# Caring after Francis: Moral failure in nursing reconsidered

## Michael Traynor

Professor of Nursing Policy, School of Health and Education, Middlesex University, London, UK

## Abstract

This discussion paper considers recent nursing failures. Drawing on a selection of key literature and on-going research, it argues that nursing failures are a possibly inevitable consequence of work in healthcare systems with their combination of cognitive, bureaucratic, professional and work related pressures. It also argues that nursing has a residual tendency to be viewed as primarily character-based moral work and that this can encourage understandings of causes of failures and their solutions in similar terms i.e. as moral failures of caring requiring recruitment of those with the appropriate characters. Drawing on on-going research with those training for the profession at an English university, it suggests that while the profession focuses on the recruitment of those with a 'caring' orientation it has not developed an adequate explanation to support new recruits in understanding the causes of inadequate practice. This leaves those entering the profession without a strong model with which to understand their own work or its failures-what I refer to as 'critical resilience'.

> "All occupations—most of all those considered professions and perhaps those of the underworld—include as part of their very being a licence to deviate in some measure from common modes of behaviour." (Everett Hughes cited by (Chambliss, 1996: , 19)

This article discusses the challenging circumstances in which many commentators see contemporary nursing. The focus is on nursing in England but the theoretical and professional issues cut across national boundaries and

often across time. These circumstances take the form of a number of exposures of nursing failures leading, it is said, to a loss of public trust in the profession, remedial impositions by governments and reduced morale among nurses. Instability and accusations of incompetence at the profession's regulator, the Nursing and Midwifery Council, and re-emerging claims about the deleterious effect of degree-level entry to nursing become rolled into a sense of nursing in crisis.

My argument in this article is that: i. nursing failures are a possibly inevitable consequence of work in healthcare systems, particularly when under sustained pressure. Such pressures have effects on cultures and nurses who are not always prepared to resist them; ii. nursing has a residual tendency to be viewed as primarily character-based moral work, to an extent not apparent in other occupations, and this can encourage explanations of failures and their solutions in similar terms; iii. the profession focuses on the recruitment of those with a 'caring' orientation but has not developed an adequate explanation to support new recruits to understand the causes of inadequate practice. This may perpetuate a problem of acquiescence to poor standards and hinder the development of what we might call 'critical resilience'. I use both 'moral' and 'ethical' in this paper, roughly following the distinction made by Chamblis (Chambliss, 1996) whose work on organisational constraints to professional caring I draw on, where 'moral' issues includes those which are unformulated or unconscious while 'ethics' refers to more formal conscious consideration of moral beliefs and action, such as those set out in a code of ethics.

## A crisis of representation

Before uncritically accepting the notion of a nursing crisis, it is worth briefly considering how far this is a crisis primarily of representation – though such a crisis is no less real. What I mean is the 'crisis' might be at least partly explainable in terms of the contingencies and features of government policy-making on the one hand and of the way the media selects and presents 'stories' on the other. First the UK NHS represents a large and highly visible vulnerability for successive governments (Ham, 1999). Whether it is hospital infections, patient waits on trollies, failures in care or general inefficiencies, governments are placed under considerable pressure to be seen to act decisively to address problems (Buse et al., 2005). Second, for the media, the story of the incompetent or insensitive institution failing the vulnerable individual and of the misuse of positions of power represent prominent contemporary media themes (Seale, 2002) with more power to attract readers than 'good news' stories about nursing which predominate in the nursing trade press. Many institutions and professional groups: healthcare workers, investment bankers, the police, MPs, clergy and the media itself have been shown as failing when placed under contemporary scrutiny. Many of the failings have shown a long-standing resistance to remediation (Leveson,

2012). Finally, when privately discussing poor or even cruel nursing, many prominent and experienced nurses acknowledge that the practice has a long history but that it is entering the public gaze for the first time (possibly because of the above factors). However, whatever the reality behind the stories, the media and policy attention is real enough, and nursing organisations will be smarting and debating long after the media, politicians and the public have turned to another story. This should not surprise us because professions and institutions deal in representations and versions of themselves and their work (Blumer, 1969), realising how important these are for continued reward and influence.

In this paper my intention is to place the debate about these topics into new contexts with the aim of avoiding being caught up in the repetition of a discussion cast primarily in moral terms.


## First and subsequent responses to Stafford and similar failures

As stories began to be told and retold about events at Stafford hospital in England, where vulnerable patients were neglected by nursing staff and received poor treatment by other health professionals, further failures emerged in the UK media (BBC Panorama, 2011) and government commissioned reports (Keogh, 2013). Responses reported featured outrage and incredulity at this apparently widespread problem. The final (of three) Francis report, published in February 2013 (Francis, 2013a), made 290 recommendations reflecting its concern with failures of the Mid Staffordshire NHS Trust board and regulatory and monitoring inadequacies. Those with an interest in nursing will have closely read the report's Chapter 23 (in Volume 3) devoted to the profession. The chapter is a mixture of shocking first-hand accounts of failures, astute descriptions of features of nurse training and practice, and recommendations for remedial action that do not appear to be supported by the preceding body of evidential material and to be at least influenced by assumptions that are not stated in the report. The report as a whole focuses on system failures—a senior management under external financial pressure, a bullying and intimidated middle management, a culture of mediocrity and poor standards, and multi-regulator and professional organisation failures. Chapter 23 explores the impact on nursing of these failures along with the profession's contribution to the problem. Francis' description of the pressures on nursing recruits is likely to be endorsed by many involved in nurse education, and is supported by a number of research studies (Whitehead et al., 2013; McDonald et al., 2012; Maben et al., 2007):

> The experience from Stafford… suggests that the current university-
>
> based model of training does not focus enough on the impact of culture

and caring. It is likely that most of those entering the nursing profession

do so because of a wish to undertake work helping and caring for others.

Even in a well run organisation, the stark differences between nursing as

they imagined it to be and the reality will challenge their ability to

maintain their motivation. This can be seen even more so in the stresses

of working in an understaffed, badly led environment in which the quality

of care appears to take a lower priority than throughput and where

meeting managerially dictated targets can turn the unacceptable into the

mundane. In other words, the internal drive to insist on proper standards

of care can all too soon degenerate and be replaced by a meek

acceptance of the mediocre or worse. (Francis, 2013b: Section 23.48

page 1513)

I will return to the possibly idealised views of nurse students and their need for critical resilience later however the key point to take from this analysis is the suggestion that entrants to nursing are not adequately prepared to resist the challenges of cultures characterised by tolerance of poor standards. The Francis proposal is that: 'There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory' (Section 23.49 page 1513). The report goes on to set out the controversial proposal, currently being piloted, for prospective nurse students to complete time in health care support roles as an introduction to caring work and as a kind of trial to exclude those unfitted for such work. In addition, the report recommends selection of applicants who can 'demonstrate possession of' the values, attitudes and behaviours appropriate for the profession (p. 1513). I will argue later that the notion that it is the possession of personal ethical characteristics that predicts subsequent behavior under pressure rests on a naive and unsupported assumption. Such proposals received the support of the government (Secretary of State for Health, 2014) and talk of 'values-based recruitment' has become popular among those involved in the recruitment of the nursing and supporting workforce (NHS Health Education England, 2013).

However, the debate about remedial courses of action has expanded to consideration of more technical issues. In late 2013, BBC health correspondent Nick Triggle, commenting on a recent Health Select Committee report noted that Parliament's concerns regarding this problem had shifted from a focus on questions about training and values to questions about whether there are enough nurses being employed to provide good quality care in the NHS and nurse-patient ratios sufficient to ensure safe care (Triggle, 2013). Using workforce statistics from the Health and Social Care Information Centre, Triggle shows that the number of nurses employed (in full-time

equivalents) had fallen by about 3,000 since the Con-Lib coalition came to power in 2010. The Royal College of Nursing has claimed that there were 20,000 unfilled nursing posts in England and that 'Unsafe staffing levels have been implicated in a number of high profile investigations into patient safety' (Dreaper, 2013). The awareness of the potential dangers of inadequate nursing staffing levels seems to be emerging as a positive outcome of Francis, with the release, for example, of guidance on 'Hard Truths commitments regarding the publishing of staffing data' issued in early 2014 (Chief Nursing Officer for England and National Quality Board, 2014).

Before the final Francis report was released but in response to other highly publicised failures, the health professions published reaffirmations of professional values. In December 2012 the Chief Nursing Officer (CNO) for England published the document Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) involving the launch of the 'six Cs' alongside action plans for ensuring the best possible patient care. This included a call for recruitment to be based on applicant 'values' as well as technical skills. The document does not include any analysis of the causation of the shocking failures that are briefly mentioned but which form the impetus for the publication of the document and its description of the influence of the economic context on nursing and healthcare work is muted. Previous CNOs for England have acknowledged their constrained position within the Department of Health and the need for skill in weaving nursing concerns into a largely already determined set of policy priorities (Traynor, 2013). I would speculate that this single fact limits the kind of leadership that can emerge from this post. It can be visible, inspiring even, but it is unlikely to be controversial or critical of government health policy at large.

Another possible source of leadership for UK nursing in and out of times of crisis is, of course, the Royal College of Nursing. The RCN has responded extensively to the failures uncovered before Francis and to the report of his inquiry and a particularly important part of this response has been to focus on inadequate staffing levels and their association with poor care. However, Francis was critical of the RCN and its CEO personally. Francis considered problematic the RCN's dual role as professional body promoting standards of practice and trade union defending individuals who may have not met those standards. He also noted that Peter Carter had paid a visit to the trust and released a subsequent upbeat statement about nursing there, apparently oblivious to serious problems (Francis, 2013b: page 1512), clearly an observation that might be seen as calling his credibility into question. Finally, Francis also considered that nursing staff at Stafford failed to receive effective support or representation from RCN officers in the trust. Clearly all those organisations that came under criticism in the report of the inquiry were placed in a difficult position, as they had to accept a degree of responsibility for their own failings. However this made any criticism of the report's

recommendations or subsequent government action more difficult to mount by those organisations.

I now want to consider alternative explanations to those focussing on individual moral weakness for Stafford and similar failures.

## Nursing as character based work: women in the media

In this part of the paper I want to argue that a residual tendency for nursing to be viewed as primarily character-based moral work intersects with stereotypical representations of women in the media as these often present women in highly moralised terms.

Feminists have studied media representation of women for many decades, arguing that the media continues to present particular, often polarised, stereotypes. Some have studied the representation of motherhood in magazines (Johnston and Swanson, 2003) and in the media where it has been suggested that 'deviant' mothers—perpetrators of child abuse for example—are presented as 'monstrous', while other mothers, such as celebrities, tend to be idealised (Goc, 2007). Others have examined depictions of female offenders questioning the 'moral panic' associated with claims of increasing criminality among women (Kruttschnitt et al., 2008). Within this tradition, researchers have looked at portrayals of nurses in the media and found these to focus on apparently 'nurturing' and barely visible supporting roles in the shadow of technically expert and often heroic doctors (Gordon, 2005) or a montage of 'ministering angels, doctors' handmaidens, battleaxes or sex objects' (Hallam, 2000: p. 9).

Many analysts of nursing's history and ideology have pointed to the lingering effects of the profession's early religious orientation and the resulting disadvantages of conceiving nursing work in largely individual-moral rather than skill and knowledge-based terms (Nelson and Gordon, 2006 ). The identification of women with caring and caring work has also been seen to devalue both the work and those involved in it as it can be understood as a natural expression of femininity rather than skilled occupational work (Davies, 1998). However nurses themselves continue to be interested in exploring and promoting nursing as a morally positively loaded activity, often as an expression of virtue ethics (Gastmans C Fau - Dierckx de Casterle et al., 1998; Armstrong, 2006; Bradshaw, 2009) or in terms of a humanistic project (Paterson and Zderard, 1976; Benner, 2000). The problem with this, as Nelson argues (Nelson, 2007), is that approaches that conflate expert nursing practice with a particular ethical stance can fail to take account of the complex bureaucratic and possibly dysfunctional services that nurses have to work within and encourage the tendency for failures to be understood and discussed in moral terms. As an example of the impact of working within

managed healthcare settings, Nelson draws on Daniel Chambliss' ethnography undertaken in US hospitals but applicable to an English context. Chambliss argues that bureaucratic settings can largely remove the ethical decision-making powers that nurses might exercise:

> The nurse is a particular kind of hospital worker, one with at least three
>
> difficult and sometimes contradictory missions… be caring and yet be
>
> professional, be subordinate and yet responsible, be diffusely
>
> accountable for a patient's total well-being and yet orientated to the
>
> hospital as an economic employer. Perhaps no other occupation suffers
>
> so great a conflict between the practical requirements of the job… and
>
> the explicitly moral goals of the profession (Chambliss, 1996: p. 62)

To summarise this part of my argument, I want to suggest that the gendered history of nursing might be expected to intersect with polarised media treatment of nursing stories and reinforce a morally based discussion of nursing work and failures. Some nursing discourse unfortunately encourages this. Some prominent nurses, writing about the profession and seeking to promote its value continually present it as a morally positively loaded activity. To forestall any misunderstanding, I want to make it clear that of course nursing work *is* moral work, possibly more acutely so than many other fields of work. However, nurses' often subordinated position—to medicine and within organisational power structures—leads to them having to act within the effects of decisions largely made by others. Any presentation of nurses as (simply) individual, autonomous moral agents is likely to give a thoroughly misleading impression. Continuing my with intention to decentre moral understandings of nursing 'failures', I want to present, at some length, an incisive argument by nurse researcher John Paley who turns to social psychology to explain such 'failures'.

## Separating 'character' from action

Paley mounts an incisive critique of the mobilisation of the notion of 'compassion deficit' in and after the Francis inquiries (Paley, 2014). His argument radically recasts the debate about nursing failures from a moral focus to one in which the effects on cognition of certain contextual factors—such as being placed under pressure—can be used to explain the failure of individuals to initiate 'helping actions' in Stafford. His key move is in teasing apart the fragile conflation of compassion as an orientation or personal motivation with compassion (or 'helping' as he terms it) as an action. He argues that it is quite possible, and indeed in certain circumstances, quite likely, that compassionate people will behave in non-helping ways. He describes a series of experiments undertaken by psychologists that show that

when conditions are manipulated, people can behave in surprisingly non-helping ways such as stepping over someone, in one example an actor, who appears to be collapsing on the street. Combined with information about nursing staff shortages at Stafford Hospital, Paley argues that it is not unlikely that 'in these circumstances, attention devoted to one seriously ill patient could prevent the distress of another being recognized' (p. 6). These experiments establish the concept – and existence of – 'inattentional blindness'. Another set of experiments demonstrates the phenomenon of 'outsider disbelief', much in evidence in response to Stafford and other failures.  In these experiments subjects were asked if they would fail to notice certain apparently obvious occurrences such as the substitution of one person, mid-conversation with an entirely different person while the research subject is momentarily distracted. These experiments consistently showed that individuals' strong disbelief was not matched by their actual performance i.e. at being deceived. Paley's overall argument is that social psychology has extensively investigated the conditions in which people do or do not act in helping ways and found that contextual factors provide a far more powerful explanation than notions of character traits, virtues or compassion and that outsiders commonly fail to believe how easily and radically their behavior and observations can be affected by circumstances. He points out that the pages of the Francls reports fail to make reference to such a body of knowledge and persist in popular assumptions about caring characteristics and caring work. The final stage of Paley's argument draws on experiments such as the (in)famous Stanford Prison experiment, where students, with normal personality profiles, are asked to role-play prisoners or prison guards leading to the 'guards' behaving in dehumanizing ways toward the 'prisoners' and later being incredulous about their behaviour (Zimbardo, 2007). In this case the experimenter concluded that 'social situations can have more profound effects on the behaviour and mental functioning of individuals . . . than we might believe possible' (Zimbardo, 2007: p. 211). Again, Paley's conclusion is that testing a nurse applicant for the desired values and attitudes before they are placed in particular environments, such as an understaffed NHS organization, will reveal nothing about how they will behave once in this environment. In an argument that supports Paley's position, though reporting on ethnographic rather than psychological research, Chambliss describes the routinisation of events that would be considered shocking by lay people which occurs within healthcare settings and the 'parallel flattening of emotion that takes place as one becomes a nurse' (Chambliss, 1996). Though this flattening can become a problem, it is necessary, he argues, for the system to work because those without some degree of desensitization would be less able to help the system's patients.

Paley's argument is a reminder that it appears 'natural' for those involved in inquiries into nursing failures to see them not just as failures with moral effects but as rooted in terms of causation, at least in part, in individual moral deficiencies and discussed in those terms.

## Recruitment to nursing continues to focus on character traits

My argument has been that understandings – and promotions – of nursing as primarily morally located work can lead to a number of problems. I want to now suggest that recruitment to nurse training features a strong focus on apparent personal characteristics and that student nurses do not appear to be supported to develop a sophisticated understanding either of their work or of the range of causes for failures. I will draw on on-going research being undertaken at my own university as well as experiences in the recruitment of students.

The research, which started in 2011, aims to map the changing face of healthcare work and involves the yearly administration of a questionnaire to all nursing and midwifery students, as well as health care support workers enrolled on a course preparing them for assistant practitioner roles. The questionnaire includes questions about motivation, career intentions as well as scales intended to measure mindfulness, empathy and emotional intelligence and a personality profile. To date 1,042 students have participated. The research also involves a series of focus groups with volunteers from these courses aimed at further exploring motivations and experiences in the workplace. To date 13 groups have been convened involving a total of 123 students. The research was given ethical approval by the university's committee and some of the findings of the project have been reported elsewhere (Traynor 2013). The questionnaires revealed that 'people centred' and 'caring' motivations were the most frequently identified as important from a list of 19 offered. The focus groups provided more detail about this motivation. Focus group participants across all the nursing and midwifery programmes tended to speak of caring as a personal characteristic that could be 'lost' over time. Although members of most groups acknowledged coming across positive role models, they presented a strong distinction between themselves as caring and some more established members of nursing and midwifery staff with whom they had had contact, who they described as delivering poor and unsympathetic care. This understanding of nursing work that focused on individual characteristics could sometimes raise difficult questions about 'caring' and identity. The following passage is from a group of third year mental health branch students:

> Nurse 2: Well, on paper, nurses are supposed to be compassionate, they're supposed to have empathy, be sensitive, caring and all that, but do we have all these qualities in one person, to be able to be called a good nurse? That is another question.

> Moderator:        What do other people think?

> Nurse 4:    It's about who you are and the manner in which you treat your family or somebody else is the manner you should go and treat a patient

and we can't all have all these qualities but you use what you have… I think it's just - the thing is who you are from within, it's not something that is taught.  I can learn about medication and everything else but for me to be a nurse, for me to have it within me, it's me in a way, I don't know, it has to be.

Their talk often featured a strong distinction between an idealised picture of the 'good nurse' who was empathetic and able to control and change things 'making a difference, making a change' and the stark reality of everyday nursing where 'bad practice' was seen 'on a daily basis'. Their explanations for bad practice were primarily individual and associated with nurses who were either 'old', 'set in their ways', 'institutionalised', following routines, prioritising 'how quick we can do this' or simply lacking in compassion.

The orientation on the part of nurses and midwives in training to the notion of individual qualities is encouraged by recruitment processes, themselves a response to requirements from the regulator to assess 'good character' (Nursing and Midwifery Council, 2010). Recruitment interviews generally require applicants to tell interviewers what personal characteristics they possess that would make them a good nurse (Draper and Kenward, 2013) and in my own experiences at a single university, it is extremely unusual for a candidate not to respond by listing caring, compassion and empathy as these characteristics. However, when students are asked, in the focus groups, how they intend to avoid becoming one of the 'old' nurses that they have criticised, the responses often feature anxiety:

> P1: Just keeping in mind all these things that we've seen that were bad, to not do them.
>
> P5: Writing things down so you'll remember.  So that's something I've done so that when I come to do it myself I can look over it and remind myself what it's like to be a student….
>
> P2: I hope it's not an inevitability to feel jaded by the profession or can't be bothered to have students and I hope I don't feel like that.
> (2nd year Midwifery students 2013)

When asked how they currently manage working with staff who practice what

they see as poor care a frequent response was a pragmatic one:

> P1: Well, its a bit tricky isn't, given that actually, what I would say I am doing and I assume others… that actually, I'm not maintaining my integrity because I'm seeing this stuff going on around me on placement and I'm not really doing anything about, partly because for me, I've got sick of trying to do things about it – I've complained about stuff and it's like I end up feeling like I'm this one person who's a moaning bugger. And I kind of do feel like that so my strategy at the moment is just keep

my head down, get through placements and get them done, you know, unless I see something really terrible happen. (3<sup>rd</sup> year Mental Health Branch student)

Students appear to be drawing on personally devised strategies to manage their response to witnessing what they see as poor care. No student involved in the groups to date has referred to collective strategies developed within the profession or the university to support them in this situation. Furthermore, their explanations for poor care rely on common sense suggesting that preparation for practice, at least in this particular setting, does not equip students with a theoretical framework within which to understand or resist the phenomenon. These students are from one university of course, though they have had experience of a number of NHS organisations while training.

## Conclusion

The recent well-publicised nursing failures have generated considerable response from within and beyond the profession. The exposure of nursing cruelty strikes at the heart of nursing's public presentation and its professional discourse as orientated around caring. To date, two broad public explanations have been promoted: one is the 'bad apple' explanation, that failures are the result of individual deficit; the second focuses on workplace pressures and staffing levels. In this article I have drawn together diverse literature that offers more sophisticated explorations of such failures. Paley's argument teases apart the confusion between a caring orientation and helping behaviours, an unexamined conflation that much writing on compassion in nursing fails to note. This move enables him to investigate cognitive explanations for failures. Chambliss argues that the routinisation of nursing work that brings with it an 'emotional flattening' is an essential requirement for much healthcare work, arguing that being used to seeing pain means that one can then work with suffering people. He goes on to suggest that it is not useful to understand individual nurses as faced with ethical dilemmas. Rather their challenge is to work out the practical consequences of the already existing bureaucratic arrangements of their employers and decisions made by doctors. They work within the tension between this and the aspirations for autonomy that the profession promotes. Nineteenth century nursing presented itself as a strongly moral project and while its religious foundations have all but disappeared, many nurses continue to explore and promote the profession in terms of the virtue characteristics of nurses. This can encourage explanations of failures and their solutions in similar individualistic terms. Individualising systemic problems can maintain the status quo and protect powerful interests (Chambliss, 1996).

Those who lead the profession have not provided any sophisticated explanation for nursing failures and though they do focus, rightly, on the effect of low staffing levels on the standard of nursing care, they continue to present

individualistic and sometimes sentimental pictures of nursing work. This leaves those entering the profession without a strong model with which to understand their own work or its failures. If entry level training and professional organisations can create the space for critical examination of the forces impacting on healthcare and nursing, rather than present superficial and idealised pictures of a nurse's work, it may be that the profession as a whole would develop a kind of critical resilience required to operate in contemporary public services and public life.

## Key Points

The 'crisis' in nursing may be in part a crisis of representation because of media and health policy-making characteristics

Nursing failures are a possibly inevitable consequence of work in healthcare systems particularly when the workforce may not be equipped to resist pressures

Nursing has a residual tendency to be viewed as primarily character-based moral work and this can encourage explanations of failures and their solutions in similar terms

The profession focuses on the recruitment of those with a 'caring' orientation but has not developed an adequate explanation to support new recruits to understand the causes of inadequate practice, hindering the development of 'critical resilience'.

# References

Armstrong AE. (2006) Towards a strong virtue ethics for nursing practice. *Nursing Philosophy* 7: 110-124.

BBC Panorama. (2011) *Undercover Care: the abuse exposed*. Available at: http://www.bbc.co.uk/programmes/b011pwt6.

Benner P. (2000) The roles of embodied emotion and lifeworld in nursing practice. *Nursing Philosophy* 1.

Blumer HG. (1969) Collective Behavior. In: McClung Lee A (ed) *Principles of Sociology.* third Edition ed. New York: Barnes and Noble Books, , 65-121.

Bradshaw A. (2009) Measuring nursing care and compassion: the McDonaldised nurse? *Journal of Medical Ethics* 35: 465-468.

Buse K, Mays N and Walt G. (2005) *Making Health Policy,* Berkshire: Open University Press.

Chambliss DF. (1996) *Beyond caring, hospitals, nurses and the social organization of ethics,* Chicago: Chicago University Press.

Chief Nursing Officer for England and National Quality Board. (2014) How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability. London.

Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser. (2012) Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy. London: Department of Health NHS Commissioning Board.

Davies C. (1998) Caregiving, Carework and Professional Care. In: Brechin A, Walmsley J, Katz J, et al. (eds) *Care Matters: Concepts, Practice and Research in Health and Social Care.* London: Sage.

Draper J and Kenward L. (2013) Recruiting the right people into nursing. (accessed 9 April 2014).

Dreaper J. (2013) Union claims nursing hit by 'hidden workforce crisis'. *BBC News*. (accessed 20th March 2014).

Francis R. (2013a) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary. London: House of Commons.

Francis R. (2013b) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Volume III Present and Future Annexes. London: House of Commons.

Gastmans C Fau - Dierckx de Casterle B, Dierckx de Casterle B Fau - Schotsmans P and Schotsmans P. (1998) Nursing considered as moral practice: a philosophical-ethical interpretation of nursing. *Kennedy Institute of Ethics journal* 8: 43-69.

Goc N. (2007) Monstrous Mothers and the Media. In: Scott N (ed) *Monsters and the Monstrous: Myths and Metaphors of Enduring Evil.* The Netherlands: Rodopoi, 149-166.

Gordon S. (2005) *Nursing against the odds : how health care cost cutting, media stereotypes, and medical hubris undermine nurses and patient care,* Ithaca, N.Y.: ILR Press, an imprint of Cornell University Press.

Hallam J. (2000) *Nursing the Image,* London: Routledge.

Ham C. (1999) *Health policy in Britain : the politics and organisation of the National Health Service,* Basingstoke: Macmillan, .

Johnston D and Swanson D. (2003) Invisible Mothers: A Content Analysis of Motherhood Ideologies and Myths in Magazines. *Sex Roles* 49: 21-33.

Keogh B. (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: NHS, 61.

Kruttschnitt C, Gartner R and Hussemann J. (2008) Female Violent Offenders: Moral Panics or More Serious Offenders? *The Australian and New Zealand Journal of Criminology* 41: 9-35.

Leveson TRHLJ. (2012) An inquiry into the culture, practices and ethics of the press: executive summary and recommendations [Leveson report].

Maben J, Latter S and Clark JM. (2007) The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. *Nursing Inquiry* 14: 99-113.

McDonald G, Jackson D, Wilkes L, et al. (2012) A work-based educational intervention to support the development of personal resilience in nurses and midwives. *Nurse Education Today* 32: 378-384.

Nelson S. (2007) Embodied knowing? the constitution of expertise as moral practice in nursing. *Texto & Contexto Enfermagem* 16: 136-141.

Nelson S and Gordon S. (2006 ) Complexities of Care: Nursing Reconsidered. *The culture and politics of health work.* New York: Cornell University Press.

NHS Health Education England. (2013) *Values Based Recruitment Programme Summary*. Available at: http://hee.nhs.uk/wp-content/uploads/sites/321/2013/11/VBR-Programme-Summary.pdf.

Nursing and Midwifery Council. (2010) Guidance on Good Health and Good Character for Education Institutions. London: NMC.

Paley J. (2014) Cognition and the compassion deficit: the social psychology of helping behaviour in nursing. *Nursing Philosophy*.

Paterson J and Zderard L. (1976) *Humanistic nursing,* New York: John Wiley.

Seale C. (2002) *Media and Health,* London: Sage.

Secretary of State for Health. (2014) Hard Truths: The Journey to Putting Patients First. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry Volumes I and II. London: Department of Health.

Traynor M. (2013) *Nursing in Context: policy politics profession,* Basingstoke: Palgrave.

Triggle N. (2013) *Nurses: The engine of the NHS*. Available at: http://www.bbc.co.uk/news/health-24142611.

Whitehead B, Owen P, Holmes D, et al. (2013) Supporting newly qualified nurses in the UK: A systematic literature review. *Nurse Education Today*.

Zimbardo P. (2007) *The Lucifer Effect: How Good People Turn Evil,* London: Rider.