either the Union or the Confederacy. The title "nurse" was rather vague, and could refer to an officer's wife who accompanied her husband to the battlefield, a woman who came to care for a wounded son or husband and remained to care for others, a member of a Catholic religious community in a hospital that cared for military personnel, or a volunteer. It is estimated that more than 3,000 women served as nurses during the Civil War, caring for sick or wounded soldiers on the battlefields, in field hospitals, in hospitals

removed from battle sites, or even in their own homes. These female volunteer nurses went to the war with basic knowledge of nursing care derived from their personal experiences caring for loved ones. They learned about the care of battle-related injuries and illnesses through their own wartime experiences (Livermore, 1888).

Civil War nurses laid the foundation for professional nursing in the United States. The work they performed changed the public's perception of work by women outside the home. Many Civil War nurses left their husbands and/ or families to serve in situations that were not previously considered a proper 'place' for ladies. The work of Civil War nurses also changed public opinion about women's work in health care. Women, who had volunteered as nurses during the Civil War, came to realize the value of formal education and were instrumental in the establishment of the first schools of nursing in the United States (Roux, 2009).

Dr. Samuel Gross, president of the American Medical Association, and a reform-minded citizen, strongly endorsed the formation of training schools for nurses in 1868 after visiting public charitable facilities in New York City (Larson, 1997). Fueled by the expansion of industrial production, cities in the United States experienced rapid growth. Hordes of immigrants from Eastern and Southern Europe flocked to U.S. cities in order to satisfy a huge demand for factory workers. Many U.S. cities doubled their population each decade from 1880 until 1920, leading to crowded living conditions that often fostered the spread of disease. New arrivals to cities often lacked family members with sufficient resources to care for them in time of illness, and were left to seek care in municipal almshouses (Roux, 2009).

The sick wards of the almshouse in many large U.S. cities evolved into public hospitals. The conditions of these municipal institutions were deplorable, with detailed records providing insight into the state of nursing care. For example, patients received no diagnosis upon admission, resulting in a scenario where one patient with a leg fracture might be placed in the same bed as a patient with smallpox or tuberculosis (Roux, 2009). Records also show that nurses were often sanctioned for fighting, use of foul language, petty theft, and extortion of money from patients (Pavey, 1953).

Social reformers espoused the idea that provision of safe nursing care was important and could be delivered by persons who received a formal education. Pioneered by Florence Nightingale, the Nightingale School of Nursing was known worldwide for development of a body of work that became known as nursing ethics. The evolution of nursing ethics is an on-going process that began with development of the Nightingale Pledge. Composed by Lystra E. Gretter in 1893 as a token of esteem to Florence Nightingale, it was an oath taken by women who pledged the following:

"I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician, in his work, and devote myself to the welfare of those committed to my care."

Modeled after the Hippocratic oath the Nightingale Pledge is understood to be the first nursing code of ethics. Ethics is defined as a system of rules or principles that are used to guide human behavior and serve as a guiding force in the

development, implementation, and evaluation of nursing practice (Hudson, 2009).

A code of ethics is a fundamental document for any profession. It provides a social contract with the society served, as well as ethical and legal guidance to all members of the profession (Lachman, 2009). The purpose of the Nurse Code of Ethics is to provide a strong, understandable, specific and non-negotiable statement of the nurse's ethical obligation and duty to patients and members of the community.

Nursing ethics are situated in the principles of *nonmaleficence* - *doing no harm*, and *beneficence* - *benefiting the welfare others* in a loyal and truthful manner.

The Nurse's Associated Alumnae of the United States and Canada, later known as the American Nurses Association, in 1896 used the Nightingale Pledge as a template for establishing a code of ethics to promote the image of nursing, and to establish educational standards in nursing (American Nurses Association & National League of Nursing Education, 1940). The American Nurses Association designed their ethical codes to provide the nurse guidance for legal and ethical responsibilities to patients and, in the broader sense, to society (Hudson, 2009).

The American Nurses Association code of ethics consists of nine provisions that provide assistance to the clinical nurse functioning in progressively more complex roles and situations. Provision one exclaims the following:

Provision 1. *The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes or the nature of health problems (ANA, 2001).*

Close examination of provision one reveals that compassion is the central tenet which governs a nurse's professional relationships. Although there is continuous debate about what constitutes compassion in nursing, nursing theorists suggest that

what distinguishes compassion is that it enhances healing and leads to comfort, satisfaction, peace, acceptance, confidence, and reassurance (Schofield, 2011).

Now formally educated, most early 20th century nurses were independent contractors, receiving pay from private patients who required nursing care. These temporary nurses, known as private duty nurses, worked short periods of time caring for an individual patient 7 days a week, 24 hours a day for the duration of the patient's illness. Studies of the early 20th century labor market estimate that approximately 80 percent of practicing nurses worked as private duty nurses, making it the largest category of nursing employment (Committee for the Study of Nursing Education, 1923).

The role of private duty nurse is inherently interesting to those investigating the historical underpinnings and evolution of the American nurse workforce, for it offers a glimpse into an aspect of early professional nursing practice, that of nurse entrepreneurship (Whelan, 2012). The independent nature of private duty practice meant that nurses were responsible for seeking out patient cases and determining when, for whom, and how often they wanted to work. Further, the private duty field offered professional nursing an opportunity to build an infrastructure designed to deliver nursing care services to the public. Private duty nursing serves as an example of the original occupational role of nurses, illustrating a time when the business of nursing was truly the nursing business.

A private market for nursing services pre-dated the establishment of professional schools of nursing. Untrained individuals, some of whom functioned as highly competent nurses, and others that were less skilled often hired out when

family with sick relatives required outside help during times of illness (Reverby, 1987). As graduates of nurse's training schools entered the workplace, they too joined this market for nurse services, offering a superior commodity- a professional nurse well versed in the techniques and methods of modern medicine (Whelan, 2012).

Although demand increased for private duty nurses beginning in the late 1930s, historians highlight this period as pivotal. Nurses transitioned from private duty nurses who functioned independently to less autonomous employees of healthcare institutions (Flood, 1981). Following the World War II years, hospitals initially used private duty nurses as temporary staff nurses, but eventually sought to hire registered nurses in staff nurse positions (Whelan, 2012). Hospitals rejected the traditional private system of nursing care in favor of institutionally controlled, industrial employment model nursing services (Whelan, 2012). By the 1950s, in a complete reversal of earlier proportions, only about 20 percent of nurses identified as private duty nurses. As the century progressed, nurses increasingly sought employment through health care institutions.

THE CORPORATIZATION OF AMERICA'S HEALTHCARE SYSTEM

Industrial America faced the "problem of sickness" in the early 20th century (Hoffman, 2003). Progressive reformers, such as the American Association for Labor Legislation (AALL), proposed a system of compulsory health insurance to protect workers against both wage loss and medical costs during sickness (Hoffman, 2003). The AALL proposal was modeled on existing programs in Germany and England, and was debated throughout the country before legislation was introduced in

several states. AALL leaders felt that the most important constituency for their bill was the medical profession, and they spent much of their energy persuading doctors to support the legislation. However, their efforts confronted intense opposition from practitioners who feared that compulsory insurance would erode their incomes and were challenged by businesses, insurance companies, and conservative legislators intent on branding health insurance (Hoffman, 2003).

Managed care was introduced into America's healthcare system in the late 1920s when labor unions and some employers aimed to provide new benefits attractive to workers (Huntington, 1997). The term managed care encompasses a variety of organizational arrangements, including Health Maintenance Organizations (HMO) and Integrated Delivery Networks (IDN). Managed care in its most basic form is an insurance concept that joins the financing and delivery of health care services to covered individuals under a single corporate entity, most often by arrangements with selected providers (ANA, 1995). The original objective of managed care was to maximize the quality of care and minimize costs by providing a coordinated, seamless set of services that emphasize prevention and primary care (Huntington, 1997).

Many prepaid insurance plans, like Kaiser Permanente, opened their membership to the public after World War II and, by 1973 Congress passed the Health Maintenance Organization Act. This act required employers who offered health insurance to also offer a managed care HMO option if a qualified HMO was available (Huntington, 1997). Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: (1) an organized system for providing health

care or otherwise assuring health care delivery in a geographic area; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services; and (3) a voluntarily enrolled group of people (Huntington, 1997).

Today, Managed Care Organizations (MCO) are systems that offer a package of health care benefits, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to see providers and receive medical procedures under the plan (ANA, 1995). Managed care is usually financed by a “capitated” or prepaid mechanism, which means that a stipulated dollar amount is established to cover the cost of health care delivered for a person and is paid to a health plan or specified healthcare provider (Huntington, 1997). The plan/provider is responsible for arranging the delivery of all health care services required by the covered person under the terms of the contract (ANA, 1995). MCOs make money when they are able to provide all of the needed services to health plan members for less than the aggregate capitated payment.

The American healthcare system is presently one of the largest industries in the country. According to the American Medical Association (2013), between 1960 and 2000 annual healthcare expenditures increased from \$90 billion to \$755 billion, with significant increases in spending on obesity related illnesses (\$27 billion annually) and tobacco related illnesses (\$65 billion annually). Healthcare spending comprised one sixth of the gross domestic product in 2009 and it is projected to grow to more than 20% in the year 2018 (Centers for Medicare & Medicaid Services, 2010). Since the advent of prospective payment mechanisms, the American

healthcare industry has undergone an unprecedented restructuring. This restructuring includes a staggering rate of mergers, acquisitions and hospital closures, as well as major shifts in “where and how” care is delivered (Huntington, 1997). Regressive redistribution of health care dollars, near total integration into a free market system, and rapid restructuring and downsizing have left the system in chaos (Evans, et. al., 1997). Research involving the health care system and the private business sector indicates that organizational restructuring and downsizing efforts are associated with increased employee dissatisfaction, increased levels of job stress, higher levels of psychological distress, and greater intentions to leave the organization (Burke et. al., 1998). Likewise, since the failure of national healthcare reform proposals in 1994, the major drivers of healthcare restructuring have been unbridled competition and corporatization, and the unprecedented growth of managed care (Huntington, 1997). Cost- containment, effected in large part by managed care, has caused hospitals and healthcare systems to radically and rapidly reconfigure how they structure and provide care.

Examining the aggressive growth of Columbia/HCA, Inc perhaps best represents this trend toward corporatization and consolidation. In only seven years, Columbia/HCA grew from two for-profit Texas hospitals to an international health care delivery system of more than 330 hospitals in 37 states and two European countries, nearly 150 ambulatory surgical centers and a variety of other tightly integrated services (Heineccius, 1995). This was accomplished by acquisitions of smaller proprietary hospital chains and by partnering with nonprofit hospital systems. Columbia/HCA has achieved cost- savings through vertical integration of

all local medical services and creation of successful partnerships with physicians, volume purchasing discounts, exclusive supplier partnerships, refinancing of long-term hospital debt, eliminating excess capacity and duplication of services, and significantly reengineering operations, including nursing services.

Wherever Columbia/HCA has entered the market, competitor hospitals have rapidly consolidated or formed other alliances, giving rise to intense competition over prices and positioning for lucrative managed care contracts. The effects of this kind of market volatility and aggressive competition have far-reaching implications for consumers and nurses (Heineccius, 1995). Reengineering of operations has significant implications for the nursing profession, which include combining the demands of nursing work with the systemic demands of healthcare corporations. For example, one study found that high workloads, and low levels of reward, control and value were associated with greater nursing staff distress (Burke et. al., 1998). This combination creates a scenario where nursing work is objectified through the corporatization of America's healthcare system. This objectification places systemic demands on nurse's lived experience that contribute to widespread compassion fatigue.

The redesign of nursing work has accompanied the advance of corporate governance of healthcare. Many direct care activities that nurses are not required by law to perform are now delegated to non-professional personnel (Ebright, 2009). This redesign gives the nurse responsibility for managing more patients but provides less direct nursing care to patients. For example, I am solely responsible for treating 20- 24 patients in a 10-12 hour work shift. During the work shift, I must

conduct a pre- treatment assessment on each patient, plan the patient's course of treatment based on the pre-assessment, implement the planned course of treatment, and perform a post- treatment assessment that evaluates the patient's outcome. Due to the volume of patients I am expected to treat, I am assigned non-licensed staff who help implement the planned course of treatment by carrying out such tasks as taking vital signs and collecting the patient's height and weight. However, because the staff is non-licensed they cannot make decisions concerning the patient's treatment without first consulting with me, and any errors they make are ultimately my responsibility- the licensed professional.

The result of spreading the nurse across more patients is an enormous increase in decision making by nurses related to clinical care and workflow management (Ebright, 2009). Nurses rarely perform one part of their assignment without distraction and/or intrusion of thoughts about what the next step should be in the context of the total work shift, patient assignment, or work of the unit. Nurses often execute their assignments while making decisions about the management of very complex work environments laden with unpredictability, ambiguity, time constraints, inadequate access to resources, and lack of control (Ebright, 2009). With the added responsibility of managing the work environment, nurses are situated in a predicament that requires them to care for their patients as well as promote a healthy work environment. The focus on healthy work environments began in clinical settings with the goals of improving patient safety, promoting excellence in clinical practice, and enhancing the recruitment and retention of nurses (Brady, 2010). A healthy work environment is defined as a work setting in

which policies, procedures and systems are designed so that employees are able to meet organizational objectives and achieve personal satisfaction in their work (Disch, 2002).

This definition emphasizes the external factors that impact job satisfaction; it focuses on those things that are under the influence of the organization. This is important to note because the American Association of Critical- Care Nurses (AACN) determined that ‘unhealthy’ work environments in the clinical setting contribute to “medical errors, ineffective delivery of care, and conflict and stress among health professionals” (Brady, 2010). These characteristics of unhealthy work environments have implications for the nursing profession, making it imperative to initiate dialogue regarding the impact of the work environment on nurses. These implications are especially important to recognize during periods of restructuring, where too often what is good for health care business may not be ethical (Silva, 1998).

Thirty-seven million Americans, mostly working people and members of their families, carry no health insurance. As budgetary pressures mount at all levels of government, the "safety net" of public health programs is rapidly unraveling, and millions of poor people are falling through the giant holes that have developed in the system. Such problems invite a basic question about this tangle that we call the health care system—is it ethical? Anne Moses, an associate director at a publicly funded hospital in a major metropolitan area, stated in a recent interview, "I don't think it's an ethical system," I think the evidence for that is real simple that not everybody gets the care they need. People suffer needlessly" (Andre et. al, 1990).

As health care in the United States has become big business, organizational cultures across the industry shifted from a service oriented one to a monetary oriented one characterized by product lines, stocks, profits, competition, and megamergers. In a recent study, nurses reported feelings of pain, suffering, fear, grief, anxiety, rage, and powerlessness when they grasped that they are working in increasingly morally and ethically deviant organizational cultures (Mohr, 1996). These nurses feel like statistics and doormats instead of human beings, and report that in order to survive in deviant organizational cultures, many nurses disengage from their work, with resultant guilt and alienation (Mohr, 1996).

Furthermore, nursing work has been restructured to include filling system gaps to maintain resources needed to provide care. As one nurse explained,

“Changes in the duties have occurred gradually over the years. More tasks have been allocated to the nursing staff, for example, washing wheelchairs and beds, dusting, watering plants, preparing breakfast, as well as laying the table, which are all felt to be a burden. In some situations, I could be replaced by both a cleaning woman and a servant (Nilsson, 2008).”

Still, activities related to achieving safe, quality care (e.g. duplicate documentation, documentation required by regulatory agencies) has increased dramatically.

Although nurses may have been able to handle many of these non-direct care activities in the past, patient acuity and speed of patient movement through the current healthcare system has escalated far beyond any associated increase in nurse staffing that can accommodate the increase in patient safety initiatives (Ebright, 2009).

Current increases in regulatory requirements call for certain types of documentation that are necessary but are not relevant to the direct care of a given patient on the current shift. Because nurses are physically present at the bedside and have access to medical records, they are often seen as the ideal person to enter and update required information. For example, I am required by my current employer to educate patients about fire safety and prevention while in the clinical setting. Although fire safety and prevention is necessary this activity detracts from my ability to provide direct care related to the patient's diagnosis of End Stage Renal Disease. Organizational policies which mandate that nurses complete this work, as well as performance audits conducted to monitor compliance, only add to the unhealthy stress, associated with the systemic demand on nurses' work.

Recent studies of nurse's work identified the marked complexity surrounding the delivery of care in our current healthcare environments, and have begun to understand why intended outcomes are often not achieved (Ebright, 2003). Potter (2005) provides a description of nurses' work and identifies factors that make the work of nursing care very challenging. These factors include nurse's making frequent cognitive shifts, dealing with multiple interruptions, and developing a cognitive load having the potential for disrupting attention, all in the midst of providing care. In addition, nurse's work environments often feature missing equipment and supplies, interruptions, waiting for needed resources, communication inconsistencies, lack of time, system failures, and operation breakdowns (Ebright, 2003).

Nurses feel tired, depressed, angry, ineffective, apathetic, and detached due to multiple environmental stressors, such as increases in the number of patients assigned to each nurse, more hours of work per shift, the use of non-licensed clinical personnel instead of licensed clinical personnel, changes in work flow management, and system failures. Coupled with their experience of cumulative grief as a result of responding to complex patient needs, including pain, traumatic injury, and emotional distress, nurses are positioned at the epicenter of an environment characterized by sadness and loss which makes them particularly vulnerable to compassion fatigue (Boyle, 2006). Attention must be paid to the connection between restructuring of healthcare and nursing work which may well exacerbate the potential for compassion fatigue among nurses. A pilot study was done to investigate that possibility.

CHAPTER FIVE

RESULTS

I employ a critical, exploratory approach to guide my analysis because the study explores connections between corporatization of America's healthcare system and nurse's lived experience of compassion fatigue. Data analysis reveals that nurses working in America's healthcare system must continually negotiate the demands of corporatized healthcare where the emphasis is on capital gain, which often conflicts with the "*practice of their calling*" (Nightingale Pledge, 1893).

Below, Illustration 3 informs the reader about the inductive codes derived from the content analysis of the semi-structured life world interview and nurses' blogs.

Professional Disheartenment	Adverse Implications	Ethical Conflicts	Technological Distress
"It [healthcare] became more about the money"	Hostility towards patients	Patients receiving unnecessary testing	Systems of technology
Frequently understaffed	Disillusionment	They [patients] weren't ready to be discharged	"The system is set up so that any discrepancy can be blamed on a nurse"
Lack of time	Thinking of the patient as the enemy	Lack of organizational stability	"It [patient intake] is a catch 22"
Lack of resources	Frustration	"It [managed care] had me worried"	New Technology
Lack of fulfillment	Shock	Patients not receiving necessary testing	Astonishment
Decreased quality of care	Nurse's dissatisfaction		"It [amount of information] would fill an encyclopedia"
Patient's dissatisfaction			

Illustration 3: Emergent Themes and Their Corresponding Inductive Codes

Four major themes emerged that influence the development of compassion fatigue: professional disheartenment, adverse implications, ethical conflict, and technological distress. I continue my essential argument by drawing links between the dominant theoretical framework and results of the pilot study. Each of these themes will now be developed with illustrative quotes.

First, nurses describe a *professional disheartenment* as a result of being overworked, frequently understaffed, and lacking time and resources needed to provide their patients with appropriate and compassionate care.

PROFESSIONAL DISHEARTENMENT

Disheartenment is defined as the state of being discouraged or having the feeling of despair in the face of obstacles. Disheartenment is synonymous with demoralization and its definition is closely related to words such as dejection, depression and resignation (Webster's Dictionary, 2013). This study exposes the professional disheartenment nurses experience when healthcare "became more about the money." Nurses report a lack of fulfillment and disappointment because they "cannot give that personalized nursing care anymore."

"When I first started as a nurse it seemed like people entered the profession because it was a calling. I grew up believing that the patient was the number one concern, and when I became a nurse I kept that philosophy. When I started nursing I said that I'm going to treat everyone as if they are members of my family, but that changed, it had to change, to change with the times. You cannot give that personalized nursing care anymore. It's just, it's just not there, so it's not as fulfilling as it was when we first started (Interviewee #1)."

"I graduated in 1969 from... It was run by nuns- Sisters of Charity. The atmosphere over there was taking care of the patient and giving all of your time to the patient. It was very good and that was the way I was taught, that's what I loved about nursing."

Then as the years went on, it became more about the money. The staffing got shorter, and the quality of care was not as good. I was disappointed in that (Interviewee #2)."

In addition to their own unfulfilled expectations, the nurses also spoke of the concern they have for their patient's welfare. As one nurse reported, "You would wonder, what happened to those patients? Still, inability to complete assigned tasks as a result of being too busy left them feeling "rushed," "dreading going to work," and "doubting," their abilities.

"I would go to work and I would dread it because I knew it was going to be so busy. At the time I was working in the Intensive Care Unit. I would go in and do what I had to do. You leave, and things were not completed. You would wonder, what happened to those patients? Who was going to finish up what you had left, and if it was going to get finished? And I would come home and I would say, you know, why did I become a nurse? It's not because I wanted money, it was because I wanted some kind of reward. Fulfillment- my own self-reward. I did not have that anymore. I wanted to know that I did something good and I was doubting that. It's just too much rush into everything and it still is (Interviewee #2)."

"Well, actually I dreaded going to work after awhile! We had eight patients, some total care patient, and we would come in the morning, have our shift change, discuss our patients for about 15 minutes and then it was off and running. You barely had a chance to do an assessment on your patient. From there you ran to give meds, and from there you ran to do dressing changes. You didn't have time to stop and actually talk to your patient, to see how they were really doing. You know, it was in and out of the room! At the end of the day, you stopped and thought what did I miss? Was I able to comfort this patient? Did I do a good enough job with another patient (Interviewee #1)?"

One nurse commented, when asked about the advice they would give someone thinking about working in the nursing profession.

"Right now, I don't know if I would encourage someone to go into the nursing profession. If you [prospective nurse] are going into it [nursing profession] to be with patients and to give patient care... if they [prospective nurse] have this idea of bedside nursing and taking care of someone who is sick you [prospective nurse] have a wide awakening coming... because like we [registered nurses] said, its [nursing profession] changed (Interviewee #2)."

SUMMARY OF PROFESSIONAL DISHEARTENMENT

Recall that the dominant theoretical model postulates that compassion fatigue emerges from a stress-process framework rooted in the nurse's empathic ability, empathic response, and residual compassion stress as they relate to the nurse-patient relationship. However, this postulate does not consider the stress nurses experience as a result of not being able to engage in an empathic nurse-patient relationship due to conditions of nurses' work environments. Work environments account for nurses feeling "rushed", "unable to keep up", and "concerned about the patient's quality of care". It also fails to adequately account for the benefits that nurses may derive from their relationships with patients or for how the therapeutic relationship may potentially serve to protect the nurse from experiencing compassion fatigue (Sabo, 2009, 2010). As one nurse highlighted above "you didn't have time to stop and actually talk to your patient, to see how they were really doing." The effort of nurse's to carry out the Nightingale Pledge (1893), which encourages them to "devote myself [nurses] to the welfare of those committed to my care," are increasingly met with the constraints of a corporatized healthcare system. These constraints evoke a separate stress response originating not from the nurse-patient relationship, but from the demands of corporatized healthcare, which adds to the nurses' inability to engage in an empathic nurse-patient relationship. Nurses experience a professional disheartenment that decreases their overall sense of satisfaction with their nurse-patient relationships, which creates concern for their patient's well being.

Second, I contend that the longer workdays, decreased staffing and expanded workloads that result from healthcare corporatization add to nurses working under increasingly intense and prolonged conditions.

ADVERSE IMPLICATIONS

The Centers for Disease Control (CDC) revealed in their emergency room use annual report that 46.3% of uninsured patients sought treatment from emergency rooms because they had no other place to go (CDC, 2011). Nurses working under the intense and prolonged conditions of hospital emergency rooms and hospital units exhibited adverse implications when confronted with the challenges of difficult patient loads, staffing shortages, and sick calls. One nurse communicates how the conditions of her work environment contribute to her “thinking of the patient as the enemy” (Emergiblog, 2005).

“There are times in the Emergency department when even the most dedicated nurse can begin to feel that way. The department is full. You are holding three med/surg and two ICU patients until you can get orders/beds/nurses to move them up. You’re down a nurse because of a sick call and just try to get coverage on a Saturday evening. You have 8 people on the triage list and 14 sitting in the waiting room. Every other hospital in your county is on ambulance diversion, which means you must take the ambulance traffic. Dr. Surgeon wants everything STAT for the appy and Dr. Cardio is taking someone to the cath lab. Now. Ms. Scratchy Throat wants to know how much longer it will be and Mr. Groin Itch wants to leave without being seen. Thank god you are working with Dr. Efficient in the ER, but he’s yelling for the charts you haven’t had time to finish. You have been running for six hours, you haven’t eaten for ten hours and more than likely you’ll be overtime because someone just called in for the night shift. In walks Mrs. Mom with her three children, all under the age of four, all of them with fever, all of them to be seen. You want to scream. You want to pull out your hair. You want to laugh hysterically. You want to burst into tears. You want to yell at the top of your lungs, NO FREAKIN’ WAY! That’s when you start to think of the patient as the enemy (Emergiblog, 2005).”

As previously mentioned, nurses speak of a professional disheartenment when continually negotiating corporate demands. Likewise, nurses reveal feelings of

stress, being overwhelmed and disillusioned related to the branding of healthcare, feelings that led to one nurse to “leave” her job.

“When I first started [as a nurse] the business was geared more to patient care, and then I saw a change. I went to work for a hospital and during orientation we were told this is about making money. During orientation, this is not about patient care we are a business. I can remember, I’ll never forget that. I was very shocked because it’s not why I went into medicine. It was just so bluntly put, and you could see the change right there- that’s where medicine was going. I was disillusioned, very disillusioned (Interviewee #1).”

“The stress was really getting bad. I would leave crying several nights a week, and I felt overwhelmed a lot of the time. I was afraid for my license and for the patient’s lives because of the way care was. I decided then that I was going to leave and look for another type of nursing, because hospital care was just getting too dangerous (Interviewee #1).”

Referenced earlier, the restructuring of nurses’ work has involved increases in regulatory requirements, which demand completion of additional paperwork. One nurse spoke of her frustration towards healthcare in the following manner;

“As I’ve noted before, I often feel like a scrubbing bubble in the toilet bowl of healthcare. Only what I do is never enough. When it comes to finding a way to frustrate, over-work and add ridiculous amounts of paperwork to the nurses, they (JCAHO) will always find a way. And we will continue to jump through the hoops, because we will get “dinged” if we don’t” (Codeblog, 2002).”

SUMMARY OF ADVERSE IMPLICATIONS

The dominant theoretical model for compassion fatigue does not consider organizational factors such as state and federally mandated regulatory requirements that impact nursing work. For example, nurses are required by federal law to report all patient infections to The Centers for Disease Control in Atlanta, Georgia. State auditors issue a citation for failure to comply with federally mandated regulatory requirements to any nurse who fails to report patient infections. A copy of the citation is also sent to the nurse’s respective state board of nursing where the

citation becomes a part of the nurse's permanent record. Nurses are enmeshed in a new milieu as healthcare's organizational culture shifts to a monetary oriented one characterized by product lines, stocks, profits, competition, and megamergers. Nurses are often given the task of completing "ridiculous amounts of paperwork" because they are [in theory] "physically present at the bedside." However, as this study reveals, the restructuring of nursing work has positioned nurses everywhere but at the bedside. In practice, nurses are rarely at the bedside but are still "dinged" for not complying with regulatory requirements, which illustrates why nurses experience adverse implications. Organizations like the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) send reviewers to visit healthcare organizations and review documentation related to patient care and safety. The reviewers determine if the healthcare organization should be accredited based on their assessment (The Joint Commission, 2013). Healthcare organizations that receive accreditation in turn use the accreditation to obtain monetary funding from their respective state and federal governments. While funding is necessary to the overall operation of a healthcare system, nurses are increasingly held responsible for but are not given a voice in the process used to obtain those funds and how it affects their nursing work. This lack of voice situates nurses in the corporate discourse aforementioned by Dorothy Smith, where nurses become invisible and their work is objectified (Diamond, 1984). Above, the nurse describes her frustration with the healthcare system, stating *"I often feel like a scrubbing bubble in the toilet bowl of healthcare only what I [nurse] do is never enough."* Valent (2002) theorizes that burnout occurs when nurses cannot achieve his or her goals

and results in “frustration, a sense of loss of control, increased willful efforts, and diminishing morale.” Frustration contributes to nurse burnout- the second component of compassion fatigue (Baranowsky and Gentry, 2009).

Third, as nurses witness the continuous erosion of a healthcare system that inadequately treats patients they experience numerous *ethical conflicts* that illicit concern for the patient and contribute to nurses’ overall decreased sense of satisfaction.

ETHICAL CONFLICT

The American Nurse’s Association designed their ethical codes to provide the nurse guidance for legal and ethical responsibilities to patients and, in the broader sense, to society (Hudson, 2009); *unrestricted by considerations of social or economic status, personal attributes or the nature of health problems* (ANA, 2001). Many nurses communicate ethical conflicts encountered, as they witness, “patients not getting the care they would have gotten before managed care.” One nurse expressed deeply couched anger to the point of being “pissed,” dissatisfied, and worried.

“You know that HMO, the one that has the slogan beginning with “Be Well....”? They should change it to “Go to Hell...” because that is how they treat their members. Yeah, pardon the language, but I’m pissed. This patient nearly died last May. What the hell was “Brand X” HMO thinking when they saw this constellation of symptoms? “Let’s finish the job?” Health maintenance my derriere-Idiots (Emergiblog, 2005)!”

As multiple private company takeovers occurred, one nurse describes a work environment where company policies and nursing staff always changed, which produced “no stability.” The lack of stability contributes to both patient dissatisfaction and ultimately the nurse’s dissatisfaction.

"I can remember I worked for a hospital that sold to a private company. All the policies changed, all the staffing changed, and it just went completely down. The patients were not satisfied, and the nurses were not satisfied. Then one company would buy us and sell us to another company, and again the policies would change. There was no stability! Once the hospital let us go, we lost that stability that we had with them and the companies took over. That's what changed- this was 1999 for me (Interviewee #2)."

"I saw some nursing care that was so horrendous at times because of the shortage. Patients would be seen maybe once in the morning, and once at med time. We didn't have time to be in the rooms the way we should have been, and that was one of the things that made me say I'm giving up this hospital work because I just cried! I drove home and I cried the entire way. I cried for about a week afterwards thinking of the distress that this patient was in! Alone, in a room by herself-it was horrible (Interviewee #1)."

Furthermore, nurses reported observing work environment changes as big corporations bought smaller, private hospital facilities. As big corporations instituted managed care contracts, patients were often discharged early and either received no testing or unnecessary testing.

"Yeah, in 1995 I started working for a very small company, a physician owned company that was very up-scale. The patients had beautiful, private rooms with suites and things like that. It was really a great little hospital, and then it was bought out by a big corporation. That's when they came in and said this is a business. We are here to make money, and that's when things started to change. It went from a small private hospital to a big corporation (Interviewee #2)."

"Managed care-changed things a lot. You saw patients not getting the care they would have gotten before managed care, like some of the tests. We saw them released from the hospital, discharged earlier than what they would have been before. You know sometimes they, a lot of times they weren't ready to be discharged (Interviewee #1)."

"I saw doctors when I worked in endoscopy doing endoscopies and colonoscopies on patients that were 85 years old that really didn't need it just so they could make some money for the hospital and for themselves. They were getting it from you know from Medicare, and so that was really very poor. I saw a lot of that (Interviewee #2)."

Employing the ethical principle expressed in Provision One by considering *"the inherent dignity, worth and uniqueness of every individual*, and [I (nurse) put myself

in their (patients) place], one interview respondent expressed genuine and strong anger as she contemplated what patients experienced.

"It made me angry that the medical profession has gotten to this. Where it is about money, and people not getting proper care. It also had me worried! Can I keep up with things even with shortages or staffing? Am I going to be able to handle this and still be a good nurse? Is this what I'm really in there for? Do I want to stay in this? It made me feel that way. I put myself in their place, it made me feel like, if I'm a patient am I going to need a relative watching me, because I've seen too many mistakes. People [nurses] working over time and they make errors. I have seen it in my own family. Where a nurse made that error. Am I going to do that? You have to consider all of that. What's going to happen when I'm the patient? If I don't have any one taking care of me, can I rely on those nurses in there because they're overworked and they're understaffed? They are working over time and they are exhausted (Interviewee #2)."

SUMMARY OF ETHICAL CONFLICT

The dominant theoretical framework depicts concern as a key factor in the nurse's empathic response. Traditionally, concern is solely related to the patient's traumatic event and the prognosis governing that event. However, the corporatization of America's healthcare system leaves nurses grappling with ethical conflicts that have surfaced its aftermath. Nurses bump into a binary where their concern is connected not only to the patient's prognosis but also to the patient being treated by a healthcare system intent on profiting from their prognosis. This contributes to compassion fatigue among nurses. One nurse respondent, who witnessed unnecessary procedures performed on elderly patients, aptly states *"patients that were 85 years old that really didn't need it [healthcare procedures] just so they [doctors] could make some money for the hospital."* This exemplifies how healthcare corporatization is antithetical to nursing ethics, which are situated in the fundamental principles of *nonmaleficence; doing no harm* and *beneficence; benefiting the welfare of others* in a loyal and truthful manner.

Fourth, nurses communicate challenges associated with a type of *technological distress* imposed on them by systems of technology intended to streamline the documentation process.

TECHNOLOGICAL DISTRESS

A type of technology known as nursing informatics is now a routine part of the nursing profession. Nursing informatics is the science and practice that integrates nursing, its information and knowledge with management of information and communication technologies to promote the health of people, families, and communities worldwide (IMIA Special Interest Group on Nursing Informatics, 2009). American Nurses Association (1994) defines nursing informatics as the growth and assessment of applications, tools, processes, and structures, which help nurses with the organization of data in taking care of patients, or sustaining the practice of nursing. Applicable to all areas of nursing work, nursing informatics is used to computer generate patient documentation, automate billing for supplies or procedures with nursing documentation, monitor devices that record patient's vital signs, and monitor quality assurance and patient outcomes analysis etc. (American Nurses Association, 1994). Although nursing informatics is designed to improve how nurses manage information, still nurses reveal feeling burdened by the degree and amount of information needed to perform and record their duties.

"There are times at work when I am astounded at the amount of information that we are expected to absorb. Honestly it is hard to think of another job in which new information is given, and expected to be remembered on a daily basis. The information is not simple it is often complex- new drugs, and procedures, etc. I have had the thought of trying sometimes to write down what we are asked to retain. It would fill an encyclopedia (Codeblog, 2002)."

"Every time I go to work, there's some new piece of equipment, a new technology (most recently hypothermia therapy and abdominal pressure readings) we've just implemented, or a different way of doing a procedure (Codeblog, 2002)."

"It's a catch-22. You are supposed to move faster because there are more people to see, but every year more information is required from each patient at the point of intake (Codeblog, 2002)."

"The system is set up so that any discrepancy, any dosage error, any transcription error (we aren't allowed to Xerox the patient's list), any adverse reaction/incident... can be blamed on a nurse for writing it wrong (Codeblog, 2002)."

SUMMARY OF TECHNOLOGICAL DISTRESS

I emphasize that recent changes in nursing work includes requirements for more documentation. Nurse are increasingly held responsible for what information is documented, how the documentation is completed, and the amount of information documented. Indicated by a nurse who spoke of having "ridiculous amounts of paperwork", new technology is changing how documentation is completed. Originally designed to improve and simplify nursing work, nursing informatics creates a type of technological distress that adds to the already taxed and burdened nursing workload. As one nurse emphasized above *"It's a catch-22... every year more information is required from each patient."* Nurses talk of being overwhelmed and stressed by the requirement to obtain and document more patient information. Consistent with the adverse implications mentioned earlier, where documentation decides the funding given to organizations, nurses experience a technological distress which complicates the responsibility of *"holding in confidence all personal matters committed to my [nurse] keeping* (Nightingale Pledge, 1893). This conflict creates stress and contributes to compassion fatigue among nurses.

CHAPTER SIX

DISCUSSION AND CONCLUSION

The purpose of this study is to critically explore compassion fatigue amongst nurses currently working in America's healthcare system. I employ a pilot study designed to examine how factors of a nurse's work environment such as work overload, decreased staffing, longer workdays, etc. contribute to compassion fatigue among nurses. I extend the dominant theoretical framework by illustrating how the results of my pilot study contribute to the cascading events that encompass compassion fatigue.

The results of my pilot study reveal that nurses find it increasingly difficult to "*practice of their calling*" (Nightingale Pledge, 1893) due to the organizational restructuring of nursing work imposed by healthcare corporatization. Nurses report feeling overwhelmed, worried, disillusioned, angry, dissatisfied, concerned, and unfulfilled. Nurses routinely contend with tensions between a healthcare system designed to "make money" and the core principles of nursing ethics that embody delivery of compassionate care.

IMPLICATIONS FOR COMPASSION FATIGUE AMONG NURSES

Below, Illustration 4 conceptualizes how the four emergent themes from my pilot study –*professional disheartenment, adverse implications, ethical conflicts, and technological distress*– contribute to the cascading events of *sense of satisfaction, concern, detachment, and prolonged exposure to suffering*, in the dominant theoretical framework. The illustration also depicts how the four themes are independent in how they contribute to the dominant theoretical framework.

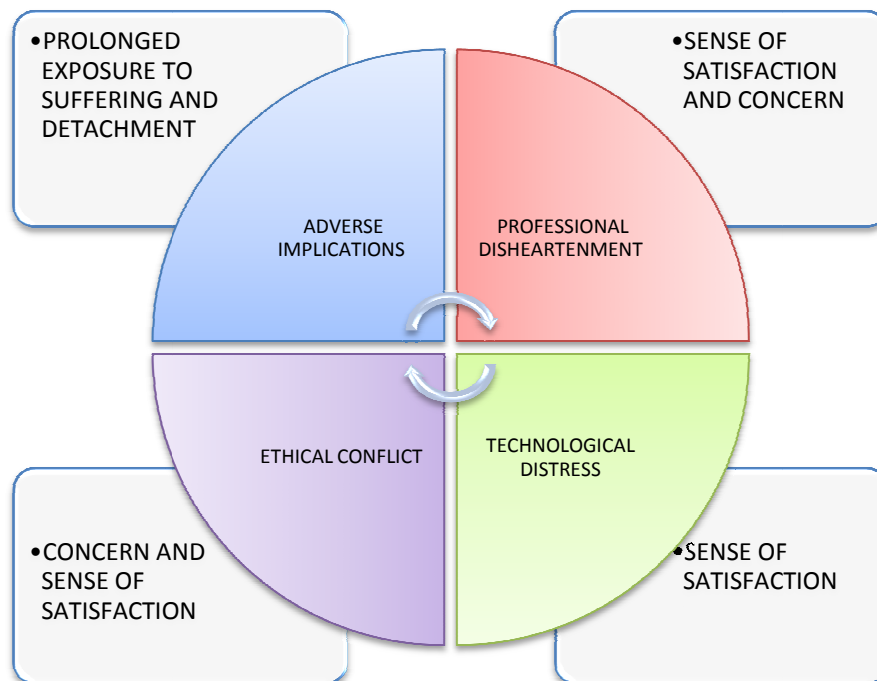


Illustration 4: Links between Study Results and Dominant Theoretical Framework (2013)

First, nurses are experiencing a professional disheartenment that contributes to their decreased sense of satisfaction and concern. The dominant theoretical framework maintains that a nurse's sense of satisfaction is critical to the nurse-patient relationship. The nurse's ability to adequately provide their patient's with the aforementioned compassionate care facilitates a therapeutic relationship that benefits both the patient and nurse. The dominant theoretical framework also asserts that concern for the patient is key to the nurse's empathic response. Results reveal that nurses express concern for their patient's well being because time constraints and insufficient resources are preventing nurses from providing quality nursing care.

Second, nurses report adverse implications including hostility towards patients, disillusionment, “thinking of the patient as the enemy”, shock, and dissatisfaction due to longer workdays and expanded workloads. The dominant theoretical framework states that exposure to a patient’s suffering and/or traumatic event directly contributes to nurses’ compassion fatigue. The dominant theoretical framework describes detachment in terms of a nurse’s inability or unwillingness to detach from the patient and situation, and identifies a nurse’s inability or unwillingness to detach as voluntary. Ultimately, this leads to residual compassion stress or emotion energy among nurses. I argue that the longer workdays and expanded workloads involuntarily locate nurses under extreme working conditions from which they are unable to detach thus prolonging their exposure to patient suffering.

The nursing profession’s occupational core is centered on giving compassionate care to members of the community and greater society in a faithful and trustworthy manner. Nursing ethics are challenged by the ramifications of healthcare corporatization. One nurse describes nursing care at her workplace, *“Where it is about money, and people not getting proper care.”* Results of the pilot study affirm my premise that healthcare corporatization is opposed to fundamental nursing ethics. Research confirms that lack of fairness and value conflict contributes to caregiver burnout (Leiter, 2006). This is also consistent with Gentry and Baranowsky (2009) who contend that compassion fatigue consists of two components secondary traumatization and burnout.

The dominant theoretical framework associates sense of satisfaction with the nurse-patient relationship. The process imposed on nurses to obtain and correctly document patient information creates a technological distress that contributes to a decreased sense of satisfaction among nurses. Nurses spend less time engaged in a therapeutic patient- centered relationship and more time concerned about accurately documenting patient information. Research supports the conclusion that work overload and lack of control play a role in burnout among nurses (Valent, 2002), and decreased sense of satisfaction directly contributes to their compassion fatigue (Figley, 2002).

I conclude that the dominant theoretical framework should include the socio-economic and political environment of nursing work and how that contributes to nurses' lived experience of compassion fatigue. Results of the pilot study generally support my proposition that the corporatization of America's healthcare system contributes to nurses' lived experience of compassion fatigue. Healthcare providers, managers, and policy makers need to consider the ramifications of branding healthcare, and address the socio-political factors that contribute to compassion fatigue among nurses.

LIMITATIONS AND FUTURE RESEARCH

Results of the pilot study indicate that the alternative approach to compassion fatigue introduced in this thesis provides a natural guide for future research. However, the nature of a pilot study leaves considerable room for continued thought and research on compassion fatigue. The historical analysis and blog analysis must be deepened and the sample size (4 nurses) is not large enough to saturate the

setting or generalize to the population. The themes derived are plausible and useful, but potential conceptual overlap may exist. Integration with the theory of compassion fatigue clearly requires more systematic study with a larger sample of nurses in various settings.

The emergence of technological distress indicates a need to further explore how rapid changes in technology influence nurses' work. Studies are needed to examine how technology is affecting nurses' documentation and issues of litigation. Is there a connection between the use of a nurse's documentation in a lawsuit and their experience of compassion fatigue? Second, studies are needed to examine the coping mechanisms employed by nurses working under the prolonged and intense work environments induced by healthcare corporatization. How do nurses manage the sustained emotional strain they experience when working under the stated conditions?

Additional factors beyond empathy must be explored to further advance understanding of compassion fatigue. These factors include resilience and hope, which may prevent the development of compassion fatigue and allow the nurse to experience healthier nurse-patient relationships. For example, hope may influence actions that nurses take to foster and support healthy nurse- patient relationships (Simpson, 2004). A shared meaning of hope between nurse and patient may enhance the quality of the relationship and improve satisfaction with nursing work.

Research supports the idea that resilience, defined as the ability to move forward in a positive way from negative, traumatic, or stressful experiences (Walsh, 2006), enhance relationships, facilitates emotional insight, and decreases

vulnerability to adverse effects from the work environment (Jackson, Firtko, & Edenborough, 2007). Exploring the role of personal characteristics, such as resilience and hope, may clarify and deepen the dominant theoretical framework.

Longitudinal studies are needed to investigate non-traditional factors that may contribute to the development of compassion fatigue. These factors include the nurse's years of experience, level of education, and institutional support. It is important for nurses to become knowledgeable about how compassion fatigue develops and to understand the importance of healthy work environments.

Compassion fatigue requires more deliberative attention from managers, educators, researchers, and nurses. Higher educational institutions need to incorporate compassion fatigue awareness training into their nursing curriculums. Healthcare employers need to recognize the role they play in shaping a nurse's work environment, and seek to adopt measures (e.g. facilitating compassion fatigue seminars) that will aid in preventing compassion fatigue among nurses.

Limitations aside, research on nursing work is scant and no other study has explored the ramifications of healthcare corporatization on nursing work or compassion fatigue. The results of this study confirm the value of the study proposition and highlight additional factors that contribute to compassion fatigue. Those factors deserve incorporation into future research, educational, and policy agendas.

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APPENDIX A

SEMI-STRUCTURED LIFE WORLD INTERVIEW QUESTION GUIDE

1. Tell me what influenced your decision to become a nurse?
2. Talk to me about the different specialties you've worked in throughout your nursing career?
3. Tell me about the area of nursing that has been the most rewarding to you?
4. Describe what the nursing profession was like when you first became a nurse?
5. Describe how the nursing profession has changed from when you first started working as a nurse till present?
6. Talk to me about how those changes in the nursing profession have affected your work as a nurse?
7. Tell me about the area of nursing that has challenged you the most, and describe the types of stress you encountered?
8. Tell me about an event or situation when the expectations of your job exceeded your scope of practice as a nurse?
9. Talk to me about your work as a nurse before managed care was introduced into our healthcare systems?
10. Describe how the introduction of managed care changed your work as a nurse?
11. Describe the differences between your stress before the introduction of managed care and after the introduction of managed care?
12. Describe how you've handled the stress you've encountered throughout your nursing career?
13. Talk to me about what motivates you to continue working in the nursing profession after so many years?
14. As you look back on your career as a nurse, what do you think you have learned over the years?

VITA

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