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**Emotional Labour in Medicine**

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# Abstract

The emotional workplace has been explored through several perspectives (e.g. Hochschild, 1983; Bolton, 2005) and within several different contexts (e.g. James, 1992; Ashforth and Humphrey, 1993; Morris and Feldman, 1996; Fineman, 2003; Ward and McMurray, 2016). Although several contributions exist on emotions within organisations, missing from these debates is the exploration of how institutional logics shape the performance and management of emotional labour on the frontline. There is also limited knowledge on how workers navigate their emotional labour process in light of heterogeneous logics. In this light, both Hochschild's (1983) and Bolton's (2005) analyses have been considered and extended in order to re-ignite debates of the emotional workplace. This thesis examines whether a lens provided by the institutional logics perspective develops our understanding of emotional labour by showing how competing institutional forces can be considered as shaping emotional aspects of work.

The empirical focus of this thesis is on the context of British medicine. Despite research evidence pointing towards the importance of health/wellbeing for healthcare professionals, emotional aspects of the medical labour process are worryingly overlooked for junior doctors (Boorman, 2009; Vijendren et al, 2015). A fundamental aspect of medicine is too often neglected by both academics and practitioners: the emotional labour in medicine. Accordingly, this thesis explores the emotional context of medical and surgical work as a means of extending theoretical debates and addressing an important empirical focus.

An ethnographic exploration into the work experiences of junior doctors offers a promising case study to explore theorising of emotional labour. An ethnographic case study approach, through an interpretivist philosophy, provides important insights into the medical labour process, allowing for immersion within the institutional context and the gathering of junior doctor narratives. I conducted 40 semi-structured interviews with junior doctors across the training grade spectrum practicing within both medical and surgical services – including a handful of consultants to help contextualise the junior doctor data. In addition to interviewing, I undertook ethnographic observations – within ward areas, training sessions/breakout rooms, specialist clinics and operation theatres. This allowed the space and scope to explore the institutional context, associated workloads and pace of work processes

in medicine. Two hospitals and a treatment centre within Wilton Trust informed this PhD - constituting a rich and insightful dataset.

In this thesis, I first aimed to uncover how institutional logics can be understood as shaping the performance of emotional labour. Changes to the political economy of the UK and associated public service reforms have brought conflicting institutional logics into the frontline of public service work. Given the shift towards neoliberalism and the political focus on the efficiency of services (e.g. Bolton, 2002), I found that multiple, competing institutional logics shape important aspects of a junior doctors' labour process, and thus the texture of their emotional labour with patients and related others. Logics of bureaucratic rationality, professionalism, consumerism and an orientation towards the community were navigated by the doctors routinely in this study – doctors were found to choose, resist and negotiate these influences depending on work contexts and situational demands. Understanding the significance of the institutional logics perspective offers the first contribution to knowledge. Secondly, I aimed to understand types of emotional labour performed by the doctors considering the identified institutional influences. This thesis, therefore, helps to bring recent work locating emotions within institutional theory (e.g. Voronov and Vince, 2012) and extant literature on emotional labour in order to examine characteristic forms of emotional labour within medicine – this offers the second contribution to knowledge. Thirdly, I aimed to explore the means by which emotions were managed on (and off) the job with patients, colleagues and others. I found that doctors tended to share work experiences and relied mainly on collective processes in order to manage the pains and pleasures of medical/surgical work. This offers the third (empirical) contribution of the thesis.

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## Declaration

I declare that all written work (unless cited otherwise) is my own and has not been submitted for an award at the University of Nottingham or any other institution.

## Acknowledgements and Dedication

Without the support of too many lovely people, this thesis would not have been possible.

Firstly, a very special thank you to my supervisors - Professor Marek Korczynski and Dr Simon Bishop. You have been the most incredible team and have inspired me with knowledge and insight, dedication and compassion. Your guidance and support throughout my PhD journey have been unequivocal – and I dread to think about the level of your emotional labour throughout the course of this thesis!

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Finally, I would like to dedicate this thesis to my late grandparents – whom I miss very much, and every day. I know you are proud.

## Conferences and Presentations

- University of Nottingham, Link 2017 Conference: Presented an academic presentation to a range of other doctoral students researching at the University of Nottingham, June 2017.
- British Academy of Management: Presented at a Doctoral Symposium, Sept 2017.
- British Sociological Association, MedSoc: Conference Presentation: Emotional Labour and Institutional Logics, Sept 2017.
- Work, Employment and Society: Conference Presentation: Emotional Labour and Institutional Logics, Sept 2018.

## Abbreviations and Acronyms

| | |
|---|---|
| NHS | National Health Service |
| ACP | Advanced Clinical Practitioner |
| GMC | General Medical Council |
| BMA | British Medical Association |
| EWTD | European Working Time Directive |
| HaSC | Health and Social Care |
| WT | Wilton Trust |
| MDT | Multi-Disciplinary Team |
| UoN | University of Nottingham |
| IRAS | Integrated Research Assessment System |
| HRA | Health Research Authority |
| R&D | Research and Development |
| NUBS | Nottingham University Business School |
| CCT | Certificate of Completion of Training |
| HR | Human Resources |
| HCA | Healthcare Assistant |
| PA | Physician Associate |
| ACCS | Acute Care Common Stem |
| FY1 | Foundation Year 1 |
| FY2 | Foundation Year 2 |
| FY3 | Foundation Year 3 |
| CMT1 | Core Medical Trainee 1 |
| CMT2 | Core Medical Trainee 2 |
| CST1 | Core Surgical Trainee 1 |
| CST2 | Core Surgical Trainee 2 |
| SpR | Specialty Registrar |
| ST1 | Specialty Trainee 1 |
| ST3 | Specialty Trainee 3 |
| ST4 | Specialty Trainee 4 |

| | |
|---|---|
| ST7 | Specialty Trainee 7 |
| ST8 | Specialty Trainee 8 |
| SA | Senior Anaesthetist |
| IV | Intravenous |
| CPR | Cardiopulmonary Resuscitation |
| G&T | Gin and Tonic |
| CQC | Care Quality Commission |
| DHA | District Health Authorities |
| PCT | Primary Care Trust |
| RHA | Regional Health Authorities |
| SHA | Strategic Health Authorities |
| CHILL | Centre for Health Innovation, Leadership and Learning |
| M | Male |
| F | Female |

# Chapter 1: Introduction

## 1.1 Research Context

This thesis is centred on the work experiences of junior doctors working within an increasingly challenging context: the UK National Health Service (NHS). The specific focus of this thesis is on exploring junior doctor perspectives of the medical labour process and the texture of their emotional labour that is performed with patients and related others. This study contributes to existing debates on emotional labour by considering how multiple institutional logics shape an individual's emotional performance at work. The focus for this thesis is the NHS – which is a rich and interesting site for research in itself – not least because of its size and importance for society. The changing landscape of the NHS has also resulted in the manifestation of multiple, conflicting institutional logics on the frontline of healthcare services. However, from this case, I develop a theoretical framework which I propose as relevant to contemporary service workplaces in general.

## 1.2 Thesis Background

The delivery of healthcare, and the medical labour process in particular, is characterised by intense physical, mental and emotional labour. The role of a doctor, for example, involves the physical administering of medical treatment – ranging from medical examination to the successful performance of surgery. The role also includes the mental labour of knowing what and how to administer medicine and the ability to respond quickly to complex, changing circumstances in hospital environments (Riley and Weiss, 2016). Perhaps for these reasons, doctors are placed on *societal pedestals* with the public investing ample levels of trust into the medical profession (Abbott, 1988). In addition to these points, doctors are required to offer clinical care, compassion and empathy to their service-users/related others. Emotional labour processes therefore appear to be central to the work role of a doctor – during interactional exchanges with patients and/or relatives. Whilst the literature on emotional labour processes of medicine is limited, there is research evidence to suggest that emotional labour performances are central to medical work processes (e.g. Kerasidou and Horn, 2013, 2016; Riley and Weiss, 2016). In this light, this study seeks to explore the means by which doctors perform emotional labour with their patients, relatives and related-others.

Following Hochschild's (1983) seminal contribution, emotional labour has been a central concern for sociologists of work and organisation (i.e. Korczynski, 2002) as well as scholars in management psychology (i.e. Ashforth and Humphrey, 1993; Gross, 1998; Grandey, 2003; Mann and Cowburn, 2005), business and management (i.e. Morris and Feldman, 1996, 1997), organisational literatures (i.e. Rafaeli and Sutton, 1987, 1989; Mumby and Putman, 1992; Bolton, 2000b, 2004a; Korczynski, 2003, 2009), healthcare and nursing studies (i.e. James, 1989; Smith, 1992; Larson and Yao, 2005; Hunter and Smith, 2007; Rogers et al, 2014), and many other fields. This body of literature has brought to light many aspects of the performance and regulation of emotion at work - mediated by the immediate context of the workplace environment (e.g. Cote et al, 2002; Fineman, 2003). Whilst early work on emotional labour was primarily conducted at the individual level of analysis, scholars have increasingly contributed to an understanding of emotional labour as an interpersonal (Cote et al, 2002), collective (e.g. Korczynski, 2009) phenomenon.

Although there has been an extensive amount of research dedicated to understanding the experience and outcomes of emotional labour, it is argued in this thesis that analysis of the emotional workplace can be strengthened by connecting institutional logics to the study of emotional labour. The institutional logics perspective has increasingly focused on the micro-foundations of institutions (Powell and Colyvas, 2008) including recent exploration of the emotional aspects of institutional logics (Voronov, 2014; Jarvis, 2017; Friedland, 2018). This thesis elaborates on this work, particularly drawing on empirical studies which identify key trends in the contemporary workplace, which has seen for example increasing convergence in the organisational forms of public, private, and third sector organisations (Bromley and Meyer, 2017). Furthermore, recent reviews exploring the expression and management of emotion within institutions (e.g. Jarvis, 2017; Voronov and Weber, 2016) have outlined some of the possibilities for analysing the performance of emotional labour in relation to the surrounding institutional context. Whilst these reviews offer several propositions, they are based on secondary analyses of existing literature as opposed to the purposeful study of emotional labour in contexts of institutional logic heterogeneity. This thesis seeks to bridge this gap and show how institutional logics are indicative of key themes in contemporary organisational change, each with distinct implications for emotional labour processes. Indeed, Curley and Royle (2013) show that the nature of emotional labour is linked to broader changes

in management and organisation. In this light, the exploration of emotional labour can be linked to extant analysis of organisational change in public services in general, and within healthcare settings in particular. Contemporary organisations thus involve the performance of emotional labour as shaped by different institutional logics. This is the theoretical gap that this thesis seeks to address.

In the context under examination in this thesis, the nature of emotional labour can be seen to be shaped by key institutional logics - namely bureaucratic rationality, professionalism, consumerism and an orientation towards the community. Emotional labour types are linked to each of these institutional logics, but I also acknowledge the complexity in connecting emotions to distinct institutional logics. I note that there are exceptions to the connections outlined between key logics and emotional labour performances in this thesis. Whilst the institutional logics perspective offers clear and valuable insights into the means by which emotional labour is performed within various workplace contexts, and the implications that this may have for all of the parties involved in the process, exceptions to the patterns observed are also outlined.

## 1.3 Aims, Objectives and Questions

Following the above, my research aims are driven by a practical desire to explore and better understand the well-established concept of emotional labour within the context of professional work. Emotional labour has been thoroughly explored within the service sector - for over a span of thirty years. However, comparatively little is known about how professionals perform and manage their emotions with service-users and related others. The aim of this thesis, therefore, is to detail how professionals perform emotional labour in the context of an increasingly changing institutional setting – the UK NHS. Specifically, then, I am interested in the work organisation of junior doctors, the means by which emotional labour is performed by these doctors in medical and surgical services, and how the impacts of these emotionally-laden interactions (with patients, relatives and related others) are managed on- and off-the job. In this thesis, I explore key institutional logics that continue to penetrate important aspects of the NHS and shape the work organisation of medicine. I am particularly interested in the influence of these logics on emotional labour performances and how the pains and pleasures of the medical labour process are individually and collectively managed.

As such, the objectives of this thesis are as follows:

- To gain insight into the work experiences of junior doctors considering institutional complexity and change
- To explore key institutional influences upon the work organisation of medicine/surgery and how these influences are routinely navigated by junior doctors
- To explore key institutional influences as shaping emotional labour performances
- To explore different types of emotional labour in light of institutional complexity and change
- To explore how technical and interactive elements of medical/surgical work are individually and collectively managed
- To consider influences of gender on the emotional labour process

In this light, I am interested in the contemporary emotional workplace and the importance of negotiating emotional labour within the context of professional work. To explore these interests, I couch my levels of enquiry within the NHS institutional context and explore the work experiences of junior doctors in order to contribute more widely to existing emotional labour debates.

### 1.3.1 Research Questions

Considering the gaps in our knowledge on the topic of emotional labour, emerging research questions from current debates on emotions and institutions are:

1. What are the key institutional logics informing the work organisation of doctors?
2. How do key institutional logics influence the emotional labour of doctors?
3. What are the pains and pleasures associated with the emotional labour of doctors?
4. What are the emotion management strategies enacted by doctors?

## 1.4 Thesis Structure

Following this introduction, a review of the literature is presented in the second and third chapters of this thesis. In chapter 2, an overview of the literature on emotional labour and institutional logics is provided. The chapter begins with an analysis of current debates within

emotional labour theory – considering Hochschild's original thesis, conceptual development, issues of gender and processes of managing emotions with colleagues and others. This chapter then turns to outline Bolton's (2004, 2005) work on emotion management as a theoretical extension to Hochschild. Chapter 2 also offers insight into institutional logics scholarship and the relevance of this perspective for extending debates on emotional labour processes of work. Following this discussion, chapter 3 outlines emotional labour within the context of medicine – it starts by broadly highlighting the use of emotions within professional services and narrows its focus into that of healthcare settings and medicine. In considering medicine, the chapter offers a brief overview of the NHS – further highlighting the relevance of institutional logics to the study of emotions at work. The chapter then examines the literature on the work organisation of doctors – including experiences on the frontline of work. This discussion offers an insight into doctors' emotional labour experiences, the importance of peer relations within medicine and collective processes of managing work. Knowledge gaps are identified in relation to emotional labour debates and research questions are detailed at the end of chapter 3.

Chapter 4 explores the methodological and philosophical foundations of the research undertaken in this study – ontological and epistemological assumptions are outlined and the importance of the chosen methods in line with the aims of the thesis are explored. An explanation for conducting this research is included with more specific details on the case study approach – informed by both interview and observation techniques. Steps involved in both the data collection/analysis process are offered. Furthermore, research and ethical approvals to conduct this study are outlined and ethical/moral standards adhered to during this thesis are also detailed in this chapter. Key to this discussion is the role of the researcher. To close this chapter, a statement of reflexivity is offered in light of the dataset and analysis.
In chapters 5-8, the empirical data and analysis are presented. Chapter 5 outlines the social context of medicine – this highlights the relevance and importance of considering the influence of institutional logics on medical and surgical labour processes within healthcare settings. This chapter thus highlights the complexities of medicine – offering an insight into increasing work pressures and working conditions for junior doctors. Chapter 6 provides an insight into the emotional labour experiences of doctors. The analysis in this chapter supports the relevance of the institutional logics perspective for extending debates within emotional

labour theory. The chapter introduces, for example, four types of emotional labour in light of four key identified logics guiding the medical, surgical and emotional labour process. Following this exploration, chapter 7 offers an insight into the pains and pleasures associated with engaging in emotional labour processes of work – supporting the notion that emotional labour indeed represents a double-edged sword (Bolton, 2005). Chapter 8 then offers an insight into methods of managing emotions with colleagues and others. This chapter shows the importance of collective coping, relative to individual methods, and introduces the importance of humour within healthcare contexts and medical/surgical labour processes.

Chapter 9 offers a discussion of the data – findings of this study are considered in light of previous literature within the fields of emotional labour and institutional logics. Empirical and theoretical contributions are also offered at the end of the chapter. Chapter 10 then presents the conclusions of the thesis and offers recommendations for practice. Fruitful directions for future research are also explored – in line with the findings of this study. The chapter closes with limitations, final thoughts and reflections.

## 1.5 Summary

This chapter has introduced the thesis. It has offered an insight into the study in terms of the research context and background. It has also detailed the aims, objectives and research questions that inform the nature of this study. This section has further provided a thesis structure to offer an insight into how the remaining thesis is organised.

# Chapter 2: Emotional Labour and Institutional Logics

## 2.1 Introduction

This chapter introduces literature in fields of emotional labour and institutional logics. It outlines existing debates on emotional labour and explores the relevance of the institutional logics perspective for extending emotional labour debates. Opening sections explore the original thesis of emotional labour (i.e. Hochschild, 1979, 1983) and outline the conceptual developments that follow. In doing so, these sections unpack the origins, processes and refinements made to the emotional labour concept – highlighting issues of gender and exploring the importance of coping methods. The discussion then considers Bolton's (2000, 2005) extension of the emotional workplace – challenging the position of the original thesis. Later sections introduce the relevance of the institutional logics perspective for exploring work processes within large, hybridised institutions (e.g. Skelcher and Smith, 2015; Bishop and Waring, 2016). Recent developments within institutional analysis are highlighted – including contributions focusing on the role of emotions within institutions.

## 2.2 Emotional Labour

The following section explores existing debates in emotional labour literature. It outlines the original thesis, explores extensive conceptual development within the field, considers issues of gender and the managing of emotional labour processes with colleagues and others. This discussion then considers the work of Bolton (2005) on emotion management – an exciting alternative to the original theory.

### 2.2.1 The Original Thesis

In early management theories, particularly in those introduced within the first half of the 20$^{th}$ century, emotions in institutional settings were considered as disruptive and inconvenient – posing threats towards the logic of rationality within modern organisations (e.g. Ward and McMurray, 2016). However, Hochschild's (1983) seminal breakthrough of *the managed heart* challenged this position. Influenced by the dramaturgical perspective of Goffman (1959, 1967), Hochschild's analysis of workplace emotion offered those concerned with organisational behaviour a new lens through which to explore workplace interaction

(Wharton, 2009). Hochschild's (1983) conceptualisation of emotional labour, therefore, provided an important insight into the social foundations of emotion and the implications of managing emotions at the frontline of service industries (Wharton, 2009).

Hochschild's contribution to sociology is based on the notion of emotion management (emotion work in the private realm) – a reference to the means by which people actively shape their feelings and a recognition that social, cultural and institutional structures place restraints on these efforts (Wharton, 2009). The term feeling rules is used in order to outline norms in relation to the appropriate type and amount of feeling that should be experienced in specific situations (i.e. Goffman, 1959; Hochschild, 1983). The process of emotion management occurs as people try to accommodate these norms. For example, Hochschild implies that in line with societal and cultural expectations, it is usual for one to experience happiness at a wedding, sadness at a funeral and anger in light of injustice (e.g. Wharton, 2009). When an emotional display does not align with associated feeling rules and is distinctive from that which is considered culturally appropriate, Hochschild (2012) suggests that people then search for an insight into why this emotional behaviour appears to be strange. In addition to societal and cultural expectations, feeling rules are also influenced by one's work and status as an employee. In relation to employees and the influence of organisations on their emotional labour processes, feeling rules guide the means through which individuals understand their own emotions, the emotions that they must express in the context of their work and the degree to which they must express these with service-users and others (e.g. Theodosius, 2008: 17). Clearly, it follows that emotional requirements and intensities will differ within different professional groups and workplaces.

In the context of Hochschild's original thesis, similarities and differences were explored between the feeling rules of airline attendants and debt collectors. An important contrast between these two workplaces can be considered in relation to the customer's status during interactional exchange (Hochschild, 1983; Wharton, 2009). In Hochschild's thesis, the behaviours of airline attendants aligned with feeling rules which sought to elevate the status of the passenger, whilst potentially subordinating their own feelings. Roles that are based on deference (e.g. to lower one's status before the customer) are typically occupied by disadvantaged groups (including women) (Wharton, 2009). Additional feeling rules

characterising low-status workers include the requirement for continuous *service with a smile*. These feeling rules are common within contexts of hotel industries (e.g. Igbojekwe, 2017), fast food restaurants (Paules, 1991; Leidner, 1993), retail staff (Sutton and Rafaeli, 1988; Godwyn, 2006) and other forms of frontline service work.

By contrast, debt collectors arguably had a greater sense of control over their emotions and status – as they were to intimidate and thus lower the statuses of their service-users. An important feeling rule for Hochschild's debt collectors, therefore, was to create a sense of urgency and to deflate the mood of the debtor - by lowering their status and sense of importance (Wharton, 2009). The emotional labour of debt collectors needed to achieve a sense of threat and intimidation – thus increasing their own status and encouraging them to assert power and masculinity in line with organisational aims (Hochschild, 1983). Masculinity has also been found to be relevant to the feeling rules associated with other workplaces. Leidner (1991), for example, found that although insurance salespeople were required to display politeness/friendliness to their service-users, male salespeople often focused on the perceived aggressiveness, considered necessary to win sales, as a means of driving their emotional labour performances. In Wellington and Bryson's (2001) study, women have also been found to play on their sexuality and gender as a means of winning large amounts of business.

In addition to the above, studies of emotional labour have also been extended to professional work contexts – including, but not exclusive to, legal services, healthcare and medicine and teaching and academia (Wharton, 2009). Whilst professions are characterised by expertise, power and autonomy (e.g. Abbott, 1988), professional workers are still required to perform emotional labour with clients/others. Furthermore, despite professionalism and its associated status, research suggests that several feeling rules guiding emotional labour processes within professional work contexts are influenced by gender (James, 1992; Bellas, 1999; Simpson, 2007). In her study of paralegals, for example, Pierce (1995) observed that the feeling rules differed for men and women undertaking the same paralegal position. Paralegal is a predominantly female occupation – this important point shapes its work organisation and work role - including the level and type of emotional labour that workers

are expected to perform (e.g. Wharton, 2009). Whilst females in the firm were expected to be friendly, nurturing and supportive of male attorneys, Pierce (1995) found that male paralegals were not expected to conform to these rules.

Emotional labour processes are also integral to the work role of teachers/academics (e.g. Constanti and Gibbs, 2004; Ogbonna and Harris, 2004). Feeling rules in the context of education are further found to offer interesting insights into their gendered nature (Bellas, 1999). Sachs and Blackmore (2010), for example, found that the teaching profession was characterised by feeling rules pertaining to female qualities. Said rules encouraged and expected female teachers to provide compassion and understanding to both students and staff members. In contrast, however, Benesch (2018) highlights that vigilance, indignation and retribution were all especially relevant to teachers' emotional labour in light of specific situations. In higher education contexts, these feeling rules were largely undertaken as a means of upholding university policy. For example, academics were encouraged to be hyper-vigilant in their management of student plagiarism. This feeling rule promoted an objective, impersonal and unempathetic process in the discipline of students who had plagiarised in their work (Benesch, 2018). Clear tensions play out in these contexts between professional expertise and responsibilities, and the empathy that professionals might feel for their students. This tension between competing expectations is particularly relevant to the context of medicine, and the feeling rules/institutional influences guiding emotional labour processes of junior doctors. This notion will be explored in the next literature chapter.

Following the above, Hochschild's dramaturgical analysis of airline attendants and debt collectors suggests that people perform emotional labour in the public domain of work through different methods of acting. In the context of airline attendants, workers were observed to be specifically trained in order to manage their own emotions and those of their customers. This work was undertaken in order to deliver a sense of calm, comfort and reassurance to their passengers. In contrast, debt collectors were observed to show aggression, intimidation and to invoke feelings of fear in those people who owed money to the employing organisation. In order to achieve these states, both airline attendants and debt collectors suppressed and limited the emotions that they displayed to their service-users

(Hochschild, 2012). These workers were required to manage their emotions in light of the social context. In Hochschild's analysis, therefore, it appears that individuals attempt to align internally felt emotions with normative expectations and thus they alter what is felt privately – this type is referred to as *deep acting*. The process of deep acting is therefore likely to include an alignment between personal and professional expectations (Hayward and Tuckey, 2011). Alternatively, people may aim to bring outward emotional expressions in line with internal feelings and thus change what is felt publicly – this type is referred to as *surface acting* (Hochschild, 1983). Both types of emotion management are characterised by the process of emotional labour (as opposed to emotion work) because this process forms part of the individual's paid employment. Emotional labour is thus defined by Hochschild (1983: 7) as:

> *…the management of feeling to create a publicly observable facial and bodily display; emotional labour is sold for a wage and therefore has exchange value.*

Considering the work of several authors (e.g. Hochschild, 1983; Gray, 2008), common characteristics of the emotional labour process appear to include:

- Direct public contact: face-to-face or verbal
- Employers which can exert influence or control of the emotional labour processes (e.g. through training and supervision)
- Producing specific emotional states within another individual or group

Workers are typically required to shape their emotional displays in line with the requirements of their employing organisation – said organisations are considered to constrain the efforts of their workers (Wharton, 2009). In this light, Hochschild considered the commodification and control over one's feelings as an exploitative process (Ward and McMurray, 2016). Hochschild highlighted that feelings are exchanged for a wage in light of Marx's alienation concept. It is unsurprising, therefore, that Hochschild (1983) identified several negative consequences of the emotional labour process. These include, but are not limited to, exhaustion, burnout, alienation and depersonalization. These consequences have received

substantial support within associated academic literature (e.g. James, 1989; Wouters, 1989; Sharrad, 1992; Fineman, 1993; Wharton, 1993; Grandey, 2003; Smith and Lorentzon, 2005; Zammuner and Galli, 2005; Ward and McMurray, 2016). Responses to these negative consequences include compliance and feeling emotionally numb (e.g. Hochschild, 1983; Ward and McMurray, 2016). Other authors have found responses to include emotional dissonance (Morris and Feldman, 1996), anger and frustration (Van Maanen and Kunda, 1989; Tolich, 1993) and active resistance to the emotional labour process (Van Maanen, 1991; Bolton and Boyd, 2003; Bolton, 2004b, 2005).

Although negative consequences of the emotional labour process have been widely researched (Hochschild, 1983; Wharton, 1993; Morris and Feldman, 1997; Ward and McMurray, 2016), the positive consequences of emotional labour have received comparatively less research attention. Whilst Hochschild's (1983) analysis focused specifically on the negatives, other authors have suggested that, under certain working conditions (e.g. lack of material control and increased autonomy), then workers might also derive meaning and pleasure from their performances of emotional labour (Korczynski, 2002). Bolton's (2005) typology addressed the issue of research focusing only on the negatives associated with emotional labour by showing that emotional labour processes represent a double-edged sword. There are both positive and negative consequences of providing emotional labour to service-users (Bolton, 2000b, 2004; Korczynski, 2002). This point is elaborated on in the section of extensions to emotional labour.

### 2.2.3 Conceptual Development

Hochschild set the terrain for the investigation into the emotional workplace and has provided the domain of sociology with a social understanding of emotions. Her work offers an important opening into the exploration of emotional labour and she has kindly invited others to explore the notion. Since the publication of her original thesis, emotional labour has been explored within several different workplaces (e.g. James, 1992, Mann and Cowburn, 2005) and within several different sectors (e.g. Smith, 1992; Wellington and Bryson, 2001; Constanti and Gibbs, 2004). In addition to exploring emotional labour within several workplace contexts, researchers have also adapted and developed further the concept.

Ashforth and Humphrey (1993), for example, add to Hochschild's contribution by suggesting that emotional displays at work can become routine, effortless and also genuine. The authors develop the concept by suggesting emotional labour refers to the act of displaying appropriate emotions. Morris and Feldman (1996, 1997) suggest that the emotional labour process instead refers to the effort, planning and control needed to express organisationally desired emotion during interpersonal transaction. Kruml and Geddes (2000) outline emotional labour as what employees might perform when they are required to feel/project the appearance of specific emotion; Diefendorff and Richard (2003) introduce the management of emotions as an element of the work role and Johnson and Spector (2007) suggest that emotional labour is an expression of organisationally desired emotions by service agents during service encounters.

In addition to these contributions, authors in the context of occupational psychology (Gross, 1998, Gross and Thompson, 2007; Grandey, 2015) have reconceptualised emotional labour as an emotion regulation process – said authors have introduced emotional labour as the process of regulating both internal feelings and external expressions as a means of achieving organisational goals. It is important to note, however, that such perspectives do not appear to be conceptually distinct from Hochschild's original thesis – regulating internal feelings is in line with deep acting processes and modifying external expressions clearly reflects the process of surface acting. Indeed, an interesting observation from the literature on emotional labour and neo-institutional perspectives is that scholars who have recently considered the role of emotion within institutions borrow the term *regulation* as opposed to tracing roots back to Hochschild's original thesis – whilst Hochschild's work is acknowledged, this is only in brief. Instead it appears that institutional scholars equate the process of emotional labour with regulation (e.g. Voronov and Weber, 2016; Lindebaum and Ashkanasy, 2017). These points are detailed below in the section exploring emotions within institutions.

In light of the above, several research studies and reviews on the topic of emotional labour have highlighted the development of the field from Hochschild's original contribution – within disciplines of social psychology, organisation sociology, human resource management, amongst other literatures (e.g. Steinberg and Figart, 1999; Wharton, 2009; Ashkanasy and

Humphrey, 2011; Grandey and Gabriel, 2015; Barry et al, 2018). This body of work has emphasised the importance of emotional labour processes as involving the regulation and performance of emotion at work (e.g. Gross, 1998; Grandey et al, 2013) and has also considered contextual elements which might influence the management of emotion at the organisational frontline (e.g. Gross, 1998, Grandey, 2015). In doing so, research evidence on emotional labour has highlighted outcomes in relation to employee wellbeing (e.g. Tolich, 1993) and antecedents which consider the importance of personal/organisational characteristics in shaping the emotional labour process (e.g. Morris and Feldman, 1996; Grandey, 2015).

Whilst many emotional labour scholars trace their roots back to Hochschild's (1983) original thesis, it is surprising that only a few scholars consider her acting dichotomy to outline the phenomenon or explore its process in the workplace. An exception to this is perhaps the conceptual work offered by Ashforth and Humphrey (1993) – who recognise the importance of surface/deep acting methods, but who also claim that genuine/routine emotion characterises the emotional labour process in several workplace settings, and thus introduce the additional type of *neutrality*. Furthermore, despite the development of the emotional labour concept, most of the associated research offers an important insight into the emotional workplace but does not outline alternative theoretical perspectives as a means of furthering our understanding. Hochschild's analysis can therefore be built on for the following reasons. Firstly, Hochschild's thesis has been criticised by some for being too simplistic (e.g. Brook, 2009; Butler and Stoyanova Russell, 2018), particularly in its focus on emotion work in the private realm of the home and emotional labour in the public domain of work. Researchers have argued that Hochschild (1979, 1983) introduces an over-simplified dichotomy between the two forms of emotion management. This dichotomy is problematic because it mixes material analysis with an analysis of the subjective experience of emotions. In this light, Hochschild introduces a two-fold perspective of emotional labour in which employees may choose to surface act or deep act during workplace interactions. Her theory is also folded into an assumption of one dominant feeling rule: the dominance of the organisation and customer sovereignty over the worker. As Hochschild (1983: 86) notes:

> **…***where the customer is king, unequal exchanges are normal, and from the beginning customer and client assume different rights to feeling and display*.

However, as other researchers have acknowledged (see Korczynski, 2002; Bolton, 2004, 2005), not all service interactions are unequal, but in fact they can be interpreted as being embedded within wider social relations. The notion of social embeddedness (i.e. Polanyi, 1957; Granovetter, 1985) allows for a view of the pleasures, including job satisfaction, that workers can gain from social interactions that are an integral aspect of the economic transaction. Hochschild's sole focus on an unequal, deferential exchange between the sovereign customer and frontline worker, and her focus on the managerial imposition of feeling rules should therefore be reconsidered (see Wouters, 1989; Korczynski, 2002). Certainly, in some organisations frontline workers are in a subservient position to the customer – especially when they are expected to manage abuse and frustration (e.g. Ward and McMurray, 2016) – to this end Hochschild's theorizing has merit (Korczynski, 2002). However, other instances involve different relations between workers and service-users (e.g. healthcare, education, social work) and thus Hochschild's assumption that the axial principle of the customer/worker interaction is that of subservience to the customer does not necessarily pertain to all service interactions (Korczynski, 2002). Indeed, emotional labour will bring about the greatest pleasure and meaning for workers when they have autonomy over their feeling rules and have socially embedded interactions with customers (Korczynski, 2002). Other researchers have therefore attempted to classify different aspects of emotional processes at work, based on the circumstances, conditions and practices of work that frontline workers are faced with.

Following the conceptual evolution of emotional labour processes outlined above, it appears that there are now many types of emotional workplace. The majority of empirical analyses outline the processes and outcomes of emotional labour within service industries – examples include beauty salons (Toerien and Kitzinger, 2007), ride operators (Van Maanen, 1991), fast-food workers (Leidner, 1993), bill collectors (Sutton, 1991), and waitresses (Paules, 1991). Examples outside of the service sector include social work (Aldridge, 1994) and caregiving (Lively, 2000), police officers (Martin, 1999), magistrate work (Anleu and Mack, 2005) and work in the sex trade (Sanders, 2005), amongst several others. Two avenues of work which

have received extensive academic attention in terms of emotional labour refer to teaching industries (Bellas, 1999; Constanti and Gibbs, 2004; Isenbarger and Zembylas, 2006; Hebson et al, 2007) and nursing and midwifery within healthcare settings (e.g. James, 1989, 1992; Bolton, 2000b; Henderson, 2001; Hunter, 2005; Lopez, 2006).

In sum, the discussion so far provides an overview of Hochschild's original thesis and highlights conceptual advances in relation to emotional labour processes, experience and coping. The two most dominant sociological perspectives on emotional labour have been offered by Hochschild (1979, 1983) and Bolton (2000, 2004, 2005) (discussed below as an extension to emotional labour theory). Although I am aware of further contributions to the field of emotional labour, including analyses by Ashforth and Humphrey (1993), Morris and Feldman (1996, 1997) Kruml and Geddes (2000) and Grandey (2003, 2015), I do not review this body of work in detail given the limited scope of a PhD thesis, and because these authors do not offer complete theoretical perspectives on emotional labour. As acknowledged in sections above, Ashforth and Humphrey (1993) introduce one additional type of emotional labour – *neutrality* – to add to Hochschild's types and outline the notion that emotional labour can feel routine, habitual and therefore effortless in some contexts. Morris and Feldman (1996/7) present a framework outlining only sub-dimensions of emotional labour. Kruml and Geddes (2000) offer an account on emotional labour seeking to remain faithful to Hochschild's original conceptualisation – exploring its distinct dimensions and potential antecedents. Grandey's analysis (2003/15), based on Gross (1998), proposes factors (individual differences/social support) that are considered to drive emotional labour performances and its associated outcomes. Although these contributions provide conceptual evolution on the emotional labour process, they do not offer complete accounts of the emotional labour theory. This study therefore seeks to extend the analyses offered by Hochschild in order to re-ignite debates on the emotional labour topic following increased institutional complexity, processes of uncertainty and contradiction and change within contemporary organisations.

There has been extensive conceptual development and evolution of the emotional labour concept, with a plethora of empirical research studies outlining the processes/outcomes associated with emotional labour performance and management within several workplace

contexts. Whilst debates on emotional labour conceptualisations are important, other issues in relation to the emotional workplace have considered those of gender divisions and processes of coping with emotional experiences in (and out) of the workplace. The following sections explore these streams of literature and then this chapter turns to explore Bolton's extension of Hochschild's original thesis as a means of adding theoretical clarity to the contemporary emotional workplace.

### 2.2.4 Issues of Gender

Following the discussion on conceptual development, this section outlines gendered divisions of emotional labour. Considering Hochschild's original contribution, it appears that there is a clear gendered aspect to her work which is only briefly acknowledged. She studied the feeling rules associated with two gendered occupations: female flight attendants and male debt collectors. She showed that women must be *nicer* than usual, and men must be *harsher* than natural in order to successfully carry out emotional elements of their work. However, her analysis of the gendered components of emotional labour is incomplete. Since her work, authors have considered gender in relation to the emotional workplace and the implications this raises for both men and women (e.g. Acker, 1990; James, 1992; Hall, 1993; Simpson, 2007).

Emotional labour is considered as gendered at several levels within and outside of the workplace. Authors have suggested that the emotional labour process is associated with the sexual division of labour (Simpson, 2007), whereby traditionally men have been located within the world of work and women have been assigned to caring/nurturance in the private realm of the home (Sturdy, 2002). The sexual division of labour is based on and continues to contribute to the split in society between personal feelings and economic production, in addition to the clear divisions which exist between rational and emotional, public and private (Grandey, 2000; Simpson, 2007; Ward and McMurray 2016). In addition, the division between the private realm of the home and the public world of work compounds the already low status of natural, unskilled women's work carried out under the facilitation of the gendered division of labour (James, 1993; Gray, 2008). Such a division continues to perpetuate the rational and emotional divide of male and female, respectively. In this light, it has been suggested that

emotional labour is predictably a gendered notion underwritten by the interplay of gendered ambiguity of emotions themselves, the sexual division of labour and the division of our public/private worlds (Simpson, 2007). The rationale stemming from most of the literature appears to be that emotions are positioned as the natural domain of women (e.g. Simpson, 2007; Wellington and Bryson, 2001; Gray, 2008).

In addition, following sexual divisions of labour, feminist theories were amongst the first to outline that most service work is occupied by women. As Hall claims in her study of waiting staff, 'gender colours what we expect as good service' (1993: 452). Research also suggests that service encounters vary according to the gender of the worker in terms of emotional content/behaviour (e.g. Acker, 1990; Hall, 1993; Simpson, 2007). Although both men and women might effectively conduct technical elements of their labour process, workplace interactions they provide are often differentiated based on their sex. Female police officers, for example, are perceived as lacking an authoritative demeanour of their male counterparts; and male airline attendants are described as giving a less cheerful service in comparison with female colleagues (Hall, 1993).

In this light, an additional aspect of gender and emotional labour concerns the natural abilities of women to deliver interpersonal services (e.g. Taylor and Tyler, 2000) – an aspect which is argued to be constructed, and thus concealed and devalued, as a natural part of *doing gender* (Hall, 1993; James, 1989, 1993; Adkins, 2001). Authors have shown that emotional labour processes are considered as being more suited to women as the processes pertain to their feminine characteristics as opposed to those of masculinity. In the context of service work, therefore, managers tend to assume that female workers can accomplish more successfully the caring, emotive aspects of work involving interpersonal skills which they supposedly possess by virtue of their sexual, biological difference to men (Taylor and Tyler, 2000; Simpson, 2007).

Considering the above, it appears that there might be a division of emotional labour based on gender. Several authors have suggested that female workers are considerably more likely than their male counterparts to be expected to engage with emotional labour (see James, 1989; Simpson, 2007; Gray, 2008). Other authors have shown that female workers can use

their feminine traits to their advantage as a means of winning business (Wellington and Bryson, 2001). In workplace contexts assumed to involve strong aspects of emotion and care, such as teaching and nursing, then research evidence also points to a division of emotional labour based on gender within which women are expected to engage within emotional processes with increased frequency and intensity (James, 1989; Smith, 1992; Simpson, 2007; Gray, 2008).

### 2.2.5 Managing Emotions

Workers employed within a range of different industries engage in emotional labour. Their emotional displays might be shaped by managerial design and control systems seeking to address higher organisational interests (Hochschild, 1983; Vincent, 2011) or they may be self-generated responses to interactions with either clients, customers or colleagues (Bolton, 2004/5). By accepting both the positive and negative outcomes associated with emotion management in the workplace, it follows that workers will form some sort of response to these. It is plausible that they will either share their positive emotional experiences with colleagues and others or rely on a variety of means to cope with them. The sharing of emotional experiences can improve positive affect in the organisation and foster well-being within workplace relations (Gable et al, 2004). Further, both individual/collective coping methods might help one to alleviate work-related tensions as a result of managing complex emotions, and thus the workers avoid the adverse outcomes of emotional exhaustion, depression and burnout, commonly associated with the emotional labour process (Mann, 2003, 2005). The notion of coping is also considered as functional to the management of organisations, in that workers can find ways to cope with their emotional performances and so engage in further emotional work when necessary (Korczynski, 2003). Considering these points, the next section will explore these issues in relation to emotional interactions with colleagues and others.

#### 2.2.5.1 Sharing and Coping

The sharing of positive work experiences has received little academic attention. Current literature is derived from positive psychology and it points toward the association between the sharing of work-related experiences and a simultaneous improvement in the well-being

of workers (Lambert et al, 2011; Lambert et al, 2012). This is often termed *capitalization* within associated literatures (Langston, 1994). It helps to clarify how people tend to cope with social events, cultivate their emotions in a positive way and enhance the social bonds that they share with colleagues and others (Gable et al, 2012). In the context of this thesis, emotional labour is a performance with associated outcomes and coping methods. Thus, collective responses to emotional labour outcomes, either through the sharing of positive experiences or through collective processes of managing emotion is likely.

Following the brief exploration into the sharing of positive emotional experiences, the various coping methods associated with negative emotional labour outcomes are now discussed. Given that emotional labour has been studied within several different disciplines (i.e. psychology, sociology, and human resource management), then scholars associated with these fields have identified several coping strategies. For example, psychologists and various management researchers tend to emphasise the importance of individual coping strategies in relation to emotional labour (Mann and Cowburn, 2005). Emotion regulation techniques are commonly cited in which the worker regulates their own behaviour according to the situational context (Gross, 1998; Rogers et al, 2014). This helps one to find meaning in work and avoid feelings of anxiety and depression. It is particularly characteristic of the caring business (Mann, 2003, 2005). Cognitive restructuring is further discussed – this helps one to alter the meaning of events and thus it may lead to sincerer emotional performance, benefiting both worker and employer. This technique might have some resemblance to Hochschild's *deep acting* strategy of performing emotional labour in the airline industry. Furthermore, self-monitoring ability and capacities to remain aware of one's behaviour are also stressed within the literature (Abraham, 1999). Here, the worker is better able to monitor their emotional behaviour than comparable others and thus they are better able to avoid emotional drainage on-the-job (Mann, 2005). Potential workers tend to be recruited on this basis and this is especially reflective of customer-service sectors, within which labour is both *deskilled* and *less skilled*, relative to alternative work industries (Macdonald, 1995).

The above provides insight into individual coping strategies that are commonly relied on in order to manage the emotional labour process. A significant limitation of emotion management literatures, however, is the neglect of collective emotional labour processes.

This notion was initially acknowledged by Hochschild (1983: 114) in *the managed heart*. She briefly discussed the occasional banter swapped by flight attendants with both colleagues and customers during their shifts. She also mentions, in passing, that attendants may seek emotional support from one another in order to deal with abusive customers. Just as this argument sparks interest in the reader, however, Hochschild begins to discuss a different topic. In her work, collective emotional labour is neglected and thus it remains an underdeveloped aspect of her theory. Since the seminal introduction of emotional labour theory, authors have considered the importance of collective emotional labour processes – both empirically (e.g. Cricco-Lizza, 2014; Mann, 2005) and theoretically in Korczynski's contribution of *communities of coping* (Korczynski, 2003).

Considering the above, Korczynski (2003) argues that the idea of a collective nature to emotional labour is well positioned within the broader sociological conceptualisation of organisational emotions. Sociology stresses the social nature of emotions and behaviour and thus it is wise to focus on emotional labour as being essentially a *collective* process as opposed to an *individual* one (Elias, 1987; Fineman, 1996). Further, Korczynski (2003) successfully incorporates the customer into the analysis of social relations at work (Whyte, 1946). He argues that customers are increasingly seeking service quality from their interactions with workers (Heskett et al, 1997). During service encounters, the interactions are organised to indicate to customers that they are in charge (Benson, 1986). In fact, the workers are leading said interactions, but this process ensures that customers feel more sovereign (Korczynski, 2003). However, given the delicate nature of the consumption process, the myth of enchantment can quite easily lead to the experience of disillusionment (Korczynski, 2003). Here, the customers realise that they lack the sovereignty implied by service interaction, and thus they are likely to react angrily towards the worker. Customers may become irate and abusive and thus cause meaningful pain towards them. In this way, the displeased customer constitutes an additional dimension of the social relations of service-work (Korczynski, 2003). In order to cope with this customer abuse, workers are likely to seek social support from one another. In doing so, they are likely to form emergent, oral-based communal coping strategies – and this is considered an important aspect of collective emotion work.

## 2.3 Extensions to Emotional Labour

Bolton (2000, 2005) developed theorizing of emotional labour by arguing that the analysis of the contemporary emotional workplace requires a more detailed, multi-dimensional analysis. In her typology, Bolton (2005) proposed a distinction between four types of emotion management: pecuniary, prescriptive, presentational and philanthropic. Parallel to, though not overlapping with, these emotion management types, is the recognition of four important feeling rules: commercial, organisational, professional and social. This work suggests that forms of emotion management are guided by several different feeling rules. Bolton and Boyd (2003: 295) offer an example of such emotional complexity, highlighting the multiple feeling rules observed to guide emotional processes of work at the frontline:

> *… during a social encounter within the workplace they may well perform 'presentational' emotion management, while in direct, face-to-face contact with a customer of the company they may be expected to perform 'pecuniary' emotion management as a means of producing 'customer contentment' or, equally, they can decide on whether to offer 'philanthropic' emotion management as an extra 'gift'…*

This analysis therefore provides an exciting research avenue to extend debates on emotional labour because it exposes that the key assumption of Hochschild's (1979, 1983) original thesis, that there is one dominant logic of the employer/sovereign customer, must be reconsidered.

In Bolton's analysis, the human subject is placed at the centre of organisational analysis. In this light, the feeling rules, associated motivations and workplace performances constitute the emotional realities of frontline workers. Bolton's focus on individuals as being active, knowledgeable agents suggests that they are skilled emotional workers and can offer emotional performances in multiple ways. This notion is explored via Bolton's '4Ps' typology. In light of this work, pecuniary emotion management is guided by commercial feeling rules – this is perhaps the one which is mostly closely aligned with Hochschild's understanding of emotional labour. Prescriptive emotion management is associated with both organisational

and professional feeling rules. Presentational/philanthropic types are argued to draw on non-institutional social feeling rules. In this light, Bolton clearly outlines in her typology that emotion management types can be guided by multiple feeling rules at one time.

In addition, Bolton (2004, 2005) makes a clear distinction between material (regulated) and social (autonomous) forms of emotional labour. For example, Bolton suggests that pecuniary and prescriptive emotion management types constitute material forms – as these are both governed by institutional feeling rules (e.g. commercial, organisational and professional). Presentational and philanthropic types constitute essentially social forms - governed by non-institutional feeling rules in line with 'implicit traffic rules of social interaction' (Bolton, 2005: 133).

Despite this categorization, there are significant differences between the pecuniary and prescriptive types of emotion management. The pecuniary type, guided by the commercial feeling rule, is most closely equated to Hochschild's conceptualisation of emotional labour, and is therefore associated with cynical performance, profit-seeking behaviours and instrumental motivations – often resulting in alienating consequences for workers. The prescriptive type, on the other hand, is guided by organisational and professional feeling rules; this type widens the motivational basis for emotion management by also considering altruistic and status-seeking behaviours, in addition to instrumentality. This difference in motivational processes outlined by Bolton (2004, 2005) implies that workers might identify with their work role in addition to feeling involved with their employing organisation and/or professional body – therefore influencing sincere, authentic performances of workplace emotion. This is particularly reflective of the professional feeling rule, which is not directly imposed by employers, but instead guidelines of the profession are learned, internalised and adhered to by members through processes of secondary socialization (Berger and Luckman, 1966). Such a distinction between pecuniary and prescriptive emotion management is also important for considering the associated outcomes of these emotion management performances. In light of Bolton and Boyd (2003), for example, adverse effects of the emotional labour process are mainly associated with the pecuniary type (also reflective of Hochschild's analysis).

In light of this analysis, Bolton also appears to reserve authentic/genuine emotional performances for both presentational and philanthropic types of emotion management - which rely on social feeling rules and are therefore derived from processes of primary socialization. Bolton claims that these forms of emotion management offer a sense of stability and ontological security to workers engaging within emotional interactions. In the context of work, both presentational and philanthropic types are conducted in safe 'spaces' which workers might create in order to escape from organisational feeling rules, imposed by employers. These spaces are also used by workers for processes of resistance and misbehaviour, swapping banter between colleagues and others, gift giving, forming and maintaining occupational communities within the workplace and creating and maintaining identity (Bolton, 2004, 2005). For Bolton, authenticity is most closely associated with the philanthropic type, offered as a gift exchange for certain users, and this notion is most often set against the pecuniary type associated with the commercial feeling rule given that in these circumstances workers are controlled by organisational display rules and thus lack autonomy.

In sum, Bolton argues that the emotional workplace is informed by different emotion management types related to her key abstract feeling rules. This is an important insight and represents an important development in the understanding of emotional labour (e.g. Vincent, 2011). However, Bolton's analysis can be built upon because her four-part typology does not clearly reflect the four types of feelings rules, she identifies. For Bolton, the pecuniary emotion management type is governed by the commercial feeling rule, prescriptive emotion management is associated with organisational and professional feeling rules and both presentational and philanthropic types are argued to draw on non-institutional, social feeling rules. Only her pecuniary emotion management type is directly reflected by one feeling rule. Her remaining analysis of emotion management presents a framework in which emotion management types are not aligned with identified feeling rules.

Whilst Bolton's analysis shows the blurring and blending of emotion management types, associating different forms of management with multiple forms of emotional labour can be clarified further by exploring in more detail the institutional contexts of the contemporary workplace. One approach to doing so would be to consider the perspective of institutional

logics. In light of Curley and Royle (2013), for example, research evidence suggests that within the same organisation, distinctive logics may manifest and apply over time – meaning that emotional labour requirements also change. Whilst there is useful insight in Bolton's analysis, it is also important to consider changing institutional contexts and the implications that this raises for emotional labourers. In this light, Bolton's key insight – that emotional labour types are linked to abstract feeling rules – might be usefully considered through the institutional logics perspective. Bolton's abstract feeling rules, for example, can be considered as being embedded within wider institutional logics. I therefore consider institutional logics literature in order to develop an alternative perspective of emotional labour facilitated by an analytical lens provided by the key logics identified. The institutional logics perspective can make a vital contribution to an appreciation of the worker as an emotive being – choosing, resisting and negotiating the various influences associated with multiple logics seeking to shape their emotional labour process. The next section thus outlines the institutional logics perspective, considers recent contributions to the field and explores the relevance of this perspective for extending theory on the emotional workplace.

## 2.4 An Introduction to Institutional Logics

The discussion so far has considered existing debates on emotional labour – including conceptual distinctions and theoretical perspectives on emotional processes of work. Missing from our understanding, however, is the exploration of emotional labour in light of changing institutional contexts. In order to address this gap, a lens provided by the institutional logics perspective can help to theoretically develop our understanding of workplace interactions and emotional performances. Institutional scholars have recently started to appreciate that multiple logics manifest at the frontline of work – the growth of neo-institutional theory, for example, is usually outlined as countering rational-economic understandings of organisations, and instead appreciating other, additional influences (Alvesson and Spicer, 2019). Neo-institutional theory is now a widely used approach in organisation studies – providing a sociological insight on the formation of institutions and the relationships between institutions and behaviour of actors (e.g. individual, group and organisations). There are different branches of neo-institutional theory – the branch informing the nature of this thesis is that of institutional logics (Alford and Friedland, 1985; Thornton and Ocasio, 2008, Thornton et al, 2015; Yu, 2015; Alvesson and Spicer, 2019).

In the sections that follow, an overview of institutional logics literature is provided. This overview considers origins and definitions of the institutional logics perspective and recent developments within the field – exploring multiplicity/heterogeneity of logics, inhabited institutions and the role of emotions within institutional contexts. In particular, in line with the focus of this thesis, debates on emotional process of work within institutional theory are explored as this work has provided an important foundation for the empirical work of this study. The institutional logics perspective is then considered in the context of healthcare – recent changes at the governmental level have meant that most of the literature explores implications of institutional logics within healthcare settings (Currie and Spyridonidis, 2016). The healthcare context is thus chosen as informing a new perspective on emotional labour and institutional logics.

The term *institutional logics* was introduced by Alford and Friedland (1985) as highlighting symbolic, analytical modes, helping to describe the contradictory practices and beliefs inherent within institutions of modern western societies. The authors conceptualised society as an inter-institutional system comprising of several normative structures, each with their own associated logic: market-capitalism, state-bureaucracy, democracy, family and religion. These logics outline the assumptions, beliefs and normative expectations by which the behaviour of many individuals in the workplace is guided. In this light, institutional logics might help organisational actors to organise their professional lives and provide detailed meaning to their social realities (Thornton and Ocasio, 1999: 804; Thornton, 2004; Dunn and Jones, 2010; Sanders and McClellan, 2014). More recently, Thornton et al (2012) have offered a less contextually specific and more inclusive set of institutional sectors: market, state, community, family, religion, profession and corporation. Today, the institutional logics perspective has become an important strand of organisational theory – commonly considered when exploring connections between macro-level and micro-level phenomenon (e.g. Lounsbury, 2007).

As mentioned, organisational fields are increasingly characterised by institutional complexity, comprising of multiple, conflicting logics, as opposed to being dominated by a single one (Greenwood et al, 2011). In addition, multiple logics might be conflicting and competitive, but also cooperative and blurred at the institutional frontline (Goodrick and Reay, 2011; Waldorff

et al, 2013). Logics are symbolic – their meanings are not fixed but instead interpreted and negotiated (Currie and Spyridonidis, 2016). In this way, institutional logics are subject to interpretations by individual institutional actors (McPherson and Sauder, 2013) who might seek to engage predominantly with certain logics, for example, those based on existing identity or interests, whilst resisting the influence of others. Research also suggests that actors can engage in strategies that allow potentially conflicting logics to co-exist (Reay and Hinings, 2009), resulting in the segregation of people, work practices or audiences that are influenced by key logics in their own work (Greenwood and Suddaby, 2006). This is likely to manifest as a challenge, however, where people and practices are co-dependent, in the context of, for example, healthcare settings (Currie and Spyridonidis, 2016). In these contexts, institutional complexity must be continuously managed and negotiated, and institutional workers are commonly required to balance the influences of multiple logics (Battilana and Dorado, 2010).

In this light, it appears multiple logics, manifesting at the societal level of analysis, are observed to impinge on work processes in different ways and in different contexts. Importantly, institutional scholars have recently started to appreciate that conflicting logics appear to have implications for the use and manipulation of emotion at work (e.g. Voronov and Vince, 2012; Voronov, 2014; Jarvis, 2017; Friedland 2018). Whilst this body of literature offers fruitful analyses of cognitive/emotive work processes, missing from our current understanding is the implications that key logics might have for micro-social foundations of work. This thesis therefore explores emotional labour in connection with identified key logics impinging on the medical, surgical and emotional labour process.

### 2.4.1 Heterogeneity, Agency and Emotions

Recent contributions to the institutional logics literature consider multiplicity and heterogeneity, non-determinism, with an increased focus on institutions as inhabited, and the recognition that institutions involve emotions as opposed to only norms and cognitions. Researchers have started to appreciate, for example, that particular organisational contexts are subject to heterogeneity of logics (Greenwood et al, 2010; Thornton et al, 2015) – emphasizing that such heterogeneity is both influenced from the top-down and negotiated from the bottom-up. Traditionally, institutional scholars have also been criticised for being

overly deterministic in their approach to the exploration of organisations – recent developments in the field therefore emphasise non-determinism within the institutional logics perspective, highlighting that institutions are inhabited by institutional actors who can negotiate/re-negotiate the influence of multiple logics (e.g. Scully and Creed, 1997; Reay and Hinings, 2009). In this light, work in this area has included attempts to reconceptualise institutions as inhabited by both thinking and feeling actors, who produce and re-produce logics in institutions within contexts of interaction (Hallet and Ventresca, 2006; Bishop and Waring, 2016). Further to these aspects, one of the most recent, and perhaps important contributions to the institutional logics perspective, refers to its recognition that institutions involve emotion as well as cognition, norms and values. The next section therefore explores recent developments on emotions within institutions as a means of furthering institutional scholarship and highlighting the relevance of the institutional logics perspective for contributing to current emotional labour debates.

### 2.4.2 Emotions in Institutions

Recent developments of the institutional logics perspective seeking to explore the value of emotions within institutions has included a focus on the emotional/cognitive aspects of work and the extent to which local manifestations of institutional logics shape and constrain emotional experiences in the workplace – as Voronov suggests: 'a fruitful direction for future research in institutional logics might involve identifying how a particular logic constructs and shapes not only cognitive processes and organises schemas, but that it also prescribes and proscribes certain emotions' (2014: 186). In addition, recent work in this area shows that micro-level interaction and behaviour exert an influence on macro-level logics that shape contemporary work organisation. Several studies have also revealed influences of institutional logics at the micro-level of work organisation (e.g. Toubiana, 2014; Friedland, 2018; Zietsma and Toubiana, 2018; Zietsma et al, 2019).

In this light, recent developments of the institutional logics perspective have been argued to extend the understanding of the human subject within institutional theory to include emotional as well as cognitive aspects (Voronov and Vince, 2012). This work has further suggested that emotions form a constituent part of forming attention, understanding/meanings,

intentions and motivations, and in disciplining actors to dominant institutionalised norms (Friedland, 2018). In addition, institutional logics shape which forms of emotional displays are appropriate and legitimate in the context of the organisation. Indeed Voronov (2014) notes that institutional contexts shape the normative distinction between rationality and emotions; activities in line with dominant logics are more readily construed as rational, while those outside are identified as being rooted in emotion. Several studies informed by the institutional logics perspective have recently considered the management of emotion at work (Voronov and Vince, 2012; Voronov and Yorks, 2015; Zietsma and Toubiana, 2018; Friedland, 2018) and the literature so far has provided a promising insight into the experience of emotions within institutions. In this way, authors are increasingly recognising that emotions are not isolated from our daily experiences within workplace contexts; instead they are central to how we perceive and understand our social and professional worlds (e.g. Voronov and Vince, 2012; Zietsma and Toubiana, 2018). Whilst these recent developments have started to appreciate the importance of emotional aspects of work, scholarship might also consider the implications that this raises for emotion labour performances.

As discussed in sections outlining emotional labour and subsequent conceptualisations, a handful of contributions within institutional scholarship have equated emotional labour with regulation processes (e.g. Voronov and Weber, 2016). Voronov and Weber also introduce the term 'emotional competence' as a means of suggesting that institutional actors are committed to performing competently in line with institutional requirements through processes of institutional conditioning. A binary distinction is outlined through which actors regulate internal emotion via processes of private regulation and public authorisation – this distinction is two-fold and requires further elaboration. A critique of this perspective (e.g. Lindebaum and Ashkanasy, 2017) indicates that Voronov and Weber, whilst advancing our understanding of emotions in institutions, have not considered the importance of multiple levels of analysis in their theorising. More importantly, Lindebaum and Ashkanasy point out that several employees may resist institutional conditioning and will thus not necessarily be committed to displaying emotional competence in the way Voronov and Weber suggest. In line with Hochschild's original thesis, Lindebaum and Ashkanasy suggest that workers may feel alienated from both material and autonomous aspects of their labour process and that this important point needs further academic attention. An important issue with this critique,

however, is that the authors themselves point to a binary distinction between committed workers who show evidence of 'emotional competence' and those who feel alienated/depersonalised from emotional processes of work. Given the above discussion of heterogeneity, this offers an opportunity to consider the way individuals might navigate multiple institutional pressures on their emotional performance at work.

In addition to these points, emotional labour studies begin observations of the emotional workplace with the opposite assumption in mind: i.e. engagement within emotional labour *itself* results in alienation (e.g. Hochschild, 1983; Tolich, 1993; Morris and Feldman, 1997). In this light, whilst these secondary analyses offer important contributions to our understanding of emotions and institutions, future work might consider the exploration of emotional labour in light of contradictory institutional pressures. This might help to ensure that the logic guiding emotional work processes offers more than a simple binary distinction. These issues are addressed in this thesis through an exploration of medical, surgical and emotional labour processes.

Following these aspects, recent contributions have clearly furthered our understanding of the integration of emotions within contemporary, increasingly hybridised institutions (Voronov and Weber, 2016; Lindebaum and Ashkanasy, 2017; Zietsma and Toubiana, 2018). However, it also appears that only few arguments have been made which seek to link institutional theory to the experience and display of emotions at the organisational frontline, and theoretical and empirical insight within this domain remains limited. The institutional logics literature has not yet considered the implications for emotional labour analyses despite making attempts to acknowledge the importance of emotions within institutional contexts. Said analyses of the institutional, emotional workplace, therefore, provide an important basis for which institutional logics might be considered as extending debates on emotional labour and management processes.

## 2.5 Summary

This chapter has introduced literature on emotional labour debates and institutional logics. It has outlined existing theories on emotional labour and has explored the relevance of the institutional logics perspective for extending theory on emotional labour processes of work. The opening sections of this chapter focused on outlining the original thesis of emotional labour (e.g. Hochschild, 1983) and the conceptual developments that have followed since this seminal work. The chapter then focused on the importance of Bolton's (2000, 2005) extension of the emotional workplace – therefore challenging the theoretical position of the original thesis. Later sections introduced the relevance of the institutional logics perspective for exploring emotional work processes within large, hybridised institutions (e.g. Skelcher and Smith, 2015; Bishop and Waring, 2016).

# Chapter 3: Emotional Labour of Doctors

## 3.1 Introduction

The discussion so far has considered debates on emotional labour and has provided a brief overview of the institutional logics perspective – exploring recent developments within neo-institutional theory on the integration of emotions within institutions. In this chapter, the discussion focuses more specifically on emotional labour within the medical context – first highlighting the performance of emotional labour within professions in general, and then considering emotional labour processes within medicine in particular. In doing so, the chapter outlines logics influencing work within both public/private sector professional bureaucracies and provides a historical overview of the NHS. In light of this overview, the interplay of institutional logics within healthcare settings are explored – and the rationale for exploring emotional labour processes in light of these identified logics has hopefully been made clearer. Logics of bureaucratic rationality, professionalism, consumerism and an orientation towards the community are highlighted as shaping medical, surgical and emotional labour processes. The chapter then offers insight into the work organisation of junior doctors. Following this context, the chapter details our current knowledge of emotional labour experiences in medicine and the importance of sharing and coping with the work.

## 3.2 Emotional Labour of Professions

New public management and marketisation reforms have, some suggest, led to a blurring of multiple, contradictory logics, which are observed as influencing the work organisation of several workplace contexts (e.g. Van den Broek et al, 2014; Noordegraaf, 2015). Professional services such as healthcare, academia, law and financial work experience organisational transitions – including, for example, the pervasiveness of budget control, managerial supervision and workplace reform (Noordegraaf, 2015). Such transitions shake the very foundations of what it means to provide a 'professional' service and to act in line with 'professional' guidelines. Typically, a professional provides a service to a user – consider cases of patients, students, clients. A professional is autonomous yet committed to their profession and the core values that guide their work (Freidson, 1994, 2001). However, in light of contradictory logics, the abilities of professionals to provide adequate services may become threatened (e.g. Noordegraaf, 2015).

Institutional logics has become a dominant theoretical perspective for exploring work organisation in contemporary society (e.g. Besharov and Smith, 2014; Noordegraaf, 2015). Given that key logics are observed to impinge on work organisations of several hybrid institutions, the rationale for exploring the influences of logics on micro-foundations of interactional work is becoming increasingly important (Powell and Colyvas, 2008). Such logics have increased the demand for emotional labour processes in light of changing institutional contexts.

Several research studies have considered the emotional labour of frontline service workers (e.g. Korczynski, 2002). Professional groups have been comparatively ignored. An important reason for this is that elite professions have traditionally had greater control over their work and are less subject to managerial control (e.g. Lipsky, 1980, 2010), although several authors suggest there have been changes to the structure of professional work in light of institutional complexity in recent years (Currie and Spyridonidis, 2016). Another important reason is that professionals are expected to deeply identify with the profession that they become members of – they undergo processes of secondary socialisation and internalise the profession's core values (Berger and Luckman, 1966; Strauss, 1975; Bolton, 2005; Timmermans and Oh, 2010). However, the status and autonomy of occupations identified as 'professions' is subject to ongoing change (Abbott, 1988; Lupton, 1997) and several authors have noted the increasing imposition of new logics of managerialism and bureaucratic work structures over professional work organisations (Besharov and Smith, 2014; Noordegraaf, 2015; Currie and Spyridonidis, 2016). Public service professionals particularly are commonly understood as having their work rationalised in light of the new public management movement. It is therefore important to explore the emotional labour of professional services.

Whilst existing research has mainly neglected the emotional processes of professional work, exceptions to this neglect include a handful of empirical studies outlining the emotional labour associated with teaching and academia (e.g. Constanti and Gibbs, 2004; Ogbonna and Harris, 2004; Isenbarger and Zembylas, 2006), nursing and healthcare practitioners (e.g. James, 1992; Mazhindu, 2003; Bolton, 2000b, 2005; Theodosius, 2008; Gray and Smith, 2009; Rogers et al, 2014; Kerasidou and Horn, 2016 ), financial services (e.g. Wellington and Bryson, 2001) and paralegals and law firms (e.g. Pierce, 1999; Harris, 2002; Anleu and Mack, 2005;

Boon, 2005; Westaby, 2010). This section provides an overview of these findings – highlighting what is already known in relation to the emotional labour process of professional groups.

### 3.2.1 Private Services

Professional service firms are structured differently to customer service organisations/occupations - particularly those that are typically examined by emotional labour scholars. Whilst customer service firms can be characterised by dual logics of efficiency and consumerism (e.g. Korczynski, 2002), professional bureaucracies are also informed by logics of the associated profession. The concept of the professional bureaucracy can be traced back to Mintzberg (1979) – who highlighted distinct features of a professional workplace relative to other service firms. These distinctions include specialist knowledge/extensive training as an entry point into the profession, an increased level of autonomy and control over work processes and decentralised hierarchal structures allowing frontline professional workers a greater degree in decision-making. Professional bureaucracies are also characterised by ranking and filing measures – allowing certain professionals to become elites (e.g. partners) and thus these individuals are more fully implicated in the financial performance of the profession. Examples of these professions, with opportunities for certain individuals to become elites/partners, include legal services and medical services – particularly general practice surgeries.

Harris (2002) explored the emotional labour of barristers. A distinction is made between public emotional labour – that which is performed with clients, witnesses and external colleagues, and private emotional labour – that which is performed with co-workers. Although barristers are observed to display expected emotions, Harris (2002) suggests that that these processes are performed differently to that which is observed in customer-service work. Harris (2002) shows, for example, that the emotional labour processes of barristers originate from several different elements of work, including but not exclusive to: organisational structure, the nature of work, audience expectations, occupational acculturation and the importance of self-image – reflecting features of a professional bureaucracy. Given these points, barristers are often found to suppress genuine emotion and display those which are expected of them. More recent research on immigration solicitors,

however, has shown that solicitors endeavour to build mutual trust and confidence with clients and therefore offer genuine displays of emotion (e.g. Westaby, 2010).

In the context of barristers/solicitors, workers tend to experience both positive/negative outcomes of engaging within emotional labour processes of work – said outcomes might be dependent on the situational contexts shaping interactional exchanges between worker and client. Considering the study on barristers, outcomes include emotional exhaustion and increased levels of efficiency, sincerity and a stronger sense of professionalism (Harris, 2002). Westaby (2010) also highlights the pains and pleasures associated with emotional labour processes in law firms and further outlines the importance of social relations on-the-job – through which solicitors collectively form informal communities of coping (e.g. Korczynski, 2003). In this light, these empirical studies highlight the double-edged nature of emotional labour processes, with an appreciation that both workers/employers can drive its performance at the frontline (see also Bolton, 2004, 2005), and that workers can manage their emotional experiences backstage through collective coping mechanisms (e.g. Westaby, 2010).

Whilst emotional labour within legal firms appears to be an embedded process of the work, resulting in both positive and negative outcomes, emotional labour processes of consultancy professions are used by workers themselves, in order to generate high levels of income. In contexts of accountancy and other financial services, in which transactional exchanges occur between professional and client, professionals are found to engage within emotional labour processes as a means of alluring clients and winning large amounts of business (e.g. Wellington and Bryson, 2001). This is an insightful finding because it exposes that, in some contexts, workers might engage within emotional labour processes in line with their own instrumental motivations and identifications they hold with professional bodies. Whilst such a notion is not explored in Hochschild's (1983) thesis, it is acknowledged in the work of Bolton (2000, 2004, 2005).

In addition, Wellington and Bryson (2001) outline a gendered dimension to their findings by highlighting that women make greater use of their sexuality in winning business through client meetings and in order to advance careers/increase promotion opportunities. It is important to note that most employers within financial industries incentivise commission and

other types of performance-related pay and thus workers are trained to present a specific face of professionalism – possibly influenced by the *presentational emotion management type* (e.g. Bolton, 2004, 2005) and are therefore driven to bend these processes to their own advantage. Using impression management (e.g. Gardner and Martinko, 1988; Leary, 2019) combined with emotional labour processes, these professionals can win large amounts of business and often do not experience the negative implications of doing so (Wellington and Bryson, 2001). These findings suggest that despite the prescribed display rules, professional workers themselves are the biggest drivers of their emotional performance. As a result, the potential benefits of said emotional work are likely to outweigh any negative aspects: e.g. commission levels and a higher-paid salary. Importantly, however, there is inadequate research to generalise such findings and therefore further exploration may be needed to outline the emotional labour associated with private sector professions in general, and financial services, more specifically.

The above has provided an insight into private sector work. Here, it is common for professionals to drive their own emotion management as a means of satisfying clients, in addition to these expectations being embedded within organisational culture. However, given the political focus on increasing the efficiency of services and the significant increase in consumer expectations, changes to organisational structure and a stronger orientation towards customer-service might be considered as having significant implications for emotional labour processes within public services (e.g. Bolton, 2000a, 2000b). In this light, the following discussion will outline empirical work associated with the emotional labour of workers in teaching/academia and nursing/medicine workplaces.

### 3.2.2 Public Services

In contexts of teaching (e.g. Constanti and Gibbs, 2004; Isenbarger and Zembylas, 2006) and academia (e.g. Ogbonna and Harris, 2004), emotional labour is considered an integral aspect of the labour process. Scholars reveal that emotional labour is experienced as significantly more intense and to a greater extent in these contexts than within other occupational groups (including service work and back office positions) (e.g. Berry and Cassidy, 2013). Although there is also a gendered dimension to the emotional labour of teaching (e.g. Bellas, 1999), scholars have suggested that the need for emotional labour within educational services has

become increasingly important in recent years. For example, whilst there is an inherent caring aspect to the work processes of teachers (e.g. Isenbarger and Zembylas, 2006), logics manifesting on the frontline of higher education workplaces have increased the demand for emotional labour processes from all workers. In light of increased managerialism and a stronger orientation towards consumerism within academic contexts, it is a common expectation that academics should manage their emotions at the frontline of their work (e.g. Constanti and Gibbs, 2004). These processes result in increased satisfaction of the student and a larger scale of paying students for the university employers. Research finds that academics often suffer negative outcomes associated with the emotional labour process including exploitation, exhaustion and depressive symptoms (Gibbs, 2002).

Furthermore, considering recent changes within academic institutions in relation to heightened managerialism, scientific management practices and a stronger orientation toward a customer-service ethos, university lecturers are increasingly being required to perform emotional labour as a means of gaining competitive advantage (e.g. Constanti and Gibbs, 2004; Berry and Cassidy, 2013). The re-labelling of students as *consumers*, for example, has intensified work processes and has increased the demand for emotional labour performances by both academic and non-academic staff (Constanti and Gibbs, 2004). Despite the adverse effects associated with emotional labour in academic workplaces, however, there is research evidence which highlights the process as constituting a source of pleasure and satisfaction for those in teaching capacities (e.g. Isenbarger and Zembylas, 2006).

The discussion thus far has outlined emotional labour processes within the private sector: law firms and financial services and within public services of teaching and academia. This section now outlines the emotional labour associated with the nursing labour process and other healthcare professionals (e.g. doctors). Considering recent NHS reforms and an ideological shift in light of neoliberalism principles (Bolton, 2000b, 2002), it appears that there is an increasing demand for the management of emotion at the frontline of healthcare services by healthcare managers. Whilst majority of the literature has considered the emotional labour of nurses (e.g. James, 1992; Mazhindu, 2003; Bolton, 2000a, 2000b, 2004, 2005; Theodosius, 2008; Gray and Smith 2009; Cricco-Lizza, 2014), doctors have been comparatively ignored.

In line with conflicting logics influencing the work organisation of healthcare contexts (e.g. Currie and Spyridonidis, 2016), it follows that there is a significant demand for emotional labour performances in light of these competing influences. Research suggests that emotional labour within nursing is now a routine requirement in order to ensure the quality delivery of patient care (e.g. James, 1992; Smith, 1992; Bolton, 2000b; Gray, 2008; Cricco-Lizza, 2014).

Routine requirements of emotional labour within nursing labour processes are likely to reflect divisions of labour within the healthcare context – for example, with nurses, healthcare assistants, midwives and other non-medical healthcare professionals required to perform intense, routine and/or genuine displays of emotional labour with service-users, relatives and others as an integral aspect of their job role (e.g. James, 1993; Gray, 2008). In light of divisions of emotional labour (e.g. James, 1993; Gray, 2008), research has outlined that emotional processes of work are influenced by immediate conditions of work, external controls and regulation bodies and are subject to divisions of labour - with nurses, for example, engaging within in-depth, routine displays of emotional labour processes and doctors continuing to address medical and surgical issues in patients. In this light, emotional labour is integral to the labour process of several healthcare roles, however it is also an under-recognised, invisible aspect of employment involving contact with people. In addition to the discussion of professional bureaucracies above, highlighting central features of a profession which make the work organisation clearly distinct from other service organisations, discussions of divisions of labour, and indeed emotional labour, help to explain the wealth of literature outlining emotional work processes, consequences and methods of coping within nursing and other healthcare professions, and the relatively little academic attention paid to the medical labour process in comparison.

Further to the above, emotional labour has been examined in several healthcare settings across the years. Examples include paramedic students (Williams, 2013a, 2013b), nursing care workers (Rodriquez, 2011), nurses (James, 1989; Smith, 1992; Bolton, 2002; Theodosius, 2008; Gray and Smith, 2000, 2009), midwives (Hunter, 2005), care home aides (Stacey, 2011), and medical students (Smith and Kleinman, 1989). There is a handful of contributions outlining emotional work processes of doctors (e.g. Rogers et al, 2014). Riley and Weiss (2016: 11) review contributions of emotional labour within healthcare contexts and outline

important themes which appear to capture the emotional work processes of a range of healthcare occupations. In a review which considers nurses, midwives, paramedics, medical students, care workers (amongst others), the authors suggest there are four important themes at play which collectively capture experiences of emotional labour in healthcare settings. These themes refer to:

- The professionalism of emotion and gendered aspects of emotional labour – this theme outlines who is expected to perform emotional labour and offers a critique of *emotion work* as *women's work*. This theme essentially reflects the division of emotional labour within healthcare contexts – an important point that will be addressed in later sections of the thesis.
- Intrapersonal aspects of emotional labour – this refers to the means by which healthcare workers manage their own emotions in the context of work.
- Collegial and organisational sources of emotional labour – this theme acknowledges means by which emotional labour is employed in order to support social relations and manage conflicts with colleagues and within the organisational hierarchy.
- Support and training needs of professionals – this considers the importance of support and training needs enabling professionals to manage their emotions and those of their patients, relatives and colleagues on-the-job.

This review therefore highlights multiple ways in which emotional labour is deployed within healthcare settings. Riley and Weiss (2016) further stress that organisations often overlook the value or importance of the *taken-for-granted* emotional labour processes involved in healthcare work. This review raises important implications for further study – it highlights the cost of caring in different healthcare contexts and outlines methods of support and training that may be required in different organisations. The review also highlights the importance of regulating emotions and events at work. Emotion regulation strategies are generally employed during clinical events or patient interaction - helping workers to find meaning in their work in light of difficult contexts. In Cricco-Lizza's (2014) paper on 'the need to nurse the nurse', for example, findings suggest that nurses manage difficult situations at work by reflecting on the good days as opposed to the bad. In the neo-natal intensive care unit observed, nurses were found to balance 'the sadness of infant loss with the joy of helping

babies and families recover…' (2014: 624) – showing how nurses might reframe unfortunate events in order to find meaning in their work.

In exploring the gendered, personal, professional and cultural barriers to emotional labour, Riley and Weiss (2016) further suggest that these findings may contribute to our understanding of factors affecting stress and burnout, issues of retention and premature departures from specific healthcare professions (e.g. medicine). In this light, this review provides an important foundation for exploring emotional labour processes within contexts of medicine, and specifically, those associated with junior doctor work. Later sections in this chapter explore emotional labour within medicine.

Whilst the emotional labour process of medical/surgical work is currently underexplored, there is research evidence to suggest that emotional labour is an integral aspect of the medical labour process and that it may raise implications for the wellbeing of workers (e.g. Rogers et al, 2014). This is therefore an important context of professional work to explore. Whilst an insight is offered in this section, later sections in this chapter examine the work organisation and interactional elements of medicine given the empirical focus of this thesis.

Medical professionals often work on the frontline of patient care; they therefore engage in considerable amounts of emotional labour (Rogers et al, 2014). Like several workplace contexts discussed previously, emotional labour processes within medical/surgical services also result in positive (satisfaction/reward) and negative (burnout/exhaustion) outcomes for staff. Doctors, for example, report anxiety, exhaustion, depressive symptoms and stress as a result of manipulating emotions for the benefit of their patients (Karimi et al, 2014; Rogers et al, 2014). Monrouxe et al (2015) support this notion by highlighting that foundation doctors engage within increased emotional labour processes at the frontline when compared to senior doctors, and therefore junior cohorts appear to be most vulnerable to symptoms of work-related burnout, depression and they may even become suicidal. Monrouxe et al's (2015) findings further suggest that foundation doctors rely on emotion regulation strategies in order to manage and cope with their emotional work at the organisational frontline. The researchers show that poor emotion regulation is associated with adverse effects in terms of health and wellbeing for staff.

Furthermore, medical doctors often view the outward expression of inappropriate emotion as negative and inward suppression as desirable, and thus emotion regulation is heavily relied on during the practice of interactional work tasks – reflecting Hochschild's method of surface acting. An important aspect to note here, however, is that emotion regulation strategies are not individual processes. They represent a wider interpersonal phenomenon (Monrouxe et al, 2015), distributed amongst colleagues and throughout the wider clinical context. This indicates that junior doctors, required to engage within intense emotional labour processes, consider the importance of social relations and collective modes of managing emotion as integral to their work (Miller, 2009). Collective aspects of emotional labour, although acknowledged by Hochschild's (1983) original thesis and supported by an exploration of service work by Korczynski (2003), remains underdeveloped.

The above has highlighted emotional labour processes characteristic of different types of professions in both the private and public sector. Emerging from this discussion is the significant reform to the NHS in which multiple logics appear to shape the work organisation of doctors – including their emotional labour processes. In light of literature exploring the emotional labour of healthcare professionals, for example, Bolton (2002) notes that the patient is commonly redefined as the consumer of healthcare services. Following opening sections in this chapter, it has been acknowledged that both the managerial (bureaucratic rationality) and professional logics interplay at the frontline of healthcare work – impinging on important aspects of the labour process. Later sections of this chapter, therefore, consider the historical context of the NHS and the emotional labour process of healthcare professionals, namely doctors, who are observed as navigating multiple logics by means of conducting their work.

## 3.3 Emotional Labour in Medicine

In the sections that follow, a brief overview of the NHS is provided, and the work organisation of medicine is discussed in light of professionalism, changes to working arrangements, education/training and experiences of frontline work. Later sections focus specifically on the literature outlining two important sub-dimensions of medical work: emotional labour and peer relations, and then this chapter highlights the importance of sharing/coping with

emotional labour processes. Following these points, the research questions considered important to address are detailed in the summary, bringing the chapter to a close.

### 3.3.1 Institutional Context of the NHS

The focus of this thesis is on British healthcare – with a specific emphasis on junior doctor work processes and associated emotional labour experiences. In this light, this section considers an overview of the historical context of the NHS - outlining its inception, development, new public management movement and implications for the interplay of logics at the frontline.

#### 3.3.1.1 Introduction

Britain's National Health Service (NHS) has been referred to as the Labour Government's most fundamentally socialist inception (Klein, 1983, 2013). It came into existence in 1948, following the 1946 Act of introducing the NHS laid down its terms. Under those terms, architect of the system, Aneurin Bevan, was charged with the duty of promoting the notion of comprehensive healthcare in all of England and Wales. This comprehensive healthcare was designed to achieve improvements in the physical/mental wellbeing of the public, and to ensure developments in the prevention, diagnosis and treatment of illnesses (Klein, 2010). The primary purpose of the system, therefore, was to provide and secure the effective provision of healthcare services – services which would be free of charge at the point of delivery for the entire UK population (Klein, 2010).

Since its inception, the NHS has been marked by significant periods of reform and structural change. The monolithic model introduced in 1948 positioned the service as unique amongst other healthcare systems of across the globe (Klein, 2010). The NHS today, however, reflects that of a pluralist model with a large influence from private sector principles and ideology (Webster, 2002). Political debate is preoccupied with the future direction of the NHS. This debate is centred on the ideological shift toward increasing the efficiency of services, thus containing political expenditure (Klein, 1998; Freidson, 2001). It is also concerned with increasing patient choice – given that the position of the patient has changed in recent years. Patients or public service-users are increasingly being relabelled as the consumer(s) of healthcare services (Freidson, 2001; Bolton, 2002). In this light, professional autonomy is

threatened and there is now little need for the deference to medical authority because public service-users can online shop, are knowledgeable agents and challenge the perspectives of the doctors (Klein, 2010). Nevertheless, elected officials remain stringent in their efforts as they continue to adapt the structure of the NHS in line with advancements in medicine and technology, the changing demographics of contemporary society and alongside widespread consumerism (e.g. Klein, 2010; Greaves et al, 2012; Gabriel, 2015; Gabriel, 2018).

#### 3.3.1.2 Development

At the time of its establishment, the NHS was considered a significant social experiment in healthcare. It was inspired to a large extent by the Tredegar Mutual Aid Society – founded in Tredegar, South Wales. This also provided healthcare free at the point of use in return for contributions from its members (Matthews, 2017). The British NHS was further inspired by Cronin's (1937) seminal book: *The Citadel* which outlines the struggles of an idealistic young doctor working within Wales and London, and also by the work of Beatrice Webb – one of the most important British contributors to the socialist tradition (Harrison, 2000).

The re-shaping of the NHS along market lines might have been further influenced by American healthcare (Le Grand, 1999). Healthcare in the United States, for example, is provided by distinct organisations which operate within and are largely owned by the private sector. Only a small proportion of healthcare services in the United States is owned by the state. Given that the majority of American healthcare is privately owned, the services tend to reflect private sector philosophies. In addition to being one of the most expensive healthcare systems across the globe, for example, there is an increased focus on efficiency and rationalised service, imposing managerialism and clinical governance (Le Grand, 1999). The British NHS was introduced as a socialist healthcare model in order to offer equal access to healthcare for all of the public – however, the system has been reconfigured along market lines as a means of achieving increased efficiency (Klein, 2010).

The NHS was initiated with a vision of a centralised, integrated and hierarchal bureaucracy (Greener, 2009; Jones et al, 2013) – a tripartite system consisting of hospital services, primary care (i.e. general practitioners) and local authority services (e.g. Harrison, 1993; Webster, 2002). The NHS was alone amongst its capitalist associates to offer comprehensive healthcare

to its entire population as a right of UK citizenship (Klein, 1983; Webster, 2002). It was founded upon the core principles of funding on the basis of general taxation, services being free at point of use, treatment decisions based upon clinical need as opposed to one's ability to pay and that the entire UK public would be eligible for care (Bishop and Waring, 2016). The public service, therefore, was considered an outstanding example of 'socialised medicine' within the western world by many outsiders and thus the NHS soon attracted both national/international attention (Webster, 2002; Klein, 2010; Jones et al, 2013).

The first and second decade were characterised by a period of growth and economic optimism for the NHS (Webster, 2002). In addition to medical/technological advances and the better evaluation of healthcare services, organisational management became a key priority. The Cogwheel Report of 1967 was introduced in order to examine the clinician's positioning within the hospital setting (Layland, 2018). Clinicians were subsequently encouraged to become increasingly involved in both strategic and economic decision-making within the system – highlighting aspects of early managerialism and extending bureaucratic structures of the NHS together (Webster, 1998, 2002; Kitchener, 2000). Alongside this development, The Salmon Report (1967) emphasised the need for an improved nursing structure – it encouraged a hierarchal order of nursing staff and thus raised their professional profile within hospital management. Furthermore, postgraduate education centres were introduced into British healthcare and thus doctors, nurses and other clinical staff were able to foresee a strong future for the NHS (Webster, 1998, 2002).

Following this initiation, a series of developments and restructuring have characterised the NHS from the time period 1970-2020 – reflecting the growing market managerialism associated with the NHS. These developments are bullet-pointed below in order to provide a brief overview and to outline implications for the manifestation of multiple logics at the organisational frontline. NHS developments, at the political level, include:

- **1970-74: Conservative led by Edward Heath**: This time led by the conservative party was characterised by 'corporate' approaches to the management of public health. The move towards a population-based funding system continued but relations between management and staff deteriorated under powerful and largely disaffected trade

unions. These proposals were delivered by the labour party in the following years (Webster, 2002).

- **1974-79: Labour led by Harold Wilson (1974-76) and James Callaghan (1976-79):** This period led by the labour party marked two important changes to the NHS. Firstly, in 1974, improvements were made to the tripartite system by combining hospital and local authority services and bringing these under the management of Regional Health Authorities (RHA). Secondly, the labour party acknowledged the importance of consensus management within the NHS – the recognition that the NHS is comprised of a multi-skilled workforce and thus all staff groups must have an input in decision-making strategies (Webster, 2002).

- **1979-90: Conservative led by Margaret Thatcher:** During this period, government officials emphasised both choice amongst the public and competition between healthcare providers/purchasers with the intention to increase the efficiency of healthcare and to introduce tighter budget control. A system which was once reflected social equity and collective compassion was thus transformed into one characterised by market principles and private sector philosophies (Klein, 1983; Webster, 2002). Three important changes marked the restructuring of the NHS during this period. Firstly, in 1982, the conservative government sought to increase decision making and power for local authorities in order to ensure the local level can be held accountable for mistakes/adverse outcomes. In this light, government officials excused themselves of responsibility by shifting decision-making processes closer to the patient. Secondly, in 1983, layers of general management were introduced into the NHS. In light of the Griffiths Report, which suggested that the NHS lacked an adequate management structure, this introduction constituted of non-clinical managers who were responsible for strategy, economic decision making and budget control. Such a change thus strengthened the hands of bureaucrats over clinicians (Webster, 2002). This is an implemented change predicted by Freidson (2001) who argued that such managerial imposition would threaten the autonomy held by clinicians in hospital and care settings. This period also introduced the internal market (1989) founded on a purchaser-

provide split, whereby primary care procured services from hospitals - the aim of this initiative being to improve efficiency through 'managed competition' (Webster, 2002).

- **1990-1997: Conservative led by John Major**: In light of Thatcherization, this period further developed the internal market – with, for example, RHAs contracting/purchasing healthcare from either their own or other authorities' hospitals (Le Grand, 1999; Klein, 2010) and GPs were given a budget to purchase services for their patients (Rosen and Mays, 1998). Such an initiative increased the competition for resources on the internal market and echoed the first wave of marketisation of the NHS (Webster, 2002; Timmins, 2012; Bishop and Waring, 2016).

- **1997-07: Labour led by Tony Blair:** This period stressed the importance of collaboration and cooperation as a means of increasing efficiency and quality delivery of healthcare services, and it introduced an increase in managerialism at the organisational frontline. These aspects combined to constitute the modernisation of British healthcare (Klein, 1998; Webster, 2002). A significant emphasis on patient choice and an increase in service quality arguably reflect the rise of consumerism and neoliberal principles (Bolton, 2002; Gabriel, 2015), and the NHS shifted towards a consumer ethos in its drive toward modernisation. The NHS was also reorganised such that District Health Authorities (DHA) were replaced by Strategic Health Authorities (SHA) and Primary Care Trusts (PCT).

- **2007-10: Labour led by Gordon Brown:** This period saw the introduction of the Care Quality Commission (CQC) – a new health and social care regulator.

- **2010-15: Coalition led by David Cameron (Conservative) and Nick Clegg (Liberal Democrats):** Perhaps the most important introduction of this period was the Health and Social Care (HaSC) Act in 2012. This was the largest attempt at the national level to promote privatisation within the NHS via a series of market principles. The HaSC Act was thus considered an extension to the previous neoliberal changes already reflected within British healthcare. Patient choice also increased, and the NHS was reshaped along market lines in hope for greater efficiency of healthcare services.

- **2015-2016: Conservative led by David Cameron:** This time period saw the rise of the industrial strike action of junior doctors against the state – given significant changes made to their contracts and work organisation proposed by Secretary of State, Jeremy Hunt.

3.3.1.3 The New Public Management Movement in Healthcare

Following the historical context outlined above, governments/policymakers continue to search for new ways to rationalise healthcare and improve services in line with economic efficiency measures. Healthcare systems seek to further ensure that they are responding to consumer preferences in line with neoliberal principles, societal change and address other demands of healthcare accountability (Numerato et al, 2012; Waring and Bishop, 2011; Waring, Currie and Bishop, 2013). The introduction of these mechanisms has often been promoted as the new public management movement (Hood, 1991, 1995; Kitchener, 2000; Leicht et al, 2009). Importantly, several healthcare systems across the globe have been implemented in contexts in which market-based competition and patient choice are continuously being encouraged (i.e. England's NHS) (Ferlie et al, 1996; Numerato et al, 2012).

New public management (NPM) is a term coined by Hood (1991) - its core themes are reflected in the political reforms associated with various reorganisations of the British healthcare service. NPM offers a summary of the ways in which public sector institutions can be reorganised in order to rationalise tertiary services (Dunleavy and Hood, 1994). The essence of NPM is that the public sector is increasingly being encouraged to imitate private sector principles as a means of achieving greater efficiency. In the UK healthcare context, private sector principles are evident through the introduction of increased competition (i.e. the internal market), payment by performance and contractual procedures between healthcare providers. NPM has also discussed that public service sectors such as the NHS are increasingly favouring the introduction of general management processes in order to increase responsibility/accountability at the local level of work.

Furthermore, the NHS continues to respond to consumer preferences which is a key characteristic of private sector organisations (Nancarrow and Borthwick, 2005). The NHS is thus being driven toward a combination of a market-based and customer-service ethoses - in

which there is increased competition amongst the workforce and patients/traditional public service-users are being re-defined as the consumers of healthcare (e.g. Bolton, 2002). In this light, the concept of NPM clearly captures the changes associated with NHS reform. NPM highlights the recent shift toward economic efficiency and consumerism in line with societal change, and this shift is increasingly being understood as characterising the fundamental logics of Britain's public sector services. Although the NPM movement can be applied to the wider public service sector in Britain; in the context of this thesis, the example of the NHS and medical work organisation is presented in order to reflect the notions of NPM.

### 3.3.2 Implications for Institutional Logics

In light of the institutional context of the NHS outlined above, implications for the consideration of institutional logics are raised. In sections that follow, the institutional logics perspective is considered in the context of healthcare in line with the empirical focus of this thesis. Healthcare institutions represent common settings for the exploration of multiple institutional logics. This has been evidenced in several studies that take an institutional logics perspective in examining the implications of field-level change within healthcare contexts (Kitchener, 2002; Reay and Hinings, 2009; Goodrick and Reay, 2011). In healthcare systems across the globe, academics have commonly observed the intrusion of a business-like/managerial logic upon the previously dominant professional logic (Reay and Hinings, 2009), with healthcare institutions being recognised as an increasing site of contestation between multiple, contradictory logics (Scott et al, 2000). Authors have considered the negotiation or contestation of both managerial/professional logics in the context of several professional services (e.g. Noordegraaf, 2015). Authors have also explored the interplay of ideal-types of managerial and professional logics – recognising that these are not descriptions of what happens in the context of work, but instead represent analytical models by which to compare empirical observations across institutions (Thornton and Ocasio, 2008).

In addition, empirical studies show that professional logics are nuanced in healthcare settings and thus multiple professional logics might be enacted by doctors. Doctors, for example, maintain a high degree of autonomy and clinical judgement and are expected to self-police their professional practice. In this light, traditionally, they remain relatively free from external

regulation (Abbott, 1988; Freidson, 1988) and are observed to follow *mindlines* when determining clinical interventions, as opposed to standard guidelines set out by the institution (Gabbay and Le May, 2004). However, research also suggests that the professional logic is not monolithic – nurses are observed to commonly align with more holistic care approaches for the patient in comparison with doctors, and they tend to accept greater hierarchy intra-professionally, whereas doctors tend more towards collegial organisation structures (Currie et al, 2015). It follows therefore that nurses with managerial backgrounds are likely to be perceived within their profession as senior to their nursing colleagues and are effectively able to manage their peers (Currie et al, 2015). Meanwhile, general managers, even at executive levels of the institution, struggle to exert influence over doctors, despite being able to exert greater control over other, non-medical professionals, such as nurses (Reay and Hinings, 2009; Waring and Currie, 2009).

Within hierarchies of this kind, the position of hybrid managers, who combine managerial and clinical responsibilities is an interesting one to observe. These positions have been introduced, in part, to address policy implementation gaps as opposed to controlling professional groups through managerial processes, which enable the integration of clinical and managerial duties, and thus allow for professional governance from a distance (Martin and Learmonth, 2012). In this light, hybrid managers are expected to proactively manage their professional colleagues (e.g. doctors, nurses, others) towards organisational goals (Ferlie et al, 2013). However, in highlighting the nuances of the professional logic, in comparison to hybrid nurse managers, doctors moving into hybrid managerial positions are commonly observed to enact a more representative, than a managerially informed hierarchal, hybrid role (Llewellyn, 2001). Clinical hybrid managers thus orientate towards professional interest as opposed to strategic organisational interest (Waring and Currie, 2009; Spyridonidis, Hendy and Barlow, 2015).

As literature indicates, the interaction between institutional logics may be more ambiguous and contested than originally assumed by policymakers, even after attempts of co-opting different clinicians into hybrid managerial roles. Furthermore, in considering interactions between managerial and professional logics, research suggests that ideal-types of corporate and market logics cannot be disaggregated. Thornton et al (2012) suggest that

corporate/market logics blend and blur, combining to suppress the influence of professional logics, in their empirical work. In the context of British healthcare, this appears to be the case, particularly during Currie and Spyridonidis's (2016) study period (2009-12). During this period, the British NHS appeared to be characterised by a sustained intrusion of market forces, performance management and increased regulatory control to which healthcare providers needed to respond - originally derived from the new public management movement (Hood, 1991; Ferlie, Fitzgerald and Pettigrew, 1996). Recently, the intrusion of managerialism has been reflected in the following aspects: intensive performance management, particularly around waiting lists and times for patients, with sanctions for 'failing' organisations (Lewis and Appleby, 2006) and greater influence given to commissioners to strategically plan and purchase healthcare over those organisations delivering healthcare to service-users (Ham, 2004, 2008). Given the apparent aim of policymakers to penetrate the monolith of the NHS into separate, flexible aspects, through market means, as with other public sector organisations in England (e.g. academia), organisational survival of the NHS may well be threatened. Studies show, for example, that following poor performance, hospitals might be taken over, often by private sector organisations, or closed indefinitely (Waring, Currie and Bishop, 2013). Given increases in political influence and regulatory control, competition between contradictory logics is likely to play out at the organisational frontline.

In light of the above, there appears to be an important rationale for exploring institutional logics in relation to contemporary healthcare work. At the political level, the NHS has been subject to significant re-structuring and organisational reform. This has resulted in the manifestation of conflicting logics at the organisational frontline – each logic seeking to motivate, constrain and/or restrict the work of doctors and other healthcare professionals. The remainder of this section thus provides a brief insight into conflicting institutional logics observed to shape work processes within healthcare contexts. The four logics referred to are bureaucratic rationality, professionalism, consumerism and an orientation towards the community.

#### 3.3.2.1 Bureaucratic Rationality

In line with an ideological shift towards neoliberalism, healthcare work is increasingly characterised by principles of economic efficiency, resource constraints and budget control,

alongside imposing managerialism, and thus reflecting the structure and principles associated with private sector work organisations (e.g. Bolton, 2002). British healthcare services are increasingly rationalised in order to provide efficient care to an ageing population. The logic of bureaucratic rationality is therefore associated with imperatives of rationalised work, economic efficiency and (state-imposed) managerialism within public sector services (Hood, 1995). The worker is expected to bracket-off personal interests and motivations and apply the standards and procedures of the bureaucratic form in order to achieve maximum efficiency. In light of bureaucratic rationality, service-users should be dealt with impersonally and objectively in line with key objectives of the institution.

In addition, management as a distinct function was introduced into British hospital contexts with the implementation of the Griffiths Report (DHSS, 1983) – as noted above, this proposed fundamental changes to the management structure of the NHS as a means of achieving greater efficiency of services. The introduction of general manager at hospital level marked a new managerial style that reflected Griffiths' commercial background (Bolton, 2002). Whilst new managerial processes eroded the basis of consensual management in place previously (Ackroyd, 1994; Klein, 1995), control/autonomy was transferred from medical professionals to financial managers – the emphasis shifting towards economic efficiency and the delivery of quality services to consumers of healthcare (Klein, 1989; Bolton, 2002).

#### 3.3.2.2 Professionalism

The logic of professionalism implies that the professional has a high degree of expertise, power and authority over a body of codified knowledge (Abbott, 1988; Thornton et al, 2012). The work organisation of professionals is constituted by relational networks of individuals and professional associations. Entry into a profession is maintained via formal systems of membership and this is obtained through prolonged training and specialist knowledge acquired by the professional over a lengthy period (Mintzberg, 1979). Professionalism, guided by the medical profession and guidelines set out by the General Medical Council, offers doctors a sense of ontological security and autonomy over work processes and decision making. Doctors thus base their clinical judgement on what is best for the patient as opposed to what is required by general managerial processes. In this light, it can be argued that the

logic of bureaucratic rationality appears to threaten the previously held dominant logic of professionalism within healthcare institutions (Friedson, 2001).

#### 3.3.2.3 Consumerism

Further to the above, organisations are increasingly placed in competition with one another within contemporary markets - not only through price but also in the way that organisations seek to attract and enchant customers as a means of generating and maximising profit. This leads organisations to a logic of enchanting customers as sovereign figures (Korczynski, 2002). Under neo-classical economics literature, sovereign customers are positioned as the directors of market activity and thus the logic of consumerism involves organisations attracting their customers by directing frontline workers to promote a sense of enchantment (also see Vargo and Lusch, 2017). In healthcare contexts, several governments over the years have sought to integrate the consumer into healthcare dynamics by enhancing patient choice and cooperation – an example of this within the NHS might be the introduction of feedback mechanisms within individual departments, hospitals and Trusts (Currie and Spyridonidis, 2016). Indeed, the NPM philosophy clearly reflects an ideological shift toward newly valued entrepreneurial behaviours/activities (DoH, 1997), where patients/service-users are re-defined as the consumers of healthcare (e.g. Bolton, 2002).

#### 3.3.2.4 Community Orientation

Lastly, the logic of community orientation draws on the concept of social embeddedness (i.e. Polanyi, 1957; Granovetter, 1985). For frontline workers seeking meaning in their work, service-users may be regarded as 'socially embedded' individuals (Korczynski, 2002). In this light, when two individuals undertake an economic exchange, they are also taking part in a social relationship – one which can have meaning or displeasure quite distinctive from the economic exchange that is taking place otherwise (Korczynski, 2002). In this way, workplace interaction between worker and service-user can be considered as social in addition to economic/transactional. An orientation towards the community, therefore, is based on socially embedded relationships shaped and maintained by frontline staff. Perceived socially embedded relationships might be influenced by ones' social upbringing and/or socialisation processes or the context in which they learn and grow. The implied basis of the relationship

between the organisation and service-user is that of a socially embedded one. In this light, doctors might offer more of their emotions to patients and others considering the social context. Similar findings have been found in other healthcare settings (e.g. Bolton, 2005; Stacey, 2011). In Bolton's thesis, she calls this emotional 'gift giving'.

In light of significant organisational reform, medical cohorts, such as junior doctors, have been positioned at the sharp end of the reconfiguration of Britain's healthcare system along market lines, reflected in the radical changes to their employment contracts. Despite strong opposition from the British Medical Association (BMA), changes were imposed at the government level to junior doctor work contracts as a means of extending weekend working. The conservatives resumed full power in 2015 and Jeremy Hunt was elected as the Secretary of State for Health but appointed to Ministerial Office. Jeremy Hunt instructed changes to junior doctors' employment contracts and these changes appear significantly important in re-organising the distribution of power amongst medical professionals, non-clinical management and central government (Bishop and Waring, 2016). The balance of power between professionals, managers and the government have characterised the organisation of British healthcare for a considerable length of time (Klein, 2010), and the 2012 reforms, clearly reflected in the introduction of the HaSC Act, constitute the most recent addition to the political and historical context of the NHS.

Importantly, there has been a significant impact that continual change has had upon the frontline staff of the NHS, namely frontline junior doctors and management, with respect to their professional identities, wellbeing and commitment to the British healthcare service (Waring and Bishop, 2011). In this light, junior doctors have been situated at the sharpest end of recent NHS reform. This thesis, therefore, seeks to understand junior doctor working arrangements at the organisational level, and consider their emotional experiences with both patients, relatives and related others, given that these medical cohorts are employed on the frontline of patient care and thus engage in considerable amounts of patient contact/interaction. Following sections of this chapter explore the emotional labour of healthcare professionals, in brief, and that of medicine in more detail, in line with the focus of this study.

### 3.3.3 Work Organisation of Doctors

This section explores the work organisation of medicine – with a particular focus on junior doctor work. Junior doctors have been placed at the sharpest end of NHS reform and are increasingly employed on the frontline of patient care and service delivery. Junior doctors constitute an important medical cohort because they have endured significant changes to their work roles and contractual arrangements. The changes to junior doctor employment contracts are likely, to some extent, to have had adverse impacts upon their wellbeing and overall commitment to the health service in England. Considering this, it is necessary to consider the organisation of their work and how this organisation might have changed in line with multiple institutional logics impinging on their labour process. In light of four key logics: bureaucratic rationality, professionalism, consumerism and an orientation towards the community, this section explores the working arrangements of junior doctors facilitated by a discussion of: the changing nature of medical professionalism, working hours/work intensity driven by efficiency, contemporary medical education/training and the experiences of frontline patient care.

#### 3.3.3.1 Medical Professionalism

As can be seen from the preceding sections, the control of clinical practice has undergone substantial change in the NHS (Kitchener, 2000; Bishop and Waring, 2016). Doctors are extensively exposed to management control mechanisms that have adversely affected the nature of medical professionalism. These developments have emerged in reaction to several changes that have affected the Britain's healthcare system – these changes include the welfare state crisis, reinforced market procedures (Harrison and Ahmad, 2000), the changing position of the patient (Light and Levine, 1988; Freidson, 2001) and publicly exposed medical failures (i.e. Weick and Sutcliffe, 2003). Central government in England is increasingly concerned with improving the efficiency of healthcare services and responding to demands of healthcare accountability (Klein, 2010; Numerato et al, 2012). As previously discussed, the introduction of these mechanisms has been promoted by the new public management movement and has reflected trends in many public service sectors (Hood, 1991). Although there is little evidence of de-professionalism amongst different medical cohorts, there is increasing evidence for doctors' interpretation of a decrease in medical autonomy and sense

of dominance over the medical field (Holliday, 1995; Hannigan, 1998; Exworthy et al, 1999; Harrison and Smith, 2003). This has further resulted in the hindering of the acquisition of skills at the junior level (Broom et al, 2009). In light of Numerato et al's (2012) review, the professional culture of medical doctors has substantially changed under the pressure of managerial processes and professional autonomy levels are subsequently affected. Their review indicates that managerial imperatives present an ideology which contributes to the shift of healthcare services toward the criteria of efficiency, rationalisation and the standardization of medicine. In this way, the perspective of the medical doctor is diffused – in addition to the delivery of quality patient care, doctors are increasingly concerned with the notions of accountability, healthcare evaluation and other managerial priorities (Kitchener, 2000; Numerato et al, 2012). Consequently, senior doctors have little time to provide adequate supervision for their juniors and thus this often results in the hindering of skills and on-the-job learning for junior doctor cohorts (Numerato et al, 2012).

Importantly, however, several studies have discussed the resistance to management by doctors, reflecting the continued strength of the medical profession. This notion of resistance is contrary to the theoretical position of managerial dominance over professionalism (Numerato et al, 2012). Furthermore, there are contexts of clinical directorates, hybrid identities and professional hybrids (i.e. Noordegraaf, 2007) in which clinical practices and managerial responsibilities are combined. Still, these arrangements rely on the acceptance of managerial imperatives by medical professionals (Numerato et al, 2012).

#### 3.3.3.2 Reducing Work Hours and Increasing Intensity

In response to the government's implementation of various efficiency measures, working hours and levels of intensity have significantly changed for senior doctors generally, and junior doctors particularly in the context of British healthcare. In the NHS, junior doctors have been typically expected to work for long hours at a time. These working hours tend to be considered unsafe and unsustainable for the health and well-being of junior doctors (Gander et al, 2007); these working hours are also considered as unsafe for the provision of healthcare services and for the quality delivery of patient care (Pounder, 2008). There have been efforts to reduce NHS working hours for doctors in recent years. In line with the European Working Time Directive (EWTD), for example, the working hours of junior doctors have been

considered an issue of concern within health and safety legislation. This legislation applies to the UK NHS in addition to other European healthcare systems. It outlines the working hours of junior doctors that is considered safe for medical practice.

The EWTD originally passed as law in 1993. Historically, junior doctors and others in medical training were excluded from the provisions or requirements of this legislation. However, given that the issue of long working hours was challenged as health and safety law, changes were brought about from August 2004 and it was decided that medical professionals in training must also be incorporated (Pounder, 2008). By this time, working hours of junior doctors were limited to 56 hours per week, and by 2009 the length of working hours decreased to 48 hours. In support of these changes, an abundance of literature has previously suggested that sleep deprivation, sleep restriction and the enforcement of unnatural circadian cycles each contribute equally to cognitive/motor impairments, injuries and clinical error (Taffinder et al, 1998; Owens et al, 2001). Medical professionals are not immune to these effects (Weinger and Ancoli-Israeli, 2002). Researchers have additionally claimed that junior doctors working over 48 hours per week are significantly more prone to adverse health outcomes (Allard et al, 2002) and are at increased risk of experiencing fatigue on-the-job (Gander et al, 2007).

The reduction in working hours for junior doctors was expected to increase their well-being and improve the delivery of healthcare for patients of the NHS and other healthcare systems across Europe. However, alongside these changes, there has been a significant increase in work intensity for junior doctors practicing on the frontline of medicine. Junior doctors are increasingly expected to work harder in reduced spaces of time and thus shorter working hours are conflicted with considerable work pressures (Pounder, 2008). In light of this time pressure, work intensity has been reported to have had a negative impact upon the delivery of interpersonal care, medical education/training and the number of clinical errors documented in recent years (Olsen et al, 2009; Milne et al, 2015). It appears that doctors are expected to balance increased requirements of the role – such as administration, emotional work processes and clinical care – and thus their work has intensified in line with a reduction to their working hours. Given the impinging bureaucratic aspects of medicine, doctors also appear less able to identify with their work as medical professionals in several contexts (e.g. Hekman et al, 2009; Waring and Bishop, 2011). Although a reduction in working hours is

necessary for junior doctor well-being, the rules of the EWTD appear to have compromised the medical service with respect to increased intensity and pressures of work for doctors - these rules have also threatened the quality delivery of care for patients (Pounder, 2008; Goddard et al, 2010).

#### 3.3.3.3 Medical Education and Training

This section firstly explores undergraduate/postgraduate medical training and the role of Royal College examinations. This section then explores the process of medical education and training in the context of the work organisation of doctors outlined in discussions above.

The first step to becoming a doctor is to study medicine at undergraduate level or via a graduate medical course. This usually takes between four and six years of study. Following graduation from medical school, students qualify as doctors and progress onto postgraduate training (BMA, 2020). The most common route is to undertake the foundation programme and higher specialist training. During the course of this time, trainees are referred to as *junior doctors*. It can take up to 15 years to become a qualified consultant in a specialist medical/surgical (or alternative) area. The foundation level consists of an integrated two-year programme (FY1 and FY2) – here doctors complete rotations in various specialist areas/general training in order to practice as a doctor within the UK. This programme acts as a bridge between undergraduate medical training and specialty/general practice training (BMA, 2020). Doctors must undertake and complete the two-year programme in order to develop their practical/technical skills and competencies and gain knowledge of how to manage acutely ill patients.

Following successful completion of the foundation programme, doctors continue their training in either a specialist area of medicine (e.g. geriatrics, stroke, orthopaedics etc.) or in general practice. There are approximately 60 individual specialities to choose from and the area of medicine that doctors decide to specialise in will determine the length of training required (BMA, 2020). Specialty training is delivered in three main ways: run-through training programmes (lasting approximately three years for general practice and between five and seven years for other specialties); core and higher specialty training programmes (lasting between two and three years and are followed by an open competition to enter a higher

specialty post); or via the Acute Care Common Stem (ACCS) (a three-year training programme for trainees wishing to work within emergency medicine, general internal/acute internal medicine or anaesthesia) (BMA, 2020). In order complete specialty training, most doctors are also required to pass relevant membership exams offered by the Royal Colleges. These exams are considered as widely challenging for trainees and it is common for individuals to sit exams more than once in order to be successful. Demands are placed on trainees to balance their full-time work with the level of study required to pass these exams.

After completing one of the specialty training routes outlined above, and successfully passing associated examinations, doctors are then awarded a Certificate of Completion of Training (CCT) – allowing them entry onto the GMC specialist or general practice register (BMA, 2020).

Following the exploration of medical training routes, this section now discusses the experiences of medics in light of the work organisation of doctors outlined above. Literature suggests that medics undergo a prolonged period of training and socialization into the profession in which they adopt particular professional dispositions. Becker at al's (1961) classic analysis of medicine discussed the nature of student culture, student autonomy and the importance of *communities of fate* in which medical students develop and become embedded within the professional culture of medicine.

Medical students, junior doctors and those continuing to climb the medical hierarchy within the NHS, must work toward competencies outlined by the General Medical Council (GMC). The GMC provides regulated medical education and training guidelines and outlines the general duties of being a doctor (as will be explained below). Following recent NHS reform, medical education and training within the UK has accordingly changed and is increasingly perceived as being inadequate by medical students/early-career doctors in training (Brennan et al, 2010; Yon et al, 2015). In this light, from undergraduate education to the level of training required for the position, early-career doctors often report high levels of anxiety, stress and exhaustion as a result of what is now expected of them (Scallan, 2003; Bleakley and Brennan, 2011). Several pieces of literature in this domain claim that junior doctors, especially, suggest scope for improvement within the UK medical training system (Lowry, 1992; Kendall et al, 2005). They report that the increase in work intensity comprises their organisational training,

that there is a lack of guidance from their seniors and that there is a lack of formal education in practice (Yon et al, 2015). This is most notably due to increasing numbers of senior doctors adopting managerial roles (Numerato et al, 2012), and pertains to a general assumption amongst senior clinicians that *experience equals learning* (Scallan, 2003). However, according to Becker et al (1961) and Scallan (2003), the latter assumption is not necessarily appropriate for structuring the medical education of students or the training of junior doctors given the various other factors that need to be considered (i.e. student culture and autonomy) and a variety of specialties that the doctor can eventually choose to work in.

In relation to the changes in working hours outlined above, junior doctors often report that given the associated time-pressure and increases in work intensity, their medical education and practical training is significantly compromised (McGowan et al, 2013). As discussed by Pounder (2008), junior doctors work on the frontline of healthcare – during the day, overnight and at various times throughout the weekend. At the same time, these doctors receive their formal/informal training and tend to learn from their seniors on-the-job. Training generally occurs daily. The implications of the reduction in working hours has inevitably fallen upon the level of training junior doctors receive (Goddard et al, 2010). They are often pulled out of their shifts when they are receiving most of their active training and thus informal learning/knowledge-sharing about particular conditions is compromised (Goddard et al, 2010). In addition, academics explain that it is not simply the loss of exposure to formal/informal teaching. There are also concerns relating to the loss of continuity of exposure to progressive illnesses and patient health. Reduced time in the hospital often means that it can be difficult for junior doctors to appropriately observe and learn from a progressive health condition (Pounder, 2008). Such an observation can also present as lifesaving for the patient and thus there is not only an educational risk, here, but also that of public health. Diagnosing setbacks or identifying subtle deteriorations in illnesses will also become problematic given that the junior doctor spends considerably less time with their assigned patients. The evidence suggests that patients also begin to worry as their doctors frequently change over the course of their treatment (Pounder, 2008). Patients have valid reasons to be concerned as they are unable to form trusting relationships with the professionals responsible for their medical health – the EWTD has exacerbated this issue (Goddard et al, 2010; Monkhouse, 2010).

Research in this area has also documented that a reduction to junior doctor working hours and a subsequent increase in work intensity has been found to increase episodes of sick leave amongst various junior doctor cohorts – the implementation of the EWTD is clearly affecting the levels of training that junior doctors receive, however, in this light, the EWTD can also be considered to be detrimental to junior doctor well-being (McIntyre et al, 2010). Following the economic shift towards efficiency of healthcare, it is clear here that junior doctors have been placed at the sharp end of recent NHS reforms and there have been compromises to their medical training processes which elicit particular affective dispositions amongst doctor cohorts.

Junior doctors have further discussed that transition periods are difficult to manage. In contemporary medicine, the transition from academic-based studies to practice-based training within the NHS is a challenging experience, given the dramatic changes to junior doctor learning environments, teaching styles and expectations of their work by seniors (Brennan et al, 2010; Kendall et al, 2005). Although the importance of learning through service delivery and the need for strong educational supervision has been acknowledged (e.g. Kendall et al, 2005), this is problematic within medical practice because it does not always translate from theory. Several researchers, for example, have argued that a tension remains between the need for service delivery and for a structured development programme for junior doctors - this remains unresolved (Browne et al, 2003; Kendall et al, 2005).

In addition, professional socialisation has been commonly discussed with respect to medical education and training (Scallan, 2003). It is clearly important for doctors to learn the emotional ropes of being a doctor, in addition to the assimilation of essential norms, values, attitudes/behaviours of the medical profession. Professional socialisation also includes the overt education system through the frequent examination of knowledge and skill and also the informal adoption of attitudes, behaviours and culture of medicine (Becker et al, 1961). These socialisation processes are generally transmitted by apprentice-style learning techniques or on-the-job medical training from seniors and other teaching role models (Scallan, 2003). At critical transition periods, professional socialisation can induce stress within both medical students and junior doctors, i.e. when they are expected to uptake increased responsibility and climb the medical hierarchy alongside providing quality delivery of patient care. Considering

this, the available literature argues that medical students/junior doctors would benefit from increased support from their peers. For example, formal peer support systems could help one to cope with the perceived anonymity of the training process, reduce the stigma of stress signalling weakness and facilitate learning environments which are more open to discussing the mental illness of medical professionals (Scallan, 2003). This will help to decrease stress levels associated with medical education and training for tomorrow's intake of junior doctors, and thus help to make small improvements to the medical labour process (Kendall et al, 2005). In this light, the important notions of sharing/coping with work experiences is a central theme of this thesis – discussed in more detail in later sections of the chapter.

#### 3.3.3.4 Experiences of the Frontline

Other experiences on the frontline of patient care have been explored in recent literature. Junior doctors have discussed that their current work practices do not allow for effective collaboration between with their colleagues and other healthcare staff (Paice et al, 2002). There is a strong need for an increase in the amount of time that junior doctors can spend with their colleagues, allowing them to share patient experiences and collectively learn from one another (Paice et al, 2002). Similar findings have been discussed by Milne et al (2015). These authors have focused on the difficulties with collaborative working amongst junior doctors due to healthcare rationalisation, efficiency measures and the tightening of budgets at the government level. The authors have argued that junior doctor work roles are constrained by the daily stresses associated with fulfilling their clinical work roles. Work patterns of junior doctors involve managing both intra-personal (i.e. with other junior doctors) and inter-professional (i.e. with other healthcare staff) boundaries in order to provide quality patient care. Spanning these boundaries in medical work facilitates the negotiation of sharing information with relevant staff members and the gaining of information for one's own work (Milne et al, 2015). This collaboration is often compromised due to the national focus on increasing the efficiency of healthcare services - with respect to imposing managerialism, time pressures and pay by performance.

Managing collaborative working within complex clinical and organisational hierarchies is perceived as challenging by medical professionals. The interactive negotiations that do take place by junior doctors are carried out in tacit and passive manners as opposed to being

explicit or active (Milne et al, 2015). Furthermore, Milne et al. discuss a level of disrespect that lies between inter-professional boundaries, i.e. between junior doctors and nurses, and this tension is often found to inhibit the collaborative effort required for practicing medicine inter-professionally (Milne et al, 2015). Junior doctors are focused and have little time to interact with peers or share knowledge. Some research has suggested that junior doctors are often uni-professional in nature in that they spend considerable amounts of time in isolation, completing their work tasks alone (Westbrook et al, 2008). Importantly, however, conflicting findings by Weller et al (2011) suggest that there has been a recent shift in medical work arrangements, in which junior doctors/nursing staff often work in strong collaboration with one another in order to achieve quality patient care.

Following the above experiences of frontline medicine, McGowan et al (2013) have argued that junior doctors face significant challenges in the current healthcare environment, working with staff shortages/cutbacks to healthcare expenditure, alongside an increased demand for healthcare and increased public expectations. The authors conducted research with 20 junior doctors and concluded medical workloads were too heavy, thus unmanageable. This meant that doctors' perceived time with patients felt rushed and this negatively impacts upon the interpersonal care that they are capable and often keen to provide. Junior doctors also felt that their workloads were unrealistic due to the concurrent reduction in working hours and increase in intensity – they felt that there was limited time for medical training and clinical decisions were increasingly being made under sleep deprivation (Weinger and Ancoli-Israeli, 2002; Gander et al, 2007). The result was that often clinical work/decisions led to error and compromised the delivery of patient care (Bogg et al, 2001; McGowan et al, 2013).

### 3.3.4 Emotional Labour Experiences and Peer Relations

Sections above have explored the work organisation of medicine. In the sections that follow, sub-dimensions of the medical labour process are explored. Two key sub-dimensions of the medical labour process refer to emotional labour experiences for frontline workers and the importance of peer relations. These will be discussed respectively. Several pieces of research discuss the importance of providing emotional labour within healthcare settings (e.g. Bolton, 2002; Zapf and Holz, 2006; Hunter and Smith, 2007; Haque and Waytz, 2012). Often within healthcare literatures, the process of emotional labour is referred to as compassionate or

interpersonal care – these concepts consider the texture of emotional labour that healthcare workers perform with patients during interactional exchanges (Hunter and Smith, 2007). Most of the literature in this area has focused on the nursing labour process and thus the interpersonal care provided by nurses (James, 1992; Chambliss, 1996; Cricco-Lizza, 2014). Authors have also discussed the emotional labour process of nurses under market-driven healthcare (i.e. Bone, 2002) and the implications of efficiency and consumerism on frontline nursing staff. Research also continues to find that the emotional labour performed by nurses is related to an improvement in health outcomes for patients (Bone, 2002; Anderson and Agarwal, 2011).

In comparison with nurse cohorts, there has been relatively little effort to understand the emotional labour experiences of junior doctors in training. In light of work intensification and medical training, doctors are trained to adopt particular emotional displays during work (e.g. stoicism). Examples of stoic emotional norms include contexts characterised by detachments - in which doctors remain detached from their patients, treat them like objects in order to provide effective treatment, and thus provide *care* through the display of instrumental/neutral emotion (Mintzberg, 1979; Ofri, 2013). However, considering NHS reform, it is worth considering the implications of both efficiency and consumerism logics on frontline medical staff (in addition to influences associated with professionalism and an orientation towards the community). Efficiency measures often seek to constrain the amount of time available for interactional care, thus compromise processes of emotional labour (Paice et al, 2002). In light of consumerism and the tendency of Britain's healthcare environment to respond to consumer preferences (Nancarrow and Borthwick, 2005), however, doctors may feel encouraged to manage their emotions in order to provide quality services to consumers of healthcare. Furthermore, one's sense of medical professionalism and ability to respond appropriately to social situations is likely to influence the nature of emotional labour amongst junior doctor cohorts. Such emotional work is likely to be carried out with patients on a routinely basis - though the performance of emotion at work is also likely to be managed with colleagues and others on-the-job.

Considering the above, directing academic attention to the emotional labour experiences of junior doctors is becoming increasingly important – particularly following influences of the

identified logics that seek to motivate, restrict or constrain the emotional labour processes of junior doctors. NHS reforms at the government level have exacerbated the demand for emotional labour processes at the frontline of healthcare. In this light, the first part of this section will discuss current knowledge on emotional labour experiences in medicine. The section will then explore the methods of coping with emotional labour processes amongst healthcare professionals, generally, and junior doctor cohorts, more specifically.

Among interpersonal relationships, it has been acknowledged that the doctor-patient relation is one of the most complicated to manage (Ong et al, 1995). This relation involves important interactions between unequal positions, with doctors occupying higher levels of authority relative to the patient (Freidson, 1974, 2001). The interaction that occurs between the doctor and patient is often involuntary and concerns issues of vital importance – some of these issues are highly sensitive and require close cooperation by both the doctor and patient (Ong et al, 1995). As a result, doctor-patient interaction can be emotionally laden (Chaitchik et al, 1992). Interpersonal communication is acknowledged as the primary tool through which the doctor and patient exchange important information (Street, 1991). Accordingly, the medical profession is calling for the adoption of increased *humanism* or empathy in the physician-doctor relationship (Jones et al, 1992) – allowing both the patient and doctor to manage emotions and facilitate healthcare progression. Positive affect and the emotional care provided by doctors are associated with improved healthcare outcomes for patients (Ong et al, 1995). Emotional care is further found to reduce patient anxiety in relation to their health conditions (Fogarty et al, 1991).

Importantly, doctors do not always feel prepared to manage the emotional requirements of their labour process (Kafetsios et al, 2013, 2016). They often report adequate communication skills in relation to managing the medical concerns of their patients, but research finds that fewer junior doctors are comfortable in engaging within emotional labour processes during particular interactions as they feel that they are under-trained in aspects of *managed care* (Cantwell and Ramirez, 1997). Further, junior doctors tend to avoid enquiring about the emotional concerns of ill patients – a lack of time and an inadequacy to manage emotions are commonly reported issues in relation to this. These issues associated with the provision of emotional care reflect the logic of market rationality (i.e. economic efficiency) as informing

the emotional labour of junior doctors. In line with previous discussions in this chapter, these findings also suggest that junior doctors may need further training (Cantwell and Ramirez, 1997; Weissman et al, 2006). Furthermore, doctors often discuss that they can share work-related experiences with colleagues but only a limited proportion of medical cohorts feel that they would benefit from organisationally directed care programs (e.g. professional counselling or Schwartz rounds) (Cantwell and Ramirez, 1997). This will be considered below.

In this light, recognising the significance of patient-doctor relationships, in which crucial communication and interpersonal care takes places, is particularly important at a time where healthcare delivery in global contexts has been subject to large-scale change. Jones et al (1992) have discussed the concerns of medical consultants in response to a reduction in junior doctor posts and an expansion in consultant clinical positions. Considering the NHS reforms of the early 90s, consultants feared that in addition to clinical task performance being compromised, junior doctors would have little time to spend talking to patients and to emotionally care for their needs (Jones et al, 1992; McGowan et al, 2013). The more recent organisational changes are likely to further constrain the emotional labour provided by doctors and will continue to do so as the landscape of the healthcare environment continues to be re-shaped along market and consumer lines.

An additional sub-dimension of junior doctor work considers the nature of peer relations. There is literature that explores the inter-collaboration between various cohorts in medicine, for example, that of consultants and doctors and that of junior doctors and nurses (McCallin, 2005; Martin et al, 2010; Weller et al, 2011). There is comparatively little evidence, however, to suggest that pressures to compete and collaborate co-exist within the hospital setting, and specifically occur between groups of junior doctors. Researchers have acknowledged that given recent healthcare reform the competition for junior doctor positions is likely to increase (Andrew et al, 2010). Given this, it might be likely that competitive processes play out between junior doctors more generally within the hospital. This is a key area to explore because it may inform whether social support systems are formed by junior doctors at work, and these support systems can be important when the need for emotion management arises on-the-job.

Aspects of collaborative working are often discussed in light of informal, social learning processes. The restraining of collaborative work practices can be linked to internal/external pressures for greater accountability, rise of consumer preferences and intensifying measures of budget control at the government level (Adler et al, 2007). Authors mentioned in the preceding section, for example, discuss that junior doctors commonly report time-constraints and, therefore, limited opportunities to work collectively with their peers (Paice et al, 2002; Radcliffe and Lester, 2003). They report that work patterns are fragmented and there is little opportunity for communication with both colleagues and patients on-the-job (Jones et al, 1992; Paice et al, 2002). However, Adler et al (2007) have more recently argued that medical work conducted by doctors is gradually shifting away from uni-professional processes. Within uni-professional processes, doctors largely work in isolation in their offices and attend to patients only when necessary. Adler et al (2007) contend that medical work is increasingly becoming more collective, and thus doctors are spanning into the boundaries of inter-professional and intra-professional work. Within these boundaries, doctors have the scope to form integral *communities* in which they learn to share knowledge, work experiences and transmit important information. These communities, therefore, help doctors to learn from one another on-the-job within supportive, collective working environments (McCallin, 2005; Adler et al, 2007). Furthermore, this shift toward conducting work within inter-professional and intra-professional boundaries is outlined within recent medical education curriculums and frameworks (McCallin, 2005) – this shift is thus considered an integral aspect of the medical labour process. Collaboration processes may also assist in the improvement of health outcomes and the delivery quality patient care (McCallin, 2005) - as will be acknowledged below.

As mentioned above, the nature of peer relations within the medical labour process can effectively inform the likelihood of doctors forming collective support mechanisms. For example, if the process of competition is highly evident amongst junior doctor cohorts, it is unlikely that colleagues will rely on one another for organisational learning or the sharing of work-related experiences. If pressures to cooperate remain salient between junior doctors, due to healthcare environments shifting toward the efficiency of services and time-constraints limiting the opportunities to perform medical work collectively (i.e. Paice et al, 2002), junior doctors are unlikely to have the space to form communal practices. However, if

the shift toward cooperation and collective working is adopted by medical professionals (i.e. Adler et al, 2007), then in addition to the sharing of specific practices, doctors may be able to form informal, crucial support systems in which they can better cope with their emotional experiences with patients/relatives.

### 3.3.5 Sharing and Coping with Emotional Labour

Sharing experiences and coping with work pressures is characteristic of medical labour processes, even though it may not be acknowledged in this way. At the government level, collective processes were evident during the industrial strike action of 2015-2016 by junior doctors. Arguably, the protests and involvement in persistent strike action against the new employment contracts can be viewed as a collectivist movement on part of those doctors in training, with consultants and other senior members of the medical profession supporting their decisions. This strongly reflects the continued strength of UK medicine and is consistent with collective aspects to managing work pressure and organisational practice in the NHS (Hannigan, 1998). Other forms of communal practices by junior doctors refer to informal processes of collective working (e.g. Brown and Duguid, 1991), working in teams (Firth-Cozens, 2001; Lewis, 2005; Lewin and Reeves, 2011; Shaw et al, 2012), and the formal implementation of structured forums by healthcare management in order that doctors manage their work experiences. These processes include Schwartz rounds and opportunities for professional counselling provided by the organisation (Pepper et al, 2012).

Schwartz rounds refer to structured forums and are arranged to allow members to speak about their emotional experiences regarding a case/patient. They allow a range of workers employed within the hospital-setting to come together for (usually) one hour on a monthly basis and share stories/experiences in order to unburden emotional tension (Pepper et al, 2012). Importantly, organisational teams/structured forums in which staff can come together and discuss work experiences are those which are prescribed by employers/management. This also refers to ‘managed care’ processes. However, the collective spaces for emotional coping might differ from that of team working/Schwartz rounds in that healthcare professionals staff might form emergent, but equally important, informal groups, and enable one another to release emotional tension accumulated from their medical practice on a routinely basis. They may form collective communities in which they are able to share

knowledge, experiences and cope with the dark side of emotional labour (e.g. Ward and McMurray, 2016), helping them to derive a sense of satisfaction from their work, and unburden any negative emotion associated with the care of their patients.

In addition to the points above, the role of humour might also be considered as an important collective process within institutional contexts. Workplace humour has been explored in several workplaces (e.g. Sanders, 2004; Mawhinney, 2008; Korczynski, 2011) - as constituting forms of workplace resistance (e.g. Taylor and Bain, 2003; Mallet and Wapshott, 2014) and as a means of negotiating different aspects of work (e.g. Bolton, 2000a, 2000b; Mawhinney, 2008). Whilst many studies offer functionalist analyses of the role of humour in medicine and other healthcare professions (e.g. Zeigler, 1998; Moore, 2008), and have considered the role of humour as an important aspect of storytelling (e.g. Calman, 2001), there is little research evidence which highlights situated meanings derived from the process of humour within medicine, or that which points to the role of humour as a collective, shared experience between a cohort of frontline workers. An interesting research avenue, therefore, is to explore workplace humour as fostering social relations and facilitating shared experiences of medicine.

## 3.4 Summary

This chapter has focused on the emotional labour of doctors. Opening sections have explored emotional labour processes within traditional/non-traditional professional bureaucracies and have highlighted the multiple, contradictory logics that appear to guide work processes in these contexts. This chapter then focused on emotional labour within healthcare services. It outlined the changing landscape of the NHS – considering its inception and development over the years. The discussion then explored the emotional labour of healthcare services at the general level, and the work processes and interactive experiences of doctors with patients, relatives and others, more specifically. This discussion has offered an empirical insight into what is already available on the research context informing this thesis. Following this review, this thesis focuses on the following research questions:

5. What are the key institutional logics informing the work organisation of doctors?
6. How do key institutional logics influence the emotional labour of doctors?

7. What are the pains and pleasures associated with the emotional labour of doctors?
8. What are the emotion management strategies enacted by doctors?

# Chapter 4: Methodology, Methods and Design

## 4.1 Introduction

This chapter discusses the research methodology, research methods and qualitative design of this thesis. It outlines the process of conducting the research and the research questions that are considered necessary to explore emotional labour processes in light of changing institutional contexts. The chapter includes a description of the decisions made during the design of the research, the process of collecting interview and observational data and the means of conducting qualitative data analysis. Although it briefly introduces the philosophy of this research, this chapter does not engage within detailed discussions of the competing research paradigms – it would be difficult to do these philosophical debates justice here given the limited scope of a PhD study (Lincoln and Guba, 2000; Saunders et al, 2016). This chapter further introduces relevant methodological literature on qualitative strategies, the case study research design and the selected research methods which have informed the texture of this thesis.

The opening sections of this chapter describe the philosophical foundations of knowledge, introducing subjective ontology, interpretivist epistemology and key principles of qualitative research. Later sections introduce the case study design and justify this approach taken to conduct the study as an appropriate response to the exploratory research questions detailed below. Later sections also discuss the research process, including first contacts, initial authorisation to carry out the study and access to junior doctor cohorts. This chapter further explains how the study was conducted, including a discussion of the pilot interviews, the collected data (interview and observational), the process of (thematic) analysis, ethical considerations and a final section on reflexivity to address the cathartic nature of the interview process and any personal influences upon the obtained data. The chapter concludes by providing a brief summary.

## 4.2 Research Questions and Objectives

Following the literature review on emotional labour and institutional logics, there remains an important research gap in our understanding of the emotional labour process within

professional contexts and the means by which frontline workers manage emotional experiences. In this light, emerging research questions from current debates on emotions and institutions refer to the following:

1. What are the key institutional logics informing the work organisation of doctors?
2. How do key institutional logics influence the emotional labour of doctors?
3. What are the pains and pleasures associated with the emotional labour of doctors?
4. What are the emotion management strategies enacted by doctors?

To address these questions, the empirical work consists of both semi-structured interviews and ethnographic observations. Semi-structured interviews were conducted with a sample of junior doctors - including a handful of consultants and junior doctor equivalents. The interviews explore how these individuals understand their emotional labour during interactions with patients, relatives and related others, and the logics that they perceive to be influencing their emotional work/management on the frontline. Alongside these interviews, a series of observations are carried out on hospital grounds/wards, specialty clinics, operation theatres and during various training sessions. Detailed field notes are taken during these observations and these notes are related back to organisational/sociological perspectives in order to understand the data in a broader theoretical context.

## 4.3 Philosophical Foundations of Knowledge

Considering the research questions listed above, a qualitative interpretive approach is selected as the most appropriate for this thesis. The interpretive approach subsumes the position of writers who have been critical of the application of the scientific model to the study of the social world (Bryman, 2015). Interpretivist research locates the interpretation of individuals at the core for understanding, producing and developing knowledge (Saunders et al, 2016). In broad terms, the ontological position adhered to herein is a position of social constructionism – the position that (social) reality cannot exist in a physical, identifiable form, but instead it is the stream of the consciousness and experiences of individuals (Bryman, 2015; Saunders et al, 2016). By departing from the notion of an external reality, the social constructionism approach allows one to uncover the social meanings that individuals attach

to their experiences and the social processes by which they create, reinforce and reproduce their material subsistence/experiences (Saunders et al, 2016) - in relation to the organisation of their work, their performance of emotional labour and the means by which the doctors manage these processes. In this light, the very core of interpretive philosophy is concerned with the empathetic understanding of the social world as opposed to the physical forces that are deemed to act on this (Bryman, 2015).

This ontological position also helps one to develop an understanding beyond the current scope of sociological/organisational debates on the nature of emotion work and management by field-level actors, which mistakenly emphasise the negative impact of engaging within (emotional) workplace interactions and practices (i.e. Hochschild, 1983). Based on an interpretive epistemology, it can be assumed that those interviewed for this study have access to important knowledge regarding their emotional interactions with service users, relatives and others. The content of these interviews, therefore, i.e. what the respondents share with the researcher, can be considered as representations of this knowledge and thus a depiction of their social, emotional and (medical) cultural realities (Bryman, 2015). Accordingly, in this thesis, the obtained truth is not *absolute* but instead it refers to the captured experiences of the respondents and the notions that have been decided by their personal human judgement (Atkinson and Hammersley, 1998; Bryman, 2015).

The positioning of truth as decided by individual human judgement and as an act of interpretation also extends to the analysis of observational data fieldnotes. During observations, the broader context within which doctors work and interact is captured. Observations were conducted on hospital premises, specific ward areas, operation theatres, specialty clinics and during various training sessions that junior doctors participated in. Individual interactions (i.e. between doctor and service-user) and more collective interactions (i.e. between doctors and service-users and between doctors, colleagues and others) were noted in detail during these observations. The data obtained during the observational process were simultaneously related back to sociological and organisational theories - helping to understand the landscape of medical and surgical services in more detail, the nature of emotional labour during interactions and the management of this emotion - at the individual and collective level. The observations further facilitated explorations of how multiple,

conflicting institutional logics inform the nature of medical and surgical practice. Considering the research process and collected data, the framework of institutional logics and emotional labour is presented as a contribution to theoretical knowledge.

## 4.4 Research Strategy, Design and Methods

### 4.4.1 Strategy: Qualitative

Following the above, this study can be described as generating qualitative research data, with a qualitative research strategy and design. Primarily, this choice was driven by the nature of the research questions and the overall subject of the thesis. However, qualitative research is also associated with a subjectivist ontological position and an interpretivist epistemology, given the answers to the questions that it seeks to explore (Saunders et al, 2016). Quantitative research, on the other hand, is usually considered appropriate for testing previously developed theories or it intends to search for suspected correlations/relationships between pre-defined variables (Bryman, 2015). This study was not concerned with the measurement of emotion at work or the impact of emotional performance as represented by a numerical scale (e.g. Grandey, 2003). Instead, this study adopts an interpretive, qualitative strategy and approach seeking to explore the texture and management of emotional labour from the experiences and perspectives of the research participants involved. In this thesis, the research questions being asked are open-ended and they intend to explore the work organisation of junior doctors practicing medicine within the UK NHS, their emotional labour processes and the ways in which they share, manage and cope with these experiences with their colleagues and others.

### 4.4.2 Design: Case Study

In line with the previous section, the current research study is not concerned with pre-defined variables which are easily manipulated and isolated from their broader contexts (Bryman, 2015). Instead the study is raising important exploratory research questions in relation to intricate and complicated social aspects of contemporary work organisation (Creswell and Poth, 2016). Accordingly, and considering the methodological insights that have been outlined above, it was felt that the qualitative case study design was the most appropriate and feasible strategy for this thesis. The origin of the case study approach can be traced back

to anthropology and sociology in the social sciences, however, case studies have also been adopted for study in a wide range of diverse disciplines: psychology, medicine, law and political science etc. (Yin, 2013; Creswell and Poth, 2016).

Although the term *case study* is somewhat unclear and it may potentially be applied to all research which include a unit of analysis (i.e. case) (Creswell and Poth, 2016; Saunders et al, 2016), case study designs are concerned with a holistic investigation of the case or topic of interest within a bounded system or context (Creswell and Poth, 2016). Case studies generally investigate topics of interest over a specified period, often using several different research methods, and therefore case studies tend to involve multiple sources of information (e.g. observations, interview transcriptions) (Bryman, 2015; Creswell and Poth, 2016).

In this light, case studies typically entail a detailed and intensive analysis of a single (or multiple) case (Bryman, 2015). Case studies are concerned with the thorough, social complexity and specific nature of the case under investigation. They represent an in-depth strategy of inquiry into the topic of interest within its real life setting or context (Yin, 2013; Creswell and Poth, 2016), and therefore, the capacity of a case study is argued to generate detailed insights into the study of a phenomenon within its natural setting. This leads to rich, empirical analysis and the development of new theory (Bryman and Bell, 2011). Furthermore, case studies are often used to help researchers understand the interactions between the topic of interest and its broader context – as many authors have suggested, interactions between a social issue and its broader context are most effectively understood through the in-depth case study strategy (Dubois and Gadde, 2002: 554). A detailed analysis can therefore be designed by researchers to identify the wider contextual elements of the case, and perhaps further help one to understand the influences of the situation and implications for action and future practice.

Considering the above, this study adopts an exploratory case study research design (incorporating crucial elements of ethnography) in order to understand the current institutional environment of the NHS in Britain, with a focus on two contrasting clinical cohorts – medicine and surgery. The choice of case study was directed by the assumption that it would be almost implausible to investigate, or at least, attempt to purposefully control the multifaceted nature of emotional labour, disregarding the broader context within which this

work occurs. Importantly, these notions have been under-developed or remain neglected in previous literatures (e.g. Hochschild, 1983; Grandey, 2000). The case study design allows one to integrate the broader context into the core of the research as case studies constitute an important, strategic and empirical inquiry which examine a particular social issue within its real-life setting (Stake, 2005; Yin, 2013). Case studies further allow for the exploration of the social issue even when the boundaries between the social issue/phenomenon and context remain unclear (Yin, 2013; Creswell and Poth, 2016). In this light, the case study design is considered the most appropriate for the study into emotional labour processes and institutional logics.

As mentioned earlier, this study adopts a qualitative research strategy, and relies on two qualitative research methods: semi-structured interviews and ethnographic observations in order to fully understand the dynamics of the case. Methodological literature suggests that there are several ways to conduct case studies and obtain answers to specific research questions in organisational and sociological research (Creswell and Poth, 2016). For this thesis, a qualitative, abductive and exploratory approach is adopted in order to provide answers to the research questions outlined above (Denzin and Lincoln, 2011; Creswell and Poth, 2016). The logic of abductive reasoning suggests that in order to modify theories and contribute to existing literature, it is necessary to combine elements of deduction (moving from theory to data) and induction (moving from data to theory) (Suddaby, 2006; Bryman, 2015). In this thesis, it is suggested that previous theories of emotional labour and management can be developed further. Previous theories are either one-dimensional and/or emphasise the negative aspects of emotional work and management at the expense of the positive aspects (e.g. Hochschild, 1983), or they do not consider the broader institutional context to fully explore the complexity of the emotional workplace (e.g. Bolton and Boyd, 2003; Bolton, 2005). In this study, the abductive approach is applied to offer extensions to existing theories and develop new theoretical/empirical insights based on the literature that is already available (Saunders et al, 2016).

In addition to abductive reasoning, this study draws on the exploratory approach - exploratory research allows the researcher to ask open-ended questions and gain detailed insights into the topic of interest. Relative to the explanatory approach, which is concerned

with causation between variables, and relative to the descriptive approach, which seeks to provide descriptions or accounts of events/situations (Creswell and Poth, 2016), the exploratory approach is useful because it allows one to clarify their understanding of a particular social issue within its broader context (Bryman, 2015). Through abduction and the use of the exploratory case study design, the obtained data can be used to contribute to and generate new theory based on the previous literature in the same domain (Bryman, 2015; Creswell and Poth, 2016; Saunders et al, 2016).

### 4.4.3 Case Selection/Descriptions

As mentioned above, the specific case selected for this research study is the NHS, England. Nottingham University Business School (NUBS) accepted this study and provided ethical approval for the data to be collected. Research and Development (R&D) approval was obtained from Wilton Trust for this study, allowing the researcher to contact potential research participants, and to collect data from both Carrington and Deanside hospitals, within Wilton. Within this site, two clinical cohorts were primarily chosen to inform the nature of this thesis: medical and surgical services.

With the help of a local collaborator, participants were contacted for interviews via email and posters were circulated in paper form on hospital premises, and electronically via email, aiming to provide detailed information about the study. A series of observations were made on ward areas and hospital premises as suggested by the local collaborator - for the researcher to adequately collect data in relation to the work experiences of junior doctors.

As discussed, two different clinical cohorts were chosen for this study - given the significant contrast between medical and surgical services, junior doctors practicing within both medicine and surgery were selected for this research in order to explore the multifaceted ways in which professionals carry out emotional labour with service-users and related others. Previous literature has suggested that in addition to large differences in the work organisation of both medical and surgical trainees, both cohorts are also likely to interact with service-users in different ways and thus provide different types of emotional care to their patients – in light of this distinction. It has been argued, for example, that surgical doctors tend to be more stoic and firmer in their approach to care and often, they objectify their patients in

order to improve their physical health (Mintzberg, 1979; Ofri, 2013). Medical trainees are often dealing with less severe/complicated health-related issues and thus have increased time and capacity to provide interaction-based, empathic care to their patients (relative to surgical trainees). In order to explore these differences, a sample of junior doctors practicing in the context of medicine/surgery were chosen to inform the nature of this empirical research. However, other doctors/ equivalents practicing in alternative specialties of the Trust were also welcomed to take part.

### 4.4.4 Research Methods

In line with social constructionism, a qualitative research strategy and the case study design, the research methods adopted in this study refer to the semi-structured interview and ethnographic observational methods. In the context of field research, observations are widely used to understand the broader setting of the topic of focus, but semi-structured interviews also play an important role in this data collection process (Flick, 2018). In this thesis, semi-structured interviews and observational methods, in combination, provided a detailed insight into the contemporary institutional context of UK medicine, the increasingly changing work organisation of junior doctors in line with the changing landscape of the NHS, and the workplace interactions that junior doctors tend to encounter with their service users, relatives and others.

The primary research method in this study refers to the semi-structured interview method. Semi-structured interviews are widely used in the social sciences and in sociological research - in order to provide answers to the exploratory research questions of the sensitive social issues that these disciplines raise (Bryman, 2015; Flick, 2018). It is characteristic of the qualitative interview method that a series of open-ended questions are brought to the interview situation in the form of an interview guide (Flick, 2018); the questions within the interview guide essentially constitute an unpacked version of the overall research questions being asked in the study (Saunders et al, 2016). It was hoped that the questions of the interview guide are answered freely and flexibly by interview respondents (Flick, 2018). In semi-structured interviews, respondents are to provide their own perspective on the topic under investigation – rambling or going off on a tangent is often encouraged as this gives the researcher insight into what the respondent considers as important in relation to the research

topic (Bryman, 2015). Furthermore, within semi-structured interviews, the interview guide that facilitates the researcher is used to provide some direction during the process. Researchers are permitted to depart significantly from this guide should they wish to, and researchers often ask new questions that follow up the replies of the respondents during the interview. Researchers may also vary the order of the questions and even the phrasing (Mason, 2002; Bryman, 2015). In this light, semi-structured interviews are flexible and allow researchers to respond to the direction in which the respondents choose to steer the process. This may result in researchers adjusting the emphases in the research in line with new (unexpected) insights, which may emerge during the interviews (Mason, 2002; Bryman, 2015).

In addition to the above, scholars have claimed that the semi-structured interview method adopted in the context of field research can be considered as a series of friendly conversations with a strategic purpose, and into which the researcher introduces new elements and questions as emerging from the research process (e.g. Flick, 2018). Core features of semi-structured or qualitative interview methods include: the interactional exchange of dialogue; an informal, conversational style; a thematic and topic-focused approach and most of these interview methods operate from the perspective that knowledge is situated and contextual (Mason, 2002). This means that the interviewer is concerned with ensuring that the relevant contexts are brought into focus so that situated knowledge can be produced. In light of this, the interview contents of this study, i.e. what the respondents share with the researcher in their responses to the questions being asked, can be assumed to be accurate representations of their situated knowledge in relation to the topic under exploration, and thus their responses can be considered as an interpretation of their social, cultural and emotional realities (Mason, 2002). Using semi-structured interviews, I was able to find out about important aspects of junior doctor work organisation and the nature of their emotional interactions in the workplace. The interviews generated rich, empirical data and provided this study with a clear insight into emotional labour processes and management involved in professional work. The interviews were conducted from the perspectives of medical and surgical trainees. Considering the influence of institutional logics, both cohorts provided a detailed insight into the changing landscape of the NHS, the resultant experiences of their

work organisation and the multi-faceted ways in which the doctors perform emotional labour with patients, relatives and related-others.

In addition to qualitative interviews, this PhD study also relied on observational field notes in order to analyse the broader context in which UK junior doctors practice and interact with key stakeholders. Methodological discussions in relation to the specific role of observation as a sociological or social science research method have been at the core of the history of qualitative research (Flick, 2018). There are various conceptions of the term *observation* in the literature and scholars have also claimed that the definitions of observation and ethnography can be difficult to separate. Many years ago, there was a change in terminology and *ethnography* became the preferred term to use (Bryman, 2015). Observations can be classified as a researcher participating in the field or choosing to remain as an external observer – ethnography constitutes a more general strategy of the observational process in which observation and participation are interwoven with other methods of data collection (Flick, 2018).

Nevertheless, both conceptions, observational methods and ethnography, draw attention to the process by which researchers/interpreters immerse themselves within a context, setting or group for an extended period (Bryman, 2015). These researchers observe the interactions and behaviours, listen in on various conversations and potentially ask questions to find out more about the context and overall topic of focus (Bryman, 2015). Researchers will collect whatever data are relevant and available in order to shed light onto the issues with which they are concerned (Atkinson and Hammersley, 1998; Saunders et al, 2016; Flick, 2018).

In this light, the observational method adopted herein is that of ethnographic observation. The features of observational and ethnographic methods that the research process of this study adhered to also include a specific emphasis on exploring the nature of a particular social issue or phenomenon, as opposed to testing concrete hypotheses about them. There was a tendency for the researcher of this study to work mainly with unstructured data – i.e. that which had not been coded at the point of data collection with respect to a closed set of analytical categories (Flick, 2018). The use of these research methods also meant that the process of data analysis would require and involve an explicit interpretation of the meanings,

experiences and behaviours of human action (Atkinson and Hammersley, 1998) – this is discussed in further detail in later sections.

In the context of this thesis, semi-structured interviews were inter-linked with observations - for example, in addition to providing insight into the broader context in which medical/surgical doctors practice, observational data also provided prompts for interview questions/provided opportunity to recruit doctors for interviews.

Table 1: List of Observations

| **Observation Type** | **Number of Observations** | **Location** |
|---|---|---|
| Ward (HCOP) | 4 | Deanside |
| Ward (Medical Admissions) | 1 | Deanside |
| Training Session | 5 | Deanside Hospital, HCOP Seminar Room |
| Operation Theatre | 2 | Deanside |
| Clinics | 4 | Deanside Treatment Centre |
| Breakout Areas | 3 | HCOP Breakout |
| Emergency Department | 1 | Deanside |

## 4.5 Research Process

In this study, the research process was shaped by the researcher's access to and engagement within the different case sites selected for data collection. The researcher faced several challenges in carrying out this study – firstly, gaining initial access to the desired samples proved to be incredibly difficult given the complicated and lengthy ethical procedure involved when negotiating NHS approval. Secondly, understanding and *becoming familiar* with the NHS environment felt like an alienating process. Prior to conducting the PhD study, the researcher had very little understanding of the dynamics of the healthcare environment and thus understanding the different case sites selected for study took some time and getting used to. Only the usual roles of either *patient* or *visitor* to the hospitals were available for the researcher to draw upon when entering the case study sites. Nevertheless, conversations with informed supervisors and colleagues who had extensive experience researching within

the healthcare context proved to be very useful in conducting this study. These conversations helped to provide important *insider* information - for example, the many differences between the professional and hierarchal groups of the NHS and the tensions that remain (and indeed have increased in light of political initiatives) between managerial staff and doctors (Numerato et al, 2012).

### 4.5.1 Obtaining Authorisation, First Contacts and Access to Participants

As mentioned, the study required an intensive ethical procedure. This procedure is discussed in more detail in later sections of this chapter - here a brief overview is provided. The ethical approval for this research was obtained from Nottingham University Business School (NUBS). An Integrated Research Assessment System (IRAS) online form was completed for the researcher to obtain both the ethical and Health Research Authority (HRA) approval necessary to conduct the study. The completed IRAS form was sent to the ethical committee at NUBS and was reviewed by two ethical officers. The form was also sent to an externally assigned HRA assessor. The sponsor team overlooking this process helped the researcher to complete all these necessary procedures adequately - ensuring that all sections had been completed with adequate knowledge and detail.

Following months of review, ethical approval had been obtained from NUBS and the HRA, and Research and Development approval was sought from the specific NHS Trust – Wilton Hospitals - that this study proposed to include in the research process and use for data collection. After the approvals had been obtained, the researcher began liaising with potential contacts within Deanside/Carrington hospitals who were able to help steer the research process in a positive direction. A local collaborator was contacted at Deanside hospital, who helped the researcher to circulate important information in relation to the study. The collaborator helped to circulate emails providing information about the study to other important contacts in the hospitals, and to the junior doctors who were considered as potential recruits for the interviews as they met the eligibility criteria. In these emails, details of the study were provided including information about observations on hospital premises. It was also noted that for those who did not wish to be observed, they could make themselves known to the researcher/local collaborator and efforts would be made to ensure they were

not observed during the data collection process. In light of this collaboration, research respondents came forward via email and voluntarily agreed to take part in the interviews.

### 4.5.2 Interview Sample: Studying Medicine, Professionals and Emotion Workers

A total of 40 research respondents contributed to the semi-structured interview process – the doctors were from various demographic backgrounds, there was an even split of males and females and a variety of foundation, core trainee and registrar-level doctors took part in the study. At each of these training levels, doctors are still considered as 'junior' within the context of British healthcare. In addition to this, the sample also consisted of 3 consultants and 2 junior doctor equivalents: 1 Physician Associate (PA) and 1 Advanced Clinical Practitioner (ACP). The roles of PA and ACP were introduced to support the work of junior doctors – said individuals are now qualified doctors but they complete medical work. There is no defined sample size for the observational stage of data collection. The interactions of various junior doctors were observed on hospital premises/ward areas, operation theatres, clinics, breakout rooms and observations also took place during the training sessions of the junior doctors within these hospitals. The table below details characteristics of the sample.

Table 2: List of Respondent Characteristics

| **Training Grade/ Position** | **Number of Respondents** | **Male** | **Female** | **Other Relevant Information** |
|---|---|---|---|---|
| **Foundation 1** | 4 | 3 | 1 | |
| **Foundation 2** | 8 | 3 | 5 | |
| **Foundation 3** | 2 | 1 | 1 | |
| **Core Training - Medicine** | 10 | 6 | 4 | |
| **Core Training - Surgery** | 3 | 1 | 2 | |
| **Registrar Level Trainee (ST1-ST8)** | 8 | 3 | 5 | Including 1 part-time (60%) |
| **Consultant** | 3 | 3 | 0 | Medicine, Surgery and Anaesthetist |

| | | | | |
|---|---|---|---|---|
| **Junior Doctor Equivalent** | 2 | 1 | 1 | One Physician Associate (FY1/2 equivalent) and one Advanced Clinical Practitioner (ST1/2 equivalent) |

In order to feel adequately prepared before conducting the research, a small pilot study was carried out with two individuals employed within the NHS and contacted through personal university links. The two pilot interviews were conducted before the interview process began – this process is explained in the section immediately below. All the interviews for this study were conducted at a time and place convenient for the research respondents. Often this meant on the hospital premises; other times it meant within a café or other public setting deemed safe and appropriate for conducting research interviews. Although there were no perceived risks beyond those encountered in everyday life, the researcher ensured that the chosen interview locations adhered to the obtained ethical approval and were in line with the University of Nottingham's policy and guidance on Lone Working and Out of Hours Working (2012).

## 4.6 Data Collection

### 4.6.1 Pilot Interviews

After designing the interview questions in the interview guide, these were then piloted with two junior doctors who were recruited through close contacts of the researcher. The first pilot interview was carried out with a medical trainee practicing in Deanside, Wilton as a doctor and as a teaching fellow of medicine. The second pilot was conducted with a locum doctor practicing in surgical services. Given that medical doctors practicing within the UK NHS were selected for the pilot interviews, these respondents were suited to the task and were considered as representative of the case study. Both interviews lasted for approximately one hour – this gave an indication of time duration for the main interview process. Both interviews were informative of the topic under investigation - they provided a detailed insight into the

contrasting work organisations of medical and surgical practice, and they were also reflective of the doctors' work experiences/emotional workplace interactions and practices.

The two pilot interviews also proved to be very useful in that they helped to examine the feasibility of the research approach and the appropriateness of the questions being asked during the interviews (Bryman, 2015). Both respondents were kindly asked to read the questions in the interview guide at the end of the interviews and to comment on the nature of the questions being asked by the researcher. Considering this feedback, some of the questions were rephrased and rearranged in the guide in order that the overall research questions could adequately be answered. Further benefits of conducting these pilot interviews included assessing the effectiveness of the design of the study, determining whether the research protocol was realistic and practical, identifying any logistical issues with the design of the research and the researcher gaining insight/experience into as many of the aspects of the research process as possible - before commencing the 'real' data collection process (Bryman, 2015). Prior to conducting the pilot interviews, the researcher ensured to review and revise her interviewing skills and read around various methodological texts about interview participation roles that can be adopted for effective interviewing in qualitative research. Having read around these tips, the researcher preceded to put them into practice during the pilot interviews. From listening to the interview recordings of the pilot interviews, the researcher realised and noted that she tended to comment and question the respondent more often than necessary. On reflection of this process, the researcher was more aware and conscious of her frequent interjections during the 'real' interview process and thus she made strong effort to manage the silences of her respondents better in order to allow respondents time and space to elaborate on their responses. Having made all the necessary changes in light of the pilot interviews, the research process progressed onto the actual interview stage.

### 4.6.2 Interview and Observational Data

Following the pilot interviews, the study progressed onto the main stage of interview data collection. Interviews were conducted with the junior doctor cohorts at a time and place most convenient for them – as is true with the pilot interviews, often this meant on hospital premises and other times it meant on public settings deemed safe and appropriate for conducting qualitative research. As a gesture, individuals taking part in the interview process

were offered tea/coffee and cake from the researcher as a means of saying thanks, but no other incentive was provided for taking part in the project, and in this way, their participation was entirely voluntary in line with ethical principles and guidelines (Bryman, 2015). Before the interviews commenced, respondents were permitted enough time to read through a complete information sheet, which provided important details in relation to the nature of the study and the rights and responsibilities of the respondents. Having read through the information sheet, respondents were then required to either provide written informed consent or decide that they did not wish to take part. In this study, all of those that initially agreed to take part in an interview provided informed consent and voluntarily took part in the interview process.

In order to analyse the interview data adequately, the aim was to ensure that a set of techniques were established in order to develop a simple, clear and systematic process, and to further ensure that the techniques were accountable to the specific aims of the research project and its philosophical assumptions. Throughout this thesis, a position of interpretivism and social constructionism has been held, allowing individuals to discuss their own personal experiences in relation to their work, emotional labour and management of these processes. In this light, the overall goal of this empirical study has been to explore and understand the dynamics of the emotional workplace through the perspectives and experiences of the individuals interviewed.

As mentioned, the processes of interviews and observations were conducted simultaneously. Alongside the interviews, the observations took place on relevant hospital wards and premises, within operation theatres, clinics and during various training sessions of the junior doctors – this allowed me to gain a detailed insight into the broader context of healthcare work. Specifically, observations were focused on the work experiences of junior doctors and their (individual and collective) interactions with service users, colleagues and others in order to understand the multifaceted nature of emotional labour within the NHS.

## 4.7 Data Analysis

The most common and widely adopted approach to qualitative data analysis refers to the process of conducting *thematic analysis.* Thematic analysis is a widely used technique across

a vast number of disciplines. These include psychology, sociology and clinical/health sciences (Braun and Clarke, 2006). Thematic analysis emphasises the examination, interpretation and recording of patterns in qualitative data – these patterns are also known as themes. The technique is based on the search for central themes and subthemes from the collated datasets. In the context of this study, this refers to both interview transcriptions and observational fieldnotes (Bryman, 2015). The themes observed are important to the description of a social notion or phenomenon and are associated with a specific research question or objective (Braun and Clarke, 2006).

In line with the above, the patterns emerging from the data are identified through a rigorous process of data familiarisation, coding and theme development. When searching for these patterns, scholars have suggested to observe for repetitions in the data, metaphors and analogies, i.e. the means by which research participants represent their thoughts and feelings, and theory-related material, i.e. using social science concepts as a facilitator for the generation of new ideas (Bryman, 2015). An important advantage of adopting thematic analysis is that it is theoretically-flexible – this means that the technique can be deployed with several different frameworks in order to explore a variety of different research questions (Bryman, 2015).

In this thesis, thematic analysis is approached in an inductive manner. This means that the processes of data coding and theme development are guided by the content of the datasets and the interpretation of the researcher. Accordingly, the thematic analysis approach adopted in this study adheres to a six-phase process developed by Braun and Clarke (2006). Firstly, in the phase of data familiarisation, the researcher reads and re-reads the data in order to become fully immersed within its content. Secondly, with respect to data coding, the researcher becomes involved in generating labels/codes, seeking to identify important features of the data that are considered relevant to answering the overall research question. This phase further requires the researcher to code the complete dataset (both interview transcriptions and observational fieldnotes), and then to collate this information and all the relevant data extracts in combination for later stages of analysis. To facilitate this process, a qualitative data analysis computer software package is used - known as NVivo. This software

is an important piece of kit for researchers working with rich, empirical and text-based data (Bryman, 2015).

In the third phase, the process of searching for themes begins. The researcher is required to examine the codes and collated data in order to identify the broader and contextual patterns of meaning (which constitute potential themes). This phase then involves the researcher to collate the data relevant to each candidate theme (Braun and Clarke, 2006) - in order to work with the data and review the viability of each candidate theme identified. The fourth phase constitutes the process of reviewing the themes – the researcher must check the candidate themes against the datasets to determine that they produce a convincing, theoretical narrative of the data, and one that adequately provides support for the overall research question. In this phase, it is common for the themes to be refined – often this process involves the themes to be divided into sub-themes, combined, or discarded completely.

In the fifth phase of this framework, the researcher must define and name the generated themes. This involves the researcher to develop a detailed and informative analysis of each of the themes, in order to work out the scope and focus of each theme and determine the narrative of each. It also involves the researcher to decide on an appropriate name for each of the themes (Braun and Clarke, 2006). Lastly, in the final phase, the researcher is involved in writing up this analysis by intertwining the analytical narrative and data extracts, and then to contextualise this analysis in relation to the existing body of literature (Braun and Clarke, 2006). This phase then leads onto the discussion chapter of the thesis.

Considering the above, the phases of Braun and Clarke's (2006) framework appear to be sequential. However, importantly, each of the phases build on the previous and thus this type of analysis becomes a recursive process – one in which there is movement back and forth between the different phases. In this way, this framework adopted for conducting thematic analysis is not a rigid process. Instead, with increased experience, the analytical steps constituting the phases described above often blend some of the processes in combination with one another, making the exact procedure difficult to outline.

## 4.8 Ethical Considerations

The next section outlines key ethical standards which are necessary to consider when working with research respondents and others during the research process (Bryman, 2015). As mentioned above, the procedure of ethical approval for this study was an intensive and time-consuming process. The IRAS form had been completed online, as directed by the ethical sponsor team at the University of Nottingham, Business School – this form consisted of a 25-page document detailing the nature and research process of the PhD study. The form, alongside several other documents, was circulated to the University of Nottingham, Business School's ethical review committee for ethical approval to be obtained, and to the (externally based) Health Research Authority (HRA) assessor for approval to conduct research within the NHS. These forms and documents were also sent to the Research and Development (R&D) team at the local NHS Trust, which this research study sought to work with – namely, Wilton Trust.

The ethical process began in May 2017, accumulating in lengthy forms and descriptions of the research process to key parties. Approval to conduct the study in WT was received from the HRA in October 2017, and ethical approval from NUBS review team shortly followed. Having obtained the necessary ethical and HRA approvals to commence the study, the R&D team of Wilton Trust was approached for the empirical work to begin. In December, the researcher was informed that they would need to obtain a 'research passport' from the R&D in order carry out the study on the hospital premises and in order to recruit NHS staff for the interviews. To obtain this research passport, it was necessary for the researcher to attend a 20-minute interview with the Research and Innovation Manager working for the R&D team. After attending this interview and having key forms and documents reviewed by the manager, the signed research passport (by both the researcher and the manager) were circulated back to the R&D team for further review. On completion of this review process, the necessary R&D approval was negotiated in March 2018 and the research study began.

The research design of this study has carefully adhered to the University of Nottingham's *Code of Research Conduct and Research Ethics (2013).* The core ethical principles adhered to in this study include respecting others, the voluntary nature of participation, obtaining informed consent, integrity and quality, full disclosure of the research to participants, maintaining

confidentiality and anonymity in line with the Data Protection Act, the protection from psychological/physical harm to participants and avoiding or disclosing conflicts of interest (Bryman, 2015). Considering these principles, participants' informed consent, confidentiality and anonymity, protection from harm, and storage and security of the research findings are each discussed in detail below.

### 4.8.1 Informed Consent

The principle of informed consent is one of respecting others, reflecting a moral concern for the autonomy and rights of privacy for potential research participants (Saunders et al, 2016). It requires the researcher to provide enough information/assurances to participants about taking part in the study, and to inform the participants of the purpose of conducting the research. This allows individuals to understand fully the implications of their voluntary participation and to reach an informed, considered and freely given decision in relation to taking part in the research (Saunders et al, 2016). In this light, in the context of this PhD study, all of the participants were required to provide written consent before taking part in the interviews. This consent was obtained on an informed consent form, which outlined the rights and responsibilities of the research participants and provided detailed information about the nature of the study (see Appendix 1). The informed consent form was developed and devised in line with the University of Nottingham, Business School's research guidance and protocols (available on the workspace database).

On this consent form, participants were informed about the nature of the research project and the time necessary for their involvement in the study. The form also provides information in relation to data collection methods, the dissemination of research findings, and the procedure for withdrawal from the study should the participants wish to do so at any time during the course of interviews (and observations) (Bryman, 2015; Saunders et al, 2016).

### 4.8.2 Protection from Harm

In the context of research ethics, harm can entail several different facets: physical harm, harm to the development and growth of individuals, a loss of self-esteem, induced stress from the research process and psychological distress (Bryman, 2015). In methodological texts, it is noted that all research must take care to not cause any type of harm to the research

participants involved in the study. In social science, particularly, topics of interest can be sensitive and highly emotional. This study is specifically asking questions about the nature of doctors' emotional work with patients and others, and thus care was taken to ensure that interviews did not delve into issues of concern or distress. It was also ensured that if the interview discussion began to make a respondent feel uncomfortable, then another question would be asked to lighten the ambience of the interview process, and if the respondent remained upset, the interview would be stopped completely. The respondent could then be referred for further support. Protection from harm is further addressed in ethical codes of conduct by advocating care over maintaining confidentiality and anonymity of respondent records and other identifying information (Bryman, 2015). The ethical principle of maintaining confidentiality and anonymity is discussed next.

### 4.8.3 Confidentiality and Anonymity

Maintaining confidentiality and anonymity requires that the identities, records and personal data of individuals involved in the research should be kept safe, private and confidential. This principle further requires that researchers should take care when the findings of the study are being published to ensure that respondents are not identified/identifiable by any means. Importantly, qualitative research may raise certain difficulties in maintaining the confidentiality of respondent information – in this study, the names of research respondents were protected using pseudonyms to protect their identities and ensure that their responses are not identifiable in the report of the findings (Bryman, 2015).

The principle of confidentiality and anonymity neatly leads onto the issue of data protection. One aspect of confidentiality and the management of research data refers to the protection of individuals' data (Bryman, 2015). In the UK, the Data Protection Act (1998) confers specific obligations on all people and institutions who hold personal data on other individuals. In this light, research findings must comply with this Act and thus the obtained data of this study is stored in an encrypted, password-protected file on the researcher's desktop and backed up on the UoN server. The interview transcript copies do not include the names of respondents, and all copies are securely kept in a locked cabinet in the researcher's office, on university premises. Furthermore, the interview transcribers have been required to sign a letter stating that they will fully comply with the obligations of the Data Protection Act (1998) (Saunders et

al, 2016). In the context of this thesis, it is completely understood that there is an environment that takes the ethical considerations of confidentiality, anonymity and data protection very seriously (Bryman, 2015). Accordingly, it is important, as a researcher, to ensure that these considerations are fully complied with in order to conduct ethical research (Bryman, 2015).

### 4.8.4 Storage and Security

Further to the above, the storage and security of research data must also be considered during the research process. As mentioned, all information and data are stored and secured in an encrypted, password-protected file on the researcher's desktop and all related documents are stored within a locked cabinet in the researcher's office, on NUBS premises. All copies of interview transcripts are also securely kept in the same locked cabinet in order to ensure their security.

## 4.9 Reflexivity

### 4.9.1 Talking is Therapy

Conducting qualitative research is a subjective process – it is therefore important that qualitative researchers comply with the practice of self-reflection and reflexivity (Bryman, 2015). Reflexivity refers to the process of observing research practice and self-examination. It is a complicated task, incorporating interpretation in addition to reflection, and requiring researchers to think about their personal experiences during the research process (Bryman, 2015). In this light, reflexivity involves the researcher to consider and interpret their role in the study and the means by which this may influence the focus of the research (Bryman, 2015). Reflexivity also ensures that researchers acknowledge their impact upon the processes of the research study and the outcomes (Holland, 1999). In order to adhere to the process of reflexivity in this study, I kept a research diary - reflecting on the experiences that I encountered during data collection processes. Specifically, following each interview and each observation period, I noted key words in relation to my thoughts, feelings and beliefs at the time, reactions to the collected data and findings, and in relation to the interactions with those who took part in the research study (Bryman and Bell, 2011; Bryman, 2015).

Considering initial stages of this thesis (those which precede data collection), I expect that my pre-understanding of the field of emotional labour and the institutional logics perspective will have influenced how I have conceptualised, organised and conducted my empirical research. In addition, at the stage of data collection, I remained aware of my presence as a researcher co-constituting what was said and enacted by those taking part. Semi-structured interviewing, for example, provides a deep insight into peoples' daily experiences and therefore constitutes a stream of dialogue between both researcher and respondent, which can be studied to better understand social organisations, institutional order and frontline experiences within many contexts. I adapted my style of interviewing at times to encourage the openness of respondents – often I would probe at interesting themes that were raised in order to stimulate important/more detailed discussion on that specific topic. I would sometimes play devil's advocate, and I would often share personal experiences of my workplaces, if deemed appropriate, and as an attempt at building stronger rapport. I would also use humour as a defence in light of increased anxiety/discomfort that respondents may have felt – around the notion of my being 'different' as an outsider (Finlay, 2002), but also in light of my own anxiety in being thrust into a workplace setting very different to that which I feel accustomed to. I realised during the initial stages of my data collection that this humour was appreciated by doctors as it was almost entirely reciprocated when used. Throughout the course of my fieldwork, therefore, I felt that the use of humour and a light-hearted attitude to collecting important data was necessary in order to ensure the comfort of the respondents, whom would, at the same time, be making assumptions about me and my position in research.

Furthermore, as I became increasingly immersed into the context of Wilton Trust, I was commonly mistaken for either another junior doctor or a medical student – by both staff and patients. On one occasion, for example, during some observation work on a geriatrics ward, the consultant conducting the ward round mistakenly assumed I was a medical student in training and proceeded to give me his stethoscope. I had to explain that I was a researcher and I felt that I had brought unnecessary attention to myself. It was also awfully difficult for me when elderly patients (often suffering from dementia/other cognitive impairments) would call out to almost anyone that would listen to them on the ward areas. Given the high-pressured nature of ward environments, often these patients were ignored or offered very

little attention by healthcare professionals. As a researcher looking into the work experiences of doctors, I was not able to speak to the patients as I wished to at that time - but often patients who were bored, upset and lonely would attempt conversation with me as a means filling their personal voids, and because they also perceived me to be *one of the team*. As an empathetic individual with a keen interest in emotion, then I wished to sit with them and help as much as I possibly could. However, I was in a vulnerable position to do so for ethical reasons and thus I had to remain aware of the boundaries between myself and the patients.

Given the constant need to tread the line between outsider and being *one of the team* I sometimes found it difficult to keep my personal research agenda/objectives distinct from the targets and pressures of the institution. I often felt frustration considering the service pressures that surrounded the hospitals in a similar way to that of the doctors - who feel this frustration daily. After sometime, I realised that my position as a researcher conducting fieldwork with doctors/others taking part served two important roles: 1/ to allow detailed insight into the institutional context of the NHS and the associated emotional labour that was required on part of the doctors involved, and 2/ to provide a safe space for the doctors to express their feelings associated with their work experiences, particularly in light of the changing political landscape of the NHS. In this light, in the next section, I discuss my experience of semi-structured interviewing as a cathartic process for the junior doctors.

### 4.9.2 Catharsis

A catharsis refers to an emotional release. The concept originates from the discipline of psychology and can be traced back to the ancient Greek term - 'katharsis', meaning 'cleansing'. According to scholars within fields associated with psychoanalysis, then this release of emotion is related to an individual's need to relieve unconscious conflicts. A common/relatable example would be the experience of stress over a work-related incident – this may cause an individual feelings of frustration, tension and uncertainty. As opposed to the individual releasing these felt emotions inappropriately, he/she may instead choose to release said feelings in a more productive way – e.g. through physical activity or shared experiences with entrusted others. Importantly, the findings of this thesis (explored in chapters 5, 6, 7 and 8) outline the importance of both - individual (e.g. physical activity) and

collective emotion management (e.g. shared experiences/communities of coping) - as central to releasing emotional burden in the context of British healthcare.

Considering my semi-structured interviewing experience, there were several instances where I felt that the process provided a safe space for the doctors to release their feelings of frustration, tension and uncertainty. Given the institutional context of the NHS, significant changes to junior doctor work contracts and the low morale that continues to manifest on the frontline, it is unsurprising that doctors were keen to talk to me if they could find the time, and when they did it felt to me as though they were 'venting' or experiencing a form of 'catharsis'. Indeed, many of the respondents who took part in this study would share the opportunity of taking part in this research as 'free therapy' and a chance to 'bitch about the system' to their colleagues. From their enthusiastic body language to the topics in conversation that were discussed during interviews, then I increasingly began to feel that I was part of a much wider process. I was not simply collecting data for the purpose of my thesis interests; I was also helping the doctors to cope with the pressures of their work by allowing them to speak freely and passionately about their experiences and to soundboard their emotional burdens on me. It was a privilege.

## 4.10 Summary

In this chapter, I have outlined the methodology and methods of the present research, detailing its process, design and means of qualitative data analysis. I began this by outlining the research questions considered as important and necessary to explore for this study. I then introduced the foundations of philosophical knowledge/research in social science – the stances of interpretivism and social constructionism were discussed, without engaging within detailed philosophical debates of the many competing research paradigms that are adopted by researchers to guide their work. In later sections, the focus of this chapter moved onto the design of the thesis, discussion of the (comparative) case study approach to research, which incorporated (observational) elements of ethnography. This approach was justified as an appropriate response to the questions that the study is raising by including a qualitative, abductive and exploratory strategy in order to provide answers to the research questions listed. This then led to a discussion of the research process, including ethical approval, first

contacts and access to the sample. The data collection stage was introduced next, with a focus on the process of conducting pilot interviews, and the collection of interview and observational data. The process of coding, theme development and thematic analysis was then discussed considering the framework provided by Braun and Clarke (2006). This helped me, as the researcher, to consider the interpretive techniques adopted for this study, including the consideration of how and where the observational data could be aligned with the analysis of the interviews. Lastly, the chapter turned to issues of research ethics, discussing the key ethical considerations believed to be important for this study: informed consent, confidentiality and anonymisation. I conclude the chapter with an important discussion of my reflexivity and research dynamics – in which I outline the cathartic nature of the interview process for those who took part.

# Chapter 5: Social Context of Medicine

## 5.1 Introduction

This chapter is the first of the four data chapters. Opening sections describe the research site in order to contextualise the following analysis of doctors' work experiences, introducing the Wilton NHS Foundation Trust and the medical/surgical workforce. These sections then discuss the demographics of the public, relative to those taking part in this study, and outline the context of the clinical departments in which doctors conduct their work. Later sections outline the work organisation of both medicine and surgery. They discuss how four institutional logics: bureaucratic rationality, professionalism, consumerism and community orientation are present in both the organisation of medical/surgical work and in the doctors' emotional labour processes. Later sections also explore the importance of peer relations between and within junior doctor cohorts and seek to facilitate our understanding of the importance of a collective, supportive working environment - providing a safe space for juniors to share their work experiences. This then opens further debate on the performance of emotional labour discussed in subsequent data chapters.

## 5.2 Setting the Research Scene

### 5.2.1 Introducing Wilton NHS Foundation Trust

Wilton NHS Foundation Trust consists of three teaching hospitals and a series of specialist clinics, comprising its Treatment Centre within a large British city. Wilton Trust (WT), created through the merger of two, previously separate, hospitals and gaining foundation status, is one of the biggest acute Trusts within England – employing just under 15000 staff members across its four sites. My fieldwork was conducted at two of the largest hospitals under this Trust – Deanside, which focuses on emergency care, and Carrington, which focuses on planned care and elective surgery for patients with long-term conditions. Both hospitals provide specialist care in several different specialties including Major Trauma, Neonatology and Stroke Medicine.

Wilton Trust is the principal provider of acute general, specialist and tertiary hospital care for over 2.5 million service-users within the local area, and it is committed to offering specialist

services for an additional 3-4 million users across the region of Wilton. Due to the history of the Trust, Deanside and Carrington hospitals have a close working relationship. This has manifested itself via shared medical/surgical staff, job rotations for junior doctors spanning both hospitals and teaching/training activities taking place across both sites for all the doctors. Due to staffing issues within the Trust, and by extension the NHS, the hospitals both appear to 'borrow' doctors from one other in order to fill rota gaps.

### 5.2.2 Demographics of the Public

Wilton is a post-industrial city, dominated by two large universities and service sector work. The city alone has an estimated population of 300, 000 habitants. Much of the public within Wilton identify as being Christian, with only small proportions of ethnic minorities. This is reflected within the medical/surgical cohorts practising in the Trust's hospitals. Interestingly, the mean age within Wilton is approximately 35 years, with approximately one third of the population aged between 18-29 and full-time university students comprising a large proportion of the population. Despite the young average age of the city, Wilton has a higher than average rate of people who have a limiting long-term condition/illness or those with a disability. This is also discussed by an overwhelming number of doctors within this study and has therefore meant that the largest clinical department within Deanside hospital is that of geriatrics – also referred to as Healthcare of the Elderly (HCOP). Importantly, the Trust does not serve the city of Wilton alone. The young urban population of Wilton is matched by an elderly population within other rural villages/regions of the catchment area – this includes regions of relative social deprivation and thus helps to explain the high service-user volume within geriatrics/HCOP of both hospitals under Wilton Trust.

Despite being unrepresentative of Wilton city alone, this observation does reflect the United Kingdom in general – a longer life expectancy across the UK, and by extension, the globe, means that people are living for much longer, but are simultaneously developing long-term conditions and illnesses, and therefore rely on healthcare services as a means of symptom management. This notion is echoed by Dr Stephens (FY1) during one of my observations on geriatrics – he states: 'it becomes a matter of symptom management as opposed to curing the patients'. This suggests that, in line with life longevity, elderly service-users present an additional challenge/burden for the NHS because they often cannot be cured of their

conditions but remain in hospital whilst healthcare professionals work to ensure that their symptoms remain under control (Corbin and Strauss, 1988).

### 5.2.3 The Medical and Surgical Workforce

In this study, the doctors I spoke with formed a diverse, but cohesive group. Although predominantly a White workforce, there were also doctors from ethnic minorities and there were equal numbers of men and women. Despite these demographical differences, all the doctors seemed to have bonded quite closely over the work processes. For example, I obtained my sample largely by doctors sharing my information/details about the study with one another – out of the 40 doctors I spoke with I only received two email replies. This might suggest that the doctors had formed a collective identity in which they frequently interacted with one another to share information. The remaining interest for the study came from shadowing doctors on site, or previous participants kindly sharing word of the study for me on-the-job. One doctor advertised the nature of this study to her colleague in front of me during an observation I conducted: 'it's basically an opportunity to bitch about the system…free therapy', and many of the doctors seemed to be interested in this. It was also a common observation that doctors would share stories and swap banter with one another during their working day – either within the small office spaces, on the ward areas or during the training sessions, suggesting that they formed a collective group of workers and their professional status as a junior doctor seemed to be adequate for them to have bonded over the nature of their work.

Although the doctors did not seem to be split on lines of ethnicity or gender, there was much more cohesion amongst the doctors of the same training grades – perhaps because they were experiencing a similar aspect of the job. The foundation-level doctors for example tended to integrate, and the core trainee-level doctors tended to bond well with each other in addition to the registrar-level doctors. There was not necessarily a clear divide between these individual training grades, however I did notice that doctors of a similar grade did tend to 'stick together' and were more likely to vent to each other on-the-job about the nature of their work.

Despite there being similar numbers of men and women in this study, medicine is still perceived by society as a male-dominated career and this notion is reflected by several doctors that I spoke with during my fieldwork. Most of the female doctors, for example, irrespective of training grade, suggested that they had been subject to sexist remarks on-the-job or are frequently referred to as 'nurse' within specific specialities. Interestingly, these societal preconceptions seemed to be so deeply embedded within medical culture that most of the female doctors were not adversely affected by them. Most female doctors were unaffected by being called 'nurse' by patients and often took the label as complimentary as it suggested to them that they had compassion. Whilst there is a gender mix within cohorts of the junior doctors, there were clear pressures on female doctors to play up to male stereotypes, including preconceptions of the service-user population.

Other factors that doctors did comment on are in relation to cultural and racial issues. Much of the cohort which took part in this study are of a White background – reflective of Wilton city and wider society in Britain. In general, I did not hear much discussion of racial issues that the doctors had personally experienced, but it was not uncommon for the doctors to tell me about the racial/cultural experiences that they had observed with their colleagues. Dr Laine, who is a female registrar, tells me: 'I think they treat you differently with race…I get a lot of "oh thank goodness you're White" …which I feel sorry for, then people who are not…I've witnessed a few [patients] question them about where they're from and when they came to this country and that sort of thing…I'm like for goodness sake, shut up'. In addition, for several ethnic minorities, then cultural and racial issues also remain a major barrier in the way that they are professionally perceived by patients, and in terms of their career progression.

Traditionally, medicine has been an elite profession and medical schools continue to draw a disproportionate number of students from non-state schools (Freidson, 2001; Steven et al, 2016). The cohorts that I spoke to during my fieldwork reflected this in several ways, e.g. by telling me that they were from a family of doctors or that they had familial pressures placed upon them to succeed in medicine or surgery. However, the cohorts were not entirely a homogenous group – some of them did speak to me about being the first ones from their family backgrounds to enter medicine. Nevertheless, this did not seem to surface as a barrier to their career progression or in forming a collective, common identity with the other juniors.

Being a junior doctor seemed to be adequate for doctors to form a cohesive bond with one another on-the-job.

### 5.2.4 Training Grades

The junior doctor label covers several different training grades. In this study, 14 doctors were in their foundation training – 4 Foundation Year 1, 8 Foundation Year 2 and 2 Foundation Year 3. In terms of medical training, 10 doctors were in their core medicine training, 6 of the doctors are medical registrars, 1 is a medical consultant in geriatrics and 1 is an anaesthetics consultant. In terms of surgical training, 3 of the doctors were in their core surgical trainee years, 2 of the doctors were experienced registrars and 1 is a plastic surgeon consultant. Other individuals who took part in this study include: 1 Physician Associate (PA) and 1 Advanced Clinical Practitioner (ACP) – both job roles have been introduced within the NHS in order to address the shortage of NHS doctors and to reduce the workload of medicine. Both individuals (ACP/PA) claim to work closely with the other doctors, and complete work associated with the foundation/core trainee level. In light of these training grades, a significant observation made during my fieldwork is the importance of experience. In many cases, and discussed by the majority, if not all, of the doctors, then experience plays a highly important role in medicine/surgery. The learning of doctors tends to be largely experiential and this is perceived as more valuable than scheduled training - as will be discussed in later sections. The resilience and emotional management of doctors also tends to be an experiential skill - their confidence in themselves as professionals appears to improve with increased exposure in the job and with greater experience of medical/surgical practice.

### 5.2.5 Spaces and Places: Medicine and Surgery

For medical work experiences, I observed ward areas, breakout rooms and training spaces. In line with an ageing population, geriatrics/HCOP constituted the largest clinical department within both Deanside and Carrington hospitals. In this light, most ethnographic observations were conducted on wards/units associated with geriatrics: HCOP, Medical Admissions Unit and the Frailty Unit. In this thesis, observations were only conducted at Deanside hospital given the networks I had initially built with the doctors working here.

One of the biggest surgical specialties within Wilton Trust is that of Major Trauma and Orthopaedics. Accordingly, to gain an insight into the nature of surgery, I conducted ethnographic observations within Major Trauma and Orthopaedics and then began to shadow some of the surgeons in other areas - in order to tease out similarities and differences between surgical work processes. For my observations within surgery, I observed within the Major Trauma specialty – ward areas and theatres. I also shadowed a core trainee-level doctor during an on-call shift and then I shadowed a consultant in his skin cancer clinic on two separate occasions. Most of the ethnographic observations followed male surgeons, although within the specialty, I did notice several females in scrubs during departmental meetings and training sessions, and a mixture of training grades/other members of the healthcare profession.

## 5.3 Institutional Logics Informing Medicine

Following the context of the research site outlined above, this section will now focus on the logics informing the work organisation of British medicine. Considering my analysis, four important institutional logics are understood as informing the nature of work in both medicine and surgery. These logics manifested during the interviews with doctors and during the observations I conducted on site - helping to contextualise and add rigour to my dataset. Here, the logics are outlined and discussed in the context of shaping the work processes associated with medicine/surgery. In the following chapter, these logics will then facilitate the analysis of the emotional labour of doctors practising within Deanside and Carrington hospitals.

### 5.3.1 Bureaucratic Rationality

In this section, the work processes of junior doctors are analysed considering the wider rationalisation of healthcare work. Three important institutional pressures are identified as shaping the work organisation of medicine and surgery: the managerial focus on efficiency, the bureaucratic control of doctors' time and increasing issues surrounding understaffing. These ideas are introduced in this chapter but are developed further in subsequent ones in order to facilitate the analysis of contemporary emotional labour processes.

#### 5.3.1.1 Focus on Efficiency

The political focus on increasing the efficiency of public services is widely evidenced within Wilton Trust. Considering recent governmental initiatives, doctors on the frontline of medicine are expected to practise 'efficiently' in order to manage high volumes of patients and other institutional pressures of time constraints and staffing levels. The junior doctor group that I spoke with are also on very structured training pathways – medical training can last up to 15 years before a consultancy position is reached and obtained. The doctors are expected to complete several job rotations of approximately 4 months (FY1/2), choose between medicine/surgery routes (CT1/2) and then they move onto their chosen specialist training programme (e.g. Speciality Registrar). These times are the minimum and can be extended by doctors obtaining an Academic Clinical Fellowship or by opting for a dual certification in another speciality. These times can also be extended by doctors not passing an exam and increased competition amongst the cohorts. The structure of this training has changed from several years ago and is indicative of the increasing rationalisation of medicine. For example, doctors are expected to work across different workplaces in order to complete their rotations, making it very difficult for them to settle in one region and maintain autonomy over their work processes. In order to climb the training ladder, then doctors are also expected to pass various exams and show evidence of competencies/skills whilst working. Should doctors not pass an exam, they must retake, re-apply for the position and complete locum work/become a Trust Grade level doctor in which they are not on the training pathway anymore, but can resume alongside academic attainment.

In this light, the junior doctors were observed to have little control over their work within Wilton – for example, they were observed to simply initiate the care plans that have been previously designed by their seniors and they would often update the senior doctor on the ward with progress throughout the day. Updating seniors was a more common observation amongst the very junior doctors (e.g. FY1/2), but this was also observed in those with specialist clinical practice experience, suggesting an element of bureaucratic control of medical and surgical work at all levels of training. Typically, junior doctors would conduct ward rounds with their seniors – during the ward round, the senior doctor would conduct the clinical observation and the junior would scribe/make detailed notes of the interaction. After the initial ward round, then doctors would be expected to see service-users later in the day,

mainly to ensure that they are stable on the wards. Junior doctors were also expected to carry out mostly administration work – the ordering of tests, bloods, writing lists and updating medical forms etc. constituted a large part of their working day. This is a reality of medicine that most of the juniors did not expect at the end of their medical degrees, nor at the onset of their training.

Following the above, the political focus on efficiency within healthcare clearly shapes the work organisation of medicine in both medical and surgical cohorts, and across the training grade spectrum. Medical and surgical training remains largely under the control of the General Medical Council, however, in terms of spacial/temporal elements of this work, then some of the training can be considered as being increasingly rationalised by human resource (HR) processes within the hospitals. Rota coordinators, for example, often organise cover and swap junior doctors' shifts which means that the doctors can quite frequently practice on other rotations to maintain 'safe staffing' levels and thus the training of these doctors is often compromised.

Increased efficiency can also be experienced as dehumanising by the doctors – reflective of the wider literature on bureaucratic rationality in general, and rationalisation processes more specifically, in which workers are reduced to 'cogs in a machine' (e.g. Morgan, 2006; Iliffe and Manthorpe, 2019) working hard to achieve the best that they possibly can. As Dr Richards, a core medical level trainee, said to me:

> And then it becomes if you're in just part of a massive machine and just doing whatever you're meant to do. And if you want to sort of finish at a reasonable time you learn to do everything efficiently and really fast and sometimes not thinking too much…we need to see patients really fast because otherwise you will not be able to see everyone. So that impacts on the quality of communication with the patients, you don't always get the most detailed history. And I know like in theory they say it all comes from history and examination, and actually when you have to fill in all the paperwork and then prescribe the medications and then do something else you just start to cut corners and try to find ways of doing things faster.

Here, the doctors clearly experience a contradictory tension within their work – they are expected to manage high patient volumes but also ensure that care is not compromised. Having to work fast on-the-job and get through the patient lists can be a difficult take for the doctors, because as they collectively argue, 'the stakes are much higher in medicine' and it is not a sustainable solution within healthcare. Dr Irfan makes this point clear when he tells me: 'you can't be at maximum efficiency for 50 years', suggesting that he does not see a future within the NHS, and he is not alone in this contemplation. As a result of the rationalisation of healthcare, several doctors are opting out of the profession - they are unable to cope with the service pressures and remain at the forefront of low morale manifested within the workforce. Dr Irfan (M), a core medical trainee, continues:

> You have to be efficient. You have to think smart. You could spend 40 minutes with the patient and be very accurate in your diagnosis, be very accurate in your management plan, say this patient has got their bloods from six months. I've had a look at his x-rays from three month ago, and that's very accurate. You can't spend 40 minutes anymore, you have to do 20 minutes, so what you do is check their clinic letter, check their last blood results and just make a spot diagnosis and move on to the next one. You have to have that fine medium between spending a lot of time or spending too little time. Spending too little time and it's dangerous, you can do big things, too little time. Too much time and you're compromising other people's care, so you have to have that happy medium in the middle which is efficiency. I think doctors, the last two years, we've really learned to do that.

An alternative approach on efficiency, as stated by Dr Chau:

> I think the key areas of pressure is just trying to work within the constraints of finances, isn't it? I mean we all know that you are always pushed to sort of work as hard as you can and perhaps even harder, even when you're working 100% anyway, to deliver more and more each day and more and more each week and each month. And I think it's what you have to do is just try and make do with what you have, isn't it?
>
> (Dr Chau, M, Consultant in Geriatrics, 26.11.2018)

It seems that the most senior doctors are aware of the service pressures – in which staff and service-users are reduced to *numbers* – however, they are also aware that very little can be done at the organisational level. The medical workforce is to work at the dictates of the broader system, and as noted by many of the doctors taking part in this study, then that system is currently 'broken'. Even when junior doctors try to expend their time fairly with the service-users, there is this constant looming fear that penetrates their work organisation. Despite trying to afford service-users the time that they deserve, then there is an existing pressure from more senior, more experienced doctors to get the work done quicker. These senior doctors are in constant battle with hospital management. Dr Chapman (F, FY2) illustrates this point clearly:

> Day by day, you do end up just devoting however much time you need to sort a problem out with a patient, but you do always have someone who's looking at the bigger picture and who's saying, "You need to be doing ward rounds faster. You need to be writing discharge letters sooner." And it is something that is becoming more and more apparent.
>
> The impact of efficiency is also reflected by a very junior doctor, who is on his first job rotation in geriatrics, thereby suggesting the importance of experience within medicine. The FY1 tells me that: 'the last few weeks have been hectic' and that he is 'already working as efficiently as possible' as he continues to update his notes.
>
> (Observation Notes, Geriatrics)

#### 5.3.1.2 Time Constraints

Bureaucratic control is increasing in multiple ways – this includes a more regimented control over the doctors' time. In light of this control, the majority of the doctors spoke to me about there not being enough time within medicine – this often meant that they would stay behind to finish tasks or that they would have to hand their leftover jobs to other doctors covering subsequent shifts. The nature of this bureaucratic control over the doctors' time in medicine is also evidenced during my observations. On geriatrics, for example, the ward areas felt chaotic and busy, with doctors pacing up and down the corridors, seeing service-users swiftly

– almost as they walked by, and completing the associated paperwork with very little control over their working day.

Dr Maine (M), who is a core trainee-level doctor within medicine, discusses the impact of time constraints on service-user care:

> I think that time pressure is a pretty constant problem in the areas that I've worked in the NHS. I think that's because of staffing issues, because of workload and patient burden, but not having enough time for people, can clearly affect the quality of the care you're giving them. It can be quite difficult or upsetting, knowing that you're not perhaps dedicating as much time as you would want to. Quite a good rule I've been taught is to treat people like you would treat your grandmother or your mother and if I think, how much time would I really want a doctor to be spending with my grandma, there have been times when I've thought, I'm not actually able to give that to people for one reason or another.

Dr Mistry, another core trainee level doctor in medicine echoes the same issue: 'when you're rushed off your feet, you have lots of things to do, most of them being urgent, it's very difficult to have that time to speak. But that means you have to use the limited time you have to talk about things in a well enough way to provide them with the relevant information, not doing it in a way that's rushed or compromising'. The bureaucratic control over doctors' time often means that doctors are unable to provide the care to the service-users that they otherwise would like to. Inevitably, this is experienced as detrimental to patient care in terms of health outcomes, or in terms of the level of interaction that the doctors can afford to expend without compromising the care of other service-users on their list.

Only a handful of consultants were interviewed during my fieldwork, mainly as a means of contextualising my analysis of the more junior level doctors. However, Dr Chau in geriatrics facilitates our understanding of how the nature of time constraints is experienced in more senior clinical positions relative to junior doctors. Dr Chau accepts that the bureaucratic control of doctors' remains a service issue within Wilton Trust, however he takes a more pragmatic approach in that he is also aware very little can be done. He tells me during our interview:

> I think everyone would prefer to have more time with your patients, but the difficulty is where do you draw the line? And the thing is, from a managerial perspective, it's impossible. You know, if someone says, "Oh, I need to spend 20 minutes per service-user" and someone else says, "Oh, I need to spend 40 minutes with a service-user" and things. I know that there are some guidelines as to on average how much time you should spend per service-user but those are just guidelines and I think you just have to sort of like work with an average figure for the most part, isn't it? Accepting that some people will take longer, like an hour, because that's what it is.
>
> (Dr Chau, M, Consultant in Geriatrics, 26.11.2018)

Given Dr Chau's level of experience within medicine, from this quote it is suggested that it is relatively straightforward, and perhaps even easy, for the doctors to decide on how much time to spend with service-users who they perceive will require longer. However, at a more junior level, then this can be a difficult decision to make and almost always means that the pressure is high and that doctors will be held behind on their shift to complete associated work. Dr Sirity (F), who is in her foundation level one training, suggests:

> I don't spend as much time as I would like to with patients. I certainly would like to explain things so that a service-user understands. Sometimes, I just don't have the time. You feel pressured about the fact that there's five waiting, and there might be only two or three doctors on a ward on call at the weekend where there's not full staffing. So, you can feel pressured, so you don't have as much time as you want. I would like to spend more time, but I just can't. I try and condense it as much as I can.

Clearly, there is marked difference between the consultants' perspective on managing the bureaucratic control of time and a more junior member of staff who tries to manage the pressure, but it can be experienced as more difficult than perhaps the senior doctors realise. It is likely that senior doctors have control over their own work relative to the juniors who are mostly observed to be following orders. In addition to training grades, there is also a clear difference between experiences of medicine and surgery in relation to managing time on-the-job. Dr Spacey, a registrar level doctor within medicine, reflects on this difference for me:

> I think if you've got – say if you're doing surgery and you've got a stable person who's had, you know, moderate surgery but they're young and not cognitively impaired, then I think that is enough, you know, "How are you and how is the pain?" but I think in our cohort of patients [geriatrics], because they're complex and they're elderly, a lot of them do have cognitive impairment. You need more time to actually spend talking and examining, talking to and examining patients to get to the bottom of things.

However, a more junior level doctor on a surgical job rotation suggests that the issue of time constraints is experienced as an institutional pressure and therefore is also apparent within general surgery. He tells me:

> …there are not enough doctors and there's not enough time. I'd love to be able to spend at least ten minutes talking to every service-user, but it's very hard to because there's so much more — It shouldn't be more important things because patients should come first, but if you've got all these scans to organise, all these blood tests to do, all these chest drains to pull out or put in, you don't have time to satisfy every service-user...
>
> (Dr Furtal, M, FY3, 7.11.2018)

In this context, the increasing evidence of bureaucratic control within medicine is seen to shape the work organisation of doctors. The administrative tasks/increasing level of paperwork results in there being inadequate amounts of time left to spend with service-users. However, from ethnographic observations and interviews with other doctors practising in surgery, then there does seem to be less of a time burden within surgical specialties relative to medical ones. Perhaps the above quote is reflective, instead, of experience as a mediator in the work organisation of medicine, as opposed to the perceived differences within surgery and medicine as clinical departments.

Most of the doctors in this study are angry at the NHS system – they are angry at our government for rationalising healthcare in the way that it has, and they are frustrated because they must deal with the consequences on the frontline of patient care. However,

they learn to manage the pressures of bureaucratic control and work with what the resources they have - despite knowing that service-users deserve better. As Dr Austin (FY1) tells me:

> …often the challenge is that you want to do a lot more than you are able to because of the lack of time, lack of resources, lack of staff. Often on our ward there's 28 patients and often there'll be two doctors, so that's 14 each, and it does not give you much time to spend with each patient so you're kind of always like doing the bare minimum, like fighting fires rather than actually proactively doing the best that you can. You're just doing the best that you can with what you've got rather than the best that the patient can get.
>
> (Dr Austin, M, FY1, 1.06.2018)

#### 5.3.1.3 Understaffing

During my fieldwork, the managerial control of resources (including human resources) was also significantly apparent. The managerial control over resources is considered as a political imperative to gain maximum output from the Trust and a means to reduce costs of healthcare. Such imperatives have led to several outcomes on the frontline of medicine and surgery – one of these outcomes is related to the nature of understaffing within Wilton Trust. The level of understaffing was clearly observed within both medical and surgical departments of the hospitals, with the junior doctors frequently complaining to me about rota gaps and high service-user volume due to there not being enough doctors practising on the wards. Following this, staffing issues presented a problem across the entire Trust, and by extension the NHS at large, with the increased migration of doctors to other healthcare systems worldwide, and the notable decrease in medical student intake at university-level. There is also a significant lack of continuation across the departments, specialties and hospitals within Wilton – this largely resulted into the issue of the entire Trust being understaffed, and thus compromises the health and safety of service-users (and indeed staff members). Dr James (F), who is a medical registrar, explains the ways in which she has experienced understaffing as an institutional pressure of the job:

> I think one of the difficulties is we very often don't have enough staff. This is general, and I'm sure lots of people will tell you this. But when you are under a lot of pressure,

> there's not enough staff and then you are – you necessarily have got to be very quick in the ways that you are working. So, for example, on a night shift – I've had night shifts where I've been the only doctor managing six bays of acutely unwell patients. So, you're managing about 40 acutely unwell patients and then within that, people can become unwell in unexpected ways and you have to try and manage all of that. There is a point where you get to say three o'clock in the morning, and even if you have slept well that day, naturally, your circadian rhythm is telling you that you should be asleep by now and you feel cognitively that you're slowing down.

Dr Prescott also tells me about her experiences of understaffing and how this impacts her personal life:

> Sometimes you cry about the situation just because it's a horrible situation for that person to have to deal with, and some people have incredibly unlucky situations to deal with that you just think, really, this one person has gone through all of this? But as long as you do all you can, which is why the stress and lack of staff and everything is frustrating because you don't always feel that you can do that, and more and more you come away from a day at work feeling like you couldn't, unless you stay three/four hours late, which is not uncommon. It means I miss putting my baby to bed and I don't see her for days on end because I'm late from work. But the alternative is that you don't sleep because you know that you've not given that best care to that patient, and they deserved it.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

In addition to being experienced as an institutional pressure, the nature of understaffing also affects the doctors' mental and emotional wellbeing. Limited staffing across the hospital clearly creates a problem in terms of heavier workloads for each doctor and high volumes of service-users to see on ward rounds. However, some of the doctors also discuss this pressure in the context of their emotional wellbeing – in more senior positions, doctors are held highly responsible for the occurrence of medical mistakes. Given the shortage of medical staff, (and other members of the healthcare workforce), then often these mistakes are inevitable and can compromise the quality of care to users. Dr Asad is a medical registrar – he clearly expresses that understaffing can result in what he calls 'emotional pressure':

> The short staffing is definitely an issue, so we're trying to make the best patient care and improve the quality of care with the limited staffing, so that will not only give a physical burden but also the emotional burden also to make sure they do not make any mistakes, and especially if you get in high level, like registrar and consultant, the emotional pressure is immense.
>
> (Dr Asad, M, CMT2, 20.11.2018)

The nature of understaffing is experienced by doctors despite their training grade, but in my study consultants take more of a pragmatic viewpoint. More senior doctors understand the pressure and continue to battle with hospital management/rota coordinators to fill the gaps in order to maintain 'safe minimum staffing', but even the more junior doctors are aware that senior clinicians and management are constantly firefighting with one another due to the service pressures that both are faced with. Clinicians are faced with a limited number of doctors on the frontline and thus the increased likelihood of medical mistakes; hospital management are faced with external pressures, including a lack of funding and strict targets trickling down from governmental level. It is not uncommon for clinicians and managers to firefight. It is also not uncommon for the more junior members of staff to be on the receiving end of this constant battle:

> …we need forty-four and we have twenty-five [doctors]. Now the consultants are quite frustrated because they need junior doctors as much as we need the consultants, and – so they have taken it up to management and HR saying we need more doctors, and the response has always been the same. You need to give us evidence, you need to draw up a business plan and tell us how we can fund this, or why you need these doctors; and they have done that. The consultants have done that time and time again. They've provided the evidence and they've provided the experiences that they've had, and it's the same response, each time.
>
> (Dr Ahmed, M, FY1, 5.07.2018)

In light of the analysis above, the influence of imperatives associated with rationalisation of work further shapes the nature of emotional labour within medicine and surgery. In the context of Wilton, I argue that the imperatives of this logic mean that doctors must provide

emotional labour in the face of increasing efficiency reforms, high patient volumes and a limitation of healthcare resources. The next data chapter focuses on how wider rationalisation of work (in addition to the other identified logics) shapes the emotional labour process at the frontline of medicine and surgery.

### 5.3.2 Professionalism

The logic of professionalism guides the professional behaviours of the doctors in this study. In this section, I describe the work processes of junior doctors in light of the wider imperatives that influence the junior doctors to act in accordance with professional logics. These work processes are outlined in the context of the General Medical Council and the shared decision-making model. These aspects of professionalism are commonly discussed by the doctors and are understood in this study as influencing the nature of their work organisation during medical and surgical practice. These ideas are introduced in this chapter in order to provide insight into the logic, and these ideas alongside others, are further elaborated within subsequent chapters in this thesis in order to outline the emotional labour processes associated with medicine/surgery.

#### 5.3.2.1 GMC Guidelines

The General Medical Council (GMC) has published a series of guidelines on the nature of medicine - including *good medical practice*, *what it means to be a doctor* within the NHS and *maintaining a professional boundary between you and your patient*. The GMC has therefore helped to influence the professional behaviours adopted by both medical and surgical cohorts. In this study, when asked about the nature of professionalism, majority of the doctors referred to the GMC guidelines in some way or another – suggesting that in addition to working in line with bureaucratic imperatives, doctors also work at the behest of their consultants and senior role models.

Majority of the doctors referred to the publication of GMC guidelines as shaping their professional behaviour with service-users, relatives and colleagues. The GMC has published a clear set of guidelines on managing professional boundaries and working towards empathetic communication – an element of medicine that has changed in recent years and has influenced

the work of doctors from paternalism to more a patient-centred approach. Doctors tended to discuss these guidelines with reference to respecting the wishes of service-user, remaining confidential in their care and building trust with services-users and families. As Dr Sirity (F, FY2) tells me during our interview: '…there's actually General Medicine Council guidelines, a whole book on good medical practice that they try to encourage students. Unfortunately, I don't think it's read that much but I think its basic principles that I think anybody with a good moral compass would have', suggesting that these guidelines are deeply embedded within us as individuals. And Dr Furr (F, FY2) elaborates:

> I think the GMC itself says a lot of things, that everything – they always say, everything you do, act professionally. In our signs-off, in our training, they ask you, so you have to do sort of case based discussions on people, or they call them like mini clinical observation things, and it says about the areas that the person who's filling out the form is judging you on, and they can be on sort of admission, clerking, management and investigation of a patient. Complicated illness, follow-up and then the other one's professionalism, so it kind of comes into everything. In your training you have to, basically a big tick for everything, because everything you're meant to be professional for, but it comes into the GMC stuff a lot.
>
> I was only talking about that a few months ago, which is a bit odd; but I think, so a lot comes from the GMC and your employers, so they can sort of hold it over you; I think the public as well. You're expected to be, slightly super-human probably, but then at the same time, to be unprofessional in front of a patient would be very worrying for that patient, so obviously people understand that…
>
> (Dr Furr, F, FY2, 21.06.2018)

Dr Furr discusses the dark side of professionalism here – that the GMC can hold things which are deemed unprofessional against the doctors and that creates a little fear amongst the juniors who are trying to balance service pressures of the job. In this light, some of the doctors appeared somewhat sceptical of the council because often the GMC use these guidelines to sanction doctors that do not follow through with all professional criteria irrespective of the context. In addition, it is not uncommon for the doctors to feel that the public still expects

doctors to know everything and be everything – 'super-human' is the word used by Dr Furr to explain that they are placed on a societal pedestal and this means that the doctors have several expectations placed on them, and that they must adhere to.

Further to the above, Dr Furtal, a FY3 doctor practising on a surgical job rotation in major trauma, laughs when I ask him what it means to be professional. He tells me: '…the GMC guidance (laughs)… best interest at heart, respect, treat them like a real person' which seemed quite a sceptical response to me, and additionally suggested that some doctors did not treat service-users as real people, as a means of coping with the work. In the context of professionalism, then Dr Furtal uses humour to represent his scepticism of the GMC guidelines – perhaps because they are too obvious and only require an individual to have a 'moral compass'. Perhaps because these guidelines are used to punish doctors for unprofessional behaviours as opposed to them being perceived as encouraging.

#### 5.3.2.2 Shared Decision Making

Considering the GMC, several guidelines have been published which appear to echo the political focus on the empowerment of service-users and increased autonomy. This is reflected in the move from paternalism, in which doctors dictate patient care and treatment, to the widely adopted *shared decision-making* model and an increased focus on a two-way relationship between doctors and service-users. Clearly then, there is an association between logics of bureaucratic rationality, consumerism (discussed below) and professionalism here – doctors are observed to work in line with imperatives associated with bureaucratic control and therefore their professional autonomy is affected on-the-job. However, the doctors also work in line with professional guidelines, given most of their work organisation is regulated, and indeed controlled, by the GMC. In addition, although it is observed that much of the doctors' work organisation is shaped by service pressures/resource constraints of the job, there has been a significant change in the management of patient care, and this is likely to be shaped by the customer-focused organisation. Dr Mayfield, a consultant in anaesthetics, tells me: 'I think there has been a step change in the way we – and probably even in the ten years that I've been practising medicine – the way we relate to patients and make decisions about them. And the current phrase that we use is 'shared decision making' and that's decision making between the patients, the anaesthetists and the surgeons', thereby suggesting that

service-users are encouraged and motivated to take an active role in their healthcare and treatment. This is also mirrored by Dr Asif who states:

> There's a less paternalistic role to medicine where we tell you what you're going to have and that's it. It's a two-way relationship. We arrange appropriate treatment for what they want, but there can be examples where we're going to offer treatment that's not appropriate for them, and they can obviously say no to whatever treatment we're offering…
>
> (Dr Asif, M, CMT2, 16.04.2018)

Similar experiences are discussed by Dr Spacey, an experienced registrar within geriatrics medicine, who provides a little more insight into the increased expectations of service users in line with service-user empowerment:

> …it used to be very paternalistic, "I'm the doctor, this is what I say." And now we do more of a shared decision-making model. But then sometimes that leads to the rise of, I want this, even if it's not appropriate for that particular patient, so yeah. I actually find them – not so much in my patient group because obviously they're old – you know, the older generation are still a bit more accepting. I find their relatives who are all – there's something, what do they say, the baby boomer generation are very much, "We are the consumers of the NHS", yeah.
>
> (Dr Spacey, F, ST7, 27.02.2018)

The above suggests that there are negative connotations associated with the empowerment of service-users and the shared decision-making model, specifically in terms of raising service-user expectations and feeding into a consumer culture (as will be discussed below). However, some of the doctors certainly seem to prefer the model of shared decision-making over paternalism, as it reduces the responsibility/burden on them in terms of knowing how best to treat the users. Dr James, also a medical registrar in geriatrics medicine, tells me:

> I don't want my patients to look up to me and take my word as *gospel*, because actually, we should be – it should be equal. We are equals and we need to have that very equal discussion and reach an agreement on what their care should be.

In a similar light, Dr Stephens (FY1) explains how the shared decision-making model can be perceived as positive: 'I think patients are generally very good now and they're taking a bigger part in their own like management, so your own blood sugars, they know when to come in, what things to look out for, and that's probably one of the pluses of having so much information available online now'.

There are different experiences associated with the move from paternalism and towards that of shared decision-making – many of the doctors perceive this transition as health as healthcare should be a negotiated and equal discussion. However, some of the doctors also experience tensions and conflicts in the way that healthcare is negotiated, particularly with relatives of the service users who may have unrealistic expectations of the care that the NHS can provide.

Notions in relation to shared decision-making are also reflected in my observation notes. I observed several interactions between doctors and other members of the multi-disciplinary team and service-users during the time of my fieldwork, and much of the time these interactions felt shared between professional and service-user. Sometimes the service-users preferred doctors to take more leadership – this was observed when they were unsure what to expect and would say things like 'well you're the doctor, you tell me'. Other times, service-users took an active role in their health and provided doctors with information and options that would work best for them. The observation below clearly illustrates the nature of shared decisions between doctors and service-users – in this context, the service-user is fed up of hospital, is unable to sleep due to the constant buzzing and would like to go home and return as an out-patient. The junior doctor here acknowledges these concerns and explains she will do what she can in order to help with the situation:

> This was a negotiated discussion – there is evidence of patient empowerment and the patient being more informed than previous years even amongst the elderly population (HCOP). Again, FY2 reassures patient /relative during the interaction that she will push for the best possible outcome in terms of the patient going back home – even if this means that the patient returns home but then re-enters hospital for a short time in order to have procedure. Relative then explains to the doctor their pressing worry of the patient developing other medical problems due to being in a hospital bed and that

> the patient is unable to sleep well at night due to the busy/loud nature of the ward. FY2 appears to become empathetic toward both patient /relative: she kindly explains that she understands the noise is a significant issue for the service-users but sadly the ward is very busy – given an ageing population and increased volume of patient.
>
> (Observation Notes, F, Geriatrics, 23.02.2018)

Following the analysis of the influence of professionalism, the imperatives associated with this logic also shape the nature of emotional labour performances within medicine and surgery – as will be outlined in the next chapter. In the context of Wilton, I argue that the logic of professionalism influences emotional processes of professional empathy in the context of both medical and surgical services.

### 5.3.3 Consumerism

In this section, I look at how the consumerism logic also influences the work organisation of junior doctors. Wider imperatives of the consumerism logic are outlined in the context of material features of medical/surgical work and the move towards a customer-focused organisation. For example, in light of the private sector, then feedback mechanisms are being taken more seriously within the NHS in order to gain insight into service-user experiences, manage complaints and sanction healthcare professionals when is considered appropriate. Doctors I spoke to are also increasingly expected to manage the expectations of their service-users and relatives in order to avoid said complaints and issues of consumer litigation – these issues are also highlighted in subsequent chapters.

#### 5.3.3.1 Managing Expectations: Patients

Following political initiatives emphasising service-user empowerment, and the large number of sources available online in relation to healthcare and medicine, a consumer culture continues to permeate the public healthcare industry within the UK. Within Wilton Trust, a common observation was the increased expectations of the service-users and their family members, and doctors would often comment on how these expectations have changed in recent years. Often, healthcare professionals perceive these expectations to be unrealistic

and can find the management of the associated interactions difficult. As Dr Spacey (F, ST7) explains:

> … I think it's definitely a consumers' market now. Like I say, kind of 10 years ago when I first qualified, people were more willing to accept your decisions as doctors. So, you'd say, "Well, I don't think we should do this scan" or whatever. But now they'll come with a whole host of questions and, "Well, I've read about this treatment. Why can't I have it; why aren't you offering this? Why aren't you offering that?" And I think there's a lot more patient choice nowadays and the way we communicate with patients is different.
>
> I think it becomes more challenging where patients come in and demand things and you have to turn round and say, "Well, I'm sorry, that's not available on the NHS" because we have the NICE bodies and things like that, that say actually, it's not worth funding. So that's challenging. But I do think in one way it's a good thing because it makes us all think about what we're doing.

The move towards a customer-focused organisation and the resulting permeation of a consumer culture within Wilton Trust has resulted in a level of transparency. As Dr Spacey states in the illustration above, imperatives associated with the logic of consumerism makes doctors more conscientious and more inclined to think carefully about the work that they are doing. This is likely to make doctors feel insecure and intimidated on-the-job, but perhaps also helps to reduce the likelihood of medical mistakes, complaints from the service-users and outcomes of consumer litigation.

In addition, there are now feedback mechanisms in place within hospitals as a means of empowering service-users and in order for them to shed light on their experiences of their care – some of the doctors within Wilton have expressed that there is a constant fear of receiving negative feedback on-the-job and much of their work organisation is shaped in light of this fear in order to avoid consumer litigation outcomes. In this light, an overwhelming number of the doctors discuss how working in line with the imperatives of a consumer culture has an influence on their work processes and the way in which they treat their service-users. As Dr Maine (CMT2) suggests:

> …in order to keep people on side, and keep people happy, you almost do need to bend to their will a little bit and say okay, we'll give you this treatment if you need it, even if it's not something urgent or that you have to worry about. I think – essentially because you want to keep people happy rather than what's good for them, which is an odd dynamic really. I think partly as well, the dynamic used to be, the doctor knows best and now I think it's more like a consumerist culture that it is patient centred.
>
> (Dr Maine, M, CMT2, 27.06.2018)

Even though Dr Maine acknowledges this is an 'odd dynamic' – to give into service-user expectations without an urgent medical rationale or justification for certain treatments - he, alongside many other healthcare professionals, state that they do tend to give into service-user demands in order to keep them happy – and indeed avoid complaints on the ward. This is also echoed by Dr Rowe, a medical registrar, which suggests that these expectations can be difficult to manage even in light of increased experience within the medical profession:

> You don't want it to but I guess if they're asking for extra things that you're not sure whether they really need, and if they're being pushy about it, I don't know if it's made me ask for extra tests, I think I would be running it past my senior maybe more rather than just trusting my judgement that they don't need such and such. I might go well if they really are pushing for it then actually, I will go and discuss it with my consultant and make sure they're happy that we're not going to be ordering every test under the sun because they don't really need it. Yeah, sometimes people just don't accept that. So, it has to come from your consultant rather than you.
>
> (Dr Rowe, F, ST4, 6.03.2018)

Dr Rowe does not necessarily tell me that she will 'bend' to the will of her service-users, but she does explain how she would be more inclined to seek advice from her seniors if service-users come across as 'pushy' or demanding. She is reluctant to tell me, but from her discussion, it seems likely that doctors are heavily influenced by the consumer culture permeating the NHS. This culture can make the doctors feel insecure in their own clinical judgement – an outcome of the doctors' work processes that is unlikely to have been the case

several years ago. The permeation of a consumer culture within the NHS has additionally increased the demands of the service-users and means that often doctors will give into the expectations in order to keep the patients 'happy' and avoid negative outcomes.

#### 5.3.3.2 Managing Expectations: Relatives

In light of the above, managing the expectations of service-users presents a real challenge for healthcare professionals. However, from this study, the expectations of the relatives/family members are experienced as an even bigger issue within the NHS, across different training grades and specialities. Dr Austin (M, FY1) talks about his experiences of relative expectations:

> More often than not it's the patient's relatives that cause the issues than the actual patients themselves because they've got quite a different viewpoint of maybe what you should be doing or if they have any kind of medical training, sometimes they almost know a little bit too much that they can't – but not enough to actually know what's going on and that can be quite difficult because they think they know a lot more than they necessarily do.
>
> People will always come in and tell you what they want and it's just not really how it works. I mean they do to an extent, but obviously, you know, they kind of come to get an opinion on things rather than to come and demand a treatment or demand an investigation. Particularly relatives will be quite demanding sometimes. They'll be like, "I want this blood test. I want this scan of some sort."

Clearly, the relatives of service-users present a bigger problem than the service-users do themselves because the relatives are more likely to be conducting the research online via Google and come into the hospital informed and with several questions. Dr Stafford (F, CMT1) elaborates for me:

> …they're [relatives] the ones that go home and do the Googling and do the research and they're the ones that are fighting for the best care for their relative, even though it might not necessarily be the right thing (laughs). So, I've had lots of experiences where I've got into a lot of conflict with relatives more than the patient.

Although these expectations can frustrate the doctors, it is usually accepted that the relatives are simply concerned for their family member and wish to ensure that the best possible care is provided for them by the NHS. It seems that much of the public are keen to challenge the perspectives of healthcare professionals – relative to several years ago in which the 'doctor would know best'. Both Dr Wie and Dr Terry outline the challenging aspects of managing relative expectations, but suggest that they are understanding of where the relatives are coming from:

> I think the most challenging bit is actually family members more than patients. I know deep down it's not their fault. They're worried about their family member, they're feeling all these things because their family member is sick, and that's fine. Sometimes it's difficult when you're working incredibly hard and the family member is borderline verbally abusive. You're like, this is not what I need today. So, that can be a bit challenging.
>
> (Dr Wie, F, FY2, 10.09.2018)

And Dr Terry (FY2):

> You can occasionally get people who are quite demanding but it's always coming from a good place – it's normally family that are demanding on behalf of patients and it's because they're worried about them, and you can understand why. It's been very limited actually when I've had patients themselves being really demanding. It is usually family.
>
> (Dr Terry, F, FY2, 25.04.2018)

In this light, managing the expectations of service-users/relatives is a difficult aspect of the work organisation in medicine. For the more junior doctors, these increased expectations can result in much frustration, though the juniors try to maintain focus of where the relatives are coming from. Increased expectations are still experienced differently for the more senior doctors, who can reflect on how the NHS used to be in comparison with how it is in contemporary society. As Dr Spacey explains for me, only one decade ago were people more willing to accept the perspectives of the doctors, but today they present challenging questions and place demands on all healthcare professionals working on the frontline. This inevitably

increases the medical workload and influences how these service-users/relatives are managed and interacted with. The logic of consumerism, then, can be seen to shape and influence the nature of medical and surgical work within Wilton Trust.

Considering the above, imperatives associated with the logic of consumerism also shape the nature of emotional labour performances within medicine and surgery – as will be outlined in the next chapter. In the context of Wilton, the influence of increased expectations and a consumer culture permeating the NHS influences emotional processes of consumerist empathy in the context of both medical and surgical services.

### 5.3.4 Community Orientation

The logic of community orientation stems from the notion of social embeddedness (Polanyi, 1957) – this notion suggests that the actions of individuals in society are largely shaped by the social context within which these actions function. In the context of medicine, then the actions/behaviours of doctors are also largely influenced by context-dependent factors of a given situation. In this study, an orientation towards the community in light of social embeddedness was the most difficult logic to tease out. This is because it is the subtlest and least dominant logic evidenced within medicine and surgery, with the other logics of bureaucratic rationality, professionalism and consumerism being much more visibly influential. In this thesis, the logic of community orientation is observed in line with a desire to make a difference for the service-users and their relatives. However, it was a common observation to observe the dominance of the other logics during times where doctors were trying to draw upon conventional forms of social behaviour – thereby being influenced by the nature of social embeddedness.

#### 5.3.4.1 Making a Difference

Several doctors in this study discussed the importance of making a difference for the service-users, given that often service-users are perceived to be at a very vulnerable stage in their lives when in hospital. Accordingly, the doctors would make a conscious effort to offer more time to the service-users where appropriate and provide more than simply a clinical service during interactions. This provides insight into the community orientation logic because in order to respond to wider social norms, then doctors must first consider themselves as a

'social being'. For example, Dr James (ST1) tells me about the importance of making time for the service-users in order to feel as though they have made a difference to the user in some way or another. The logic of bureaucratic rationality is dominant in most medical situations as there is a constant time pressure that is experienced by the doctors and other healthcare staff in light of managerial control. However, doctors in this study explain the importance of affording service-users that time if they perceive it to make a big difference to their day. They also acknowledge that often 'you don't have to be a doctor' to do these things for the users – it can be something as small as offering them a five-minute conversation. For example, Dr James (F) tells me:

> Things that are really nice are chatting to a patient and having the opportunity to make a difference. So, for some of our elderly patients for example, they don't get to talk to anybody in a lot of their days. So, sometimes, somebody who – if we're not massively busy, someone who can take ten minutes to ask them about how they're really feeling and how their mood is and those sorts of things, it's the first time someone has maybe done that in quite a few months. So, that's quite nice, that you can make a difference on that really minor level.

In a similar light, Dr Tsansaraki (F, CST1) who is practising within general surgery echoes the importance of making time for service-users in order to make an important difference to their lives:

> Another positive aspect of my role is when I get to speak to patients outside the medical side of things, and you can tell it's patients that they've been needing to talk to someone for some time, and I find that quite positive as well because, apart from medical professionals, we're also people in a set environment that patients can open to us too. And the more time I spend in my role, the more I find I enjoy that bit more because, at the end of the day, it's not just about fixing wounds and treating, you know, injuries, it is about – it's – the biggest satisfaction is when you find out that you've actually made a difference in someone's life.
>
> (Dr Tsansaraki, F, CST1, 13.11.2017)

Here, Dr Tsansaraki takes a moment to reflect on the importance of caring for the service-users irrespective of the surgical context – suggesting that an orientation towards the community is apparent, and indeed important, within the NHS. The influence of this logic is understood as leading to increased job satisfaction for the doctors and resulting in improved quality of life for the service-users. These notions are also reflected on by Dr Pratt (F) in general medicine:

> It makes you feel good because you feel like you've actually made an improvement, even if it's a time buying thing, just so someone isn't upset or freaked out through the day because that's when complaints come in, when you've not been communicating or they feel like you're hiding stuff from them. Once you've taken the time to be open with someone, explain, you know that you've helped them feel better and taken some pressure off people further down the line.

However, in addition to increasing job satisfaction for junior doctors, then making a difference to the lives of service-users is also a means of reducing the likelihood of complaints within Wilton. There is clearly an overlap in the influence of institutional logics in this context. For example, as opposed to wanting to make a difference to the users, it may well be that Dr Pratt is outlining the complaint culture within the NHS at present, and therefore it is the consumerism logic that is influencing her work organisation as opposed to an increased orientation towards the community.

Further to the above, an additional example of imperatives associated with the nature of social embeddedness is provided by Dr Chapman (F) in the context of 'having extra time', and therefore being able to make a difference to service-user lives'. This also helps to highlight the differences between and within medical and surgical specialities:

> I do make a huge difference to those patients, mainly because I do have the extra time to spend with them to find out if they've got anything wrong with, for example, the timing of the medication that they're taking. If, at home, they take it at eight o'clock instead of six o'clock when the nurses give them, I have the time to make slight tweaks to the drug chart, and patients tend to really appreciate that.

Following the above, then the nature of community orientation requires doctors to perceive themselves as social beings in order to respond to the imperatives of wider social norms. In light of this analysis, the influence of the community orientation logic is considered to shape processes of social empathy – here, 'you don't need to be a doctor' to care for the users.

Overall, part two has outlined four key influences of the work organisation of medicine: bureaucratic rationality, professionalism, consumerism and an orientation towards the community. These logics are elaborated on in more detail within subsequent chapters of this thesis in the context of emotional labour and management of the doctors working within Wilton Trust. The third part of the current chapter outlines the nature of social relations between and within the medical profession – this helps to provide further insight into the nature of medical and surgical work within Wilton Trust – the nature of social relations is discussed in the context of team working and on-the-job training.

## 5.4 Peer Relations

Peer relations between doctors and other members of the healthcare profession manifested most clearly through the nature of multi-disciplinary teamwork and the experience of inter- and intra-professional working amongst the cohorts. Other elements of social relations at work were discussed in relation to teaching and training sessions. This section focuses on outlining social experiences of medicine and surgery in order to tease out the meaning of social interactions within and between members of the multi-disciplinary team.

### 5.4.1 Multi-Disciplinary Teams

The multi-disciplinary team (MDT) within medicine comprises of several different healthcare professionals, who work collectively in order to support and care for service-users with complex medical/surgical needs. Members include doctors, nurses, allied health professionals and pharmacists – other members, e.g. social workers, may be opted into the MDT as appropriate to the service-user-group (Gorman, 1998; Royal College of Physicians and Royal College of Nursing, 2012). The rhetoric and practice of the MDT is somewhat divergent (Royal College of Physicians and Royal College of Nursing, 2012) – whilst the rhetoric outlines that all members of the MDT are to proactively engage in ward rounds to offer perspective, from observations conducted in this study, only doctors would carry out the ward rounds in

which they assess the service-users, and other members of the MDT would input to the care plans behind the scenes or at separate times. Importantly, the MDT did serve to facilitate the experiential learning of the doctors, to foster the nature of social relations and improve the working experience for the majority of those involved in this study.

All the doctors shared their perspectives on the MDT and nature of team working within medicine. For these doctors, the experience of collaborative working with different healthcare professionals was mainly positive. The MDT tends to be experienced as a strong element of the job, helping to nurture healthy workplace relationships and acts, to a large extent, as a shared experience in which doctors (and other healthcare professionals) feel as though they are 'in this' together. Dr Maine (M, CMT2) tells me how the day runs much smoother if the nature of the MDT is positive:

> I think there are regular staff members on our ward, and because we get on reasonably well – that's the key thing. If you like who you're working with or you're able to at least be civil to who you're working with then it makes everything run smoother and work a lot better. It's often quite hard when you go into a different area. For on call for example, I cover lots of different wards where I don't know who anybody is, and it just slows everything down, how it gets done. But the multi-disciplinary work at the moment works well.

These points are also present in Dr Prescott's statement:

> And actually, you work with the best people. You work with nurses that mean well and doctors that mean well and it's really refreshing to work in that environment. Not everyone has that chance to work with other really awesome people. When you have consultants that you really look up to, you just think, I want to be like you because of how you treat your patients.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

Dr Bates (F), a registrar in stroke medicine, also discusses the importance of the MDT. Here, she outlines the MDT as allowing for debrief on-the-job and therefore it is experienced as a 'shared experience' between the members:

> I think I find that sort of thing very valuable because nurses debrief after arrests and difficult situations always better than doctors do. We never do it, not really. And I'm usually – I usually have good working relationships with everyone on the ward, so with all members of the team and I think there's a sort of real value in sitting down with everyone and saying, "That was really hard, wasn't it?" Or, "This is really distressing" and just having that shared experience.

In this light, the nature of the MDT is being experienced as a safe space for staff members to reflect on difficult situations that arise during their daily work experiences. In addition to facilitating the learning of healthcare professionals and allowing for different perspectives on patient-centred care, then the MDT also serves as an important space for coping with workplace pressures that arise from the work processes of medicine and surgery, fostering the important nature of social relations. As Dr Pattinson (F, FY2) also tells me:

> I think the best part for me is the supportive team environment. I get on really well with my colleagues; everyone from the healthcare assistants all the way up to the consultants. There's a real team vibe and I feel that the consultants are really good at promoting that and they do a lot of teaching and they really involve every part of the – everyone as part of the team.

Given that there are several different professionals involved in the MDT, it follows that not all members will agree with each other considering their individual targets/professional objectives. Usually, this is when the logic of bureaucratic rationality is dominating and thus seeks to influence the work organisation of medicine in terms of time constraints. Dr Pratt (F, FY2) states:

> I mean it's tricky because everyone has their own pressures. Between the nurses or the physiotherapists or other people, they have their own time pressures for their own objectives. They don't always line up with what the medical or the doctor ones

> are. So, sometimes there can be a bit of bumping heads between people. The nurses might say, we need to get these letters done for the patient so that they can get home, because maybe they're from a care home and obviously they need to be there for 3pm. The transport needs to be sorted out at midday, whereas I might be there in the morning saying, I need to sit down and write this letter, but I've actually still got to refer them for these out-patient scans and bits and pieces, and if I don't do that, then their care going forwards isn't actually going to be set up. If you've got an hour to do all of it, as well as everything else for everyone else, then it's quite stressful and sometimes tempers tend to boil over a bit.

In addition to these experiences, then the MDT also facilitates the sharing of ideas amongst the team and provides a collective voice to service-users/relatives. It was not uncommon for doctors to talk about unrealistic expectations of service-users on-the-job, as outlined above, and therefore, in this light, the service-users are more likely to listen to the professional if there are several perspectives providing similar advice. As Consultant Sheeran tells me:

> …most specialist care in the NHS now involves multidisciplinary teams. So, you can get your MDT to review the person's case so then instead of just my voice they'll have six or seven other voices as well. So, it provides people with the chance to say, "Well, maybe we should do this or maybe we should do that."

The nature of social relations manifesting through multi-disciplinary working within medicine and surgery is an important aspect of the job, which helps to provide a collective and supporting environment for the junior doctors.

### 5.4.2 Teaching and Training

Following the discussion above, the nature of peer relations was also reflected within teaching/training experiences of the junior doctors. However, just as the logics identified above influence the work processes of medicine, these logics also impinge on the ability of doctors to attend training sessions due to institutional pressures. It is a common observation that juniors are unable to attend scheduled, 'protected' teaching given the pressures that manifest on the wards, and that there is inadequate staffing to manage these pressures.

Nevertheless, it became apparent towards the end of my fieldwork that scheduled teaching has two main functions: to be educational and improve one's medical practice and to allow for collective experiences of the job to be talked about/released. As Dr Bates (F) illustrates:

> I think talking to peers is really important, so I think the times where I've been the most stressed is where I don't feel like I'm part of the team and I'm on call so much that I'm missing out on things like teaching because some of – my personal opinion is that teaching has two functions. So we have like weekly teaching as trainees, so one is the educational bit and two, is the kind of group ranting so you can get to sit down with your peers and discuss, "Well, I've had this this week and this has happened" and there's that sort of shared experience.

The perspective of Dr Bates is also reflected by various ethnographic observations that I conducted during my fieldwork. For example, in geriatrics, I was sat in the Doctor's office and a FY2 and ST7 doctor were discussing the upcoming teaching session: 'due to the pressures the ST7 asks the doctor whether she can cover some other work instead of going into the teaching – the FY1 replies: "teaching is where we can zone out"'.

(Observation Notes, F, Geriatrics 23.02.2018)

This experience of 'zoning out' is also reflected within observation that I conducted on during a later training session – the following observation helped to contextualise these ideas and understand in more detail the importance of 'escaping the ward' for doctors as a means of venting with peers/colleagues. For example:

> This is a full/popular training session – there are many doctors present. I wonder if they have come for the educational aspect of the session, or in order to escape the ward pressures and catch up with colleagues. The main trainer at the front is a visiting neurologist from Germany doing a tour of the universities in the UK - basing session on research – the trainer has a medical and biomedical background. Discussions are focused around stem cell analysis and new medicine that has come available for Parkinson's Disease. The talk seems interesting, however, as I observe the room, I notice that some doctors are disengaged – they are using phones whilst the lecture is

> happening - zoning out of the educational aspect, potentially because they are tired. Other doctors are actually falling asleep during the presentation - evidence of fatigue and being overworked. It is also common to see doctors whispering to one another, sharing conversations. This suggests to me that some doctors come to training as a means of hitting 70% requirement target or to take a break from the ward. Other doctors are looking at social media on phones, doing other things (i.e. checking flights!).
>
> (Observation Notes, Geriatrics, 23.02.2018)

The nature of social relations can be understood as being important for the notion of shared experiences – this is integral aspect of medical and surgical practice. For example, often the doctors will discuss workplace events on-the-job and vent their frustrations as a form of coping. Interestingly, these notions are also negotiated through humour and sexualised jokes on the ward – this aspect of the work is elaborated on in subsequent chapters.

## 5.5 Summary

This chapter has outlined the social context within which my fieldwork was conducted. The Trust is introduced and demographics of the public relative to the social characteristics of the sample are also discussed in this chapter. The chapter then outlined imperatives associated with multiple logics informing the work organisation of medicine and surgery, providing insight into the complexity of this work. The chapter then focused on the manifestation of peer relations between and within junior doctor cohorts, considering multi-disciplinary team-working and teaching/training sessions, helping to illustrate the importance of a supportive and collegial working environment for the junior doctors.

Importantly the logics identified as a means of outlining the institutional context of medicine and the nature of medical/surgical work organisation are integral to understanding the experience of emotional labour and management – this is the focus of the next chapter. Furthermore, the importance of peer relations within the healthcare profession cannot be overstated – these relations manifest within the experience of the MDT and training sessions on-the-job thereby creating a safe space for the doctors to collectively discuss their work

processes. These experiences are also integral to the notion of *shared experiences* which is analysed in the context of managing emotional labour in the final data chapter.

# Chapter 6: Emotional Labour of Doctors

## 6.1 Introduction

In chapter 5, I outlined the social context of medicine showing how imperatives associated with key institutional logics inform the nature of work processes within medical/surgical services. In this chapter, I elaborate on these imperatives in order to show how different emotional labour types are informed by the four key logics, and how doctors enact these processes – choosing, resisting and negotiating micro-social aspects of their labour process. Micro-level processes associated with the nature of medical/surgical work manifest and are negotiated in light of these logics.

Emotional labour as introduced by Hochschild (1983) refers to a process in which emotions are manipulated by only one of two means: surface and deep acting. Bolton (2005) extended this analysis by arguing that emotion management is multi-dimensional, though her framework can be theoretically built upon (as discussed in my literature review). In this chapter, a keyway in which I recognise institutional logics influencing the doctors' emotional labour is through the way that they relate/communicate with people using the service. I show how the four key logics influence the texture and type of emotional labour that is provided by doctors on the frontline of British healthcare. In the context of medical and surgical practices, the emotional labour types provided by doctors refer to emotion neutrality, professional empathy, consumerist empathy and social empathy.

Importantly, the first three types of emotional labour outlined in this study are influenced in a top-down manner by imperatives associated with key institutional forces. Logics of bureaucratic rationality, professionalism and consumerism permeate our society at large and the institutions within it – these logics, therefore, can be clearly seen to shape the work organisation and emotional labour types of medicine and surgery within Wilton. The last influence on emotional labour outlined in this study is that of an orientation towards the community. The logic of community orientation stems from the notion of social embeddedness – Polanyi (1957) argues that economic (and other) activity cannot be isolated from the social context within which it is embedded. The actions/behaviours of individuals within society, therefore, are largely shaped by the social context within which these actions

function. In this light, the influence of the community orientation logic is received by the doctors in a bottom-up manner. Doctors resist imperatives of other, more dominant logics – they then negotiate the influence of community orientation by enacting conventional display rules/forms of behaviour as a means of satisfying the importance of social empathy on the frontline of British healthcare.

## 6.2 (Often Resisting) Bureaucratic Rationality

### 6.2.1 Emotion Neutrality

Considering the previous chapter, institutional pressures within Wilton Trust are associated with the increasing efficiency of healthcare services, the bureaucratic control over doctors' time, and thus a decrease in professional autonomy over the medical labour process, and an increase in the workload/volume of patients within both Deanside and Carrington hospitals. The increased volume of patients, in light of an ageing population and advances in medical/surgical treatment, often means that doctors cannot afford to offer more of their emotions during service interactions and are therefore influenced to remain calm/interact neutrally.

Dr Richards speaks about the influence of efficiency – this imperative means that doctors must manage high patient volumes thereby influencing the level (and type) of 'communication' that can be offered by the doctors to their patients. Dr Richards tells me that often the doctors may begin to 'cut corners' in order to manage the medical labour process - as the bureaucratic control of their time and the increasing efficiency of the service means that they cannot manage the volume of patients in any other way. For example, (emphasis added):

> …we need to see patients really fast because otherwise you will not be able to see everyone. So that impacts on the quality of *communication* with the patient, you don't always get the most detailed history. And I know like in theory they say it all comes from history and examination, and actually when you have to fill in all the paperwork and then prescribe the medications and then do something else you just start to cut corners and try to find ways of doing things faster…
>
> (Dr Richards, F, CMT2, 9.05.2018)

Dr Stafford (CMT1) also illustrates these points:

> …there are either too many patients that you need to know about, or you just glossed over superficially because you were running around doing things and not really interacting with patients. Especially if the registrar does the ward round and then gives you the jobs afterwards so you might be dealing with jobs for someone you have never met before at all…
>
> …It's really tricky in this day and age, because you find that you're making these really quick decisions and you haven't really bonded with the patient, you've only known them for a day, you've got these results and you have to tell them. I think ultimately it would be nice to invest some time in patients so that you know who they are, how to best approach the news, and in what language or form they'd want to know, how much information they'd want to know. But it's difficult nowadays because you just can't…
>
> (Dr Stafford, F, CMT1, 19.06.2018)

In addition, Dr Sani explains how often said imperatives can result in a process of standardization in which there is very little clinical judgment involved in the care of patients and this is perceived as problematic by the doctors. Given that doctors are not afforded adequate amounts of time to provide holistic care through taking a detailed history of the individual in front of them, then the nature of medicine increasingly resembles that of a 'production line' service. For example, Dr Sani tells me:

> …because no-one has the time to actually sit down and go through a very thorough history or address them in a more holistic way we just tend to like, okay, this person if they can eat and drink order an ultrasound and send them home. The patient next to them the same, if they can eat and drink, order an ultrasound, send them home. So, you kind of come up with these standardised plans which don't really involve any clinical judgments, they tend to just be in place so that we can have as much bed space as possible. And it does feel like it's a repeated process that you do for individual

> patients who are completely different from each other, so that's the kind of production line.

In this light, the medical labour process is influenced in some ways by imperatives of the bureaucratic rationality logic. Doctors often find it difficult to interact emotionally and meaningfully with their patients as a result of increasing institutional pressures that continue to shape the work processes of Wilton Trust. However, despite these influences, in some contexts, doctors are found to resist imperatives associated with rationalisation. Some doctors show that they are in control of their own time, maintain a level of autonomy over their work processes and choose to prioritise specific patient cases when this is perceived as important. This suggests that there is space and scope for doctors to negotiate their own work and take back control of their labour process from increasing managerialism. Dr Bates tells me:

> …I think (pause) some of it is about how you prioritise your day. So, I have always got time if the patient needs the time. So recently I had a very busy day that was relentless and not in a good way and was getting pulled all over the place; kept getting interrupted, and stress levels were sort of pretty high. And one of our patients was in a side room and dying really and she was – she was actually really frightened. And I was in the middle of a busy ward round and kept getting interrupted. And I just heard her say, "Doctor" she was just panicking, and so I went and sat with her and calmed her down and held her hand until she wasn't panicking anymore. And at that point kind of time stopped. It doesn't – nothing else around you matters because the most important thing is that patient in front of you. So, I think you just have to prioritise your time and I knew I couldn't sit in there all day, but I could sit in there until she calmed down and until someone took over…
>
> (Dr Bates, F, ST1, 20.02.2018)

### 6.2.2 Becoming the Scapegoat

Another keyway in which I identified the nature of neutral emotional labour in medicine/surgery was during interactions in which the doctors are scapegoated by patients and/or relatives. Considering the above, then the pressurised environment in which doctors conduct their work often means that medical mistakes occur, patients feel frustrated with the

constraints and limitations of the NHS system and senior doctors are sometimes found to leave the juniors to deal with emotional elements of the medical labour process. In these contexts, doctors interact neutrally and remain calm in the face of negative talk/potential abuse, but most often the doctors understand that the patients are angry at the wider NHS as opposed to being upset with the level of care that has been provided by doctors on the frontline of work. For example:

> …we don't do everything right, things go wrong. If someone signed a consent form that said, "After your surgery there's a 1% chance that this might happen," and then obviously that happens, the next day those patients are depressed and angry and they're like they start looking to legal actions. And it's understandable because it's part of it. Sometimes patients just take it out on junior doctors when they've had a negative interaction with a consultant...
>
> (Dr Sani, F, CST2, 16.05.2018)

> …I find that – it's obviously difficult when someone's being quite aggressive, or being difficult, then it's hard to keep the bedside manner because, you know, they're attacking you, so you've got to just take it basically and you can't say anything back; but I guess that's bedside manner as well isn't it, I don't know (laughs) I don't know…
>
> (Dr Furr, F, FY2, 21.06.2018)

And Dr Prescott (CMT2) elaborates on these notions:

> …so, you eventually get around to seeing her at the end of the shift, after you've tried to see all the sick people first, because she's not sick, she's just angry. She was saying, "Oh, I feel like you're fobbing me off. I feel so frustrated. I'm going to self-discharge. I'm so frustrated." And it is very hard after you've had a whole day of really poorly people and you're thinking, we're doing the best for you here and there's a real reason why we are delaying your operation. She even got her diary, saying, "I've got it written down for Monday. Why are you going to cancel it?" And I'm saying, "Well, (a) it's not even me, it's my consultant." "Where's he?" "He's not here at the moment." And the

> whole situation was— people often find someone and target them, and unfortunately, I was that person.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

In these contexts, it can be difficult for doctors to resist imperatives of bureaucratic rationality – they accept there is little they can do emotionally and in order to re-gain control of the situation the doctors remain calm, express neutral emotions and allow patients/relatives to scapegoat them (i.e. Ward and McMurray, 2016). Most of the doctors suggest that they understand perspectives of the patients' – their upset and frustrations and that they are aware that patients are angry at the wider service delivery as opposed to the care that is offered by individual doctors. Sometimes, however, doctors find it difficult to remain calm in the face of constant abuse and thus they resist bureaucratic imperatives – instead they may engage in the interaction in order to uphold their professional status. In the end, however, they let show that they are still understanding of the limits of the NHS system. Dr Tsansaraki (CST1) tells me:

> I had a very heated argument with a lady over the phone, different Trust, because she thought that her mum had not had all the necessary tests while she was an inpatient. And I tried to explain those were the necessary tests and she did have them, and she started accusing me that I was lying, that the whole department was lying, that – so I just had to say, "Look, I'm not going to argue about my integrity over the phone," but it became like a very heated argument and she actually involved the matron and, you know, the complaints team of the hospital which in the end, I mean it was very obvious that that person was just frustrated overall because her mum had been in and out of hospital for many months. It wasn't the investigations.
>
> (Dr Tsansaraki, F, CST1, 13.11.2017)

Considering current institutional pressures, this section has shown that, in some contexts, doctors are unable to provide the emotional care that they would like to offer their patients – they are scapegoated by users/relatives, subjected to verbal abuse and thus rely on neutral emotional labour in order re-gain control of situations. Often, this means that doctors are unable to emotionally engage with their users on a meaningful level due to the bureaucratic

control of their time and the institutional pressures that continue to manifest within both hospitals. However, there is also evidence to suggest that doctors maintain a certain level of control over their labour process – they are found to negotiate aspects of their day to day workload through prioritization and through taking back control of their time. In turn, this helps the doctors to provide for sick patients and satisfy the emotional elements of the medical labour process. In this light, then doctors are found to resist certain influences and choose alternative means of navigating their workload.

## 6.3 (Mostly Choosing) Professionalism

In this section, I discuss the nature of professional empathy that is provided by doctors in contexts of medicine and surgery. Due to the physical, social and emotional differences associated with both medical and surgical practices, I provide insight into professional empathy within medicine/surgery in turn. As healthcare professionals, doctors choose to offer professional empathy in order to look after sick patients, but they must also maintain a level of social (emotional) distance. In the context of medicine, doctors respond to imperatives associated with professionalism by providing professional empathy to the patients under their care. Simultaneously, doctors maintain a level of social distance in order to effectively treat the patients and avoid the clouding of clinical judgement. In the context of surgery, a wider process of professional empathy occurs. In this section, I introduce the *emotionless theatre*, the process of dehumanisation and the division of emotional labour.

### 6.3.1 Medicine: Professional Empathy and Social Distance

Within medical contexts, the texture of professional empathy/social distance is most clearly observed during interactions between patients and doctors on ward areas. I observed a number of these interactions – sometimes shadowing doctors on their ward rounds, and at other times following behind doctors when patients would call out to them. I gained insight into the nature of professional empathy by observing how doctors approached patients during interactions and examinations – I paid close attention to the bedside manner of the doctors and how closely their behaviours and emotional responses matched the rhetoric of what was expected of them in terms of their adherence to professionalism (GMC, 2020). In some contexts, patients were confused, unsure of their surroundings and required constant

reassurance from healthcare professionals. In others, the doctors explain that patients can be more difficult to interact with and manage. A significant degree of professional empathy is also required when delivering untoward news to patients and/or relatives – often within private side-rooms in order to allow recipients of the news to process and feel. Professional empathy on part of the doctor is necessary in all these contexts – and more. For example, in an observation I conducted on geriatrics Dr Smith is trying to reassure an elderly, confused patient:

> We walk over to the patient from the office to the ward area. The doctor has a medical file in her hand. We get to the patient and as the doctor kindly introduces herself, I help to draw the curtains to a close around the patient's bed. The patient is sat upright, and she is wide awake. 'Hello Maureen, I'm Dr Smith...I've come to see you'. The patient appears to be confused and upset. She says to the doctor that she feels 'lost' because 'people' (HCAs/medical workers) keep coming to check her/examine her and that 'I don't understand why they keep coming...where am I, I'm at home'. The patient seems to be unaware that she is in the hospital and instead thinks she is at home – the FY2 kneels down on the floor to meet the eye level of the patient. She is kneeled down beside the side of the bedframe and is trying to reassure the patient that 'you are OK, you are in the hospital'. The patient then calms down and listens to the doctor – 'can somebody please get me a cup of tea' to which the doctor explains that the staff come around every so often to offer refreshments to the patients. As the patient calms down, the FY2 attempts to medically examine the patient. She asks the patient politely if she can have a listen to the patient's chest. The patient says yes and then explains to the FY2 that she is having pain in various places of her body. The FY2 is still at the side of the bed and is leaning over the patient to do her examination – she maintains a level of physical distance from the patients and she has been very polite/patient with the patient – this reminds me of another doctor who in an interview tells me that 'it is so important to do the review properly, you have to make sure you do spend enough time and you don't cut it too short just to get other work done'. In the present interaction, the doctor has spent more time (a few minutes) trying to re-orientate the patient and reassure her that she is OK and in the hospital.

(Often complete medical reviews can only last up to a couple of minutes due to time pressure).

(Observation Notes, F, Geriatrics, 23.11.2018)

And in the observation below, Dr Wie tries to manage a confused, dementia patient – she is drawing on professional empathy but is also concerned about hospital management and investigations into the work/responsibility of doctors when patients fall over:

> A patient begins to wander out of her bed – staff do not notice, so I inform the FY2 after a few moments. The FY2 immediately walks over to the patient: 'Stacey, are you alright…I don't want you to fall over…we get into a lot of trouble if you do' the FY2 explains to the patient (who has deteriorating dementia). The patient is confused: 'come with me (she tells the FY2) let's go home'. FY2: 'you're in the hospital at the minute (the FY2 looks over at me whilst with the patient and chuckles). Patient is very confused – FY2 is patient and calm with her and allows her time to process what she is saying. The FY2 tries to disorientate the patient in order to walk her back to her seat. The patient is now safe in her chair and the FY2 offers/pours her some water. FY2 walks back over to where I am stood – 'dementia patients are really challenging – nothing you say to them gets through as they just forget'. FY2 continues to explain: 'doctors or staff in general are blamed for patient falls, all falls are reviewed by an incident report and investigation, that's why so many doctors will frantically say 'please sit down, please sit down'…the senior nurses/consultants investigate into patient falls – it's sort of a 'whose fault was it?' culture'.
>
> (Observation Notes, F, Medical Admissions Unit, 29.10.18)

A further common example of observing the nature of professional empathy is when doctors 'break bad news' to their patients – although doctors choose to do this in different ways, the sensitivity of the context of breaking bad news calls for heightened professional empathy on part of the doctor. In these contexts, doctors often take patients/relatives into a side-room in order to comfort them. Within Wilton Trust, then taking the users/relatives into side-rooms often meant an additional layer of privacy and intimacy in which those involved in the interaction can process information in a safe space and manage their emotions accordingly.

During one of my earlier observations, I shadowed Dr Spacey (F, ST7) on a geriatrics ward and observed her break bad news to two siblings – their mother was elderly, frail and close to the end-of-life stage:

> The doctor prepared herself in the office before taking the relatives into a quiet space. In this room, she offered the relatives tea/coffee and water. She then kindly offered the relatives a seat and closed the door – I quietly sat behind her and observed the interaction. The atmosphere was emotionally tense and the expressions of the relatives neutral. I was not aware of the entire context, but I was briefed by Dr Spacey that she would be breaking bad news to the relatives of an elderly service-user and it would be a sad situation to observe. Dr Spacey pulled up a chair close to the relatives before she started to probe and tease out the level of information that the relatives already had – it was a difficult interaction and I felt sad immediately. Dr Spacey slowly explained to the siblings that their mother's condition was deteriorating; she was unresponsive to medicine and to verbal communication and it would therefore be a good time to call other relatives. Immediately, tears began to shed – those of the siblings and those of mine. Dr Spacey remained collected as she held the woman's hand and comforted her during her time of loss. Despite the constant beeping and high number of service-users still to be seen on the ward round, Dr Spacey chose to allow time and space for the siblings to both process the information and share emotional stories of their mother in a safe and supporting environment. It was a beautiful yet heart-breaking observation – one that I feel privileged to have been a part of.
>
> (Observation Notes, F, Geriatrics, 27.02.2018)

In addition to the examples above, Dr Sirity (F, FY1) illustrates a time which required professional empathy for a more difficult patient. She manages her internal emotions in order to maintain her sense of professionalism – although this became difficult for her in light of the context and thus, she also remains socially distant:

> ...there was a gentleman that I had to put an IV cannula in to give some IV fluids and that sort of thing. Sometimes some patients might have difficult veins. You might not get in on the first try. It might be the second, and usually I get it by the second time.

But honestly, these are the things that you might not get right away, and patients might not understand about that, or they expect you to be perfect. They expect you to get it on one go, or they think you don't know what you're doing essentially. So, that was one patient essentially that I encountered.

When I went in, because when you insert the needle, you have to manipulate a little bit, which I understand is uncomfortable, but you're trying to minimise as much discomfort as you can and just get the needle in because it's better than withdrawing and trying again, because the initial stick is what hurts the most. Anyway, when I was in the middle of manipulating, he was like, you didn't get it, did you? I was like there; the needle is still in his arm. I'm saying no, sorry, you just need to stay a little still. I'm trying to manipulate it. I'm trying to avoid it coming out because I don't want to have to re-stick you again. Then he was like – he actually started swearing. He said, this is a nightmare, just stop, stop, and forget it. So, I just withdrew the cannula. What was really funny is that we had actually inserted a cannula already for him, but it was an arm, and my colleague had said, are you sure you want it there, usually we try to avoid putting it at the elbow because it's uncomfortable for bending your arm. 'Yes, just go ahead and put it there' he said. It was ten minutes and he asked for re-siting of it. I went to do it and then he said forget it, I'd rather live with the one in my left arm. Well, we did kind of tell you it would be uncomfortable on that site. Then for him to react like that – the thing is, I did apologise. I just had to – this is the thing as well; I suppose positive professionalism. We're expected to be robots in a sense. We can't say anything obviously to the patient, which I understand. It is about maintaining professionalism, but sometimes I feel like we have to be a bit less than human sometimes.

I asked Dr Sirity if she felt genuinely sorry when she apologised to the patient. She explains:

I guess in that moment, no, because as I said, if I stuck a patient and they were very understanding or whatever, I would of course feel genuinely sorry, even before I started apologizing. It's a difficult cannula or whatever I'm putting in. But when he started swearing, obviously I stopped feeling sorry. But I maintained my professional stance and had to apologise anyway, or I felt I had to. I don't know if there was any

> alternative to be honest. If we said anything back, it could lead to a complaint or that sort of thing. You just want to avoid any trouble, so you just say sorry I suppose. I probably, honestly speaking, didn't really mean it at that point in time after he started swearing and behaving like that because I was already apologizing before he started.
>
> (Dr Sirity, F, FY1, 14.12.2018)

In this light, then professional empathy is provided by caring for patients in order to satisfy the emotional requirements of being a doctor. However, doctors are also required to maintain social distance from their patients – they must respect the bed-space and privacy of their patients and try to not become too emotionally involved in their care. Often the doctors talk about the importance of striking the right balance between professional empathy and social distance during interviews and this was also observed during many of the interactions that I shadowed on site. For example, within medical practice, doctors maintain a professional barrier in order to separate themselves from their patients. As Dr Richardson (ST1) states:

> …there has to be obviously a professional barrier so it's about maintaining that is important. Treating patients with respect; they are – they're people and understanding that patients have autonomy at the end of the day. They can choose to do what they feel is best even if that isn't what we think is best, and that can be quite difficult sometimes. But it's about respect at the end of the day and treating people like humans.
>
> (Dr Richardson, F, ST1, 7.11.2017)

And Dr Rowe (ST4) also discusses the importance of both professional empathy and social distance:

> I think there's that, trying to be empathic, so trying to have an involvement with your patients but not being too involved. So, keeping a certain amount of distance but understanding the position they're in…
>
> …we all try and be professional and not take things on board and we're sort of, you know, we're taught about being empathetic but not sympathetic, so trying to step into

> someone else's shoes but not taking stuff home with you and everything. So, it's difficult, so you want to be able to separate yourself from the situation, say, no this is not about me, this is about whatever. But sometimes that can be hard to do that because obviously we're all human aren't we; we all have emotions and want to be liked and want to do the best job we can.
>
> (Dr Rowe, F, ST4, 6.03.2018)

The above clearly illustrates the importance of providing professional empathy for patients but also maintaining a level of social distance in order to effectively care for them. The logic of professionalism influences doctors to interact with the patients in a way that draws on professional empathy (considering BMA/GMC guidelines), but one which also ensures that the doctors do not become too emotionally invested. In this study, the doctors suggest that this can be a difficult balance to strike. Dr Wie (FY2) who is a junior doctor on the Medical Admissions Unit suggests:

> …it's about striking the right balance between having empathy and understanding emotions and why people feel emotions in the scenario that you've been in, [and] also having the right amount of distance. So, you can be empathetic without being emotionally invested. I think that's difficult to strike that balance, and I know that there are plenty of people out there who don't do it particularly well. I suppose the ones that you get a little bit more emotionally invested in are the ones that you can see yourself in.
>
> (Dr Wie, F, FY2, 10.09.2018)

In this light, it can be difficult for doctors to be empathetic without becoming too emotionally involved in the process. Doctors wish to provide the best care possible for their patients - as Dr Wie suggests that 'this is an integral part of being a medic'. However, sometimes the doctors find it difficult to provide professional empathy for other reasons - particularly when patients have been difficult to interact with. In these contexts, perhaps doctors remain even more socially distant from the patients. Dr James (ST1) tells me:

> It's very difficult at that point, particularly when you're feeling tired, to maintain that professional sense of caring and wanting to do your best for your patient because actually, there's a little part of you that says do you know what? I really just want to leave this. In a lot of other things, you'd say okay, that's fine. I can't deal with you now, but obviously you have to try and overcome that and do your best for them. That's quite psychologically difficult, I think.
>
> (Dr James, F, ST1, 10.09.2018)

She elaborates for me (emphasis added):

> …there's some people who have more challenging personalities than others, so sometimes you have to really just get on with it and just treat them as a patient rather than – *you're not trying to become friends with them*; you're just trying to treat them and get on with them in that respect, whereas others are very simple, like would be very amenable to what you're saying and things.

Here, Dr James (F, ST1) tells me that doctors are not trying to be friends with their patients – particularly the more difficult ones. This is positioned in opposition to the influence of community orientation which suggests that doctors will offer more of their emotion in order to care for their patients – perhaps because they can relate to them, they feel more attached to them or they simply get on well with them in comparison to others.

In addition to the above, then Dr Ahmed (FY1) illustrates more explicitly how the nature of professional empathy can make doctors feel - particularly at a very junior level. His statement shows how being empathetic towards emotionally vulnerable patients can be taxing for the doctors. Amid providing professional empathy and remaining socially distant, then doctors can become emotionally vulnerable themselves. Dr Ahmed (M, FY1) tells me:

> …the patient's family got more and more upset, and more and more aggressive and started to take it out on the nursing staff, and I was already delayed in finishing my shift, so after a few hours I was asked to go and speak to this family. That turned out to be quite a lengthy conversation, two hours, and a lot of high emotions running, so the patient's family were crying, they were trying to console them, I also keep a

> professional distance and tried to explain the situation and trying to get to the bottom of their concerns and their feelings.
>
> You're holding your professional ground at the time, but I remember as soon as I walked out, I went into the medical office, and I was completely, it was late at night and emotions got to me, and I started to cry; and there was nobody there that I could speak to. Then you go home, you've got to come back and start the whole thing all over again…

Following this, then doctors appear to offer professional empathy whilst maintaining social distance from patients, simultaneously. Doctors choose to draw on the professionalism logic whilst resisting imperatives associated with the increasing rationalisation of the NHS. Doctors are further found to resist the nature of consumerism in the context of more difficult patients – consumerism is perceived as problematic by doctors for the NHS and this is elaborated on in a later section of this chapter. It also seems that doctors are aware of the balance between treating patients as 'people' but also understanding that they are there to treat the patients and avoid formation of social ties (Dr James, F, ST1) - this suggests that doctors are resisting elements of the community orientation logic in order to fulfil their sense of professionalism at work.

### 6.3.2 Surgery: Professional Empathy and Social Distance

In the context of surgery within Wilton Trust, this study uncovered a process of wider professional empathy – on team-based ward areas and within the operation theatres. In these contexts, then whilst professional empathy was apparent, the process of maintaining social distance was less ambiguous and much stronger. In this section, I will outline the nature of professional empathy and social distance within various surgical contexts by offering perspectives of the surgeons and by reflecting on my own observations on the research site. I will also introduce my experience of being inside the *emotionless theatre* - the process of dehumanisation that occurs in order to operate on the patient and the division of emotional labour – with different types of doctor assuming different emotional labour roles.

I first noticed differences between medical and surgical services in ways in which doctors referred to their patients. In surgery it was a common observation to find surgeons refer to conditions, limbs and processes as opposed to the individual person or patient case. For example, in the observation below I sit with a trainee surgeon in a departmental meeting of the Major Trauma/Orthopaedics specialty. This meeting is routine – it happens at the beginning of each day for surgeons to discuss patient cases/workload for the day following admissions 24-hours prior. In this observation:

> All the surgical doctors seem to speak firmly and directly about the patients – they seem to be very much straight to the point, with the only small talk around the case being humour-related i.e. if doctor makes a joke – this feels particularly true relative to medical cases on the HCOP wards. The consultant seems to be very stern speaking – the doctors also appear to have neutral facial expressions when discussing either the 'leg' or the 'pelvic' for example – as they discuss and analyse the x-rays. Smiles seem to be rare unless the surgeon makes a joke at the front. The surgeons all refer to the patient's body part that needs surgery as opposed to the actual patient when discussing the case. One of the doctors (in major trauma) that I interviewed talked about trying to maintain this distance and also about how surgery was very similar to engineering (he had an engineering background before medicine) and he talked about how the nature of the engineering field inspired him to take surgery (as opposed to medicine) in order to *fix people* – various tools/knives/blades are used in order to make the patient better through surgery.
>
> (Observation Notes, Major Trauma, 26.10.2018)

Perspectives from the surgical doctors themselves also helped to provide insight into the nature of surgery and how doctors rely on the objectification of the patient in order to effectively carry out operations and 'fix' them. Dr Austin (M, FY1) explains:

> It's very much like – it's not so much that you're doing it for them as a patient, you're more like focused on the condition so like you're trying to treat what's going on rather than worrying about them as a person because it's all quite inhuman when you're in

there, like they're covered up, you can't see their face. It's all just an area of skin that you're operating on…

…it's quite odd, especially if you've never met them [user] before, if you're just called to go and help and then you see their name later and you're like, "Oh, that's what you look like. I've seen inside you, but I've never actually seen you."

(Dr Austin, M, FY1, 1.06.2018)

And Dr Tsansaraki (F, CST1) also tells me about her experiences:

…you forget about the fact that it's a person. I found it – when I first started operating, I found the most emotionally challenging bit after the operation had finished and we would take all the drapes off and the patient would be turned round and the anaesthetist would wake them up, so when the patient starts waking up, I would find that quite stressful because that's when you click and you're like, "Shit, that's a real person. Oh my God…"

…yeah, it's very easy to zone out, very easy to zone out. It's quite interesting because sometimes when patients are not under general anaesthesia, when they just have a local anaesthetic, it means they're awake, we're just operating on their arm, they're completely awake. Maybe they have something to calm them down and they have a drape in front of them so that they don't see what's happening, that happens in caesarean sections as well. But I'm bringing this as an example of how much we zone out is that when you have like three surgeons on top of an arm and they forget that it's attached to a patient and they just start…you know, relaxing and having unprofessional discussions and then the anaesthetist just turns and goes, "Guys, there's a person here. This arm is attached to a person. Calm down. Like no need to be so unprofessional." "Okay, fine, sorry."

(Dr Tsansaraki, F, CST1, 13.11.2017)

Considering the above, it follows that doctors in surgical specialties rely on social distance from the patient as a means of navigating through work processes – this might also be considered as a coping mechanism negotiated through shared discussion of the workload and subtle instances of humour on-the-job.

### 6.3.3 The Emotionless Theatre - A Moment of Epiphany

Within operation theatres, the wider process of professional empathy became clearer for me to understand and analyse. During procedures and rituals of surgery, then a process of dehumanisation occurs in which the patient's body is objectified by the surgeons. Arguably, this allows for successful surgery and may be considered as a coping mechanism on part of the surgical doctors. The process of dehumanisation is facilitated by the physical separation of the *patient as person* via use of blue drapes and curtains – these instruments separate the patient's limb needed for surgery from the remaining body/face – stripping the patient of their notable person properties. During these operations, then the patient's face is usually always separated as a means of infection control, but also in order to facilitate the process of dehumanisation. Within these contexts, I notice something very interesting. Amid observing surgeons prepare their kit for surgery, the occurrence of the dehumanisation process and rituals/procedures associated with conducting operations, then there is also *the division of emotional labour.* During contexts of surgery, the senior anaesthetist (SA) involved was observed as the bearer of heightened professional empathy. The SA of any surgical procedure is responsible for an intense reassurance process in the anaesthetic room prior to the operation and is also responsible for looking after the patient throughout the process of surgery. In contrast, then the surgeons are responsible for conducting the necessary rituals in order to perform a successful operation, whilst being bounded/facilitated by the context of an *emotionless theatre*.

#### 6.3.3.1 The Hip Fracture Replacement (26.10.2018)

In the observation below, it is my very first-time observing negotiations between surgical doctors and anaesthetics in the operation theatre. Here, I observed a hip fracture replacement and I begin to understand the complexities of emotional labour in the context of performing surgery:

There are 5 doctors/theatre assistants stood around the patient's bed – I wonder if the patient feels scared/intimidated – I feel scared for her. The doctors update the patient of every action they do – it is difficult to keep up with the notes. Whilst preparing for surgery, they are friendly and ask, 'would you like a pillow?' – I imagine making the process more comfortable for her. At this point, the doctors refer to the patient by her name (they were not doing so in the meeting earlier!) – 'we're going to pop your arm into this for support Jane, can I borrow your arm?' one of the doctors ask. The doctors re-position the patient on her side and get her ready for dressing/draping. They are to do an alcohol-based clean of the area that is going to be operated on. The doctors are speaking slowly and kindly – they wait for the patient to respond before continuing – could this be because the patient is responsive?

The scrub nurse then gets up and assists with the surgical kit handling for the surgeons – he hands them another blade. I walk over toward the anaesthetists who are still having a chat – the junior runs out to get coffee and the senior asks me about what I'm doing. I tell him about my PhD and he kindly offers to help me with an interview and then proceeds to tell me a little more about his own role: in this case, the procedure has a big impact on blood pressure because the patient has a pacemaker. 'We provide a core standard of care that requires us to stay with the patients in surgery and ensure they are safe, looked after and well monitored' (SA).

The patient looks at the SA (male). He holds her hand as she calls out for him. 'Don't worry, this is all normal OK? It will be like this for the next few minutes and you're doing brilliantly'. The patient screws her face and looks as though she is in a lot of pain – I immediately feel worried. The SA tells me it's OK, she can feel the banging. He caresses her face and hair and holds her hand: 'I'm going to give you some more medicine, OK? You're doing really well'. The patient now looks like she is crying – the SA continues to reassure softly. 'What's the matter at the moment?' He slowly injects medicine into the patient's hand and patient makes a large scream sound. She asks for water – potentially because of the drug? 'You're doing ever so well'. The medicine seems to be kicking in fast – the patient almost instantly falls asleep. The SA looks over

at monitor and keeps a close eye on it. He holds Jane's hand as her eyes close - 'you are doing so brilliantly'. His care sounds genuine and authentic – even I felt reassured.

Following this epiphany, then I began to observe the division of emotional labour increasingly in the context of surgery – with anaesthetic doctors being bearers of increased professional empathy and surgeons remaining socially distant, detached from the patient as a person and negotiating the dehumanisation process through physical and social barriers of surgical procedures. In the next observation, I observe a smaller operation in which surgeons are to 'fix' a middle-aged lady's wrist fracture. Again, a senior anaesthetic is responsible for the sedation process and for reassuring this patient of the surgical process/outcome – much of this emotional labour occurs in a small side-room attached to the main operating theatre. During this time, surgeons are preparing their kit for surgery and build their excitement for the procedure that awaits them.

6.3.3.2 The Wrist Fracture (21.11.2018)

Below, I observe a sedation block being given to the patient – the interaction is mainly between the senior anaesthetist, a clinical governance officer who facilitates the work of the anaesthetist and the patient - with some interruption from the surgical doctors. In this context, the SA (male) uses humour as a means of engaging the patient and guiding her through the anaesthetic process. Although the division of emotional labour is apparent, with anaesthetic doctors providing professional empathy and surgical doctors dehumanising the patient, in this observation then the patient is expected to fall asleep and thus there is a reduced level of professional empathy necessary:

SA: 'how are you feeling now Vicky? Numb, pins and needles?'
Vicky: 'yep'
SA: 'has the pain gone yet?'
Vicky: 'no' and she laughs. Probably in pain and frustration – laughter masking the pain/frustration she no longer wishes to feel.
Clinical Governance Officer: 'awh you're nearly there sweetheart' exaggerated tone but seems kind in general.

Registrar who will be performing surgery pops into the anaesthetics room and holds the patient's arm – 'has it gone to sleep yet?' The use of 'it' when referring to the limb suggests that the dehumanisation process may have already begun.
Vicky: 'nearly'. The staff now begin to remove the patient's cast on her arm.
SA: I'm just going to give you some Gin & Tonic now, OK? – The anaesthetic doctor kindly jokes with the patient about giving her drugs for her anaesthetic block.
Vicky: 'that's delightful, thank you' – as the SA inserts liquid into the patient's IV drip.

The patient's cast is now completely off – her arm looks a little out of the usual shape.
Vicky: 'so how did you know that I was a G&T girl?' To the SA.
CGO: 'he gets a good vibe (the staff all laugh)'.
SA: 'we're going to take you in now and sedate you, you'll be sleeping but arousable, OK?'
Vicky: '…you wouldn't think I would be such a wuss after having three kids'

Both patients I have observed in surgery seem very scared about it, despite having much larger procedures like caesareans/childbirth. I can almost relate – I feel very scared for them.

Vicky: 'so what's the advantage of the block over general anaesthetic?' Patient seems curious and SA explains to her that she will be awake with the block and will be able to go home straight after recovery (of approx. 40 minutes).
SA: 'you'll be able to go home, and you won't need to stop over' (hospital pressures?)
SA: 'you're OK with penicillin dear, and is your Gin & Tonic working? (soft banter with the patient to ease her worries of surgery?). The patient nods.
SA: 'OK good, we're pretty much ready to go, quickly going to ask you a few things' – SA begins physical examination... '…good you're going to go into theatre now'
Registrar male shouts out: 'ready for us' yep.

## 6.4 (Mostly Resisting) Consumerism

In this chapter, thus far I have outlined the influence of bureaucratic rationality and professionalism in the contexts of medical and surgical practices. This section will now discuss

the nature of consumerist empathy – here, doctors are observed to resist the move towards a model of being subservient-to-the-consumer in light of their dominant sense of professionalism – however, following patient empowerment and the rise of consumerism within British healthcare, then there is some evidence to suggest that the texture of their emotional labour alters in light of consumer/organisational demands.

### 6.4.1 Consumerist Empathy: Performing on Stage and Accepting Frustration

In order to manage patient/relative expectations, avoid complaints/negative feedback and processes of litigation, then this study finds that doctors have become somewhat conditioned to ensure that matters do not escalate on the frontline of British healthcare. In these contexts, doctors discuss the nature of performing on stage and accepting frustrations in order to manage the demands of their patients and avoid untoward outcomes. For example, the informal discussions below show how the permeation of a consumer culture within the NHS and the introduction of feedback mechanisms can influence the performance of consumerist empathy:

> This doctor talks to me about having a strong and constant fear of receiving negative feedback – feedback mechanisms are well established in the NHS and it is very easy for patients to make complaints about doctors that quickly escalate. The doctor discusses that the surveillance and feedback mechanisms that have been introduced into the NHS recently tend to drive the emotional labour – the nature of the interactions with patients and colleagues. The doctor finds himself being superficially friendly as a means of getting the work done. The doctor also talks extensively about individual emotion management – he tells me that he avoids having medical conversations with colleagues as it can be a burden or increase the problem and so he will try to deal with the stress alone, individually. He tells me he relies on neutral expressions, remaining calm on-the-job and maintaining emotional distance from patients – he also talks about being friendly as much as possible, but this can be difficult because he, like all of the other doctors/staff, is under constant time pressure. His interactions are quick and superficial - it is simply done as a means of getting the

job done.

(Informal Discussion, M, Surgical Doctor, 1.06.2018)

…the doctor talks about the excessive admin/procedural and paperwork aspect of the job – which no-one tells you about in medical school, but it constitutes a very large part of the daily work. The doctor discusses that they are required to relentlessly order tests and update medical records – much more than the patients are actually attended in order to be examined but the doctors – patients are probably seen for around 5-10 minutes but the admin work that comes with each patient can take up to 20 minutes more – sometimes this is because the records have not been accurately updated by other doctors who have previously examined the patient so a thorough understanding of the patient's history is compromised. Often, accurate notes are not written down on the records due to time constraints, resulting in error. The doctor tells me that he often feels emotionally drained on-the-job, because we live in a society where patient relatives come across as increasingly demanding (i.e. they ask for specific tests for their loved ones), but the NHS is under-resourced and is not supposed to provide a luxury service to the patients. Often the relatives come in misinformed – they have read something on the internet or have heard about a particular, similar case to that of the patient and wish for them to be treated in the same way – sometimes it is not appropriate nor necessary and this can mean that the doctor has to spend even more time with the patient's relative in order to explain why they are/they are not doing certain medical work in the care of the patient. The doctor also tells me that patient relatives can be demanding, particularly when they come into the discussion medically misinformed, but ask for specific services which the NHS is unable to deliver as a healthcare organisation because the costs are too high, and the resources are too limited. The doctor tells me that he is aspiring toward surgery: 'medicine is not for me, I'm not a medic'.

(Informal Discussion, M, FY1, 1.06.2018)

In this light, it appears that some doctors synthesise responses to the bureaucratic rationality, professional and consumerism logic. In the first example, then the doctor discusses the importance of remaining calm, maintaining social distance and ensuring to come across as

*friendly* as possible on the frontline of medicine - as a means of getting the job done. In the second example, the doctor shares his perspective on the level of administration associated with the medical labour process – an already difficult aspect of the workload to manage given the high volumes of patients. This difficult aspect of the work is exacerbated by misinformed patients who enter the hospital and 'demand' specific tests/procedures – as the doctor discusses, then the NHS 'is not a luxury service' akin to those in the service sector and therefore having to explain these issues to patients can be a burdensome task, requiring amplified levels of consumerist empathy.

Following these insights, doctors are almost always required to manage how they feel and interact in a way that will de-escalate the situation. Sometimes doctors are responding directly to the 'consumer' of the NHS; in other contexts, they are responding to the requirements/prescriptions of hospital management and their employing Trust. Responding to these imperatives means that doctors perceive themselves to be 'on show' or 'performing on stage' given that they are on the frontline of medicine. For example:

> …I think a lot of it's about probably learning how to manage that yourself because we don't work in an environment where there's a little brief at the beginning and everyone sort of says is everyone okay to begin with. Everyone's just thrown in at the deep end and that's true of all jobs, but I think it's probably easier if you can kind of sit behind a desk maybe and – or hide in an office if you're having a bit of a rubbish morning. Whereas if you're sort of thrown out onto the ward it's a bit different; you're kind of on the stage, yeah…
>
> (Dr Bates, F, ST1, 20.02.2018)

> …you're on show all the time as well so patients are seeing you working all the time…
>
> (Dr Richardson, F, ST1, 7.11.2017)

In addition, Dr Tsansaraki (CST1) helps to illustrate the demands placed on doctors by both the consumer and the NHS system. She tells me:

> …the nature of us having to be very professional and respond to all complaints and all allegations made, again, that makes it a consumerist nature. So, every time there's conflict, we're encouraged by seniors of our teams to sort of like go down the route of the *customer's always right*. So, you're never going to go back to a patient and just say, "Actually, you're wrong. We're right. You're an idiot." Like no matter what that person does or perceives, your job is to address all of their concerns and apologise even if you haven't done anything wrong. So, yeah, there's a consumerist nature from both the patients but also the way the system expects us to treat them.
>
> (Dr Tsansaraki, F, CST1, 13.11.2017)

Providing consumerist empathy considering dictates of the Trust/consumer of healthcare can be a difficult, but integral aspect of medical work – particularly when expressed emotions are not internally felt by the doctors. Dr Bach (FY3) illustrates the manipulation of emotion necessary for the job when managing different patients:

> …some people are really mean and they don't start being nicer just because they're sick, and you have to really manage your emotions around that and go yes, I'm going to have to be nice to them and treat them with respect, but they're also being really horrible whether that's because they're a pretty grumpy, rude person in general, or because they're sick and it's brought out the worst in them…
>
> (Dr Bache, F, FY3, 15.08.2018)

This suggests that doctors are required to accept frustrations from difficult patients in similar ways to that of service workers in the customer-service sector. Dr Bache (FY3) is not alone – many of the doctors point to the observation that patients can be difficult to manage and therefore the nature of the empathy provided on-the-job changes and emotions are managed externally – similar to what Hochschild (1983) refers to as surface acting. For example, both Dr Stephens and Dr Furtal are foundation-level doctors – they both illustrate that patients can be difficult, and emotions must be manipulated:

> …there was a point where I didn't want to, you know just, not shout, but just bluntly say to her, no, just you have to stay in that's it (laughs), obviously I couldn't say that, so yeah.
>
> (Dr Stephens, M, FY1, 28.08.2018)

> It's hard to be sympathetic towards someone who you think is a knob (laughs). Obviously, you always talk to patients with respect and equally, blah blah, but we're all human and if you don't like a person it's hard to give them respect properly. You have to sometimes breathe in a few times, look away, come back (laughs) when you've calmed down.
>
> (Dr Furtal, M, FY3, 7.11.2018)

In other contexts, responding to the level of consumerism within the NHS was also evident from observations that were conducted on ward areas – but for different reasons to those indicated above. Considering the observation below, it can be difficult for doctors to feel genuine empathy for all of the patients that they care for and, in some circumstances, then doctors choose to 'fake emotions' for the sake of the patient. In this context, I shadow an Advanced Clinical Practitioner (ACP) who conducts medical work at a junior doctor level. He is on his ward round, being pulled in several directions by staff members, and discusses the fear of Human Resources by joking about my presence as a researcher – (he relies on dark humour as a means of negotiating medical work):

> The ACP begins discussing the notes with HCA in relation to a patient we are about to go and see. This patient is uncomfortably in her bed – she appears less able and less medically fit than the previous patient. ACP returns to the computer desk with her medical file – he sits back down at the desk and loads the notes on the system. I ask him briefly about the patient. ACP: 'she's not fit for anything, not even a haircut'. ACP jokes again – he relies on dark humour as a means of getting through the work. I smile. ACP: 'well do you disagree?' The ACP then jokes about having to be careful what he says around me – he compares me to Human Resources. ACP: 'It's like rather than wait for the complaints to come in, you're sat here in person monitoring me!' We laugh together and I assure him that's not the case. The ACP is now discussing the notes with another member of the MDT – dietician. He explains to me that he has

spoken with the patient's family (going from the notes) but he hasn't actually examined the patient. He explains to me that she would not benefit from CPR and this is something that relatives struggle to hear – it is a medical decision that doctors make and relatives take this as if the doctors have given up. ACP: 'it's a rather uncomfortable position to be in when you have to tell the patient's family that we cannot resuscitate (use CPR) when you haven't actually met the patient' …'when the nurse/HCA is done, we'll go over and see her'.

…we now go over to speak with the patient: she is lying in bed and once again the ACP kneels beside her. ACP: Mrs. Walter, the nurse came to see me. She told me you are having some pain again. Patient: Oh, it's all over, it's horrible, can I have some more morphine? The patient desperately asks the ACP. She seems like she is in a lot of pain. ACP: well painkillers are coming around for you, where is the pain? Patient: it's all over. (she begins to cry/sob quietly in pain). ACP: Let me have a look. The ACP begins to examine the patient 's knees/legs. He holds her hand as he does so. ACP: 'I see you have arthritis in your hands too'. Patient: 'Oh for years now…and I'm so scared of falling'. ACP: OK let me ask my friend, the physiotherapist if she can come and help you. Patient mumbles – difficult to understand her. ACP: '…and let me have a feel of your tummy' – he begins to examine. Patient: 'I just can't take this anymore'. ACP: 'we're going to get you feeling better... (softly speaks with patient) …we'll do what we can…and when you get a bit better, we'll do some work on your legs, build their strength. I'm just going to have a listen to your heart'. ACP is constantly reassuring patient whilst trying to conduct a physical examination – I wonder how exhausting this must be. He uses the stethoscope – the patient calms down a little.

This was a 95 y/o terrified patient – the ACP was using managing his internally felt emotions – he was caring and kind, but he didn't internalise those feelings – I asked him about this, and he explains that he finds it exhausting. ACP: 'I can fake being nice to her for 10 minutes if it's going to make her feel better'. Me: does it get tiring? ACP: '…what faking being nice to patients? YES! It's fucking exhausting' he tells me. In light of previous discussion, perhaps Mr. Haslam's emotional labour with patients and others is driven by the organisation as a means of avoiding complaints.

(Observation Notes, Geriatrics, 12.11.2018)

The nature of consumerist empathy was difficult to tease out in the above observation – this is because although the patient was not necessarily perceived as a consumer, the doctor still responded to her in this way in order to manage his own emotions and avoid complaints that come into the Trust. His perspective on consumerist empathy is contextualised clearly in our interview later:

> …it's anyone that works in any sort of customer care or healthcare or whatever you want to call it, you don't act the same for every customer. If you go into a nice hotel, I don't expect to be treated the same way as everyone else who walks into that hotel. If someone comes into that hotel once every week, I expect him to be treated differently to me who is there on a weekend break. And if I ask at the bar for a drink and the barman says, "We haven't got it," and I say, "Well, just pick something then, mate. Don't care. I just want to get trashed. I've had a shitty day." I don't expect them to turn around and go, "Absolutely, sir, I'll make you something up straight away." I don't expect them to be like, "I'll make you someone, mate, don't worry," and just be nice, you know. You would be treated differently in a bar to... So why would you expect you to be treated exactly the same in a hospital environment. We adapt the role to suit the patient. It's all just a job…
>
> (Mr Haslam, M, ACP, 12.11.2018)

## 6.5 (Often Negotiating) Community Orientation

Imperatives associated with bureaucratic rationality, professionalism and consumerism can all be considered to exert a top-down influence on the doctors' emotional labour. Considering previous sections, then there is scope and space for doctors to navigate micro-social processes of their work – through processes of negotiation, choice and resistance. The imperatives examined thus far relate to more macro-level institutional logics. In this section, however, I introduce the notion of an orientation towards the community and thus the reliance on conventional forms of behaviour during interactions with patients. In these contexts, doctors are keen to provide genuine, authentic empathy to *people* whom they care

for, can often relate to and therefore wish to offer more of their time/emotion in order to feel like they have made a difference.

### 6.5.1 Social Empathy

Doctors are often influenced by the community orientation logic because the clinical situation is familiar or relational to their personal lives in some way. When patients remind the doctors of their own families, relatives and loved ones, then the doctors are more likely to resist the dominance of other workplace imperatives and respond to those associated with conventional forms of behaviour. This can affect anybody who is present within the situation, including all members of the MDT. It reminds the workers that they can 'feel' and be 'human' at times – even if this is deemed as unprofessional. Dr Wie (FY2) practices on the Medical Admissions Unit – she illustrates this point for me during our conversation:

> …there's a mother and daughter interaction that I will always remember because it reminds me of my mum and me and those are the ones where it hits you and it will stay with you. Mum was dying, and daughter was struggling to come to terms with it and they were having a really beautiful moment and everyone who was treating them came out of the room crying because they all put themselves in their shoes. Those are the ones you remember but I think you remember it for good reasons and that was a really beautiful moment. It still makes you sad, but I think you're allowed to be a little bit human sometimes.

And similarly, Dr Asif (CMT2), a more experienced doctor within medicine, tells me about the nature of his work and what it means to be human within intensive care (emphasis added):

> …I've been working on intensive care and they've just had a gradual decline from not being able to – we've been treating them for sepsis, and we've talked about stopping their treatment with family and their – hearing a lot of their family with emotional stories about their loved one. You're there as a *person*, a *human being* and then you go home and that affects you in terms of, that's – you get to know them more as a person and then you get more emotionally affected by seeing them die and the

> family's emotions. It would be hard not to be affected by that, even though you see it day in day out…
>
> (Dr Asif, M, CMT2, 16.04.2018)

These examples clearly show that often junior doctors choose to respond to the logic of community orientation by resisting imperatives associated with other competing institutional logics. The doctors choose to provide genuine, authentic empathy to their users if they feel that they require such emotional labour. In addition to the dominance of rationalisation, it was also common to hear that the logic of professionalism can act as a barrier to responding to imperatives associated with an orientation towards the community. Doctors are aware that they should maintain a good level of professionalism – even in the face of difficult experiences/situations that present themselves within the hospital setting. However, sometimes doctors choose to become more emotionally invested in the patient's circumstance in order to show a genuine and authentic level of empathy. Dr Mustafa (FY2) explains:

> I think all in all it's very important to be professional, but at the same time I think, I've found anyway now, and it's been over a year now since I've been working as a doctor and it's very difficult sometimes to find the balance between being professional but also, you know, we're human at the end of the day and you need to have some, show some feeling and obviously compassion and empathy, but it's where to draw the line where sometimes, you know, you might be completely invested in, you know, a particular patient that unfortunately passes away, or even something, you know, they get diagnosed with cancer, or you know, it's okay to show some emotion but I think, with experience you start to, you know, you don't want to be too, what's the word, I guess you become too de-sensitised, to what's going on, but I don't want to be that doctor who just kind of, you become, you know, you're just doing your job.
>
> (Dr Mustafa, M, FY2, 24.10.2018)

Similar notions are illustrated by Dr Furtal, an FY3, practicing within the Major Trauma unit of Deanside hospital. Dr Furtal and I have had informal conversations about the dehumanisation of service-users within clinical settings – he tells me that often the process of dehumanisation

occurs due to the high volume of users and the pressures on the system and often because it can help junior doctors to cope with the nature of surgical work. However, when asked about his take on caring for patients, he tells me: 'I don't like that approach. It's too impersonal. I enjoy talking to patients. I enjoy spending a few minutes, if I can, with them saying what's going on. Even if they are drowsy and delirious, I still try and have that sort of person-to-person relationship'.

In addition to these perspectives, emotional labour as influenced by an orientation towards the community is highlighted by an ST3 surgical doctor practicing within Orthopaedics:

> The doctor talks about the importance of emotional investment (in surgery) in order to treat patients – discusses that often with children/young adults he finds it difficult to not become invested during the interaction – he tells me that after a difficult accident, and when one of the passengers did not survive at such a young age, then he even shed a tear with the father when discussing the news, a couple of days later and so the emotional aspects of the work can take a toll on the doctors. The doctor did not have to break the bad news himself, but he was one of the main doctors involved in this family's care – and so when he saw the father a few days later, he had a chat for a few minutes as he had already managed to establish a strong rapport with him and he ended up becoming tearful at the situation. This doctor explains how important it is to really care for the patients – 'otherwise you are not really a doctor'.
>
> He further states that he would never leave work at work as the stakes (patient care/safety) are too high. He explains: '…when you are a doctor, you are a doctor every day for the rest of your life and not just when you are at work.' It seems that this doctor does not stop caring for his patients – he tells me that he would happily answer work calls during non-working hours, particularly because he would want to know how his patients are doing, and often if there is an urgent query it can be important in the care of the patients.
>
> (Informal Discussion, M, ST7, 31.10.2018)

Further examples of an orientation towards the community stem from my observations of the skin cancer clinic of Wilton Trust. In these observations, I identify an orientation towards

the community with respect to emotional labour by noting the instances of 'humour' and 'banter' offered by the doctor to patients/relatives. In this context, a senior surgical doctor works closely with a specialist nurse – they both see outpatients who are either awaiting surgery, in need of surgery or whom are required to attend clinic as part of their post-surgery care-plan. The clinic is situated within the treatment centre of the Trust – a modern building with more modern consultation rooms than those of the main hospitals. Throughout my time spent observing in this clinic, the nature of the work felt much like a customer-service operation with doctors seeing patients one-by-one and offering a plan for surgery or briefing the outcome of a previous one. Despite the material elements of the treatment centre that made the clinic feel much like a customer-service, the doctor here almost always humoured the patients/relatives and seemed to also offer much more of his emotions during the interactions. It was only when I began to observe the texture of the interactions as opposed to the material elements of the building and consultation room that I understood the emotional labour of the doctor. For example, in the observation below the consultant is interacting with the patient (P) (and nurse):

> The patient and doctor/nurse joke about emotional labour and my role as researcher of the consultant's emotional work with patients and colleagues. P: 'so do I need to give him a hug then?' Patient jokes considering the interaction. Con: 'Ah she's just assessing whether I can get through this or not without crying'. P: 'I haven't brought you any tissues!' Consultant: I'll wipe it on my sleeve'. Patient to me: '…and what about my emotional well-being, when I don't get to see him anymore?' Con: 'that doesn't matter!' All laugh. Con: 'can we have a look at you?' politely asks the patient. P: 'sure, where do you want me?' Nurse: 'pop your trousers off for me, this way' (walking toward bed space). P: 'gosh do you know; I don't get my legs out for anyone' all laugh again. Con: 'well thanks very much, we're honoured!' The consultant carries out the examination behind closed curtains. The patient is here on a follow-up appointment and the consultant checks stomach, leg and foot. Con: 'can we get a photo of that today?' P: 'yes'. Con: 'OK that would be great'.
>
> Curtains open after patient has dressed self and consultant walks over to the desk to update notes on the computer. Patient to me: '…you need to observe him at the other

hospital, it's more traumatic for him there!' Consultant: 'ha is that right?' Patient continues to have a laugh: '…I've been over there so many times and the nurse comes out and explains that the doctor (consultant) is running late…we just put it down to him being a really good doctor…he gives you more than the allocated five minutes!'(…is this patient complaining about the waiting times via humour/joking?) Nurse: 'ah well you should see him at the end of the clinic, come 1230pm, it's because it's still early' she jokes back with the patient. Consultant: '…at that time, she's sweeping me off the floor!' All laugh.

The consultant continues to brief the patient about how well she's doing – and the nurse walks her out. Consultant updates medical records online and summarises nature of interaction into his Dictaphone. This was a very light-hearted, humorous interaction in which patient, consultant and nurse bounced off one another. I wonder if the interaction involved any emotion management or if the consultant genuinely felt like humouring the patient. It felt genuine to me as a researcher – it felt more like the doctor cared about this patient.

Another example of the doctor and patient interacting within the same clinic:

The consultant introduces me again and then speaks with the patient. Consultant: 'Hi there, how are you doing?' P: 'yeah, good thanks' Con: '…we have some company in the clinic today, Priyanka is doing a PhD on my emotional work'. P: 'ah right'. Consultant: '…so try not to stress me out today' con lightly humours the patient. P: 'yes right, well I'll do my best with that' both laugh. Con: 'so how's it going? Have you any concerns on your skin at the moment?' P: 'no I don't think so…'

Consultant is reading the patient's notes. 'So, you've been through all of these tests…there is no evidence of any cancer in the bone…there is some degenerate change, arthritis, and so the MRI scan has shown arthritis'. P: 'right OK' Con: 'can we have a look at you?' P: 'you can' Con: 'right this way for me' walking towards the bed space…'and any other dodgy moles on you?' P: 'not particularly no, I've still got strange pains and things'. Con: 'and any swelling?' P: 'sometimes here under the arms, but it doesn't last…I think it's when I've been doing too much…still think I can do what

I could 20 years ago!' Con: 'funny that, isn't it?' P: 'have to admit defeat' Con: 'well it's all looking good; I can't complain too much at you'.

Both now walk back over to the desk and the consultant arranges for the next appointment with the patient. Con: 'so we'll book to see you again late April'. P: 'hmm' Con: 'great, well stay out of trouble' P: 'will do, thanks so much'. Con to me: 'it's a refreshing change to have a patient like that' satisfying and enjoyable interaction. With some patients, the doctor seems to offer more of his emotion, banter and social chit chat – with others he is more reserved, stern and allows for the bare minimum. Much of the emotional labour perhaps depends on the patients themselves.

(Observation Notes, M, Skin Cancer Clinic, 10.01.2019)

In this light, doctors also respond to conventional forms of behaviour when interacting with patients – drawing on the notion of social embeddedness. In these contexts, doctors are found to negotiate micro-social aspects of their work processes through humour – but it is also evident that when doctors are 'bantering' and 'humouring' their patients, then they are offering more of their emotions than required for the technical/surgical aspects of the job.

## 6.6 Summary

This chapter has outlined different types of emotional labour in the context of medicine/surgery. It has shown how imperatives associated with bureaucratic rationality, professionalism, consumerism and an orientation towards the community influence the emotional labour of (junior) doctors on the frontline of British healthcare. In some contexts, within Wilton Trust, doctors are observed to resist specific imperatives and choose to adhere to others – suggesting that there is space and scope for doctors to negotiate and navigate the medical labour process. In other situations, then it is observed that doctors may find it difficult to resist the dominance of certain logics and therefore respond to these imperatives when interacting with patients, relatives and others on-the-job.

In this light, main patterns in the data suggest that the logic of bureaucratic rationality exerts the strongest influence on the medical labour process, including micro-social elements of

work. Despite exerting the strongest influence within and between gender, ethnicity and social class, and across the training grade spectrum, then the majority of the doctors are seen to mostly resist imperatives associated with rationalisation as and when they can. Further to this pattern, all doctors seem to negotiate and/or choose responding to imperatives of professionalism, whilst mostly resisting the consumerism logic when interacting with patients and others. Interestingly, the majority of doctors are also found to enact an orientation towards the community – usually this relies on resisting imperatives associated with the macro-level logics of bureaucratic rationality, professionalism and consumerism.

Following the above observations, it is also important to note that there is difficulty/incompleteness in knowledge of the researcher in fully grasping and understanding the aspects of emotional labour. In many interactions between doctors and patients, there is an overlap between the influences of logics and between the types of emotional labour/empathy that is offered by the doctors.

In this chapter, I have outlined complex processes of doctors' emotional labour. I have also illustrated the influence of four key logics shaping emotional work in the form of empathy on the frontline of medicine and surgery. Following the examination of emotional labour processes, in the next chapter, I offer an insight into the pains and pleasures associated with doctors providing different types of empathy to their service-users and related others.

# Chapter 7: Pains and Pleasures

## 7.1 Introduction

In previous data chapters, I described the nature of junior doctors' work, including the social and medical context and the nature of emotional labour performances in light of conflicting workplace demands. In this chapter, I show that despite the changing institutional landscape, resulting in increased pressure on doctors' time and autonomy, there are both pains and pleasures associated with medical and surgical work (e.g. Zapf and Holz, 2006). These outcomes are associated with work processes and the technical aspects of medicine, in general, and the nature of emotional labour during interactions, in particular. What we will come to see is that the pains and pleasures associated with the medical labour process appear to pertain to different, conflicting institutional logics. Importantly, as mentioned in the previous chapter, then participants of this study described a range of emotional responses, contingent on a number of different factors (e.g. biographical/temporal work and technical/interactional work), but nevertheless, there did appear to be notable patterns in these responses that pointed to a relationship between certain aspects of junior doctor work and emotional performances on-the-job.

In addition, there appears to be a balance between the pains and pleasures of medical/surgical processes and the micro-social aspects of this work. In opening sections of this chapter, I outline the pleasures of the medical labour process which include treating patients (and thus confirming growing professional expertise) and receiving gratitude and appreciation from patients/families (and thus confirming altruism on part of the doctors). There are clear overlaps between both treating patients and receiving gratitude – these are outlined below. In later sections, I outline the pains associated with medical/surgical practices which include doctors' stress and wellbeing, difficulties in switching off from work and the experience of emotional drainage - in which interactive elements of the labour process are emotionally-intense and thus take toll on doctors' own sense of self/emotional health.

## 7.2 Pleasures

### 7.2.1 Treating Patients - Confirming Professional Expertise

Despite the many institutional challenges that junior doctors must navigate through on a routinely basis, an overwhelming proportion of the participants in this study would 'still choose medicine' as their career option. These doctors, irrespective of demographic variable, commonly discuss the high degree of job satisfaction that is associated with medical work and particularly the importance of receiving feedback from patients and their families. This suggests that even though service pressures continue to manifest on the frontline of medicine and shape the changing institutional context of Wilton Trust, and the NHS at large, junior doctors are still able to derive a sense of satisfaction from their work generally, and from the emotional labour performed with patients more specifically. Treating patients and deriving a sense of job satisfaction, as a result of technical and micro-social elements of work, help to confirm professional expertise on-the-job. In addition, the level of feedback received from patients, families and others reassures them that they are completing good, important work and this feedback fuels doctors' motivation for them to continue in the profession.

Although most doctors discuss the nature of job satisfaction, they do so in different contexts and in different ways. Importantly, in this study, the doctors discuss their sense of job satisfaction in relation to both the technical elements of medical/surgical work and the micro-social elements in which the doctors perform types of emotional labour with their patients, relatives and others. Seniority and increased experience within the profession also seems to play a significant role. Within medical services, Dr Maine (CMT2, M, 27.06.2018) explains to me:

> I think that the best thing about being a doctor is the satisfaction of trying to make people better and getting that feedback and genuinely feeling like you make a difference. I think the more senior you get, the more that happens. So, I have started to get that in dribs and drabs. If you make a correct diagnosis or something like that, there's something really satisfying about genuinely helping someone to then get feedback from them saying thank you. That can be from something very small like just explaining a situation clearly to changing a diagnosis.

In this context, Dr Maine discusses the nature of job satisfaction with respect to the technical elements of the labour process and considering receiving positive feedback from the patients following an interaction, diagnosis or care plan. Firstly, he explains job satisfaction following a successful diagnosis, and therefore following the feeling of being correct – this arguably affirms professional expertise and status. Dr Maine also outlines the importance/satisfaction associated with helping other people. One suggestion here is that receiving feedback from satisfied patients reinforces their growing identities as altruistic professionals, whose work helps other people and contributes to society. During instances of positive interactions with patients/relatives, junior doctors appear to derive pleasure from having their idealised professional selves confirmed to them in medical practice. It was interesting to note that respondents unanimously described the pleasure that came from treating patients successfully and from gaining their thanks and appreciation. This, it could be suggested, appeared to be a central element of the profession of medicine for the doctors.

In another example, Dr Bates (ST1, F, 20.02.2018) discusses her experiences of job satisfaction. In this context, the doctor clearly illustrates how the interactive/communicative element of medicine between doctors and patients is perceived as a rewarding aspect of the job, which pertains to the importance of micro-social elements of work:

> I like talking (laughs) and I get a lot of satisfaction from building up a good rapport with patients and their families. I think that it's really valuable to be able to have a patient sort of – is pleased to see you because they're in a very stressful environment and being in a hospital is very scary and we forget that because we walk through the doors every day. But just to be able to kind of be that person that makes them feel a bit more relaxed or that makes them feel safe.
>
> I find it really rewarding. And I think there's – I've never got in trouble for being honest and being kind of completely up front with people and just explaining things as they are. And I think that's very powerful I think, to be able to have a frank, realistic conversation with someone and just make sure that everyone is involved. We don't get many complaints because everyone has been communicated with too much. It's usually the other way around, yeah. I think you can have a big impact that way.

Here, Dr Bates shows that performing emotional labour with patients by building good rapport leads to increased job satisfaction. Doctors often achieve this by making an effort to make patients feel safe within the hospital environment – once this has been achieved then doctors feel as though they have made an important difference to patients and their families - this is commonly discussed by participants of this study as a positive, rewarding aspect of the work and pertains to the logics of both professionalism and an orientation towards the community. Types of emotional labour associated with these logics are difficult to disentangle – there may well be an overlap between professional and social empathy here.

Further to these perspectives, Dr Tsansaraki (CST1) also perceives the nature of her work in surgical services as rewarding – she explains that there is 'a great deal of satisfaction when you actually treat someone's issue very clearly and very quickly and you see them recovering well'. Like how Dr Bates experiences reward in medicine, Dr Tsansaraki goes onto state that job satisfaction is further derived from the communicative element of the role and hearing patient perspectives. She provides an example:

> …the other night I had someone who had come in because of an injury, but – and it was the middle of the night and because it was a sort of a safe environment, they opened up to me. They said that actually they have been suicidal and depressed for years and even though that injury was unrelated to that, they found that it was quite nice to be in a space where they could talk about it and receive a bit of help. So that kind of made them open up and be a bit more accepting of help with that issue, whereas in the community they never really initiated that process by going to their GP. So, yeah, having a more personal connection, but also allowing people to express themselves is also satisfying.
>
> (Dr Tsansaraki, F, CST1, 13.11.2017)

In this light, the distinction outlined above becomes important. Some of the doctors, particularly those within surgical services, do not work in patient-facing roles and mainly see their patients when they are asleep or processing test results. In the example above, it seems that satisfaction is derived from both the technical and interactive aspects of the medical labour process. Dr Tsansaraki discusses the satisfaction she feels in observing her patients

'recover well' in addition to hearing/listening to patient perspectives. Similarly, Dr Mayfield, a consultant in anaesthetics, offers a further example in which technical satisfaction is key. He discusses the importance of job satisfaction and how this relates to the level of feedback received from patients after surgical procedures. From his statement, it also appears that there is potentially less of an emotional spill-over within an anaesthetist role, despite the role requiring intense emotional labour – given that Dr Mayfield discusses his on-the-job satisfaction as being 'very self-contained'. This might suggest that given most NHS patients are elderly, frail with deteriorating health, an important aspect of contemporary medicine is the doctors' ability to feel as though they have been successful in bracketing off short-term positive effects from longer-term health status of patients. For example:

> …probably the most satisfying thing as an anaesthetist is walking out of the hospital at the end of the day and knowing that all of your patients have gone through their surgical procedure and they've recovered well and they're not in pain and they're doing well in recovery. And you then hand them over back to the surgical teams, so I get an immense sense of satisfaction and warmth, you know, knowing that I've done a good list and it's very self-contained.
>
> …so it's often very, you know, it's often reassuring them that you've done the right thing, that they [patients] say afterwards, "Well, that was much better than I thought" or, "That was brilliant I can't – I don't know how "…and then often a very good way of measuring whether you've done a good job is whether the patients would say – if you said to the patients, "Would you have that again? You know, if you broke your other hip would you have that again?" And they'll almost always say that yes, they would. It's often their preconceptions about what it will be like that puts them off.
>
> (Dr Mayfield, M, Consultant Anaesthetist, 30.11.2018)

And Dr Spacey (ST7) within geriatrics elaborates on these perspectives:

> …I suppose I have kind of said a lot in this interview about the negative stuff but as I said at the beginning of the interview, it's like if it was that bad, I would have quit by now. And it is my patients that keep me going and the work can be very rewarding,

> and I have lovely colleagues. And it's the people around you as well. And if you have consultants as well and people who recognise the work, you're doing…
>
> (Dr Spacey, F, ST7, 27.02.2018)

In these contexts, junior (and senior) doctors within both medical and surgical departments express the positive aspects associated with a career in medicine. Despite the increase in service pressures, which continue to shape the institutional dynamic of the NHS, most of the doctors discuss positive aspects of the role with respect to a high degree of job satisfaction and reward considering both technical and interactive elements of work. Interactive elements of work are associated with service interactions between doctors/patients and their families, but also between colleagues and others on-the-job with respect to reassurance and receiving positive feedback.

It is important to note that many of the doctors themselves discuss that further job satisfaction (both technical and interactive) is derived when they feel that they can make a difference to their patients. Job satisfaction, in light of technical and interactive elements of work, is normative under the professionalism logic – doctors constitute an intelligent, ambitious group of individuals who are motivated by the science, physiology and therefore technical aspects of the workload. Increasingly, however, doctors also wish to make a difference to their patients' quality of life and thus discuss the humanistic values of caring and supporting patients and their families. These notions closely align with the logic of professionalism but also with an orientation towards the community - this shows that the medical/surgical activity of doctors is embedded within the social contexts and circumstances presented by the institutional environment and patients/relatives.

### 7.2.2 Gratitude and Appreciation - Confirming Self-Identity

Following the analysis above, the majority of doctors also discuss the importance of receiving gratitude and appreciation from patients and families – this also relates to both the technical and interactive elements of medical labour process. The level of gratitude and appreciation that patients show for doctors within both medicine and surgery is perceived as a 'rewarding' aspect of the role. From receiving a 'thank you' from patients and their families to being

brought in cards, gifts and treats - this gratitude makes doctors feel satisfied, reassures them that they are doing a good job and confirms their altruistic self-identity as doctors. For example, Dr Irfan explains:

> Patients can be very grateful that you've given them information. They can be very grateful for your care. I think that's very positive. Gratitude is, to a doctor, very – it's like music to their ears. If sometimes you don't get – you don't get gratitude from your seniors, you don't get gratitude from other staff. You don't get gratitude from relatives but when a patient says to you, 'Thank you doctor,' you've helped a man breathing, I think that's a positive interaction.
>
> I think sometimes in the form of cards and thank you doctor, even just verbally, it's nice. You can go home and drive back in the car and just think, you know what? That was worth it today. It was worth just speaking to relatives or speaking to the patient and they've thanked you in the end. They've thanked you because they know you've helped them, and I think that's a very positive interaction.
>
> (Dr Irfan, M, CMT2, 8.07.2018)

Dr Sirity (FY1) also discusses the importance of patient gratitude on-the-job. She explains how this can make her feel valued in her work:

> When they say thank you so much. I've had times where patients say, they really appreciate all that you're doing for them and they understand that we have a hard job. That actually really warms my heart. Those are the moments that actually keep me going and remind me, this is why I came into medicine. We don't really get it that often. Patients generally say thanks, but it goes a bit further when they say a bit more. It just seems like exactly how they feel and the gratitude they have and when they understand the pressures that we're under, because you feel that much more appreciated and so I mean, I remember actually a lady was saying – I can't remember her situation, but I just remember that she was saying, she understands just how hard it is and how much we do and thank you so much for doing all this for my son. We really appreciate it and, actually, she and her son gave us some chocolates, a big box

> of chocolates to the ward to say thanks to the staff. It was really nice. That doesn't happen very often I don't think, but it makes all the difference.
>
> (Dr Sirity, F, FY1, 14.12.2018)

Importantly, considering the above, some doctors discuss the importance of gratitude and appreciation from patients and their families, even when the medical/surgical outcome has not been so positive. Dr Mistry (CMT2) tells me about his experience of helping a critically unwell patient during an on-call shift, including the nature of his interaction with the family. He explains:

> One of the amazing things is when you have someone who's so critically unwell that you don't know where it's going to go, you still have to maintain a level of professionalism to show family and the patient that you are doing the right thing for them, and that they're receiving the top level of care that they deserve for their condition. An example of that would be I had someone who was admitted with cancer, which was early diagnosis, looking very unwell, and despite treatment passed away. But the family were very thankful for the care that we had provided as a team and that was very humbling, because I was in an on-call capacity, so in that kind of capacity you're on your own faced with these situations. To know that you've portrayed your team in a positive light, despite such a negative circumstance is very humbling.
>
> That experience is never easy. Actually, I had to – because the patient was so unstable, I had to deliver that information over the phone, which is even more challenging, because you don't have the ability to react to emotions or provide the same level of empathy, even an informal touch of the hand or something. But because of how well we did in a difficult circumstance, despite me giving that information over the phone, it still led to positive reinforcement from the people, so thanking – despite them being very upset understandably.
>
> (Dr Mistry, M, CMT2, 24.11.2018)

In this light, despite a negative medical outcome, the interactive, emotionally-laden elements of the work are still perceived as positive for doctors – this closely relates to the logics of

professionalism and community orientation in that these contexts closely rely on both professional and social empathy for doctors to help/support patients following the social circumstance. Importantly, gratitude and appreciation in these contexts are particularly necessary in repairing the doctors' positive self-regard because patients failing to recover is harmful to the professional status of doctors. This potentially explains why these cases are clearly remembered by the doctors as the associated gratitude helps to support, reassure and confirm doctors' positive self-regard.

Dr Prescott (CMT2) outlines a similar experience:

> I had a lady on a ward a couple of years ago and she was so, so unwell and she had lots of things go wrong and she got sicker and sicker. Her daughter had just lost her husband and was just clinging to her mother like she was going to lose everyone if her mother died. And unfortunately, this lady did die. And for me, I came away from the situation feeling like she'd had a long hospital stay and there were things that maybe, in hindsight, could have gone differently for her, but then I got a letter from her daughter saying that (laughs) I was like a guardian angel for her mother and, throughout the whole torment of her hospital stay and as she was dying, she kind of looked to me as a pillar of strength. She sent me a little packet of seeds, because she used to bring flowers into her mother's room, the same flowers, you know, crocuses or something, and she sent me a little packet of seeds to say, 'Plant this and it will remind you of my mother'. So, I've never forgotten that because I actually felt like… not let her down, but I hadn't been completely at peace with that patient passing away. But actually, for that patient and for her daughter, and ultimately for that patient, the most important thing to her was that her daughter was okay, even if she died. That was reassuring. It was a nice interaction, even though the outcome was sad.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

And Dr Wie (FY2) discusses an experience she had with a patient with a chronic medical condition, but who was still very appreciative of the doctors' time:

> …a really good experience I had recently was of a reasonably young girl, I was looking at when I was covering a completely different area over the weekend because we were short staffed, and she had a chronic condition that meant that she couldn't breathe very well. I had a little bit more time to spend with her and talk about the issues that she felt that she had, that she couldn't go through on a ward round, because they happened so quickly. Because you have that little bit more time, the patient actually feels like you're listening to them. She thanked me at the end of the day which is one of those things where it makes your week, because she was genuinely grateful for the fact that someone had taken the time to actually listen, which we don't often have a chance to do. Those are the interactions where people are genuinely grateful, even if you feel like you haven't done a whole lot of them sometimes you actually have. So, those are the good experiences.
>
> (Dr Wie, F, FY2, 10.09.2018)

Considering the above, doctors collectively talk about feelings of reward and satisfaction following signs of gratitude and appreciation from their patients/relatives. These feelings fuel the nature of their work processes and encourage them to move forward in a difficult, pressurised working environment. Importantly, a sense of gratitude and appreciation from patients/families is experienced as a positive outcome of medicine by senior doctors as well as the juniors. Dr Spacey (ST7) tells me about her experiences in geriatrics with patients/families who can be very appreciative for the care that they have received and how this makes her feel on-the-job:

> When they [patients] smile at you like, you know, and there's one lady who I absolutely love on the ward at the moment. She's in a side room and every day we go and see her and she's like, "Thank you for coming. It's so lovely to see your face."
>
> …it's really nice when they say, "Oh, thank you for coming" or, you know, "Oh, you've got a nice smile". I think one patient said to me the other day, she said, "Oh, you're a really lovely doctor, you are." And that makes you feel kind of really good about yourself and that they're appreciating kind of what you're doing.

> …I've had like an interaction with the family this morning, so I guess the other part of geriatrics is the interactions with the family, almost as an extension of the patient. And the daughter of a lady who is very poorly this morning, she just said, "Thank you so much like to everyone on this ward, like you've been amazing. We wish our mum had come to this ward straightaway. This is a fantastic ward and we won't have anything said against you" and that's nice as well, so – when people say just thank you and we've been really pleased with the care…so it's getting at least some recognition of the amount of effort that you put in and what you're doing and having the occasional thank you.
>
> (Dr Spacey, F, ST7, 27.02.2018)

In this light, then little signs of gratitude and appreciation are perceived as very important for doctors in the context of British healthcare. These elements of the medical labour process can make the doctors feel valued, increase their sense of job satisfaction and provide the motivation for them to continue as doctors despite the manifestation of increasing institutional pressures and challenges. During some of my observations, I also uncovered a sense of reward and satisfaction when patients were clearly feeling appreciative of the doctors' care. In one context on a geriatrics ward, for example, an anxious patient relies on the advanced clinical practitioner for reassurance and emotional support:

> The ACP is constantly reassuring the patient whilst trying to conduct a physical examination – I wonder how exhausting this must be. He uses the stethoscope – the patient calms down a little. ACP: So, I'm going to get some painkillers for you, and get some medicine for the water in your knees – that will help to reduce the pain. I'm also going to restart your diabetes tablets, OK? Patient: I'm so sorry for being such a trouble. ACP: You're not a trouble at all…we'll do everything we can for you. Patient: I appreciate everything you do, I'm so grateful. ACP: I know you are. Thank you. He smiles loudly.
>
> (Observation Notes, M, Geriatrics, 31.08.2018)

And in the context of the skin cancer clinic that I observed on occasion, an example of gratitude/appreciation from a patient who is perceived as dramatic by the doctor but who is

also very appreciative of the doctors' care, and who verbally expresses this during the interaction:

> The nurse returns: 'he is here, so we can see him now' Con: 'OK' he firstly dictates letter for previous patient. He takes a swig of his coffee and says: 'right, are we ready for some drama?' the consultant already anticipates this interaction to be dramatic/eventful – I ask why, and the consultant says: 'he is just a generally dramatic person'. The consultant opens the door to call in the next patient. P: 'Hi, how are we? It's not been the best of mornings so far…' perhaps the consultant was right, the patient, in this case, leads the interaction and already has a story to share. The patient proceeds to discuss his eventful morning in relation to road works and cement. The nurse tries to bring him back on track. Nurse: 'oh, goodness, how are you anyway?' P: 'yes, very well thank you. In a very good place mentally…' Con: 'that's great' P: 'and I have to tell you' to the consultant 'thank you very much for all your help, support and your reassurance. I really do appreciate everything that you've done, and everybody else involved so thank you' patient expresses gratitude to consultant – this must feel satisfying. Con: 'well thanks, cool. You're welcome' P: 'do you want to see it?' it feels like the patient is still leading this interaction Con: 'yes, we will…'
>
> (Observation Notes, M, Skin Cancer Clinic, 10.01.2019)

These observations help to contextualise the level of gratitude and appreciation received from patients and their families, and how it can make doctors feel on-the-job. Most doctors, irrespective of gender, ethnicity and class, tend to discuss gratitude and appreciation as a highly rewarding and satisfying aspect of the medical labour process and therefore as an important aspect of the work. Interestingly, however, it is clear also from this observation that doctors in practice can come across as sceptical/dismissive of receiving feedback from patients. In the context above, the doctor describes this patient as 'dramatic' and offhands a small 'oh cool' and 'thanks'. This suggests that there is a potential difference between what doctors suggest (e.g. that they enjoy receiving thanks/appreciation from patients/relatives) and from how they respond to this appreciation in practice. This might be explained by the performative nature of the interview process and the requirements to play the good caring doctor - particularly when under observation.

As implied throughout the chapter thus far, then these pleasures associated with medical/surgical work closely align with the logics of professionalism and an orientation towards the community. In both logics, humanistic values of caring, supporting and being there for other people are highlighted. It is therefore normative for the doctors to discuss that they enjoy helping and making a difference to the lives of others, and that they derive job satisfaction from the technical/interactive aspects of the work, in doing so.

This chapter has outlined the pleasures associated with the medical labour process so far. However, in addition to pleasures associated with medical/surgical care, there are also negative experiences of the work and these can impact on the doctors' health and wellbeing. In the next section of this chapter, I outline pains associated with technical aspects of British healthcare and from the interactive, emotional elements of the work processes. Said pains closely relate to the logics of bureaucratic rationality and consumerism penetrating the NHS. Outlining both the pains and pleasures of this work helps to show why the performance of emotional labour is often referred to as a double-edged sword (Bolton, 2000b, 2004).

## 7.3 Pains

### 7.3.1 Stress and Work Pressures

All of the doctors experience high levels of stress. In light of increased rationalisation, the very nature of the medical labour process means that doctors work under significant amounts of institutional pressure with the lives of their patients at stake. Although work-related stress is an accepted, common outcome of the workload, following this study, the nature of this stress can certainly negatively affect the wellbeing of doctors. Different contexts and situations at work bring with them different forms of stress; some doctors are stressed considering the increasing workload, others are more affected by the interpersonal encounters with patients/relatives and others. Dr Prescott (CMT2) shares her experiences of work-related stress:

> …I don't think I would be a very good doctor if I didn't ever get stressed. And often, unfortunately, the friends that I've seen that have burned out, quite often they're the best doctors that have cared the most. I think, unfortunately, kind of hand-in-hand with caring, it often means that you get stressed and frustrated by situations.

> Sometimes you cry about the situation just because it's a horrible situation for that person to have to deal with, and some people have incredibly unlucky situations to deal with that you just think, really, this one person has gone through all of this? But as long as you do all you can, which is why the stress and lack of staff and everything is frustrating because you don't always feel that you can do that, and more and more you come away from a day at work feeling like you couldn't, unless you stay three/four hours late, which is not uncommon. It means I miss putting my baby to bed and I don't see her for days on end because I'm late from work. But the alternative is that you don't sleep because you know that you've not given that best care to that patient, and they deserved it.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

Similarly, Dr Maine (CMT2) explains:

> I think that – it just has a snowball effect of adding to stress. I think there are times when you're in a particularly difficult situation, it can be particularly upsetting as well. I've certainly been upset by things that happen in the hospital and you really take them home with you and you can feel down about them. So, things can take time to process and I think there are certain events that you can deal with quite quickly and there are certain events that stay with you for a long time. I suppose ultimately, they can make you better if you can get over them and deal with them, but at the same time they can really drag you down and can be quite difficult. It can be quite stressful, disheartening.
>
> (Dr Maine, M, CMT2, 27.06.2018)

Considering these examples, work-related stress arises within several different contexts and can take significant toll on doctors' wellbeing. This is implied because doctors are constantly having to make difficult, conflicting decisions - often they take home with them pressures of the hospital environment and find it difficult to balance the medical and emotional requirements of the work. In light of Dr Maine and many other juniors, sources of pain associated with medical/surgical work arise specifically from three different sources: firstly, caring for patients and negative health outcomes can result in doctors feeling defeated, depersonalised and sad; secondly, increased workload and institutional pressures – and thus

the experience of conflicting logics penetrating the British healthcare system constitute an additional source of stress; and thirdly, negative emotional labour – pertaining directly to interactive elements of the work and when it can be too difficult for doctors to manage heightened emotions.

In this light, then Dr Pratt (FY2) also illustrates:

> Just stressed about doing everything that you want to do. I think the two big things; the big topic is time pressure. Often you can't do everything you want to do for your patients in the time that you have and sometimes you stay late to alleviate the stress of providing the right care, and then obviously that pushes stress on the rest of your life, because you've got home at seven o clock, you can't do X, Y, Z you wanted to or you've had to cancel something else for work. So, there's that side of it and again just briefly mention the stress of are people going to complain, are people going to be happy with what I'm doing when people are visibly unhappy? There's that stress because although you feel like you're doing the right thing medically, a lot of it is – nobody wants to be seen as a bad doctor or bad at their job, but you can be because of that duality between providing care and providing the emotional social side of the job. So, that's quite stressful.
>
> (Dr Pratt, F, FY2, 28.08.2018)

Here, Dr Pratt discusses pains of the medical labour process in light of two sources of stress outlined above – increased workload and service pressures in terms of time management and the experience of negative emotional labour. Doctors are constantly manipulating their emotions in order to manage those of their patients - in the context above, then there are concerns about complaints from patients should doctors fail to do this adequately resulting in increased work-related stress. These notions clearly relate to the logic of bureaucratic rationality considering increased workload and time pressures, and to that of consumerism driven by the fear of complaints and negative feedback by patients/families.

Another example of work-related stress stems from the experience of doctors being on-call. An interesting notion here is that although on-call work appears to be a recipe for stress, it

has been an embedded aspect of the doctors' role over a long period of time. In this light, arguably on-call work has not emerged from increasing rationalisation/managerialism within the NHS. It is likely, also, that hours of on-call work have decreased over the years in line with the European Working Time Directive, but patient volumes have certainly increased alongside this. In these contexts, work-related stress is likely a result of the high volumes of patients that doctors must manage in a shorter space of time, and thus can still be considered a product of the changing institutional environment of the NHS.

To illustrate the above, during some of my fieldwork, I observed the nature of a surgical doctor on-call. This experience felt chaotic. The surgeon was controlled by a small electronic 'bleep' – he was pulled in several different directions in order to offer treatment to patients with various, complex conditions. Due to the nature of the on-call environment, then upon receiving a bleep, the surgeon was unaware of the condition of the patient and what he would be required to do for them on arrival. Doctors on-call would often be responsible for all major departments of the hospital and could therefore be 'bleeped' to any location. During this observation, from the morning to the afternoon I shadowed the doctor within the major trauma unit, the emergency department and the fracture unit and then the doctor went out to complete administrative tasks. In this context, the surgeon acted as part of a team in the major trauma unit – where the patient had managed to tear off his hand with a saw at work; the surgeon was then bleeped to the emergency department and conduced the examination of a cyclist who had come into collision with a moving vehicle; and lastly I shadowed the doctor to the fracture unit in which he was required to plaster a young girl's leg in order to reduce swelling and for her to then be able to be taken for surgery. The doctor moved quickly in response to his bleep but did not talk too much as we made our way to the different departments – he was visibly stressed for most of this observation although I could see that he tried to remain as calm as possible. This observation helped me to understand perspectives of other doctors who discussed work-related stress in the context of on-call work.

For example, Dr Mistry (CMT2) illustrates his experience of being an on-call doctor when asked if he feels stress on-the-job:

> Yes, not sometimes, a lot of the time. On call it's very stressful because essentially, you've got the same number of patients but there's only you as opposed to twenty other people who would have been there normally. So that's very demanding and stressful. More generally if you think about – take away who a doctor is, you're looking after another human being, that human being is unwell, and they're placing all their trust in you to try and help them feel better. That element in itself is always in the back of your mind when interacting with different people on a daily basis. And that can be very stressful, depending on the person in front of you. So, if they're particularly emotional or get an emotional reaction, that can accentuate that stress even more and provide an increasing emotional burden which you have to take away with you afterwards.
>
> (Dr Mistry, M, CMT2, 24.11.2018)

And sometimes doctors stay behind at work as opposed to handing over patients to on-call teams in order to avoid the lack of continuation in patient care. Dr Rana tells me:

> …there are many days that you're very stressed at the end of the day. There are days sometimes where you're staying back late, you have to stay back an extra hour, which is unpaid just because you had jobs to finish off, or things have taken longer than you expected, or you've got results that you haven't expected or need to act on. There are teams that work on call in the evening and night, but sometimes, you know the patient best already, so it's easier for you to finish off-the-job rather than give it on to someone else who has never met the patient. So, I think that can be very stressful.
>
> (Dr Rana, M, CMT2, 15.02.2018)

In this section, I have outlined the nature of work-related stress stemming from several different contexts within Wilton Trust. As illustrated above, doctors' stress arises from the caring elements of work combined with negative health outcomes, workload/institutional pressures and negative emotional labour. In the context of medicine, doctors' stress means that doctors are constantly having to manage how they feel – considering difficult service interactions, untoward health outcomes and as a result of increased institutional pressures.

During my time in the field, and as I uncovered the level of stress surrounding the medical labour process, I delved deeper into the impact that this had on doctors' personal lives and their wellbeing. In this study, the majority of doctors discussed having difficulty switching off from work and the experience of feeling emotionally drained following certain encounters. The next sections of this chapter will discuss a difficulty in switching off from the medical/surgical labour process (which potentially resonates with Dr Mayfield's point earlier about work being 'self-contained') and the nature of emotional drainage for the doctors in the context of British healthcare.

### 7.3.2 Difficulty Switching Off

Just like experiences of work-related stress, doctors' reasons for having difficulty in switching off vary from contexts, situations and interpersonal encounters at work. From delivering bad news to patients and their families to an 'out of routine' event that occurs on the frontline, then doctors commonly discuss finding it difficult to switch off from work and 'taking things home' with them. For example, Dr Richardson (ST1) tells me:

> …it's a bit more – it has to be a bit more dramatic in order for us to report on it, sort of thing because so much stuff becomes routine; it has to kind of stand out for you to be a bit more affected by it. I think when you're doing long shifts it's very hard to switch off from work, so I sleep better on nights than I do on long days. Long days, I'll come home after 13 hours and I will dream about work all night and I'll be back up the next day; you don't really feel like you've slept. Whereas on nights you're so shattered you just sleep. But when I'm tired, I definitely stress about work more. And it can be difficult to switch off. Sometimes appropriately so…
>
> (Dr Richardson, F, ST1, 7.11.2017)

And Dr Asif (CMT2, 16.04.2018) elaborates more on the emotional elements of work which can make it difficult to switch off from when away from the hospital environment:

> …you never know what hits you, whether it be patient stories that have affected you emotionally, especially when it's patients you've gotten to know or whether it's

> patients your age or younger and you can relate to them when they're having a difficult time. It could be hard to deal with that bad news, death. I think that's human nature, but you try to cop off but it's not always easy.

Other emotional elements of work stem from the delivery of bad news to patients/relatives. This can be an emotionally taxing experience for junior doctors, and often they find themselves most affected by it when having finished their shift at work. Despite making a conscious effort to leave work at work, doctors sometimes find that emotional experiences stay with them for a longer period of time. Dr Wie, who is in her second year of medical training, illustrates this experience:

> I don't think any doctor likes giving bad news. You get better at it, but I don't think it ever gets easier. A lot of the time, its family members who take it worse. I think that makes it really challenging. I've had it where I've given a family news that their parent was end of life. The person got moved to a hospice bed, which, they're nicer beds. The hospital had a hospice there. The patient got moved there and unfortunately passed away very quickly. But the family remember you as the person who told them that their loved one was going to die. Then later, unfortunately, when the husband came back in, that was all he remembered of me. You're the person who told me my wife was going to die and it's her funeral tomorrow. You feel in those moments that you have ruined their world, even though you're delivering bad news as part of your job and you can't help the fact that this person is going to die. It's a natural part of life. You deliver this news and they will always remember you, even if you don't remember them, because you do it so often. Those are really hard.
>
> …anyone who is a human being and understands emotion understands that is exceptionally sad. It certainly is a skill that you have to learn as a doctor, when you leave that room that experience stays there because you have other people to look after. You have other sick people. You might have other bad news to give, and when you get home, you have to look after yourself and leave work at work. Now, I don't think any of us are excellent at it. To a certain extent, you will bring some of it home but it's about getting that balance and trying to leave about 95% of it at work. Then

> the cases where they really get under your skin, then they stay with you. There's certainly been a few experiences like that which stay with you a bit longer.
>
> (Dr Wie, F, FY2, 10.09.2018)

Further to the examples above, Dr Rowe, a medical registrar, explains the difficulty in being able to separate oneself from emotional encounters, despite being socialised into doing so on-the-job. This also suggests that medical experiences can affect doctors' wellbeing after said experiences have occurred in the workplace:

> …we all try and be professional and not take things on board and we're sort of, you know, we're taught about being empathetic but not sympathetic, so trying to step into someone else's shoes but not taking stuff home with you and everything. So, it's difficult, so you want to be able to separate yourself from the situation, say, no this is not about me, this is about whatever. But sometimes that can be hard to do that because obviously we're all human aren't, we, we all have emotions and want to be liked and want to do the best job we can.
>
> (Dr Rowe, F, ST4, 6.03.2018)

Following the above, it seems that the very nature of the medical labour process can make it difficult for doctors to switch off from their work – increasing their work-related anxieties and disrupting their work/life balance. Doctors are encouraged from their seniors to not take aspects of work home with them, but this is often experienced as a challenge due to the emotionally laden texture of the many interactions that doctors have with patients and their relatives. Often doctors must move on swiftly from said interactions, in order to care for the next patient on the list, but when specific interactions are 'sad' then these experiences can take toll on the doctors' emotional wellbeing.

In this light, doctors commonly find themselves being unable to switch off from work as a result of both technical/interactive elements of the work. In terms of the technical aspects of medicine, then concerns about whether doctors have remembered to update all records, initiate all care plans and complete all outstanding jobs on the ward often torment the doctors

long after their shifts have finished. In terms of the interactive elements, doctors also find it difficult to not feel emotionally affected by the various encounters that they experience with patients and their families. As Dr Wie explains, it only takes for an individual to 'understand emotion' to know that the nature of medical work can be very sad and therefore certain interactions tend to make it difficult for the doctors to entirely switch off from their working day. These notions clearly relate to logics of professionalism and an orientation towards the community, which emphasise humanistic values, and thus it is expected that doctors feel affected by these associated negative experiences.

### 7.3.3 Emotional Drainage

In addition to experiencing work-related stress and having difficulties in switching off from work, doctors discuss more specifically the effects of emotional elements of work, how this can make them feel and the importance of looking after themselves in order to manage these interactions. Dr Richardson (ST1) tells me:

> I feel quite comfortable doing it [breaking bad news] but I think it does sort of take it out of you emotionally, just seeing people's reactions to it and you sometimes have to just kind of wrap yourself in cotton wool or sort of put a bit of a wall up to it because it can become quite emotional. So, there was a patient recently who I had who was quite young who died, and it was expected but she had lots of family who were understandably very upset. And that was quite – that was probably one of the more emotionally challenging ones that I've had because of the level of kind of emotion that was involved.
>
> (Dr Richardson, F, ST1, 7.11.2017)

More specifically, the majority of doctors in this study refer to certain contexts as 'emotionally draining' – this is the toll that emotional aspects of the medical labour process can have on the doctors' own wellbeing. Following interactions with patients and their families, then this can leave doctors feeling estranged from their sense of self and from others around them (e.g. Hochschild, 1983). Dr Irfan (CMT2) elaborates on these points clearly in the context of medical services:

> They're [interactions] personal and sometimes when you get home and you're a bit quiet and your friends and your family ask you why you're quiet, they can never really relate to you and you don't want to mention it, you don't want to bring it up again, but you're just a bit subdued and you're maybe just staring into vacant space.
>
> …I said, these guys, what have they done to deserve this? One of the patients was quite a big football fan and he was talking about the England game on Wednesday, but he was an inpatient having chemotherapy. I really thought about it, you know what, let me just go visit him actually at seven o'clock when the game's on, and watch the game with him but I wasn't sure about confidentiality or consent, so I didn't do it in the end, but I thought he could be my friend. He could quite easily be someone I know, and he's got leukaemia. I remember I went home and cried that day.
>
> (Dr Irfan, M, CMT2, 8.07.2018)

In this light, certain experiences of medical work can be emotionally intense, and doctors can feel negatively affected by these contexts long after they have left from the interactions. Dr Irfan continues:

> …at the same time, it is emotionally very draining, especially – I even recollect, the other Friday, I had about six heavy patient conversations throughout the day of dealing with imminent death, breaking to families, just on one ward. Even nursing staff and senior staff who have been there for decades were like, are you sure you're okay?
>
> (Dr Irfan, M, CMT2, 8.07.2018)

Further to the examples above, Dr Asif shows that some situations are more emotionally-intense than others – specifically, critical cases which involve young patients or those whom remind the doctors of their own personal experiences with their friends/families. He explains:

> I think quite a lot of young patients who are diagnosed with metastatic cancer, whether they be my age or younger, as young as – you know – I remember being called to confirm the death of quite a young patient, 18-year-old…with their diagnosis,

> especially in their 20's, when they're working and they've got brain tumours and they're high functioning and they're dealing with their own thought process. I think that's very emotional and demanding and you can relate to the same problems that I have at my age. They don't have to be my age either. They could just be someone – I've been working on intensive care and they've just had a gradual decline from not being able to – we've been treating them for sepsis, and we've talked about stopping their treatment with family and their – hearing a lot of their family with emotional stories about their loved one. You're there as a person, a human being and then you go home and that affects you in terms of, that's – you get to know them more as a person and then you get more emotionally affected by seeing them die and the family's emotions. It would be hard not to be affected by that, even though you see it day in day out.
>
> (Dr Asif, M, CMT2, 16.04.2018)

Despite the implications of feeling emotionally drained, the majority of doctors in this study accept that difficult, emotional experiences form part of the interactive aspects of the medical and surgical labour process – again, pertaining to the logic of professionalism. It is an accepted aspect of the work process that lives are at stake and doctors are unable to save all patients. Given the caring aspects of the labour process, then it also follows that doctors may feel affected by certain situations and contexts. Doctors become 'used to' these experiences, but they do not become desensitised to the emotional texture of the interactions. Dr Spacey (ST7) explains:

> …we have had a lot of deaths on the wards which I think again like emotionally does take its toll on the team. Although you become used to it; it becomes part of your job, I think we still do sometimes feel a bit sad and it does sometimes get to us and we think oh, we haven't been able to save like anyone this week. It's been a really tough week despite our best efforts.
>
> I was actually feeling quite emotional myself I think especially when the daughter started crying and the husband was – and I just had a little bit of a tear in my eye and like I say, we've done a lot of this recently. We've done a lot of breaking bad news and it does, sometimes you just come and sit in the office and you think – ohhh, you know,

> I can't break any more bad news today. I've done it often enough – and I might go home and just debrief with my husband and just get it off my chest because it's emotionally draining.
>
> (Dr Spacey, F, ST7, 27.02.2018)

## 7.4 Summary

In this chapter, I have outlined the pains and pleasures associated with the technical and interactive elements of the medical labour process. All of the doctors in this study experience both pleasant and difficult experiences on the frontline of British healthcare. Importantly, however, despite the increasing bureaucratisation of the NHS, and the significant increase in premature departures from the profession by doctors, in this study, the majority of participants explain to me that they would 'still choose medicine' as their career choice, although they do not anticipate the NHS to remain as we have previously understood it, or as we now understand it, in the next few years to come. Patterns of the pains and pleasures experienced by doctors seem to be constant across and between demographic variables of the sample - including gender, ethnicity and class and within the various medical and surgical specialties. An interesting observation is that experience and position in the medical hierarchy plays an important role, in terms of the pains and pleasures associated with medical/surgical work, and in relation to emotional labour outcomes. Perhaps this is because doctors have more autonomy over their work processes in line with increased experience, seniority and career progression.

It is also important to note that pains and pleasures associated with technical and interactive elements of the medical labour process appear to align with different institutional logics - as identified in chapters 5 and 6. As highlighted throughout this chapter, in relation to the pleasures, deriving job satisfaction from medicine pertains clearly to the logics of both professionalism and an orientation towards the community. With respect to professionalism, then it can be argued that it is normative for doctors to say that they enjoy helping/caring for patients and derive satisfaction in doing so. This is because the legitimacy of the medical profession rests on such humanistic values. Identity, in this context, is also important because it introduces a mechanism by which institutional logics are translated into peoples' responses to emotional moments at work. It follows that moments of emotional performance that

conform to professional logics (e.g. the stress associated with caring for a palliative patient) may translate into a positive experience for the doctors because they confirm the doctors' aspirations of working towards professional identity. However, moments of emotional performance which conform to the bureaucratic rationality/managerial logic (e.g. the stress associated with rationing healthcare service in light of performance targets) potentially translates into negative experience for the doctors because these notions challenge the doctors' aspiration towards a professional identity.

In terms of community orientation, doctors might also discuss said values as a pleasure of the medical labour process as it feels good for them to help people in light of the social context/situation. This is a particularly interesting finding because all healthcare staff can listen to patients/relatives attentively, but it is mainly the doctors who are able to diagnose patients, prescribe medication and operate on them, in addition to fulfilling emotional labour requirements of the work process. In relation to the pains associated with the medical labour process, then these experiences pertain to the logic of professionalism and community orientation, but also to those of bureaucratic rationality and consumerism. A common source of work-related stress appears to be related to the institutional context of work – increasing rationalisation has resulted in high patient volumes, time constraints and a decreased sense of autonomy on the frontline of work. In the context of difficult patients, then it can be argued that this relates to the logic of penetrating consumerism within the NHS. In this light, then the experience of emotional labour within medicine and the pains and pleasures associated with its performance pertain to distinctive institutional logics, which at times may overlap with one another, and at other times, specific logics may dominate certain situations.

# Chapter 8: Managing Emotion

## 8.1 Introduction

Following the previous chapter, in which I outlined the pains and pleasures associated with the medical labour process, in this chapter I show how doctors manage their emotions in light of their work-related experiences. Multiple strategies are used by doctors in order for them to manage their own emotions, as well as those of their patients, relatives and others. These strategies can be grouped in terms of individual and collective methods of managing emotion. In this light, in opening sections of this chapter I outline avenues of institutional support provided by Wilton Trust in order to support the health/wellbeing of the doctors (and other healthcare professionals) on-the-job. I then outline individual methods of coping with emotional labour commonly discussed by the doctors. And in later sections, I discuss the (informal) collective methods of coping that doctors are found to rely on in order to manage the pains/pleasures associated with the medical labour process, and emotional labour experiences on (and off) the job. In these sections, I also include the doctors' experience of managing both positive and negative emotion and a discussion highlighting the nature of humour used by doctors as a means of coping with the pressures of their work. It is appropriate to include the analysis of humour in the discussion on the collective management of emotion because humour is a collective, social process.

## 8.2 Experiences of Institutional Support

In this study, when asked about the level of support provided by Wilton, all of the doctors appear to acknowledge that there are several amenities available should doctors need to use them in order to support their health and well-being. From designated support staff, staff exercise groups and a safe space to congregate, within the context of Wilton Trust, much institutional support seems to be available for use by the doctors. However, the extent to which these amenities are perceived as useful or supportive varies within and between the doctor cohorts. Most of the doctors accept that there is institutional support available, emphasising the extensiveness of the services in place at Wilton, relative to other Trusts in the context of the NHS. However, it can be inferred from many of the doctors' accounts that said support facilities are perceived as having more symbolic value as opposed to being perceived as substantive or useful. Some doctors also outline that the support available is not

well communicated to the doctors/staff or that they perceive the use of these amenities as a weakness/threat to their professional identity and thus choose not to use them. Other doctors in this study are more cynical of the support in place – arguing instead that said services/amenities available to the doctors do not solve the bigger issue of resource constraints and increased work pressure – resulting in ill health and premature departures from the profession.

### 8.2.1 Institutional Support: Substantive and Symbolic

Following the above, many doctors of this study discuss the amenities/services available within Wilton, particularly highlighting the designated support staff within the hospital environment. For example, Dr Bates (ST1) tells me:

> …there's lots of stuff that I'm aware of, so we have a junior doctor liaison officer, I think that's her title. So, she's been kind of a good person to try and drive a bit of change in terms of encouraging people to seek support and be supported. And there's quite a big wellbeing drive at Wilton as well, so there's like a wellbeing room upstairs…and they do like meditation and things at a set time every day. I'm not sure how many people actually manage to get there at 12.30 or whatever the time of day, but I think the fact that they're even doing that and showing that is really positive.
>
> And they do lots of activity things; they're doing like a couch 5K and step challenges and all of that sort of thing. So, I think there is a real drive to support trainees. I think there's always more that can be done but I think it's really positive. I've definitely seen it change in the last five years.
>
> (Dr Bates, F, ST1, 20.02.2018)

Whilst the quote above appears to suggest that support was available, it could also be said that several doctors stated that they had limited time to engage with these facilities. It might therefore be suggested that such activities hold greater symbolic value in presenting the Trust as supportive as opposed to actual substantive emotional support. From Dr Bates' account, she seems to suggest that the support holds symbolic value as opposed to being received as useful for the junior doctors given the time constraints. Although, Dr Bates does suggest that there has been 'a real drive to support trainees' in light of the changing political landscape of

the NHS. Dr Furr also elaborates on these notions – highlighting the importance of designated support staff employed specifically to attend to the health/wellbeing of doctors. In contrast to Dr Bates, however, her account points to the actual value of support provided by Wilton from first-hand experience. She tells me:

> There is, actually here anyway, which is really good, a junior doctor liaison officer who is amazing, and she was one of the first in, this was one of the first Trusts to implement that; she is amazing. So, my father died during this last year and she was amazing for that, so they were really kind and amazing and then my time off within A&E led from that sort of thing, and they were amazing about it. So there, I think, this Trust is very good at putting things in place, and I know she's sort of going to other Trusts around the country who want her to go and talk to them about what's going on. And her door's always open if you need to talk to her about being stressed or anything like that. Not so much the day-to-day being a doctor and the problems on the wards, but if it's affecting your ability to work, or if you've got something going on outside of work that's affecting your work, she's great.
>
> (Dr Furr, F, FY2, 21.06.2018)

Although junior doctors are aware of the institutional support available, they suggest that it can be difficult to access these services considering the service pressures associated with medicine and surgery. In addition, many of the doctors stated that they knew of points of support that had been implemented by the Trust, however, most of the doctors also appeared to feel as if these avenues of support were more of a symbolic gesture, rather than a real, important solution to their emotional needs. Some of the doctors who accessed the services did suggest that they found them useful. In the context of medicine, Dr Irfan (CMT2, 8.07.2018) highlights the difficulties in accessing the support services/amenities. He tells me:

> …you have your support networks, your supervisor. There is the doctor's liaison which I think is quite new within this Trust which is very good. They're very good. There are support networks. But it's not always easy to access things. Your supervisor might be away. You might feel too busy to access the support. You might not know your supervisor that well if you're just moving into a different role. It can be difficult.

Dr Laine (ST7) is more positive about the institutional support in place at Wilton - suggesting she is confident that she can access the services should she need to. She highlights an important social aspect of the institutional support provided by Wilton – the Doctors' Mess space which allows for doctors to form collective, social ties with one another and to informally provide/receive collegial support. Interestingly, however, although Dr Laine seems mostly positive about the support available, she questions the effectiveness of these services given that a significant number of junior doctors are known to take stress leave/depart from the profession prematurely. She explains:

> There's a lot of support in place. I have supervisors and then there are various junior doctor forums and things. There is something – I get emails about the staff wellbeing, but I don't know if that is the NHS or Wilton, but they're – I think that might be the university rather than the hospital. I don't know. But they often are offering yoga and things. You get the wellbeing emails. Occupational health is good. I once went to see them more about eczema rather than stress, but they questioned me about stress at the time. So, that was quite nice.
>
> I think colleague support. So, when you're with a junior doctor, and live at the hospital, there's the doctors mess and the doctors mess evenings and that social aspect to it, because often when you're starting fresh from medical school, coming somewhere new, you don't know anyone. So, that can be additional difficulty. I think there are things in place. I'm not sure that – well, because everyone seems to be going off on stress all the time, I don't know how effective they are, but I haven't had to use many of them, but I feel I've got support if I need it.
>
> (Dr Laine, F, ST7, 11.06.2018)

In this light, it appears that for some of the doctors, the institutional support provided by the Trust is adequate and has substantive value; for other doctors, however, there appears to be an underlying subtext here that implies these services are somewhat disconnected from the everyday emotional processes at work, and therefore, they do not help to address those needs. Dr Laine also discusses the importance of the Doctors' Mess facility at Wilton – again, showing that the space is available but that it is also difficult to access due to increasing service pressures.

Further to the above, Dr Maine (CMT2) discusses that despite services/amenities being available for use by doctors within Wilton, these are not always well communicated to the staff. From his account, it seems as though he is more sceptical of what is in place and clearly confirms the disconnect between the services that are available and that which might be needed to address the emotional wellbeing of the doctors. He tells me:

> I think there are programmes that exist, and I know there are welfare services that exist if you are really concerned with it, but it's not a mandatory thing. It's not particularly well communicated throughout the hospital to be honest. We all have supervisors who are supposed to be the first port of call if you're feeling particularly stressed, or if stress if affecting you outside of work. There are things that exist, but outside of there being somebody to talk to in theory, there's not very much at all.
>
> I think that it's quite an overlooked area and I think that there are very few people in the hospital who wouldn't get at least some sort of benefit from having – if not a personal service, which might be a bit unrealistic, but at least flagging up clearly what to do. Here's a meditation app or whatever that can help with your stress. Here's different articles to read that might help you, or CBT techniques. Those little things that even if it's not one to one counselling, some sort of support would make a massive difference, to me, I'm sure it would to a lot of people.
>
> (Dr Maine, M, CMT2, 27.06.2018)

In this context, Dr Maine appears to confirm that the support available constitutes more symbolic value than anything that might be particularly useful for the juniors. He explains some of the 'little things' in his account above that indicates, perhaps, doctors are searching for something more than what is currently available at the hospital in order to address their emotional wellbeing and other health-related needs.

### 8.2.2 Institutional Support: Increasing Pessimism

Considering the above, many doctors in this study are aware of the support available at Wilton – perceived by some as symbolic, and others as substantively valuable. These notions are indicated by the doctors' accounts in the examples above, however, some of the other

doctors are more vocal/pessimistic in relation to their feelings surrounding the services available. For example, Dr Stafford (CMT1) explains:

> It's really difficult in hospital. I think they do have things, it's just that whether we're afraid to access it because it means that you're looked down on, it makes you sound weak, I don't know. I think I've just never accessed them because I feel I have other ways I can be supported. I think they'd be handy for some people.
>
> (Dr Stafford, F, CMT1, 19.06.2018)

These differences between the junior doctors are likely to stand for several reasons. For example, some of the doctors may wish to acknowledge the support that is available, particularly in the context of other Trusts which have not provided as much to help them with their emotional needs. Other doctors may simply perceive the support as inadequate at managing wider structural issues of the NHS at large, and some may even feel fearful of being perceived as *weak* if they were to accept what is on offer. This is highly important in the context of medicine – it suggests that the stereotypes still exist, and it can mean that doctors are not making use of services when they may well benefit from them. This notion can also be interpreted as reflecting the medical culture more widely – in line with professional norms and identity, doctors may feel reluctant to accept help from others and potentially prefer to navigate the medical labour process themselves. Additionally, from Dr Stafford's account above, even though she outlines the usefulness of institutional support for other doctors, this potentially does not mean that it is of any significant use, but instead, this can be considered mainly as a means of the some of the doctors positioning themselves (as stronger) against (imagined) others who might find these amenities and services 'handy' (because they are potentially not as strong/independent as the respondent might feel).

Furthermore, from the accounts of the doctors, then the new contract for the juniors brought about with-it unhappiness and low morale in the workplace – accordingly a number of services were put in place in order to combat these issues or to place a HR sticking plaster on a more structural-wide issue that is not being adequately addressed. Although most doctors

appear to have welcomed these services and see symbolic value in what is being offered; other doctors are clearly more sceptical. For example, Dr Prescott (CMT2) tells me:

> …it's funny you should say that, actually. When I returned from maternity leave, I had an induction because obviously I'd come back after a year. Lots of people have inductions, so it wasn't just me. It was a room of people, a room of doctors starting again. The thing that I noticed, that has never happened before, is we had three different people stand up at the front and say, "I'm from Wellbeing. If you need to talk to anyone about what's going on, then please come and see us." One of them was in charge of the absence reporting and sickness and stuff, and she said, "If you phone up and say you've got D&V but actually it's because you can't bring yourself to get out of bed in the morning, please just tell us that."
>
> I think it's all come from the unhappiness, the low morale that's around at the moment since all the contract stuff has come in, and obviously just the general stress of the job. But also, there's been a lot of junior doctors killing themselves. There's been a lot of suicides, so everyone's kind of— whether or not they're— the cynic in me is saying, well, they're covering their backs, and actually, you go to that person and they don't have time for you. But they portrayed that they genuinely care, and I would hope that they do.
>
> (Dr Prescott, F, CMT2, 14.03.2018)

Further to this, some doctors perceive means of institutional support to motivate doctors to 'just deal with it' as opposed to helping them to combat feelings of stress and improve their emotional well-being. In this light, some of the doctors are more cynical of the support in place, suggesting that instead of solving the embedded resource problems, the NHS simply wants doctors to deal with their work-related stress and continue to help their patients. Dr Ahmed (FY1) provides an example:

> …so, we all, F1s had to attend the resilience course. It was taken up with mixed feedback, some F1s appreciated it, and they tried to give you tools to cope with stresses of the job, to switch off and things like meditation. Things like, almost essentially compartmentalise between patients, so that if one has affected you

> emotionally you don't allow it to affect the other. How did you take to that? To me (laughs) I know I wasn't alone in feeling this way, it was very much a kind of, thinly veiled way of saying, just deal with it. We're not actually going to improve the situation for you. That resilience course, essentially it was, just deal with it…
>
> (Dr Ahmed, M, FY1, 5.07.2018)

As suggested by Dr Ahmed above, a great deal of medical and surgical work relies on the doctors being skilled at 'compartmentalizing' their work. Many services that are available for the doctors at Wilton also depend on such compartmentalisation – suggesting that doctors should be able to identify and objectify difficult, negative emotion and 'deal with' them away from the frontline of work.

Considering my analysis above, it might be argued that several doctors accept Wilton provides adequate services/amenities to support the health and wellbeing of its staff – it is clear from these sections that many doctors value the support that is on offer – even if some of the doctors suggest that this support is only of symbolic value. And the doctors also seem to suggest that these services are better received in the context of other NHS Trusts, that perhaps are not as supportive. It is also potentially worth noting here that, from the doctors' accounts above, the institutional support provided by the Trust appears to be increasing. One interpretation of this might be that in light of staff shortages, the Trust is desperate to hold onto its junior doctors; another interpretation is that low morale penetrates the system and scandals surrounding junior doctors' health and wellbeing are on the rise, or that local HR initiatives are influencing the increasing levels of support provided by the Trust.

However, in this study, the doctors also appear to suggest that the available facilities work mostly in theory. Given the service pressures associated with the medical labour process, it is often difficult for the doctors to appreciate and make use of the support available to them – they routinely find that they are too busy, there is little time on-the-job or the services have not been well communicated to them. Most importantly, then doctors can feel that the Trust is simply encouraging staff to 'just deal with' their issues in relation to work-related stress/anxieties as opposed to focusing on the underlying issues of resource constraints and (under)staffing. This might be considered as problematic – particularly in the context of British

healthcare which continues to be re-shaped along market lines and is being steered in a direction that does not seek to look after its employees.

## 8.3 Individual Methods of Coping

In this study, the doctors were asked about how they managed/coped with work pressures and associated emotional encounters that they faced with patients, relatives and others. The doctors discussed the importance of several different strategies – the ones that were commonly discussed in relation to individual methods of coping include exercising and taking breaks/time-out from work when necessary. Exercising was a coping strategy that doctors relied on outside of the medical labour process/work context. In contrast, doctors discuss the importance of taking a break or time-out from work on-the-job if they felt that this would be beneficial to their health and wellbeing and if they perceived that their workload permitted it. Both strategies are outlined below.

### 8.3.1 The Importance of Exercise

Many doctors tell me that a common way to deal with the stresses and strains of medical work is via exercise. Most of the doctors discussed the importance of exercise or physical activity in order to release work-related stress and to clear one's head. Here, the doctors themselves are drawing on discourses of catharsis to explain their coping in a normative way. Although phrases such as 'clearing your head' are somewhat cliché, they are commonly used by the doctors in order to explain the importance of forms of catharsis for addressing emotional needs. Some doctors engage within collective sports activities and others simply find running a more than helpful means of improving their health/wellbeing. For example, Dr Mustafa (FY2) tells me:

> I play a lot of football, so I think from a social kind of point of view, but also from a, even a mental, health point of view, I feel that playing football gives me a nice, you know, time to destress and I'm very, you know, I always try to incorporate that into my weekly routine, at least once a week, to play football.
>
> (Dr Mustafa, M, FY2, 24.10.2018)

And Dr Irfan elaborates (CMT2):

> …a lot of it's physical. I need to take stress out physically, as in go to the gym. I feel like I've – I feel like when my muscle is aching, I've got something else to concentrate on, you know, and my mind's completely away from work. My legs are aching, my bones are aching, you know, I'm tired from the gym. I think physical activity's a brilliant way to relieve stress, brilliant way.
>
> (Dr Irfan, M, CMT2, 8.07.2018)

Interestingly, considering Dr Irfan's account, a visceral description is given which might also be interpreted as *dramatic*. In this context, he suggests that he must exercise to the point that his body is 'aching' in order to numb himself from the stresses and strains of work. This is potentially an exaggeration, but nonetheless an important expression of the pain that he feels following aspects of work that lead to negative emotion.

In addition, I found that exercising was important for both male and female doctors in this study. Whilst male doctors tended to highlight sports and other physical activities, women were also likely to highlight yoga alongside these points. This gender distinction is interesting given that exercise norms remain so clearly gendered. For example, Dr Prescott (CMT2) explains:

> …any opportunity I do get, I know that if I'm feeling stressed and emotional, then I need to run off some energy and get out in the countryside. I've got a big dog that I take out to Derbyshire, and I do yoga. Yoga keeps me quite chilled and grounded (laughs).
>
> (Dr Prescott, F, CMT2, 14.03.2018)

And Dr Wie (FY2) elaborates:

> …I like to – I find working out quite helpful. Anyone that says they work too many hours to do exercise is rubbish. You can always fit in half an hour and I find it wakes me up better for the day if I do it in the morning and then the evening, it's actually half an hour you're only thinking about oh my god, my lungs are going to burst out my

chest because I'm working really hard. That helps. It's cliché to say yoga, but I do enjoy yoga.

(Dr Wie, F, FY2, 10.09.2018)

### 8.3.2 The Importance of Time-Outs

In addition to exercising as a means of releasing emotional burden, doctors in this study also seemed to rely on taking small breaks on-the-job. From their accounts, it is indicated that such time-out can help doctors to manage their own emotions following interactions with others, and to collect themselves before having to continue on with patients, relatives and others. For example, Dr Bates (ST1) explains:

> …I (pause) someone told me very early on that there's never – there's not really any situations that you can't walk away from for five minutes. So obviously in an emergency you need to stay but if it's just really, really busy and there's loads of stuff getting on top of you, actually taking yourself outside for five minutes is probably in everyone's interest; just to sort of breathe, because the ward can sometimes feel quite claustrophobic.
>
> (Dr Bates, F, ST1, 20.02.2018)

And Dr Pratt (FY2, 28.08.2018) elaborates, also referring to elements of training that the Trust provides in order to support doctors' health and wellbeing, but again suggesting that these tend to work mostly in theory. She tells me:

> It's all these things about taking five minutes to reflect on things or sit in silence, visualization and things, which to be fair, I've done a couple of times at work, but often it's finding the space to do it. It's always a hectic thing, that's the culture. It's also quite hippy dippy, and people don't do that because it's a very British, stiff-upper lip type of – just crack on with things not taking time for yourself. So, although there are little bits of training, I don't think the environment allows you to utilise the techniques that they do teach you.

Miss Palmer, working in the Frailty Unit of the Trust, also sheds light on the importance of taking small breaks. Here, she tells me that she can manage difficult patients on-the-job who might get physical or violent as a result of their illness/condition. However, emotionally laden encounters with patients and others can take more of a toll and, in these contexts, it can be important to 'have a breather'. She explains:

> I suppose that's probably the thing that gets to me most, is little things that people don't really notice. Whereas someone with dementia trying to hit you doesn't bother me at all (laughs). So yeah, aggression and violence, I kind of just take a step back and it's generally nothing personal. So, yeah. But then when you've got moments like that, you just sort of go away and have a breather and just go…and then it's fine. You just go back and get on with it. So, yes, but generally not to the point where it affects anything. It's just that kind of 'I just really need to take a break right now' (laughs).
>
> …I think, when I'm at work, nipping up to Costa and just taking ten minutes to have a breather and trying to switch off a little bit, or trying to think about what it is that you need to do to improve things is always good. Going for a walk is always good. It's difficult during the day, but if it's a weekend and you're feeling a bit stressed, then I always like to get outdoors a little bit.
>
> (Miss Palmer, F, PA, 13.11.2018)

Further to these perspectives, Dr Irfan (M, CMT2, 8.07.2018) elaborates on the importance of taking time-out for the doctors – in order to remain focused on the patient in front of you. He tells me that it is sometimes necessary to start afresh:

> I think medicine, it teaches you to not take your work home and also, as bad as it sounds, forget about the patient you've spoken to, go to the next patient because their problem could be completely different. Your focus is on the patient in front of you and you wouldn't be doing them justice if you're still, in the back of your mind, with the patient from before. So, you just have to zone out and go to the next patients. Sometimes a coffee break helps, so if you've broken bad news, you're emotionally drained yourself, just have fresh air, cup of coffee, go back to your ward round and then start afresh.

Often doctors must navigate/justify the importance of taking small breaks in light of their workload – they must assess the situation in front of them and if all seems stable enough, then it is mostly considered appropriate to take some time out to look after oneself. Dr Mustafa highlights this for me:

> Sometimes it's like, you know, I would literally just take a break, because my, I think, strategy is, because before I'd be like, okay, I've got like, it's about maybe one o'clock, say a typical day, it's about one, that's usually around the time, you know, you get a bit, you're quite hungry by that time and you need something, some fuel to get you going. When I first started, I'd be like, oh shit, I've got like loads of things still to do, let me just do a couple more jobs. Obviously, a couple more jobs means then you're just, it's just never-ending. But what I do is, now, I try, it doesn't always work, if there's, if it comes to the point where I think, I need to take a break now, I look at my job list, if a patient is literally, like, they're not like vomiting blood, or they're literally very unwell, then I think it's always appropriate to take a break. Even sometimes if it's a ten, fifteen-minute break, it's a comfort break, so then I would do that.
>
> (Dr Mustafa, M, FY2, 24.10.2018)

In the section above, I have outlined individual coping methods used by doctors to counter their emotional experiences with patients, relatives and others. The majority of doctors in this study point to the importance of exercise as an off-the-job method in order to cope with their workload pressures and emotional experiences. The nature of this exercise may include physical activity, group sports, yoga and meditation – the doctors each express that these methods can help them to release their work-related stresses and anxieties. In terms of on-the-job methods, all of the doctors in this study also point to the importance of taking small breaks or a time-out from the work if the context/situation permits it. The doctors explain that sometimes it is important to 'start afresh' given the stressful and emotional nature of the medical labour process. And thus, if it can be considered appropriate and safe to do so, doctors take small breaks from the work in order to pull themselves back together and continue with their medical duties.

In this light, the use of individual coping methods for doctors is clearly important. All of the doctors in this study point to the importance of releasing work-related stress via forms of exercise and taking small breaks in order to cope with an increasingly intense and emotional working environment. In addition to these methods, all doctors in this study also discuss the importance of collective methods of coping with work-related experiences and emotional labour. This chapter will now outline the importance of shared experiences and communities of coping in the context of British medicine. This analysis helps to show how doctors form collective, cohesive groups of workers and learn to informally cope with the stresses and strains of medicine and surgery on and off-the-job.

## 8.4 Collective Methods of Managing Emotion

Managing emotion on-the-job is a social, collective process. In this study, doctors were asked about their positive and negative emotional experiences of work and which of these they tended to recall. Although the doctors tended to dwell most significantly on negative experiences, and thus negative emotion, the doctors did discuss the importance of sharing positive experiences also. In this section, I outline the sharing of positive experiences within Wilton Trust – there is limited data on this notion, but it is important, nonetheless. I then outline coping with negative experiences/emotion – which is highly important/significant in the context of British healthcare. Lastly, I outline examples of humour - the swapping of banter and jokes made between colleagues as a means of coping with the (often highly emotionalised) medical labour process.

### 8.4.1 Sharing Positive Experiences

During the interview process, doctors were asked to elaborate on both positive and negative experiences of their work. Many of the doctors found it difficult to remember concrete examples of positive experiences and the majority suggested that they do not find it easy to share their positive experiences of work with one another in a collective context. In this study, some of the doctors were even pessimistic in relation to the work processes and discuss that there is not much positive about being a junior doctor. For example, Dr Miles (CMT2) tells me:

> …I don't think that there's a lot of positive as a junior; you're basically just doing things you're being asked to do. You don't see patients in clinic where they're well and where you've done something and that's improved their quality of life. So yeah, I'd say yeah, I probably don't have many – like don't think about the positive things as much because there isn't as frequent – there isn't very – like it's not positive very frequently…
>
> (Dr Miles, M, FY2, 29.10.2019)

This statement seems to echo the recent demoralisation of junior doctors – a common finding that doctors are stressed, feel undervalued and increasingly unhappy given recent institutional changes. In addition to this perspective, Dr Pratt (FY2) suggests the implications of negative experiences, considering the increasing service pressures, the importance of a good team and lack of recognition for a job well done:

> I guess the negative stuff hits harder. I think also, because of the high expectations and the job, although this job again – I've got a nice team so I'm complimenting them a lot. They give you good feedback and say good job on this, so I've remembered more of the good with this job than other jobs. Again, surgeons, sorry, but doing the good stuff and the good things that happen, they're just expected, that's how it should be. Whereas, the bad stuff, that's what shouldn't happen and that's when you get called out on it and that's when – that stays with me more because we know something has not gone well but then we've had other people telling us, this didn't go well. You should have done something different, whereas you don't get that so much with the good stuff. We know something went well but it's not as recognised as when the bad stuff happens.
>
> (Dr Pratt, F, FY2, 28.08.2019)

Following the above, most of the doctors also tell me that it is much easier, perhaps even more natural, to focus on the negative experiences at the expense of the positive ones. The negative experiences of work and the negative interactions with others tend to stick with the doctors much more significantly. For example:

> …when patients have written letters to me and all the nice experiences, but there's something – I think there's something quite searing about memories of very strong negative experiences, which when you have another negative experience, those negative experiences come back to mind. I think that's natural…
>
> (Dr Asif, M, CMT2, 16.04.2018)

> I think we talk about the negative a lot more than the positive, in a sort of offloading sort of way. But I think if you were to look at kind of the conversations that we have, I do always say, you know, if someone has said something really sweet, "Oh, that man was really lovely. He really cares" and that sort of thing. And I think that's littered within what we talk about but usually it's more productive when we're offloading. (laughs).
>
> (Dr Bates, F, ST1, 20.02.2018)

> I would say overall, I have more positive experiences but the negative ones I remember the most. I can't think of specific – I was trying to think of specific examples of positive experiences. I can tell you lots of negative experiences. But I think overall, they're mostly positive.
>
> (Dr Laine, F, ST7, 11.06.2018)

From these examples, it appears that the doctors focus much more on the negative experiences of their work than they do on the positives. The doctors explain that they often learn from their emotional, negative experiences of work and therefore reflecting on these experiences is important. For example:

> I think you're more likely to talk through negative things and see what should be learnt from it and destress a bit. But I would also say, I had a really great patient today, or this happened and that was a really nice experience.
>
> (Dr Terry, F, FY2, 25.04.2018)

> I think you remember more of the negative ones, but they're often the ones that you learn quite a lot from as well. So, the whole – you know, the way that you learn is through mistakes and things like that and when things don't go quite to plan. So, I've

got – I could probably tell you more examples of negative things off the top of my head than positive things. But the positive ones are really positive.

(Dr Richardson, F, ST1, 7.11.2017)

What I learnt from the positive ones is I did a good job, whereas I reflect on the negative ones a lot more, so I learn a lot from the negative ones. So, there's a lot more conscious processing of it. I think that's what it is. I've had positive experiences and I've internalised, yes, I can do this, I'm alright. I'll consciously think about the negative ones because I'm often modifying my behaviour as a response to them…I think if the positive ones hadn't sunk in that much, I would have left.

(Dr Bache, F, FY3, 15.08.2018)

Sometimes doctors are mindful that sharing positive experiences can make them come across as boastful. Given that most of the junior doctors within the NHS are having a difficult time with contractual changes, increasing service pressures and changes to the institution along market lines, some of the doctors discussed that 'you don't want to blow your own trumpet', perhaps in case other doctors have nothing positive to share at all. As Dr Rowe (ST4) explains:

…because sometimes positive ones you're like, well you don't want to blow your own trumpet too much. And actually, you don't need always to discuss the positive ones because they're positive and they make you feel good. But it's the negative ones where it's been difficult that you feel that you want to discuss it because you need to get it off your chests. So, you don't feel you need to discuss the positive ones in a way that you do with the negative ones...

(Dr Rowe, F, ST4, 6.03.2018)

In this section, I have provided an insight into the sharing of positive emotional experiences. Some of the doctors discuss that there are positives associated with medicine – mostly in the form of the interactions with patients discussed in the previous chapter. However, a common observation in this study is that doctors tend not to discuss these experiences with each other – mainly because it is easier to focus on the negatives and doctors do not want to come across as boasting about themselves, especially when low morale surrounds the NHS context given

recent political changes. Reflecting on the above, we can also consider the role that discussing negative emotional experiences has for the doctors of this study - in relation to gaining emotional support from peers and others. One understanding might be that doctors collectively enter a shared emotional space and thus develop collective coping when discussing negative emotional experiences of work. In the next section, therefore, I outline the importance of coping with negative emotion. Doctors have discussed that they tend to focus much more heavily on the negative experiences – in the following section of this chapter I outline these notions as processes of coping with the pains and pleasures associated with the medical labour process.

### 8.4.2 Coping with Negative Emotion

Following the above, when doctors were asked to elaborate on how they coped with difficult work-related experiences, including emotional encounters with patients, relatives and others, then all the doctors in this study, regardless of their training grade/experience within the role and other demographic characteristics, immediately pointed to the significance of supportive colleagues. An important means of coping with work-related experiences, in general, and emotional encounters, more specifically, is for the doctors to form collective, *communities of coping*. This concept was introduced by Korczynski (2003, 2009) as a means of outlining the behaviour of service workers who come together informally (often against management) in order to cope with difficult and abusive customers on the frontline of work. The concept of communities of coping can be applied to doctors in the context of British healthcare in order to show how they also form cohesive, informal groups and share their experiences as a means of coping with the often difficult and emotionally-laden experiences associated with the medical labour process.

In the context of forming communities of coping, many doctors discuss the importance of venting and seeking reassurance from their peers in order to boost their confidence or self-esteem. Many work-related experiences within the medical labour process can leave doctors feeling exhausted, drained and anxious of their own medical judgements – especially when medical mistakes occur. In this light, it can be highly important for doctors to discuss their experiences with one another and seek support in order to feel reassured. Dr Irfan (CMT2) tells me:

> It's a really good way to vent your anger, to speak to colleagues and perhaps they can give you some advice and just a bit of reassurance is quite helpful as well. So when they say yes, I don't think you were wrong – if there's a difficult patient and you relay the story to a colleague, and just a bit of reassurance that what you did was right, really can help your self-esteem because you come out from the consultation feeling demoralised because a patient's been really angry, being very abusive, patient's not – we've not come to an agreement and it can be quite abrasive confrontation with a patient. Once you've left that confrontation, your self-esteem is quite low, then you go to speak to a doctor, a colleague of yours, and just tell them what's happened. That certainly can help you in the sense that you get some – it's about camaraderie, you're part of a fraternity and they can say perhaps they had a similar experience to you and then you don't feel as bad as you did a few minutes ago. Sharing experiences, I think, is a brilliant coping strategy…

In this example, Dr Irfan explains the importance of speaking to colleagues and seeking reassurance in order to improve self-esteem. He explains that in medicine you are part of a 'fraternity' or a *community* and therefore it is highly important to have these discussions in order to help one feel better following difficult interactions with patients, relatives and others. Dr Irfan elaborates on the importance of sharing experiences with other doctors:

> …sharing negative experiences with colleagues is very therapeutic and you share to gain empathy and sympathy from your colleagues, and to open up. I think getting things off your chest is very therapeutic. You feel a big load off your shoulders but it's keeping the positive feelings – well, for me anyway, I find it helps. If I keep it to myself, I'm just as happy as if I shared it. The negative, certainly, you have to share, otherwise you don't know – it's just good to get another opinion. What would you do in my situation? What would you do? To get a second opinion from a colleague, it certainly puts your mind at ease…
>
> (Dr Irfan, M, CMT2, 8.07.2018)

Dr Maine (CMT2) offers similar perspectives to those of Dr Irfan. He discusses the importance of sharing experiences with colleagues and using humour on-the-job as a means of coping with stressful situations:

> …it makes you feel much better. Sometimes having a laugh about something makes you feel a million times better, and talking to somebody and them saying actually, I've been in a situation a thousand times worse than yours. Stop moaning about your situation, just deal with it. Hearing something like that makes everything feel better. That shared experience, being able to have jokes whatever, makes a real difference…
>
> I think getting stuff off your chest and knowing that people have had similar situations makes you feel really good. I think it's quite cathartic, I think it's quite – in the same way that people vent at you, you venting at someone makes things a lot better, and even if that is reflected back at you, I think you just need it. It's part of human nature to unload your problems.
>
> (Dr Maine, M, CMT2, 27.06.2018)

And Dr Rowe (F, ST4, 6.03.2018), who is a more senior doctor within medicine, explains the importance of forming cohesive networks with colleagues and others in order to be able to share work-related experiences, seek reassurance from others and escalate to more senior members when appropriate. She tells me:

> …I find that you quite quickly – although you move round kind of every four months – make close relationships with people, and I think it's because you're in a similar situation where actually we need to support each other. Talking to people. Talking to my husband, talking to colleagues. Discussing difficult situations with people. Knowing what your limits are and when to involve your consultant and say I'm at a loss here what's gone on here and I don't know, and not being scared to call them at three o'clock in the morning if you really need to…
>
> …yeah, it's the reassurance that, you know, you're not, everyone's in this together and we've all had similar situations and we're trying to keep our heads above water and manage. But we all struggle and it's knowing that can be really helpful…

Further to the above, many of the doctors also stress the importance of teaching/training sessions for the doctors to 'catch up' with one another and 'share their experiences' of medicine. Dr Bates (ST1) explains that teaching sessions can be useful for doctors to

collectively discuss their work with one another. During teaching/training sessions, the doctors are given the time and space to share their experiences of the work. This clearly helps the doctors to cope with the stresses and strains associated with the medical labour process – by sharing and seeking reassurance from one another, the doctors come to an important realisation that they are not alone and that they are all experiencing similar work-related pressures. Dr Bates tells me, elaborating on the importance of sharing experiences with similar others, and refers to the nature of this sharing as 'group therapy':

> I talk to someone and I think I find it's usually more helpful to speak to someone who is in the same profession that understands so that you don't have to explain everything, and because they just know what it's like to be in that situation or a similar situation. And who can understand why you might be stressing about various things and – yeah…I think I find that sort of thing very valuable because nurses debrief after arrests and difficult situations always better than doctors do. We never do it, not really. And I'm usually – I usually have good working relationships with everyone on the ward, so with all members of the team and I think there's a sort of real value in sitting down with everyone and saying, "That was really hard, wasn't it?" Or, "This is really distressing" and just having that shared experience. I think it's very valuable. Group therapy.
>
> (Dr Bates, F, ST1, 20.02.2018)

In this light, Dr Bates' account seems to contrast with notions surrounding management initiatives and institutional support that have mainly symbolic value. Dr Bates outlines the 'real value' in shared experiences and group discussions as a means of debrief. It is also important to note here that whilst many doctors are keen to share their experiences of work during teaching and training sessions, due to increasing service pressures within Wilton Trust, it can be difficult for doctors to escape their workloads. As outlined in chapter 5, then many doctors would prefer to attend their scheduled, protected teaching in order to learn, share experiences and 'zone out' from the medical labour process. However, imperatives associated with the logic of bureaucratic rationality can make this a difficult reality for the doctors. Therefore, the doctors' time and space to share their experiences with one another is often compromised.

Dr Richardson (ST1) elaborates on the notion of shared experiences by telling me that having supportive colleagues can make doctors feel less alone and help them to better manage their reactions to emotionally laden encounters. She tells me that it is useful to share these experiences so that doctors can understand that their experiences are indeed 'normal' on the frontline of medicine. Dr Richardson (F, ST1, 07.11.2017) provides an example:

> …I've been in a situation before where I was telling some colleagues about something that had happened, or I'd seen or been involved in. And they were like – oh, my gosh, that's really awful. And – oh, okay (laughs) because at the time you just take it as okay, this is what it's like. And so actually, that was really useful for me because I was like oh, okay. That actually really was quite unhelpful or really bad and that's kind of (pause) that was a situation where I'd been involved in a very traumatic arrest, sort of emotionally traumatic arrest. And then come away from it and just been told, "Right; you need to go and see this patient now" and just kind of no, "Do you want to have a coffee, or do you want a biscuit?" Or none of that kind of looking at it – so okay, that sounds horrible, move on, which wasn't helpful. And that was kind of the, "Oh, this is what it's going to – this is what it needs to be like and actually, it doesn't need to be like that." Yeah. So, I think sharing that sort of thing is really useful actually, because it helps you kind of understand that you're not alone in it, understand your reaction to it and that that's completely normal…

#### 8.4.2.1 The Doctors' Mess

Further to the above, it can be suggested that Wilton Trust provides the physical space for an important informal collective mode – the means by which this space is used reflects collective informal processes. The Doctors' Mess is a place in which doctors can come together, relax on their breaks, discuss their work with each other and even take naps during lengthy shifts. The Doctors' Mess facility was observed during my fieldwork – I was walking with a surgical trainee in order to carry out an interview and he suggested we could do this in the Doctor's Mess. Below I provide a description of the space following this observation:

> I follow the surgeon – he leads the way to Floor D. We walk past many wards on our way to the mess. We turn the corner and as we approach the entrance to this room, I

notice in big, bold red letters 'RESTRICTED ACCESS' – I realise that only doctors have access to this area. I follow the surgeon into the room – it is a big, open space but is also congested with old furniture; crowded with unnecessary tables/chairs and there are only a limited number of sofas near the T.V. area. The sofas appear old and worn – they do not look particularly comfortable (or clean – too many spillages!). The surgeon kindly offers me coffee before we begin our interview and I accept. As he enters the kitchen, which is located on the left of the doctors' mess, then I use this opportunity to fully explore the area with my eyes. It isn't a particularly welcoming space – old tatty furniture, multiple drink/food stains on the tired carpet and only a limited number of important resources e.g. computers (which are situated along the widths of the area). I think I only notice approx. 6 computers in a row. A few doctors are sat at these computers – they appear to be working. I turn my head and notice one doctor laying on one of the sofas – he is resting his eyes with his arm above his face. He looks exhausted. I notice a couple of other doctors sat at the other end of the space, talking and laughing together – they seem to be catching up and sharing discussions.

The surgeon returns and offers me a seat at the table – the table is circular and relatively large with space for at least 6-8 chairs. Dr Hall then tells me briefly about this space. I learn that it is where doctors can come to on their breaks, particularly for some rest during lengthy shifts. It is common for doctors to use this area to catch up on sleep and share experiences of their work with one another. The room is open-plan and appears to be very spacious – however, there are only a handful of doctors using the area and it strikes me that this is the norm. It is usually too difficult for doctors to escape the ward areas – even when they are owed a short break and therefore it isn't used as much as should or could be. I also notice the doctors carrying their bleeps which suggests to me that when the bleeps begin to sound, doctors must rush back to the ward areas. This notion is also supported at the time of my second and last interview conducted in this mess area – the junior doctor suggested we could use the mess area, as it was 'usually quiet', for our interview and that she must carry her bleep with her as she is not usually permitted to leave the ward area for a length of time.

(Observation Notes, M, The Doctors' Mess, 9.10.2018)

Following my experience of the Doctors' Mess, although the doctors acknowledge the social aspect to this facility, it appears as though this reflects more of a symbolic gesture as opposed to one of meaningful social value. From my observation, I did not notice much collegiality or cohesiveness by the junior doctors, and the facility seemed to be more of an empty outlet providing a safe space for doctors to catch up on rest - due to their long shifts and subsequent deprivation of sleep. Many years ago, the Doctors' Mess facility available for the junior doctors of any given Trust has allowed for informal discussion, on-the-job learning and a safe space to cope with the stresses/strains of work, collectively. Following significant increases in service pressures, it seems as though doctors are unable to make real, meaningful use of this space because it is too difficult to leave the ward areas, and thus their informal learning processes suffer and the doctors have difficulty in accessing collective, social support from colleagues (e.g. Waring and Bishop, 2010).

#### 8.4.2.2 Humour as Coping

Further to the above, in which I have outlined collective methods of sharing positive/negative emotion, I now provide insight into social understandings of humour within medical and surgical contexts. Context is central to understanding the experience and role of humour during social interactions. In this study, humour was observed within technical and interactive elements of work, and within and between professional cohorts. Given that context is crucial for understanding workplace humour, it is important to unpack the contextual elements in which humour occurred in order to understand its situated meaning and significance for the doctors involved. In this light, this section outlines examples of humour observed within technical/interactive elements of the labour process and that which was observed within and between the social relations formed at work.

##### *8.4.2.2.1 The Technical Labour Process*

In light of previous chapters, the morale surrounding the junior doctors is low and many doctors are experiencing their work in a negative way. Logics penetrating the NHS influence the means by which work processes are routinely navigated by the doctors – much of the data in this thesis suggests that the context of medical/surgical work is intense, service demand is

increasing and there is little resource to support the junior doctors practice medicine on the frontline. In this light, the routine navigation of medical and surgical work processes frequently involves humour. In the extract below, I observed the interactions of the multi-disciplinary team on the Medical Admissions Unit. In addition to discussing the workload, there are strong elements of humour used by the all the staff. For example:

> The FY2 is updating the 'huddle board'. There is an ongoing discussion between the junior doctors and consultants – it all feels very light-hearted, with plenty of smiles. I feel as though they are using these smiles to mask something. It also feels like the staff members have been advised of my arrival – no one asked me who I was – as if they already knew? Perhaps the FY2 had already let the team know I'd be shadowing today. As I reach the team, I say hello and stand to the side with my notepad. The consultant (old, Asian, beard) looks over at me sternly, as I make eye contact, he smiles. The FY2 is stood in front of the huddle white board – she is allocating ward bays to the doctors. I hear in the discussion that a doctor has called in sick and so another consultant from the hospital has been called into help this morning. The consultant asks me about my PhD topic and upon my explaining, he jokes with me and the MDT, stating 'doctors are generally happy people…you should observe us now versus 5pm when we all want to go home…see the change in morale' – all laugh. The FY2 follows: 'yeah come and speak to me at 5pm' in a sarcastic tone of voice.
>
> (Observation Notes, F, Medical Admissions Unit, 24.11.2018)

In this example, what appears to be funny or at least ridiculed by the doctors via sarcasm is the institutional context of the NHS – the doctors appear to joke about demoralisation surrounding medical work and the role of humour appears to be important for emotionally managing these challenges on-the-job. It is also possible that the consultant (who is arguably the most senior individual within the MDT in the example above) led the humour in the huddle context to ensure that doctors were somewhat distracted from the work intensity and the service pressures that have been surrounding the NHS for some time, and that would no doubt manifest during this shift.

The next example is of an observation I carried out during a seminar discussion on Major Trauma surgical cases. Here, the doctors share information, learn from one another in a community of practice (Brown and Duguid, 1991) and use sarcasm/banter when discussing the cases – often in relation to the cases themselves:

> Case 3: Pedestrian vs Car – one of the doctors begins to speak: '…apparently she was just walking along, and the car rolled down the hill, unknown speed and she was trapped under it'. Another member of staff in the seminar room: 'they said she had a large open wound to her left buttock'. The consultant then opens the discussion to the audience re. the procedure/treatment of the patient. The junior doctor at the front continues to present the case – he briefly discusses the primary survey recordings…'and she has the wound to the left buttock'. Consultant: 'do you know how long she was in CT after bloods?' Presenter shakes head to indicate no. MDT member in audience: 'there wasn't a delay in CT, it was at a normal speed. Consultant: 'oh so it was slow then?' All laugh in seminar room.
>
> (Observation Notes, Seminar Room, 25.03.2019)

In the example above, I was still with Dr Hall shadowing his work during an on-call shift. After the emergency case at the beginning of the shift, we were able to make this meeting in which the surgeons and other members of the MDT had gathered to share their knowledge of the case, and to discuss what can be done in future to improve patient outcomes. During this session, I noticed the use of humour, sarcasm and banter led by several doctors who were part of the discussions. Sometimes the role of humour played out in relation to the patient cases – the cases were almost always discussed by case number/limb and never by name. Often the humour was important for doctors to negotiate their conflicts/tensions in relation to other staff members/departments. For example, in the extract above, then the consultant makes a joke about a delay in another department of the hospital (e.g. normal speed of work = slow). It is possible that the role of humour in this way masks the pressures of the hospital environment, encourages MDT members to continue in their roles and helps the doctors to cope within an increasingly changing institutional environment.

In another surgical example, I observed a lecture-based discussion in which the MDT discusses the caseload for the work that has come in 24-hours prior. The meeting seems to provide a space for informal learning; the team members appear to be discussing caseloads in a community of practice. As the cases are discussed, jokes are also made – this helps to keep the environment light-hearted and less tense in light of difficult patient cases. For example, here the discussion on this case was coming to an end:

> The presentation ends and the doctors continue to discuss the same case – it is difficult/too technical to make out what is being discussed. Surgeons seem to use lots of humour when discussing patient cases: '…pissing blood from her left chest so I packed it – and I thought you know what? (laughs out loud) she's dead'. This is a conversation about a patient in a different hospital whose ribs somehow ended up in her heart – unable to make out complete context of case but noted that doctors make light of situations or cases that would be considered rare and extreme in non-medical contexts.
>
> (Observation Notes, Major Trauma Meeting, 25.03.2019)

It is difficult to tease out the social understandings of workplace humour – in the context above the doctors seem to find fatal patient cases amusing and for non-experts it is difficult to understand why this might be the case. One interpretation might be that such humour has an important role in helping doctors to collectively cope with the emotional nature of medicine and surgery. Informally and collectively, doctors share their work experiences and navigate similar aspects of the job, every day. It follows therefore that the situated meanings of the contextual humour that is played out is significant from the doctors' community perspective and does not appear to make too much sense to non-experts. As Becker discusses, one should look for sense when things appear crazy.

*8.4.2.2.2 The Interactive Labour Process*

In addition to the above, humour was also noted within contexts where doctors would joke with their patients during interactions. This might potentially imply that the role of humour is played out within many situational contexts of medicine. The situated meanings of such humour are therefore unique and relevant only to the context in which it is played out.

In the context below, I was conducting an observation on the Medical Admissions Unit at Deanside hospital. Dr Wie (FY2) was on the ward and was working closely with her consultant to attend to a heavily constipated elderly patient. The consultant, prior to the interaction below, felt frustrated. Dr Wie swapped gentle banter with me as I enquired about what was happening. Further into the interaction, I also noticed that the consultant was joking with the patient. This humour was clearly reciprocated. It might be considered that the consultant was drawing on the logic of community orientation as he interacted with the patient, and from what I observed, then the consultant might have been using humour as a means of masking his pent-up frustration from other staff that he had previously stated as being 'incompetent' at completing the ward round.

> The consultant decides that the patient is to be given a rectal examination. I look at them both a little confused and the FY2 fills me in: 'fingers in the backside' as she smiles. 'I think the consultant might do it, although I have done it plenty of times.' She smiles again: 'standard daily practice' and we laugh. We enter the side room – the consultant leads the way and the interaction with the patient. I follow in. Consultant: 'Good morning' Mrs. Ray: 'morning' in a very quiet voice. Consultant: 'you've met the young doctor, I'm the old doctor'. Mrs. Ray: 'oh are you retiring?' the patient jokes with the consultant in reciprocation. She mocks him for his age. Consultant: 'well I should have already retired, but they brought me back' as he winks, and they all laugh. FY2 scribes the interaction, I observe and note.
>
> (Observation Notes, F, Medical Admissions Unit, 24.11.2018)

This was a light-hearted interaction – allowing the consultant to examine the 'backside' of the patient, as Dr Wie tells me. The use of language during this interaction seemed humorous to both doctors and the patient – suggested by the laughing that followed the discussion. The conversation felt natural and was clearly appreciated by the patient given that she reciprocated the conversation using sarcasm and smiling.

In another example, one of the surgical trainees outlines her frustration in relation to managing patient expectations. In the interview extract below, Dr Sani provides a concrete example of a patient coming across as entitled/consumer-like. Often doctors are expected to

manage expectations of patients/relatives – sometimes this can mean that patients get their way. However, elective surgeries are booked on an emergency basis and often the public can find this difficult to understand. It is likely to be perceived as inconvenient for many people. Below, Dr Sani highlights her frustrations and there is some use of humour towards the end of the example that clearly helps her to cope/mask her frustrations on-the-job:

> I was bleeped to go and see this patient and said, 'Look, I'm going to walk out if I'm not next in line for theatre.' I have to explain to them the nature of emergencies and that if it's a life-threatening emergency it's going to go first because now it's the NHS. And they were like, 'Well why do you not have a second theatre, why is it just one list?' And I was like, 'You have to understand the limitations of our work…I was in theatre and the scrub nurse was holding the phone to my ear while your nurse was telling me your issues. That is literally the best I could have done.' Like when you know you've done your best, you've reached your limits and people are still like, I don't care, I want to be next in line. And it was quite funny because the patient's relative went, 'This is unacceptable service. I will take it to the news.' And I was like, "We have been in the news for about two years." (laughter). You've seen it.
>
> (Dr Sani, F, CST1, 16.05.2018)

Importantly, I noted the importance of humour in almost all medical/surgical contexts that I observed/discussed with the doctors. For example, whilst the above shows how the nature of surgical work is negotiated through humour during an on-call shift – in the contexts of the emergency department, doctors' offices where shared discussions can openly take place and during the fracture clinic, other observations conducted on hospital ward areas showed doctors joking openly with patients, with each other on-the-job and with other staff cohorts within multi-disciplinary teams.

In light of the above, I felt that humour was frequently relied on during interactions between peers, patients and relatives. I found that doctors would joke with their patients and the patients would often reciprocate the doctors' jokes. For the patients, the jokes/banter were perhaps reciprocated as a means of escaping their feelings of loneliness/boredom within the hospital environment; potentially also as a response to the doctors' attempts at drawing on

the logic of community orientation. I also observed the significance of humour swapped between colleagues as a means of getting through the workload and I found that the doctors would often joke with me or in my presence during observation work. In this light, I noted that humour was mostly effective as a coping strategy if it was being played out in a social, collective context. Many of the jokes used were medicine/surgery related or were about particular individuals within the department/ specialty – I often struggled to fully understand all that was going on, but I laughed along with the respondents anyway.

In this section, I have attempted to analyse some of the humour that I observed during my fieldwork. I have aimed to provide an insight into the situated meanings of this humour, showing how humour might help the doctors to negotiate the tensions and pressures of their work roles.

## 8.5 Summary

In this chapter, I have outlined the services/amenities provided by Wilton Trust in order to support the health and wellbeing of NHS doctors. I have also outlined the multiple strategies (individual and collective) that doctors discuss as being an important aspect of managing their own emotions, as well as those of their patients, relatives and others. All doctors in this study, irrespective of training grade, learn strategies to manage their emotions on-the-job. The doctors discuss the importance of individual methods to support their individual health/wellbeing; they also discuss the significance of supportive colleagues and forming close social ties with other doctors in order to cope with the technical and interactive elements of the medical labour process.

There is some indication that doctors may share positive experiences of work with one another as a means of informal learning, but it is much more apparent that doctors are keener to share their experiences of the negatives in order to debrief and feel better about their work situations. Importantly, the strongest means of coping with work-related experiences and performance of emotional labour is via the formation of collective, cohesive *communities of coping*. The doctors did not specifically state that supportive colleagues are the most important source for managing their stress and emotion. However, it is clear from the discourse/enthusiasm used, and their body language, when the doctors discussed notions of

shared experiences, collective coping and the importance of a supportive network, that collective methods of coping can be considered the strongest amongst junior doctor cohorts (relative to individual methods and avenues of institutional support). Humour has also been analysed as a collective coping strategy – a method which is used in almost every medical/surgical context involving several doctors. Humour is particularly useful for the doctors to negotiate workplace conflicts/tensions by swapping banter and making jokes with one another, and even their patients. Indeed, humour tends to form a significant aspect of the shared discussions that doctors engage within as observed during my fieldwork.

Considering the above, it appears that the formation of social networks allows doctors to informally offload on one another, share their experiences of the associated workload and feel reassured that they are each facing similar work pressures together. This is an interesting and important observation, especially given that *collective coping* is a relatively new theme within emotional labour literatures. This will be an important step-forward in this field.

Furthermore, it is important to note that both types of strategy, the use of individual methods and the formation of communities of coping, appear to be constant across and between demographic variables of the sample - including gender, ethnicity and class, and within the various medical and surgical specialties. Some of the subtle differences within/between the cohorts have been teased out throughout the chapter, and although some of the respondents suggest that increased experience within the role may help doctors to manage their emotions better in light of difficult interactions, there is no key data which implies that more senior doctors do not manage their emotions in similar ways to those who are more junior (and vice versa). It appears that all doctors rely on strategies to cope with the technical/interactive elements of the labour process; all doctors appear to rely on a combination of individual methods (including exercising and short breaks) and collective methods via the sharing of experiences. And for all of those taking part in this study, then the strongest method of coping with the stresses and strains of medicine is through a reliance on supportive colleagues, the sharing of experiences (on and off-the-job) and the forming of collective, communities of coping.

# Chapter 9: Discussion

## 9.1 Introduction

This chapter provides a summary of the findings of each of the data chapters and contextualises said findings within the broader streams of literature. The chapter closes by detailing the empirical and theoretical contributions of the thesis.

## 9.2 Novel Insights into Institutional Logics within Healthcare

### 9.2.1 Setting the Scene

The purpose of the first empirical chapter was to set the research scene, offer new insights into the social context of the NHS and highlight key institutional logics considered to influence the work organisation, and therefore, emotional labour of junior doctors. This chapter aimed to provide an important insight into the nature of contemporary medical and surgical labour processes – outlining the institutional context within which junior doctors perform/manage emotional labour with patients, colleagues and related others. In this light, there are significant gaps in our current understanding of the emotional labour of professionals – as detailed in previous chapters of this thesis.

The British NHS provides a critical setting in which to explore the emotional labour of doctors. Recent changes to public service work have brought conflicting logics into the frontline of the medical/surgical services (Hood, 1995). Said logics are routinely negotiated by professionals. Following the influence of these logics, different types of emotional labour are performed – with each logic guiding the work processes of doctors in different ways. In turn, doctors are found to navigate their work processes: resisting, choosing and negotiating the means by which they provide emotional care to patients, relatives and others.

### 9.2.2 Institutional Context of Medicine

This thesis considers the relevance of institutional logics in developing our understanding of emotional labour. The institutional logics perspective can make a vital contribution to an appreciation of the professional as an emotive being – resisting, choosing and negotiating the imperatives associated with multiple logics seeking to shape their emotional labour process.

The institutional logics perspective can be used as an analytical lens to explore texture of interaction between workers and others. In this thesis, logics manifesting on the frontline of British healthcare are those of bureaucratic rationality, professionalism, consumerism and community orientation. The navigation/contestation of these logics has been observed to inform junior doctor work processes and therefore the performance of their emotional labour.

In light of opening chapters, several studies have identified healthcare as an important setting for the exploration of multiple institutional logics (e.g. Kitchener, 2002; Reay and Hinings, 2009; Currie and Spyridonidis, 2016). Previous studies have found that multiple logics co-exist within healthcare institutions - jointly informing organisational contexts and shaping the work processes of clinical and non-clinical staff. Healthcare institutions thus provide an increasing site of contestation between multiple institutional logics (Scott et al, 2000). Changes to work arrangements of public services have also introduced conflicting logics to the frontline of British medicine (Hood, 1995; Currie and Spyridonidis, 2016). In this study, for example, multiple logics have been observed as influencing the work organisation of junior doctors, and therefore impinging also on important aspects of emotional labour. During workplace interactions, doctors have been observed to remain neutral in the face of patient frustration, be empathetic and distant simultaneously, respond to consumer demands through cynical performance and provide social empathy in order to regain back their sense of autonomy. These findings appear to reflect academic literatures on institutional logics. The intrusion of the bureaucratic rationality/managerial logic on the previously held logic of professionalism in healthcare is a common observation (Reay and Hinings, 2009) – influencing neutral expressions in doctors/others. A shift in ideology towards neoliberalism has also increased public demand and expectation (e.g. Gabriel, 2015, 2018) – meaning that doctors (and indeed other healthcare professionals) navigate the logic of consumerism. An orientation towards the community, influenced by notions of social embeddedness (e.g. Polanyi, 1957; Granovetter, 1985), implies that doctors/others can choose to respond to social contexts when providing emotional labour to patients, relatives and related-others.

## 9.3 Novel Insights into the Emotional Labour of Junior Doctors

Considering the institutional context outlined above, the second empirical chapter explored the performance of multiple emotional labour types. Specific types of emotional labour, which have not yet been addressed in academic literatures (in a single framework), have been identified and explained in relation to the broader institutional context. Four types of emotional labour have been outlined – these emotional labour types directly map onto the institutional logics considered to shape medical and surgical work processes. Details associated with each emotional labour type have also been explored. In line with Bolton's analysis of the emotional workplace, this chapter develops our understanding of emotional labour as a process dependent on surrounding aspects of organisation and management. This study builds on the work of Bolton (2000, 2005), however, by showing that emotional labour processes are embedded within wider institutional logics. Emotional labour is therefore performed in several different ways by the doctors and appears to be guided by the institutional context.

As I note above, the institutional logics perspective has started to focus on the micro-foundations of institutions (Powell and Colyvas, 2008) - including recent exploration of emotional aspects of logics organising work processes (Voronov, 2014; Jarvis, 2017; Friedland, 2018). Recent reviews exploring the expression and management of emotion within institutions (e.g. Voronov and Weber, 2016; Jarvis, 2017) have outlined some of the possibilities for analysing the performance of emotional labour in relation to the surrounding institutional context. Whilst these reviews offer several propositions, they are based on secondary analysis of existing literature as opposed to the purposeful study of emotional labour in contexts of institutional logic heterogeneity. This thesis has addressed this gap by showing how institutional logics are indicative of key themes in contemporary organisational change - each with distinct implications for emotional labour processes.

Emotional labour performance is shaped by logics of bureaucratic rationality, professionalism, consumerism and an orientation towards the community. Different types of emotional labour are linked to each of these institutional logics. The institutional logics perspective offers clear and valuable insights into the means by which emotional labour is performed within medical and surgical services, and the implications that this may have for

those involved in the process. However, there is complexity in connecting key logics to distinctive types of emotional labour and there are exceptions to the patterns that I have observed. A handful of extracts in my dataset, for example, point to instances of spill over between logics and emotional labour types – there is thus an interplay between the logics in practice and emotional labour types might appear to blend at the organisational frontline. This issue is addressed in a later section in this chapter.

### 9.3.1 Emotional Labour Debates

In light of opening chapters, there have been several contributions to emotional labour theory over the last 40 years (e.g. Sutton, 1991; Van Maanen, 1991; Hunter, 2005; Isenbarger and Zembylas, 2006). Authors have provided empirical and theoretical insight into the emotional workplace – majority of the literature in this domain however trace their roots back to the seminal work of Hochschild (1983) and, more recently, Bolton (2000, 2005). Both authors offer theoretical perspectives on emotional labour – seeking to explore the means by which frontline workers engage with the emotional labour process. Whilst Hochschild (1983) outlines a two-fold perspective – in which service workers might surface/deep act during interactional exchange with customers, Bolton extends this analysis by suggesting that the emotional labour process is instead multifaceted. Her analysis indicates that types of emotion management are guided by abstract feeling rules. This thus challenges the position of Hochschild by exposing that the key axis behind the original emotional labour theory, that of subservience to the consumer/employer, must be reconsidered.

Bolton's understanding of the emotional workplace is motivated by different emotion management types related to her key abstract feeling rules. This partly reflects what I outline in this thesis – that the key axis behind emotional labour types is related to a distinctive institutional logic. However, although Bolton's understanding of emotional labour successfully addresses limitations associated with that of Hochschild's, her analysis might be strengthened further via a lens provided by the institutional logics perspective. One reason for this is that Bolton's four-part typology does not clearly reflect the four types of feelings rules – as highlighted in literature chapters. Bolton's work can thus be built on through the analytical lens of the institutional logics perspective because this lens clearly shows the mapping of key logics onto different emotional labour types. Bolton's initial insight – the use

of feel rules as the basis for an emotional labour typology – can therefore be extended to acknowledge institutional contexts and implications for the emotional labourer.

### 9.3.2 Emotional Labour: An Institutional Logics Perspective

This chapter now outlines an institutional logics perspective on emotional labour. Since its introduction, the concept has been developed and re-developed as a means of analysing the management of workplace emotion in contemporary society (e.g. Ashforth and Humphrey, 1993; Morris and Feldman, 1997; Gross, 1998; Grandey, 2003; Kruml and Geddes, 2000; Bolton, 2004; Humphrey et al, 2015). As societies change, it follows that the means by which emotions are performed and managed on-the-job also develops. Institutional complexity, increasing uncertainty and settings within which co-existing logics manifest at the organisational frontline reflect the multiple means by which micro-level processes of work are also conducted. An ethnographic exploration of NHS junior doctors develops our understanding of the multiple emotional labour types performed at the frontline of work. In this section, therefore, emotional labour types are explored as guided by distinctive institutional logics in the context of medicine. Identified logics in this thesis refer to bureaucratic rationality, professionalism, consumerism and an orientation towards the community. Each of these logics have distinctive implications for performances of emotional labour, associated pains/pleasures and methods of coping. These details are explored as the chapter unfolds. Whilst this study examines the influence of key logics on emotional labour types, exceptions to these patterns are also acknowledged. In line with the blending/blurring of logics at the frontline, for example, performances of emotional labour are also likely to merge (discussed in a later section).

#### 9.3.2.1 Often Resisting – Bureaucratic Rationality

The imperative of rationalisation is manifest in the focus on increasing efficiency of services, that leads to tight time constraints and understaffing. During observation work, for example, it was common to see hospital wards lacking appropriate staffing levels – with minimum doctors and nurses on shift due a shortage in the professions. In interviews, doctors also revealed the tendency of Wilton Trust to risk 'safe staffing' levels as a means of resource restraint. The imperative of rationalisation was often resisted by junior doctors. Despite this

stated resistance, several instances in the data revealed that, given increasing work pressures, doctors had no choice but to provide emotional labour aligned with wider rationalisation of work. The logic of bureaucratic rationality is thus linked to the first emotional labour type: emotion neutrality.

In this study, doctors appeared to adopt emotion neutrality towards patients – these processes were amplified in the face of scapegoating by patients/others. Constraints of the healthcare system result in families and patients feeling increasingly frustrated – doctors are therefore commonly scapegoated by service-users/relatives and must stand strong in the face of verbal (but not usually physical) abuse. During interactions of this kind, doctors tend to act with emotional neutrality. Doctors have difficulty in conjuring feelings of empathy towards their patients/others in such circumstances – despite the understanding that often service-users are frustrated at the inadequacies of the healthcare system as opposed to being frustrated at the doctors, personally. In some contexts, doctors reflected regretfully on this and searched for other opportunities to offer other forms of emotional work.

Emotion neutrality has been acknowledged by Ward and McMurray (2016) when outlining the dark side of emotional labour – the authors highlight that healthcare professionals must manage verbal/physical abuse from service-users and this influences performances of emotion neutrality. In this chapter I note that imperatives of rationalisation can influence neutral expressions/performances in doctors when providing emotional labour to their service-users, relatives or others.

#### 9.3.2.2 Mostly Choosing – Professionalism

The medical profession has its own set of guidelines and modes of conduct, representing its unique mission (Strauss, 1975; Timmermans and Oh, 2010). Recruits into the profession accept these guidelines/modes as constituting a normal pattern of behaviour and as such they are internalised. The medical profession, therefore, alongside other elite professions, is not simply considered as *just a job*, but instead a lifelong career, a new way of life (Lupton, 1997; Bolton, 2005). Attached to this profession is high social status, material gain, public service and normative standards of care which the recruit submits to enthusiastically in order to pursue his career as a medical professional. In this light, professionals are described as

undergoing ‘secondary socialisation’ (Berger and Luckman, 1966), developing a new set of guidelines which in turn shape their behaviour at the organisational frontline (and indeed, backstage).

Following the influence of the professional logic, medical and surgical work processes are conducted within the remit of professional boundaries and in line with associated normative ethics. The practice of a doctor in the British healthcare context is regulated by the GMC and it therefore follows that associated guidelines influence their work processes. In relation to emotional labour, doctors are required to provide a specific bedside manner – incorporating compassion and empathy, whilst also maintaining social distance from the patient (GMC, 2020).

Imperatives associated with the logic of professionalism introduce the second emotional labour type: professional empathy. In my analysis, doctors are observed to mostly choose professionalism when conducting their work. They submit to the prescriptions of their professional roles. And they willingly provide professional empathy to their service-users as a means of upholding their professional status, and to meet the expectations of their colleagues, seniors and the public in relation to the ideal image of a professional. Indeed, Dr Furr (FY2) explains that doctors must be ‘super-human’ in order to meet certain professional values, implying that doctors are placed on a societal pedestal, reflecting the image associated with being a professional. In interview examples, it appears that doctors consciously identify with professional norms and values, whilst in observation work additional emotional labour performances appear to manifest in light of conflicting logics.

Aspects of professionalism involve both compassion and social distance. Professional empathy, therefore, requires doctors to ‘strike a balance’ between offering compassionate care to patients/relatives, whilst also maintaining a level of social distance to ensure that professional boundaries are respected (GMC, 2020). Considering the data in chapter 6, this is a difficult balance to strike when treating/interacting with patients (and others). As Dr Wie explains:

> …it’s about striking the right balance between having empathy and understanding emotions and why people feel emotions in the scenario that you’ve been in, [and] also having the right amount of distance. So, you can be empathetic without being

> emotionally invested. I think that's difficult to strike that balance, and I know that there are plenty of people out there who don't do it particularly well. I suppose the ones that you get a little bit more emotionally invested in are the ones that you can see yourself in.
>
> (Dr Wie, FY2, 10.09.2018)

Particularly in the context of delivering bad news, doctors have been observed to show compassion, repress/express specific emotions at the same time, whilst offering small gestures of care (e.g. handholding, offering tea and coffee etc.) in order to provide comfort. Bolton's (2005) analysis of the emotional workplace might perhaps consider this example as a reflection of emotional 'gift giving' within medicine. In this study, however, whilst it might be interpreted that one's socialisation is having an influence from the bottom-up in these contexts (and therefore doctors are choosing to draw on the community orientation logic), examples of delivering bad news might also pertain to professional empathy. In these instances, the professional logic is guiding the doctors in order for them to offer empathy in line with the standards of care prescribed by their profession and to avoid expressive displays of emotion. Whilst some patients/relatives welcome such displays, the public place doctors on societal pedestals and have trust in the profession. Accordingly, doctors must work to maintain their status in the eyes of the public by relying on professionalism as guiding their emotional labour.

Importantly, several doctors have suggested that this balance is one of most difficult aspects to navigate within medicine – cases present themselves which make doctors feel numb, insecure, sad and drained. But an active display of this emotion would be problematic and challenge their perceived perception in the eyes of the public. Doctors therefore tend to manage their emotions during the interactions but take the time backstage in order to collect themselves again – often through shared experiences.

Furthermore, imperatives of professionalism and bureaucratic rationality were commonly observed to conflict with one another – mainly because the imperatives associated with both desire conflicting outcomes (e.g. Reay and Hinings, 2009). Literature has indicated the frustration that public sector professionals experience at the imperatives of rationalisation: resource constraints, understaffing, imposing managerialism and standardisation, but

professionals work very hard not to show this to their users (Lipsky, 1980). Importantly, junior doctors appear to resist rationalisation imperatives and choose instead to adhere to others. There were occasions, however, where this was not entirely possible, and bureaucratic rationality dominated the medical, surgical and emotional labour process (as I have outlined above). In addition to the dominance of rationalisation, it is also useful to note that imperatives of logics are observed to blend in healthcare contexts – particularly in light of the changing norms of the medical profession and the rise of hybrid managerial-professional roles (e.g. Noordegraaf, 2015).

Perspectives from consultants have further helped to shed light on the increasing conflict between professionals and managers at the frontline. Whilst clinicians were mainly concerned with the health/wellbeing of their patients, non-clinical managers (e.g. enactors of rationalisation processes) were also concerned about healthcare costs, budget control and hospital bed counts. In this light, imperatives associated with both the professional and rational logics were commonly observed to be in conflict. Frontline junior doctors were to navigate these tensions. In the face of this conflict, however, doctors were observed on many occasions to resist imperatives associated with the bureaucratic rationality logic and choose instead to respond to the influences of professionalism – potentially reflecting their secondary socialisation into medicine (e.g. Berger and Luckman, 1966). During their service-interactions, therefore, it was a common observation to find doctors providing what I have termed professional empathy to patients, relatives and related-others.

Further to the above, logic heterogeneity has increased the need for emotional labour processes within medicine. Divisions of labour, for example, reflect hierarchal structures within healthcare contexts – with specific occupations responsible for specific aspects of the labour process. The performance of emotional labour has been typically embedded within the nursing labour process (e.g. James, 1989; Smith, 1992; Bolton, 2000b). In addition, whilst medical education and practice has taught doctors to remain objective and impartial when offering clinical care, GMC guidelines have now changed to reflect the importance of empathy and compassion during interactional exchange. The changing context of medicine, therefore, requires doctors to be competent emotional providers in addition to medically and surgically treating patients.

Following these points, professional empathy was clearly observed when doctors delivered 'bad news' to their patients/families. Considering my analysis, professional empathy involves balancing empathetic processes of care with that of social distance in order to objectively treat patients' medical problems but to also offer emotional support in light of difficult circumstances. Contrasts between processes of empathy and social distance become strikingly apparent in the context of operating theatres – discussed in a later section as highlighting an important division of emotional labour.

9.3.2.3 Mostly Resisting – Consumerism

Reflecting the original contribution of Hochschild (1979, 1983), emotional labour as being shaped by the dictates of the organisation/sovereign customer is still a common occurrence within contemporary workplaces in which interactions (face-to-face or voice-to-voice) occur between worker and service-user. In the context of medicine, the logic of consumerism, and therefore consumerist empathy, was mostly resisted by medical/surgical doctors. Despite this one not being a dominant logic within the healthcare context, on occasion I observed patients, relatives and others playing the role of a healthcare consumer – as has been previously noted by Bolton in her study on nursing (2002). This therefore required doctors to respond to demanding patients. Considering the ideological shift that continues to shape the NHS along market lines, then doctors often have no choice but to provide consumerist empathy to their service-users – by exaggerating, faking and cynically displaying empathy to *consumers*. In these instances, doctors might rely on processes of surface acting (e.g. Hochschild, 1983) in order to please demanding consumers and to avoid potential escalation. Indeed, the new control and feedback culture associated with British healthcare means that doctors are increasingly trained to *keep the patients happy* to ensure that service-users provide the associated NHS Trust with positive feedback (e.g. Greaves et al, 2012).

In this light, under the logic of consumerism, doctors perform on stage and continue to accept the frustrations of their patients, relatives and related-others. Although doctors were observed to resist the move towards a model of being subservient-to-the-consumer in light of their strong sense of professionalism, following an increase in patient empowerment and the rise of consumerism within British healthcare (e.g. Bolton, 2002), there is some evidence to

suggest that the texture of the doctors' emotional labour alters in light of consumer/organisational demands.

For example, in order to manage the expectations of their service-users, to avoid complaints, negative feedback, processes of litigation and other forms of clinical governance, the doctors of this study have developed skills to ensure that trivial matters do not escalate at the front-line of their work. In these contexts, the emotional labour performances of doctors are shaped by organisational demands (e.g. implementation of feedback mechanisms) and sovereign consumers (e.g. who retain the power to provide negative feedback) – reflecting Korczynski's (2002) concept of a *customer-orientated bureaucracy* in service work. Doctors perform on stage and accept frustrations in order to manage patient/relative expectations and avoid potential escalations. Similar to the context of service industries, professionals might be left isolated from their work and from the negativity/abuse of the *customers* whom they serve (e.g. Korczynski, 2003; Ward and McMurray, 2016). Doctors might therefore have little choice but to respond accordingly. As Taylor and Tyler (2001: 70) suggest:

> *He [the customer] can really talk to you how he wants. Your job is to deal with it.*

Although there are clear distinctions between contexts of both service and professional work, there is an observable shift towards consumerism in British healthcare, with patients acting as customers of medical/surgical services (e.g. Bolton, 2000b). Doctors were quick to recognise the potential influence of consumerist discourse and held up the notion in interviews, to a certain extent, that *the patient is always right.* In other respects, however, doctors appeared keen to distance themselves from this notion and often pointed to the potential damage caused by the extension of consumerism to the role of a patient. Indeed, some of the cohort examined in this study were unphased by the demands of the organisation/healthcare consumers alike and continued to conduct their work in light of imperatives associated with professionalism – highlighting the strength of the medical profession. In contexts in which this was observed, doctors were found to choose the professionalism logic and maintained clear social distance from demanding, abusive and/or difficult consumers of the healthcare service.

#### 9.3.2.4 Often Negotiating – Community Orientation

Emotional labour, as being performed in light of social contexts, is missing from current debates on the topic. Authors have considered that emotional labour is embedded within wider social relations (Korczynski, 2002) and that emotional labour can be considered as *gift giving* in certain circumstances based on processes of 'the basic socialised self' (Bolton, 2004, 2005). However, emotional labour as being specifically embedded within the logic of community orientation is missing from our current knowledge. In this study, I show that in addition to the influences of rationalisation, professionalism and consumerism from the top-down, an orientation towards the community is often negotiated by the doctors from the bottom-up. This is a similar analysis to Bolton's understanding that nurses often offer their emotions as *gifts* to specific patients thereby adhering to the *philanthropic* emotion management type. Philanthropic emotion management is also considered in the context of managing emotion with colleagues and others on-the-job. In this thesis, however, I tease out the performance of emotional labour and the managing of emotion through individual and collective processes in separate sections. In doing so, I hope to add clarity to the notion of performing emotional labour and to that of managing emotions at the frontline or backstage of work.

Following the above, this study suggests that doctors might choose to offer more of their emotions to those they consider deserving or in need - in response to the social context which presents itself at the frontline of work. This type of emotional labour is based on their individual socialisation processes and has the potential to provide doctors with the autonomy and sense of control which other logics (e.g. bureaucratic rationality and consumerism) seek to constrain. Considering an orientation towards the community, doctors are placed back in control of their emotional labour process because they *choose* to provide this type of empathy – the performance is thus genuine, authentic and sincere. Whilst Bolton (2005) acknowledges the small spaces of gift giving and Korczynski (2002, 2009) stresses the importance of wider social relations, in this study I acknowledge the social context (as opposed to the institutional) which allows the workers to offer more of their time, work and therefore emotions. In doing so, doctors can *make a real difference* to the life of the patient whom they are treating. Indeed, in the data I outlined on pains and pleasures of the emotional labour process, most of the satisfaction in relation to interactive elements of work appears to

be derived from contexts in which doctors choose to respond to the influences of community orientation.

The logic of community orientation therefore introduces the notion that doctors might also provide social empathy to service-users – in line with Ashforth and Humphrey's (1993) analysis of genuine emotion, Bolton's philanthropic type (2004, 2005) and Korczynski's (2002) elaboration of emotional labour as a process embedded within wider social relations in workplace settings. Following this analysis, I hope my observations contribute to Bolton's (2004, 2005) critique that emotions within organisations cannot be folded into an assumption of one dominant logic – i.e. Hochschild's (1983) understanding of the *transmutation of feeling* through the capitalist labour process. For Hochschild, all emotions within organisations are commercially motivated and are prescribed by management – whilst I have provided support for this notion through consumerist empathy, my analysis extends this argument by showing that there are other means by which emotional labour might play out on-the-job. In addition, whilst the recognition of multiple emotional management types has been outlined in Bolton's (2004, 2005) '4Ps' associated with emotions in organisations, I have added to this commentary by showing how doctors perform emotional labour in light of the institutional context at the frontline, and how individuals might manage their emotions through individual and collective processes backstage (explored later in this chapter). I have also built on Bolton's analysis of the emotional workplace by also showing how distinctive logics might map onto key emotional labour types – outlining how, theoretically, emotions might be guided by specific logics. However, as acknowledged, I am aware that there are exceptions to my theoretical mappings and that imperatives associated with institutional logics will blend and merge at the organisational frontline. In light of blending logics, it follows that emotional labour processes will also blur. This is considered in the section below.

### 9.3.3 Blending Logics, Blurring Emotional Performances

As acknowledged in opening sections, there are exceptions to emotional labour types being influenced by only distinctive logics. In light of blending logics, these instances of spill-over between logics mean that emotional labour processes might also blur. Co-existing logics at the frontline of work call for the navigation, contestation and negotiation of said logics by individual actors. The term *hybridity* is given to organisations in which multiple, conflicting

logics are observed to manifest at the frontline of work (Skelcher and Smith, 2015; Bishop and Waring, 2016). Hybrid organisations, therefore, are carriers of multiple institutional logics, each seeking to guide the work processes of individual actors. Importantly, as can be seen above, multiple logics co-existing within healthcare settings tend to conflict with one another, and blend at the frontline.

Institutional scholars have long recognised the multiplicity of logics guiding organisational and individual processes of work, even if specific co-existing ones are observed as being more dominant than others (e.g. Dunn and Jones, 2010; Sanders and McClellan, 2014). Considering this multiplicity, scholars have also observed how individual actors respond and manage their work processes. In line with the institutional logics' non-deterministic approach, the ability of individual actors enacting processes of work at the micro-level is acknowledged as affecting the means by which said individuals can manage and respond to the influences of key logics at the frontline (Skelcher and Smith, 2015). In this study, for example, I show how doctors might choose, resist and/or negotiate the imperatives associated with key logics at the micro-level of work.

Given that imperatives associated with key institutional logics are often observed to blend in organisational settings, it can be a difficult task to tease out distinctive implications of specific logics on micro-level interactions. In this study, for example, whilst the influence of rationalisation imperatives is clearly distinctive from imperatives associated with community orientation, in relation to emotional labour, it is important to recognise that frontline workers are indeed as Bolton and Boyd (2003) describe 'skilled emotion managers'. Considering institutional logic multiplicity, emotional performances of doctors' blur during interactional exchanges with patients, relatives and related-others. Doctors may choose specific emotions, they might provide an influx of emotion associated with plural logics at one time, or they might synthesise imperatives associated with multiple logics in order to offer emotional labour.

There are some examples in my dataset which reflect the discussion above. An informal discussion with a surgical doctor reveals:

> …the excessive admin/procedural and paperwork aspect of the job – which no-one tells you about in medical school, but it constitutes a very large part of the daily work. The doctor discusses that they are required to relentlessly order tests and update medical records – much more than the patients are actually attended in order to be examined by the doctors – patients are probably seen for around 5-10 minutes but the admin work that comes with each patient can take up to 20 minutes more – sometimes this is because the records have not been accurately updated by other doctors who have previously examined the patient so a thorough understanding of the patient's history is compromised. Often, accurate notes are not written down on the records due to time constraints, resulting in error. The doctor tells me that he also often feels emotionally drained on-the-job, because we live in a society where patient relatives come across as increasingly demanding (i.e. they ask for specific tests for their loved ones), but the NHS is under-resourced and is not supposed to provide a luxury service to the patients. Often the relatives come in misinformed – they have read something on the internet or have heard about a particular, similar case to that of the patient and wish for them to be treated in the same way – sometimes it is not appropriate nor necessary and this can mean that the doctor has to spend even more time with the patient's relative in order to explain why they are/they are not doing certain medical work in the care of the patient. The doctor also tells me that patient relatives can be demanding, particularly when they come into the discussion medically misinformed, but ask for specific services which the NHS is unable to deliver as a healthcare organisation because the costs are too high, and the resources are too limited. During interactions of this kind – the doctor feels numb and scapegoated, he listens with a neutral expression on his face, or surface acts in order to manage the emotional state of the service-user. The doctor also tells me that he is aspiring toward surgery: 'medicine is not for me, I'm not a medic'.
>
> (Informal Discussion, FY1, 1.06.2018)

In this light, it appears that doctors might be guided by logics of both bureaucratic rationality, consumerism and aspects relating to professional identity at the same time – such multiplicity of logics raises important implications for the emotional labourer. The doctor shares his perspective on the level of administration associated with the medical labour process – an

already difficult aspect of the workload to manage given the high volume of patients. This aspect of the work is exacerbated by misinformed patients who enter the hospital and 'demand' specific tests/procedures. As the doctor explains, the NHS 'is not a luxury service' and that managing these issues with patients can be a burdensome task, requiring amplified levels of an influx between emotion neutrality and consumerist empathy. In addition, whilst the doctor above is clearly reflecting on issues of rationalisation and consumerism, it is also likely that he is making choices about his professional identity as a doctor. In interviews/discussions, these details are reflected on by the doctors and are thus relatively simple to tease out. In observations/practice, however, it can be difficult to distinguish between performances of professional empathy and emotion neutrality given that both of these aspects require a level of distance from the service-user – depending on the context.

### 9.3.4 The Divisions of Emotional Labour

#### 9.3.4.1 Gender

Emotional labour is considered as gendered at several levels within and outside of the organisational context. Authors have suggested that the emotional labour process is associated with the sexual division of labour (Simpson, 2007) - whereby traditionally men have been located within the world of work (and therefore rational production processes) and women have been assigned to caring/nurturance in the private realm of the home (Sturdy, 2002). The sexual division of labour is based on and continues to contribute to the split in society between personal feelings and economic production, in addition to the clear divisions which exist between rational and emotional, public and private (Grandey, 2000; Ward and McMurray 2016). In addition, the division between the private realm of the home and the public world of work compounds the already low status of 'natural', 'unskilled' women's work carried out under the facilitation of the gendered division of labour (Gray, 2008). The literature on gender and emotional labour appears to suggest that processes of performing/managing emotions is the natural domain of women (e.g. Wellington and Bryson, 2001; Gray and Smith 2000, 2009; Mulholland 2002; Simpson, 2007).

A second aspect of gender and emotional labour concerns the natural abilities of women to deliver interpersonal services (Taylor and Tyler, 2000) – an aspect which is argued to be

constructed, and thus concealed and devalued, as a natural part of doing gender (Hall, 1993; James, 1989; Adkins, 2001). Authors have shown how emotional labour processes are considered as being more suitable to women as the processes pertain to their feminine characteristics as opposed to those of masculinity. In the context of service work, therefore, managers tend to assume that female workers can accomplish more successfully the caring, emotive aspects of work involving interpersonal skills which they supposedly possess by virtue of their sexual, biological difference to men (Simpson, 2007).

Considering the above, it appears that there might be a division of emotional labour based on gender. Several authors have suggested that female workers are considerably more likely to be expected to engage within emotional labour processes in comparison to their male counterparts (James, 1989; Simpson, 2007; Gray, 2008). Other authors have shown that female workers can use their feminine traits to their advantage (e.g. Wellington and Bryson, 2001). In workplace contexts assumed to involve strong aspects of emotion and care, such as teaching and nursing, then research evidence also points to a division of emotional labour based on gender within which women are expected to engage with such processes with increased frequency and intensity (James, 1989; Smith, 1992; Simpson, 2007; Gray, 2008).

In the context of this thesis, a traditionally male profession has been chosen to offer a case study into the multiple means by which emotions are performed and managed. Aspects of gender were somewhat apparent, but not to the extent outlined above. A potential reason for this might stem from the choice of case study considered for this thesis – medicine is a traditional male-dominated career choice and most emotional and caring aspects of healthcare work is still expected from nurses or similar others. It is important to note that when asked about implications of gender during my fieldwork, then most of the doctors I spoke with did not feel discriminated against on the basis of their gender. Additionally, the data suggests that female doctors also did not feel as if they were expected to provide more of their emotions than their male counterparts. Indeed, some of the female doctors informing this thesis explained how often their male colleagues would engage within and feel affected by emotional labour processes. In considering a division of emotional labour based on gender, however, important aspects to outline concern the doctors' choice of specialism/seniority and public preconceptions of *who is doctor and who is nurse.* In terms of specialty choice,

more numbers of men were working within or towards surgical practice. In terms of seniority, this thesis also interviewed a handful of consultants – all of whom were male. This might suggest that the nature of medicine still accommodates male career progression over female.

Whilst there is a clear gender mix in this study (19 females and 21 males), gender divisions of emotional labour were somewhat apparent amongst the group examined. For example, most female doctors indicated that they have been subject to sexist remarks on-the-job. In line with societal expectations, most female doctors explained that they are frequently referred to as *nurse.* Interestingly, this study finds that the nurse label to female doctors has been so deeply embedded within medical culture that many of the doctors were unphased by it – suggesting that it should be taken as a compliment because it suggested to them that they had compassion. Other female doctors, however, were significantly irritated by being called nurse or other pet names - suggesting that it played down their status as doctors in comparison to their male counterparts.

The points raised above might further be indicative of the intense, additional pressures placed on female doctors to play up to male stereotypes, including preconceptions of the service-user population and expectations of their seniors if female doctors are to seemingly progress along the medical hierarchy. Indeed, a reason why some of the female doctors feel complimented when being referred to as *nurse* might be an example of their compassionate qualities during service interactions (i.e. in line with an orientation towards the community) which might conflict with interactions characterised by social distance/emotion neutrality etc.

#### 9.3.4.2 Experience

Whilst divisions along gender lines are important, of greater importance in the context of this study is the notion of experience within the role as a mediator of adverse effects associated with the emotional labour process. This study found that experience within the medical/surgical role allows for emotional processes of work to become increasingly familiar and therefore somewhat easier to negotiate at the frontline (e.g. Shaw et al, 2012). This notion is particularly reflective of institutional contexts which require doctors to respond to the imperatives of rationalisation/consumerism, but where doctors in the same contexts

actively choose to resist such influences and allow themselves to be guided instead by logics of professionalism and an orientation towards the community.

However, interactive elements of the labour process often required doctors to show sincere emotion. Furthermore, within circumstances in which there were unexpected diagnoses/illnesses, deaths and other unfortunate news to be delivered, then as the doctors have explained, such processes do not become routine (as Ashforth and Humphrey (1993) have otherwise claimed), and it is always a difficult aspect of medical/surgical work to accomplish. Nevertheless, with increased experience in the role, the emotional labour process becomes an easier task to perform with service-users/others.

#### 9.3.4.3 (Emotional) Role Allocation

Following the above, perhaps the most important point of discussion in relation to the division of emotional labour concerns the dehumanisation process and division of emotional work processes in relation to role allocation. In light of chapter 6, I observed two operating procedures during my time in the field: a hip replacement and a wrist fracture. During this time, through intense and revealing observations, I experienced what might be referred to as a research epiphany. This epiphany occurred in relation to the varied nature of emotional labour performances with respect to both depth and intensity of the process. Whilst observing in theatre, I noted that depths and intensities associated with emotional labour processes were divided unequally between the different roles within medicine and surgery. The specific pathway chosen, therefore, was a key indicator of the depth and intensity of the required emotional labour performance. Whilst surgical doctors engaged within dehumanisation processes of the body in order to effectively operate on the specific part/limb to be 'fixed' (e.g. Timmermans and Almeling, 2009; Haque and Waytz, 2012), anaesthetic doctors, in contrast, were required to engage within in-depth emotional labour processes in order to calm, reassure and support said patients whilst preparing them for their surgical procedure. The emotional labour processes for anaesthetist doctors extended to operating procedures if patients were to be kept awake.

The important balance required for providing professional empathy is clearly apparent in the examples offered above. Whilst surgical doctors maintain an emotional, social distance from

the patient during operating procedures, anaesthetic doctors are instead required to provide in-depth processes of reassurance, empathy and emotional support to patients who are expectedly worried and anxious about their operations.

## 9.4 Novel Insights into Pains and Pleasures

### 9.4.1 Overview of Outcomes

Following the recognition of multiple emotional labour types, the third empirical chapter outlined the pains and pleasures associated with performing emotional labour with patients, colleagues and others, and it explored the implications that such emotional work may have for professionals. Considering the data, mixed outcomes were noted in relation to the experience of emotional labour for junior doctors, supporting the notion that emotional labour can be considered a double-edged sword (Korczynski, 2002; Bolton, 2005). There were data to suggest that emotional labour allows for both positive/negative experiences on-the-job with service users and relatives.

Hochschild (1983) identified negative consequences of the emotional labour process - including exhaustion, burnout, alienation and depersonalisation. These consequences have received substantial support within associated academic literature (e.g. James, 1989; Wouters, 1989; Grandey, 2003; Smith and Lorentzon, 2005; Zammuner and Galli, 2005; Ward and McMurray, 2016). Responses to these negative consequences include compliance and feeling emotionally numb (e.g. Hochschild, 1983). Other authors have found responses to include emotional dissonance (Morris and Feldman, 1996, 1997), anger and frustration (Van Maanen, 1991) and active resistance to the emotional labour process (Van Maanen, 1991, Bolton and Boyd, 2003; Bolton, 2004).

Although negative consequences of emotional labour have been widely researched (Hochschild, 1983; Wharton, 1993; Morris and Feldman, 1997; Ward and McMurray, 2016), the associated positive consequences have received less research attention. Whilst Hochschild's (1983) analysis focused specifically on the negatives, other authors have suggested that, under certain working conditions (e.g. increased autonomy), workers might also derive meaning and pleasure from their performances of emotional labour (Korczynski,

2002). Bolton's (2005) typology addressed the issue of research focusing only on the negative aspects associated with emotional labour by showing that emotional labour processes represent a double-edged sword. There are both positive and negative consequences of performing emotional labour with service-users (Bolton, 2000a, 2000b, 2004; Korczynski, 2002). In this study, I offer support for this notion by outlining the pains and pleasures associated with the emotional labour of a junior doctor. In line with the narrative so far, I show how these outcomes are embedded within the wider institutional logics informing the texture of this thesis.

### 9.4.2 Treating Patients: Expertise

An important pleasure derived from medical/surgical work processes and associated workplace interactions is the confirmation of professional expertise for the junior doctors when treating their patients. Considering the data on this notion in chapter 7, this pleasure is clearly embedded within the logic of professionalism within a medical/surgical context. Doctors tend to derive meaning from their work and enjoy emotional encounters with their patients as a means of confirming their professional expertise. This reflects Bolton's analysis of the pecuniary and professional emotion management types – individuals receiving job satisfaction from the work that they do when their professional identities are in alignment with that of the overall organisation. Missing from Bolton's work, however, is the exploration of emotional labour under influences of contradictory logics manifesting at the frontline of hybridised institutions. In the context of Wilton, multiple logics are observed to dictate the work processes within medical and surgical services - and often at the same time. The blending and blurring of co-existing logics, impinging on work processes and emotional labour performances, helps us to see emotional work processes in a different light, particularly in contexts of changing logics within institutions. An insightful means of considering emotional labour outcomes, therefore, might be to consider the wider logics within the specific context at hand.

### 9.4.3 Gratitude and Appreciation: Self Identity

A second pleasure derived from emotional labour processes refers to feelings of gratitude and appreciation that most doctors experience on-the-job. This pleasure was observed to

help doctors confirm their sense of self-identity and altruistic nature. This outcome might be considered as being embedded within both the professional and community orientation logics. For example, there is an underlying narrative of care which plays out in the context of medicine and therefore receiving gratitude and tokens of appreciation from patients/others is likely to repair a doctor's positive self-regard and strengthen their sense of altruism. This pleasure might also be associated with emphasising the importance of treating service-users as people first, patients second, in order to truly care for their illnesses. Arguably, this outcome also pertains to an increasing sense of job satisfaction (e.g. Morris and Feldman, 1997; Korczynski, 2002; Bolton, 2005) derived from medical/surgical work – including both technical and interactive elements of the labour process.

### 9.4.4 Stress and Work Pressures

In line with the intrusion of rationalisation, associated outcomes of performing absent/neutral emotional labour often result in stress and work pressures. Perhaps it is more useful to consider these emotional labour performances as highlighting the existing stress/work pressures apparent within medical and surgical services. Recent changes to work organisations within British healthcare contexts have indicated the ongoing stresses that are pervasive within hospitals – as highlighted within opening chapters of this thesis. Associated influences of bureaucratic rationality – e.g. resource constraints, understaffing, managerial imposition and reduced autonomy – is responsible for, and further exacerbates, ongoing work intensities - resulting in additional stresses and work pressure. For example, interactional exchanges in light of the dominance of rationalisation are likely to be characterised by absent/cynical emotional labour performances. Workers are either controlled by time, restricted by resource constraints or expected to manage the frustrations of service-users. As chapter 7 highlights, these contexts are likely to add to the stresses and pressures of junior doctors.

Whilst previous work has considered outcomes of work-related stress amongst several types of healthcare professional (e.g. Bolton, 2002; Mann and Cowburn, 2005; Karimi et al, 2014; Riley and Weiss, 2016), there is a limited discussion of work-related stress amongst clinicians. Although Rogers et al (2014) have outlined work stress and resultant burnout amongst junior doctors, empirical support for this outcome in the context of medicine is limited. In addition,

researchers have not yet considered wider influences shaping these emotional labour outcomes in the first instance.

This study sought to empirically address this issue – logics of bureaucratic rationality and consumerism might both be considered to compound work-related stress levels amongst junior doctor cohorts – potentially because imperatives of such logics conflict with the professional and social motivations of doctors and because these imperatives might also be considered as reducing previously-held levels of autonomy amongst junior doctor cohorts. Associated stresses of rationalised/consumer-focused work processes and resultant emotional labour performances might also mean that doctors have a difficult time switching off from their work and feel emotionally drained on-the-job. These two outcomes are discussed below in further detail.

### 9.4.5 Difficulty Switching Off and Emotional Drainage

Additional pains associated with engaging in emotional labour processes refer to doctors having trouble in switching off from their work and experiencing an outcome that I have termed *emotional drainage*. A difficulty in switching off from work is an important outcome of emotional labour – this is likely to be embedded within logics of rationalisation and consumerism. This is because both logics influence work organisation in medicine/surgery, and therefore emotional processes of work, often against junior doctor motivations. As mentioned above, said logics are associated with doctors losing previously-held autonomy and, given that they are also resisted by doctors at the frontline, the influence of these logics on emotional labour is likely to result in adverse outcomes. A difficulty is switching off from work often means that doctors take much of their emotional/mental burdens home with them from work – managing these contexts in collective spaces is observed to make doctors feel a little better again (as will be discussed in the next section of this chapter).

In this thesis, emotional drainage is commonly associated with feelings of exhaustion. Indeed, this is referred to in associated literatures as the experience of emotional exhaustion and has been supported extensively in the context of service work (e.g. Morris and Feldman, 1997; Grandey, 2003). This pain associated with emotional labour performances might be closely aligned with the logic of consumerism. Again, this observation might be because

consumerism notions are resisted by junior doctor cohorts, and although negative effects might also be observed as being derived from other logics, other logics are also associated with the pleasures of engaging in emotional labour performances. In this thesis, consumer-focused aspects of interactional work are not particularly observed as also resulting in pleasures for junior doctors. This is perhaps because the label most doctors identify with when serving their service-users is that of the *patient*. Consumers acting as *king* within the NHS (e.g. Bolton, 2002) are not typically welcomed by junior doctors during technical nor interactive elements of work.

## 9.5 Novel Insights into Managing Emotion

The emotional demands within contexts of British hospitals constitute a source of both pleasure and pain for frontline workers. This study shows that doctors are expected to express, suppress and manage a variety of conflicting emotions during interactional exchanges with service users/relatives. In this light, following the discussion of emotional labour processes and outcomes, in this section, I discuss the multiple methods of managing emotion that doctors are observed to rely on when navigating their work. In doing so, I highlight the conceptual distinctions between emotional labour and emotion management – both processes which might be considered as being embedded within wider logics informing the texture of medical/surgical work organisation. Previous discussions in this chapter have outlined current debates on emotional labour and how the process might be influenced by multiple institutional logics. Outcomes associated with emotional labour processes at the frontline have also been discussed in relation to previous literature. In this section, I show how emotional labour performances might be managed on- and off-the job. Following chapter 8, methods of emotion management refer to a variety of individual and collective processes. This study provides empirical support for both individual/collective means of managing emotion – the theme of collective emotional labour is particularly important given that it has been neglected in associated literatures (Korczynski, 2002). In this study, collective processes of emotion management highlight the importance of social relations, shared experiences and the informal formation of communities of coping. In addition, this study reveals the role workplace humour as a collective process of managing emotion.

### 9.5.1 Individual

Several individual coping strategies have been observed in this study – the most significant of these refer to taking regular breaks from practice and to consistently engage within exercise in order to recharge from work and manage the work-related stressors/anxieties that continue to result from medical labour processes. Doctors explain the importance of these strategies as facilitating the texture of their work and helping to counter the emotionally laden experiences that doctors are expected to navigate with patients, relatives and related-others at the frontline.

### 9.5.2 Collective

The data in this thesis suggest that collective processes of managing emotion are significantly more important, and effective, than individual processes in the context of both medicine and surgery. Following the previous chapter, doctors are commonly observed to engage within collective processes of work with one another, and, on occasion, with their service-users. Some of the data suggests that doctors share positive experiences of work. This might be considered a process of collective, informal learning and therefore reflecting that of a community of practice within the medical context (e.g. Brown and Duguid, 1991). However, an important observation is that doctors are generally aware of the low morale and negativity that has been surrounding British healthcare work in recent years, specifically the work of junior doctors, and therefore they are mindful of being perceived as boastful. This is particularly important for this junior doctor cohort given that most doctors appear to be navigating quite a volatile and unpredictable period within the NHS. In addition to the sharing of positive work experiences and emotional encounters, there is significantly more evidence generated from my fieldwork to suggest that doctors rely on one another for mutual emotional support, as a means of managing their own emotions and sharing experiences of the work that might be too difficult to manage alone. An important observation in this study is that doctors enter a shared emotional space and therefore develop collective methods of coping when discussing negative emotional experiences of work. This study thus borrows Korczynski's (2003) term of *communities of coping* as a means of strengthening the collective nature of emotional labour/management within professional contexts.

In this light, the management of emotion appears to be a social, collective process. Whilst the theme of *collective emotional labour* was originally recognised in Hochschild's (1983: 114) work, it remains an underdeveloped concept. Hochschild (1983) suggested that the emotional tone of airline attendants was set by the upbeat banter they were observed to swap with their passengers. Emotional labour might also be considered a collective phenomenon in the sense that airline attendants were observed to rely on one another for mutual emotional support. However, just as this discussion begins to intrigue the audience, Hochschild moves onto outline a different topic. In this way, the collective theme of emotional labour remains neglected and underdeveloped.

Since the introduction of this concept, however, by highlighting the importance of social relations within the context of call centre work, Korczynski (2003) has strengthened our understanding of collective emotional labour within service industries. Through an analysis of four call centre organisations, Korczynski (2003) has shown how frontline workers form informal social relations in order to manage their experiences of irate/abusive customers. Despite the acknowledgement by Korczynski (2003) that the application of communities of coping might be limited to the context of call centre work, given that in this type of workplace, collective coping can develop during the labour process. Other researchers have provided empirical support for the concept in several workplaces, including contexts of healthcare (e.g. Lewis, 2005; Shaw et al, 2012; Cricco-Lizza, 2014). Whilst much of this work considers the experiences of nursing, empirical support for collective processes within medicine remain limited. This study addresses this gap in our knowledge. A very important observation in this study is that doctors constitute a large, cohesive and collegial group who bond with one another and share work experiences. With increasing demands for emotional labour, doctors congregate in safe spaces in order to debrief with one another and negotiate workplace tensions. Considering the data outlined in the previous chapter, an important aspect of the emotional labour process is being able to manage emotions backstage with similar others. This provides junior doctors with a sense of solidarity and unity from their colleagues - which might otherwise be taken away during aspects associated with the medical/surgical labour process. In this light, by highlighting the importance of managing emotions backstage, I hope to have made a clear distinction between emotional labour performance with service-users/others and emotion management processes which occur away from the frontline of

work. Just as with the multiple performances of emotional labour, it is likely that there will also be overlaps with methods of emotion management backstage. Indeed, some research has highlighted that frontline staff manage their emotions whilst performing emotional labour with service-users (e.g. Bolton, 2002; Mawhinney, 2008). However, it is helpful to allow for conceptual distinctions between processes of emotional labour and emotion management. In line with the data of this thesis, the emotional labour process is mostly observed through interactional exchanges with service-users and others, and the emotion management process appears to occur backstage through collective methods of coping and sharing experiences of the job.

#### 9.5.2.1 Importance of Humour

Further to the above discussion, the last section of this chapter seeks to outline the importance of workplace humour within contexts of medicine and surgery. Following the data analysed in the previous chapter, the role of humour appears to be quite an important one within British healthcare services. Workplace humour has been explored in several different organisations (e.g. Sanders, 2004; Mawhinney, 2008; Korczynski, 2011) - as constituting forms of workplace resistance (e.g. Taylor and Bain, 2003; Mallet and Wapshott, 2014) and as a means of negotiating different aspects of work (e.g. Mawhinney, 2008; Bolton, 2000b, 2004b). In line with Korczynski's (2011) analysis of humour within a taylorised factory setting, central to this study are the social relations formed by doctors as a contextual element of workplace humour. Humour was observed in both the technical and interactive aspects of the labour process and within and between professional cohorts. In this light, central to workplace humour within medical/surgical contexts is the observation of social relations and therefore its collegial, collective texture. Humour is thus considered as an important method of collective coping. Indeed, it is also considered collective in the sense that it tends to form a significant element of the shared discussions that doctors engage within.

In this study, the role of workplace humour has been explored within the technical and interactive labour process. In relation to technical aspects of work, the routine navigation of medicine and surgery frequently involves the role of humour. For example, as analysed in chapter 8, doctors are observed to ridicule and make jokes with each other about the institutional context of the NHS. This suggests that the role of workplace humour constitutes

an important mode of collective coping at work. In addition, in relation to interactive elements of medical/surgical work processes, humour was observed during interactional exchanges between doctors and service-users and was often relied on as a collective process between colleagues, patients and relatives at the organisational frontline. Importantly, specific aspects of healthcare work allow for humour to constitute an element of the labour process – further suggesting that humour might provide a means by which doctors manage their emotions on-the-job. In the context of the operating theatre, for example, often patients would be under anaesthesia and therefore doctors are able to humour one another, make jokes about the patient and be silly during the labour process. Often doctors need to be reminded, for example, that a patient is lying on the bed, under the blue sheets (e.g. Dr Tsansaraki, CST1) – with senior members of staff suggesting to the juniors that they should tone down their fun.

Although this thesis did not set out to contribute to studies on workplace humour, an important observation is that humour is embedded within micro-social processes of medicine and surgery, and its role can be interpreted as a collective mode of coping at both the frontline/backstage of work. In this study, I feel that the role of workplace humour is important for the routine navigation of work-related processes (e.g. Korczynski, 2011), as a means of negotiating workplace tensions/conflicts (e.g. Mawhinney, 2008) and as a collective response to getting through the work (e.g. Bolton, 2000b). This study therefore provides additional support for previous work which has explored workplace humour as a means of managing work-related processes.

In light of above discussions, the table below presents an institutional logics perspective on emotional labour, emotion management and its associated pains and pleasures. Also detailed within this framework is the process of enactment – this is the extent to which workers allow for the imperatives of multiple institutional logics to guide their work.

Table 3: An Institutional Logics' Perspective on Emotional Labour

| **Institutional Logic** | Bureaucratic Rationality | Professionalism | Consumerism | Community Orientation |
|---|---|---|---|---|
| **Emotional Labour** | Emotion Neutrality | Professional Empathy | Consumerist Empathy | Social Empathy |
| **Enactment** | Resisted | Chosen | Resisted | Negotiated |
| **Pains and Pleasures** | Stress<br>Work Intensification<br>Difficulty Switching Off | Satisfaction<br>Gratitude<br>Confirmation of Expertise | Stress<br>Drainage<br>Exhaustion | Satisfaction<br>Gratitude and Appreciation |
| **Managing of Emotion** | Collective<br>Individual | Collective | Collective<br>Individual | Collective |

## 9.6 Thesis Contributions

This thesis has made an important step forward in empirically and theoretically contributing to debates on the emotional labour topic. Empirically, I have provided insightful accounts of medical and surgical emotional realities – in light of the dataset which consists of 40 interviews and rich observation fieldwork. There is limited literature concerning the emotional labour of junior doctors, and in considering the changing institutional context of medicine, in which multiple, contradictory logics are brought to the organisational frontline, the demand for emotional labour performance appears to have significantly increased in recent years. Given intentions to prematurely leave the medical profession and issues in relation to work-related stress, an important rationale for conducting this work was to explore the workplace realities of frontline doctors and to uncover how their issues might be addressed in both practice and theory.

Theoretically, I have contributed to the literature by outlining a new, institutional perspective on the performance and management of emotional labour. In doing so, I have built upon and extended the important work of key authors in the field and have offered new insights into the technical and interactive elements of work within an institutional context of great

importance. This study shows the utility in introducing the institutional logics perspective as informing the study of emotional labour.

I have also provided additional support for important themes in relation to emotional labour processes and outcomes. This study shows, for example, that there are clear divisions of emotional labour within the contexts of medicine and surgery. The most important of these divisions, I believe, is that which I observed within operating theatres in relation to processes of dehumanisation and emotional role allocation. I also feel that that the theme of collective emotional management (neglected in the seminal work of Hochschild) has been addressed in this thesis. By teasing out differences between emotional labour as being a process of work at the frontline, and emotion management as being a means of coping with associated outcomes backstage, then I feel that I have provided further support for the importance of social relations and shared experiences within the context of British healthcare, and by extension other similar professional contexts.

An important issue to address, in light of this thesis, however, is that of the blending and blurring of logics at the frontline of work – detailed above. Despite the combination of interview and observation data, a methodological issue raised by this study is the possibility of truly knowing reasons for emotional labour processes. Whilst the institutional logics perspective offers a valuable insight into the performance of emotion at work, associated pains and pleasures and methods of coping, it remains a difficult task to exactly tease out processes of emotion work within technical and interactive contexts.

## 9.7 Summary

This chapter has provided a summary of the findings of each of the data chapters and has contextualised these findings within the broader streams of literature. The chapter has also detailed the empirical and theoretical contributions of the thesis.

# Chapter 10: Conclusions

## 10.1 Introduction

This chapter concludes the thesis. An overview of the study is provided, empirical and theoretical contributions are articulated, and methodological considerations are explored. Limitations and directions for future research are then outlined and recommendations for practice follow. The chapter closes with final thoughts and reflections on the PhD journey.

## 10.2 Thesis Overview

This thesis sought to contribute to existing debates on emotional labour. The NHS case study of junior doctors has offered a rich insight into the emotional realities of frontline medical and surgical work – a previously under-explored research context. British healthcare has been subject to radical organisational change and reform since the inception of the NHS – the medical profession is still one which faces considerable institutional challenges (Vijendren et al, 2015). In light of recent industrial strike action and contractual changes to junior doctor work arrangements, the medical context has offered an important and fitting case study to extend debates on the emotional workplace. The ethnographic exploration of both medical and surgical work processes provided several new insights to the emotional labour of doctors in both of these clinical specialties.

A key finding of this research is the influence of institutional logics on the medical, surgical and emotional labour process. Each logic is observed to motivate, constrain and/or restrict elements of doctors' work processes, and therefore the means by which doctors offer emotional labour. Key logics identified in this study refer to bureaucratic rationality, professionalism, consumerism and an orientation towards the community. These logics each, respectively, have important implications for emotional labour types of emotion neutrality, professional empathy, consumerist empathy and social empathy. The study also examined how doctors navigate these influences through processes of resistance, choice and negotiation. Whilst the institutional context is most likely to inform these navigation processes, this study also found instances where professional agency and meaning making might inform the medical, surgical and emotional labour process. Whilst institutional logics guide micro-level work processes from the top-down, for example, the study also recognises

the influence of doctors' agency and meaning-making from the bottom-up – particularly when doctors *choose* professionalism over more dominant logics. In addition, whilst doctors are observed to resist the wider rationalisation of work, they are also observed to negotiate their emotional responses to an orientation towards the community – seeking to *make a difference* to the lives of their patients and others. Whilst these findings are not central to the thesis, they do provide a promising avenue for future research on emotional work processes within medicine.

The central contribution of this thesis is the application of the institutional logics perspective to the performance of emotional labour. This, I argue, is a useful perspective as it allows us to consider how the nature of emotional labour is linked to broader changes in management and organisation (e.g. Curley and Royle, 2013). In this way, it links the study of emotional labour with extant analysis of organisational change in public services in general, and within healthcare settings in particular.

This study has also outlined the pains and pleasures associated with technical and interactive elements of the medical and surgical labour process. Pains and pleasures associated with the emotional labour process are only briefly acknowledged within sociological and organisational literatures (e.g. Korczynski, 2003; Bolton, 2005). This study therefore provides support for emotional labour literature which suggests that emotional processes of work represent a double-edged sword (Bolton, 2005). Performing emotional labour with patients, relatives and others can be both painful and pleasurable depending on the institutional context and the nature of the interaction. In addition, the study finds that junior doctor work experiences, namely interactional exchanges between doctor and service-user, are managed both collectively and individually, on (and off) the-job. Medicine is largely experienced as a *shared experience* with colleagues and others.

## 10.3 Contributions

This thesis has empirically and theoretically contributed to debates on emotional labour processes. Empirically, I have provided accounts of medical and surgical emotional experiences – in light of an illuminative dataset of 40 interviews and rich, ethnographic observation work. As noted, literature concerning the emotional labour of doctors is currently limited and thus

presents a research gap. Moreover, several individuals have identified changes in the constellations of institutional logics guiding healthcare organisations (Reay and Hinings, 2009; Currie and Spyridonidis, 2016), which we may expect to place additional emotional labour demands on healthcare professionals. In addition, there are premature departures from the medical profession within the UK – this provides an important rationale for exploring workplace experiences of frontline doctors. Workplace stress/burnout are likely to contribute to doctors' decisions to leave the profession. It is thus important that such issues are addressed in both practice and theory (see sections below).

Theoretically, I have contributed to existing debates on emotional labour by offering an insight into how institutional logics shape the performance and management of workplace emotion. In doing so, I have extended the important work of key authors in the field (e.g. Hochschild, 1983; Bolton, 2005) and have offered new insights into the technical and interactive elements of work within an increasingly changing institutional context. This study thus highlights the relevance of exploring institutional logics as informing emotional labour processes within professional work contexts.

In addition, this study highlights that there are clear divisions of emotional labour within the contexts of medicine and surgery. Divisions of emotional labour processes within the theatre context was perhaps the most important one that I observed – in relation to processes of dehumanisation and emotional role allocation. In addition, the theme of collective emotion management (neglected in the seminal work of Hochschild) has been addressed in this thesis. By teasing out differences between emotional labour as being a process of work at the frontline, and emotion management as being a means of coping with associated outcomes backstage, then I have provided further support for the importance of social relations and shared experiences within the context of British healthcare, and by extension other similar institutional contexts.

In addition to the above, there is an opportunity to generalise findings from this thesis to other similar contexts following the logic of analytic generalisation (Yin, 2013). The exploratory case study is used to inform this thesis (Flyvbjerg, 2006; Saunders et al, 2016). This type of case study closely resonates with Stake's (2005) definition – he suggests that the exploratory case is specific, interrelated and purposive. It rests on constructionism or

constructivism and considers a holistic approach to the gathering of qualitative data. The exploratory case is also empirical, interpretive and emphatic (Stake, 2005).

Whilst there remains difficulty in generalising qualitative case study findings to other contexts, Flyvbjerg (2006) and Ruddin (2006) defend the concept of qualitative generalising – suggesting that cases can be generalised to other similar circumstances and situations given the in-depth analytical investigation involved (Yin, 2013). Yin (2013) suggests that generalisations from qualitative case studies are not intended to offer 'proof' of a phenomenon/finding in a statistical sense. Instead, such generalisations build theoretical premises which function as an important analytical tool to make assertions about other contexts similar to the one studied. This notion reflects the term analytic generalisation (Lincoln and Guba, 2000; Yin, 2013). In this light, there is an opportunity to generalise from this research context to others that are similar. Similar contexts to that which has been examined in this study refer to other professional institutions. These contexts include higher education and legal services – where competing institutional pressures also appear to impinge on the work organisation and emotional labour processes of frontline professionals in similar ways. This opportunity to generalise to other contexts (e.g. within healthcare settings specifically or within other professional institutions, more generally) offers an exciting avenue for future research. Ideas on generalising from this study are therefore highlighted in section 10.5 as offering fruitful directions for future research.

## 10.4 Methodological Considerations

I chose the exploratory case study approach for this study (e.g. Stake, 2005) – combining interview and ethnographic research methods. This allowed me to explore the institutional context in which the doctors practiced medicine and surgery. As an ethnographer, an insight into this context allowed me to identify and observe key institutional logics play out at the organisational frontline of healthcare settings. This insight also helped me to observe the means by which doctors choose, resist and negotiate institutional influences upon their labour processes. The practices, conflicts and tensions that manifest within and between the physical spaces of an institution also became clear to see. For example, ethnographic observations offered an insight into the working conditions of doctors on ward areas, the small breakout rooms that doctors took breaks in and the doctors' office space, with a

capacity of two or three people, but which continuously had people entering and leaving for information and updates.

In addition, conducting an ethnographic case study allowed for an immersion of *me* within the research context. During early weeks of field work, for example, I felt somewhat distressed when observing specific interactions between doctors, patients and relatives – particularly in contexts where doctors were required to relay bad news to patients/relatives. Observing the calm within doctors suggested to me that they had developed methods of coping with emotional experiences to protect themselves and to be successful in the field. One particular observation, in which I shadowed a senior registrar 'breaking bad news' to an elderly patient's son and daughter, left me in tears. I spoke with the registrar following the incident – who was calm, collected, empathetic and distant whilst she allowed the relatives to process the information. This doctor appeared to be drawing on professional empathy at the time – she explained to me that whilst it never becomes easy, experience in the role helps to manage the emotional aspects of the work. This sparked an interest in observing junior doctors of different training grades in order to explore the impact of experience on the emotional labour process – as highlighted in chapter 9.

During my time in the field, I was also able to identify with the doctors and build a rapport with many of them. They would then use me as a sounding board during observations in a way that suggested they either had little opportunities to discuss their work experiences on-the-job or they felt frustrated all the time. With increasing exposure to the institutional context, I learnt that both of these options were true – doctors tended to feel frustrated with low morale characterising the work environment and they had little opportunity to discuss their frustrations on-the-job, as noted in chapter 8. Doctors also used me as a counsellor during interviews in which they chose to 'offload' or release their pent-up anger/frustrations at the system. Some of the doctors also explicitly asked me if my research could help fix the institutional limitations of the Trust, and by extension the NHS. These observations are of central importance to this thesis and would have been much more difficult to uncover without spending extending periods of time with the doctors in their places and spaces of work.

Despite the important points highlighted above, the use of the case study method places limits on opportunities for generalisation to other institutional contexts. This is acknowledged

in more detail in the last section of this chapter. A further important issue to address is that of the blending and blurring of logics at the frontline of work. Despite the combination of interview and observation data, a methodological issue raised by this study is the impossibility of truly knowing reasons behind emotional labour processes. Whilst the institutional logics perspective offers a valuable insight into the performance of emotion at work, associated pains and pleasures and the methods of coping, it remains a difficult task to exactly tease out processes of emotion work within technical and interactive contexts.

## 10.5 Limitations and Directions for Future Research

A wealth of data has been generated by this study. Whilst some scholars may view the qualitative case study design as limited in that it can be difficult to extrapolate findings to other contexts (e.g. Saunders et al, 2016), several methodologists have considered the potential for such generalisations in terms of theory building/and extension (e.g. Lincoln and Guba, 2000; Stake, 2005; Flyvbjerg, 2006; Yin, 2013). As noted in sections above, there is a clear opportunity to generalise from this case study in light of Flyvbjerg's (2006) notion of qualitative generalising. I believe it is also important to open further avenues of research in order to consider new ideas and explore the essential issues that continue to raise implications for employees of the new emotional workplace. It is therefore hoped that this thesis will facilitate the grounding for further research on emotional labour debates. Promising generalisations are thus considered in this section as directions for future research.

### 10.5.1 Healthcare Contexts

In light of this thesis, directions for future research might consider the influence of institutional logics on emotional labour processes within several other healthcare contexts. This study, for example, observed the context of one NHS Trust – that of Wilton. Analysis could be developed by examining the identified logics within other hospital settings within the UK. This would help to highlight the importance and relevance of the institutional logics perspective for furthering our understanding of emotional labour processes. In addition, in light of the current COVID19 pandemic, it might also be important to consider the emotional work processes of doctors and explore the implications of this in terms of staff wellbeing and mental/emotional health (e.g. Greenberg et al, 2020). Following this, important interventions

might then be outlined and addressed as a means of helping healthcare professions to manage these aspects of work.

### 10.5.2 Medicine and Surgery

This study originally sought to explore the emotional labour process of junior doctors within medicine and surgery as two distinctive clinical specialities. Given the limits of a PhD thesis and the difficulties in obtaining NHS approval for research, the remaining time-frame did not quite allow for a comparative study exploring emotional work processes in medicine and surgery, with surgeons being very difficult to obtain access to by nature of their work. Despite this issue of access, I was able to shadow a handful of surgeons within and outside of the operating theatre and thus I have been able to make some comparisons of emotional processes at work in light of the medical and surgical labour process (most specifically in relation to the emotionless theatre, dehumanisation process and divisions of emotional labour). However, an interesting avenue for future research might be to extend this ethnographic study and to observe differences between the emotional labour of medics and surgeons. These specialities provide an insight into the complexities of a doctor's work organisation – with this study highlighting the importance of social distance and professional empathy as a means of engaging in emotional processes of work. A more purposeful exploration of emotional labour processes of both surgeons and medics will thus offer further insight into the emotionless theatre, dehumanisation processes and other divisions of emotional labour. Whilst these aspects have been considered as important discussion points in this thesis, they have not been commented on in significant detail.

### 10.5.3 Professional Institutions

As highlighted above in section 10.3, a third direction for future research might be to step away from the healthcare context and to observe that of other professional institutions – namely higher education/academic contexts which appear to be facing similar institutional pressures in terms of wider rationalisation of work, the decline in professionalism, an increase in student expectation and the desire to make a difference to academic journeys. The institutional logics perspective as influencing emotional labour processes might thus also be observed in the work of academics employed within higher education institutions.

Considering the recent strike action within these workplaces by professors of all grades, insightful observations are likely to be revealed in terms of academic and emotional labour processes.

## 10.6 Recommendations for Practice

Following the above, recommendations stemming from this thesis are outlined below. These are categorised under the heading: Implications for Management.

### 10.6.1 Implications for Management

This study highlights several institutional challenges in relation to emotional labour and retention, premature departures from the medical profession, exhaustion/burnout and emotional/mental wellbeing. This study thus raises important implications for practice.

Associations between emotional labour processes and wellbeing have been well-established in the literature. Healthcare settings face increasing challenges – particularly in terms of the retention of doctors, and indeed other healthcare workers. In this thesis, exploring the relevance of the institutional environment as shaping experiences of emotional labour has been a central focus – facilitated by a discussion of key institutional logics and how these might shape emotional work process. It follows therefore that an appreciation of institutional contexts in light of emotional labour offers important opportunities for improving practice and management. In sections below, recommendations are offered which serve the potential to address some of the negative implications associated with the emotional labour process.
These recommendations are discussed in light of the logic of bureaucratic rationality – given its dominance as an institutional logic and its resultant negative outcomes for junior doctor cohorts. Challenging aspects of the medical labour process often pertain to the logic of bureaucratic rationality – for example those associated with resource constraints, understaffing and imposing managerialism. These aspects in combination provide a difficult space for doctors to conduct their work. A reorganisation of services to improve the working conditions of doctors, and other healthcare staff, is an unlikely outcome in the increasingly constrained and pressurised NHS. More practically, however, managers might focus on smaller-scale institutional changes that are both more feasible to achieve and which may help to improve the working experiences of healthcare professionals.

Challenges in relation to resource constraints – including limited time on-the-job and issues of understaffing – have a direct impact on the texture of emotional encounter between doctor and patient, relative or other. The emotional labour in response to the user is often quick, unmeaningful and *rationalised* as doctors are required to meet patient expectations in light of increasing work pressures and limited time frames. There is clearly an impact on quality service delivery in these contexts – rationalised encounters often result in increasing patient frustrations and thus issues of scapegoating. Emotional labour responses to said scapegoating tend to result in emotion neutrality. Given that doctors must enact emotional labour within limited time frames and respond to issues of scapegoating, they also limit their connections with patients/others in order to shorten the interaction they offer. In this light, there is an impact on the quality of patient experience.

Other implications for human resources are raised as a result of widespread consumerism within the NHS. Previous research has also noted issues of *consumer as king* within healthcare contexts and the impact this has on healthcare staff (e.g. Bolton, 2002). Nurses, for example, tend to surface act with consumer-like patients. However, changing logics within organisational contexts has resulted in doctors managing patient/relative expectations and this can prove a challenging/draining aspect of the work. In this study, for example, many doctors comment on situations in which patients/relatives are misinformed in relation to available medical treatment or maintain too high expectations of the British healthcare system. One way in which issues of consumerism might be addressed is to manage public expectations of the NHS in terms of what is and what is not feasible for various medical illnesses/conditions.

These findings are relevant for those leading on issues of service delivery, resource allocation and hospital management – resource constraints, understaffing and limited time frames for work have important implications for doctors' emotional labour processes. Whilst it is important to provide timely care to patients, with a fair distribution of resources across the scale of the national service, it is important to recognise the indirect impact of such *rationalisation* – most importantly, the texture of junior doctor emotional labour. Indeed, issues of this nature have informed junior doctor decisions to prematurely to leave the profession (Lambert et al, 2018). These findings and recommendations are also important for

healthcare policy, at the general level. As the NHS continues to respond to competing institutional pressures (e.g. professionalism versus bureaucratic rationality), the implications for those who offer routine emotional care in an under-resourced institutional environment also continue to grow. Whilst increasing attention is being offered to the wellbeing of healthcare staff, partly seeking to address issues of recruitment, retention and turnover of healthcare workers, limited attention, if any at all, is being given to the pains and pleasures associated with emotional labour processes.

Also important to those managing service delivery within the NHS is the relentless need to manage emotions on-the-job, engage in emotional labour processes with patients, relatives and others and to be offered little backstage space to cope with intense emotional processes of work. These issues tend to be exacerbated by the increasing workload and intensity associated with being a junior doctor. However, this study also reveals that the space within which doctors practice offers little opportunity for offstage offloading/collective experiences at work. Whilst doctors have expressed the importance of collective, shared experiences, there is still inadequate institutional support to allow for this. Small doctors' offices (with capacity for 2-5 people) and the doctors' mess space located at a significant distance means that when doctors do find some opportunity to collect themselves, emotionally, this presents itself as an additional challenge and often occupies doctors' personal time. The recommendation for counterbalancing the pains of emotional labour, therefore, might also extend to ensuring adequate space for doctors to alleviate emotional experiences offstage/backstage and away from patient vicinities. Schwartz rounds have been implemented in several British hospitals, yet not all, and the doctors' mess space appears to be of mainly symbolic value, with doctors not finding the time to catch up in these spaces given the heavy workloads. Indeed, during observations within the doctors' mess, I only noticed a handful of doctors making use of the area – either on computers or catching up with sleep, and especially not for the collective purpose for which these spaces were first introduced into hospital medicine.

## 10.7 Final Thoughts

At the beginning of this thesis, an exploration of emotional labour within the medical context was considered important in light of increasing institutional complexity. As this study has

shown, the NHS appears to be informed by multiple institutional logics. Said logics have been observed to impinge on the medical, surgical and emotional labour process within Wilton Trust. The end of this thesis, however, has witnessed the outbreak of the terrible COVID-19 pandemic. The final stages of writing and editing this work occurred in a state of national lockdown. During this time, I constantly thought about how doctors, nurses and other healthcare professionals continue to fight on the frontline of this virus, and how I appreciate the importance of their work even further. I recognise the implications that this pandemic is likely to have for all key workers during this time – and specifically in the context of healthcare. As already highlighted by Greenberg et al (2020), for example, COVID-19 is likely to raise significant implications for the emotional and psychological wellbeing of healthcare workers. It is therefore recognised that the demand for emotional aspects of work within medicine, and indeed other healthcare professions, is likely to continue to increase in the near future – resulting in pains and pleasures and managed on/off the job with important peers/support networks.

Despite the above, I do feel inspired by the possibilities offered by the findings of this thesis. I am also enthusiastic that this PhD is only the beginning for what I envision will be a lifelong career of research on a topic of great importance. As stated, I believe that the implications raised from this study have the potential to improve the working experiences of junior doctors; and interventions are important now more than ever in light of the current pandemic. Whilst this thesis has shown the importance of exploring emotional labour within the medical context, I feel that this study also raises important implications for professionals employed within similar institutional contexts (e.g. higher education). As mentioned above, fruitful directions for future work in this area might include further analyses of healthcare work – within and between the different healthcare professions. Future research in this area might also include an analysis of other, similar professional institutions – including but not exclusive to the academic context. For my career as an academic, I am devoted to the exploration of emotional pressures on professional work.

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# Appendices

## Appendix 1: Consent Form

**Title of Study: Emotional Labour Experiences of Junior Doctors.**

**IRAS Project ID:** 229928

**Name of Researcher**: Priyanka Vedi

**Name of Participant:** **Please initial box**

1. I confirm that I have read and understand the information sheet version number 4.0 dated 31.07.2017 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview/ will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐

6. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |

2 copies: 1 for participant, 1 for the project notes.

# Appendix 2: Information Sheet


Participant Information Sheet

(Draft Version 4.0 / Final version 1.0: 31.07.2017)

IRAS Project ID: 229928

**Title of Study:** Emotional Labour in Medicine.

**Name of Researcher(s):** Priyanka Vedi

**Chief Investigator:** Professor Marek Korczynski

**Co-Investigator:** Dr Simon Bishop

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

**What is the purpose of the study?**

The purpose of this study is to explore the emotional management undertaken by junior doctors within the NHS. This is known as the theory of emotional labour; it was originally introduced by Arlie Hochschild. The study is being undertaken as part of a PhD qualification in Business and Management.

**Why have I been invited?**

You are being invited to take part because you are a member of medical staff in the targeted professional group for this study. We are inviting approximately 25 participants like you to take part.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

**What will happen to me if I take part?**

You will be invited to take part in an interview with the researcher. This will be on a one-to-one basis and is expected to last approximately an hour. It is likely that just one interview will be necessary for this study. During the interview process, the interviewer will ask you about your work experiences and job role. Some of the questions asked will be pre-scripted and others will be a result of the conversation between the participant and interviewer. The interviews will be recorded via an electronic device (Dictaphone) for transcription purposes. This research will take place at a time and place convenient to the participant. Observations will also be carried out on the chosen wards.

**Expenses and payments**

Participants will not be paid (an inconvenience allowance) to participate in the study.

**What are the possible disadvantages and risks of taking part?**

There are unlikely to be any physical risks or disadvantages of taking part in this study. However, it is both acknowledged and appreciated that discussing previous (emotional) experiences can be uncomfortable for participants. Accordingly, the confidentiality of all participants, their stories and experiences, will be treated with sensitivity, care and respect.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help to understand the impact of emotional management and how this may influence patient care and medical staff experiences.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details

are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Justin Waring:

justin.waring@nottingham.ac.uk, Nottingham University Business School.

**Will my taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for 6 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

**What will happen if I don't want to carry on with the study?**

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

**What will happen to the results of the research study?**

This research is being undertaken as fulfilment of a PhD – it is part of an educational qualification. It is likely that the results of this study will be published in an academic journal(s) and also disseminated during research conferences and workshops etc. This is a continuous process during the course of the PhD but is most likely to take place upon completion of the project (i.e. 2019/20). You will not be identified in publications/reports.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and is being funded by Nottingham University Business School.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham Research Ethics Committee.

**Further information and contact details:**

**PhD Researcher:** Priyanka Vedi
Nottingham University Business School
lixpv13@nottingham.ac.uk
**Chief Investigator and Supervisor:** Prof. Marek Korczynski
Nottingham University Business School
marek.korczynski@nottingham.ac.uk
**Co-Investigator and Supervisor:** Dr. Simon Bishop
Nottingham University Business School
simon.bishop@nottingham.ac.uk

# Appendix 3: Interview Guide

**Emotional Labour Experiences of Junior Doctors: Questions for Interview Guidance.**

**Introduce self – PhD Student at UoN**

**Introduction to study: to explore the experiences of junior doctors working with patients and colleagues.**

**Questions aimed at individual emotional management:**

Could you tell me about how you chose medicine/surgery as your option for specialist training? (Also potentially follow up on any mention of issues relating to relationship with patients.)

What are the key aspects of your role?

What do you feel is generally expected of you in terms of professional behaviour and how you treat your patients? (Stocism/Care/Professional conduct).

Could you tell me about some of the positive aspects of your role and how these make you feel?

Can you tell me about some of the challenges you face working here with patients? Is it sometimes hard for you then?

(Why/ How so?)

Do you think it will be hard in the future also? How do you know what is expected of you?

Could you tell me more about your interactions with patients in a typical day please? How many patients would you expect to typically see, and how long do you have to speak to each patient?

Can you tell me about some of your positive interactions with patients – what makes you feel that it has gone well?

Can you tell me about some of your negative interactions? How has it gone less well for you?

Do you think it is difficult these days to support patients/make close relationships with them? Why?

Several pieces of research discuss that there isn't enough time to support patients – do you think this applies here? How so?

How do these time constraints make you feel? Would you prefer to have more time with your patients?

Research also talks about the rise of consumerism (i.e. Bolton, 2002) - do you believe your patients are more like customers now? For example, are they more demanding or do they expect a different type of service?

Do you think this influences the way you treat your patients?

Sometimes, do you feel stressed at the end of, or during, a working day? In what way, how frequently?

Are you able to switch off from work easily? Do you sometimes think about your working day when you are not at work?

Do you have any strategies/techniques for coping with the stress and strains of work?

Although things have obviously changed in terms of composition of the workforce, medicine was once traditionally a male occupation. Do you feel patients treat you differently because you are a woman?

Is the organisation/hospital doing stuff to help you cope with the stresses and strains of work, or learn from your experiences? Do they make you have training?

Can you tell me a little bit more about your on the job training please?

Do you tend to catch up with colleagues/friends when in training?

**Questions aimed at collective emotional management:**

Who do you tend to share issues with – is it other doctors in training?

Senior colleagues?

Other professional colleagues and workmates from the department you work in?

Does sharing issues with colleagues help you to let off steam (cope)?

Do you find that you remember positive experiences with patients as well as negative ones?

Do you tend to discuss both of these types with colleagues/friends? How does this help you?

Is there anything more you would like to tell me about your working experiences? i.e. with colleagues/patients?

Do you have friends at work? Do you work together much?

**Thank you for your time!**

# Appendix 4: Letter of HRA Approval

NHS
Health Research Authority

Professor Marek Korczynski Nottingham University Business
School Jubilee Campus, Wollaton Road Nottingham Email: hra.approval@nhs.net
NG8 1BB

24 October 2017

Dear Professor Korczynski

**Letter of HRA Approval**

| | |
|---|---|
| **Study title:** | **Emotional Labour in Medicine** |
| **IRAS project ID:** | **229928** |
| **Protocol number:** | **17073** |
| **REC reference:** | **18/HRA/0270** |
| **Sponsor** | **University of Nottingham** |

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

**Participation of NHS Organisations in England**

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

*Appendix B* provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

**Appendices**

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

**Scope**

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

**User Feedback**

The Health Research Authority is continually striving to provide a high-quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

**HRA Training**

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **229928**. Please quote this on all correspondence. Yours sincerely

Maeve Ip Groot Bluemink Assessor

Email: hra.approval@nhs.net

*Copy to:* *Ms Angela Shone, University of Nottingham – Sponsor Contact*
*R&D, Nottingham University Hospital NHS Trust – Lead R&D Contact Miss Priyanka Vedi, University of Nottingham – Student*
*Dr Simon Bishop, University of Nottingham - Supervisor*

**Appendix A - List of Documents**

The final document set assessed and approved by HRA Approval is listed below.

| *Document* | *Version* | *Date* |
|---|---|---|
| Copies of advertisement materials for research participants [EL Poster] | Final Version 1.0 | 31 August 2017 |
| Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) | | 26 July 2017 |
| HRA Schedule of Events | 1 (HRA final) | 16 October 2017 |
| HRA Statement of Activities | 1 (HRA final) | 16 October 2017 |
| Interview schedules or topic guides for participants [Interview Guide] | 1 | 31 August 2017 |
| IRAS Application Form [IRAS_Form_07092017] | | 07 September 2017 |
| Letter from funder [Nottingham University Business School PhD Scholarship 2016/17] | | 14 March 2016 |
| Letter from sponsor | | 06 September 2017 |

| | | |
|---|---|---|
| Participant consent form | 2.0 | 18 October 2017 |
| Participant information sheet (PIS) [Participant Information Sheet] | Final Version 1.0 | 31 August 2017 |
| Research protocol or project proposal | 1.0 | 31 August 2017 |
| Summary CV for Chief Investigator (CI) [Korczynski CV] | | |
| Summary CV for student [Priyanka Vedi CV] | | |
| Summary CV for supervisor (student research) [Simon Bishop CV] | | |

**Appendix B - Summary of HRA Assessment**

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations*, *capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.**

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Ms Angela Shone Tel: 0115 8467906
Email: sponsor@nottingham.ac.uk

**HRA assessment criteria**

| Section | HRA Assessment Criteria | Compliant with Standards | Comments |
|---|---|---|---|
| 1.1 | IRAS application completed correctly | Yes | The applicant confirmed that this research study only involves NHS staff. |
| | | | |
| 2.1 | Participant information/consent documents and consent process | Yes | Changes were made to the CF to align it with HRA Approval standards. |
| | | | |
| 3.1 | Protocol assessment | Yes | No comments |
| | | | |
| 4.1 | Allocation of responsibilities and rights are agreed and documented | Yes | A Statement of Activities has been submitted and it is intended for this to be used as the contract between the Sponsor and NHS sites. |
| 4.2 | Insurance/indemnity arrangements assessed | Yes | Sponsor's insurance policy will cover the design, management and conduct of the study.<br><br>NHS indemnity will apply for the conduct of the study while on NHS premises/under the duty of care of the |

| Section | HRA Assessment Criteria | Compliant with Standards | Comments |
|---|---|---|---|
| | | | NHS.<br><br>Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study |
| 4.3 | Financial arrangements assessed | Yes | Funding has been secured from the Nottingham University Business School Scholarship.<br><br>There will be no financial provisions to the sites. |
| | | | |
| 5.1 | Compliance with the Data Protection Act and data security issues assessed | Yes | The applicant confirmed that no personal identifiable data will be included in the transcriptions.<br><br>Forms containing personal data will be stored in a |

| | | | |
|---|---|---|---|
| | | | locked cabinet in the Chief Investigator's office.<br><br>An external university-accredited suppler may be used to transcribe audio recordings. A confidentiality agreement will be in place. |
| 5.2 | CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed | Not Applicable | No comments |
| 5.3 | Compliance with any applicable laws or regulations | Yes | No comments |
| | | | |
| 6.1 | NHS Research Ethics Committee favourable opinion received for applicable studies | Not Applicable | No comments |
| 6.2 | CTIMPS – Clinical Trials Authorisation (CTA) letter received | Not Applicable | No comments |

| | | | |
|---|---|---|---|
| 6.3 | Devices – MHRA notice of no objection received | Not Applicable | No comments |
| 6.4 | Other regulatory approvals and authorisations received | Not Applicable | No comments |

**Participating NHS Organisations in England**

| *This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.* |
|---|
| There is one type of participating NHS organisation in England; therefore, there is only one site type.<br><br>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.<br><br>If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach<br>to information provision. |

**Confirmation of Capacity and Capability**

| *This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.* |
|---|
| Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.<br>• Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix. |

- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

**Principal Investigator Suitability**

| *This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).* |
| --- |
| A Local Collaborator (LC) is expected for this type of study.<br><br>GCP training is not a generic training expectation, in line with the HRA statement on training expectations. |

**HR Good Practice Resource Pack Expectations**

| *This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken* |
| --- |
| Members of the external research team will attend NHS organisations to conduct observations with staff in clinical areas; therefore, a Letter of Access would be expected. The pre-engagement checks should include a standard DBS check and Occupational Health Clearance. |

**Other Information to Aid Study Set-up**

| *This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.* |
| --- |
| • The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio.<br>• Some activity will take place outside the NHS. HRA approval does not cover activity outside the NHS. Before undertaking activity outside the NHS, the research team must follow the procedures and governance arrangements of responsible organisations. |