

# RECONSIDERING DETACHED CONCERN

*the case of intensive-care nurses*

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**ABSTRACT** The concept of detached concern, as proposed by Renée Fox in *Experiment Perilous* (1959), is often used in the literature today in a way she did not intend. Rather than viewing detachment and concern as dualities, scholars frequently conceive of them as dichotomous, emphasizing detachment over concern. We reconsider detached concern here through the stories 37 intensive-care nurses told about their most memorable patients. While many described efforts to keep emotionally distant from patients, they also expressed concern for patients they felt connected to, especially those who were a first for them, who were long-term primary patients, who surprised them, or who died. The care nurses provide for these patients is shaped sociologically by their training and institutional contexts and is not an aberration or indicative of their losing control of their feelings. Instead, it is evidence of the dual nature of detached concern and of the importance of viewing the concept as describing more than emotional detachment.

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IN HER NOW CLASSIC *Experiment Perilous* (1959), Renée Fox introduced the concept of detached concern: “In the ‘emotional aspects’ of his relationship with the patient,” “the physician is expected to maintain a dynamic balance between attitudes of ‘detachment’ and ‘concern.’” He is “to be sufficiently detached or objective toward the patient to exercise sound medical judgment and maintain his equanimity” while simultaneously being “sufficiently concerned about the welfare of the patient to give him compassionate care” (p. 86). Robert Merton wrote of a similar phenomenon in *The Student-Physician* (1957), arguing that the “physician must be emotionally detached in his attitudes toward patients, keeping ‘his emotions on ice’ and not becoming ‘overly identified’ with patients.” He must also, however, “avoid becoming callous through excessive detachment and should have compassionate concern for the patient” (p. 74).

Following Fox and Merton’s initial conceptions, numerous studies have described how health-care workers are trained for detached concern, how they maintain it, and what historical and contextual factors influence its practice (Carmack 1997; Coombs and Goldman 1973; Coser 1979; Hafferty 1998; Halpern 2001; Lief and Fox 1963; Mannon 1981; Olesen and Bone 1998; Smith 1992; Woodward 1997). Scholars have asked not only about physicians, but also about how nurses, emergency medical technicians, and a wide range of other health-care workers manage their emotions on the job (Mannon 1981). Many recognize that health-care workers’ management of their emotions is shaped sociologically by their different professional trainings, as well as by the institutional contexts in which they work (Hochschild 1983).

While Fox and Merton emphasized both emotional detachment and concern in their original conceptions, scholarly attention has emphasized the *detachment* part of the concept more regularly than the *concern* side of the equation (Coombs and Goldman 1973; Hay and Oken 1972; Mannon 1981; see Anspach 1993 and Grove 2008 for exceptions). As Fox writes in her autobiography: “The notion of ‘detached concern’ that I coined years ago . . . frequently appears in medical, medical education, psychiatric, nursing, and social-work literature . . . it is usually invoked in connection with discussions about how the care of patients by health practitioners can be more effectively ‘humanized.’” In many instances, however, Fox argues that the concept is

interpreted in a way that I did not intend . . . ‘detachment’ and ‘concern’ are defined as dichotomies rather than as dualities; ‘detached concern’ is considered to be a form of detachment; and it is viewed critically as representative of a traditional medical stance that places greater emphasis on cognitive detachment from patients’ feelings than on empathic emotional attunement to them. (pp. 101–2)

When scholars do pay attention to concern, they often conceive of it as health-care providers’ failure to cope. For example, in their 1973 study of intensive-care unit staff, Coombs and Goldman point to situations, like those with children, in which “patients elicited so much concern that an emotional detach-

ment was not maintained” (p. 349). Rather than seeing concern as related to detachment in the dualistic way Fox intended, they view it as the failure of detachment and as its opposite. Such emphasis in the literature likely reflects the difficulties health-care workers have (or scholarly observers imagine they have) maintaining distance rather than expressing concern. It also likely reflects the norms of detachment that dominate in many health-care workplaces, especially intensive-care units (Guillemin and Holmstrom 1986; Johnson and Martin 1968; Zussman 1992).

In this article, we reconsider the concept of detached concern with particular attention to *concern*. We describe which patients health-care providers feel concern for through the stories they tell about their most memorable patients. While providers could talk about difficult patients, technically challenging cases, or gruesome incidents, those we interviewed spoke almost exclusively about patients and their families that they came to feel close to in some way. The types of patients and situations they described center on those who were “firsts” for providers, who were long-term primary patients, who surprised them, or who were dying. We analyze these stories about patients for what they suggest about health-care providers’ social roles.

Our focus is on nurses, specifically nurses who work in the neonatal or medical intensive-care units at the same large academic hospital. Compared to physicians, nurses typically have been socialized into a distinct culture of care. Many, however, work in institutional environments that may, for reasons of time, money, technology, or other factors, make it difficult for them to express concern for patients (Bone 2002; Fox, Aiken, and Messikomer 1990; McQueen 2000; Olesen and Bone 1998). Studies of intensive-care nurses present contradictory evidence about the extent to which and ways in which nurses express concern. For example, in *Intensive Care: Medical Ethics and the Medical Profession* (1992), Robert Zussman describes doctors and nurses on a medical intensive-care unit as detached, “largely indifferent to matters of identity or character” (p. 43). Some nurses actually decide to work there, he argues, because the context privileges their technical skills and allows them to avoid getting involved in the emotional lives of their patients. Other scholars, like Joan Cassell in *Life and Death in Intensive Care* (2005) describe nurses in a surgical intensive-care unit as more emotionally involved with patients and families. While the physicians “focused primarily on curing disordered bodies,” Cassell writes, it was “the nurses who waved to patients . . . hugged patients, held their hands, embraced grieving family members” (p. 6). She continues: “It was the nurses I asked when I wanted to learn a patient’s family constellation or ‘story’” (p. 6). We do not address the extent to which the nurses we interviewed are detached and concerned; rather, we describe who they are concerned for and how they maintain that concern. Our goal is to rebalance the disproportionate attention paid to detachment in scholarly discussions of detached concern.

## BACKGROUND

The earliest sociological investigations of detached concern among health-care workers developed from Talcott Parsons's (1951) analysis of the medical system. Parsons used the term "affective neutrality" to describe how physicians attempted to avoid over-sympathizing with patients, treating them instead in objective "scientifically justifiable" terms (p. 435). Believing this approach overemphasized detachment, Renée Fox in *Experiment Perilous* (1959) countered that "detachment" and "concern" needed to be in "dynamic balance." She and Harold Lief later wrote about how medical students are trained for detached concern (Lief and Fox 1963).

Over time, a range of scholars drew on the notion of detached concern, but they tended to emphasize the ways physicians and other health-care professionals are, or learn to be, detached, rather than caring and expressing concern for patients. Beginning with Sir William Osler, the late-19th-century "father" of modern medicine, some commentators argued that detachment was a necessary component of effective health-care provision and that emotional expressions undermined objectivity and the quality of care (Feldstein and Gemma 1995; Halpern 2001; Johnson and Martin 1968). However, many patients expect that health-care professionals will display a certain degree of empathy and concern towards them, and they place a premium on good social relations and emotionally supportive relationships, especially with nurses (Halpern 2001; Henderson 2001; Smith 1991).

Rather than considering broad social notions of detachment and concern in medical settings, we view detachment and concern as dual role obligations that are components of the work professionals face throughout the health-care system. These demands—to provide competent care for patients and to manage their own emotions—are not mixed in equal proportion for all professionals or patients, and they are strongly influenced by the norms and strains built into the structure of different health-care professions and institutions and the social roles of various providers. Physicians, for example, have long been trained to be more emotionally distant. According to Fox (1959), new doctors come to embody this perspective by a kind of intellectualization, whereby they focus on the scientific rather than emotional aspects of the work. Their ongoing coping strategies include the use of protective humor and scientific magic (see also Christakis 2003).

Although the concept of detached concern was developed to explain the feelings and behaviors of physicians, it has also been used to describe the experiences of nurses.<sup>1</sup> Tensions around care emerged in nursing with the development of the profession. Before World War II, nurses lived highly regimented lives,

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<sup>1</sup>Whether the concept actually fits health-care workers other than physicians is an open question best answered with comparative data from a range of health-care professionals. We argue here that nursing has a distinct history that has emphasized care much more than has the training received by physicians. That said, the concept of detached concern has been used by sociologists to explain the experiences of nurses, which is why we revisit it here.

in which they were expected to control their emotions (Reverby 1987). In the postwar context, women's changing labor market position created broader employment opportunities. Nursing leaders tried to retain women in nursing by developing the profession as "colleague of the doctor rather than the handmaiden" (Gow 1982, p. 2).

Some leaders tried to enhance the professional identity of nurses by creating a distinctive body of knowledge. Through this process, some nurses began to adopt the medical model of detached concern. Other nursing leaders, however, emphasized a separate and distinct role for nurses as "expressive specialists," likely more in line with their work historically. In this approach, doctors maintained their place as instrumental specialists, while nurses focused on building and maintaining therapeutic relationships as "the 'humanizer' of patient care" (Gow 1982, p. 6). These approaches granted different positions to the role of emotion, with the first subsuming the caring aspects to the more technical ones, and the second focusing more on the value of the caring component of the work. Since the 1970s, the amount of attention directed to care has increased in the nursing profession, as evident in textbooks, monographs, and throughout the work of nursing scholars. However, nursing shortages, increasingly sophisticated technology, burnout, and other factors continue to present barriers to nurses' expressing concern, and many nurses must negotiate these barriers throughout their work (Bishop and Scudder 1990; Chambliss 1996; Fairman and Lynaugh 1998; Fox, Aiken, and Messikomer 1990; Seymour 2001).

This negotiation is evident in several studies outlining the strategies nurses utilize to develop, and in some cases maintain, emotional distance from patients and families (see Bolton 2000). In a study of intensive-care unit nurses, Hay and Oken (1972) found that humor alongside "gross denial" was a common mechanism used to achieve detachment. Similarly Dan Chambliss (1996) outlined strategies nurses used to maintain distance from patients' suffering, including limiting entrance to the unit, following routinized rituals, and using humor as a means of tension release—. In her review of the research on stressors in palliative care settings, Mary Vachon (1998) highlighted the ways oncology nurses attempted to gain control over their surroundings, often by trying to set limits on some aspects of their work. Finally, in their study of dying patients, Glaser and Strauss (1965) found that while nurses experienced an impulse to comfort patients, they engaged in strategies of both "outright avoidance" and "expressive avoidance" to avoid emotional involvement in situations where they knew a patient was dying.

Nurses do this negotiation within a distinct culture of nursing that is almost exclusively female. This culture emerges from the daily hands-on care that nurses offer patients, through bathing, touch, and contact with private body parts and fluids (Wolf 1988). Fox and colleagues observe that nursing care is a continuum: "It entails an ongoing relationship to patients in all phases of illness and of the lifecycle" (Fox, Aiken, and Messikomer 1990, p. 230). While nurses sometimes use highly technical instruments in caring for patients, they also offer touch, a kind

word, and other more humanistic elements of care as they provide what tends to be more holistic care than is provided by physicians. “Ideally, a caring relationship with patients as defined by nursing,” Fox and colleagues argue, “entails a dynamic ‘turning toward the other’ meeting of nurse and patient through which the nurse enters and empathetically shares the patient’s situation and suffering” (Fox, Aiken, and Messikomer 1990, p. 232). Such an approach is taught through professional training and often reinforced by nursing colleagues on the job.

Maintaining a balance between detachment and concern in the context of this culture of nursing may be especially difficult, however, for nurses in medical contexts in which serious illness and death are prevalent, such as intensive-care units. In such contexts, norms of detachment are often publicly dominant among the staff. Emotional outbursts are discouraged because of the potential some believe they have to undermine care (Guillemin and Holmstrom 1986; Johnson and Martin 1968; Zussman 1992).

As a counter to this emphasis on detachment, we interviewed intensive-care nurses about their most memorable patients. The stories we heard of the patients and families they felt connected to and for whom they expressed concern clustered into four groups: patients who were a first in some way, who were long-term primary patients, who surprised them in some way, or who were dying.<sup>2</sup> Given the negotiations around care in the history of nursing, we were not surprised by these examples of concern. We offer them as a corrective to studies that emphasize only how nurses develop and maintain detachment.

### RESEARCH METHODS

Our attention to and the challenges nursing presents to the notion of detached concern currently used in sociological literatures developed when one of us (Wendy Cadge) shadowed and conducted interviews with nurses working in medical and neonatal intensive-care units at a large academic hospital. WC found nurses speaking of some patients in emotionally rich language not obviously indicative of detachment. For example, they described some current and former patients not by their illnesses or medical conditions, but by reference to family situations, funny stories distinct from gallows humor, and personal characteristics.

Based on these early observations, we asked 37 intensive-care nurses in interviews about the patients and families that were particularly memorable to them. All of the nurses worked at City Hospital, a large academic hospital located in a major northeastern metropolitan area and ranked as one of the best hospitals in the country. The nurses interviewed worked in the neonatal (N=20) or medical (N=17) intensive-care units at City Hospital, each with beds for 18 patients. Work on each unit is fast-paced, intense, and unpredictable. Staff members see

<sup>2</sup>These groupings are different from those described by Coombs and Goldman (1973)—children and those who were especially cooperative—as patients eliciting significant concern.

medically and ethically complex cases daily, and they are often required to work with families to make difficult decisions. Death is common: at about 20%, or three to four of the 18 patients in the medical intensive-care unit and about one baby per month in the neonatal intensive-care unit dying per month. Both ICUs practice primary nursing, assigning nurses to specific patients that they stay with throughout their hospitalization (see also Cadge, n.d.).

Between October 2005 and June 2006, when these interviews were conducted, the neonatal ICU employed a total of 60 nurses and the medical ICU 65. E-mails and signs posted in the unit invited all of the staff nurses to participate in this research project about “personal beliefs and work.” Participants were offered two free movie tickets or \$10 gift certificates to the hospital coffee shop in exchange for an in-depth interview. Individual nurses suggested other nurses who might participate, and reminder e-mails about the study were sent until no further nurses came forward to be interviewed.

The first author (WC) conducted in-depth semi-structured interviews, which included questions about each respondent’s personal background, experience in the ICU, memorable patients, self-care, and personal beliefs. Most of the interviews took place in a private conference room, either during or immediately before or after a shift. All of the interviews were recorded and transcribed. The data analyzed here was gathered in response to questions about which patients and families stood out for nurses as particularly memorable. We intentionally did not ask about nurses’ connections and detachments from patients more directly, fearing that we would get idealized responses not indicative of their lived experiences. The data was then coded inductively. In contrast to other strategies for analyzing qualitative data, this approach relied on the data to direct our attention to key themes that showed us when nurses developed emotional connections (Emerson 2003).

Demographically, all but three of the nurses interviewed were women, almost exclusively white women. All had first degrees in nursing—either an RN, BA, BS, or some combination—and about one-fifth had or were working on second degrees like MAs. All had experience nursing before starting in the intensive-care, sometimes after completing intense hospital-based training programs. Some nurses had worked in other units at City Hospital before starting to work in the intensive-care unit. Each nurse worked eight- or 12-hour shifts, often alternating between days and nights, for 40 hours per week on average. Nurses ranged in age from their early 20s to their mid 60s, with the medical ICU nurses in their mid-30s and the neonatal ICU nurses in their mid-40s on average. Likely as a result of their ages, the nurses in the neonatal ICU had been nurses, had worked at City Hospital, and had worked in the neonatal ICU for longer than the nurses in the medical ICU. Nurses in the neonatal ICU had almost twice as many years of experience in intensive-care (13.8 years) as did those in the medical ICU (7.5 years).

## FINDINGS AND DISCUSSION

Nurses who worked in the neonatal and medical intensive-care units were clear—as evident in current literatures—about their overarching efforts to keep some emotional distance from their patients. They described their efforts to provide compassionate care but also spoke of trying to maintain emotional space using the language of professionalism, boundaries, or survival—what they need to do to continue working there. Despite such attempts at distance, however, most described experiences with and memories about some patients that stick with them long after the patient leaves the hospital.

Dottie, a long-term nurse at City Hospital, explained: “I think that what has helped me all these years is to build a wall . . . not to get too emotionally attached to patients.” Her wall has not been complete or indestructible, however: “there have been certain patients that have just tumbled that wall down . . . for the good or for the bad because sometimes they’re going to die and that breaks your heart.” In some situations, it was patients’ attitudes or behaviors that led her wall to crumble, while in others it was the length of time she knew the patients or the intensity of the experience they shared.

Most of Dottie’s nursing colleagues shared her attempts to maintain emotional distance but still had the occasional patient or family that breached the emotional divide. As they described particularly memorable patients, the nurses interviewed spoke about four categories of patients and families with whom they became more emotionally involved than detachment-heavy notions of detached concern would suggest. Rather than describing these individuals in detached clinical language, in terms of their medical diagnoses, or through gallows humor, what dominated the stories the nurses told was the details of the patients’ personalities, families, and the experience of caring for them.

*Firsts*

Several intensive-care nurses remembered patients who represented firsts for them—the first time they used particular treatments, or their first primary patient. Tamara, for instance, spoke of the first child she treated who went on ECMO (extracorporeal membrane oxygenation), a heart-lung bypass machine used to treat some of the sickest infants in the unit. Pointing to the corner of the unit where she cared for this baby many years ago, Tamara illustrated the holistic care nurses provide when she spoke of his kind parents, the thanks they heaped on the unit when he survived, and how much she enjoys seeing this family at yearly reunion picnics the unit hosts for children who were on ECMO. Many other nurses talked about the connections they developed with their first primary patients. Nancy became a godmother to her first primary patient: “I got very close to her. It was the very first primary patient I had in the NICU and I took care of her for 8 months . . . I became her godmother because she was dying,” but she did not die. “Now I’m Mama Nancy and I go to her birthday



party every year and we keep in touch.” Joanne similarly remembered her first primary patient—his delivery, how sick he was, and the next two months she spent with him in the unit. Like Nancy, Joanne stayed in touch with this family: “His parents will drop me an e-mail picture” now and then.

Linda says she will “never forget” her first primary patient who lived for three months before she died. Linda was very attached to the baby and went to her funeral: “it was the first and last infant funeral I’ll ever go to.” Struggling to make sense of the baby’s death, she listened closely to the priest at the funeral who said everyone is born and lives for a reason. She struggled to find meaning in this child’s life concluding both that the baby showed her parents unconditional love and that she needed to not get so close to patients and families in the future: “You work here you have to care for the families but you can’t get too close . . . or you’ll burn out right away.”

#### *Long-Term Primary Patients*

Many of the nurses spoke of relationships they developed with patients that they took care of as primary patients for months, getting to know their personalities, their families, and their stories. As with patients who were “firsts,” these examples show nurses developing bonds with families, not just with patients. These are the cases, several nurses explained, that take the most out of them, because they get so close. They are also the cases they find most rewarding in their work, because they show the difference they can make as nurses. In the medical ICU, several nurses spoke of a young patient they had recently treated who had her second liver transplant on what was to be her wedding day. Judy explained that she was “here for months and was so close to death so many times.” It was a “huge, long process that nobody knew which way it was going to go.” Judy and several others nurses spoke at length about how close they got to the patient’s family during this process, visiting with them on the unit and staying in touch after she was released following a successful transplant.

Other nurses similarly described the emotional attachments they formed with long-term patients and their families. In recounting the story of a baby she took care of for seven months before he went home, Peggy says: “the ones that stand out the most” are those that “take the most out of me—the most effort to get them out the door.” Peggy became close to this family, keeping in touch and exchanging photos as the baby grew. Similarly, Jennifer spoke of a baby she took care of for three months before he went home: “I got close to the family . . . I still keep in touch with the family like through e-mail . . . they stood out because they were there for so long and I really kind of got attached with the family.” Nancy cared for a woman for six months in the medical ICU. “I got a little involved,” she said with a laugh, implying that she got very involved with the patient, her husband, and their three children. The patient went to a rehab hospital before she returned home, where Nancy visited her. She continues to hear from her now and then.

Unlike in pediatrics, where patients are transferred from the neonatal to the pediatric ICU when they reach a certain age, nurses in the medical ICU take care of some patients (and their families) over multiple hospitalizations, getting to know them and their situations intimately. While this may also be the case for physicians, it is the daily hands-on care nurses provide that nurtures and supports their relationships. “I have a primary patient that has a pretty catastrophic illness,” Dottie explained, “but he’s dealt with it all his life. He comes in and he tells the doctors in the university what needs to be done and he is always smiling. You feel like you can never forget him. I think those are the kind of patients that I remember the most.” While Dottie remembered a patient she got to know over multiple admissions who handled a difficult situation with grace, Angela remembered families who do the same. In caring for a patient with cystic fibrosis on and off over a period of time, she explained: “I became really close with his family and they would send me cards for Nurses’ Day and they wrote me beautiful letters telling me how thankful they were for everything I did for them.” Angela maintained a relationship with this family for several years, even after the patient died.

In the emotional connections they described with patients and families, nurses spoke of making a difference in more and less explicit ways through the daily hands-on physical care they provided. Illustrating an explicit way, Lillian spoke at length about a patient she cared for as a young nurse who was frequently in and out of the hospital. She got to know him and his family, teased him, and played practical jokes on him with a group of nurses (which he reciprocated). One morning this man was in the ICU and went into cardiac arrest while attempting to use the urinal:

I heard the red alarm . . . ran down to his room, there was a doc, a therapist, a couple of nurses in the room, and they had the fibrillator and they were all standing. . . . I grabbed the paddles and people were like “You can’t do it here, there’s water.” I said, “Throw towels under my feet or whatever.” And I defibrillated him and he opened his eyes and said “thanks.”

Not only did Lillian deal with urine in this story, but she took a personal safety risk in providing care to this patient.

In a similarly dramatic and equally explicit example, Christina pointed to the unique responsibilities of caring for infants when she described a severely ill infant who was close to going home and then had to have emergency surgery. Describing her relationship with the child’s mother, Christina said, “to see them [his family] come back to visit us and the look on their face like—I single-handedly fixed J.! I wasn’t in the OR, I didn’t perform the surgery, but in her [the mother’s] eyes I was one of the people that, you know, got J. through this . . . these kids will stay with you forever.”

It is not just the experiences but the items families sometimes give to nurses that reinforce the memories and emotional connections they develop. J.’s mother gave Christina a scrub shirt as a thank you gift, “And I wear it all the time and

I'm like 'Thanks J.'" Lillian developed a close relationship with a patient and his family while he was in the hospital:

He had this [stuffed] frog . . . I don't know, his pregnant daughter had put on the bed or whatever. And I came in on Monday morning and I walked into the unit and the frog is sitting on top of the monitors. And I knew he had died. I was like, "Oh my God." And one of the nurses came up to me and said, "His daughter wanted you to have the frog." So I mean, things like that you remember.

For Lillian, the frog symbolizes the closeness she developed with this family. In addition to the notes and cards they sometimes receive from patients and families, these small gifts are a connection to people they worked with closely, and they create and signify particular memories for nurses.

### *Surprises*

In addition to firsts and long-term primary patients, a number of the patients and families nurses remember and feel close to are those that surprised them in some way. Nurses in the neonatal ICU talk about the patients they call "miracle babies"—those that they expected to die but lived. These stories follow a similar trajectory, in which a baby is admitted with serious problems, often takes a turn for the worst, is expected to die, and then does not. For example, Lisa described the personal background and experience of a baby who was "incredibly sick" and was put on ECMO. "We thought . . . she's going to die the minute we take her off ECMO." The staff waited for the baby's parents to arrive before turning off the machine, "and those two hours waiting for the parents to come in were the worst two hours of my life." When they actually turned off the machine, Lisa remembers, "we waited and we waited and we waited and we waited and she didn't die. And one day turned into two days and two days turned into three days and she survived and was perfectly 100% healthy. I'll always remember her because she was an unbelievable miracle." Sarah similarly describes "the miracle babies," calling some by name: "ECMO, you know those babies without ECMO wouldn't be here." Christina and Judy described the same "miracle" patient: the staff "told his family millions of times that he may not live and he's home now and he's doing fabulous." It is not just these baby's survivals that nurses describe in these examples when they speak of them, but their own emotional roller coasters as connected to the infants that happened in the process.

Unlike in the neonatal ICU, nurses in the medical ICU remembered and felt close to patients who died but whom they expected to live, especially younger patients. Angela described a 35-year-old woman that she took care of for several months before she improved and was transferred from the ICU to a regular hospital floor: "She got better, went to a floor . . . all the problems that brought her to the ICU had resolved." When she was a few days away from going home, however, she unexpectedly developed a head bleed and died. "That was probably the most devastating day," Angela recalled, "I cried a lot on that day in the

unit.” Rob talks about these kinds of surprise cases more generally as what makes particular patients stick out for him because of the impact they have: “Something major happened [with a patient] and you remember that, forever.”

### *End of Life*

The final group of patients and families nurses described as especially memorable and with whom they developed personal connections are those they accompanied through end-of-life situations. Rather than the themes of saving evident in some of the earlier stories, nurses made clear in their descriptions of end-of-life situations what they bring to these patients/families: support in creating or repairing bonds between people before someone dies, support through the decisions often involved when someone dies in a hospital, and their physical presence and sometimes touch at the time of death. In the words of Marilyn, the most memorable cases are those in which the patient dies: “You pretty much remember just about every patient you’ve gone through that with and every family you’ve gone through that with.”

Several nurses in both units told stories about helping to create or repair relationships before a patient died, thus reinforcing the important roles they play with families. In the neonatal unit, these stories often focused on helping parents bond with their child. Abby spoke of a particular family she worked with for several weeks whose newborn was going to die. She explained, “Part of my job is to create” a bond between parents, especially mothers, and infants, “to help families feel that bond, go through the process and be able to let their baby go. And this family was able to do that.” Parents are better able to grieve, she explained, when they have created this bond. In the medical ICU, stories tended to focus on repairing relationships or on creating memories for families before their loved one passed away. Barbara, for example, spoke about supporting an ill woman in her relationship with her adult son before she died, and Becky of helping to facilitate communication between a dying man and his former wife. “I really felt like I contributed to her healing for the rest of her life,” Becky reflected.

Similarly emphasizing family care and the personal relationships they facilitate, Barbara described at length how she worked with the palliative care team to create an environment in the unit in which a dying patient could spend his last few days with his large family, including his five-year-old daughter. She and others set up a nearby break room with crayons and coloring things, so this young girl could move back and forth between her father’s hospital room and her “little work room.” “She made pictures for everyone and I have one of her paintings that she made for me on my refrigerator. And it will probably stay there forever,” Barbara remembered, indicating how much this situation touched her personally.

Nurses also spoke of the patients they supported through the process of dying in the intensive-care unit, a highly medicalized process often involving different difficult decisions, as described by anthropologist Sharon Kaufman (2005). Nurses described attending family meetings and helping families understand and

talk through their options. A nurse in the neonatal ICU found this process especially difficult for children with neuromuscular defects, and she described supporting families and “really sitting with them” as they worked through the situation. A nurse in the medical ICU said she was similarly impacted by these situations in which “we sat down with the family, had family meetings, and made it a very peaceful process” of withdrawing care. Describing a particular patient she took care of for three months in the ICU, Tamara described supporting the family throughout the hospitalization, including going to the patient’s wake after he died. Abby similar described how she supported a patient’s wife, hugging her, talking with her, and explaining things to her throughout his last days: “It was a slower death but he was comfortable and she was able to spend a little time with him, like a month. . . . and I went to the wake and they were overwhelmed that I would come.” Most nurses spoke about just spending time with patients and families, while some also attended wakes and funerals, not regularly, but for those few patients and families with whom they felt a special bond.

Providing support, especially to families, as their loved ones died in intensive-care was not always easy or without conflict, and the difficult patients, families, and situations stayed in the minds of some of the nurses. “Even the challenging families . . . they can be very burdensome and the families are very needy . . . but I’ve become very close to them . . . and found that just talking to them and including them . . . you get a more empathetic view on things,” explained Marilyn. Laura spoke of several families who “really struggled” with their loved one’s dying, but to whom she continued to reach out while their loved one was in the hospital and through sympathy cards after the individual passed away. Nurses also described instances in which they helped to broker conflicts between patients and families and their physicians. Rob described supporting a family as they repeatedly made a patient’s wishes known to a medical team who was proposing additional invasive treatments that the patient would not want. Nancy described a situation in which the physicians wanted to withdraw care, but the patient’s wife wanted to continue treatments. The patient’s wife sat by his bed all day, and Nancy described sitting with her, rubbing her back and just being with her in silence as he “declared himself” and died.

Finally, nurses described especially memorable patients as those at whose deaths they were present, or which they helped to orchestrate in some way. Because death in ICUs has so much to do with turning off machines, it can sometimes be planned in ways that will be most meaningful for families. Judy spoke of working with a family and physician to “plan a really nice day for the baby” when withdrawing care, so that the baby would have a “meaningful death, the way the parents wanted it to be.” Similarly, Rob was present with the patient and family he spoke of as he died, providing support at the time of death. “I think I made a difference,” he explained. The “family was happy” with the care they received on the unit. Rob remembered this not just because the family was happy

with the care, but because of the relationship he forged with them and the patient in the process, and because of the range of ways in which he offered care.

### CONCLUSION

Intensive-care nurses at City Hospital often maintained emotional distance from the patients and families in their care. Their detachment, however, was not complete. They also expressed concern for many patients and, in some instances, they developed memorable emotional bonds. As Fox and colleagues describe in an article focused on how nurses cared for AIDS patients in the early years of the disease, these emotional bonds reflect the daily physical care nurses provide for patients, the intimate body fluids with which they are in contact, their roles as educators about health and the hospital as an institution, and—mostly prominently—their work not just with patients but with their families (Fox, Aiken, and Messikomer 1990). Nurses provide care for patients in these situations because of the ways they are professionally trained and socialized within distinct nursing cultures of care, and they express concern in these situations not because they fail to be detached or to control their emotions, but because concern is also an integral, if not daily, component of their work.

While the nurses we interviewed likely employed some of the strategies of detachment described in existing literature about detached concern, their stories show that the care and concern they provide is an ongoing process that they negotiate. They sometimes cry with patients, keep in touch, and develop relationships that continue long after the patient is discharged from the hospital. This concern is shaped by nurses' training, which does not emphasize emotional distance to the same degree as medical training, and by the institutional contexts in which they work. Nurses in the neonatal unit, for example, tend to be more comfortable with outward displays of emotion than those in the medical intensive-care unit, though a larger sample is needed to verify this finding.

Fox originally argued that health-care providers need to be concerned about their patients in order to provide compassionate care. The memories intensive-care nurses carry with them show that even as they try to maintain emotional distances, they are not detached from all their patients, and that this lack of detachment is part of their social role. They are also concerned and emotionally attuned to some in ways that need to be more clearly brought back into scholarly conversations about detached concern. Broader themes related to physical touch, family connections, holistic care, and education appear to be central to the ways in which groups of nurses care (Fox, Aiken, and Messikomer 1990). Therefore, rather than seeing detachment and concern as dichotomous, they should be viewed as dualities that are negotiated in ongoing ways by a wide range of health-care providers.

To better understand detached concern, we need to reconsider the concept

with particular attention to *concern*. Nurses are historically and structurally positioned between the impulse to detach and the demand for care that shapes their experiences in particular ways. Considering how they experience concern is an important step in reevaluating detached concern, and it may complement scholarship about how other care workers, such as home health aides, childcare workers, and nannies provide face-to-face services intended to support an individual's needs or well-being (Folbre 1995). Similar to the case of intensive-care nurses, these occupations "encompass both instrumental and affective relations" that frequently come into conflict (Abel and Nelson 1990). While intensive-care units differ from other workplaces in the institutional setting, technicality, and intensity of the work, analytic comparisons across health-care workers and workplaces will continue to rebalance scholarly understandings of detached concern.

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