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TO CARE OR NOT TO CARE

A literature review of patient's and nurse's view on good respectively bad care and burnout in nursing

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In the nursing profession, caring is the most essential part. It is used by nurses' everyday and is an integral part in the responsive nurse-patient relationship. The main aim of this study was to investigate caring in nursing. Furthermore, because of Maslach (1998) statement that close contact within the nurse-patient relationship contributes to burnout in nurses, the authors wanted to investigate studies exploring the cause of burnout in nurses.Additionally, the cause of burnout in nurses is explored. The authors reviewed 11 scientific studies, performed in the past ten years around the world. The results showed that five main themes could be identified. These were: patient's view of good care, patient's view of bad care, nurse's view of good care, nurse's view of bad care, and the process and consequences of burnout.

Keywords: Burnout, caring, empathy, nurse-patient relationship, nursing.

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I sjuksköterskeprofessionen är omsorg en viktig del. Det används av sjuksköterskor varje dag och är en integral del i det bilaterala förhållandet mellan sjuksköterska och patient. Syftet med denna litteraturgranskning är att undersöka omsorg i omvårdnad samt se om omsorg kan orsaka utbrändhet. Författarna har granskat 11 vetenskapliga studier, gjorda till och med tio år tillbaka runt om i världen. Genom analysering av resultaten identifierades fem huvudteman: patientens syn på god omsorg, patientens syn på dålig omsorg, sjuksköterskans syn på god omsorg, sjuksköterskans syn på dålig omsorg, samt processen och konsekvenserna av utbrändhet.

Nyckelord: Empati, omsorg, omvårdnad, sjuksköterska patient relation, utbrändhet.

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INTRODUCTION

In eight months we, the authors, will become nurses. We will get our license and go to work, with all the responsibility and challenge that lies within. Certainly we want to do the best we can to give our future patients good and qualitative care. Personally we believe that in order to give quality care, nurses must truly care for their patients. With this we means giving adequate care, have an honest interest in the patient, treat the patient with empathy and respect, preserve integrity and autonomy and also getting involved in a responsive nurse-patient relationship. To see if we somehow are right in our assumptions we will explore patient's and nurse's view on good respectively bad care. Since we have a feeling that a general preconception is that being involved (not sexually) in a patient could be a risk factor for burnout, we will also explore the relationship between caring for patients and the risk factors of burnout. In the result we will present not only the eventually risk factors connected to caring and burnout but also those most common to cause burnout in nurses.

BACKGROUND

This section gives a brief introduction in the nursing profession, presenting a short summary of the history of nursing. Thereafter a summary of the characteristics for the nursing profession is presented together with the description of competence for the Swedish registered nurse. Furthermore the concept of caring in nursing and the aspects of the nurse-patient relationship are explained. Finally a presentation of burnout is given.

The Nursing Profession

The history of caring in nursing contains patience, everyday work, understanding and female knowledge (Holmdahl, 1990). Nursing ethic was relatively straightforward; the nurse had a duty to care for the patient. Nursing has had militaristic and religious foundations, and caring in nursing was viewed a suitable women's work. Nurses were caring for the patients as an unquestioned good (Tarlier, 2004).

When caring is described as a fundamental value in nursing, the description is connected to love one's neighbour and caritas. Altruistic motives are considered fundamental in nursing. The commandment about love one's neighbour is the Christianity's ethical demand on people, the fundamental rule of Christians (Jahren Kristoffersen, 1998).

To understand what is essential in the nursing profession, Jahren Kristoffersen (1998) has identified the following characteristics:
- Skills based on theoretical knowledge
- Training and education
- Organisation of profession
- Rules for professional behaviour
- Ideal of profession; i.e. that the practician of the profession is more orientated towards society, or patients interests than towards own interests
- Autonomy
- Monopoly in practising profession.

The National Board of Health and Well-fare in Sweden has a description of competence for the registered nurse made in 2005 (Socialstyrelsen, 2005-04-25). It includes recommendations in knowledge, competence, experience and approach. The following section describes the nurse's ability of informing educate and interacting with the patient:
- Communicate with patients, relatives, personnel and others in a respectful, keen and empathic way
- In dialogue, give support and guidance to patients and/or relatives to enable optimal participation in treatment and care
- Inform and educate patients and/or relatives, individually and in group, with consideration to time, way and content
- Make sure that patients and/or relatives understand given information
- Observe patients that do not express their need of information or who has special needs of information.

Fitzpatrick et al (1992) conducted a literature review with the purpose to investigate the role of the nurse in high-quality patient care. Their study states that to conduct high quality care, a high-quality nursing performance is demanded. The ultimate aim of this nursing should be to provide enhanced patient care. Within high-quality nursing lays competence in the application of theory and skills in clinical environment. Those skills consist of mastery of psychomotor and affective skills, in addition to the nurse’s critical, creative and reflective thinking abilities. The nurse should be knowledgeable, able to give good information, to make an assessment of needs, device a plan for care and evaluate it. Furthermore the nurse should have a holistic approach to health care with attitudes and skills favourable for the patient.

Caring in Nursing

The central concept for this degree project was caring in nursing. Tarlier (2004) made a literature review to explore the moral and ethical foundations of nursing from the perspective of personal and public morals, and responsive nurse-patient relationships as the reflection of ethical nursing knowledge. She found after reviewing several studies that many theories in nursing concluded that nurses make a difference to patient outcomes, and speculated that this happens because nurses care for their patient. But Tarlier means that there is so far little evidence to support this claim and also means that the concept of caring is sacred to nurses and caring occurs almost incidentally as nurses enact a larger body of underlying moral philosophy into daily practice.

Jahren Kristoffersen (1998) has divided caring in nursing into four aspects. The first aspect explains that care must be motivated through emotions, meaning that feelings characterizes the nurse-patient relationship and that the others existence means something to the nurse. Furthermore the nurse is devoted in the relationship and in its outmost form is willing to be delighted or suffer for the patient. Jahren Kristoffersen (1998) means that caring in nursing can be reduced to sentimentality if the emotional commitment does not result, one way or another in an active action for the patient who suffers. Feeling compassion and sympathy is therefore claimed not to be enough in nursing.

The second aspect is tasks in caring, and Jahren Kristoffersen (1998) expressed this as both the will and the ability to take action - two important sides of nursing. The wish to be willing to take action by the nurse and develop an inner motivation to care for the patient is also emphasized, as well as the importance to improve experience and competence to develop the necessary foundations to provide professional care.

Caring within the nurse-patient relationship is the third aspect and is explained by Jahren Kristoffersen (ibid) as reciprocity within the patient-nurse relationship. This is characterized by: caring for the other or by mutual caring, and caring for each other. Caring as moral in nursing is the final aspect, claimed by Jahren Kristoffersen to be relevant as there exists no non-valued caring. Kari Martinsen (in Jahren Kristoffersen, 1998) compared caring in nursing to solidarity with and responsibility for the weak. Additionally, Jahren Kristoffersen (ibid) claimed that through attitude and action the nurse would contribute with positive experiences and results for the patient or the opposite.

Nurse-patient relationship

Tarlier (2004) defined in e literature review three essential elements within the nurse-patient relationship: respect, trust, and mutuality.

Respect within the relationship: The ethical basis of respect depends on treating others as inherently worthy and equal, acceptance of others, willingness to listen to others, genuine attempts to understand another and the other's situation and sincerity.

Mutuality within the relationship: The nurse and the patient mutually explore the patient's needs and strengths.

Trust within the relationship: Trust depends on the patient's ability to predict the nurse's moral responses, based on an evaluation of the nurse's moral character.

The common characteristics of trust found by Hupcey et al (2001) among the definitions included in their literature review: being an expectation of something, having confidence in someone, and being involved in relationship. Nursing has applied the concept without a clear conceptual development. For instance, there are frequent citations of implications for practice without research-based evidence and the concept has been bound to the nurse-patient relationship. Furthermore Hupcey et al recognized attributes of trust: dependency on another individual to have a need met, choice or willingness to take some risk, an expectation that the trusted individual will behave in a certain way, limited focus to the area or behavior related to the need, and testing of the trustworthiness of the individual. The authors also recognized boundaries of trust: the decision to place oneself in a dependent or vulnerable position is not based

on some assessment of risk. Furthermore Hupcey et al (2001) estimated the outcome of trust to be an evaluation of the congruence between expectations of the trusted person and action (ibid).

The environment, as it is a factor affecting the nurse-patient relationship, should be arranged to promote health among both patients and personnel, according to Jahren Kristoffersen (1998). Furthermore, the frames of the organisation affects the nurse and patient by e.g. different nurses assigned to the patient on every shift which leads to difficulties understanding the patient and give the optimal care. Also nurse-to-patient ratio affects the relationship, the higher ratio of patients per nurse the lower the quality of care. The community, culture and outlook on life also affect the relationship by e.g. differences in religion, believes and/or upbringing (Jahren Kristoffersen, 1998).

According to the description of competency units for the registered nurse (Socialstyrelsen, 2005-04-25); using empathy in caring is an important part of nursing, as the nurse should have an empathic way of being. Empathy is defined as the ability to empathize, which means to understand and share the feelings of another (AskOxford.com).

Kunyk and Olsen (2001) clarified the concept of empathy in their concept analysis. The purpose of their analysis was to describe empathy as presented in the nursing literature between 1992 and 2000. They found empathy to possibly being a result of the close connection and identification with another person. Empathy was also regarded as a communication strategy and Kunyk and Olsen expressed additionally the definition of empathy as helping another to know that you care for him as an individual. Further, the patient- perceived empathy was considered as the patient's feelings of being understood and accepted by a nurse. If understanding the patient's needs, emotions, and circumstances, empathy is fundamental to the nursing practice (ibid).

Morse et al (1991) have explored the characteristics of empathy and defines different levels of empathy in caring (Table 1). The *first level patient-focused* is triggered by an emotional insight of the nurse. Empathy is an automatic response to the patient' suffering and naturally comforting. Pity is a component of this way of empathizing and expresses the nurse's regret of the patient's situation. Although, Morse et al (1991) notice that pity might lead to transient/temporary self-pity. Sympathy is another component of the first-level empathy. It is the nurse's own sorrow for the patient's suffering, and it must be genuine to be effective in caring (ibid).

Table 1. Illustration of the different levels of empathy.

	Patient-focused response	**Self- focused response**
First- level	Pity Sympathy Consolation Commiseration Compassion Reflexive reassurance	Guarding Shielding/steeling/bracing Dehumanising Withdrawing Distancing Labelling Denying
Second- level	Sharing self Humour Reassurance (informing) Therapeutic empathy Confronting Comforting (learned)	Rote behaviours "professional style" Legitimising/justifying Pity (false/professional) Stranger Reassurance (false)

Source: From Morse et al, 1991. Edited by the authors.

Compassion in the first-level response is described as recognition and mutual sharing of the patient's suffering. Morse et al (1991) claim that it is not possible to avoid pain and still be compassionate. This may lead the nurse to, avoid in some cases withdraw from, the patient's suffering to shield him/herself from the suffering and emotional involvement. Consolation is a part of empathy that has a soothing function, the nurse's support and giving hope to the patient and is used frequently. Commiseration is a sincere expression from both the nurse and patient of agreement and understanding, because of the mutual response to a common experience. Thus the expression: all nurses should be a patient at least once (ibid).

Morse et al (1991) further claim that because nurses are constantly exposed to suffering and emotional stress through first-level responding, the nurse learns to develop *patient-focused second-level* response. Second-level response is a form of pseudo engagement, generally therapeutic to the patient. This way of response keeps the nurse at a distance from the patient, at an arms length. There are two forms of second-level response. The first form is therapeutic empathy that the nurse learns to use in understanding the patient. This removes the nurse from the potential risk of personal involvement and keeps the nurse-patient relationship at a professional level. The second form, emotional empathy, is learned through experience, the experience to sense and respond to the patient's suffering (ibid).

When the nurse blocks or ignores feelings, resulting in lack of engagement with the patient, Morse et al (1991) explain that the nurse has developed *self-focused, first-level* response. The nurse shields, withdraws and guard him/herself which results in responding to the patient's suffering in a labelling, dehumanizing, distancing and denying way. This often occurs when the nurse is burned out, too tired to be sensitive (ibid).

If the nurse becomes completely detached to the patient, and treats the patient as an object it is referred as *self-focused, second-level* responding. This way of responding is not beneficial to the patient; it can actually have devastating affects according to the authors. The loss of the nurse being the patient's advocate is one of the misfortun-

ate affects of self-focused, second-level responses. The patient's needs are completely ignored and the patient is a mere object to the emotionally detached nurse (Morse et al, 1991). We, the authors of this degree project, can draw the conclusion from the facts presented above, that there is a relation between nurse burnout and caring in nursing. The following section gives a further exploration of burnout and its effects on caring.

Burnout

Maslach (1998) defines burnout as a state of both physical and mental exhaustion. She describes it as a process that can manifest itself in psychosomatic symptoms such as insomnia, fatigue, emotional tension or gastric ulcer. The sense in the nurse of weakening performance and losing the self-esteem causes feelings of self-pity, leading to a self-destructive behaviour. The decrease of self-esteem is a typical feature in depressions, as a reaction to the feelings of failure or loss (ibid).

Contributors to burnout can be external factors e.g. lack of positive feedback, bad relationships with colleagues but also internal factors such as personality. Maslach (1998) claims that if the nurse, in the contact with patients, commits deeply on a personal level within the nurse-patient relationship, he/she can adopt the problem of the patient. This might lead the nurse to engaging into the patient's problem in a certain way and on a personal level become affected. According to Maslach (ibid) an abnormal commitment could also lead to negative issues when the nurse- patient relationship is broken. Breaking the relationship can be emotionally devastating for those strongly committed (ibid).

Maslach (1998) states that close contact between nurse and patient is a contributor to nurse's burnout. Having the ability to empathize is one of the main features in the caring profession, but there are two types of empathy: emotional and cognitive. The difference can be significant in the burnout process. Maslach considers that emotional empathy is a weakness, making emotions vulnerable. This will eventually result in an emotional defence, which leads to burnout (ibid).

Maslach (1998) carries on that as the process of burnout continues, the nurse might perform his/her tasks as a matter of routines, treating the patients as things rather than human beings. The nurse avoids eye contact when speaking to the patient or has a moderate physical contact when handling the patient. This asocial attitude will make the nurse appear cold and reserved, even cruel and inhumane and eventually, burnout will not only affect the nurse his/herself but also the caring of the patient (ibid).

AIM

The main aim of this study was to investigate caring in nursing. Furthermore, because of Maslach (1998) statement that close contact within the nurse-patient relationship contributes to burnout in nurses, the authors wanted to investigate studies exploring the cause of burnout in nurses. Therefore the questions at issue of this study were:

- What is the patient's view on good respectively bad care?
- What is the nurse's view on good respectively bad care?
- Does caring cause burnout?

METHOD

In this section a description of the methods and procedures used to collect the data will be presented. The design of this study is a literature review in which the results are based on scientific studies.

To narrow this study, the moral and ethical aspects in nursing care were not included, nor the spiritual, religious and existential aspects. Though these might have been interesting to investigate, there were not time enough. It was also decided not to use any theoretical framework because the authors did not want to risk the study becoming too narrow in relation to the aim and questions at issue.

In the selective process, the first criteria were the abstract containing; the patient's view on caring in nursing; the nurse's view on caring in nursing; or burnout combined with caring in nursing. If the study qualified, a review on the results determined whether the study was to be further analysed or not. The ethical aspect was regarded by the fact that the studies used in this literature review were ethically approved before it was published in articles.

The flow of tasks in preparing this study was performed according to Polit et al (2001). First the keywords and concepts to be searched for were identified. The references of studies used in this study were identified through electronic search (Table 2). Using the aim and the questions at issue, essential keywords were: Nurse-patient relationship, Burnout, Caring, Nursing, Care, Good, and Bad (Table 2).

Reading the title, abstract and/or introduction assessed the relevance of the studies presented in scientific articles found. Studies including health-care personal in general, and not nurses specifically were excluded, partly to narrow down the number of articles presenting studies to review and also to be relevant to the aim of this study. Additional limits used were: only items with abstract, human, English and not more than ten years old.

When the studies had been selected they were further analysed. This time the purpose was to find common themes among the results in the studies. Comparing with the aim and questions at issue: What is the patient's view on good respectively bad care? - What is the nurse's view on good respectively bad care? -Does caring cause burnout? This lead to five themes: patient's view on good care, patient's view on bad care, nurse's view on good care, nurse's view on bad care and the process of burnout and consequences of burnout in nursing care. The themes involving nurse and patient's view on good respectively bad care were analysed again and divided into three sub-themes: patient's needs, nurse's action and nurse's attribute, according to Polit et al (2001).

Table 2. Overview of literature search.

Keyword	**Found**	**Reviewed**	**Used**	**Author**
Pubmed:				
Burnout, empathy, nurse-patient relationship	17	4	1	Maytum et al, 2004
Nurse-patient, good, bad, caring	3	3	1	Lövgren et al, 1996
Gift, nurse-patient relationship, caring, nurses, interview	1	1	1	Yonge & Molzahn, 2002
Meaning for nurses, caring, nursing, skill	3	3	1	Wilkin & Slevin, 2004
Patient's needs, measuring, caring	1	1	1	Fagerström et al, 1999
Burnout, nurse, hospital, quality of care	22	3	1	Aiken et al 2002 b
Linda H. Aiken and Sean P. Clarke	9	3	1	Aiken et al, 2002 a
Quality of nursing care, patient's perspective, study	22	6	1	Irurita, 1999
Blackwell-synergy:				
Burnout, nurse, caring, patient, nurse-patient relationship, qualitative study	52	13	1	Billeter-Koponen & Fredén, 2005
Nurses, professional, caring, altruism, qualitative	45	4	1	Bolton, 2000
Quality nursing care, qualitative research, nurses perspective, patients needs, dissatisfaction, insufficient	33	3	1	Williams, 1998
Total	208	44	11	

Source: Conducted by authors

Finally the studies shown (Table 2) were reviewed once again according to the assessment template, see appendix two a & b and three a & b. Two a & b contains authors: Aiken et al (2002) a, Aiken et al (2002) b, Billeter-Koponen and Fredén (2005), Bolton (2000) and Fagerström et al (1999). Three a & b contains authors: Irurita (1999), Lövgren et al (1996), Maytum et al (2004), Wilkin and Slevin (2004), Williams (1998) and Yonge and Molzahn (2002).

11 high- qualitative studies were selected nine qualitative and two quantitative. The assessment template consists of the qualitative assessment and a description of the studies used in results. This final review determined whether the study was suitable in this degree project or not.

RESULTS

This section presents the research findings of the study according to the themes identified in the data collected. During the literature review the following themes were identified: patient's view on good caring, patient's view on bad caring, nurse's view on good caring, nurse's view on bad caring, and the process of burnout, and consequences of burnout in nursing care.

Patient's view on good care

To answer the first question at issue: What is the patient's view on good respectively bad care four studies were used. All four contained nurse attribute as a sub-theme to qualify care (Bolton, 2000; Fagerström et al, 1999; Lövgren et al, 1995; Irurita, 1998). In three of the studies additional sub-themes, patient's needs and what nurses do were identified (Lövgren et al, 1995; Fagerström et al, 1999; Irurita, 1998). All four studies used are qualitative interview studies.

Patient's needs

Lövgren et al (1995) conducted a qualitative interview study in Sweden including 80 patients and 12 patient's relatives. It was found that being listened to, trusted, understood, and consoled, supported, taken seriously and seen as a whole human being were of great importance for the quality of care. Fagerström et al (1999) found in a semi-structured interview study conducted in western Finland that the patients need in caring situation appears as a demand for confirmation of human dignity and longing for contact i.e. being seen, understood and accepted. In this study the 75 participants expressed needs were: comfort, well-being, security, and hope, and guidance, dialogue, being seen and understood. Irurita (1998) states in an Australian study with 23 patients that there is a need to be able to trust the nurse. The same transcribed interview study emphasized the importance of treating the *patient as a person* and not just a patient. Which is supported in Lövgren et al (1995) by mentioning the need to be *seen as a whole human being* and by Fagerström et al (1999) by empathizing the importance to have the *existential/spiritual needs* met and be *taken cared of holistically*.

Nurse's action

Something that patients clearly find important in qualitative care is *the nurse being there when needed* which is expressed in Irurita (1998), Fagerström et al (1999) and Lövgren et al (1995). According to Lövgren's et al (1995) findings, not having to wait, a swift and competent assessment, adequate pain relief, a correct medication, clean clothing, a clean bed, tasty food, good information, physical exercises as well as time and flexible routines is things the nurse does to contribute to good caring. The participants to further contribute to good caring, such as the nurses arranging some amusements and hobby-activities expressed some extra aspect. The nurse should also give the patient good information to make the patient feel safe (Lövgren et al, 1995). Another way to make the patient feel safe is to see the patient even if was no procedure to perform (Irurita, 1998).

Nurse's attributes

Knowledge, *skills*, and *competence* is three important attributes of the nurse (Fagerström et al, 1995; Irurita, 1998; Lövgren et al, 1995). In Irurita's study 1998 the importance of nurse as a friendly person and cheery environment was expressed. Like the nurse is well prepared, preserving integrity, having good interpersonal skills and having concerns for patients as an individual. Nurses who showed empathy and compassion for their patient were contributing to the quality of care. A sense of humour was emphasized: small jokes were important as well as technical skills (ibid). Bolton conducted a study in 2000, by semi-structured interviews and observation, on women who had been patients on a gynaecology ward in UK (United Kingdom). They remembered the ward sister with fondness for using humour in nursing care, and attribute their successful recovery to having a good laugh (Bolton, 2000).

Patient's view on bad care

The following studies Lövgren et al (1995) and Irurita (1998) contained the same sub-themes as presented in patient's view on good care: patient's needs, what nurses do and nurse's attributes.

Patient's needs

According to Lövgren et al (1995) bad caring would be to not being respected or taken seriously, being mistrusted, not being supported were contributing to bad care. Furthermore the feeling that one is a bother and being forced to accept help makes the patient dislike the care. In Irurita's (1998) study it was shown that lack of time to sit down and talk to patients, especially when they were worried or afraid lowered the quality of care.

Nurse's action

In Irurita's (1998) study it was showed that if the nurse failed to answer bell the patient felt extremely vulnerable, suffering from embarrassment or feelings of insecurity. Delays in respond led to a negative impact on the quality of care. According to the participants in the study conducted by Lövgren et al (1995) bad care would also involve treatment failure, poor pain relief, no physical exercise, having to wait, no diagnosis, enforced treatment or discharge talks on the phone. It would also involve carelessness about hygiene and dressing wounds, incomprehensible or no information, the nurses forgetting care tasks and/or doing the work in a slovenly

fashion, misjudgements and inflexible routines. Last but not least going trough insulting examinations lead to low quality of care (Lövgren et al, 1995).

Nurse's attribute

According to Lövgren et al (1995) and Irurita (1998) the nurses not being attentive, forgetting patient and breaking promises resulted in bad care. Also Lövgren et al (1995) results showed that talking about the patient instead of to the patient, treating the patient as if on a conveyor belt and the nurses showing malice and/or irony and treated patients with difference would contribute to bad caring.

Nurse's view on good care

The second question at issue in this literature study was: What is the nurse's view on good respectively bad care? The answer of this question is presented in following sub-themes: patient's needs, nurse's actions and nurse's attributes (Wilkin & Slevin, 2004; Williams, 1998; Yonge & Molzahn, 2002). The study by Bolton (2000) is presented last, and is not dissected into sub-themes because it presents a conclusion to nurse's view on good care. All four studies used are qualitative interview studies.

Patient's needs

To provide hope is according to Yonge and Molzahn's (2002) Canadian study important in qualifying the care. This is supported by Wilkin and Slevin (2004) in their qualitative interview study conducted in UK at an ICU (Intensive Care Unit) with 46 full-time working nurses. Furthermore they (Wilkin & Slevin, 2004) stated that comfort, listen, reassure, support and to preserve patient's dignity and privacy is important to qualify the care. Time for the patient is equally important for both nurses as well as for the patients themselves according to Wilkin and Slevin (2004). This is supported in both Yonge and Molzahn (2002) and Williams (1998). The interview study by Williams is conducted in Australia with 10 nurses and 12 postgraduate students. The three studies (Wilkin & Slevin, 2004; Williams, 1998; Yonge & Molzahn, 2002) also agree upon the fact that the nurse must see to all the patients needs and give care in a holistic way.

Nurse's actions

The nurse ought to be truly present interacting with the patient (Yonge & Molzahn, 2002; Wilkin & Slevin, 2004). Furthermore the nurse should find solutions and be conscious of what the patient is experiencing (Yonge & Molzahn, 2002). Also act as an advocate, give and interpret information (Wilkin & Slevin, 2004). Additionally Wilkin and Slevin stated that the nurse ought to acknowledge patients vulnerability and remain a sense of calm in the caring situation.

Touch was considered as therapeutic, a way of showing care, limiting distress in the patient. This is supported in both Yonge & Molzahn (2002) and Williams (1998). The interview study by Williams is conducted in Australia with 10 nurses and 12 postgraduate students.

Nurse's attributes

The nurse ought to be committed, involved, thoughtful and considerate towards the patients, which are shown by Yonge and Molzahn's (2002) interviews with 18 nurses working in a variety of health care centres. Furthermore the nurse must be competent and skilled according to all three studies (Wilkin & Slevin, 2004; Williams, 1998;

Yonge & Molzahn, 2002).

Conclusion of nurse's view on good care

Nurses on a gynaecology unit fiercely defend nursing as a vocation, which was expressed in Bolton's study 2000. They confirm continually the view that their emotional attachment to the job reflects their commitment to quality patient care. You can't be a nurse if you don't care, it's impossible to not get involved with the patient's grief, anxiety, anger and worry. The nurses' opinion was that if you can remain out of the picture emotionally, then you are not in the right job. The nurses saw the motional stress of the job as bringing the greatest potential for job satisfaction. To employ feeling rules of the profession, yet also offer additional kindness beyond their professional care. Nursing is an overwhelming drive to care for people. The offering of the gift of emotion work, the increased emotional involvement brings a sense of satisfaction. It is stressful, but gratifying at the same time. None of the nurses express regret at becoming involved or recount situations where they use professional feeling rules in an attempt to maintain distance. They desperately want to help even if it can be traumatic for them. There are cases where the nurses are only able to maintain the professional face in attempt to suspend their judgement concerning morality (Bolton, 2000).

Their highly skilled performances enable an understanding of how caring does require skill, over and above natural feminine qualities, and is not something that everyone is equipped to do. You have to really, truly care and at the same time be able to cope with caring too much and remain professional (Bolton, 2000).

Nurse's view on bad care

There were little information to find about nurse's view on good care and therefore, this section is not divided into sub-themes as the ones above.

According to Williams' (1998) interviews, low quality nursing care was related to the omission of nursing care required to meet the patient's needs. Low quality nursing care had no therapeutic effect or was actually detrimental to the well being of the patient. The cause of inability to provide quality nursing care was identified as; limited time available for nursing care delivery, availability of resources (human or physical) were seen to impact on the amount of time. Dissatisfaction and stress in the nurse when quality care was not delivered. Stress was found to lead to reduced positive attributes and competence, which had a negative impact on the therapeutic effect of quality care (ibid).

Further contributors to bad care according to Wilkin and Slevin (2003) were staff shortages, being busy, lack of time, patient's inability to communicate.

Assessment of patient's view on good respectively bad care and nurse's view on good respectively bad care

In order to conclude the two first questions at issue: nurse and patient's view on good and bad care, a table was conducted. In the discussion of the result a smaller version of this table will be shown. To empathize what the nurses and patient had in common in their view on good and bad care.

Table 3. Summary of nurse and patient's view on good and bad care.

	GOOD		BAD
Patient	**Being:** - Accepted - Consoled - Listened to - Seen holistically - Supported - Taken seriously - Trusted - Understood - Comfort **Nurse expressed:** - Compassion - Empathy - Friendliness - Humour - Genuine interest - Tenderness	**Other:** - Ability to trust nurse - Adequate pain relief - Clean clothing, bed - Correct medication - Dialogue - Dignity - Existential/spiritual needs met - Flexible routine - Good information - Guidance - Hope - Interpersonal skilled nurse - Not waiting - Nurse being there when needed - Physical exercise - Security/feel safe - swift competent assessment - Tasty food - Well-being - Well-prepared nurse	**Not Being:** - Remembered - Respected - Supported - Taken seriously - Trusted **Nurse not:** - Answering bell - Attentive - Having time to talk - Keeping promises **Other:** - Being treated with indifference - Carelessness about hygiene and dressing wounds - Discharge talk on phone - Enforced treatment - Feeling one is a bother - Forced to accept help - Insulting examination - No diagnosis - No physical exercise - none or bad information - nurse showing malice/irony - Poor pain relief - Treated as if on a conveyor belt - Treatment failure
Nurse	**Being:** - An advocate - Comforting - Conscious of patients experiences - Considerate - Decisive - Empathic - Informative - Skilled - Supportive - Thoughtful - Truly present	**Other:** - Acknowledge patients vulnerability - Finding solutions - Giving personal touch - Having time - Listen - Meeting patients need - Preserving dignity - Providing hope - Reassure patient - Remaining sense of calm - View patient holistically	**Being:** - Dissatisfied - Busy - Stressed - Unable to meet patients needs **Other:** - Not having enough time - Patients inability to communicate - Staff shortage

Source: Bolton, 2000; Fagerström et al, 1999; Lövgren et al, 1995; Irurita, 1998; Yonge & Molzahn, 2002; Williams, 1998; Wilkin & Slevin, 2004. Edited by the authors.

The process of burnout and consequences of burnout in nursing care

A higher emotion exhaustion and greater job dissatisfaction in nurses were strongly and significant associated with patient-to-nurse ratio in a cross-sectional analyses of linked data from 10 184 staff nurses, 232 342 general, orthopaedic and vascular surgery patients discharged from the hospital between April 1st 1998 and November 30th 1999 and administrative data from 168 non-federal adult general hospitals in Pennsylvania (Aiken et al 2002b).

Adding one patient per nurse to a hospital's staffing level increased burnout scores by 23% and job dissatisfaction by 15%. This implied that 8:1 patient-to-nurse ratio compared to 4:1 patient-to-nurse ratio increased burnout scores by 129% and job dissatisfaction by 75%. Patient mortality increased by 7% with every additional patient in the average nurse's workload in the hospital, the difference from patient-to-nurse ratio 4:1 and 6:1 would be a 14%, and from patient-to-nurse ratio 4:1 to 8:1 would be a 31%, increase in patient mortality (ibid).

Further findings were that if all hospitals had 6:1 patient-to-nurse ratio there would be 2, 3 (95% CI: 1.1-3.5) additional deaths per 1000 patients with complications. Increasing patient-to-nurse ratio from 4:1 to 8:1 there would be a 5, 0 (95% CI: 1.2-7.6) excess deaths per 1000 patients and 18.2 (95% CI: 7.7-28.7) per 1000 patients with complications (ibid).

Aiken et al (2002a) has performed a multisite cross-sectional survey to examine the effects of nurse staffing and organizational support for nursing care on nurses' dissatisfaction with their job, nurse burnout and nurse reports of quality of patient care in an international sample of hospitals. The study was conducted in adult acute-care hospitals in the USA (Pennsylvania), Canada (Ontario and British Columbia), England and Scotland. The participants were 10 319 nurses working on medical and surgical units in 303 hospitals across the five jurisdictions. Nurses working in hospitals with weak organizational support for nursing care were twice as likely to report dissatisfaction with their jobs and to have burnout scores above published American norms for medical personnel. Both nurse staffing and organizational support for nursing care had significant impacts on nurse-expressed quality of care. Nurses in the hospitals observed to have the lowest levels of support for nursing care, were more than twice as likely to rate the quality of care as fair or poor (Aiken et al, 2002a).

Billeter- Koponen & Fredén (2005) states in their Swedish qualitative interview study that having experience is implied as important in nursing. It makes everything easier for the nurse to concentrate on the tasks involving the patients if the nurse knows how everything around works. The nurses interviewed were all suffering from burnout and had been absent from work two months or more, one of them said about the nurse-patient relationship, that to know a patient takes time. If the nurse cannot give enough time the patient needs, the nurse will feel stressed. Important for a nurse is the patient but today nurses are office workers, as expressed by the participants. The nurses' feel that today the patients are just stores up and when the workload is heavy, the wish for more staff is very pronounced. Nurses compensate this by starting earlier; not taking breaks, thinking about work long afterwards going home (ibid).

The participants of the study, conducted by Billeter- Koponen & Fredén (2005), developed feelings of not being adequate, blaming themselves for burnout. The contact and care relation with the patient was said to give the nurse a positive experience of professionalism, giving a feeling of doing something good. The nurses expressed a lack of energy to listen and had no energy to arrange anything, or solve a problem. The process leading to powerlessness was expressed as a combination of work overload and unclear tasks or changes in staff. The participants spoke about physical symptoms and changes in personality. Stress, burnout and the process of burnout was not changing the valuation of meeting a patient as an individual and building a professional relationship, but affecting the ability to meet people (ibid).

According to Maytum et al's (2004) descriptive qualitative pilot project, the most commonly cited example of issues leading to work related triggers of burnout was seeing too many painful procedures done to patients, too much sadness, and too much death. Other triggers experienced by about half of the 20 paediatric nurses included a sense of unreasonable expectations on the part of some families, seeing patients unable to have a "normal" life, and being the sounding board for too many sad situations. Approximately one fourth of the participants identified angry, yelling relatives and noncompliant patients and relatives as triggers.

The majority of participants described the Minneapolis, Minnesota, health care system's problems that lead to stress and burnout. These included unreasonable policies, staffing shortages, insurance frustrations, excessive paperwork, needing to justify their position, and a feeling of general health care system dysfunction. Approximately two thirds of the nurses identified at least one type of role-specific trigger of burnout. Lack of support and a feeling of being on your own was the most commonly cited trigger in this category. 60 % of the participants cited excessive demands of work as triggers for burnout (ibid).

The nurses expressed concerns about being unable to give good care because of lack of time, repeated needs to put in overtime or double shifts, needing to work overtime and be at home, and having too many projects to do. 75 % of the nurses identified personal triggers that precipitated burnout. By far the most frequently cited personal trigger was becoming overly involved in the nurse-patient relationship or crossing professional boundaries. Other examples of personal triggers were found to include taking things too personally: having unrealistic expectations of self: the job was thought not to fit their personality: trying to get personal needs met through work: outside commitments: and family problems (Maytum et al, 2004).

DISCUSSION

In this chapter the conclusions drawn about the meaning and implications of the findings in the study is presented. The method, result and future value of this study is discussed.

Discussion of method

Regarding this degree project we choose to write in English. We know that it is possible for readers to find some mistakes in words, grammar and syntax. The reasons for choosing English were among others: definitions of concepts are all in English and it is difficult to make an accurate translation into Swedish. Also we have both been studying abroad and plan to work abroad in our profession. Since both authors speak and read English more or less fluently it was not really a problem for us to conduct this literature review in English. Most important we feel that the fact that we did not have to interpret literature back and forth has made this degree project more truthful to its sources, the studies, and their aim.

The method of this study was chosen to be a literature review: collecting and analyzing the results of empirical studies published in scientific articles. The method chosen might be limited concerning the gathering of material. According to Hartman (1998) following criteria's must be regarded in choice of material: the information must be relevant to the aim of the study, the source must be available and it must be ethically approved to use the source of information. Despite this, the authors agreed to the choice of method because of the somewhat theoretical nature of the aim and questions at issue. The possible answers of the questions at issue were expected to be found in the results of already conducted studies, not dating back more than ten years.

The search limits were used to make the search as relevant as possible; the abstract was the first criteria because of its overview of the article. Secondly this degree project only regards human and English was a natural limit because of the author's inability to translate other languages.

The authors used several different keywords and combinations to narrow the search down to a manageable number of articles found (Table 2). Many times we have found as many as 500-3000 with keywords relevant to our degree project. As seen in table 2 there are still some searches that have resulted in around 45-50 articles found, not all of these have been reviewed. This is because many articles are found in search with the same keywords, and also some articles found have been reviews and quantitative, and we searched for qualitative interview studies.

In every literature review the result is based on interpretations of others interpretations. This can lead to a questioning whether the result is true or not. No matter how hard the authors have tried to stay objective in reading, it is impossible to ignore the fact that the prior understanding affected the result at some degree (Hartman, 1998). We consider further scientific research essential and recommend this, possibly using both qualitative and quantitative methodology in order to understand more about caring in nursing.

Regarding the availability of material, limitations were caused by the fact that some scientific journals were missing in the local libraries: the Malmö University Hospital's library and the library at Malmö University. Adding the fact that password and registration were demanded for accessing many electronic journals further limited the authors in the search for electronically published studies.

The studies selected for further analysis were reviewed once and compared to the aim of the study. The concepts found in the studies were of great importance because they had to be the same as the ones described in the background and aim of this study. The authors found it useful to photocopy or print out from the Internet the selected studies. This was to enable highlighting and underlining crucial information in the analysis. Furthermore, in order to facilitate organising the analysis of data all the articles containing empirical studies and literature reviews were numbered by putting the authors' names in alphabetical order. Though the literature reviews were not used in the results, some were used in other parts of this study.

The next step in the flow of tasks was to summarize the notes of results from the chosen studies for further analysis. To be sure not having the analysed results put out of its context and minimize biases, the full articles presenting the studies were read again. Finally the material was themed according to the aim of the study and the major characteristics found in the studies' results. Since our two first question at issue: nurse and patient's view on good respectively bad care, were highly compatible with the themes discovered in the seven studies used (Bolton, 2000; Fagerström et al, 1999; Irurita, 1998; Lövgren et al, 1995; Wilkin & Slevin, 2004; Williams, 1998; Yonge & Molzahn, 2002) they also became themes. Those themes were very extensive and therefore further analysed, by highlighting all characteristics of the themes, and thereafter divided into three sub themes: patient's needs, nurse's action and nurse's attribute. Those characteristics are all presented in table 3, after additional analyses some differences were discovered, those are presented in table 4.

According to course 9 in Nursing Science we are told to use a theoretical framework to support our examination paper. We examined, among others, Watson, Morse and the Grounded theory and tried to combine one of them with our literature review, none of them were adequate for our aim. Also we had the opinion that it narrowed this type of study we performed. After trying to follow a theoretical framework we decided to discharge the theoretical framework and focus on getting the examination paper finished on schedule.

Discussion of result

The aim of this study was to caring in nursing. By answering the questions at issue: Patient's view on good respectively bad care, Nurse's view on good respectively bad care and Does caring cause burnout, we, the authors identified five main themes and three sub-themes in the results. These themes were supplemented with an easy presentation in table 3 of the common characteristics found in the reviewed studies. To understand these characteristics it felt natural give a brief explanation of these in the background.

The following themes were selected after a careful review of studies used. The first themes were patient's view on good respectively bad care and nurse's view on good respectively bad care (Table 4).

Table 4. The differences between nurse and patient's view on good and bad care

	PATIENT		NURSE
GOOD	- Accepted - Consoled - Taken seriously - Trusted - Understood - Humour - Tenderness - Dialogue - Guidance	- Nurse being there when needed - Security/ feel safe - Well-being - Interpersonal skilled nurse - Trustworthy nurse - Adequate pain relief - Correct medication - Clean bed and clothes - Physical exercise - Tasty food - Flexible routines	- Remain sense of calm - Acknowledge patients vulnerability - Advocacy - Conscious of patients experiences - Decisive - Thoughtful - Finding solutions - Giving personal touch - Meeting patients need - Reassure patient
BAD	- Not remembered - Not respected - Not taken seriously - Not trusted - Nurse not answering bell - Nurse not attentive - Nurse not keeping promises - Forced to accept help	- Insulting examinations - Treated as if on a conveyor belt - Feeling one is a bother - Treatment failure, no diagnosis - Poor pain relief - No physical exercise - Enforced treatment - Discharge talk trough phone - Carelessness hygiene, dressing wounds - Nurse showing malice/irony - Treated with indifference	- Busy - Stressed - Unable to meet patients needs - Patients inability to communicate - Staff shortage - Dissatisfaction

Source: Bolton, 2000; Fagerström et al, 1999; Lövgren et al, 1995; Irurita, 1998; Yonge & Molzahn, 2002; Williams, 1998; Wilkin & Slevin, 2004. Edited by the authors.

As shown in table 4 there are some differences in good and bad care according to nurse and patient's view. First of all the patient's view is more detailed than the nurse's. This could be because the nurse's gather many characteristics in good and bad care in the phrase's "meet patient's needs" and "unable to meet patient's needs". This is not explained in the studies (Bolton, 2000; Fagerström et al, 1999; Lövgren et al, 1995; Irurita, 1998; Yonge & Molzahn, 2002; Williams, 1998; Wilkin & Slevin, 2004) and therefore we, the authors, cannot determine whether it is so or not. Furthermore it may be possible that the nurses have been asked, or chosen them selves, to disregard the task aspect. Since we have not had access to the interview questions and the studies (ibid) do not tell whether they have focused on task, relationship, organisation or other aspect, this remains unanswered. But it would surely been interesting to find out. Another possible factor in the difference is that it is much easier to give positive and negative critique to others than to criticize one self. Also we must keep in mind that the nurses are in their caring-role every working day, and are easily blinded by the well known. The patients however are in the hospital a given time and have more time and ability to reflect over care before, during and after their stay.

Another interesting finding in the difference in view's is that patients states "dialogue" (Fagerström et al, 1999) in good caring and nurses states "patients inability to communicate" (Wilkin & Slevin, 2003) in bad caring. We think that the nurses mean the patients physical inability to communicate, but we can not be sure

since it is not explained in the study. If it is not so, maybe nurses assume that patients are unable, unwilling or what ever, to communicate which would surely bring the quality of care down. The last theme identified in our result was the process of burnout and the consequences of burnout in nursing care. This answers our third and last question at issue: Does caring cause burnout?

According to Aiken et al (2002a), Aiken et al (2002b), Billeter-Koponen and Fredén (2005), and Maytum et al (2004), caring do not cause burnout. However nursing seems to bring a risk of burnout in the profession. Reasons shown in the result is i.e. a high nurse-to-patient ratio. This not only contributed to burnout and job dissatisfaction but also patient mortality (Aiken et al, 2002a), which we find really interesting. A couple of weeks ago a Swedish paper (non-scientific) published an article about doctors in Sweden having too few patients assigned to them. It was a question about money and effectiveness. The study (Aiken et al, 2002a) only shows consequences of a high nurse-to-patient ratio so we can only assume that it would be seen similar affects in a doctor-to-patient ratio.

Authors' final words

First of all we must say that working with this degree project has been really interesting. We have discovered a subject in nursing that we from the beginning of our education found ridiculous. We were not able to see any use with a lot of old ladies sitting and thinking about how to care. For us it was obvious that you care about people and is emphatic if you choose to become a nurse. Otherwise we believe that you are in the wrong profession. Now that we have done some research of our own we believe there is not enough knowledge about caring in nursing. And that it should be emphasized in the nursing education.

In English caring is just a (grammatical) inflection of care therefore the meaning stays the same. In Swedish, on the other hand, we have in nursing two different words with different meanings. "*Omsorg"* which would be translated as *caring* and "*omvårdnad"* which would be translated as *care*. Those translations are not correct or really possible to make e.g. there is *caring science* and "*omvårdnadsvetenskap"* which means the same thing. Also in English you would say *give care* to the patient or *caring about* the patient and mean the same thing. In Swedish you would say *"vårda"* the patient and "*bry sig om/ge omsorg"* the patient, and not at all mean the same thing.

With these examples we hope to illustrate the complex nature of the concepts in nursing and the great importance of understanding the concepts. We find this degree project truly useful because it builds a foundation for all nurses to use in our profession. Furthermore we hope that this degree project will emphasize the importance of having crystal clear concepts in nursing and that they interact well with each other. It highlights the many factors contributing to good and bad care. It also shows that there are differences in what nurses and patients rate as good care. It is of essence because after all nurses give care to human beings, just like you and me and in order to do this in a therapeutic and meaningful way nurses must know what the patient's view of good care is.

Last but not least you can not be a nurse and give care if you do not care!

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APPENDIXES

Appendix1: Glossary

Appendix 2: Assessment template, authors, A-F

Appendix 3: Assessment template, authors, I-Y

Appendix 1

GLOSSARY

Definitions of concepts collected from the web-based Oxford Dictionary (AskOxford.com).

Affect: *Noun* Psychology emotion or desire as influencing behaviour.

Burnout: *Noun* physical or mental collapse.

Care: *Noun* the provision of what is necessary for the welfare and protection of someone or something. *Verb* feel concern or interest. Feel affection or liking. (*care for*) look after and provide for the needs of. Derivatives: caring, noun and adjective.

Ethic: *Noun* a set of moral principles.

Ethical: *Adjective* relating to moral principles or the branch of knowledge concerned with these. Morally correct.

Nurse: *Noun* a person trained to care for the sick or infirm. *Verb* give medical and other attention to. Treat or hold carefully or protectively.

Profession: *Noun* a paid occupation, especially one involving training and a formal qualification. Treated as *singular or plural* a body of people engaged in a profession.

Trust: *Noun* firm belief in the reliability, truth, ability, or strength of someone or something. Acceptance of the truth of a statement without evidence or investigation. The state of being responsible for someone or something. (*trust to*) place reliance on (luck, fate, etc.). Have confidence; hope.

Appendix 2

Author and year:	Aiken et al, 2002 (a)	Aiken et al, 2002 (b)	Billeter-Koponen & Freden, 2005	Bolton, 2000	Fagerström, 1999
Type of study:	quantitative	quantitative	qualitative	qualitative	qualitative
Aim: Clearly formulated	yes	yes	yes	more development needed	yes
Founded on earlier research	yes	yes	yes	yes	yes
Theoretical framework: Sufficient comprehension	yes, conceptual model	yes	yes	yes	yes
Description	yes, detailed	yes	yes	yes	yes
Agreeability with aim	good	good	good	unclear	good
Definitions comprehensible	yes	yes	could be further described	yes	yes
Definitions' agreeability with choice of theory	good	-	good	good	good
Informants: Description	10 319 nurses from medical and surgical units in USA, Canada, England and Scotland	10 184 nurses, 232 342 patients and administrative data from hospitals in USA	10 nurses, not at work 2 months or longer because of long-lasting stress and burnout, Sweden	insufficient, nurses at genecology ward in USA	75 patients committed to hospital in Finland
Agreeability with aim and method	good	good	good	unclear	good
Ethic: Beneficence	yes	yes	yes	-	yes
Respect for human dignity	yes	yes	yes	yes	yes
Method: Data collection	self-administered questionnaire	-	interview	interview and observation	inteview
Agreeability with aim	good	good	good	unclear	good
Agreeability with theoretical framework	good	-	good	-	good
Structure	organized support subscale	-	semi structured	semi structure	semi structure
Appropriateness of informants	good	good	good	good	good
Measures taken to avoid bias	yes, excluded hospitals with <10 response	-	-	yes	yes
Data collection: Adequacy	good	good	good	unclear	good
Appropriateness	good	good	good	good	good
Researcher appropriateness	good	good	good	good	good
External factor bias	-	-	-	no	no
Qualitative or quantitative data	quantitative	quantitative	qualitative	qualitative	qualitative
Quality of data: Credibility	high	high	sufficient	low	high
Dependability	-	very good	good	sufficient	very good
Ability to confirm	-	yes	yes	difficult	yes
Transferability	good	good	-	unclear	good
Analysis of data: Appropriate method to aim and theory	yes	yes	yes	yes	yes
Results: According with aim	yes	yes	yes	yes	yes
Interpretation: Coverage of results	good	good	good	good	good
Supportive evidence	yes	yes	yes	yes	yes
Compliance with earlier research	yes	yes	yes	yes	both, presented well
To theoretical framework	-	-	yes	-	yes
Evaluation of methodological decisions	yes	yes	-	yes	-

Appendix 3

Author and year:	Irurita, 1999	Lövgren et al, 1996	Maytum, 2004	Wilkin & Slevin, 2004	Williams, 1998	Yonge & Molzahn, 2002
Type of study:	qualitative	qualitative		qualitative	qualitative	qualitative
Aim: clearly formulated	yes	yes	yes	yes	yes	yes
Founded on earlier research	yes	yes	yes	yes	yes	yes
Theoretical framework: sufficient comprehension	yes	yes	yes	yes	yes	yes
Description	small	yes	yes	yes	-	-
Agreeability with aim	-	good	good	good	-	-
Definitions comprehensible	yes	yes	yes	yes	yes	yes
Definitions' agreeability with choice of theory	adequate	good	good	good	-	-
Informants: description	patients in acute-care hospital in Australia, need more description	80 patients, 12 relatives in primary health care in Sweden	20 pediatric nurses in USA	nurses in ICU in United Kingdom, insufficient presentation	10 nurses in acute care hospital and 12 postgraduate students in Australia	18 nurses in health care centre and community agencies, Canada
Agreeability with aim and method	good	good	good	good	good	very good
Ethic: beneficence	yes	yes	yes	yes	yes	-
Respect for human dignity	yes	yes	yes	yes	yes	yes
Method: data collection	interview, observation	interviews by nurses	interview	interview	interview, observation	interview
Agreeability with aim	good	good	very good	good	good	good
Agreeability with theoretical framework	good	good	good	good	-	-
Structure	-	semi structure	semi structured,	semi structure	semi structure	longitudinal, semi structured
Appropriateness of informants	good	good	very good	good	good	good
Data collection: adequacy	good	good	good	sufficient	good	sufficient
Appropriateness	good	good	good	good	good	good
Researcher appropriateness	good	good	good	good	good	good
External factor bias	-	no	no	-	-	-
Qualitative or quantitative data	both, mainly qualitative	qualitative	qualitative	qualitative	qualitative	qualitative
quality of data: credibility	sufficient	high	high	high	high	sufficient
Dependability	good	good	good	good	good	good
Ability to confirm	yes	yes	yes	yes	yes	yes
Transferability	good	Very clear	pediatrics might narrow	ICU nurses might narrow	possible	unclear
Analysis of data: appropriate method to aim and theory	yes	yes	yes	yes	yes	yes
Results: according with aim	yes	yes	yes	yes	yes	yes
Interpretation: coverage of results	good	good	good	yes	yes	yes
Supportive evidence	yes	yes	yes	yes	yes	-
Compliance with earlier research	yes	-	-	-	yes	yes
To theoretical framework	-	yes	yes	-	-	-
Evaluation of methodological decisions	-	yes	yes	yes	-	-
Measures taken to avoid bias	completed with quantitative data	yes	yes	-	yes, seminars with other researchers	yes