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The latest in a series of papers from the results of the RN4CAST study (Sermeus *et al.* 2011, Ball *et al.* 2014, Ball *et al.* 2016) rightly focuses on the context in which safe nursing care is delivered to patients. Drawing on an impressive data set across 12 European countries (Ausserhofer *et al.* 2014) using quantitative methods, Ball *et al.* argue that there is a consistent relationship between registered nurse staffing and care left undone which shapes patient outcomes. In the most recent article which focuses on the contextual factors which influence care left undone, Ball *et al.* (2016) present the results from a Swedish study which compares staffing in the UK and Sweden against care left undone to argue that the time of shift, patient mix, nurses' role and practice environment all have a significant relationship with care being left undone and the volume of activities not completed. Ball *et al.* (2014) describe an interesting and neglected feature of nursing work: the supervision of direct patient care. Their results show that in both Sweden and the UK, a significant proportion of direct patient care is supervised by registered nurses (RNs) and carried out by others. It is this supervised or delegated care from RNs to nursing support staff which is a neglected aspect of nursing work in the literature upon which I wish to comment.

Delegation is a ubiquitous feature of all nursing in acute hospitals in the UK. Effective delegation relies on confident communication from the RN to the health care support worker and a knowledge of role boundaries and care outcomes of delegated actions. (Magnusson *et al.* 2014). Yet delegation is under researched which is surprising when newly registered nurses (NRNs) are known to find delegation a challenge, especially when acute hospitals are reportedly so busy. NRNs ask themselves: "How can I learn to work more quickly?" (Magnusson *et al.* 2014; Johnson *et al.* 2014). The risk of making mistakes appears to be always on NRNs' minds as they are increasingly charged with taking on more and more responsibility. This has created an emotional burden so great for some NRNs that it has blocked their learning (Magnusson *et al.* 2014).

The idea that emotions shape our everyday working lives is not new (Balint 1957, Clifford *et al.* 2000). The reality of medical and nursing care and its inherent emotional challenges is recognized by a leading writer in this area, Anton Obholzer, who describes the NHS as the "keep-death-at-bay service" (Obholzer & Zagier Roberts 1994,171). By this he means that not only do nurses and doctors strive to assist the patient in recovery from illness and injury, but that they also try to "keep death at bay" at an emotional level. They do so by denying the emotions elicited in caring for the sick and the injured, the anxiety of caring for the sick patient and the knowledge that death is ever present.

Isabel Menzies published her seminal study on the organization of nursing work in 1957 (1970). Menzies argued that nurses distance themselves from patients emotionally and practically by constructing hierarchies of nursing work. She explained how the anxiety evoked in the nurse by the patient's dependence and sickness was suppressed in a variety of defences. Menzies' social defence systems in the case of nursing involve:

- splitting of the nurse patient relationship through reduced contact
- depersonalisation and denial of the significance of the individual patient for the nurse
- detachment or denial of feelings towards patient
- elimination of decisions through a ritual task performance
- checks and counterchecks to reduce responsibility for decision making
- collusive social redistribution of responsibility and irresponsibility
- purposeful obscurity in the formal distribution of responsibility
- reduced impact of responsibility by delegation to superiors

- idealisation and underestimation of personal development possibilities
- avoidance of change

These defences effectively mean that nurses fail to acknowledge and experience their emotional connection with patients; as a result, they (the nurses) distance themselves from their own anxiety and their patients' pain.

Further studies in the 1960s, and the use of Balint seminars in sexual health, showed how nurses could acknowledge their anxiety if supported and taught how to do so (Clifford 2000). There is more recent work drawing on psychoanalytic theory in women's health (Walker & Allan 2011) reproductive health (Allan 2009) and student nurse learning (Allan & Parr 2011; Allan et al 2011). Latterly, we observed that the effect on nurse teachers of the move to Higher Education (Smith & Allan 2011) was in some ways like a form of grieving which had not been acknowledged, and was therefore defended against. Work drawing on Arlie Hochschild's Emotional Labour (1983) has also contributed to this area of emotions in nursing: Nicky James' study of hospice care (1991), Pam Smith's work (1992, 2013) on emotional labour and student nurse learning as well as Theodosius' work (2008) on emotional labour in health care.

In Ball *et al.*'s paper, I am again struck by the complexities of the relationship between the macro (the policy context of health care services and the organizations in which nursing is situated) and the micro (organizational life including its emotional challenges) and how this is experienced in terms of autonomy and choice for individual nurses. I think the inherent tensions in this relationship have been partly resolved by organizing nursing work as a set of tasks to be delivered more or less interchangeably by whoever is on duty for a shift irrespective of the relationships at the emotional level between individual nurses and patients (Menzies 1957). This task allocation change din the 1990s when there was a 'flowering' of nursing work which began to challenge these defenses with the development of nurse led units (Kitson & Currie 1996, Manley 1997) and of primary nursing (Savage 1995), all of which indicated a consistent move away from task allocation. Sadly I have not observed these approaches in current nursing practice since the early 2000s.

Perhaps even more importantly, in terms of resolving the tension between collective defences against anxiety of caring, these tasks have been evaluated differently by nurses themselves; some are seen as more or less valued (Goddard 1953). Goddard suggested that tasks such as medical rounds, drug rounds, wound dressing and writing up nursing notes were more valued as high status tasks while washing patients, dealing with excreta and the other unmentionables of daily nursing work were seen as having a lower status and so were less valued. We might substitute managing discharge and patient pathways, and bed management for today's higher status tasks which are highly valued (Allan *et al.* 2011). My point is that nurses have always valued certain tasks more than others throughout the 20th and into the 21st century. Goddard categorized these tasks into: technical, affective and basic. She argued that the most highly valued of these was the technical and the least valued, the basic (essential) work of intimate care. I think it is significant that the 'dirty' work, the 'body work' if you like, is devalued, and even stigmatized or perceived of by nurses as stigmatizing (Allan 2010). I see this devaluation of essential caring work as further evidence of nursing's collective defence against the anxiety inherent in the caring relationship.

Micro factors, above all the emotions which are elicited through patient contact and shape individual and team work organization, operate at both the individual and the team level to subtly shape the organisation and delivery of nursing work including, and especially,

delegation, as well as the structural factors which are so well described and analysed in the RN4CAST study (Ball *et al.* 2014, 2016). In our recent book *Understanding Sociology in Nursing* (Allan, Traynor, Kelly & Smith 2016) we discuss how the influence of the organizations we work in, and the societal constraints under which we work (social structures), all influence our ability to perform as autonomous actors (with individual agency). We draw on sociological theory to analyse how both nursing as a profession and individual nurses' actions individually are shaped by both social structures and individual agency. We strongly emphasise how a structural approach to analyzing nursing is not sufficient to our understanding of the current problems in nursing like the Mids Staffs Inquiry or the politically expedient introduction of the proliferation of new RN support roles, such as the Associate Nurse. We need to understand how the macro and micro intersect to shape our actions and our worlds. And our actions and our worlds include our emotional lives.

On reflection, I wonder if the lack of attention to delegation and the complexity of supervising patient care are ignored because, once again, nurses (and nurse researchers) have chosen to focus on the technical rather than the affective or essential aspects of nursing work. If so, then they have most certainly defended against the implicit anxiety of care work which ultimately and ironically reinforces its very own devaluation as a profession within our modern health care systems (Latimer 2014).

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