Troubling fragments and small stories: an analysis of public commentary on nursing through a web blog

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**Summary** In recent years the media in the United Kingdom has engaged in intense debate on standards of nursing care in the National Health Service (NHS). Much of the public engagement with this debate has been carried out through social media, including blogs and micro blogs. In this manuscript we analyse a single episode of public commentary appearing on a web blog about standards of nursing in the NHS. The blog entries featured brief stories and fragments of stories about care experiences, and perceptions of nursing care. Content analysis of the published narratives identified a troubling undercurrent of indifference experienced by patients, clients and their families. These stories represent a counter narrative to contemporary grand narratives of nursing, and as such, they sit on the outer edges of contemporary professional discourse.

Increasing use of social media such as web blogs provides patients and carers with a public forum for comment that makes failures (or perceived failures) more visible to more people. Web blogs provide an important new mechanism through which patients and carers can have a voice about their own experiences of nursing care, and wider health care.

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**Introduction**

Web blogs can provide first person narratives about health care experiences. Through blogs, care recipients and their families can share their experiences and readily exchange information with others. This form of social media is increasingly employed in social research as it provides extensive opportunity for researchers to mine opinions or analyse sentiment and subjective text that may otherwise remain untapped (Denecke & Nejdl, 2009; Pang & Lee, 2008).

In recent years social media has emerged as a major form of communication on health information and opinion (Denecke & Nejdl, 2009; Shah & Robinson, 2011). Social media such as web blogs provide an avenue for the expression of consumer opinion and experience and can serve...
as a source of important information about public perceptions of care. Increasingly the media have employed web blogs as a means of sourcing and monitoring public opinions. Web blogs can provide first person narratives about health care experiences. Through blogs, care recipients and their families can share their experiences and readily exchange information with others. This form of social media is increasingly employed in social research as it provides extensive opportunity for researchers to mine opinions or analyse sentiment and subjective text that may otherwise remain untapped (Denecke & Nejdl, 2009; Pang & Lee, 2008). A number of studies have used web blog text as a source of qualitative data on patient’s perspective regarding different medical conditions and treatments (Shah & Robinson, 2011). Social media provides a unique source of commentary that is potentially of great value to nurses and other providers of health care as individuals are able to freely express opinions and their perception of experiences within the health system that may otherwise remain hidden and unheard.

Public inquiries and new avenues of public comment such as web blogs and online notice boards provide a forum through which commentary — including negative observations and critique — about health services can be made. In the UK, institutional data on the quality of hospital care and patient perspectives on care standards are made available to the public, and patients are also encouraged to comment on the care they receive via an NHS managed website (Jha et al., 2008). Greaves et al. (2012) report that this unsolicited web-based commentary correlates with patient ratings on the standard NHS paper based patient satisfaction surveys.

In this article we examine an episode of public commentary published in one United Kingdom (UK) tabloid in which the public expressed their concerns, experiences, and perceptions of the standard of nursing care in the National Health Service (NHS). The web blog forum was established in the wake of concerns raised in the Care Quality Commission (CQC) hospital inspections report (Woods, 2011).

Over the last decade a number of commentaries, reports and inquiries have provided evidence of continuing public concern over perceived failings in the NHS. Although there are many examples of good practice, which have been highlighted in various reports and inquiries, the public discourse continues to draw attention to perceptions and experiences of disregard, neglect and discrimination across the range of health services (Macdonald, 2001; MENCAP, 2007; Michael, 2008; Mullan, 2009; The report of the Independent Inquiry into Paediatric Cardiac Services at the Royal Brampton Hospital and Harefield Hospital, 2001). Of concern, these reports drew attention to repeated failings in the provision of nursing care and incidences of neglectful nursing practices. Despite the fact that uncaring behaviours by nurses have been subject to some examination in the nursing literature (Bradley & Falk Rafael, 2011; Faulkner, 2001; Person & Finch, 2009; Wiman & Wikbald, 2004), on the whole the profession has afforded less attention to unfavourable aspects of nursing practice.

Following the release of the CQC report into hospital inspections in the NHS (CQC, 2011) one media outlet ran the story “Don’t believe the horror stories about nurses” (Woods, 2011). The invited public web blog responses to this article generated considerable rejoinder from the public about their perceptions and experiences of nursing in the NHS. This web blog dataset was analysed by the authors and forms the basis of this article.

Method

In this study we undertook analysis of secondary data available in the public domain. We collected textual data on the viewpoints and experiences of individuals from an open access media publication reader’s web blog. The web blog text utilised in this study is very different to the more private discussions that occur in interactive chat rooms. Whilst cyberspace postings are often open to the public, distinctions can be made between posting that are publicly accessible and those which are publicly disseminated. The commentary analysed were intended for a public audience and freely available in an electronic form akin to ‘letters to the editor’. Readers posting on the web site used pseudonyms, and the discussion was in a tree hierarchy format, with later contributors able to see the earlier contributions. The blog used WordPress software allowing lengthier responses.

Prior to commencing the analysis of the web blog data advice was sought from the relevant institutional Human Research Ethics Committee. The HREC advised that as all material was freely available and in the public domain, no scrutiny by the ethics committee was required. There is growing consensus that web blog data can be used for research without prior approval from individuals (Eysenbach & Till, 2001). The Internet is an evolving medium for research and its use raises value-laden questions about the risks and benefits of using such technologies for research. The interpretation of web-blog analysis as human research positions the author of a web-blog as human subject, alternative stances privilege the textuality of the blog and position the blogger as an author, or a producer of material culture or political discourse (Keller, 2012). Positioning the blogger as an author, the ethical issues in analysing text from web blogs intended for a public audience have been likened to a literary exercise, similar to the study of published autobiography (Denecke & Nejdl, 2009; McGeehin Heilferty, 2011). Ethical codes and guidelines created to protect human subjects in research provide a starting point for considering the ethics of web-blog research. A challenge in this field of research is finding a balance in the interpretation of human subject ethical codes in a way which does not suspend or limit the critical analysis of public commentary, particularly that which involves sensitive or marginalised discourses. A crucial point with analysis of blogs of the type used in our analysis is that anonymity is established, as the identity of commentators remains unknown, permitting passive analysis that has no active involvement with correspondents (O’Brien & Clark, 2012).

The weblog dataset consists of 180 written posts from 52 individuals, three of whom identified as nurses or health care workers. As information provided in blogs can be affective opinion that is not based on personal experience, we separated blogs describing first-hand experience from those only containing affective opinion. Only blogs containing reported actual experience were included in the analysis.
Experiences within the blogs were revealed through storied accounts — small stories and fragments of larger stories — and these became the data. Initially, all data from the blogs was saved as a single word file. We undertook qualitative analysis of the textual data in the blog postings to systematically identify conceptual patterns from the narratives (Krippendorff, 2004; Sandelowski, 2000). Initially the blog text was exported into a word text table. Both authors read the data several times and independently identified patterns in the data by focusing upon apparent aspects of what was recounted in the text. After which both researchers independently identified words, concepts, phrases, experiences, and statements that revealed the detail of caring experiences (Coffey & Atkinson, 1996). As the analysis proceeded, additional codes were developed and the initial coding scheme was refined (Denzin & Lincoln, 2003). Following Lincoln and Guba (1985), clustering was used to bring coded text relating to the same content or event type together. To increase interpretive credibility, cross member checking of the coding and derived categories was employed to ensure audibility and conformability of the analysis (Miles & Hubermann, 1994).

Findings

The major category to emerge from the analysis was The characterisation of care as indifferent. This major category was constituted by four sub-categories: (i) Thoughtless and careless care. (ii) Unresponsive — the mask of “too busy to care”. (iii) Ignored and overlooked — the denial of care, and (iv) The hostile defence of disregard. The emergent major category and related sub-categories are described in detail below.

The characterisation of care as indifferent

Central to the concerns about the quality of care delivered were experiences of thoughtless, careless and indifferent behaviour from some nurses and care workers under their supervision. Thoughtless or careless nursing care was characterised by behaviours such as a lack of general attention and lack of knowledge of medical history. In other instances carelessness or disregard was masked behind a mantra of “too busy” to care. In its more extreme forms, indifferent nursing care was perceived as involving an insensitive disregard for patient welfare and the hostile defence of indifference.

Thoughtless and careless care

Being thoughtful and careful was positioned as a fundamental aspect of nursing care which ensured patients and family members felt safe. In contrast, a number of stories from family members recounted how the experience of thoughtlessness eroded their confidence in the care provided. In the narrative below, a daughter recounted the thoughtless care of her father:

“When asked why my Father hadn’t had a drink the woman (I won’t say nurse) said that to give him a drink would prolong his life. When my sister asked why my dad hadn’t been fed the carer said it was because he hadn’t chosen his meal from the menu, he was too weak to sit up for god’s sake!”

A number of instances of careless behaviour were recounted about nurses who placed patients at risk of harm, or caused actual harm by not providing due care. In the following narrative a correspondent details the careless actions of a nurse:

“When my aunt was seriously ill in hospital, I arrived to discover that her medicines had been placed on a table top out of her reach and had been there almost an hour. Soon after I arrived a nurse came and chided my aunt for not taking her medicine. She actually went to remove them until I intervened and watched as my aunt was given her medicines.”

At the other end of the spectrum, thoughtlessness occurred when tasks were performed in a way that stripped them of their meaning or relationship to caring. In these instances, care was delivered in an instrumental way without consideration of its purpose. Food was delivered to patients with no attention given to whether it was eaten, or, as in the narrative below no attention was given to the patient at all. Writing of how her father remained unnoticed for many hours after his death one correspondent recalled:

“The worst thing was getting the call at 9:30 in the evening to tell us he had passed away — then finding out a few weeks later that he had died at least five hours earlier than that. We only found that out because there was a police inquiry after a “suspicious” death in the hospital on the same day. So my dad lay dead for at least five hours before anyone noticed. During that time someone brought him a meal and took it, uneaten, away again — and nobody noticed he was dead.”

Unresponsive — the mask of “too busy to care”

Numerous incidents were recounted where nurses’ appeared to be impassive to the needs of patients and were described as unresponsive to patient buzzers or ignoring patients. Nurses were said to explain their unresponsiveness as a symptom of their overwork or busyness — they were too busy to assist or provide prescribed care. Although statements were made by nurses as to their level of busyness, at the same time they were repeatedly witnessed to be gathered around the front desk and a couple of ante-rooms, chatting at the nursing station, watching TV or others were said to prioritise paperwork over the needs of patients. One correspondent provided an example of nurses prioritising their paperwork over the needs of patients:

“An old lady in an adjacent bed had vomited on the floor, some 15 feet from three “nurses” sitting behind a desk. Their paperwork was clearly more important than attending to the situation.”

In a number of instances, being “too busy to care” was characterised as the invalidation of patient’s needs or the denial of their humanity and worth. In other situations “too busy to care” was used as justification for actions that were bordering on neglect. Other correspondents recounted how being “too busy to care” was used to deny repeated request for nursing care or medical attention. The implicit message
in this interaction was that patient’s needs were unimportant. In one experience recounted a family member wrote of seeking pain relief for her distressed mother and being told: ‘mum was not a priority; they had many people on the ward to care for’. Suffering and pain were made invisible behind a mask of busyness — nurses barely even noticed my grandmother quietly dying in the corner. Family members and patients who experienced nurses who were repeatedly “too busy to care” had their sense of vulnerability and worthlessness amplified.

**Ignored and overlooked — the denial of care**

This form of nursing care was positioned as a more extreme form of indifference and resulted in care recipients being repeatedly denied dignity and respect. It contrasted sharply with expectations that nurses would act with concern for the wellbeing of patients. One family member recounted the absence of respect shown by nurses at the time of the death of her mother who had a do not resuscitate (DNR) notice placed in her file:

> My father was present when she [dying mother] needed help to breathe and he asked the nurses to help. However they wouldn’t because of the do not resuscitate order. Instead they stood back and watched my mother die in the arms of my helpless father. Throughout the hospital I would notice posters claiming that the hospital treated the elderly with dignity and respect. However my beautiful mother was treated with no dignity or respect, instead she was treated like a slab of meat.

While the above scenario could be reflective of family members not fully understanding the meaning of a DNR order, it is troubling that the family are left with the distressing belief that their mother was not cared for with dignity and respect. Unfortunately, care that was characterised by the absence of dignity and respect were not isolated instances. Instead, patients experienced repeated episodes of disregard towards their care needs. Family members wrote of their loved ones experiencing total disrespect and repeatedly being overlooked or denied care:

> My 94 [year old] grandmother came out of there after 1 week a shadow of her former self. She was refused the toilet if she wanted to go more than once in an hour. She was not given water. She was allowed to half hang off her bed with her pillows on the floor — a woman who always slept sitting up. She was not given her antibiotics, leading to heart failure. It was a struggle not to cry when I saw her.

Other family members recounted personal hygiene needs being neglected to the extent that: there was solidified excrement under her finger nails that took days of soaking and scrubbing to get clean another recounted: my grandfather was neglected in hospital — left in his own waste, dehydrated and under-fed. He succumbed to C-Difficile infection and died.

**The hostile defence of disregard**

Individual nurses and care workers under the supervision of nurses were recounted to display instances of open disregard for the wellbeing or dignity of care recipient’s. In a number of instances acts of disregard towards patients were said to be justified through passive aggression or more overt hostility towards family members who raised concerns. In one such incident, recalling her request that an elderly patient who had been overlooked be provided with something to drink, a visitor was troubled by the response: *we don’t do drinks … you get it if it bothers you*. Others recounted a climate that was hostile towards their opinion and experienced passive aggression that silenced their concern and left them feeling helpless to defend the wellbeing of their loved ones:

> When I asked about my frail, demented mother being left with vomit all down her nightdress and whimpering in pain (she had a fall and broken her leg), I was faced with a passively aggressive nurse who asked me “If I wasn’t happy with her care”. Well, no I wasn’t but couldn’t say so as I had to leave her [mother] to their tender mercies.

In another instance the hostile defence of disregard had implied overtones of threat and were enacted in public:

> On the chest ward an old man asked for a drink after a coughing fit and was asked by the carer if he thought that he was in a restaurant. I told her to give him a glass of water but she ignored me, left and came back with a male nurse who told me that he was ex-services and that I should mind my own business.

**Strengths and limitations**

The Internet in general and social media sites such as web blogs is increasingly becoming an area of social research interest on the personal views and experiences of individuals. Social media provide a litmus on social discourse and attitudes, and can serve as vehicle for public discourse that is responsive to contemporary issues by providing commentary on social life as it happens (Branthwaite & Patterson, 2011). Media such as web blogs provide a potentially powerful source of information and research data, providing insights and views into ourselves as others see us and providing an important counter-narrative to the dominant discourses on nursing and health care. In this analysis, the text accessed from the web blog provided a voice to those who may otherwise have remained unheard.

The limitations of the dataset used in this analysis include the varied timeframe for the experiences recounted. It is also not possible to confirm the identity of bloggers or the validity of the accounts, and the bloggers may be a minority or not be representative of the general populations. Indeed, it may be that only those with strong negative feelings about nursing would participate in an on-line blog. However, that does not negate the importance and potential value of the information presented through this media. Future researchers might conduct comparative research of the responses gather through web-blog mediums compared to other methods. Lending weight to the findings, the stories recounted by correspondents in this analysis resonate strongly with the findings of inquiries into the NHS and in other inquiries and reports (Francis, 2010; Mullan, 2009).
Discussion

Similar to the findings from the inquiry into the into care provided by Mid Staffordshire NHS Foundations (Francis, 2010) and the damning report issued by the CQC following inspections of acute hospital and elderly care wards (CQC, 2011), which reported a pervasive failure to meet minimum standards of care, the shock and despair recounted by family members in our analysis reflected the distance between the standard of basic care expected and that delivered. Although these stories may be difficult and confronting for nurses, we believe an ethically relevant and morally concerned scholarship should look unwaveringly at that which is troubling. In the case of nursing, this requires authentic engagement with public commentary surrounding instances of uncaring and indifference.

The narratives of respondents identified many features considered fundamental to nursing care from the perspective of care recipients and their families. As a characteristic of individuals or their attitude, the capacity for caring was viewed as a requisite trait of those who nurse. Whereas the moral imperatives of nursing care were seen to be founded upon maintaining dignity and respect. Described as the core of nursing, caring is said to facilitate wholeness and healing of others (Swanson & Wojnar, 2004). The commentary analysed also repeatedly described nursing care as indifferent and lacking in thoughtfulness and compassion, and the frail elderly or vulnerable suffered as a consequence.

Indifference as a counter narrative to caring

Indifference has not been previously well-scrutinised in the literature. While much has been written about caring in nursing, there has been little study of indifferent behaviour and sparse attention has been given to examining unfavourable or uncaring aspects of nurses’ conduct. To address this limitation, in what follows we draw upon the findings from our analysis to explicate indifference as a counter narrative to caring.

Indifference has been defined as an ‘impartiality, absence of interest, or care . . . it can suggest neutrality regarding good and evil, or a lack of an active quality’ (Scott, 2007). It suggests the presence of moral disengagement through inaction or patterns of denial that disregard the risk of harm (Thompson, 2010). Indifference can be covert and unrecognised by those who engage in its enactment and reproduction, or overt and deliberate (Adams & Balfour, 1988). Negligence is characterised as indifferent or inadvertent conduct which involves an attitude of indifference or carelessness or failure to exercise vigilance (Brady, 1980).

Embedded within the practices and belief systems of institutions, it is said indifference can result in ‘inaction in the face of need’ (Henry, Houston, & Mooney, 2004, p. 517). This inaction can lead to repeated and serious violations of human rights, and erosion of the quality of services provided. Indifference can have discriminatory overtones and be founded upon gendered (Flavia Pires, d’Oliveira, Grilo Diniz, & Blima Schraiber, 2002), racist (Henry et al., 2004; Solomos, 1999), or other discriminatory concepts and values, which serve to reproduce impoverished or discriminatory practices. Administrative processes and belief systems can be reflective of indifferent or discriminatory values and practices. In prisons, indifference has been reported to include the widespread failure to obtain medical treatment, denial of care, decisions to administer less efficacious treatments, and the callous disregard for illness, pain and suffering (Petre Hill, 2002; Thompson, 2010). Indifference has been reported to result in the neglect and death of individuals with learning disability stemming from the failure to provide care and medical treatment (MENCAP, 2007) and the systematic neglect of patients in hospitals such as that identified in the Mid Staffordshire Trust inquiry report (Francis, 2010).

The perpetuation of indifference within institutions

A nurse or care worker turning their back on a single episode of suffering is troublesome. When this behaviour occurs repeatedly or is tolerated within institutions it is imperative to examine the behaviour at an institutional level and consider how thoughtless, careless or prejudiced care can become entrenched in care delivery and lead professionals to treat patients in dehumanising ways (Macdonald, 2001).

Within the organisational literature it is well established that social processes within work groups can lead to situations where acts of deviance come to be regarded as normative or acceptable to those who participate in it or witness such acts (Salancik & Pfeffer, 2003). It is known that language and habits can blind individuals to indifference in their environment and lead them to engage in unwitting prejudice and thoughtlessness. Learning about interpersonal deviance in the workplace through gossip or observation may prime onlookers towards antisocial thinking, providing cues about the types of behaviours that are acceptable in the particular context (Ferguson & Barry, 2011). Witnessing or knowing of co-worker indifference to recipients of care, particularly when repeated, may signal over time that this form of behaviour is tolerated. Among nurses and care workers repeated exposure to indifference may foster perceptions and attitudes about the acceptability of the behaviour, with individuals eventually engaging in the behaviour themselves.

Much of the instrumental or dehumanised care reported by respondents in our analysis was not perpetrated by one individual, instead, within work teams a number of nurses or care workers engaged in uncaring, cruel or demeaning behaviours. This suggests that group norms in these services had evolved towards a tolerance of indifference to patients and their care needs. The reported acts of disrespect, abuse, and cruelty — often performed in public — suggest that these behaviours had become normalised and legitimised within these work teams. Furthermore, the hostile defence of abuse towards patients and their family members is evidence that nurses and care workers were willing to employ aggression to exonerate each other of any moral culpability in wrongdoing. This involvement and apparent tolerance by work teams in acts of indifference resonates with research into corruption and rule breaking within organisations. It is known that when individuals who seem most closely connected with wrongdoing are identified they are not recognisable as deviant, but instead as ordinary individuals — someone rather like us (Anand & Rosend, 2008;
Anand, Ashforth, & Joshi, 2005). Similarly, reflecting on the Holocaust and the role of ordinary people in participating in or tolerating atrocity Arendt wrote of the banality of evil (Arendt, 1963). She detailed how seemingly ordinary people can, within a sanctioned context, see themselves as ‘‘cogs in the wheel’’ and commit terrible acts.

Indifference and the moral disengagement of care

In exercising moral agency individuals generally refrain from acting in ways that violate their ethical standards because such conduct would cause them self-sanction. In so doing, individuals have both the power to refrain from behaving inhumanely and the power to be proactive and humane (Bandura, 2002). The many mechanisms that operate within organisations for disengaging moral control, at both the individual and collective level, can operate to diffuse or displace moral responsibility. When moral agency is disengaged individuals can disregard ethical standards and work in ways that divorce actions from their moral context (Adams & Balfour, 1988). Selective moral disengagement describes the social cognitive processes through which individuals come to consider themselves as moral agents while engaging in immoral behaviour (Bandura, 2002). Moral disengagement requires that immoral actions are stripped of their moral significance. It has been identified that moral disengagement is strongly correlated with unethical conduct (Moore, Detert, Trevino, Baker, & Mayer, 2012), and much has been written about moral disengagement in settings such as prisons, the military and corporate business. To date, little attention has been give to understanding selective moral disengagement among nurses and care workers.

In the data analysed in this paper, acts of nursing care such as the provision of water and meals to frail and elderly patients had in many instances become technical or instrumental actions — divorced from their human purpose. Similarly, other acts of caring such as personal care were divorced from nursing or the responsibility of nurses. In the accounts of correspondents, meals and personal care were reduced to administrative tasks — forms filled and boxes ticked. In this context, the actions of carers and caring were separated from their human and moral context, removing any sense of personal responsibility (Dillard & Ruchala, 2005). In contrast, correspondent`s accounts framed these acts of “basic” nursing care as requiring attitudes and skills that ensured the care was delivered in a way that it had a positive effect.

The denial of care reported by respondents may not reflect a conscious decision on behalf of nurses and care workers to neglect patient’s care needs or cause them harm, it is more likely that it manifests social cognitive mechanisms which served to shape their conduct. Bandura (2002) theorised that cognitive restructuring can be used by individuals to remove any need for moral engagement when committing unethical or immoral acts. The more alarming forms of indifference that emerged from our analysis such as the denial of care and failure to treat pain, the delivery of careless or thoughtless care, and the use of denigrating language towards patients, were acts which served to dehumanise patients or attribute to them blame or a less worthy status. When nurses and care workers lefts patients to soil themselves rather than offering assistance, teased patients in pain, or laughed at the elderly patient stricken on the floor, they engaged in behaviours that were unethical — behaviours that one would expect would cause a nurse or care worker considerable moral distress. In these situations it is possible that individuals avoided experiencing personal distress from their actions through engaging in cognitive restructuring processes that fostered personal and social norms tolerant of indifference and ongoing moral disengagement within work teams.

Institutional enablers of indifference

Understanding the perpetuation of indifference within nursing teams requires consideration of enabling factors beyond the level of the individual towards consideration of organisational climate and structural factors in the delivery of health care. It has been asserted that the dominance of economic discourses in health care have influenced service delivery in ways that increase the likelihood of unintended harm (Heggen & Wellard, 2004). There is also evidence that the work environment of nurses influences their capacity to provide quality care. Further, in 2004 in a study of nurses in the UK, 90% reported they did not have sufficient time to provide care (Survey, 2004).

Modern managerial practices can legitimate indifference behaviour in the pursuit of targets. In a pressured and resource limited environment there is risk that harmful behaviours become reframed as acceptable when it meets the needs of the organisation. In the face of situational inducements or situational pressures individuals may engage in cognitive processes that enable them to reframe unethical conduct as acceptable. To survive in this type of environment nurses may learn to disengage their moral compass as functionaries of bureaucracy.

Conclusion

The commentary analysed in this paper followed a period of intense public debate about care standards in the NHS. It is feasible that the narratives analysed may be high impact lower probability events which occurred over a period of time. Further, by coalescing patient experiences, and generating conversations around certain types of experience, such web-blogs may provide a condensed focus on features of the patient experience. Whilst these small stories and fragments of stories do not give us access to the narrators or direct knowledge of the context of the experience or events, this does not diminish their value. Their importance lies in their capacity to trouble the dominant discourse and to provide a counter-narrative that demands scrutiny.

Questions surrounding the nature of what is written about the failure of nurses and care workers to provide adequate care are vital. To date, nurse researchers and scholars have written little on carelessness and indifference enacted by nurses and care workers, and there has been a paucity of research in this area. We propose that indifference is an under explored and troubling phenomenon, one of
fundamental relevance if we are to understand the nature of failure to care in modern health care organisations.

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