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REVIEW

The link between task-focused care and care beyond technique: A meta-ethnography about the emotional labour in nursing care

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Abstract

Objective: To synthesise the available body of qualitative work regarding the experiences of registered nurses and nursing students in managing emotional demands of care.

Background: Care is the central part of nursing, and its provision is linked to interaction with patients. Comprehensive care allows emotions to be considered as an essential part of care. However, the emotional commitment that care demands poses a challenge for the nursing staff.

Design: Noblit and Hare's interpretive meta-ethnography, which was written and reviewed for reporting clarity using the eMERGe.

Methods: A comprehensive systematic search strategy was undertaken in PubMed, CINAHL, Scopus, Web of Science and PsycINFO in January 2020. The search included terms related to the sample population, phenomenon of interest, purpose of the study and type of research. Original or mixed qualitative articles in English, Spanish and Portuguese were included if they addressed the emotional labour experiences of nurses or nursing students.

Results: A line-of-argument synthesis based on the metaphor *The link between task-focused care and care beyond technique* was developed. Three themes from analogous and refutational translations of findings in the included nine papers emerged: (1) forces to get involved in care; (2) the cost of caring and (3) need to vent.

Conclusion: Nursing staff and students managed the emotional demands by adjusting their involvement in care. Care beyond technique is provided by nurses who have strength and motivation in themselves and in the interaction with patients to become emotionally involved in care. Task-focused care avoids emotional exposure to patient suffering due to the personal cost involved. Venting and distancing are required to emotionally reconstruct themselves and to re-engage in care.

Relevance to clinical practice: Increased knowledge about these experiences may raise awareness of the emotional demands as part of the care process, to prevent their impact and favour their support.

KEYWORDS
'emotional adjustment', 'nurse–patient relations', nurses, qualitative research

1 | INTRODUCTION

The provision of care requires that nurses are the primary contact for patients (Smith et al., 2009). In the presence of these interactions, the nursing staff are exposed to emotionally demanding care situations in which emotions play a fundamental role in fostering effective nurse–patient relationships (Bailey et al., 2011).

Care takes place in a context in which control of the organisation is expanded and emotional aspects start to impose upon the rules of conduct (Martínez Iñigo, 2001). Technological development in the health field has brought about a revolution in terms of safety, effectiveness and efficiency of care, although it has also introduced new problems (Busch et al., 2019). The automation and standardisation of care and the fragmentation of work and care pathways, often linked to rationing of time and personnel, can lead to a dehumanisation and depersonalisation of health care (Lovato et al., 2013). Critical analyses have warned about the progress of nursing practice towards the adoption of protocols and standards of quality, which are often measured from the perspective of how these protocols are met (Jones, 2016). Furthermore, health professionals are mainly evaluated based on their professional performance, and are often not considered a valuable resource but rather a risk in health care (Busch et al., 2019; Rosenstein, 2013). As a consequence, these professionals may experience stress, burnout and compassion fatigue (Rosenstein, 2013).

To deal with this approach, the concept of 'humanisation of care' has emerged (Borbasi et al., 2013). This approach views protocols as potentially dehumanising, because they tend to make patients feel like they are simply recipients of care (Nwozichi et al., 2019). The essence of nursing is aligned with the principles of humanisation; however, this is not enough to guarantee the maintenance and development of this approach, rather intentionality is necessary (Watson, 2011). The demands and problems that make it difficult to implement this approach have become more acute during the COVID-19 pandemic, and show that the humanisation of care stems from the individual efforts of health professionals (Zipf et al., 2022).

Given the relevance of emotions to nursing practice and the difficulty of dealing with emotionally demanding care, previous research has examined the experiences and perceptions of different health professionals regarding the management of their emotions (Delgado et al., 2017; Edward et al., 2017; Riley & Weiss, 2016). However, these reviews have only investigated health professionals and patients as samples, included quantitative and qualitative studies, and accessed the English literature. For this reason, this qualitative synthesis focuses on the experiences of the nursing staff, since they are the main health professionals who are expected to care emotionally for their patients and who expose themselves to the emotional demands that care implies (Smith, 2011).

What does this paper contribute to the wider global clinical community?

- Caring beyond technique entails the emotional involvement of nurses and nursing students moved by different forces such as vocation, the feeling of professional duty and the humanisation of patients.
- Getting involved in care meant a high personal cost for nurses and nursing students. This led to them having difficulty coping with these demands, especially when there were unresolved personal emotional experiences, and patient care focused on performing tasks.
- The non-exposure to the suffering of patients was the strategy adopted by the staff to rebuild emotionally and thus return to provide comprehensive care.

1.1 | Background

Hochschild (1983) states that emotional labour takes place when an individual's emotions are regulated in the workplace, having to experience and express certain emotions as part of their work. According to this, emotional labour requires 'inducing or suppressing the feeling in order to sustain an external appearance that produces, in others, an appropriate mental state and a feeling of pleasant care in a safe place' (Martínez Iñigo, 2001).

During interactions with individuals, experiences and emotional expressions are handled in such a way that, adjusting to the rules of feeling, the performance is appropriate for the situation. Prolonging situations like this can lead to conflicts between the person themselves and the role performed. When the emotional experience is not in tune with the expression included in the rules of feeling, individuals experience emotional tension or dissonance (Hochschild, 1983; Theodosius, 2008).

Hochschild (1983) differentiated two ways of expressing the prescribed appropriate emotions: superficial and deep acting. Superficial acting is characterised by the expression of emotions, demanded

by work, that are not aligned with true feelings. At times, this performance was described as 'putting on a mask' (Miller et al., 2007). Profound acting refers to 'the act of trying to change an emotion or feeling in degree or quality' (Hochschild, 1979). This occurs when the person changes their real feelings to match the emotion determined by the organisation (Bolton, 2000). Both imply the existence of an inauthentic emotion, since the felt emotion is actively suppressed in the first case, while in deep acting it changes or is modified to suit what is required by the organisation (Miller, 2002).

Smith (1992) was the pioneer for transferring the concept of emotional labour to the field of nursing. Nurses are expected to provide emotional care during their interaction with patients. That is why, in her first book, Smith (1992)) focused on the 'little things' that matter to patients, thus recognising empathy and care as the core of nursing. Eriksson (1994) also contributed to the development of a science of care with a humanistic orientation, conceiving the human being as an indivisible entity that includes body, soul and spirit. She stressed that the focus should be on care and not on the profession, since in this way it maintains and allows the health and well-being of people through a holistic approach.

The Caritative Caring Theory arises from the importance that Eriksson (1994)) gave to *caritas* as a basic reason for care, whose purpose is to relieve suffering and promote health and life. The ethics of care deals with the basic relationship between the patient and the nurse, that is the way in which the nurse encounters and interacts with the patient. However, nursing ethics is about the rules and principles that guide the work and decisions being made. An ethical care approach means that, without any prejudice, the human being is considered with respect and their absolute dignity is confirmed (Lindström et al., 2006).

Caritative caring is based on the relationship between the person who needs and expects care and the person who cares through a genuine communion and understanding of the unique human being. Caritative caring thus involves an encounter in which suffering and caring humans are active participants in their own lived worlds of experiences and wishes (Eriksson, 1994).

1.2 | Research question and aim

The above-mentioned scenario prompted the following question: What are the experiences of nurses and nursing students in managing the emotional demands that care implies? Therefore, this qualitative review aims to synthesise the available body of qualitative work regarding the experiences of registered nurses and nursing students in managing emotional demands of care.

2 | METHODS

Noblit and Hare's (1988) meta-ethnographic methodology was used to synthesise data for this study. Briefly, this approach functions by reinterpreting the results of qualitative studies with the goal of translating and merging findings such that the end product goes beyond the sum of the individual parts (France et al., 2014). The seven steps of this method are: (1) getting started; (2) deciding what is relevant to the initial interest; (3) reading the studies; (4) determining how the studies are related; (5) translating the studies into one another; (6) synthesising translations and (7) expressing the synthesis. This study followed the criteria within the eMERGe meta-ethnography reporting guidance (File S1) to improve the quality, transparency and comprehensiveness of the meta-ethnography (France et al., 2019).

2.1 | Search methods

A comprehensive and systematic search strategy was conducted using PubMed, CINAHL, Scopus, Web of Science and PsycINFO online databases in January of 2020. The search strategy was developed by SFB in accordance with the sample population (nurses and nursing students), the phenomenon of interest (emotional labour), the purpose of the study or evaluation (experiences) and the type of research (qualitative). Several CINAHL descriptors, medical subject headings and free terms for each characteristic were combined using the Boolean operators 'AND' and 'OR'. Additionally, truncations (*) were sometimes incorporated into the search headings to produce a broader search. The inclusion criteria were as follows: research articles were limited to publications in English, Spanish and Portuguese; publications must be either original qualitative articles or mixed articles from which qualitative results could be extracted; and the aim of the article must focus on the emotional labour experiences of nurses or nursing students. Review articles, discussion papers and grey literature were excluded. No time limits were used. Back-and-forth tracking and manual searches were also conducted.

2.2 | Search outcomes

The flow diagram shown in Figure 1, based on the Preferred Reporting Items for Systematic-Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009; Page et al., 2021), shows the filtering process used for this meta-ethnography. Our first pass yielded 1479 publications. This search was supplemented by additional searches of cited articles within our first pass results. After elimination of 683 duplicates, the titles and abstracts of the remaining articles were screened against the inclusion and exclusion criteria. After these limits were applied, 23 remaining articles were read completely and 14 of these were excluded since they were not primary articles or they had an incorrect phenomenon of interest, methodology and/or sample population.

2.3 | Quality appraisal

The search strategy led to 9 articles which met all the established criteria and these studies represent the core sample of this

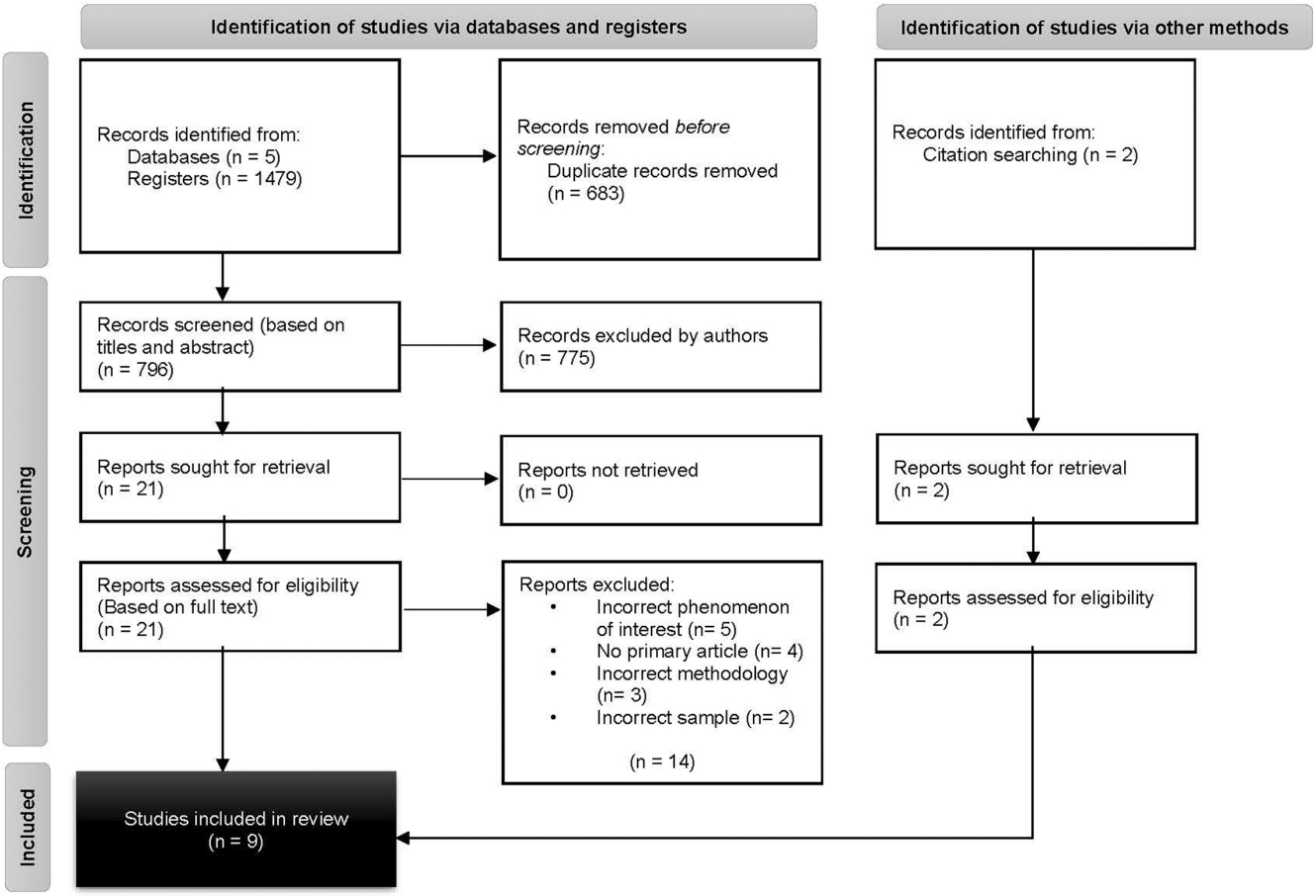

FIGURE 1 PRISMA flow diagram

TABLE 1 Quality assessment of included studies

Articles	Questions									
	1	2	3	4	5	6	7	8	9	10
Albinsson and Arnesson (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Anderson and Morgan (2017)	✓	✓	✓	✓	✓	✓	–	✓	✓	✓
Arieli (2013)	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Cecil and Glass (2015)	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Gray (2010)	✓	✓	✓	✓	–	–	✓	–	✓	✓
Hayward and Tuckey (2011)	✓	✓	–	✓	✓	–	✓	✓	✓	✓
Msiska et al. (2014)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staden (1998)	✓	✓	✓	✓	✓	✓	–	✓	✓	✓
Waddington (2005)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: ✓ Yes – Unclear ✗ No; Critical appraisal questions: (1) Was there a clear statement of the aims of the research? (2) Is the qualitative methodology appropriate? (3) Was the research design appropriate to address the aims of the research? (4) Was the recruitment strategy appropriate? (5) Were the data collected in a way that addressed the research issue? (6) Has the relationship between researcher and participants been adequately considered? (7) Have ethical issues been taken into consideration? (8) Was the data analysis sufficiently rigorous? (9) Is there a clear statement of findings? (10) How valuable is the research?

meta-ethnography. The Clinical Appraisal Skills Program (CASP) tool (Skills & Programme, 2018) was used to assess the quality of our sample. Based on this analysis, the included articles were considered to have sufficient quality for this synthesis, but the relationship between the researcher and participants was not clear in 4 articles, and 2 did not reflect upon ethical aspects. Other unclear aspects in some studies were the appropriateness of the research design and data recollection, and the rigour of the data analysis (Table 1).

The database search and article evaluations were led by LLS (steps [2] and [3]), although meetings were held with all the authors throughout the process to reach consensus in decision-making.

2.4 | Data abstraction and synthesis

A critical reading of the included studies was conducted to describe the objective, sample, methodology, data collection method and key results (Table 2). Next, first- and second-order concepts (Schütz, 1962) were extracted by LLS and SFB and transcribed in table format (step [3]). This step facilitated intra- and inter-study comparisons using defined study characteristics (step [4]). These findings were incorporated into one another by analogous (concepts in one study can incorporate into those of another) and refutational (concepts in different studies contradict one another) translations to form new third-order concepts (Schütz, 1962) in step [5]. The analysis process was iterative and involved moving back and forth within the sample data, comparing and contrasting the findings from the individual studies, and translating the findings into one another. A storyline of the phenomenon was developed in step [6] which was the basis for the line of argument synthesis (France et al., 2019; Noblit, 2016). All authors agreed on the themes and the overarching metaphor.

The Confidence in the Evidence from Reviews of Qualitative (CERQual) research tool (Lewin et al., 2015) was used to assess the findings of this synthesis which is helpful for decision makers and other users to determine their degree of confidence in the review findings (Table 3). Results of this evaluation were based on the methodological limitations of the primary articles as well as the coherence, relevance and adequacy of the data.

3 | FINDINGS

The meta-ethnography sample consisted of nine qualitative primary articles located in the United Kingdom ($n = 3$), Australia ($n = 2$), the United States ($n = 1$), Israel ($n = 1$), Malawi ($n = 1$) and Sweden ($n = 1$). The total number of registered participants was 138, ranging from 3 to 32 participants, among which we found registered nurses ($n = 88$) and nursing students ($n = 50$). The set of articles had qualitative research designs with different hermeneutical, descriptive and reflective phenomenological approaches. The data collection techniques were in-depth and conversational semi-structured interviews, as well as participant and non-participant observations (Table 2).

Next, interpretive findings of the synthesis are presented under the themes (1) forces to get involved in care, (2) the cost of caring and (3) need to vent. Table 4 shows the contributions of each of the primary articles according to themes.

The Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool (Lewin et al., 2015) showed moderate confidence in *Forces to get involved in care* and *Need to vent*, whereas the CERQual assessment of confidence for *The cost of caring* is high. This means it is likely that they reasonably represent the experiences of nurses and nursing students in the face of emotional demands that arise when caring (Table 3).

3.1 | Forces to get involved in care

Caring beyond the technique entails the emotional involvement of the professional moved by different forces such as vocation, feeling of professional duty and the humanisation of patients. Both registered nurses and nursing students use them to cope with difficulties presented during care.

3.1.1 | Vocation

The natural inclination that nurses and nursing students felt when caring acquired great relevance and empowered them to face complex care situations (Arieli, 2013; Msiska et al., 2014). Despite the economic retribution that they could acquire for carrying out their work, the vocation allows them to remember the reason why they chose nursing as a profession and also encouraged them to continue advancing and growing as future professionals (Anderson & Morgan, 2017; Arieli, 2013; Hayward & Tuckey, 2011). In the following quotation, we can observe how this nursing student maintained her integrity thanks to the emotional work fostered by her own internal motivation of wanting to be a nurse, as well as the satisfaction of being able to help others, despite the difficulties that arose (Arieli, 2013):

> I came across very difficult situations like bathing a patient whose legs are cut off… There were moments when I nearly broke down, but I did not let it happen… I need to look at everything in proportion. And I'm really strong. And I want to be a nurse. It is something I feel inside me. I feel good when I help and treat people… patients who are close to the end of life and you are the only person that treats them… to give them respect. You feel satisfaction.
>
> (Arieli, 2013)

However, the involvement in care was a great emotional burden for the nursing community (Gray, 2010). In Staden (1998), emotional labour was indicated as a demanding part of care comparable to physical labour. Despite this, the technical part continues to be the most visible and easier to record.

3.1.2 | Feeling of professional duty

The feeling of professional duty was another incentive to strive for and get involved in caring. This feeling of duty was seen by nurses and nursing students as a 'have to do' for the mere fact of being part of the nursing staff (Anderson & Morgan, 2017; Staden, 1998). The

TABLE 2 Characteristics of included studies

Authors, (year), location	Methods	Aim	Sample	Data collection method	Key findings
Albinsson and Arnesson (2019) Sweden	Hermeneutically interpreting epistemology and an abductive approach	To elucidate the emotion work as experienced by a group of nurses who tried out a customised form of a person-centred care model.	10 nurses	Semi-structured interviews and observation	The most important empirical finding is the identifying of emotional caring as a specific part of the nurses' emotion management, comprising such knowledge that is specific to the competence of nurses. Emotional caring thus forms part of caring science, affected by the organisational structure, with bearing on the nurses' room for caring actions, that is, how, when and in what way emotional caring can be carried out. Moreover, in practice, person-centredness was compatible with the commonly shared values in caring science. The empirical material also shows that emotion management can be tied to profession, positions, status and power
Anderson and Morgan (2017) USA	Qualitative research	To explore the age-based strategies that nurses in three age-groups (younger, middle-aged, and older adults) use to perform emotionally laborious tasks.	32 nurses	Semi-structured interviews	The strategies employed for dealing with emotional labour differed between the age-groups in terms of the level of acting expressed (e.g. deep and surface) as well as the confidants selected to discuss workplace emotions. There were also several common strategies that were enacted by nurses from all age-groups when confronted with emotionally taxing situations, including the use of religion, transcendence and compartmentalisation.
Arieli (2013) Israel	Inductive qualitative research	To learn how students experience clinical placements in a setting of diversity and how they cope with the emotional challenges involved.	20 nursing students	In-depth interviews	The students' experiences are characterised by emotional strains of various sorts – stress, ambivalence, disgust, frustration and conflict – that arise in three types of relationships: relationships with patients, with the clinical instructors and with other students who are on their teams. The data show that diversity has an impact on all these relationships. The data further show that the students cope with the emotional strains by using several strategies of emotional work: distancing, self-strengthening, self-motivation work and minimising significance.
Cecil and Glass (2015) Australia	Qualitative research	To investigate nurses' perceptions of emotional protection and regulation in patient care delivery	5 nurses	In-depth semi-structured interviews	Nurses' emotional regulation demonstrated by a 'professional face' was an important strategy to enable delivery of quality care even though it resulted in emotional containment. Such regulation was a protective mechanism employed to look after self and was critical in situations of emotional dissonance. The results also found that nurses experience emotional dissonance in situations where they have unresolved personal emotional issues and the latter was an individual motivator to manage emotions in the workplace.
Gray (2010) UK	Exploratory qualitative study	To look at nurse narratives on emotional labour and explore the gendered nature of emotional labour	16 nurses and nursing students	In-depth semi-structured interviews	Emotional labour is a vital resource for the development and maintenance of functioning in the health services. Gender stereotypes of the healthcare profession certainly reduce financial rewards, the movement towards professionalisation, and the visibility of emotional labour. Difficult issues and problems with others (patients, other staff, other students or family members) were discussed and resolved using shared experiences of the emotional labour involved with nursing.

TABLE 2 (Continued)

Authors, (year), location	Methods	Aim	Sample	Data collection method	Key findings
Hayward and Tuckey (2011) Australia	Qualitative study	To understand *how* and *why* work-related emotions are managed dynamically in situ	12 nurses	Semi-structured interviews	The manipulation of emotional boundaries, to create an emotional distance or connection with patients and their families, emerged as a nascent strategy to manage anticipated, evolving and felt emotions. The emotional boundary perspective offers possibilities for knowledge development that are not rooted in assumptions about the authenticity of emotion or the professional self but that instead account for the dynamic, complex, multi-layered and adaptive characteristics of emotion management.
Msiska et al. (2014) Malawi	Hermeneutic phenomenological study	To investigate the clinical learning experience of undergraduate nursing students in Malawi to explore their perceptions of the experience	30 nursing students	Conversational interviews	The clinical learning experience is suffused with emotions and students appear to engage in management of emotions, which is commonly understood as emotional labour. Emotional labour is evident in students' narrative accounts about their caring encounters, death and dying and caring-learning relationships as they interact with clinical nurses and lecturers during their clinical learning experience.
Staden (1998) UK	Phenomenology	To recognise and value emotional labour and skills involved and embodied within it. To deliberately revalue the caring component of nursing	3 nurses	Semi-structured interview	The nurses recognised emotion work as work but also that this type of work is not recorded. Learning the skills used in managing emotions was attributed to experience. All three women demonstrated a positive self-evaluation of their work, however, they felt that the society did not value care work.
Waddington (2005) UK	Qualitative study	To explore the role of gossip in the expression and management of emotion in nursing work	10 nurses	In-depth semi-structured interviews	Gossip is a feature of nurses' emotional labour in that it provides the opportunity for the expression of authentic feelings about patients and colleagues, which cannot be expressed in public, and which occurs 'behind closed doors'. These findings advance our understanding of how nurses carry out the emotional labour associated with their work in an inter-professional context.

Abbreviation: USA, United States of America.

TABLE 3 Confidence in the evidence from reviews of qualitative research (CERQual) evidence profile[a]

Summary of review findings	Studies contributing to the review findings	Methodological limitations	Coherence	Relevance	Adequacy of data	Overall CERQual assessment of confidence	Explanation of decision
Forces to get involved in care	Albinsson and Arnesson (2019), Anderson and Morgan (2017), Arieli (2013), Gray (2010), Hayward and Tuckey (2011), Msiska et al. (2014), Staden (1998)	Minor concerns regarding methodological limitations since there is a lack of clarity regarding the influence of the researcher in the investigation, and vice versa in 4 studies	Minor concerns regarding coherence (data very consistent within and across studies)	Minor concerns regarding relevance (two studies present a broader approach than patient care, including the relationship between student and clinical instructor)	Moderate concerns about adequacy of data (Only one study sample includes nurses and nursing students. Also, one study covers a small sample of participants)	Moderate confidence	Minor concerns about coherence, relevance and methodological limitations; Moderate concerns about adequacy of data
The cost of caring	Albinsson and Arnesson (2019), Anderson and Morgan (2017), Arieli (2013), Cecil and Glass (2015), Gray (2010), Hayward and Tuckey (2011), Msiska et al. (2014), Staden (1998), Waddington (2005)	Minor concerns regarding methodological limitations since there is a lack of clarity regarding the influence of the researcher in the investigation, and vice versa in 4 studies	Very minor concerns regarding coherence (data very consistent within and across studies)	Minor concerns regarding relevance (two studies present a broader approach than patient care, including the relationship between student and clinical instructor)	Minor concerns about adequacy of data as the richness of data was generally good	High confidence	Minor concerns about methodological limitations, coherence, relevance and adequacy of the data
Need to vent	Albinsson and Arnesson (2019), Anderson and Morgan (2017), Arieli (2013), Cecil and Glass (2015), Hayward and Tuckey (2011), Staden (1998), Waddington (2005)	Minor concerns regarding methodological limitations since there is a lack of clarity regarding the influence of the researcher in the investigation, and vice versa in 4 studies	Minor concerns regarding coherence (data very consistent within and across studies)	Minor concerns regarding relevance (One study present a broader approach than patient care, including the relationship between student and clinical instructor)	Moderate concerns about adequacy of data (two of the studies have small samples of participants)	Moderate confidence	Minor concerns about coherence, relevance and methodological limitations; Moderate concerns about adequacy of data

[a]Definitions of levels of confidence from the CERQual evaluation (Lewin et al., 2015): (i) High confidence: It is highly likely that the review finding is a reasonable representation of the phenomenon of interest. (ii) Moderate confidence: It is likely that the review finding is a reasonable representation of the phenomenon of interest. (iii) Low confidence: It is possible that the review finding is a reasonable representation of the phenomenon of interest. (iv) Very low confidence: It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

following nurse understood her ability to influence their patients, and her sense of importance led her to use a sense of humour as a tool to get closer to them (Anderson & Morgan, 2017):

> I always try to bring a smile on my face. I always try to bring a sense of humour and I always treat them like they are my personal responsibility and I will bend over backward to help them through this, because they're probably scared.

The presence of a smile or humour in the professional facet of them did not show their real feelings, but rather those that are part of the professional face (Anderson & Morgan, 2017; Cecil & Glass, 2015). Caring for patients meant 'suppressing any feelings that you may have and because you are a nurse and you have that uniform on, you dress for the occasion, you dress to care' (Staden, 1998). This emotional dissonance created uncertainty about the way in which they should act as nurses (Cecil & Glass, 2015; Hayward & Tuckey, 2011).

Specifically, managing emotions was a problem for younger participants, where professional experience was identified as a key element to improve emotional regulation (Albinsson & Arnesson, 2019; Anderson & Morgan, 2017). In addition, the nursing students highlighted the need to maintain contact with the patients in the early stages of their training to develop emotional regulation and empathy with the patient (Gray, 2010).

3.1.3 | Humanisation of the patient

Humanisation of the patient enhanced the emotional and cognitive connection with the patients and therefore, constituted an incentive to get involved in care that goes beyond technique (Albinsson & Arnesson, 2019). Quality care was identified with a holistic conception where the patient was seen as a human being beyond the disease and whose care requires more than the execution of techniques and tasks (Albinsson & Arnesson, 2019; Hayward & Tuckey, 2011).

The involvement in care originated in part of the nursing staff a response of rejection towards those who did not perform humanised care (Anderson & Morgan, 2017). On numerous occasions, nurses described task-based care governed by mechanised actions and lacking feeling. These actions, far from the humanisation of care, led to a cold and unflattering environment for communication with patients (Albinsson & Arnesson, 2019; Gray, 2010).

> That's the way I treated all of my patients because they were someone's, mother, they were someone's grandmother and it irritated me beyond belief when people didn't, when they treated them like they didn't care. They were just trying to hurry up and get them on the toilet and get them off, get them in the bath and get them back in bed, so they could go smoke their cigarette that irritated me a lot.
>
> (Anderson & Morgan, 2017)

3.2 | The cost of caring

Care beyond the tasks involved a great effort and an emotional burden for nurses and nursing students.

The experience of painful situations in their personal life or the low value given to emotional labour, led to multiple ways of acting (Cecil & Glass, 2015). Enduring emotional work overtime caused an emotional burden that was difficult to handle and that had an impact on the control of expressions and manifestations of nursing staff. Some nurses and nursing students were able either to show their real emotions as they are felt or to provide task-based care devoid of emotion and feelings when they did not have the necessary strength to get emotionally involved (Albinsson & Arnesson, 2019; Cecil & Glass, 2015; Hayward & Tuckey, 2011; Staden, 1998; Waddington, 2005). Thus, it was made visible how the emotional exhaustion that the continuous control of emotions supposes could lead to an emotional disability derived from a need for self-care (Hayward & Tuckey, 2011).

In the case of students, the emotional burden, the execution of tasks and techniques, and inexperience made it difficult to manage emotions (Msiska et al., 2014). As this student highlights:

> There is really a high workload yah… You have so many patients… And then you are just a student, you just have to do whatever the nurses want you to do… So, you are forced to do so many things… So, the workload is really too much.

3.3 | Need to vent

The non-exposure to the suffering of patients was the strategy adopted by the staff to be able to rebuild emotionally and thus return to provide comprehensive care.

Emotional distancing and isolation were a coping strategy common to several participants with which they were able to get away from the emotional burden and pressure of caring (Cecil & Glass, 2015; Hayward & Tuckey, 2011). The creation of borders is an example of compartmentalisation of public or professional and private life (Anderson & Morgan, 2017; Staden, 1998), as reflected by this nurse:

> The only impact they have is when I unwind when I get home. Sometimes I have frustration or sadness, but I try to get rid of that on the way home. The 10 minutes I have from the facility to my house and then I take a couple of deep breaths and let the day wash by.
>
> (Anderson & Morgan, 2017)

On the other hand, nurses also reported that sharing and talking about experiences with confidants freed them from emotional burdens and pressures (Anderson & Morgan, 2017; Waddington, 2005). Among the confidants, relatives of the nurses and other professionals

TABLE 4 Themes distribution

Articles	Themes		
	Forces to get involved in care	The cost of caring	Need to vent
Albinsson and Arnesson (2019)	•	•	•
Anderson and Morgan (2017)	•	•	•
Arieli (2013)	•	•	•
Cecil and Glass (2015)		•	•
Gray (2010)	•	•	
Hayward and Tuckey (2011)	•	•	•
Msiska et al. (2014)	•	•	
Staden (1998)	•	•	•
Waddington (2005)		•	•

Note: Symbols: ● Yes.

stood out who, in both cases, 'It allows the release of feelings, discussion of the feelings' (Waddington, 2005).

Anderson and Morgan's (2017) study emphasises the benefits on the mental and emotional health of nurses when the organisation favours resources in which nurses could express their emotions and opinions.

3.4 | The line-of-argument synthesis

The studies were combined to provide a line-of-argument synthesis that elucidated the experience of registered nurses and nursing students regarding the management of emotional labour in care situations. Three themes were synthesised in the metaphor *The link between task-focused care and care beyond technique*. This metaphor illustrates two chains in a dynamic process of approach and distancing. Care beyond the performance of tasks implies the emotional involvement of nursing in the care and the creation of bonds. It is in task-focused care where encounters and emotional connections with patients are not prioritised as a way to avoid suffering. Nurses and nursing students are represented as the link that holds both chains together.

The dynamism of this 'push and pull' activity between task-focused care and care beyond technique is given by the forces of approach and distancing related to each other. The first phase or phase of closeness between both chains represents the internal force that pushes and empowers nurses to get involved in care and go beyond techniques (*forces to get involved in care*). These forces are constituted by the vocation, feeling of professional duty, and humanisation of the patient, and allow nurses and nursing students to hold both chains together. In the intermediate or tension phase, exhaustion and the personal cost of being involved in care (*the cost of caring*) are manifested. Metaphorically, it represents the physical and emotional exhaustion that holding and keeping the chains together causes in the participants. The final or distancing phase is necessary for nurses to replenish themselves in order to be able to re-engage in patient care (*need to vent*). This represents the fact that nurses and nursing students let go of the chain of caring beyond technique to sustain only that of task-centred care (Figure 2).

4 | DISCUSSION

The metaphor 'The link between task-focused care and care beyond technique' (Figure 2) represents the experience of registered nurses and nursing students regarding the management of emotional labour when in care situations. Nurses and nursing students are represented as the link between the tasks-focused care and the provision of care beyond technique. Ideal care is one that requires the chains to stay together. Nurses and nursing students found strength and motivation in themselves and in the interaction with patients to keep such chains together. However, the emotional cost associated with the involvement of the participants in care is supposed to loosen the chain of care beyond the techniques. Task-centred care resulted from the difficulty of facing emotionally demanding care situations, the cost of which affects the emotional integrity of the participants. That is why there is a need for venting and distancing that allows them to emotionally reconstruct themselves and to re-engage in care, or metaphorically, to hold again both chains.

Eriksson (1994) presented in the Caritative Caring Theory the *caritas* as a basic motive of care, which constitutes the internal force that is related to the mission to assist, as well as one's love for others and for oneself. She established that care must be based fundamentally on the conception of the human being as an indivisible entity of body, soul and spirit, and go beyond a biomedical approach (Eriksson, 2002). Our findings show the internal motivation that the participants feel to help and serve the patients. An 'internal duty' identified as the main component of all care, and named by Eriksson (1994) as *ethos*. However, findings also show the personal cost for nurses and nursing students of providing care that goes beyond the performance of techniques.

Excellence in nursing practice is understood as the provision of comprehensive care (Lindström et al., 2006). According to this, Henderson (2001) adds the emotional commitment of nurses to

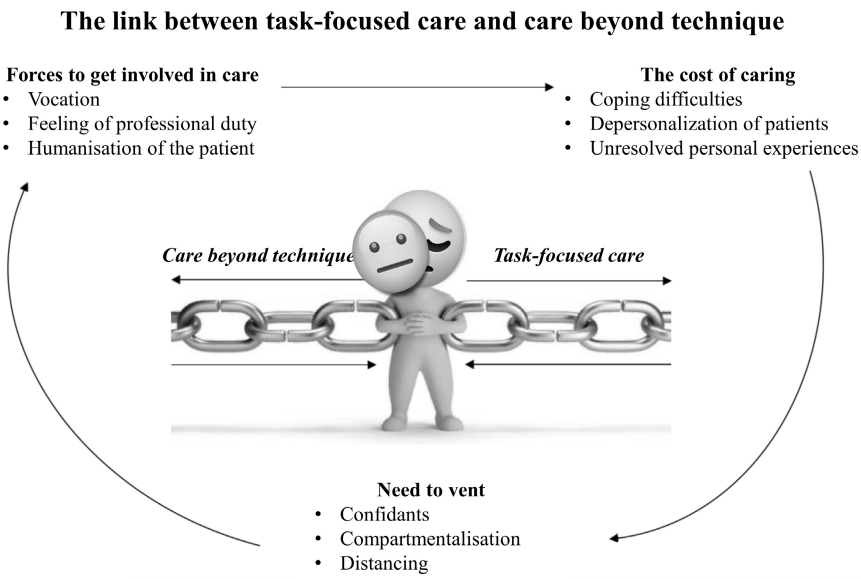

FIGURE 2 The link between task-focused care and care beyond technique

their patients that contributes to the quality of nursing care. The participants considered emotional labour as a fundamental and indisputable part of nursing work. According to Hochschild (1983), emotional labour refers to the effort made by workers to induce or suppress certain feelings in order to express the expected feelings. The use of emotional labour in the interaction with patients was identified in our findings as a tool to display feelings that are socially recognised as appropriate. This refers to Hochschild (1983) sentiment rules between 'what I feel' and 'what I should feel'. Besides, the findings support Descartes's idea of separating the rational mind from the emotional body, distinguishing between nursing involved in care and nursing focused on performing tasks, in a biomedical context (Eriksson, 2002; Huynh et al., 2008; Smith, 1991, 2011).

The social context also presents related feeling rules (Theodosius, 2006, 2008). Nursing, within the limits of the rules of professional feelings, maintains autonomy in the provision of care, which allows going beyond these rules and its professional function (Hochschild, 1983), adding an 'additional something' to the interaction with patients. This was identified as a *gift* by Bolton (2000) and is palpable in our findings through humour as a way to relieve tension. Nurses offered this humour as an *extra gift*, being rewarded with the feeling of well-being that the patients transmit and that provides them with an incentive to continue to be involved in the care.

The visibility and value contributed to this emotional aspect is relegated both in clinical practice and in training (Smith & Gray, 2001). The female image of the nurse as an angel or as a mother who exercises natural care exempts the relevance of emotional labour (Henderson, 2001; Smith, 2011). The emotion was seen as weak and vulnerable, therefore it ended up being rejected, discriminated and socially undervalued. On the other hand, the use of continuous emotional labour led to the appearance of emotional dissonances caused by the involvement in care. The difference between 'what they feel' and the professional appearance resulted in a lack of harmony. The process of managing emotions contributes to exhaustion, considering the frequency and number of encounters with patients as its main cause (Brotheridge & Grandey, 2002). This feeling of being emotionally 'worn out' or 'burned out' was identified as Burnout Syndrome (Freudenberger, 1974). Given this, depersonalisation arises as a protective method against the cost of emotional demands. An adequate degree of emotional detachment and the performance of medical tasks were seen as necessary to balance emotional engagement with patients (Henderson, 2001).

4.1 | Strengths and limitations

Meta-ethnography allows adopting an interpretive approach with an inductive process that gives the findings a new perspective (Noblit & Hare, 1988). These findings have been developed by interpretively combining and synthesising results from primary studies, thereby creating a broader perspective of the experiences of registered nurses and nursing students in managing the emotional demands of care. Contemplating these experiences provides the study with a greater wealth of findings, which could be used in the development of professional support guides. This would benefit the nursing staff in their daily clinical practice. Furthermore, our findings may contribute to the strengthening of the training of future nurses, highlighting the need to include this aspect as a transversal competence in the training programs of the nursing discipline.

The elaboration of this meta-ethnography followed the eMERGe guide (France et al., 2019) providing methodological rigour and greater confidence in the findings (File S1). The quality of the primary articles collected was critically evaluated following the CASP checklist (Skills & Programme, 2018). Furthermore, the evaluation of the findings using the CERQual tool (Lewin et al., 2015) provided transparency and credibility to them.

On the other hand, an exhaustive search strategy without time limitation allowed updating and incorporating recent articles, giving the findings a broader vision. Back-and-forth tracking and manual

searches were also conducted. Despite the diversity of cultural contexts and geographical locations of our articles, language filters (English, Spanish and Portuguese) were able to exclude other demographic contexts relevant to the study. Other limitations were in the sample. In this sense, the sample of the primary articles incorporated was mostly female and belonged to hospital environments. The development of empirical research addressing such limitations would be relevant.

5 | CONCLUSIONS

The findings of this meta-ethnographic study show the experiences of registered nurses and nursing students regarding the management of emotional labour when in care situations. The metaphor 'The link between task-focused care and care beyond technique' are represented by nurses; and students are represented as the link between the tasks-focused care and the provision of care beyond technique. Care beyond technique is provided by nurses capable of becoming emotionally involved and treating patients from a humanised perspective. On the other hand, task-based care avoids emotional exposure to patient suffering. Nurses and nursing students metaphorically try to maintain both chains despite the emotional cost involved. However, venting and distancing are required to emotionally reconstruct themselves and to re-engage in care.

The little theoretical and practical training made it difficult for these nurses and nursing students to cope with emotionally demanding care situations. Thus, greater training is needed and the provision of resources to facilitate this confrontation is required.

6 | RELEVANCE TO PRACTICE

In the face of this situation, the nursing supervisor becomes highly relevant because it has functions capable of addressing this situation. The application of caritative leadership would favour the creation of a loving and feedback environment in which the nursing community would be given the opportunity to contribute opinions that may be relevant in decision-making (Bondas, 2003). On the other hand, our findings showed the close relationship between emotional work and professional experience. Benner (1984) highlighted the importance of learning skills of involvement and care through practical experience. Taking this into consideration, we recommend the implementation of more theoretical and practical training on emotional work and emotional management in the academic training of nursing students and registered nurses. In reference to the practical aspects of nursing, enacting comprehensive care will allow naturalising of the emotions experienced during the interaction that occurs in the provision of humanising practices.

It would be interesting to include in future lines of research the experiences and perspectives of patients in contrast to the experiences of nursing professionals. Empirical studies in which data collection is triangulated through the incorporation of the perspectives of patients and healthcare professionals could provide valuable information for the practice and training of future nursing professionals. Likewise, we propose to involve other groups of health professionals to acquire a wider vision of emotional management.

AUTHOR CONTRIBUTIONS

Conceptualisation, SFB, MJMF, LLS; methodology, SFB, MJMF, LLS; formal analysis, SFB, MJMF, LLS; investigation, SFB; resources, SFB, MJMF; data curation, SFB, LLS; writing – original draft preparation, SFB; writing, review and editing, SFB, MJMF, LLS; visualisation, SFB, MJMF; supervision, SFB, MJMF. All authors have read and agreed to the published version of the manuscript.

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CONFLICT OF INTEREST

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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